# AN INSIGHT INTO CROSS CULTURAL COMMUNICATION STRATEGIES IN HEALTH

A Dissertation submitted by

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# ABSTRACT

This research study looked into what strategies were implemented in Aboriginal and Torres Strait Islander Health Services (ATSIHSs) to decrease the communication barriers between health professionals and Aboriginal people.

Historically, the lines of communication between Aboriginal people and health professionals have been misunderstood through mistrust and miscommunication and the need to undertake appropriate cultural awareness and sensitivity training. Miscommunication has and continues to lead to misdiagnosis of health issues that carry severe repercussions for the Aboriginal people with longevity far below that of their non - Aboriginal counterparts.

The data was gathered from four ATSIHSs by holding focus groups in South East Queensland. The research revealed that 17 strategies were successfully implemented by the four ATSIHSs with very good results. Findings and recommendations by way of a report will be disseminated throughout health organisations.

Qualitative research methods were used by utilising interpretivist and constructivists modes followed by thematic analysis. While the sampling area was small and the strategies used were successful in improving communication between health professionals and Aboriginal clients, there is no evidence to suggest that they are being used widely. However, further research is warranted and if the findings show that they are not being utilised their implementation would have the potential to improve communications.

Figure 1. Legends of the Dreaming.
Source: Roberts, A., & Mountford, C. (1975). *Legends of the Dreaming*. Hong Kong: Myer Publications.

# CERTIFICATION OF DISSERTATION

I certify that the substance for this dissertation has not been submitted for any other degree. I further certify that all assistance and all resources used have been acknowledged within this dissertation.

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Signature of Candidate Date

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Signature of Supervisor Date

# ACKNOWLEDGMENTS

I acknowledge the traditional owners of the lands on which this research study took place. I also pay my respects to all Elders past and present throughout Australia.

This dissertation would not have been possible without the cooperation and wealth of knowledge freely given by Goondir Health Service, Carbal Medical Centre, Kalwun Aboriginal and Torres Strait Islander Health Service, and the North Coast Corporation for Community Health. I thank them sincerely for their patience, time, and valuable contribution in revealing the strategies that they implement to decrease the barriers of communication between health professionals and Aboriginal people.

I wish to acknowledge Ainslie Roberts' contribution in way of illustrations in this dissertation. The illustrations have been reproduced, with permission, from Roberts and Mountfords' (1975) book entitled *Legends of the Dreaming*.

Special thanks must go to my principal supervisor Professor Don Gorman who gave me guidance and patiently accorded me the time and space to develop my skills as a researcher. For the support he gave me when my personal life was in a downwards spiral. With his kindness, slightly warped sense of humour, and a great deal of encouragement I was able to continue with my PhD. I need also to express my gratitude for the warmth, patience and time provided to me from my Associate Supervisor Dr. Kaye Price. For her guidance and in-depth knowledge of our peoples. To all those who supported me throughout the University of Southern Queensland (USQ) and especially the staff and other PhD students in the Centre of Rural and Remote Area Health (CRRAH); thank you. My appreciation is also extended to Associate Professor, Dr. John Williams-Mozley and the staff of the Centre for Australian Indigenous Knowledges (CAIK) for their friendship, special hugs when needed, and encouragement.

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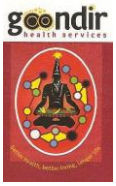

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The purpose of this dissertation is to research what strategies have been implemented to decrease the barriers in communication between Aboriginal peoples and health professionals. However, before this can be done it is necessary to understand what has gone before, as without understanding the past one cannot adequately cope with the present nor can one predict the future.

Colonisation of this country had a profound impact on Aboriginal people which is still evident in the issues that they face today (Fletcher, 2007). Differences in culture and the problems faced by Aboriginal peoples and the dominant society will be demonstrated throughout this dissertation. Poor health is one of the major problems faced by Aboriginal people. The gap in longevity is between 17 and 20 years in comparison to their dominant culture counterparts (Batumbil & Guyulun, 2009).

In contemporary society, and specifically in the health arena, there is an effort to try to ameliorate the health of Aboriginal peoples by formulating strategies that will improve communication (Trudgen, 2000). This research has endeavoured to reveal what strategies have been implemented to reduce the barriers of communication between health professionals and their Aboriginal clients. The research was undertaken by holding focus groups of four Aboriginal and Torres Strait Islander Health Services (ATSIHSs) in diverse areas of South East Queensland. The focus groups namely Emu (ten participants including one male), Goanna, (nine participants including three males). Emu and Goanna AHSs were represented by Aboriginal health professionals and workers as well as non-Aboriginal health professionals. Koala and Possum AHSs consisted of three Aboriginal participants each including one male. The focus groups which were driven by the participants held discussions on what strategies they implemented to prevent on-going miscommunication and to improve communication between their clients and health professionals. A literature review also embarked on an attempt to discover what strategies have already been undertaken on this subject and whether

they have been successful or not. It was decided that the most appropriate methodology for this research is a qualitative method which would include interpretivist and constructivist methods followed by thematic analysis. Data gathered from focus groups will be validated by them once the research is completed Each focus group consisted of the following numbers ages, and genders.

- Emu ATSIHS One Aboriginal male. Two non- Aboriginal women and six Aboriginal women. All were adults of all ages.
- GoannaATSIHS: Two Aboriginal mature aged men and one non-Aboriginal mature aged male. Three non-Aboriginal adult women and four Aboriginal adult women
- Kaola ATSIHS: One Aboriginal adult male and two Aboriginal adult females.
- Possum ATSIHS One Aboriginal adult male and two Aboriginal adult females.

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## 1.1 Literature Review

While searching through the literature the researcher discovered that some health strategies were formulated and implemented in an effort to reduce the barriers in communicating with Aboriginal peoples. Extensive searches and reading demonstrated that it was possible there were many more strategies in use than the researcher was able to discover. It appeared there was no coordinated approach to health strategies or wide publication of those strategies.

The theory in the researcher's mind was that a qualitative study into health strategies and the collating of those strategies into a manual could provide significant improvement not only in communication but in the health status of Aboriginal peoples. One of the major aspects of undertaking this research was that the researcher obtained at the end of the study a better understanding of strategies that have been demonstrated to improve or effectively enhance the communication between medical services and Aboriginal peoples.

The dissertation will describe that the beginning of the ATSIHS started back in the year of 1971 with the establishment of an Aboriginal Medical Service (AMS) in Redfern, Sydney. The Redfern AMS was founded before the Alma Ata Charter was declared and well before the Ottawa Declaration (Redfern Aboriginal Medical Service, 1991). Australian Aboriginal people were leaders in providing health care and better communication for Australian Aboriginal and Torres Strait Islander people. Since that time other ATSIHSs have sprung up throughout Australia. The National Aboriginal Community Controlled Health Organisation (NACCHO) has also been established, but not all ATSIHSs have membership with them which does not in any way diminish their capabilities or reduce the quality of service that they render.

The researcher discovered during the literature review that colonisation had and is still having an impact on the health and well-being of Aboriginal peoples. Much of their culture has been diminished and miscommunication is a major contributor for this and many other issues that Australian Aboriginal people are confronted with today (Jackson & Ward, 1999; Dudgeon, Garvey, & Pickett, 2000; Fletcher, 2007). It is important to review briefly the topics of colonisation and culture of Aboriginal peoples which may assist the reader in understanding why and how barriers of communication between the dominant society and Aboriginal peoples occurred. Examples of strategies are also depicted in an attempt to

demonstrate that health strategies may assist in better health for Aboriginal peoples as well as ameliorated communication between the two groups.

### 1.2 Colonisation

To understand the health and social issues that affect Aboriginal peoples today, it is important to understand the impact of colonisation. Colonisation was and still is a process that has had a devastating impact on the physical, spiritual, social, and cultural well-being of the many different original Australian societies (approximately 500 language groups at the start of colonisation). Prior to colonisation, Aboriginal peoples had remained relatively isolated for between 40,000 and 70,000 years and perhaps even longer (Jackson & Ward, 1999; Dudgeon, Garvey, & Pickett, 2000; Holmes, Stewart, Garrow, Anderson & Thorpe, 2002).

This country was colonised on the legal fiction of *terra nullius,* a Latin term meaning *vacant land*. From the time of the invasion, Aboriginal peoples were not acknowledged nor were their cultural heritages recognised. Their spiritual beliefs and traditional ways of hunting and gathering, their complex kinship system, as well as ceremonial practices were ignored. They were forced onto reserves, often being unable to communicate with each other as they had come from different *countries* each with its own culture, language, and or dialect (Holmes, Stewart, Garrow, Anderson & Thorpe, 2002). In some other places, such as New Zealand and Canada, where indigenous peoples have been colonised there was recognition by way of a treaty. According to Jackson and Ward (1999) this was not the case in Australia. The *settlers* recognised in 1820 that a treaty might have been of value to the relationship in that it might have reduced the violence, deprivation, loss of identity, and other problems that Aboriginal peoples were suffering. Jackson and Ward state that it is debatable whether a treaty at the time of colonisation would have changed the lives for the better for Aboriginal Australians, although they comment that the absence of a treaty with Aboriginal peoples is causally associated with poor health and social disadvantage.

We are all influenced by our history. Our present situation, our motivation, and our outlook are strongly influenced by the past. Without an understanding of what has gone before, we are prone to misunderstand the reasons why people think and behave as they do. In the case of Aboriginal peoples the historical influences on their present situation have continued to pervade their lives (Holmes, Stewart, Garrow, Anderson & Thorpe, 2002). The majority of people are familiar with the

Stolen Generations and the on-going debate on Land Rights however; too few people understand the relevance of historical processes to the lives of Australian Aboriginal peoples. A history of dispossession, oppression, racism, and barriers to communication has been instrumental in shaping their lives and their lack of opportunities for longevity and good health (Partington, 1998). It may be further argued that if the dominant society were to make a greater effort to acknowledge and learn about Aboriginal culture/s, that communication between the cultures would improve and this could lead to better heath for Aboriginal Australians (Dudgeon, Garvey, & Pickett, 2000).

### 1.3 Culture

It is important also to understand that there exists a wide range of diversity amongst Aboriginal Australians, just as there is among non-Aboriginal peoples. Across Australia, differences exist in relationships, links with the land, languages, occupations, class, gender and more (Dudgeon, Garvey, & Pickett, 2000; Holmes, Stewart, Garrow, Anderson & Thorpe, 2002). It is debated that while the media portrays Australian Aboriginal peoples as one people who are similar in many respects, socially and culturally there is great diversity among them (Bain, 1992). Partington (1998) also maintains that there is no such thing as a "representative Aboriginal" except perhaps in disadvantage. As such, they appear to share the worst housing conditions, education, and health as well as a shorter life span than other Australians. Partington argues that much of this can be blamed on the communication barriers that exist between Aboriginal peoples and non-Aboriginal people, especially health workers and educators.

Effective communication is essential in all human activity (Gallios, Ogay & Giles, 2005). As an Aboriginal woman who has associated with diverse Aboriginal language groups, this researcher has witnessed that they sometimes speak their own specific languages with each other. Children generally learn their mother's language first, progressing to their father's language as they grow. English, when learnt, becomes their third or sometimes fourth language. Baildon and Bourke (2003) comment that even then the language is Aboriginal English, which is quite different than that of Standard Australian English (SAE) spoken by the dominant culture.

It is theorised by Gallois, Ogay, and Giles (2005) that communication barriers between the dominant society and Australian Aboriginal peoples are extensively acknowledged as a significant impediment to efficient access to, and transmission of,

all services, including health. The implications of miscommunication in health care are potentially life threatening and costly (Kemp, 2001). Nevertheless, there is minimal literature and or information focussed on communication between the dominant society and Aboriginal peoples in the area of health. This research is intended to discover what the staff of the four ATSIHSs do to improve these issues.

### 1.4 Miscommunication

The literature review revealed that there have been singular studies undertaken on communicating more effectively with Aboriginal people and on trying to improve health, particularly in the field of coronary care and renal disease, as well as the training and use of Aboriginal Health Workers (AHWs). Some of these were successful up to a point and others failed completely due to the inability to understand the culture and the language spoken by the Aboriginal people that the researchers were attempting to interview.

Communication for Aboriginal peoples tends to take on a different mode. When something of importance arises and requires discussion they prefer to sit together and *yarn*. Aboriginal people may sit in a *yarning circle* and while *yarning up* discuss an array of topics before broaching the major subject that requires discussion. Even then, it could take some time, a day, a week or more before a decision is made on the subject (Robertson, Demosthenous & Demosthenous, 2005). According to Gallois, Ogay and Giles (2005) it is vital when undertaking research that the researcher must, when seeking knowledge from Aboriginal people, put the people first and the information will follow. If this is correct, then it could be argued that this also applies to health professionals when dealing with Aboriginal peoples during a consultation (Pyett, Waples-Crowe, & Van der Sterren, 2009). This dissertation describes that the ATSIHS staff understood that and implemented strategies such as providing transport for clients and yarning during the travel time. It is also demonstrated that yarning takes place during other consultations and places and is outlined in this dissertation.

### 1.5 Themes Identified

The data gathered from the four ATSIHSs disclosed that the 17 themes that emerged were on the whole replicated by each group, even if the method of doing so was individually different. Each participant group is coded with an Australian native animal name representing the health service. The animals do not have anything to do with totems or totemic sites but are simply a coding device. Represented by this

animal code are; Emu, Goanna, Koala, and Possum. The major strategy utilised was that of community control and community engagement. This allowed the Aboriginal community to have a voice in their own health care needs and what programs they would like implemented to improve their communication with health professionals.

It is vital that the reader realise that the Aboriginal clients may have come from diverse countries where their language could be different from that of the staff in the ATSIHS. To overcome the difference in language the staff of the ASTIHS realised that most, if not all, Aboriginal people were able to speak some form of English. Therefore, they adopted the strategy of speaking plain simple language instead of using medical terms or complex English. There are also a number of strategies outlined in the following chapters to overcome the difficulty of communication. One of these strategies was to employ AHWs and put in place employment capacity building programs that enabled all health professionals to upgrade their skills. The following chapters describe other significant strategies implemented by the four ATSIHSs to overcome the problem of miscommunication between health professionals and Aboriginal people.

### 1.6 Brief Chapter Overview

CHAPTER TWO: Literature Review

Chapter two journeys through a literature review to discover whether past strategies were implemented and whether these strategies were successful in decreasing the barrier in communication between health professionals and Aboriginal clients.

CHAPTER THREE: Methodology

The methodology chapter explains that a qualitative methodology was undertaken in this research with the tools of interpretivist and constructivist methods, the limitations of this research, recruitment of ATSIHSs, and their staff. It also gives the reason for adopting thematic analysis and how the research would be validated.

CHAPTER FOUR: Results

This chapter talks about the thematic analysis of data collected from four focus groups in South East Queensland ATSIHSs and Aboriginal Community Controlled Health Services (ACCHSs). Seventeen themes that emerged were on the whole, replicated by each group even if the method of doing so was individually different. To clarify which group provided the information a code has been devised so that there can be no confusion for the reader.

CHAPTER FIVE: Theme Discussion

This chapter holds an in depth discussion on what methods the ATSIHSs used to create strategies to improve the communication between themselves and Aboriginal clients.

CHAPTER SIX: Conclusion

The concluding chapter will summarise what has been written in this dissertation including the findings of the research with some recommendations. Other recommendations will be listed in a report (refer Appendix A) with the intent of disseminating it to both State and Commonwealth Governments, NACCHO, Queensland Aboriginal and Torres Strait Islander Health Council (QATSIHC), GP Connections and the newly founded general practice organisation titled Medicare Locals.

**Generalisations**

Within the dissertation references are made to Elders, dominant culture, the importance of services catering for the needs of Aboriginal staff during "Sorry Time among similar terminology. It is accepted that these terms are general however; in this author's view these terms represent the vast majority referred to in the dissertation.

**Participants**

The participants within the four focus groups included both genders, of all adult ages. The participants were both Aboriginal and non-Aboriginal and chose to participate in the research collectively. All focus groups presented excellent rapport with each other and displayed outstanding teamwork.

# CHAPTER TWO

## 2. Literature Review

Figure 3. Legends of the Dreaming.
Source: Roberts, A., & Mountford, C. (1975). Legends of the Dreaming. Hong Kong: Myer Publications.

This chapter is concerned with reviewing the literature as the basis for constructing an overview of how health professionals deal with communication barriers between themselves and their Aboriginal clients. The constructed overview provides insights to the practical realities of the steps taken by health professionals to achieve these goals. The data sourced from the literature review were perspectives of Aboriginal health professionals and workers as well as non- Aboriginal health professionals and researchers. The literature review is written in the following nine sections:

- Miscommunication, which is claimed to be the product of inadequate and misdiagnosed illness in our nation's Aboriginal people;
- An historical background, to provide the reader with an holistic sense of why Aboriginal Medical Services (AMSs) and that of Aboriginal Community Controlled Health Services (ACCHSs) were established, primary health care and community controlled health services;
- Communication;
- Language;
- Strategies in interaction and communication;
- An apathetic approach to Aboriginal knowledge and values;
- Understanding shame;
- Building relationships; and
- Yarning

Together these nine categories enlighten the reader as to why and how strategies are needed and implemented to improve communication between health professionals and Aboriginal people.

### 2.1 Miscommunication

It is widely recognised that communication between different cultures is quite taxing. For example, the National Aboriginal Health Strategy (1989) stated that the ramification for miscommunication can and does impede diagnostic accuracy and

possible quality of care. For example, Devitt and McMasters (1998) write that "communication or more precisely, the lack of communication emerged from our study as a core issue for Aboriginal renal patients" (p. 139). They went on to say that in a number of cases cultural protocol was ignored and communication impeded accurate diagnosis of renal disease (Devitt & MacMasters, 1998). Yet again it is recorded in Trudgen (2000) that lack of effective communication causes serious problems for health professionals within the dominant culture to diagnose Aboriginal patients' complaints in the usual question and answer technique. Added to this the problem of inaccurate diagnosis arises. This can be in the form of preventing the health professionals from developing effective programs in a culturally sensitive and appropriate manner and evaluating the programs to ensure accurate diagnoses. It is also noted by Trudgen that miscommunication impedes correct information of the patient's complaint which can be life threatening and prevents health professionals from obtaining proper consent before carrying out surgery on the patient.

Wrongly diagnosing a patient's illness is demonstrated in Trudgen (2000) when he tells of a patient that complained of severe headaches. The doctor in this case was about to treat the patient for hookworm when Trudgen asked "how would hookworm cause splitting headaches?", "What headaches?" was the Doctor's reply (p. 74). As Trudgen explains it, the misdiagnosis was not only just one of miscommunication between patient and doctor but also in the notes sent to the hospital by the nurse in the community from whence the woman came. According to Trudgen the nurse indicated that the woman was suffering severe pain "…that could not be located" (p. 74). The doctor treated the patient for pain in the abdominal region (Trudgen, 2000). Trudgen also claims that in his twenty years' experience of Aboriginal health matters, there have not been any doctors, particularly in Northern Territory, who have the linguistic expertise to be able to make a consistently correct and accurate diagnosis of an Aboriginal patient's health issue.

The theory of misdiagnosis mainly through the lack of ineffective communication is supported by Devitt et al. (2008) in relation to renal disease diagnosis. They state that miscommunication causing misdiagnosis can lead to the requirement of a kidney transplant which rarely occurs and ends in the death of the patient. The misunderstanding of how and when to medicate is also a serious issue that arises in miscommunication and sometimes misdiagnosis of a patient's

complaint (Franks, 2006). Miscommunication did not just happen there is a history behind this phenomenon which is outlined in the following historical background.


Figure 4. What the Doc say?
Source: Cartoon hand drawn by V. Close

## 2.2 Historical Background

### Aboriginal Medical Services: The Beginning

Dawson (2004) relates an anecdote wherein members of the New South Wales Aboriginal Legal Service (ALS) became aware of mitigating circumstances in relation to Aboriginal people accessing mainstream health services. In 1971, during the course of visiting an Aboriginal family, the ALS became aware that critically ill members of the community were not being cared for appropriately. This would appear to be the catalyst for the introduction of Aboriginal health services, as according to Briscoe (1974) "... no universal health care scheme existed in Australia at that time" (p. 167).

Appalled at the health status of Aboriginal peoples in NSW, Gordon Briscoe and Shirley Smith (known to Aboriginal people as Aunty Shirl) considered the best strategy was to call a general meeting of Aboriginal people and mainstream empathisers. The outcome of this meeting resulted in Briscoe, Smith, Paul Coe, Dulcie Flowers, Fred Hollows, Ross McKenna and John Russel putting forward a motion to establish an Aboriginal health service run in similar lines to that of the Aboriginal Legal Service (Human Rights and Equal Opportunity Commission, 2005). This group of mainstream people and Aboriginal Elders applied for a government grant to establish the first Aboriginal controlled medical service in Australia, which was established in a shopfront in Regent Street Redfern, Sydney. While the centre was run by the Aboriginal community, mainstream health professionals donated their time and expertise to ensure the success of the service (Briscoe, 1974).

The strategy first undertaken by Briscoe and Smith in 1971 demonstrated that Aboriginal communities needed to be involved in delivering healthcare to their own people (Dawson, 2004; Jones, 2006). Apart from the focus on health, this strategy was instrumental in improving communication between Aboriginal people and mainstream society in 1971 (Stewart, 1995). The outcome of communication between concerned citizens from the dominant society and Aboriginal people who attended the meeting resulted in the Redfern AMS. Foley (2000) maintains that this action inspired Aboriginal communities nation-wide to establish their own medical services.

The fore mentioned strategy undertaken in 1971 by Briscoe and Smith has been supported by Taylor and Guerin (2010). They commented that given the

historical dereliction of medical services to deliver adequate healthcare to Aboriginal people it was not by any means a revelation that fresh and innovative methods were developed (Taylor & Guerin, 2010). The authors draw attention to the current growth of Aboriginal controlled health services. In their view Taylor and Guerin assert in the past it appeared that the only authentic means of ensuring access and acceptability was to effectively segregate services. The authors argue that while this method was adopted in the past, the reasons for this action were very different than those of today (Taylor & Guerin, 2010). Taylor and Guerin claim that segregation of Aboriginal and non-Aboriginal healthcare services were a government-sanctioned policy that had very little benevolence in its intent, specifically the miscommunication that contributed to the poor health status of Aboriginal people. The authors draw attention to the establishment of the Redfern AMS which was born from an era of self-reliance and self-determination (Taylor & Guerin, 2010). The following statement from Aboriginal spokespersons is evidence that a realisation of an Aboriginal and Torres Strait Islander Health Service (ATSIHS) is necessary if communication and the health of Aboriginal Australians are to be improved.

> *Until our right to run our own health services under our own control is recognised in principle and supported in practice by Australian non-Aboriginal government, our health will not improve (Central Australian Aboriginal Congress, 2009, p. 72)*

The National Aboriginal Community Controlled Health Organisation (NACCHO) defines an ATSIHS as a health service funded foremost to offer medical services to Aboriginal and Torres Strait Islander people. It further states that an ATSIHS is not necessarily community controlled while an Aboriginal Controlled Health Service (ACHS) is a primary health care service initiated and operated by local Aboriginal communities. NACCHO espouses that this provides for better communication strategies to be formulated, delivering a comprehensive, holistic, and culturally appropriate health care by Aboriginal peoples for Aboriginal peoples (NACCHO, 2008).

The format set by NACCHO was replicated when the *Thirtieth World Health Assembly*, held in 1977, highlighted the significance of promoting health so that all international citizens had a reasonable effectual standard of health by the year 2000 (Lloyd, 2009). Further, a regional European taskforce worked together to formulate a strategy for health promotion in the World Health Organisation (WHO) European

Region. Health action areas identified in the charter were to formulate public policies, provide sustainable environments and enhance community progress (WHO, 1986; Lloyd, 2009). This aligns with the format set by NACCHO.

Saggers and Gray (1991) maintain that Australia took initiatives to improve the health of Aboriginal peoples as far back as the 1960s and 1970s, which set an initiative for other countries to replicate. Following the establishment of the Redfern AMS, similar services were formed in Fitzroy in 1973 (Nathan, 1980) and in Perth in 1974 (Reid, 1978). The strategy to establish ATSIHSs controlled by Aboriginal people with the assistance from health professionals from the dominant society started well before the Ottawa Charter was launched in 1986 (Saggers & Gray, 1991). This view is expanded in the authors' later work which describes the Alma Ata Declaration (Saggers & Gray, 2007).

Saggers and Gray (2007) indicate that international representatives at the *International Conference on Primary Health Care* in 1978 voiced the compelling need for urgent attention by all governments, health and development professionals, and the world community to further advance the health of all the people of the world. Under the WHO director, Mahler of Denmark (1973-88), the goal of "Health for All" was proposed and was formally articulated in the 1978 WHO-UNICEF Alma-Ata Declaration (refer Appendix B). The Alma-Ata Declaration proclaimed health as an integral human right and called for a reconstruction of conventional health care systems and for broad intersectional cooperation and community organising (WHO-UNICEF, 1978).

**Primary Healthcare and Community Controlled Health Services**

The definition of primary health care embraced by the National Health Strategy Working Party in 1989 originated from the WHO Alma-Ata definition (Bell et al., 2000). This is supported by Dollard, Stewart, Fuller, and Blue's (2001) interpretation of primary health care as depicted in the Alma-Ata as fundamental healthcare that it is founded on "…community control that enables the delivery of practical, integrated, culturally appropriate health care" (p. 125). They record all-encompassing health care, including technology, that is made accessible to all individuals and families in the communities in which they live.

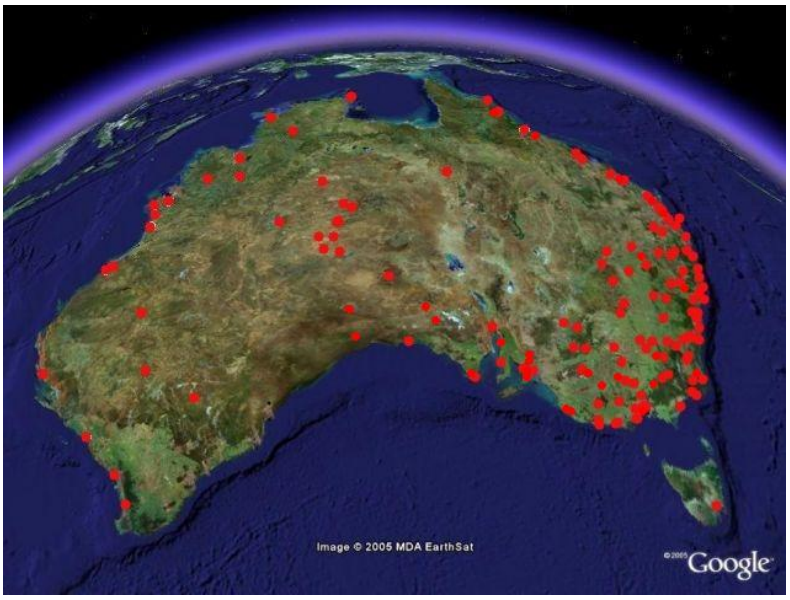


Figure 5. Map of Australia depicting NACCHO members 2007
Source: http://www.naccho.org.au/aboutus/sector.html

This strategy of provision of healthcare must involve the full participation at every stage of development by people from all over the world, including Aboriginal Australians, in the spirit of self-reliance and self-determination (Bell et al., 2000).

Sumner-Dodd (2001) supports this definition but adds that community control means that in Australia, Aboriginal peoples must have control of issues that directly impact on their health and community. The author emphasises that Aboriginal peoples must establish and control the momentum, order, and mode of change and decision making at community, regional, state, and national levels (Sumner-Dodd, 2001).

Sumner-Dodd (2001) and Bell et al. (2000) concur that community control business of health, specifically in the transmittal of primary health care, is an embedded international principle that produces the foundation for the delivery of pertinent and satisfactory health care. However, Couzos (2004) contradicts this theory by stating that there is no quick medical cure to Aboriginal health, and never will be, until mainstream Australians learn to collaborate, communicate, and create partnerships with Aboriginal people and their communities.

Dr Michael Wooldridge (2002), as Commonwealth Minister for Health when addressing the *Australian Health Ministers Advisory Council* stated that "our single most spectacular failure as a nation has been in the area of Aboriginal and Torres Strait Islander Health" (p. 17). According to Thomson (2003) the first sign of Governments acknowledging and addressing the disastrous health status of

Aboriginal peoples nationally occurred in 1968 when the newly established Office of Aboriginal Affairs identified health as one of the major areas for Aboriginal development, yet few attempts were made to correct this problem until 1987 (Australian National Audit Office, 1998).

It is recorded that in 1989 the National Aboriginal Health Strategy Working Party (NAHSWP) recommendations were endorsed by ministers in 1990 but little communication flowed between the two entities and therefore was never effectively implemented (NAHSWP, 1989). Couzos (2004) asserts that the solution really lies in Aboriginal people being allowed to experience self-determination. He further states that governments also need to play a more effective role in bridging the gap by implementing better policies and providing efficient funding (Couzos, 2004).

**Policies and Recommendations**

The essentialness of attaining efficient communication between non-Aboriginal and Aboriginal people is acknowledged in a plethora of policies and reports related to healthcare in the Australian context. In 1991, after an extensive enquiry, the Royal Commission into Aboriginal Deaths in Custody made 339 recommendations. The report found many examples of deaths in custody that could have been prevented had custodians been better trained. In particular, Recommendation 247 states that:

> *Effective communication between non-Aboriginal health professionals and patients in the mainstream services is essential for the successful management of the patient's health problems. Non-Aboriginal staff should receive special training to sensitise them to the communication barriers most likely to interfere with the optimal health professional/patient relationship (Johnston, 1991, Recommendation 247)*

Eldridge (2011) explained that the Queensland Aboriginal and Islander Health Forum (QAIHF) was established in 1990 and reconstituted in 2004 as the Queensland Aboriginal and Islander Health Council (QAIHC). According to Eldridge, QAIHC is the state peak body representing the Community Controlled Health Sector in Queensland at both state and national level. Its membership comprises 21 Community Controlled Health Services (CCHSs) located throughout Queensland. Nationally, QAIHC represents the Community Controlled Health Sector through its affiliation and membership on the board of the NACCHO. Eldridge (2011) stated that QAIHC developed the new NACCHO strategy *Cross-Cultural Awareness Training* program. The training program, which includes

communicating effectively with Aboriginal patients, their kin, and carers, is delivered to all new doctors and interns (Elridge, 2011).

Coordination at a state level is achieved through the Queensland Aboriginal and Islander Partnership formed under the Queensland Agreement on Aboriginal and Torres Strait Islander Health. The forming of this partnership was an attempt to improve Indigenous health through cultural awareness training which includes communication between health professionals and Aboriginal peoples (Doumany, 2004). Doumany (2004) emphasised that a new strategy is currently being developed by NACCHO's Cultural Safety Training Standards Committee which consists of representatives from the Aboriginal Community Controlled Health service sector. Eldridge (2011) maintains that the reason for the new initiative by NACCHO is that the organisation believes that health care services and providers that are not Aboriginal community controlled by definition cannot deliver appropriate primary health care.

Nevertheless, Eldridge (2011) argues that services that are not Aboriginal community controlled can be fostered to convey health care that is culturally safe and respectful. This strategy can only lead to improved communication between Aboriginal people and health professionals. Eldridge also claims that while this is not the only strategy, a high quality and culturally informed safety training is one strategy by which health care services can achieve this. Eldridge also proposes that there are no current health programs that cover efficient cross-cultural training.

Nevertheless the Department of Foreign Affairs and Trade (About Australia, 2008) insists that there is a provision of up to-date programs for health professionals both in government controlled institutions, and ATSIHSs. This author determined that programs were formulated by the University Department of Rural Health and the Greater Green Triangle (GGT - UDRH) Mental Health project (About Australia, 2008). The programs which include Aboriginal cultural awareness training and Aboriginal mental health training were funded via the Australian Government Department of Health and Aging and runs in collaboration with local Aboriginal communities. The program's objective is to assist health professionals and health students in realising what they may undertake as individuals to make a difference to the health and well-being of Aboriginal people (About Australia, 2008). The Department of Foreign Affairs and Trade (About Australia, 2008) explain that the

mental health program discloses a need for improved management of mental health issues.

Understanding of Aboriginal cultures must be the first step in the training of non-Aboriginal staff who are caring for the health needs of Aboriginal peoples. It is the forerunner to competent and effective communication at every level, from control of service planning and development, to clinical interactions and the design and delivery of educational programs (Brennan, 1979; Christie & Harris, 1985; Lowell & Devlin, 1998; Freemantle, Officer, McAullay, & Anderson, 2007; Mayo & Tsey, 2009). These type of programs can only improve the way the dominant society communicates with Aboriginal people and require better funding provided by governments to meet this end (Mayo &Tsey, 2009).

**State and Commonwealth Governments and Funding**

Thomson (2003) states it was not until 1994 that the Australian National Audit Office Audit (ANAO) fully funded the NAHSWP. Nevertheless it is the 1989 NAHS that remains a landmark due to the comprehensive and inclusive communication and consultation process and is extensively owned by Aboriginal and Torres Strait Islander peoples (National Aboriginal and Islander Health Council, 2003). This national process was achievable because of the existence of a national network, which was initiated in 1971, of Aboriginal Community Controlled Services (ACCHSs). The majority of ACCHSs, which are in principle healthcare services, were inaugurated by local Aboriginal people within their specific communities. The strategy was to communicate and deliver holistic and culturally suitable care within their specific communities. This strategy was implemented due to Aboriginal people not trusting that mainstream services would respond to their health requirements because of the evidence of years of neglect, miscommunication, and lack of communication in this area (House of Representatives Standing Committee on Family and Community Affairs, 2000).

In 2003 a decision was made by State, Commonwealth, and Territory ministers that the then current health status of Aboriginal peoples needed to be addressed in a positive way. Patterson, Iemma, Eberly, Dingy, and Hargreaves (2003) asserts that the ministers pledged to participate in a "long term collaborative approach to address the health of Australia's Aboriginal peoples as a dire matter of urgency. It is time… to work together across governments and across portfolios in a

spirit of bi- partisan, involving governments and oppositions and will be supported by the Australian public" (p. 30).

## 2.3 Communication

Efficient communication is broadly identified as vital to achieving a significant requirement of healthcare (Liberman, 1990; Partington, 1998; Nutbeam, 2000). Comprehensive research has been undertaken in overseas countries where there are Aboriginal people specifically in the doctor-patient communication where different languages play a major role and understanding of these languages and cultures aid in the amelioration of their overall health status (Ong, de Haes, Hoos, & Lammes, 1995; Nutbeam, 2000).

Stewart (1995) claims that the study into effective doctor patient communication and health outcomes has demonstrated a distinct relationship between competent communication and improved health outcomes such as emotional health, determination of symptoms, pain management, and physiological dimensions such as blood sugar and blood pressure accumulation.

### Non-Verbal Communication by Aboriginal People

In face to face communication, a substantial ratio of what is disclosed consists of paralinguistic or non-verbal communication. Tone of voice, facial expression, body language, eye contact or lack of it as well as eye movement, gesticulation, and postures are all consequentially influential elements of communication. In fact any or all of those elements may communicate the true nature of the interaction more precisely than do the words spoken (Braysich, 1979). Similarly, the way in which people make contact with each other conveys a powerful message (Eades, 1992; Edis, 2000).

Forms of non-verbal communication are diverse and are construed differently in diversified cultures. According to Edis (2000) non-verbal communication has a power to affect the direction of trial proceedings to a great degree. This view was also put forward by Eades (1991; 1996; 2001).

### Listening: An Effective Technique in Communicating

Fredericks (2003) determines that in the health sector, as in other areas such as housing, policing, education, social and human services, cross cultural awareness training has been acknowledged as the best way to improve communication between health professionals and Aboriginal patients as well as gaining cultural knowledge and understanding of Australia's Indigenous peoples. However McKendrick (1998)

takes another view on how to communicate. McKendrick believes that if health professionals are to learn how to communicate with Aboriginal people they must first learn how to listen. McKendrik (1998), who has worked extensively in the field of mental health, asserts that if health professionals and students are to:

> *...learn how to work with Aboriginal people; to treat Aboriginal people, they must be able to listen to what they have to say. If we are serious about teaching of Aboriginal health we must listen to what Aboriginal experts say (p. 737)*

Fredericks (2003) supports McKendrick's views with her statement that fundamental respect demands a set of principles from which listening can take place. It is important to note that Fredericks consulted and listened intently to Aboriginal women in Central Queensland as well as having discussions with other researchers in the field of Aboriginal health, communication, and language. Fredericks demonstrated that Aboriginal women in the Rockhampton region were seen as central to cross cultural training of health professionals. The interviews carried out by Fredericks and her colleagues drew on Aboriginal women's experiences with health professionals which presented a powerful insight to their lives and their views on cross-cultural training of health professionals (Fredericks, 2003; Freemantle, Officer, McAullay, & Anderson, 2007; NACCHO, 2008).

The researchers consulted by Fredericks (2003) agreed that Aboriginal women played a strong contributing role in which the women were able to place the focus on *poor talk* (yarning or communication) which hampered healthy relationship building. The researchers asserted that this was perhaps the main cause of Aboriginal families not wanting to consult health professionals and specifically the doctor who was not from their culture (Reinharz, 1992; Burt & Code, 1995; McKendrick, 1998; Oakley, 2000; Ramanazoglu, 2002).

### 2.4 Language

Achieving effective communication is hindered by issues and difficulties when disparities between linguistic environments of the service providers and the users vary from slight to advanced (Edis, 2000). Edis (2000) asserts that for many Australian Aboriginal people, English is a second, third, fourth, or even fifth language which presents enormous difficulties in trying to understand health professionals that come from another culture. Their way of living, their culture,

socialisation, and ideology may have very little in common with the service providers.


Figure 6. Map of Aboriginal Australia
Source: http://www.healthinfonet.ecu.edu.au/map-aboriginal-australia

Aboriginal people, many of whom may live in urban communities, may use a type of English as their first language but even this can result in serious miscommunication. These views are supported by Dollard, Stewart, Fuller, and Blue (2001) and Baum (2004). For example, some Aboriginal people speak Aboriginal English of which sentences and meanings of words may be very different than that of the dominant society (Oxfam Australia, 2009).

A study undertaken by Ong, de Haes, Hoos, and Lammes (1995) demonstrates when health care professionals do not speak or understand the language of diverse cultures such as the Inuit, American Indian, Aboriginal Australians, and Hispanics in the United States, patient care and clinical outcomes suffer. In support of this statement Stewart (1995), who carried out a systematic review over 25 years, found that effective communication between doctor and patients is a pivotal clinical activity that cannot be passed on to another healthcare professional or worker.

The studies reviewed were conducted in diverse medical clinics and the results are intrinsic to all health professionals, but specifically to doctors in all areas

of practice. Data sources also included retrieving articles on medical history taking, doctor-patient relations, communication, consumer satisfaction, and health care outcomes (Stewart, 1995). The outcome of this study demonstrates that effective communication between doctor and patient as well as healthcare professionals is imperative to improving the health of all patients, but specifically to those of another culture.

Ineffective communication or miscommunications are reported by Aboumatar (2009) as the fundamental cause for 65% of problems reported to the *Joint Commission* (Refer Definition p128). Team-work and communication issues end up in increased morbidity, prolonged hospitalisation, rising healthcare costs, reduced patient satisfaction, and diminishing employee retention. Teamwork and communication challenges in healthcare have been attributed to multiple reasons including the complexity of patient surgery, the hierarchal structure in healthcare, lack of cultural and inter professional training, inappropriate communication skills and so on (Parker, 2001; Paterson, 2001; Aboumatar, 2009).

**Which Way to Talk**

In her 1991 research depicting communication in Aboriginal English, Eades explains that when conversing with Aboriginal people it is usually considered impolite to directly refute or to respond negatively, particularly in encounters of unequal power or when the participants do not have a close relationship. As a result of their study into how to improve communication between Aboriginal people and their healthcare professionals Cass et al. (2002) established that the patients in their research responded to questions by the researchers with answers that the patients thought the researchers wanted to hear. The authors affirm that this is known in linguistics as "gratuitous occurrence". Triangulation demonstrated that this type of response did not denote the patients' factual experience or feelings but instead were efforts to provide correct responses as in the following example.

| | |
|---|---|
| *Physician:* | How much water are you drinking? How much water? |
| *Patient:* | Little bit water tea, little bit ga bilin [that's it] |
| *Physician:* | How much each day? Water, tea? |
| *Patient:* | Three cup, two cup, little bit [said very confidently] (Eades, 1996, p. 94; Cass et al., 2002, p. 466.) |

The researchers report that the physician believed that the patient understood what he had asked and was describing the amount of daily fluid intake; however it was later revealed that the patient had given this response because she thought that was what the doctor expected of her. The understanding that patient had on fluid restriction was that she should only drink two cups of carbonated fluid daily, but that drinking as much tea and water as she wanted was all right (Eades, 1996; 2001; Cass et al., 2002). Eades also comments that asking closed questions requiring a yes or no response was particularly prone to gratuitous occurrence as one nurse exclaimed, "I never even thought that they may be saying 'yo' [yes] when they are really saying 'no'. I never even thought of it" (Cass et al., 2002 p.470).

Language is often the first point of self-identification or of identification of others, and is the most patent form of communication. The power of language is not to be underestimated, we have to remember that when speaking either directly or in directly to someone is interacting with them (Ashworth, 1994).

The socio–cultural context of what has been spoken or penned must be understood as plainly as are the precise meaning of words and grammatical interpretations. Distinct cultural groups have dissimilar attitudes towards matters such as the use of names and titles, recognition, and leave taking as well as paying their respects to authority and seniority. Significant differences may be in the way eye contact is used or the complete non-use of eye contact. Silence and physical touch is a matter for consideration as these can be interpreted in the wrong way if the meanings of these actions are not known or identified by the dominant culture. Australian Aboriginal peoples and perhaps in other cultures modesty and shyness is a characteristic as is *shaming* or *shame* when translated, could be defined as embarrassment (Foley, 2000).

**An Experience in Research**

Eades (1982) responded to a request from Michael Williams, an Aboriginal man from the Gooreng Gooreng people of South-East Queensland, to assist him in undertaking research. The research focussed on the social history, language, and culture of his people. Eades' characterises the people in the research as South East Queensland Aborigines [*sic*] (SEQAB), people who identify as Aboriginal and whose country(refer is in South East Queensland. Eades (1982) sets an example of problems in communicating with Aboriginal people whose language and dialect

depend on what country (Refer Definitions p.127)they come from. (Or language group for example; Wiradjuri country; refer map p.22.).

Eades (1982) records that her research related to seeking information from the Gooreng Gooreng people and other Australian Aboriginal peoples from South East Queensland communities. This action, she explains, was a significant aspect of exchange of information between Middleclass White Australian (MCWA)[sic] society and SEQAB[sic]. Eades (1982) said that while MCWA use English to converse and understand each other, the same method is also used in other countries whether the language is English or their own native tongue. Yet conversations in English with or between SEQAB[sic] people rapidly uncovered substantial disparities in the way information exploration takes place and what format it takes. The following excerpt from Eades (1992, p. 94) and Eades (2001, p.103) describes this; albeit in a small way.

> *…in my own experience in trying to question Aborigines I have found, time and again, that they are confused, dysfluent or non-compliant when questioned by means of an interrogative sentence like Were you very young?, the most usual type of question for MCWA speakers. Questions in the form of a declarative with question intonation are more successful, witness such exchanges as (1) and (2):*
>
> (1) *DE:* *Were you very young then?*
> *A:* *Eh?*
> *DE:* *You were very young?*
> *A:* *I was about 14.*
>
> *(2)* *DE:* *Your husband was a Batjala man?*
> *A:* *He was a Batjala.*
> *DE:* *And where was he from, again?*
> *A:* *Beg pardon?*
> *DE:* *He was from further south was he?*
> *A:* *He's, from here, not far from X station.*
>
> *In (2) I was attempting to find out information on A's late husband, which would be relevant to earlier conversations about languages spoken in A's family. I began with the appropriate SEQAB[sic] type questions, hence successfully obtained an answer. I then reverted to the interrogative type, perfectly acceptable in MCWA{sic]conversations, but quite inappropriate here, as evidenced by the response Beg pardon.*

Fredericks (2003) suggests that research into understanding Aboriginal cultures in an attempt to build relationships by decreasing the barriers of communication has improved since Eades undertook her research. However, Fredericks emphasises that there is still much to be learned by health professionals if they are to be instrumental in communicating with and improving the health of

Aboriginal Australians including improved public health policy (Fredericks, 2003; Freemantle, Officer, McAullay, & Anderson, 2007).

Denborough et al. (2006) argues that ACCHSs and their representative organisations has been the province of substantial contention and challenge in endeavours to ameliorate Aboriginal health experiences. It is recorded that the obvious inability of policy and decision makers to listen to well organised voices calling for change from ATSIHSs is being ignored (David, 2007). It is government inability to act more fully on clear and repeated messages of miscommunication within the health sector that is the source of much disquiet within ATSIHSs (Towle, Godolphin, & Alexander, 2006).

This statement is not acknowledged by Fredericks (2003) as she asserts that public health is continuing to direct other types of training and education in an undertaking to include cross cultural awareness training in health curriculum and ATSIHSs throughout the nation. Fredericks' comments are supported within the House of Representatives Standing Committee on Family and Community Affairs Report; *Health is Life: Report on the inquiry into Indigenous Health* (2000) which contains the following recommendation:

> *Within two years all undergraduate and post graduate health science courses should include an effective cross-cultural awareness training component as well as dealing in detail with the current health status of Indigenous Australians and the factors that have contributed to their on-going social and cultural disadvantage. All continuing medical education courses should also expand on these matters and continue to expose health professionals to cross cultural learning (Recommendation NO.29, p. 107)*

**Cross Cultural Training**

It is considered by De and Richardson (2008) that cross-cultural training may only be awareness raising, demonstrating to health professionals how to better communicate with Aboriginal peoples. In some cases it may not have any impact at all on the individual participants. De and Richardson maintain that in other cases, it could well be influential in developing a change from long held beliefs and attitudes about Aboriginal peoples. It may assist in better communication that could benefit the health of Aboriginal Australians (De & Richardson, 2008). What is on offer to most government employees and health professionals according to De and Richardson is training, that for the most part targeted at how can health professionals (HPs) understand Aboriginal Australians better, how can HPs communicate more

effectively, and how HPs can offer better services to them (Pulver & Fitzpatrick 2004; De & Richardson, 2008).

There has been much written and researched into the health care consequence of language and cultural disparities between health professionals and their patients. The following are examples of strategies and attempts to reduce the barriers to communication with ameliorated health outcomes.

## 2.5 Strategies in Interaction and Communication

### Strategy One: Staff-patient Interaction; Darwin

Cass et al. (2002) undertook a study of staff-patient interaction in Darwin, Northern Territory with the intention of identifying factors limiting communication between health professionals and Aboriginal patients with end-stage renal disease. Cass et al. also wanted to identify strategies that would improve interaction between the two groups.

Cass et al. (2002) record that the investigative team gathered data through videotaped interactions between staff and patients as well as conducting in-depth interviews with all participants of a satellite dialysis unit in suburban Darwin. The participants in the study were from the Yolngu language group of North East Arnhem Land (Cass et al., 2002).

### Main Outcome Measures

To measure the outcome of this strategy, the group utilised factors influencing the quality of communication. As a result, the researchers admitted that they were disappointed to realise that a shared comprehension of key concepts was seldom reached (Coulehan et al., 2005). Cass et al. (2002) recorded that miscommunication often went unidentified. The cause of miscommunication involved lack of patient control over the language, timing, and the content and elements of interactions. Added to this there were divergent modes of conversation, and health professionals' control of biomedical knowledge and marginalisation of Yolngu knowledge.

During the implementation of the strategy Cass et al. (2002) revealed that there was an absence of opportunities and resources to create a body of shared understanding about cultural and linguistic barriers. Added to this there was deficiency of staff training in intercultural communication and the absence of trained interpreters.

### Strategies in the Hospital Setting

Health professionals in the hospital setting were attempting to decrease the barriers of communication between themselves and their Aboriginal patients, many of whom were suffering from cancer and end of life renal disease. However, the health professionals described their efforts as not being able to improve communication between the two groups. The health professionals voiced similar opinions to Cass et al. (2002) by revealing that miscommunication was either ignored

or not acknowledged. They assert that the inadequacy of patient command over language, timing, capacity, and circumstance of interaction, differential methods of biomedical knowledge as well as marginalisation of Aboriginal languages leads to major miscommunication between Aboriginal patients and health professionals. They also espouse that there was a lack of openings and resources to formulate an entity of shared understanding, cultural and linguistic distance, the absence of cultural awareness training for staff, as well as intercultural communication training. They agree that there was also a deficiency of participation of Aboriginal interpreters (Coulehan et al., 2005; Anderson, Devitt, Cunningham, Preece, & Cass, 2008; Shahid, Finn, & Thompson, 2009).

Supporting the former statements, Mackenzie and Currie (1999) maintain that direct communication between health professionals within the hospital setting and primary carers as well as discharge summaries are integral to continuity of Aboriginal patient care. Mackenzie and Currie determine that the recovery of Aboriginal patients is hindered by the inability to interact and communicate effectively as well as the lack of trust by the patient in their health professionals. These authors state that either the inability to access specialist and or their general practitioner either through ignorance of their skills, inability to communicate on acceptable level, shyness and or other cultural reasons, hampers follow up care that may cause serious repercussions to their well-being (Mackenzie & Currie, 1999).

Almost identical opinions were voiced by Shaw in 1991 who complained at that time of a deficiency in follow-up patient care of seriously ill Aboriginal patients. Shaw also considered that continuation of care was at times linked with the primary-care-patient relationship particularly in cross-cultural settings. McWilliams and Sangster (1994) maintain that in the Darwin region, culturally appropriate communication issues exist between Royal Darwin Hospital (RDH), Community Health Clinics (CHC) and Darwin Aboriginal Health Services. They assert that cultural problems complicate the continuity of a high level of healthcare for Aboriginal patients (Crawshaw & Thomas, 1993).

**Strategy Two: Aboriginal Health Workers and Cultural Mentorship**

An initiative taken by a large AMS situated in Western Sydney was to formulate and implement an on-going strategy that involved a partnership between Aboriginal health workers and general practitioners (GPs). Abbott, Gordon, and Davison (2006) declared that medical professionals at this AMS recognised the

advantage in having trained Aboriginal health workers (AHWs) when consulting and communicating with Aboriginal clients. The writers determined that continual development of Aboriginal health workers is crucial, to assist non-Aboriginal health professional with communication issues that arise when interacting with Aboriginal patients. ATSIHSs are continually being established throughout the nation and the need for interpreters and AHWs is vital in all ATSIHSs no matter their location or size (Abbott, Gordon, & Davison, 2006). It is acknowledged that ATSIHSs vary in size from the small local medical surgeries to large multi-disciplinary centres with multiple GPs and health specialist services (NACCHO, 2008).

**AHWs in Primary Health Care**

Comments by Abbott, Gordon, and Davison (2006) suggest that the work of AHWs in the primary healthcare setting emphasises that partnerships with non-Aboriginal health professionals can bring complimentary skills together to improve the health care available to Aboriginal patients. The writers suggest that this relationship decreases the cultural communication barriers experienced in non-Aboriginal health contexts. Within the Sydney ATSIHSs clinic AHWs continually undertake skills development programs. Abbott et al. (2006) claim that this includes clinical health promotion, education, and leadership roles. Some AHWs have furthered their education by undertaking training as enrolled nurses (Mitchell & Hussey, 2006) while others pursue a university based training to enhance specific skills such as communication, medical and or clinical administration or a nursing degree (Rose & Jackson Pulver, 2004).

In contrast to the above statements, Cass et al. (2002) argue that there is a deficiency of staff training in intercultural communication and the absence of trained interpreters. If there is indeed an Australia-wide shortage of adequately trained AHWs then it may be suggested that increased education and appropriate career pathways are a priority. It is essential that adequate remuneration must also be a consideration for Aboriginal organisations to permit the on-going development of AHWs as a profession and to attract other Aboriginal peoples to this much needed role (Cass et al., 2002).

**Strategy Three: Cardiovascular Education Program and AHWs**

There has been copious literature published on the crisis of Aboriginal health, including sensitivity to cultural problems in delivery of services. While cultural sensitivity has been recommended in the Australian Medical Association (AMA)

Indigenous report Card (AMAIRC, 2007) the literature review found minimal published works of actual action. The AMA Report Card also recorded that there was a deficiency of Cultural Awareness Training (CAT) for all health professions as well as AHWs. Westwood, Atkinson, and Westwood (2008) dispute this by claiming that the New South Wales Department of Health (NSWDoH) Strategic Plan 1999 together with the Aboriginal Workforce Development Strategic Plan 2003-2007 endorses five supportive strategies as well as five crucial preferences for Aboriginal health in NSW.

The recommendations were acknowledged in the five areas of focus for action in the NSW Department of Aboriginal Affairs Plan 2003-2012. One of which was to ameliorate the cultural competence of staff to be more reactive and empathetic to Aboriginal culture, needs, and aspirations. As a response to this and also as an awareness of the work being carried out by ATSIHSs with AHWs, a group of health professionals devised a plan to assist and support Aboriginal patients who suffer from cardiovascular disease (Westwood, Atkinson, & Westwood, 2008).

## 2.6 An Apathetic Approach to Aboriginal Knowledge and Value

Cardiovascular disease (CDV), specifically coronary heart disease (CHD), is the predominant cause of death in the Australian Aboriginal population (Davidson et al., 2008). Perceptions of prejudice, both tacit and overt, as well as an absence of cultural expertise in interactions, make Aboriginal peoples feel that their distinctive knowledge, values, and beliefs are being ignored. As a consequence many of them feel that the dominant society ignores their knowledge and intellect. Aboriginal patients and kin feel marginalised in interactions with non-Aboriginal health professionals and health workers (Cunningham, Cass, & Arnold, 2005).

Increasingly there is an awareness that non-Aboriginal health professionals and health workers need to be culturally competent. That is, that they must learn to, and then exhibit, respectful and knowledgeable behaviours sustained by an enabling policy environment that supports cross cultural interaction (Cunningham, Cass, & Arnold, 2005). It is reasonable to assume that Aboriginal health interventions will improve if non-Aboriginal health professionals and health workers are culturally competent. Further, it may be argued that AHWs need to be utilised in all ATSIHSs as well as mainstream clinics where there is a reasonable number of Aboriginal patients requiring consultation (Baildon & Bourke, 2003).

AHWs can, once adequately trained, play a significant role in the continuum of healthcare, not only in urban areas but in regional, rural, and remote areas (Si, Bailie, Togni, d'Abbs, & Robinson, 2006). According to Si, Bailie, Togni, d'Abs and Robinson (2006) this mainly attributes to the AHWs understanding of Aboriginal issues, knowledge and skill base, as well as accessibility and standing in their communities. Nevertheless, AHWs require support in these roles; therefore it is vital that they are aware of local resources and health professionals who can lend support. Most importantly the AHW must be made to feel comfortable in interacting with a range of service providers.

**Cardiovascular Health in Aboriginal Patients**

In an attempt to address these issues, a group of NSW organisations involved in the formulation of policy, service provision, and education gathered together in a partnership to facilitate and motivate change in respect to cardiovascular health of Aboriginal Australians. This partnership, according to Davidson, DiGiacomo, Abbott, and Zecchin (2008), included the National Heart Foundation of Australia, the Sydney West Health Area Health Service, the Department of Technical and Further Education (NSW), New South Wales Health, the University of Western Sydney and the Western Sydney Aboriginal Community Controlled Medical Service.

**Inequities in Health**

Dwyer, Shannon, and Godwin (2007) recorded that the inequities in health, avoidable health inequalities arise because of circumstances in which people and specifically a number of Aboriginal people and health professionals communicate. They add that Aboriginal Australians' socio economic situation such as poor education, housing, employment, high levels of incarceration in detention centres, and mental institutions leads to complications in all facets of life including health (Dwyer, Shannon, & Godwin, 2007). The authors emphasise that the risk for adverse health outcomes such as ischaemic disease, renal disease (Refer Definition p.128), stroke, some cancers, diabetes and hypertension and the like are linked to low socio economic standards as well as miscommunication that led to poor diagnosis skills by health professionals (Dwyer, Shannon, & Godwin, 2007). The Australian Health Ministers' Advisory Council (2008) supports many of the statements made by these authors, specifically with adverse health outcomes.

**Health Consequences through Poor Communication**

A report by Griew (2008) for the Department of Health and Ageing on Aboriginal patients outlines the disastrous health status that descendants of the original habitants of this country endure. The author reports that areas of concern are low birth weight of Aboriginal infants that is twice as frequent as that of other Australians. He suggests that correct diet during pregnancy could be due to socio-economic issues and/or poor communication when mothers attend pre-natal clinics (Griew, 2008). It is also determined by Griew that end-stage renal care has increased by 185% between 1996 and 2006. There is a similar outcome for acute rheumatic fever and rheumatic heart disease, sexually transmitted infections, and social and emotional well-being with the emphasis on mental health issues (Griew, 2008).

Watts and Carlson (2002) outline a number of strategies evidenced during their research. The strategies were on health matters which included training in ear and eye health, oral, cardio vascular health, renal care, and so on. The researchers emphasise that each strategy was formulated and implemented by different individuals within the health profession (Watts & Carlson, 2002). Paton (2002) determined that some individuals who resided in Aboriginal communities thought that it was vital that they train interpreters from their own country so that the patients could understand what it was that was being said to them (Nelson & Allison, 2000). The authors record that the key themes in their research revealed that their data focussed on strategies for facilitating effective communication with the majority of Aboriginal families and collaborating with other service providers (Nelson & Allison, 2000). Participants in Nelson and Allison's (2000) research identified resources that they perceived as *useful* in their practice, such as cross cultural training and access to Aboriginal health workers.

Ring and Brown (2002) contend that Australia is behind other developing countries, such as New Zealand and Canada, when it comes to adequate cultural training of health professionals especially in communication and linguistics. The authors claim that Australia is the third wealthiest country yet Aboriginal Australians suffer health statistics similar to that of third world countries (Ring & Firman, 1998; Ring & Brown, 2002). They comment that Australia is gripped in a cycle of unending consultation, policy, and strategy formulation. What is needed, the authors' state is to implement strategies such as the National Aboriginal Health Strategy that was introduced in 1989 (Ring & Brown, 2002). This strategy

communicated, consulted, and interacted with members of Aboriginal communities yet to date has not been fully utilised (Ring & Brown, 2002).

## 2.7 Understanding Shame

Vallance and Tchacos (2001) claim that *shame* is really more than shyness or embarrassment; in fact, they suggest it has a deeper meaning, specifically when it implies that Aboriginal people have lost face. Shame has resonances of being pointed out so that a single person is the focus of concentration, of the incomprehensible, of deep intense feelings and emotion for which there are no words. One might say it is a fear of encroaching across boundaries that may be sacred, a sense of being powerless and inept. Shame is not something that the majority of people, particularly Aboriginal people can talk about. For some Aboriginal people, shame is a form of social importance, of kinship ties and the extended family. It is one of the most piercing and potent experiences for Australian Aboriginal people. Shame is a deep, intense, heartfelt, gut feeling passed down by the spirits from the Dreamtime. This phenomenon is something that rises up from within and must be recognised beyond credibility of logic or arguable fact (Tsey, 2001; Vallance & Tchacos, 2001). Each of these individual differentials, or a blending of them, may impede or deter effective communication between Aboriginal and non-Aboriginal people (Muecke, 1992; Ashworth, 1994; Vallance & Tchacos, 2001).

## 2.8 Building Relationships

In some cultures and specifically within Australian Aboriginal cultures, people become at ease with each other by finding out what family and personal kinship they have to each other and their groups (Westone, 2011). Westone (2011) reveals that a person trying to build a relationship with an Aboriginal person must take it slowly and speak plainly. Conversation cannot be rushed. Asking direct questions and rushing into conversation may only bring total silence (Westone, 2011). The author clearly states that relationship building is vital and must be nurtured on a continuing basis (Westone, 2011). Westone theorises that healthy, trusting relationships are the crucial part of communicating and working with Aboriginal people, individuals, communities, and organisations.

### Differences in Approach

According to Westone (2011) building relationships is but one consideration. Language is another, as in many instances English may well be an Aboriginal

person's fourth or fifth language. He goes on to record that in many cultures, including the diverse Aboriginal cultures, persons from the dominant culture who sometimes use forceful self-assertive questions and or approach may be identified with exasperation or hostility (Liberman, 1990; Shannon, 1994; McBain-Rigg & Veitch, 2011; Westone, 2011). Liberman (1990) alleges that "… some Aborigines [*sic]* will try to appease an angry or pushy person by either not taking any notice of them or just agreeing with everything they say even though the Aboriginal person may not intend to fulfil any commitments they may have agreed to" (p. 30). In these circumstances, yes doesn't always mean yes, but simply a way of appeasing and having the business finished without offending the pushy person (Mitchell & Hussey, 2006; Westwood, Atkinson, & Westwood, 2008; Batumbil & Guyulun, 2009).

## 2.9 Yarning

Carrello (2009) emphasises that if mainstream Australians, and particularly health professionals, want to build trusting relationships with Aboriginal people then it is vital that people understand the concept of *yarning*. According to Carrello, yarning is pivotal to a number of Aboriginal cultures. Yarning is a practice used to transmit knowledge, build trusting relationships, is involved in a lot of decision making, conveying of cultural knowledge and stories across generations. Yarning is used to resolve hostilities and furnish education on all facets of Aboriginal life including how to raise children (Carrello, 2009).

There are differential aspects to yarning which apply to some Aboriginal people and communities and may include social and or collaborative. Social yarning according to Carrello (2009) is informal and can be about anything that Aboriginal people want to talk about. This might include passing on news or gossip, humour or advice, or any other information that people may wish to share. Collaborative yarning is more serious and might involve categories such as health or community issues. Collaborative yarning may include sharing ideas with each other and making decisions which could take an hour, a week, or much longer (Carrello, 2009; Bessarab & Ng'andu, 2010).

Yarning has potent strengths for Aboriginal people. It leads to in-depth dialogue in a relaxed and open fashion. It presents an intense source of enlightenment because Aboriginal yarning proceeds until all the information and details around issues has been talked about embracing knowledge, culture, and experience. Yarning permits for very informed decision-making because all the

matters have been discussed and heard before an Aboriginal group makes a decision on what options they may utilise and/or action to take. This procedure is a highly democratic process. This leads to the preferred action by the group (Bessarab & Ng'andu, 2010).

**Seeing but not Telling**

According to the writings of Gabb and McDermott (2007) cultural safety concerns are the fundamental reasons for multiple adverse events. For example the reluctance of health professionals and their staff in reporting problems that they witness in cross cultural interactions. The aforementioned authors also expostulates that there are numerous training programs that are delivered to staff to teach them to report on any issues that may hinder or impact on the health of Aboriginal patients (Gabb & McDermott, 2007). Gabb and McDermott stress that staff must be prepared to either alert the health professional to the mistake or problem or report it to their superior so that health professionals, no matter their ranking, take steps to ensure their patient's safety.

Gabb and McDermott (2007) also argue that numerous cultural communication programs have been developed in most western countries including Australia. Concentration on assertive communication skills and structured communication strategies play a significant role in these programs. This assist health professionals when consulting with people from a different culture from their own (Gabb & Mc Dermott, 2007).

## 2.10 Summary

It is undeniable that the literature review demonstrates that the poor status of Aboriginal health is recognised by diverse health professionals and researchers (Refer Appendix B.Alma-Ata Declaration).

Communication or lack of effective communication is evident throughout the literature reviewed. It is obvious that there was a chain of causation from the period of 1971 when the first AMS was established and 2009, when the Government introduced Closing the Gap (CTG) initiatives (Eckermann, 2005; Abbott, Gordon, and Davison, 2006; Aboumatar 2009). The establishing of the Redfern Medical Service 1971 , the first in Australia, initiated ATSIHSs of which there are over 200 throughout the nation at this point in time (NACCHO, 2008). The strategy to establish ATSIHSs controlled by Aboriginal people with assistance from health professionals from the dominant society started well before the Ottawa Charter was

launched in 1986 (Saggers & Gray, 1991). This view is expanded on in these authors' later work which describes the Alma Ata Declaration of 1978 (Saggers & Gray, 2007).

The sharing of the *True Stories* project recognised a variety of circumstances which was conducive to the serious communication difficulties revealed in encounters. Many of these elements are frequent to other areas of health care and could be envisaged to have similar outcomes for communication and quality care (Cass et al., 2002; Coulehan et al., 2005).

The attitude of the majority of health professionals demonstrated that there was sincerity in wanting to reduce the barriers of communication between themselves and Aboriginal peoples; however their lack of cultural knowledge and training were a great handicap in their efforts and still is today. It is interesting to note that a large number of strategies undertaken failed due to language issues. It is also apparent that each strategy applied in health or communication matters was not linked to any other strategies. There are significant lessons to be learned from the literature review specifically with communicating with Aboriginal peoples. When communication is ineffective it demonstrates the harm and mistrust that can arise between the dominant culture and Aboriginal peoples. A sense of respect is critical not only for researchers but all persons who communicate with Aboriginal Australians. Mutual respect is possible and is an essential pre-requisite if learning is to be developed between cultures.

It is apparent that shame is a powerful force in Aboriginal culture. It seems obvious that cultural training programs ignore this component and perhaps struggle to understand its nature and beginnings. It is significant to note that researchers fail to understand how it develops as a cultural force and the extent of its consequences. It may be suggested that greater effort needs to be put into the understanding of how Aboriginal peoples can free themselves of the evidential negative consequences of shame, especially when this phenomena is brought about by miscommunication or lack of cultural awareness, especially in communication.

The issue of shame may take intense consideration and could be a most difficult problem to address, on the other hand there is some evidence that inroads are being made in cultural training and cultural safety, albeit in a small way. There is evidence that attitudes of some of the dominant culture still need to change, especially in the area of government policy.

The policy of formulating and implementing cultural awareness programs for health professionals and other entities is the right action by governments. However, these policies need to be implemented if they are to be effective. The literature search revealed that implementation of these programs could not have been the case in many instances. The strategies undertaken according to the literature failed because of knowledge of cultural awareness, sensitivity and differences in protocols and language.

There are matters raised and argued in this chapter, as they will do in the following methodology chapter that Aboriginal health must be Aboriginal community controlled if the issues of mistrust and are to be resolved and their health status improved.

# CHAPTER 3

## 3. Methodology

Figure 7. Kangaroo
Source: Close, V. (2002) Cultural Awareness Program (Unpublished)

### 3.1 Introduction

A study was undertaken to explore the question on: "What strategies are currently being utilised in Aboriginal and Torres Strait Islander Health Services (ATSIHSs) and other health providers to overcome communication barriers for Aboriginal patients and their families". The data was collected from the four focus group participants from ATSIHSs in South East Queensland. Those persons participating were of both genders, Aboriginal and non-Aboriginal people and consisted of three each from Koala and Possum with ten participants from Emu and Goanna ATSIHS.utilising qualitative methodology and then analysing the data applying thematic analysis. The qualitative methodology included interpretivist research methods as well as constructivist inquiry which were found to be the best method of researching human behaviour. Denzin and Lincoln (2008) claim that qualitative research may be more effective when components such as subjectivity, objectivity, as well as reliability, credibility, validity, and trustworthiness are taken into account or addressed.

These components were then included in the methodology process to lend rigor to the discussions and data collecting with focus groups for the above stated question. Each of these components and the role they played within the methodology are described within this chapter.

### 3.2 The Study

A qualitative methodology was undertaken to explore the problems and barriers to communication between health professionals, their Aboriginal clients, and kin. The qualitative methodology applied also included interpretivist research methods as well as constructivist inquiry. This form of methodology permitted the researcher to include the techniques of interviewing, observation, and document analysis. The goal was to explore the behaviour, processes of interaction, and the meanings, values, and experiences expressed by the members of the focus groups (Liamputtong & Ezzy, 2005).

To identify the strategies used within Indigenous health services, the researcher listened intently to what was being said and took note of the body language used by the participants of the focus groups. The groups involved were made up of health professionals, clinical staff, and non-clinical staff. Some of the participants were Aboriginal and others were not. While Torres Strait Islanders are identified as Indigenous Australians they practise a different culture than that of the Australian Aboriginal people, therefore they have been excluded from this study. The intention in the exclusion was because the focus of the research was directed at Aboriginal clients, their carers', and family.

### 3.3 Interpretivist Framework

The research was framed around; "What strategies are currently being utilised by Aboriginal and Torres Strait Islander Health Services (ATSIHS) and other Aboriginal health providers to overcome communication barriers for Aboriginal patients and their families". Denzin and Lincoln (2008) state that interpretation of the data collected by the researcher must imply a researchers' understanding of the events, as related by the participants. In other words, interpretation is a subjective, cognitive process that commences consideration of the multiple meanings of an event, experience, or object. Interpretation is transformation; it enhances, makes clear, and refines what the researcher is hearing or seeing. From the researcher's point of view meaning, interpretation, and representation are deeply intertwined in one another (Denzin, 1998; Holroyd, 2003). Interpretive research is basically engaged with meaning and understanding of another person's words or actions (Schwandt, 2007). Schwandt (2007) explains that the term *interpreptivism* is sometimes utilised as a synonym for all qualitative research, obscuring significant discernments in rational traditions. However Schwandt argues that to a greater extent a precise interpretation of the term signifies those approaches to studying social life that present a pivotal place to *verstehen* (Refer Definitions,p.128) as process of the human sciences. Schwandt claims that the presumption of the meaning of human action is intrinsic in that action, and that the job of the researcher is to discover that meaning.

After intense research it was decided to use interpretivist methodology because this specific method was best suited to the form of research that was being undertaken. 'It was important that the researcher interpret accurately what each participant said within the focus group. This was carried out during the validation

stage by checking with each participant. Australian Aboriginal people come from diverse countries within Australia, each with their own culture, language, rules, politics, and so on (Dudgeon, Garvey, & Pickett, 2000; Holmes, Stewart, Garron, Anderson, & Thorpe, 2002).

Creswell (2003) determined that the interpretivist researcher has a tendency to depend upon the participant's views of the situation and acknowledges the effect on the research of their own history and experiences. There is a tendency to agree with Creswell as this researcher believes that she has a sociological imagination which led her to use her own life's experiences as the topic of her research. The concept of the "sociological imagination" was written by Charles Wright Mills in 1959 who provided an excellent insight into the humanist impetus behind sociology as a discipline. Huberman and Miles (2002) determined that Mills (1959, p. 11) had discovered that the sociological imagination is a way of viewing the world that can identify affinity between likely personal and private problems of the individual and significant social issues. The theory and writings of C. W. Mills (sociologist) has been written about throughout the years, but more so in the last ten years. A revival of the sociological imagination, power, politics, and the Nation, and the personal letters and autobiography by his daughters, ensure that his work lives on in the lives of sociologists and researchers (Mills & Mills 2000; Aronowitz, 2003). It is also evident that Mills is still newsworthy with a piece titled "The Deciders" written in 2006 in the New York Times newspaper (Summers, 2006).

Interpretivist research applied well to the research study. In the search for the experience and knowledge of strategies undertaken to communicate effectively with their Aboriginal clients and kin the choice was to utilise focus groups for the data collection. The interpretivist framework provided an understanding that each person would have their own perspective as to whether the strategies formulated were successful or not.

**Interpretivist Non-Verbal Communication**

Interaction is more than mere words, in fact research by Goldbart and Hustler (2005) determined that non-verbal communication, or body language, is a critical form of communication. These authors further emphasise that when people interact they continually send out and receive a myriad of wordless signals (Goldbart & Hustler, 2005). This view is supported by Pease (2001) who asserts that the gestures people make, how loud or quickly they speak, how they sit, their posture, how close

people stand to one another, eye contact and facial expressions all send strong messages to the person/s they are interacting with (see also Boren & Ramsay, 2000; Hollingsworth, 2001; Goldbart & Hustler, 2005).

The question arises whether the researcher, who identifies as Aboriginal, has enough cultural knowledge to interpret non-verbal communication accurately enough to enter her observations into her field journal for final analysis. Listening to the participants experiences, their knowledge and values, as well as what they know and think about, is pivotal to the quality of the research being undertaken (Yammiyavar, Clemmensen, & Kumar, 2008).

The researcher considered that the question asked had to be *how* and not *why*. This is because interpretive research probes how problematic transforming occurrences are organised, perceived, constructed, and given substance by interacting individuals. In framing the research questions the researcher included the following strategies outlined by Cannella and Lincoln (2004):

- The researcher located within her own personal history the problematic experience to be researched;
- Discovering how this personal issue is becoming or has become a public problem which affects multiple lives and specifically those of Aboriginal peoples, institutional, and social groups;
- Locating the sites where people with these problems do things together;
- Commencing to ask *how* not *why* these experiences happen; and
- Aiming to frame the research question into one succinct statement.

The focus was on asking the question as to how Aboriginal people from diverse countries, and therefore diverse cultures, communicate with health professionals. This led the researcher to undertake an intense literature review on communication specifically with health professionals and Aboriginal peoples.

A decision was made to approach health professionals who communicated with Aboriginal people that sought medical attention. The outcome of this action resulted in the following question; "What strategies are currently being utilised in Aboriginal and Torres Strait Islander Health Services (ATSIHSs) and other health providers to overcome communication barriers for Aboriginal patients and their families?" There was a realisation that not only was there a need to interpret what each participant was saying but that the knowledge would have to be constructed as

well as the meaning in their statements in the researcher's interpretation. This realisation led the researcher to use constructivist methodology within the study.

## 3.4 Constructivism

Constructivism is a term used to describe a theory of knowledge which stresses the active process involved in building knowledge rather than assuming that knowledge is a set of unchanging propositions which merely need to be understood and memorised (Schwandt, 2007). It was vital to the data collection phase that the researcher extract as much knowledge as possible from the participants. It was also important to gain an insight into each individual's view rather than a collective view on the strategies they used to communicate with their Aboriginal clients and family. It can be argued that no two people think exactly the same or interpret events and knowledge the same way. This discovery was made during the efforts to find a methodology that would be most appropriate to the study. It is argued by Mills (1959) that in order for people to have a comprehensive understanding of problems they are confronted with there is a need to position themselves within their era according to their history making the connection between their own personal ordeals and the mainstream policies of the society in which they reside. Mills adds that those issues occur within the character of the individual and within the range of his or her immediate relations with others. He also suggests that they have to do with one's self and within those defined areas of social life with which one becomes directly and intimately aware (Mills, 1959). In this sense, craftsmanship is the centre of one's-self and all individuals are personally involved in every intellectual product upon which they work.

On the other hand, according to Mills (1959), issues and problems have much to do with matters that surpass the local social surroundings of the individual and the scope of his or her inner life. Mills asserts that these problems are generally interwoven with the large classification issues of society where policies may be implicated and are therefore public issues (see also Aronowitz, 2003; Summers, 2006). According to Hoover, (1996) the basic elements of constructivism were founded in sociology, education, and psychology. Constructivism is a theory of knowledge (epistemology) that argues that humans generate knowledge and meaning from their experiences. Two important notions revolve around the simplistic idea of constructed knowledge (Hoover, 1996).

**First Notion**

The first is that new researchers learn to construct new understandings from what is already known. In fact Ivey, Ivey, and Zalaquett (2007) argue that there is no

evidence on which new knowledge is impressed deeply on the mind at birth. Instead learners acquire knowledge gained from previous experience. Ivey et al. explain that prior knowledge influences what recently acquired knowledge, this researcher and other learners construct from the new learning experience. This concept is also accepted by Huberman and Miles (2002), Somekh and Lewin (2005) and Denzin and Lincoln (2008). Through first-hand knowledge which she obtained by experience at an early age, the researcher was aware of some of the barriers that impeded communication between health professionals within ATSIHSs and Aboriginal patients.

**Second Notion**

The second notion is that learning is assertive rather than compliant. As a learner it was necessary for the researcher to confront her understanding in light of what she experienced in the new situation. Hoover (1996) asserts that if what the researcher, as a learner confronts, is incompatible with her present understanding, her understanding can transform to adapt new experience which remains active throughout the process. The group implement current understandings, note relevant principles in the new learning experiences, judge the consistency of prior and emerging knowledge, and as a result can adjust their knowledge (Hoover, 1996; Somekh & Lewin, 2005; Ivey, Ivey, & Zalaquett, 2007; Denzin & Lincoln, 2008).

People appear to construct the social world, both through their own interpretations of it, and through their actions based on those interpretations (Huberman & Miles, 2002; Somekh & Lewin, 2005; Denzin & Lincoln, 2008).

### 3.5 Subjectivity

Subjectivity refers to human emotions, knowledge, experience, values, and so on. Being subjective is pivotal to the quality of this research. Torrance and Pryor (2001) suggest that this is because truth is not something that can be established independently from specific contexts or the participants in the field of study. From an epistemological point of view, the notion of subjectivity has been discussed by Schwandt (2007) in terms of (a) the personal view of the individual; (b) an unsupported claim; or (c) a prejudiced or biased account. For example, just because one has a personal view and makes a statement or claim it does not necessarily follow that it is unwarranted or biased (Denzin & Lincoln, 2008).

To fully represent the meaning of subjectivity in qualitative research and using the constructivist and interpretivist methods, there was a requirement for the

researcher to stand alone as a completely separate, self–defined entity during the process. It was important though that this mindful, self-defined entity was kept separate from relationship building. To do this, the researcher had to acknowledge her own biases and prejudices and not allow them to influence the participants in any way. For example she may have experienced verstehen (or understanding) or be empathetic to a certain participant, but the need to divorce herself from those feelings was vital so that the participant could speak freely and not be persuaded by her actions or words.

When dealing with other people the researcher needed to have a good knowledge of *self*; of her values, her strength and weaknesses, and have knowledge of her own identity. Know who she is and that she is capable of allowing herself to respect not only herself but others from the knowledge of her own self-worth (Atkinson & Silverman, 1997). As a researcher, and indeed as an individual, the researcher has an obligation to learn how her own cultural background influences her behaviour. It is essential to her research that she identify her basic assumptions specifically as they apply to diversity in culture, ethnicity, race, gender, class and sexual orientation (Carspecken, 2005; 2008). Culture also includes age, gender, religion, as well as physical and mental ability. The researcher realised that she had strong, adverse feelings about some members of the dominant culture, and the way she felt that her people were unjustly treated. Age was another factor as she was brought up to respect her Elders (that is in the dominant society) but was also taught that they were too old to have any relevant knowledge about important things. This is something that this researcher fights against every day as she believes that age has nothing to do with intelligence.

The knowledge holder was, in accordance to her teachings, owned by the man of the house or by revered men of higher standing such as a priest, politician, or a boss. This researcher was not only told to deny her Aboriginality but that a woman's place was in the home. Women, when she was younger, if they were fortunate to be employed were rarely promoted and received a smaller wage than their male counterparts even if they carried out the same work. Added to this, she was subject to abuse from the dominant culture and was subject to out-dated laws and racial discrimination. The researcher was denied an education and while institutionalised encountered some traumatic experiences with general practitioners. Therefore, her traits were somewhat distrustful of the dominant society. In

identifying her personal traits she was mindful not to allow them to be seen by the participants or to influence their thoughts and input. An example of this was that the researcher guarded against answering questions in a way that might be construed as judgmental. There was an awareness of her non-verbal reactions and body language to statements that she might not agree with as well as being very careful to avoid leading questions. These actions would demonstrate that the researcher was open to all opinions and receptive to all data disclosed without bias or prejudice. Building a good relationship with each participant was vital to eliciting a natural, genuine, and interested response to her research question.

The state of subjectivity is distinguished by the skill to own an essentially theoretical, reflective, logical, and intelligent grasp of the world and of self (Denzin, 2000; Schwandt, 2007; Corbin & Strauss, 2008; Denzin & Lincoln, 2008) Throughout the research this attitude was paramount when gathering data. The importance of understanding one's own biases, prejudices views, and values help a researcher to collect unbiased information (Denzin, 2000).

**Subject/Object Relationship**

The conceptual dichotomy of subjects (thinkers and those with knowledge) and objects (what they know and think about) is pivotal to the majority of Western philosophy. Schwandt (2007) claims that research subjects can be objects of thought and knowledge as is presumed in the notion of *reflexivity*. The term reflexivity is often used in a methodology sense to relate to the system of critical self- reflection on one's own prejudices, preferences and so forth (Schwandt, 2007).

As each person puts forward their view on strategies formulated and implemented within their service it is vital that they are allowed the space to think and talk without any influence on the part of the researcher pertaining to what effect these strategies had on them and their clients. Denzin and Lincoln (2008) argue that subjectivity and objectivity can work well only by following procedure. It is understood that by following procedure one could be utilising a device that would assist in preventing reason from being corrupted by prejudice and tradition (Hoepfl, 2005). Prior to the data collection phase of the research a letter of introduction was written and posted to each participating health service outlining what to expect during the discussion. The letter also told a little about the researcher herself and explained that she was an Aboriginal woman from Wiradjurri country (Refer map p.22 and definition of 'country' under Glossary). The letter reiterated that the

participants in the focus group discussions were doing so voluntarily and could withdraw at any time without repercussion. To assist the participants to prepare for the focus group the following examples of questions that may be asked were included in the letter of introduction.

- Please describe strategies you have developed in helping you to communicate with Aboriginal patients.
- How were these strategies developed?
- Does this strategy work well for you?
- What is good or not so good about them?
- Explain how you believe it works.
- What changes over time have you seen in your ability to communicate with Aboriginal patients?

On meeting the participants a request was made that each participant state their name and position within their service at the beginning of the recording. The reason for this was once the recording was transcribed the researcher would be able to differentiate who had said what. The participants were assured that the work was completely confidential and that coding would be used so that in the final report there would be no identification of any participant. A further assurance was made by the researcher to the participants that all documents and other materials gathered from the service would be either kept in a locked filing cabinet or on an electronic device protected by a password. The researcher informed the participants that it was important that they drive the discussion. The role of the researcher would simply be to ask questions on matters they raised during the session if more information was required. In keeping with this procedure, it was pledged to the participants that the researcher would endeavour not to prejudice or influence the information that was forthcoming.

As the research pertains to humans, that is emotions, knowledge, experience, and values, it was important that there was an understanding of one's self, such as one's own emotions, values, biases and prejudices, especially if the researcher had experienced verstehen (refer Definitions, p.128) (Kellehear, 1990).

As an Aboriginal woman with the knowledge and historical emotion of the experiences of living within Aboriginal communities allowed her to be empathetic to some Aboriginal participants. Verstehen can be a powerful tool in research however,

it could well be dangerous if a researcher allowed that personal experience to influence her understanding of the data being presented (Kellehear, 1990). To prevent contamination of the information gathered by the researcher's own experience she had to be aware of her own feelings and experience and divorce herself from those thoughts when gathering the data. One needed to be fully aware of their own values and not force those values or experiences onto the participants allowing them to demonstrate their own thoughts and values that are congruent to them (Kellehear, 1990; Carspecken 2008).

### 3.6 Reliability

In quantitative research reliability pertains to establishing evidence that supports one's findings (Somekh & Lewin, 2005). If a quantitative study was undertaken, one could state that it was reliable if that study could be replicated and the results were consistent. This is not the case for notions of reliability in a qualitative study (Denzin & Lincoln, 2008). The authors record that reliability is an epistemic standard thought to be essential, but not adequate for validating the truth of a study or interpretation of a social occurrence. While as a researcher there was an expectation that replication of the study would bring similar findings there could be no solid guarantee that they would. Over time a participant or a number of participants of a focus group which implemented a communication strategy may perceive that strategy in a different light. In one's mind, this would change the information available to the researcher replicating the study.

Schwandt (2007) states that "Traditionally, social scientists assume that while not all repeatable or replicable observations or accounts are necessarily valid, all valid accounts are (at least in principle) replicable" (p. 262). Opinions are divided among qualitative researchers over whether this principal has any meaning whatsoever in evaluating the accuracy of field studies (Huberman & Miles, 2002; Schwandt, 2007; Corbin & Strauss, 2008). It is debatable that it is vital for accuracy that reliability be addressed in fieldwork by procedures such as using established methods for recording field notes and analysing transcripts (Schwandt, 2007).

To validate reliability the researcher created an analogue to reliability through observant recording of notes and of procedures for interpreting the data. Reliability is a matter of assembling steadfast evidence, and the methods used to collect this evidence. It was vital during the data collection phase that open ended questions were asked by the researcher to elicit as much knowledge as possible from the

participants. It is the opinion of the researcher that by asking the right question she obtained information previously omitted or forgotten by the participants. Open ended questions can be started with the words *who*, *when*, *why* and *how* and *with what consequence*. This was the format suggested by Hepworth, Rooney and Larsen, (1997) to help generate responses and to jog the participants' memory. During the discussion held with individual participants of the focus group within ATSIMSs and other Indigenous health providers, significant information was gathered from individuals answering the same question. This then allowed one to compare the individual statements. Thinking through comparative situations made oneself as an analyst more sensitive, in the sense that it alerted the researcher what to look for that might lend weight to the researcher to validate the information collected (Corbin & Strauss, 2008).

### 3.7 Validity

In general usage, validity is an aspect of a declaration, debate, or procedure. To say one of those actions is valid is to denote that it is sound, convincing, well grounded, accountable, or logically correct. Psychological validity presents having trust in one's remarks or knowledge claims. In social science, validity is an epistemic principle or standard. To say that the findings of social scientific research are (or must be) true and certain is to reason that the findings are in fact or must be factual and positive (Maxwell, 1992; Denzin, 2000; Schwandt 2007).

Methods that may help the researcher to validate the data collected are, looking for patterns within the data and asking one's self whether the information offered is true. To do this, the researcher must confirm, substantiate, or validate any statement that is made by the participants within her study. Verifying what has been said, in the researcher's opinion, can only be substantiated by others within the focus group. The researcher's trust in what has been said is an extremely significant factor when eliciting data from participants. Without this trust, specifically with Aboriginal Australians, from this researcher's point of view, it is doubtful that complete information may be forthcoming. To test, the decision must be made by the researcher whether the information accurately represents the phenomena to which the participants of the study refer. If the information is certain, then the information would be backed by evidence and therefore validation is affected. To further validate the data collected, phone calls were made to each participant and a copy of the transcript delivered to them for their perusal and validation. Each participant was

given the opportunity to alter, omit or add any data that they felt necessary. The result was that not one participant changed any of the information that had been transcribed (Lather, 1993; Kvale, 1995; Denzin & Lincoln, 2008).

**Credibility and Plausibility**

Credibility and plausibility are in accord with each other and may come from questions people ask themselves such as, is this story plausible, do I believe it? Alternatively, is it so outrageous that credibility must be discarded? There are distinctive features that emphasise how people, and specifically this researcher, understand the specific cultural worlds in which they live and in which they both construct meaning and utilise that meaning (Goldbart & Hustler, 2005).

In order to avoid traps of racism, sexism, ageism, class or credibility, a researcher must perceive themselves as not any different than the participants within their research (Bassey, 1999). This also pertains to the analysis of the transcripts. In this researcher's view, it is essential that the analysis and findings are free from her own point of view and bias. Applying the best form of analysis is significant to quality findings therefore, this researcher chose to utilise thematic analysis when analysing the data collected from focus groups within ATSMSs and other Indigenous health providers.

**Trustworthiness**

Carspecken (2004) suggested that in our every action and instance of behaviour we presuppose some normative or universal relation to truth and that the meaning of truth is grounded in our daily lives. This may suggest that researchers are able to articulate the normative evaluative claims of others when they start to perceive them in the same way as their participants by living inside the cultural and discursive positionalities that inform such claims (Carspecken, 2008). However Sargent, Nilan, and Winter (1997) espouse that there are diverse approaches to establishing truth and no one way of learning truth about the world as there appears to be multiple versions of multiple truths.

It could be argued that there are no holistic truths as one individual's belief may be that truth is a highly personalised concept. It is not something that everyone should, or might agree with. Truth is as one perceives it to be. Each person has his or her own their own conception of the world; each individual perceives the world differently. The researcher's view of the world may not be the view of other researchers or her participants and never can be.

To what extent is it that the guarantor of accuracy, the underwriter of truth, honesty, reality, and objectivity will be interpreted when reading the findings of the research into strategies? Williams (1999) suggests that the meaning heard by one individual may not be the same as intended by the orator. However, it may be argued that there are unconscious meanings that although not intentional, might present truth or disclose an alternative *reality* that underpins apparent actions. Given all the vulnerabilities, the need to make a favourable impression, the wanting to suppress some events, trust is a fragile gift easily shattered (Goldbart & Hustler, 2005). It is therefore absolutely essential for this researcher to record each participant's view accurately and precisely as they voice it.

Recording and or scribing each disclosed alternative reality that underpins apparent actions, as well as explicit coding and cataloguing before analysing takes place is a key to thorough research. Once that has taken place it is essential that the appropriate type of analysis be adapted to the subject that has been researched. Armed with this knowledge and after much reading on qualitative methodologies a decision was made to apply thematic analysis on the data collected in this research study.

### 3.8 Participants

The research was conducted throughout South East Queensland by visiting ATSIHSs which are part of the Queensland Government Primary Health Care Centre (QGPHCC) situated in the Brisbane suburb of Inala where there is a large contingent of Aboriginal peoples residing. South East Queensland Medical Service and other health providers that offered health services to Aboriginal peoples were chosen for this study. The literature review discussed in chapter two revealed that urban ATSIHS staff were making a concentrated effort to formulate strategies to break through the barriers of communication that exist with Aboriginal peoples but little mileage was perceived by this researcher to be made.

The focal point was to gather data on strategies formulated and implemented to assist professional health workers and clinical staff in communicating with Aboriginal patients. It is envisaged that this information will be collated and made available for the use of all health professionals and interested others in their endeavour to improve communication with Aboriginal people. While there may be Torres Strait Islanders utilising the medical services, the intention was to focus solely on Aboriginal patients. The information gathered is expected to reveal whether the

health professionals consider the extent of, or lack of, success in applying the strategies that were formulated by their staff.

**Recruitment of Participants**

When seeking participants for the research an approach was made to ATSIHSs and other Aboriginal health providers to seek out subjects who had personal knowledge of the types of experiences that would lend to the research. Assistance was sought from the National Aboriginal Community Controlled Health Organisation (NACCHO) to facilitate access to ATSIHSs. However, after numerous attempts by email, phone calls and other written correspondence NACCHO failed to respond. The lack of cooperation from eligible ATSIHSs was extremely disappointing and somewhat confusing. The research was intended to discover what strategies were implemented by healthcare services to decrease the barriers of communication between Aboriginal peoples and health professionals. It was initially thought by this researcher that the service personnel would be only too pleased to be involved, but alas this was not the case. While staff at some ATSIHS indicated that they were sure that their service was involved, they failed to respond to numerous attempts by the researcher to bring this to fruition. After a great deal of persuading over seven months, four ATSIHSs agreed to take part. An ethics application outside of the University of Southern Queensland (USQ) where the research was instigated was also a hurdle and one might even say a nightmare.

The four health services that took part in this research were located in diverse areas of South East Queensland. One was located in Dalby Queensland, another in Toowoomba, the third on the Gold Coast and the fourth on the North Coast of South East Queensland. Because of the diverse location of the participating health services several hours of travel was required by the researcher. Added to this, they were of dissimilar structure to each other and that necessitated a differential approach by the researcher particularly in the type of questions asked.

After negotiations with the CEOs and or managers of each ATSIHS who had agreed to participate in this research; a decision was reached that he or she would approach their own staff and ask for volunteers to participate in the study. The reason for this was that it was perceived by the researcher as a more ethical and productive process as she did not know the staff of the ATSIHS. Respect and acknowledgement of the CEO or manager is not only highly pertinent but essential

and protocols needed to be followed. As the researcher identifies as Aboriginal she is aware of the importance of these matters.

Once the CEO had been contacted, a letter of information involving all details of the research, consent forms for individual participants, as well as the ATSIHS were included. Requests for any recorded or printed matter that pertained to this research was also requested at the CEO's discretion. Follow-up phone calls were made and recorded in a separate notebook for further evidence, if needed, of the contacts made. Having contact by phone and correspondence was the first step in helping to the build a relationship between the researcher and the ATSIHS. As a result, when the researcher finally met with the participants she found that she was welcomed warmly, which was a great start to the data collection process and a head start in building good relationships.

### 3.9 Data Collection

Focus group discussions were held within the medical services approached. The data was digitally recorded with permission and notes were taken during the discussions. These notes included body language and conversations held outside the discussion group by participants who had forgotten to include something and felt that it was important to the way they saw the strategy that they had implemented. Staff who participated in the medical service discussion groups was asked to put forward their opinion of the content and effectiveness of their current strategies.

The participants were also asked prior to commencing the data collection process to comment on any strategies they felt needed to be formulated to decrease the barriers of communication between health professionals and Aboriginal people. The researcher emphasised again about the confidentiality of the information and assurance that their names would not appear in the final thesis and that coding during transcribing would take place. It was also explained that the process was to be participant driven and that the researcher would only ask questions if she required further information on a matter already raised (as stated in the earlier part of this chapter). It was important to have their input on all aspects of content, formulation, and implementation of strategies which may have provided crucial information pertaining to communicating with Aboriginal patients.

During the study, in some instances, the researcher was able to accumulate copious field notes, personal notes, photographs, copies of documents, and computer discs. During the research the researcher ensured Aboriginal ensured that all

material was kept in a locked case or on a laptop computer with a secure password. Apart from the safe-keeping of this material it was vitally important that the data be organised, catalogued, and indexed in a manner that made retrieval efficient.

**Journal**

A research journal was an essential item while gathering data in the field. Recording the system, the organisation, and cataloguing of data is just part of what the journal contained. Entries of information from the focus group that was not recorded as well as non-verbal actions was entered into the journal to enable the researcher to review on-going analysis throughout data collection. This method of recording may be utilised to bring forward the research. A journal is an essential commodity especially when being engaged in discussions with focus groups. A journal allows for the manual recording of unclear and unspecified information (Altrichter & Holly, 2005).

### 3.10 Thematic Analysis

Thematic analysis, frequently known as qualitative thematic analysis and interpretive content analysis, is a regular approach to analysing qualitative data that does not depend on the specialised procedures of other means of analysis. Examples of these methods are; disclosure analysis, grounded theory methodology, discourse analysis and semiotic analysis (Braun & Clarke, 2006). In using this investigative method it is necessary to scrutinise each focus groups' data individually and to assess what each individual has contributed to identify if what they are saying may not be the same as another member of the group but just put differently. After the completion of each transcript, the researcher analysed individual transcripts searching for themes and common principles. It is important that the transcripts be coded to ensure confidentiality of the participants. After completion of this task all transcripts were analysed and common themes noted. Field notes and other significant documents collected from the participating ATSIHSs were included within the theme search and analysis. Corbin and Strauss (2008) appear to agree with this method of analysis as they state that it is vital that a researcher codes the transcripts, and other data collected, according to whether it was apparent that they were conducive to emerging themes.

The use of qualitative methodology and the gathering and analysing of data from focus groups was somewhat daunting at first. Close scrutiny would be needed in the study of recordings of the discussion groups, as well as a thorough reading and

accurate interpretation of the researcher's copious field notes. A question arose of how all this information would be analysed. What system would be used? After much research the researcher discovered that thematic analysis would suit the specific data collection admirably and that it could be applied to most qualitative information. Thematic analysis is a method of making sense of related material; methodically observing situations, group interactions, behaviours, and culture (Fereday & Muir-Cockrane, 2006), encoding the data into themes and or patterns, relationships, indicators, and qualifications. A major discovery was that thematic analysis is founded on three basic stages.

- Define sampling criteria and research design;
- Develop patterns themes and codes; and
- Validate and use the codes (Fereday & Muir-Cockrane, 2006).

Added to this, a second discovery was that the analysis process involved five main procedures. Firstly it was important that this researcher recognised the themes utilising the correct focal point, which meant stepping back from the details and recognising patterns. Next there was a requirement to develop a coding system and then decode the information. This process allowed the researcher to interpret the themes and helped her gain knowledge. Consolidation of that knowledge is recorded in the following chapters; results and theme discussion.

### 3.11 Limitation of Study

The main limitation to the proposed research was that for personal and practical reasons the researcher was only able undertake the study in ATSIHSs and other Indigenous Medical Services in South East Queensland. It is therefore realised that the results cannot be generalised to other Aboriginal groups. The research undertaken is small compared to the numbers of ATSIHSs in Australia. This also restricted the researcher's ability to generalise to other groups. However, it is nevertheless likely to be of some use to groups outside of the urban arena. The results may also be useful when undertaking future research into breaking down the barriers of communication with Aboriginal peoples and of Aboriginal health.

### 3.12 Summary

In this chapter it has been depicted that qualitative research was the most appropriate method in seeking information from both Aboriginal and non-Aboriginal health professionals employed within ATSIHSs. Interpretivist and constructivist

methods followed by thematic analysis were perceived to possibly bring better results in this research than other qualitative methods.

Innovative thought and preparation by way of devising culturally appropriate initiatives and strategies by the researcher proved to be effective. While initially there were issues in the recruitment of ATSIHSs, those that agreed to be part of the process did so in a warm, friendly, and open manner.

The information collected from observation of the environment and participants which was entered into an on field journal proved to be of significance when analysing the transcripts recorded during the focus group meetings. It is also worthy of note that while just four ATSIHSs were involved with this research, the data was rich in quality. Further to this, because of the distance between each location and the number of health workers participating the information offered was varied and in one case totally dissimilar which necessitated different approaches in the data collection phase. This is evident within the following chapter of results.

# CHAPTER 4

## 4. Results

Figure 8. Legends of the Dreaming
Source: Roberts, A., & Mountford, C. (1975). Legends of the Dreaming. Hong Kong: Myer Publications.

This chapter talks about the thematic analysis of data collected from four focus groups in South East Queensland Aboriginal and Torres Strait Islander Health Services (ATSIHSs) and Aboriginal Community Controlled Health Services (ACCHSs). The data gathered revealed that the 17 themes that emerged were on the whole replicated by each group even if the method of doing so was individually different. To clarify which group provided the information a code has been devised so that there can be no confusion for the reader.

### 4.1 Code

There were four health services involved in focus group discussions. Each participant group is coded with an Australian native animal name representing the health service and a number representing which participant offered information from that service. The animals do not have anything to do with totems or totemic sites but are simply a coding device. Represented by this animal code are; Emu, Goanna, Koala, and Possum. The participants of each focus group were recorded on a recording device with field notes and observations entered in the researcher's journal. Once the recordings were transcribed a thematic analysis was utilised to discover the emergence of themes. Definitions of the themes as well as the statements made by participants to demonstrate strategies put in place to decrease the communication barriers between themselves and their Aboriginal clients are also included. It is important to note that only a small portion of the transcripts have been included in this chapter. The quotes that are incorporated in this chapter demonstrate an example of themes that were common to most focus groups.

**Themes Identified**

The themes that emerged are: Community controlled health services; Language; Non- verbal communication; Using pictures to communicate; Displaying Aboriginal artwork and logos; Yarning; Availability; Home visits; Providing transport; Providing a comfortable environment; Employment capacity building of Aboriginal staff; The importance of employing Aboriginal staff; Cultural awareness,

sensitivity and security; Cultural reconnection; Empowerment; Community engagement; and Taking into account the socio economics of Aboriginal clients.

## 4.2 Themes and Definitions

### 4.2.1 Theme One: Community Controlled Health Services

Community control is a system which permits the local Aboriginal community to be involved in its affairs in whatever protocols or procedures are determined by the community. An Aboriginal Community Controlled Health Service (ACCHS) or an Aboriginal and Torres Strait Islander Health Service (ATSIHS) is a primary health service where Aboriginal people have input into their health requirements. In this case it entails essential health care founded on practical, scientifically sound, and sociably acceptable methods accessible to individuals and Aboriginal communities in which they exist through their complete engagement at every level in the spirit of self-reliance and self- determination. It encompasses the physical, emotional, and social well-being of the whole community.

Goanna holds the view that a community controlled health service is one that is always driven by the needs expressed by the people within an Aboriginal community based on a primary health model that acknowledges the impact of the social determinants of health and makes changes to provide for the changing health needs of the local Aboriginal community.

Goanna have put processes in place to enable the Aboriginal community to determine how the service will operate. They listen to the health needs of the local community and consistently strive to formulate and implement strategies that are acceptable to the community. This health service has appointed local Aboriginal Elders to their Board of Management and over time has become an Aboriginal Medical Service that Aboriginal people can trust with their health needs.

> *...we are actually a community-controlled organisation so everything that we do is essentially driven by feedback and input from the community and I guess that's how that developed as an Aboriginal organisation. Goanna, Par. 2*

> *...and the strategy has worked well for us I think in that we seem to engage pretty well with our clients, most of the time anyway. I don't think there's anything that's not good about a strategy that is community-driven, Indigenous health in Indigenous hands, essentially. Goanna, Par. 2*

Possum recorded that a realistic application of self-determination is pivotal to Aboriginal health. The participants assert that it underpins cultural, community,

family, and individual wellbeing. Aboriginal self-determination and accountability belong at the heart of Aboriginal Community Control in the provision of primary health care.

> *Are your clients both Aboriginal and Torres Strait Islander? Researcher*
>
> *Yeah! Yeah! we got over- How many we got? Possum: Par. 1*
>
> *Over three hundred members mostly Aboriginal. Possum: Par. 2*
>
> *We have seven Aboriginal Board members who are out in the community all the time mixing and mingling with the community. We are getting a massive positive result, they are saying what they want and need to improve their health. Possum: Par. 1*
>
> *So would you say your service here is community controlled? Researcher*
>
> *Yes! Absolutely. Possum, Par. 3*

### 4.2.2 Theme Two: Language

In this instance defining language is about using words that can be understood by all clients. Staff of ATSIHSs have found that to communicate effectively with clients is to use plain simple words and in some cases although infrequent, Aboriginal English.

An example of this may be the word *womba* meaning stupid or mentally incapacitated. Further words such as *cuz*, *broth*, *girl* and *deadly* may be used (meaning: related kin or cousin; brother; as an endearment of a Aboriginal but non-related girl; as the best or greatest).

Aboriginal language in this instance refers to the way in which Aboriginal people greet and communicate with each other. Having a response in a mutual way encourages the clients to communicate with staff by building good relationships. It is apparent by the individual transcripts that the majority of clients and the Aboriginal peoples in the region speak English or Aboriginal English using plain simple words.

> *I also think that using the correct language has helped, using language that is recognised through Murri or Indigenous clients. I think it works because it makes them feel more comfortable and they recognise it rather than being separated because of words that they wouldn't normally use. I think it's a good thing medical terminology can be said in a way that an Indigenous person would say it, but not so good if it leaves things out in the way that it is said and I think that the clients react more warmly to you if you use that known terminologies. Goanna: Par. 2*
>
> *…and also using the correct language and understanding language for the GP as well, understanding words like 'womba' and some of the other*

*words that get used, so having someone that understands that local language is very helpful. Goanna: Par. l*

*…the GP or the specialist might use big terminology and a hard way of explaining 'this is what happens in the procedure', an Aboriginal Health Worker will then break that down to simpler terms for that Indigenous person to understand. Emu: Par. 3*

*…with specialists, I know an example for my mum if she's not sure of what the specialist has said or she doesn't quite understand it, she usually comes back, sees someone who she is familiar with who then either follows that up or checks it out so they can explain it back to her. Koala: Par. 1*

*One of the other things that I found working in Indigenous health over the years is about the language too. You talk about making signs and stuff like that, but when an Indigenous person comes in and says 'which way' or 'who your family?' and then they are a lot more willing to give information. Emu: Par. 2*

**IBERA**

Indigenous Body Education Resource Animation (IBERA) is a program with Aboriginal voices designed to inform the client of what is happening to a specific part of their body.

*Using IBERA the language is tailored for Aboriginal and Torres Strait Islander people and the voices are Aboriginal voices, either male or female, you get to pick depending if its women's business, then you can pick a female voice, if it's for a teenager, you can pick a teenage voice. Goanna: Par. 5*

### 4.2.3 Theme Three: Non-verbal Communication

Non-verbal communication in this context is a way in which some Aboriginal people communicate with each other by using specific signs known to Aboriginal peoples. This can be a simple gesture of a raised eyebrow, a hand signal, or a whole body movement. This is a type of communication that can send important messages to one another without speech. This specific form of non-verbal communication is unique to many Aboriginal cultural groups and much different to the non-verbal signs used by the dominant culture. It is important though to understand that the ATSIHSs in this research learn about general non-verbal communication in an informal manner and utilise this in their dealings with clients

*…there's a lot of non-verbal that goes on too …and that is really important because if you want to approach somebody sometime you just don't do it because you know that look …? (Makes facial expression) to see somebody and just go like that [gestured] without even saying a word. And so there is a lot of really unique and good things between us fellas as a group, yes, and community recognise that, the people that come in, they*

*recognise that (gestures) one sort of thing when we can do those things. Emu: Par. 2*

*…there's a lot of non-verbal communication that goes on when I see my clients. Possum: Par. 3*

### 4.2.4 Theme Four: Using Pictures, Toys, and Replicas to Communicate

Pictures can signify messages that need to be described by either using the pictures or by combining them with speech. Pictures are visual cues that are clear and representable of the real thing or concept. Communication can be assisted by pictures in situations where the user has communication difficulties such as poor literacy skills or English as a second language. In some cases toys and replicas of medical instruments and parts of the body help communicate to people, especially children, what the Aboriginal Health Worker (AHW) is trying to tell them. This form of communication also reduces fear that children and others may harbour in relation to ill health. The following excerpts support this theme.

*…and I use lots of picture books and posters of a big ear and I also …I let them play with the otoscope, they push buttons on all of the equipment, nothing is frightening, nothing is a mystery, everything is to be touched and played with and felt and they look through the otoscope and they hand it around and I have a plastic play one from a little child's pretend doctor set and I have a teddy bear and they can look in the teddy bear's ears and check bear's ears. Possum: Par. 3*

*… just a very simple evaluation form with pictures on it so they can just tick what they are feeling and sort of a bit of a graduated scale, so that's been very successful. …the previous evaluation we didn't get as many filled in so we have just adapted that to meet that need. Goanna: Par. 4*

### 4.2.5 Theme Five: Displaying Aboriginal Artwork Colours, and Logos

Australian Aboriginal art refers to art done by Australian Aboriginal peoples. Each dot, line, or marking has a specific significance pertaining to their country and community. Australian Aboriginal artwork adorns the walls, signage, and brochures in health services that have participated in this research study and has a very long history associated with it. Artwork pre-dates European colonisation as well as contemporary art by Aboriginal peoples on traditional culture and their Dreaming. However, it is not restricted to those items mentioned above but can be found on modern day clothing, vehicles, jewellery and other artefacts. Art was one of the key elements of Aboriginal culture. Artwork was used to mark a territory, record history, and to tell stories. Today while the artwork relays stories of a specific country (Refer map p.22) and or service, and in this case specific health services, it also

communicates to Aboriginal people that the place that holds this artwork is culturally sensitive and generally a place they can trust and feel safe.

> *... the blue painting over there is actually the story of our district. I suppose with the artwork and everything, we wanted the organisation to be friendly and inviting to the community. ... any paperwork or anything that we send out we've always got some sort of Aboriginal art on there, which includes our logo which is from the Aboriginal painting which is our story, yeah, and it helps to make the male clients more comfortable. Possum: Par. 3*

> *One of the reasons is because it's a reflection of our values and we value Aboriginal and Torres Strait Islander art and heritage and it's shown by we hang them up, we want to display them, we're proud of them and we want others to share in our culture and to share in the – what makes our culture unique and special. Possum: Par. 2*

North Coast Aboriginal Corporation for Community Health (NCACCH)

Our Story

The pathway is representative of the journey that NCACCH has taken from conception to the present day. The footsteps along this pathway begin small, like an infant and as the service grows and matures into adulthood, the footsteps become larger. The six circles along the pathway represent the evolving service of NCACCH over the last 10 years.
Source: http://www.northcoast.net.au/

Figure 9. Our story so far
Source: http://www.northcoast.net.au/

### 4.2.6 Theme Six: Yarning

Yarning is a form of talking or chatting with another person or persons. In this analysis yarning includes listening with respect to the stories that Aboriginal people within the community have to tell about their history, their socio-economic situation, their social and emotional well-being, and their health. It is a way of greeting, hearing local news or gossip, in finding out what mob you are from and what your business is. Yarning may be just general talk but usually it has a reason behind it. When people start yarning it may take quite a while to come around to the main reason of their communication but they will eventually raise the matter that really requires a discussion and or an answer.

Observation and listening is a significant part of yarning. In some Aboriginal communities an Aboriginal person may sit and observe a person telling them something and may not voice an opinion immediately and when they do it may be in a few minutes, hours, days, or weeks. Yarning is part of Aboriginal culture; it is a communication tool generating trust and building rapport as well as good relationships, as evidenced throughout this analysis. Goanna uses this form of

yarning with their clients and the local Aboriginal community for two reasons: (1) to elicit health issues from clients and (2) to gain information from the local community. This allows the staff of Goanna to formulate communication strategies to improve the health of their clients.

> *...so when I'm driving people around they will talk to me, I yarn to them and they reveal stuff to me that they might not tell the doctor and ...I can pass this stuff on just to help in their diagnosis or whatever like that. Goanna: Par. 6*

> *When you are talking to somebody you talk with them and not at them and try and be in their shoes and see where they are coming from, and more often than not you get that, you develop that rapport with them and they come back because they know that you are fair dinkum about wanting to be part of their health outcomes. Possum: Par. 2*

> *...got to go right back to the beginning and yarn with them because they've been traumatised and there's other issues going on. Koala: Par. 3*

> *...I believe from all of the staff that work here and at different levels that the communication has been very important and has improved since have allowed the clients and their families to yarn and be part of that. Emu: Par. 6*

> *... in the car, they start yarning. Yarning could be about everything and they get here, by the time they get here, they see an Aboriginal Health Worker, so they're going to continue their yarn and make them more comfortable before they see the GP. Emu: Par. 5*

### 4.2.7 Theme Seven: Availability

The concept of availability is one of making oneself available to client needs; many of the staff at the four ATSIHSs make themselves available to the client at locations and times best suited to the client and not the institution. Appointment times are made flexible.

> *...well, one of our clients said it makes her comfortable when she comes to us as it we are always open, always available. Goanna: Par. 3*

> *... they like that approach, they feel if we are available when they need us they are getting listened to and they feel as if they have some ownership Emu: Par. 9*

> *...we are a pretty laid back service, We try and fit in and be available for the clients If clients want us to be a support person for them when they are going to their mental health meeting with their psychiatrist, well then that's what we do. Emu: Par. 9*

> ***…**and by having a Registered Nurse(RN) specialising in child and maternal health she actually makes herself available and goes and picks those expectant mothers up makes them go along to the antenatal classes Koala: Par. 2*

### 4.2.8 Theme Eight: Home Visits

Visiting clients in their own homes is a significant contact technique that some ATSIHSs in this study have adopted. Visiting the clients crosses borders of community engagement, community consultation, client inclusion in consultations, and meeting families and building trust. Health professionals that visit clients are able to see far past the clinical problem and understand the underlying issues that may affect the social and emotional as well as health well-being of their clients. Through discussions with the client and or kin, health professionals have sometimes been able to detect health issues that clients may have that the client was unaware of. Visiting the clients at their home, specifically in the first instance, builds rapport and trust and encourages the clients to seek professional health advice in an ATSIHS or ACCHS. The following excerpts are evidence of this.

> *…What the health workers did was conducted home visits on all of our Indigenous clients within the region. We did a basic screening service and, yes just let them know about our service… and while we were doing these home visits we were able to talk one on one with families. We did pick up patients with diabetes. that they didn't even know they had, so it was learning curve for them as well…. Emu: Par. 1*

> *If clients prefer us to do home visits, we do home visits. Emu: Par. 9*

> *We are also able to talk with them in our own way we might think there is something wrong with them and are able to get them to the clinic otherwise they wouldn't have gone and got worse. Emu: Par. 6*

> *We have people in the field that visit our clients in their homes when needed, we have a very large district and have over 300 Aboriginal clients as well as some Torres Strait Islander clients. We cover a very large area. Possum: Par. 1*

> *Some of us visit the clients at home if they cannot come into here but if they need a doctor we bring them back with us. Koala: Par. 1*

The following quote while it does refer to home visits, demonstrates that home visits may contain some risk and that a health worker needs to ensure their safety by having a second health worker accompanying them when the visit is made.

> *We don't do as many home visits as we would like to and there's a number of reasons for that. For safety reasons you need two people and that takes people out of the clinic and stuff like that. Emu: Par. 4*

### 4.2.9 Theme Nine: Providing Transport

Transport in this dissertation refers to a vehicle that is used to transport clients, their family and or carer to and from medical appointments, hospitals and in

some cases other institutions such as Centrelink. The following excerpts are a sample of what all of the health services disclosed within the focus group discussions.

> *Another thing is access and transport is a really important thing for access for our community, there's not really any public transport …, so without that transport we wouldn't have people being able to access any of the services that either we or other service providers offer. Goanna: Par. 1*

> *…we do pick clients up, especially the aged or very sick other people come in by themselves. Koala: Par. 1*

### 4.2.10 Theme Ten: Providing a Comfortable Environment

Being comfortable in any setting is conducive to feeling relaxed, generating good feelings about one's self, and may also demonstrate that the client is in a safe place. Within many clients, this feeling of being comfortable and safe can open the door to interaction and communication with health professionals. Examples of this are depicted below.

> *…they see an Indigenous Aboriginal Health Worker, so they're going to continue the yarn and make them more comfortable before they see the GP so by the time they hit the GP who is the bad person, that is usually non-Indigenous they're comfortable…. Emu: Par .2*

> *So it's all about culturally sensitive and culturally appropriate from staffing to our brochures and stuff like that to the actual clinic itself, the posters. It's also a very important thing about making sure that our people are comfortable and are able to access the service without access the service without being uncomfortable. Goanna: Par. 3*

> *Also, confidence I think is really important of all the staff. What I found in my experience here is that when the staff are confident it actually creates a fair amount of confidence from the clients and they feel more comfortable and they start to realise why the staff are confident and confident staff communicate to me that I am somewhere safe, somewhere where people will look after me. Koala: Par. 2*

### 4.2.11 Theme Eleven: Employment Capacity Building of Aboriginal Staff

In this theme, employment of capacity building of Aboriginal staff begins with the employment of Aboriginal staff generally recommended by the Elders of the community in which the ATSIHS operates. Training is provided to employees in the field of Aboriginal cultural awareness, sensitivity, and safety. Employees are trained in the skills they need to carry out the specific job they were employed to do. They are given the opportunity to upgrade their skills and to learn other aspects of the tasks required within the health service. The health services in this research realise

Aboriginal culture is not monolithic but consists of numerous and diverse countries which may have their own culture, politics, rules, and different languages and so on. The staff are then trained to speak in plain and simple language to enable effective communication. Understanding the local Aboriginal cultural conventions and appropriate respects and behaviour is also prominent in their employment capacity building techniques.

**Organisational Development**

Organisational development is defined as the elaboration of management structures, processes, not only within the ATSIHS but also the management of relationships between the different organisations and the public, private sectors as well as the community.

**Staff Employed by the ATSIHS**

ATSIHSs employment capacity building is first and foremost human resource development however, there is a broader strategy at work which is about improving the education and employability of Aboriginal people per se, that is beneficial in the broader sense, beyond the care they can give to Aboriginal clients, for example, in the sense that improving education for all Aboriginal people will have long term benefits. This includes assisting and training them to:

- Maintain our cultural identity;
- Interact confidently and effectively with the dominant culture/s;
- Identify goals;
- Determine strategies to achieve their goals; and to
- Work effectively with government and the private sector to access the resources necessary to implement these strategies.

Aboriginal Health services employ Aboriginal staff on the recommendation of the Aboriginal Elders and their community. The staff are chosen by health services for their skills, culture, and knowledge of their Aboriginal community or their ability to learn these skills. A culturally sensitive process is adopted by the health services in this research when employing Aboriginal staff. A health service following this protocol will not only attract Aboriginal clients but demonstrate that all staff whether Aboriginal or non-Aboriginal have the opportunity to gain education in a health service and are better equipped to provide an effective health service to Aboriginal people.

*…and the strategy has worked well for us I think in that we seem to engage pretty well with our clients, most of the time anyway. I don't think there's anything that's not good about a strategy that is community-driven, Indigenous health in Indigenous hands, essentially, and I guess having Aboriginal and Torres Strait Islander staff is also really, really important as well and building capacity in the Indigenous workforce. So that's what I've got to say. Goanna: Par. 1*

*"I'm Aboriginal I have been employed here and trained up to be the Program's Manager here at Emu Health Service and we employ as many Aboriginal people as we can. Emu: Par. 2*

*The best thing is we can talk to the government and they talk to us and give us training in the sort of thing we want to do and that makes this health service better for the clients. We can keep on training for other positions such as RNs. Emu: Par. 3*

*The training here is, we are trained by Aboriginal trained Health Workers and some of us attend the university to further our nursing. Emu: Par. 3*

*For me I got the opportunity to make a decision and there was a little bit more incentive to actually – there were policies that came in to encourage Aboriginal and Torres Strait Islander people to actually go to university and I think that helped in overcoming some of that as well and helps us then to then go into a mainstream education like university, or training of sorts, see how mainstream – even though it's very difficult because we are still – they have had generations and generations and generations that have gone through system, understand how that system works. Koala: Par. 2*

*Whereas we've not had that opportunity so we've come in and we haven't had those experiences and we are trying to jump across that big gap where that is not part of our Aboriginal culture but it has been part of white mainstream culture to be able to do university and all that comes along with it. Koala: Par. 2*

*…so for me it's been an ability to go in and see how that side of white Australian mainstream works and then bring it back and be able to bring it back to my community in a way that they can understand because a lot of my family haven't been through high school. Koala: Par. 1*

*… we started with two staff, we've now got 13. They all Aboriginal except two or three. Possum: Par. 1*

*…about my qualifications. Well, gee, I'm a Registered Nurse and I trained through Deadly Ears which is a national body that's based in Brisbane that trains Indigenous – Aboriginal and Torres Strait Islander health workers to go to different communities and screen ear health of the children and my age group is four to 12 years of age. I also have a Bachelor in psychology. Possum: Par. 3*

*I also undergo training here at XXXXX to learn other areas of work like referrals and other administration work. This has developed a lot of skills I never had before. Possum: Par. 2*

### 4.2.12 Theme Twelve: The Importance of Employing Aboriginal Staff

The significance of the strategy is the employing of Aboriginal people in a range of roles within medical and health services that could have been filled by members of the dominant culture. One of the most important benefits is that employing Aboriginal staff indicates to clients that they are more likely to feel safe and secure because here are Aboriginal health professionals who understand their culture. During discussions with the participants of the focus groups to gather information, it was revealed that among the staff there were Aboriginal Chief Executive Officers (CEOs), Managers, psychologists, Registered Nurses (RNs), Aboriginal Health Workers (AHWs), Enrolled Nurses, and in some cases non-formally trained Aboriginal health workers, administration staff, transport drivers and other unidentified positions.

ATSIHSs need to have flexibility as Aboriginal people have different needs than that of the dominant culture. These needs mainly refer to obligations to Sorry Time, Tombstone Opening, and obligation to kin as well as other cultural commitments. The flexibility that the researcher has referred to as a previous strategy is also applied to staff as evidenced in following excerpts.

> *Of really importance is the topic of grief and loss and Sorry Business and that's important not only for our community people and our clients, but also for our staff, the majority of our staff are Aboriginal and Torres Strait Islander people and so having that flexibility, where unlike mainstream, where it can only be a direct relative and people only get two days bereavement leave, we try as much as possible to be flexible because Sorry Business is important to people's well-being. We see it the same as if someone has a broken leg or heart attack you wouldn't punish them for that, so the same with staff who have Sorry Business for whoever, like family, extended family, and even people who are kinship family that may not be seen as family in a white paradigm, that's an important person to that person and if you don't let them do their Sorry Business well it impacts on everything. And I think often Indigenous people working in non-Indigenous organisations find that to be a big barrier from what I've kind of heard. Goanna: Par. 1*

> *I am the CEO here and I am Aboriginal. My job is to oversee everything that happens here at Emu as well as be accountable for its direction and applying for funding. Emu: Par. 3*

> *…they have an Indigenous social worker at the hospital who is quite flexible, feels more comfortable coming down and working from our office because she doesn't have the same constraints on her that the Mental Health Team or the clinical approach has." Also, they don't like the dynamics up there, it's too clinical it's too matter-of-fact. You are in the door, your appointment is this time, you go, you can't just drop in. The Indigenous social worker feels she can do far better work if she comes down here and accesses Indigenous clients down at our service and that's what we do. Emu: Par. 9*

> *I'm Aboriginal I have been employed here and trained up to be the Program's Manager here at this Health Service. Koala: Par. 3*

> *We have 37 community referrers which are mostly Aboriginal and a few Torres Strait Islander people working in the community and they're stationed at all different areas of our service area, and so the client, if they need to access our service, can go and visit one of our referrers. So they receive information from us that way. Possum: Par. 2*

### 4.2.13 Theme Thirteen: Cultural Awareness, Sensitivity, and Security

Training of cultural awareness and sensitivity is an important undertaking in any health service. This applies to all cultural groups. Cultural awareness requires an understanding of one's own culture and the commonalities across Aboriginal cultures that allow people to relate and interpret any perceived differences. Cultural sensitivity means being sensitive to the differences one may have learned about through cultural awareness. Cultural sensitivity is also thinking about your own attitudes and how they may affect the person you are working with. Training in this field by Aboriginal health services is also evidenced in the following excerpts and are indicative of all the health service focus groups who participated in this research.

> *The training is, we are trained by Indigenous trained health workers and some of us attend the university to further our nursing. Emu: Par. 7*

> *Yes, plus we have cultural training, all non-Aboriginal staff are compelled to undertake cultural training which is given by Aboriginal health workers and some Elders. Emu: Par. 4*

> *To clarify that, I guess both in a sense, cultural competency or cultural awareness is very limited on the Xxxx Xxxxx. I was in a workshop with some psychologists a couple of years back and they were astounded that there was actually an Aboriginal population on the Xxxx Xxxxx. They live 10 minutes from this Health Service or they were within 10 minutes of this Health Service, their lack of understanding of knowing what Aboriginal people tend to look like. I guess for them it wasn't just that there was lots of dark skinned Aboriginal people so therefore there's not a high Aboriginal population and for me that was very disturbing I guess because their roles in the professional world is as psychologists, they've gone through a university degree, they have this degree and they've come out the other end targeted to our community and they're saying there's no Aboriginal population, or not a great deal of Aboriginal population and they live 10 minutes from where this actual service – or they were 10 minutes from where this service was. Koala: Par. 1*

> *I also delivered cultural awareness training to mainstream organisations including doctor's receptionists. Centrelink has an Aboriginal person delivering cultural awareness programs in our district. Possum: Par. 3*

### 4.2.14 Theme Fourteen: Cultural Reconnection

Cultural reconnection is defined in this theme as Elders of the community helping Aboriginal clients of ATSIHSs to reconnect with Aboriginal culture. In

some cases it is a reconnection with their culture, although it can be about whose mob and country they belong to and the struggle for recognition. Finding their Aboriginal identity and meanings of belonging in country, community, family and kinship are significant factors. Traditionally people had defined roles according to age and gender. For example, a man's role involved skills in hunting as well as cultural obligations that were important to the cohesion of the group.

The *Birthing Circle* is evidence that Aboriginal women played a significant role in that they provided most of the food for the group. Cultural obligations demand that women were responsible for early childhood rearing. Reciprocity and sharing were and still are important characteristics in Aboriginal society. Sharing along the lines of kinship and family remains an important cultural value. The following excerpts are similar to the information offered from the four health services that participated in this research.

> *We've also tried with New Directions we've tried to bring back some connection with family and culture and at the moment we had an female elder over yesterday and we had a chat and we are going to commence some yarning birth circles with the pregnant and antenatal mums with that elder and in the future do some other things with that, so that will actually reconnect them – they will find out about their origins of where they come from, name their tribe and that will be the start of the sessions that we hope will evolve into some really lovely women supporting women in their culture and they get some pride for being young mothers, young, Indigenous mums. Goanna: Par. 3*
>
> *…and the other thing is just about our systems as well. As part of our developing really adequate systems with input of the Elders, again so that we can communicate to our clients, again, what is expected of us by them and what we expect from them, so that the relationships and the rapport sort of develop over time. Goanna: Par. 5*
>
> *…but what we will be doing is the Tree of Life and that's a session that's connecting the individual to their culture, their roots, the land, family and friends, so it's done in a pictorial sense. They will actually draw a tree which will become a forest with the Elders and other people and how they weather storms and it's then correlated in how they actually face their challenges within life. So this is what we are going to be doing with the young mums and Elders in the next couple of weeks. Goanna: Par. 3*
>
> *What we were finding is a lot of the girls didn't have that information, some of that cultural knowledge has been lost, families fragmented, and so we are looking forward to that and thinking it will be very beneficial. Goanna: Par. 4*
>
> *…and at the same time on the other hand, we have Aboriginal people due to colonisation, due to the result of history where our culture was not allowed to be taught, there are a lot of those things where shame then came into it and our elders were not allowed initially and then when they – I guess there's a gap in areas where the culture has not been passed on. Kaola: Par. 1*

*How we deal with it is a case of – how I deal with it is I bring my life experiences into play and I allow that to be my communication tool, what I've learned in life, through my dad, through his parents, how the impact of that, so that's an ongoing lesson, we learn from each other, which is what as an Aboriginal person does, we teach each other different things. Koala: Par. 1*

*Oh and that's I do too, I learn from my Elders. Koala: Par. 3*

*One of the difficulties that I see, especially for a lot of the young people, now Aboriginal people have basically been in mourning for 200 and a bit years and these kids turn up on my doorstep and they don't fit in white culture but they don't fit in their own as well, and that's the big difficulty that I face with them. They have no sense of who they are, where they belong or whatever and unfortunately neither do Mum and Dad in most cases, so they've got nobody to try and guide them through the process and that's probably one of the biggest difficulties I see for the young people of today is that they just have no direction – some of them, not all of them, but the ones that I see. Goanna: Par. 5*

The last excerpt is similar to that of Possum, Emu, and Koala health services. The "Tree of Life" has been adopted by three health services participating in this research and all four have a reconnecting to culture program.

### 4.2.15 Theme Fifteen: Empowerment

Aboriginal peoples have, since colonisation, been dictated to by governments and the dominant culture. Providing strategies such as encouraging clients to contact other organisations enables clients to have the confidence to take control of their own lives, specifically for their health. ATSIHSs provide networks so that the client can communicate with them and not feel isolated when a health provider is not available.

*...but to provide services with what people's knowledge is already and then you can add on as well, so you are not taking away the cultural side of it, but you are just enhancing it with the health issues that need to be addressed as well and I believe that, that is a way of including our clients in their own health and for the betterment of themselves and for their families and communities. Emu: Par. 2*

*One of the things that I'm mindful, and it doesn't work in this area, is we are trying to empower clients to take some control of their own life and I suppose it's more important with the Indigenous community because they've had so much power and control taken away from them and to do that and to make it that they're not so co-dependent on our service that if we are not here that they don't have the support, we are trying to build networks with other services in the community and break down those barriers that Indigenous people will use them and vice versa. Emu: Par. 3*

*I guess sometimes the strategies that we do use may not work as well as what we think they will and sometimes the reason is because we haven't included the people in developing those strategies but I believe that we are getting a lot better at it now because we encourage people to come to meetings and to be part of the service here rather than just giving them things and them just coming here and expecting to get what they want all*

*the time. So it's not easy; but we are starting to include the people more now than we did. Emu: Par. 2*

The last excerpt is again similar to that of Possum and Koala Health Services.

### 4.2.16 Theme Sixteen: Community Engagement

Community engagement is about the process of involving the Aboriginal community in the services that ATSIHS provide. It includes ATSIHSs going out into the Aboriginal community and forging a relationship with that community. Community engagement involves having Aboriginal people provide input into the services and the services actually including that input in delivering the health needs of Aboriginal peoples. Some of the excerpts that pertain to this section have been mentioned in other themes and so will not be replicated here. However they will be considered in the discussions chapter wherever they are applicable.

It is also about including Aboriginal Elders and community members on the health service's Board and in advisory groups. Community engagement is a two-way street where all parties have a say in providing health needs to their community. It is important to note that in the following excerpts there is mention of community consultation. However, from the researcher's observations and understanding of what has been in the main where consultation was mentioned the action was more likely to have been community engagement.

*The strategies that we've developed to communicate with Aboriginal patients, I guess one of the biggest strategies is that we are actually a community-controlled organisation so everything that we do is essentially driven by feedback and input from the community and I guess that's how that developed as an Aboriginal organisation. Goanna: Par. 1*

*...we use all of Xxxxxx but we use our client's input to develop further programs, so as Xxxxx was saying, we will have a chat and then through their feedback try and develop programs that they would like to attend and will benefit them so that they know that they can come up with ideas and that they will be listened to and it will be utilised and then we feedback the results from that back to them. Goanna: Par. 4*

*Yes. And I would say if you are a GP or someone just coming in to work here that a lot of what's important is like what Xxxxxx was saying, to communicate, to have as many Aboriginal Health Workers and Aboriginal staff and people from the community helping you with clients because they're going to know when problems arise, who are the other family members you should talk to or what can be the underlying problems of a person. Whereas if you come from the science training you will see it in a medical way and very often the health workers who know the families will say, 'Oh no, that young child, it's not so much that they're depressed because of whatever medical – their parents are gambling and dah, de, dah.' They will know what's going on in the community and how all the other important things that you need to know*

*about to help someone. So you actually learn a lot from the health workers because everything has to be fitted into its context. Emu: Par. 5*

*I work at Xxxxxx Health Service and I'm the community Engagement Health Promotions Officer. I've been working here for the past five months and I guess in dealing with Aboriginal and Torres Strait Islander people we are looking at how can we communicate and get out into the community. I guess the service that is available here at Xxxxxx Health Service with our Aboriginal and Torres Strait Islander patients. Koala: Par. 1*

*The community – our Board members are seven Aboriginal people from all geographical areas of the Xxxxxxxx Xxxxx and Xxxxx region many of them Elders and they're out there all the time and they're getting - the feedback they get is all positive stuff because people have a choice of where they want to go. They can have a choice of which doctor they want to go and see, they can have a choice of which dentist, which podiatrist, which counsellor, all that sort of stuff. They've actually got a choice. If they get a referral to see somebody and they're not happy with it they vote with their feet and ask us can we point them in the direction of somebody else. 'That's no worries, you know, we've got plenty'. Possum: Par. 4*

*We also work closely with community where we do NAIDOC. We just recently had a community event which we had to cancel because of the rain, We have men's and women's groups as well, they are held around once a month. Possum: Par. 3*

*There are the seven Aboriginal Board members who are out there all the time and mixing and mingling with the community, we are getting a massive positive result and have been for years now. Possum: Par. 1*

**Men's and Women's Business**

Within the four health services in this research, the strategy to abide by Men's and Women's business is carried out by: providing a male counsellor for men and a female counsellor for women. In areas such as infant care or play groups, where mothers and children attend, health staff and other employees are women. Whenever possible a male doctor would attend to male patients with a female doctor consulting with female patients.

In Aboriginal cultures, many topics and issues are divided into Men's and Women's business. Those belonging to either gender are rarely mixed and discussed within their own male or female group only. In the majority of gatherings traditionally food is served as is depicted in the following excerpts.

*…and those groups are community driven as well, like they decided what they – like we have people who come and talk and present and things, but it's actually the group that decide what they're interested in and what they want to hear about and what they would like to eat. We keep the woman's stuff separate from the men's stuff. Possum: Par. 1*

*Yep, put on something for the kids you know. So it's about if your focus is communication, it's about – I don't know what some people would call it,*

*but when we do something like that we always obviously are family orientated except for say the men's – well the women's group is a different story, they can bring their kids and babies along, but the men – you know like it's a seven o'clock in the morning breakfast and that sort of stuff and the women's thing is a lunch time, so it's different there, but everything we do is focussed on family." "Just the same we keep men's business separate from women's business. We follow our cultural rules and that of the Dreaming. Possum: Par. 2*

*Yeah, yeah that's right and the men ask for someone to talk about prostate cancer and we got a doctor in the following month and free of charge, one of our providers that sort of thing. or Diabetes counselling. Koala: Par. 1*

### 4.2.17 Theme Seventeen: Taking into Account the Socio Economics of Aboriginal Clients

It is recognised by staff of ATSIHSs that their clients generally exist on welfare payments and they are empathetic to their plight. In the majority of instances the clients are financially embarrassed and so all services provided by the ATSIHS

are provided free of cost. The health service may also provide transport as mentioned earlier and assist the client in areas such as specialist and other therapist visits, mental health and medication. There is an understanding that their clients are economically deprived in comparison to their dominant culture counterparts.

A good socio economics status means having reasonable social contacts as well as employment, housing, food, money, and other amenities to have a reasonable standard of living. The following excepts will demonstrate that many Aboriginal people do not enjoy a reasonable standard of living and this affects their health as well as the ability to communicate these issues to health professionals.

*…the fact that they are financially disadvantaged as a group, employment is much lower which adds to the financial disadvantage, health is then much lower, education outcomes are much lower and obviously then the 17 year gap, the fact that there is not housing, it's very difficult to actually control your illness if you actually don't have a house to live in. I mean how do you explain you are sick because shelter is on the bottom of the Maslow's triangle, and then that intergenerational trauma as well, and there are different impacts in different areas like remote, rural, for us regional, and then urban settings as well, and these often aren't acknowledged as well. People only look at perhaps remote areas and try and extrapolate that across all Aboriginal communities, but every community is completely different. Goanna: Par. 1*

*Just back on the housing, we find that our mums are – there's quite a few emergency situations where they are needing housing for themselves if they are pregnant or with a child and some are couch surfing and it's extremely difficult sometimes for these girls and families to actually be approved for rental because they are actually following the white, Western culture, that it's actually not governed or even thinking about the way that their families, extended families live together. So we find it very*

*difficult and if the girls happen to be successful in getting a rental home or a flat then, of course, Uncle, Aunties, extended families come and then they are usually evicted because they have got the extra families there. Goanna: Par. 3*

*Following on from that, if our mums are involved with the Department of Child Safety it's an absolute issue and it's a Catch 22 because they need to get some stable housing but then they're not eligible to get it, and then they can't get off their Order because it's just this continual nightmare. Goanna: Par. 4*

*Doctor, are you are saying people are prevented from communicating their health issues to health professionals because of their social and economic situation? Researcher*

*Oh it's huge. I think everybody would say that's a huge determinant, huge factor and you've got to know, try and understand where that particular person fits and how a particular person might communicate and everybody is going to be different and if you just come in as an outsider it takes you a long time, but you can learn a lot quickly from our health workers and people that live in the community already and know. Emu: Par. 4*

*...like housing has got a big issue with our people, overcrowding. Like there's more than one family living in the homes and that's got a big impact on their health emotional status and with their self-esteem. Koala: Par. 3*

*...Aboriginal people, because it's a whole – holistically whenever we are dealing with Aboriginal and Torres Strait Islander people you've got to look at it holistically so if you have a housing like Xxxxx spoke about before, a housing issue, that may just be it's not an isolated thing because then it comes back it includes their family they are dealing with, it includes maybe they don't have housing because they just lost their job so it's all interconnected and their social, their emotional side and their physical health will actually show that that side of it. It will actually manifest itself in a physical way. So they may come in for depression or go to Xxxx'x men's group and have all this anxiety happening, but if Xxx gets in and starts yarning to them he will find out in two weeks' they're going to be evicted from their house and so there's all this stuff. Instead of if they went to a doctor who had no understanding of what the cultural holistic side of it would be, he would just go and prescribe them with something that would deal with their depression, whereas Xxx would sit with them and have a yarn and then once they start opening up and forming trust with Xxx and knowing, 'Oh, yeah' they start sharing some of the stuff. 'In two weeks we are going to be evicted from our house' he's going through this anxiety and stress and so Xxx then can connect with him and say 'Look we can help you here.' So I think that holistic side, there are physical symptoms that come out when you deal with Aboriginal people. Koala: Par. 2*

The seventeen themes demonstrate diverse issues and strategies associated with communication and health. A full discussion on these matters will be found in the following chapter.

# CHAPTER 5

## 5. Theme Discussion

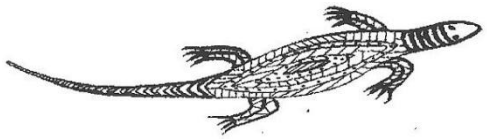

Figure 10. Lizard
Source: Close, V. (2002) Cultural Awareness Program (Unpublished)

In this chapter an in-depth discussion will be held on data collected from the health services that participated in this research of "what strategies were implemented to decrease the barriers of communication between health professionals and Aboriginal people". Deliberation will be applied to the observations made by the researcher as well as the field notes entered into the researcher's journal. Some of these entries include conversations held outside the focus groups by participants who preferred not to voice their opinion in front of their colleagues or just comments on topics they had not thought of during the data collection process. Included in this chapter is also information gathered by way of brochures and other paraphernalia that was given to the researcher.

**Investigation into Themes**

It is important to look at the themes that emerged during the thematic analysis and to consider whether they have any connection to one another and or to the existing literature in the literature review chapter. Significance will be placed on new information that arises from the research and an endeavour to discover if the strategies that the health services in this study have any bearing on decreasing the barriers to communication between the health professionals and their Aboriginal clients. The chapter will examine how and why this information may change the way in which communication between clients and health professionals can be improved by adopting the strategies that the health services in this research chose to implement. Understanding whether the strategies changed the way health professionals communicated with their clients may permit other health care professionals to adopt the same strategies or implement strategies of their own which could ultimately deliver better health care needs to their clients.

**Aboriginal and Torres Strait Islander Health Services**

There are to date over two hundred health services Australia wide that specifically cater to the needs of Aboriginal and Torres Strait Islander peoples. Out of this number approximately one hundred and forty health services are community

controlled (NACCHO, 2008). Other ATSIHSs work off information gathered from the community by other methods such as community engagement and deliver health care needs to the all Aboriginal and Torres Strait Islanders who seek their assistance.

The reluctance of many of these health services to participate in the research study was disappointing. Added to this, the area encompassed in the research had to be reduced to South East Queensland of which only four health services agreed to participate. Limitations of time, financial resources, and other practical reasons added to the difficulties that confronted the researcher. A positive contributing factor was that the four health services that agreed to participate represented diverse areas from the Western fringes of the Darling Downs to the Coast and as far up as Tin Can Bay. All four services applied strategies to improve communication with their clients, therefore a review of each of these strategies must be undertaken to reveal to what extent success was experienced in the application of these strategies. Some of the themes will be linked together as they are seen to be connected in some way or perceived to be the same as the primary theme under consideration. The following themes that are discussed allow the reader to understand the how's and why's of the conclusion that the researcher has come to in the last chapter of this dissertation.

- The first category that requires discussion is the participants of the four services in this research state that they are community controlled but does evidence really indicate that some staff are only carrying out community engagement and consultation?
- The second is socio economic status and transport. The category of low economics status has a bearing on whether Aboriginal clients or prospective clients of health services have the means either financial or otherwise to afford transport to a health service. If this is the case a discussion may reveal what strategy has been implemented to overcome this problem.
- One cannot talk about communication without discussing all the aspects of language that Aboriginal people may use. Is the language spoken by Aboriginal people difficult for Aboriginal Health Workders (AHWs) and health professionals to overcome and if so what strategies do they use to overcome this problem?

- Effective communication is the crux of whether the information received by staff and clients alike is really getting the message across or are there dire consequences from miscommunication. The discussion will reveal that miscommunication does occur and in some cases leads to wrong diagnosis and other consequences. The chapter will demonstrate that it is not only non-Aboriginal people who mis-communicate but that some Aboriginal health workers also mis-communicate because of the diversity of clients' language groups. It will be debated as to what remedy is there to correct this and who should be responsible for undertaking this task.

When discussing the research field notes and observations will also be included in this chapter.

This researcher believes that the four health services involved in this research are all efficient. She will discuss the positive strategies undertaken by the health services as well as the negative approaches. Final determinations of this chapter will be summarised after the completion of these discussions.

## 5.1 Community Control or Community Engagement

The four health services who participated in the research claimed to be community controlled although the interpretation of community control seemed to differ from one service to another. Nevertheless, it was perceived that the methods used were intended to achieve the same or similar outcomes. That is, to communicate effectively with Aboriginal people that require health care; however it is debatable whether the four health services used the same method as they claimed to. From the research carried out, Goanna Health Service runs their practice as an Aboriginal Community Controlled Health Service. By all accounts it appears to abide by the definition of Aboriginal and Torres Strait Islander Community Controlled Health Service as outlined within the previous chapter.

**Emu Health Service**

Emu Health Service claims that their service is community controlled and explained that when the practice was first established clients were not forthcoming. To try and build client numbers, with the primary goal of delivering sustainable health care to the Aboriginal community, the staff made the decision to personally visit every Aboriginal home in their district. During these visits they were able to inform individuals and families of what the new health service had to offer and assured them that the service employed AHWs. By observation and consultation

with individuals and families the staff discovered some people who required professional health care. Gradually, as the word spread and trust was built, Aboriginal people went to Emu Health Service for treatment and consultation by the General Practitioners (GPs). As one participant commented "If it wasn't for Xxxxxx and Xxxxxxx doing these visits in the first place this health service would not have got off the ground" Emu: Par. 2.

Visiting clients in their own homes continues today in some health services and specifically in Emu health service. The Mental Health Worker relates that many of her clients prefer that she visits them at home as they feel that they are patronised when they attend the public hospital. They told her that they do not really understand what they are being told and they do not like the sterile environment. This occurs to the extent where the client would rather abandon seeking help for their emotional, mental, and social well-being than attends a public clinic. Further the participants feel like they are treated as second class citizens and are generally patronised or treated as though they are less than intelligent. Some of the clients do not always understand what their medication is for and so they do not take it which may lead to hospitalisation and or being arrested for misbehaviour. It is found that health professionals that visit clients can also cross borders of community engagement and consultation. This specifically includes the client in these consultations as well as meeting families and building trusting relationships. The AHW can and does often see beyond the clinical problem and can understand more fully the circumstances that underpin a client's health issue.

Because of the diversity in health needs, the staff invited clients and members of the community to attend meetings at the practice where they were and as Aboriginal custom dictates, provided light refreshments. Only then was information forthcoming as to the perceived health care needs of the community members. As the number who attended these meetings were small, and according to the data collected, were mostly clients, it is difficult to know whether they were representatives of the entire Aboriginal community or not. However, on the evidence submitted this seems highly unlikely. The staff stated that they were able to use some of the ideas that came from the clients and their families. It is then the opinion of this researcher that Emu Health Service was not an Aboriginal Community Controlled Health Service but one that depended on community engagement and consultation with members of that community.

If an ATSIHS is to be community controlled then they need to have a voice of the people from that community, which is generally in the form of an Aboriginal Board of Management or a board that consists of a majority of Aboriginal Elders and community representatives. This Board is then able to convey to the ATSIHS the health care needs of their community. Emu Health Service does not have this contingent and therefore is not a community controlled health service in this researcher's opinion.

**Community Engagement**

Community engagement is about the process of involving the Aboriginal community in the services that the ATSIHS provide. It includes staff members of these services going out into the Aboriginal community and forging a relationship with that community. Community engagement involves having Aboriginal people provide input into the services and the services considering that input in delivering the health needs of Aboriginal peoples. Community engagement differs from community control where once the staff member has engaged with an individual or group they do not necessarily follow through with the suggestions or information provided. Whereas community control is about including Aboriginal Elders and community members on the health service's Board and in advisory groups, encouraging clients to have input into the strategies they would like to see implemented and acting on those suggestions.

**Koala Health Service**

There was similar evidence to Emu Health Service that came to light with the Koala Health Service as they also found that while there were no other ATSIHSs in their area clients were, in the initial stages, hesitant to use the centre. By visiting the Aboriginal families within their service area the Community Engagement Health Promotion Officer set about building clientele by advising the families and individuals of their service.

The Community Engagement Health Promotion Officer stated that her role was also to go out into the community and try to find a way to connect with the Aboriginal people and to assess their health needs as well as to encourage them to visit the Koala Health Service. Her technique was to build a relationship with a member of one family or ask a family that is known to her and request information about people in the community which was generally freely provided. In one case, where a young child was perceived to suffer an undiagnosed medical complaint and

possible mental health issue, a member of the community was able to advise the AHW that the main issue was that the parents neglected the child because of their gambling habits and substance abuse. This was also confirmed by other members of the Aboriginal community, some of whom were not related to the child or her family. The AHW through this method of communicating was able to identify other people in the Aboriginal community who were suffering either from diagnosed or undiagnosed illness.

This whole concept may be totally unacceptable in the dominant society and would be seen as divulging confidential matters as well as an invasion of privacy yet, a male staff member of the health service insisted that this is the way Aboriginal people communicate to each other. He was convinced that the information gathered by the Community Engagement Health Promotion Officer constituted a community controlled health service. This researcher considers that the methods taken to communicate with the Aboriginal Community in which Koala Health Service operates is one of community engagement.

**Possum Health Service**

The fourth health service was unable to service their community efficiently and effectively because of its catchment area being 7000 square kilometres. The Board of Management that consisted of seven Aboriginal members realised that with such a vast area, funding would not allow them to open enough ATSIMSs to serve all the communities in the 7000 square kilometre area, without extensive travel. Financial hardship to the client and perhaps the staff that were needed to run the health services would also be endured. To overcome this dilemma Possum entered into a partnership with Queensland Health and a brokerage model was developed.

This service has a number of AHWs in each community who are able to communicate with the Brokerage daily and ensure the health needs of Aboriginal clients are adequately cared for. The AHW obtains information as to programs and strategies required from individual clients, their community, and Elders and feed this back to the Brokerage. The staff at the Brokerage then implements the suggested strategies to decrease any communication issues and add programs that will ensure that the clients receive quality health care as required. The staff and AHWs liaise with 247 doctors and a number of diverse allied health workers, most of whom were from the dominant culture. These practices were chosen because their staff were both culturally aware and sensitive to Aboriginal peoples and were willing to deliver

adequate health care to the Aboriginal communities. There is constant communication and input from and to all persons involved in this service. While the method may differ from Goanna Health Service it is obvious to this researcher that Possum Health Service is a community controlled health service.

The four services involved in this research study claim to be community controlled but in reality community engagement and community control are two different strategies of communication. That does not mean that while dissimilar methods may be adopted to communicate with their clients, families, and communities that they are any less effective in attempting to achieve their ultimate goal of better communicating with the diverse language groups in their area. The AHWs believe that their methods of communicating with the Aboriginal community will eventually lead to better health for all involved. The services that participated in community engagement and consultation may not meet the definition of community control, yet the work they are undertaking has the same goal and that is to improve communication and better health status for Aboriginal Australians.

One can argue that the National Aboriginal Community Controlled Health Organisation (NACCHO) believes that a community controlled service can render a better service than one that uses community engagement and community consultation. However, this researcher is convinced that community engagement and community consultation can be a successful alternative method to community controlled health service. The goal for all ATSIHSs is to deliver improved health care to all of Australia's Aboriginal and Torres Strait Islanders which is at the heart of all services that wish to deliver better communication and health care to their clients. From the researcher's point of view both Koala and Emu health services do engage in community consultation and engagement and these actions within themselves are excellent strategies in communicating with community members. Their initial agenda may well have been to build a greater clientele for their respective services yet in doing so they were both actively gathering information that allowed them to provide a service to a community that may not have been aware that the services existed.

**Summary**

The four health services involved in the study claimed to be community controlled but the evidence demonstrates that under the definition of community

controlled only Goanna and Possum Health Service come under this category. Koala and Emu Health Service are more inclined to come under community engagement and consultation. While there is merit in the way that all services attend to health care matters including the continual home visits to Aboriginal peoples; there tends to be some conjecture that Aboriginal community controlled health services are the better way to go. Being a member of NACCHO, according to that service, increases quality of service. The research does not support this view as community engagement and consultation, while they are different from community control, can be just as effective. The only way either method could be improved in this researcher's view is to incorporate community control, community engagement, and consultation in their dealings with Aboriginal peoples. The methods used by the four health services are all excellent strategies for communicating with their clients or prospective clients within their community.

Community engagement and consultation by AHWs from Kaola and Emu ATSIHS informed the Aboriginal community that the ATSIHSn was operational. This strategy also provided some insight to the health status of the Aboriginal people living in their specific region. Through consultation they were able to learn of diverse language groups and information that would enable them to deliver more accurate and adequate care of prospective clients if the community had not provided pertinent information. The dominant society might well disapprove of the methods used to provide the community with information and be provided with information about people in their community. There may be questions raised of breach of privacy and confidentiality and indeed this could be true. Nevertheless, if communication is to be improved between the cultures we all need to learn about the ways of Aboriginal peoples. It is important though, if we are genuine in wanting to understand other cultures, and specifically those of Australian Aboriginal people, that firstly we have a solid knowledge of our own culture. Without this understanding communication will continue to be an issue.

Communication with Aboriginal people whether it is through community controlled services, engagement, and or consultation often reveals issues that prevent Aboriginal people from seeking health-care from health professionals. These may include communication difficulties, their socio economic status, and the failure to be able to afford transport to the relevant health service.

## 5.2 Socio Economic Status and Transport

Overcrowding, lack of a permanent dwelling or inability to afford adequate housing due to unemployment are often factors that affect an Aboriginal person's priorities in terms of seeking treatment for a medical condition. In terms of setting priorities, one respondent stated that "... it is very difficult to control your illness if you do not have a house to live in and shelter is at the bottom of the Maslow triangle" Possum, Par. 3. It makes sense then that an Aboriginal person may concentrate on the immediate need of humans, for example food and shelter, before personal health care, including arranging transport to and from a ATSIHS.

Having been informed that there are health services available to them at no cost the real dilemma for the Aboriginal community lay in how, if they wanted to visit the health service, would they manage to travel there and where would they obtain the money for transport? The four health services in this study overcame that hurdle by either providing a small bus to drive the patients or the AHW used the health service vehicle, and in some cases their own vehicle, to take the clients to appointments either at the health service, specialist appointments, and other institutions such as Centrelink. The strategy of providing transport gave the driver, whether an AHW or someone else, the opportunity to yarn with the clients which helped with communication, trust, and relationship building.

**Summary**

Most of Australia's Aboriginal communities are socio economically disadvantaged. Many live in overcrowded accommodation and many have no shelter at all. They survive on welfare and quite often their diet is insufficient to provide a reasonable status of health. Employment for Aboriginal people is the lowest in this country and denies them dignity and self-esteem. No wonder Aboriginal people, in many cases, put their wellbeing last, especially when other matters such as food and clean water take priority.

The strategy of providing transport to Aboriginal clients is indeed a very good one. However, it is logical to say that this mode of transport may only be applicable and or available to urban and regional areas. The fact that the driver of this vehicle yarns with the clients and builds trust and a relationship demonstrates a strategy well worth incorporating in any health program. In communicating with the clients that are being transported not only can the AHW illicit important health issues, but can learn during their communications as to what language group the

client comes from and whether there is a need to change the way she or he is communicating with the client.

## 5.3 Language and Cultural Awareness

To communicate with anyone, one must be able to understand their language. As mentioned in previous chapters Aboriginal people come from diverse countries with their own culture, rules, regulations, politics, and language to name but a few. Many then move to urban areas where they mix with other Aboriginal people from different language groups. Generally, there is a type of Aboriginal English that many use to communicate with each other but sometimes this may vary due to the different understanding of a word or words. When communicating with people and making sure that they receive the message that was intended it would be wiser to use plain simple language. In adopting plain simple words this may, especially in health services, prevent misdiagnosis and assist the client to understand what the health professional is telling them for example, dosage of medication, what is wrong with them, and what treatment they need to name a few. Plain simple language can prevent miscommunication.

**Cultural Factors in Communication**

Some Aboriginal people from different Aboriginal language groups may experience difficulty in using and understanding mainstream English. This theory is supported by Westone (2011) who also asserts that people from the dominant culture will ask forceful, self-assertive questions which may be translated as hostile by the Aboriginal person. In this case the Aboriginal person may decline to answer or simply say what they think the questioner wants to hear (Westone, 2011). It is also mentioned by McBain-Rigg and Veitch (2011) that some health professionals, specifically GPs, will ask a question and before the Aboriginal client can answer will ask another one shortly after not giving the client the time to process the first question. The findings in this research demonstrate that this is what is happening. It is not always only people from diverse language groups that have difficulty in communicating with the dominant culture, health professionals and or AHWs. The lack of education may be a major factor in being able to communicate well with others outside of their own grouping.

A finding of this research is that the ATSIHSs have adopted the use of English in a very simple and plain way. This then helps them communicate more effectively with their clients as well as assisting them to build trust and better

relationships. They also accompany their clients to other appointments, if requested to by the client, and often explain to the client what the health professional has told them. It is obvious, even if the health professionals have undertaken cultural awareness programs; they still on many occasions use words that are beyond the ability of Aboriginal people and other marginalised individuals to understand. In one's own opinion there is a need for health professionals not only to undertake cultural awareness programs but to be mindful of putting what they learnt into practice. Using plain language for all their clients can only lead to better communication all round.

**Summary**

It is evident that not all Aboriginal people speak the same language and that a type of communication used is Aboriginal English. Even then, there may be differences in the meaning of words. The strategy of adopting plain simple English when yarning or consulting with Aboriginal clients within the health services is most appropriate. This does not mean that Aboriginal people are not intelligent but only that their first language may be of their cultural language group and not of the Standard Australian English (SAE) as adopted by the dominant culture. It is also evident that forceful and or direct questioning of Aboriginal clients may not obtain the true answer but one that the client thinks the health professional is looking for.

## 5.4 Ways to Communicate

In this section a number of themes will be discussed as they are all linked in some way to one another. These include yarning, the use of silence, non-verbal communication, artwork, local community logos, clear simple signage, and providing a comfortable inviting environment. As was mentioned earlier, the use of plain simple language is an important tool in communicating more effectively with Aboriginal clients. Communication also indirectly is connected to cultural reconnection which will be explained more fully within this section. While the subject of enthusiasm and positive attitude cannot be labeled as a strategy it is important that this in included in the findings.

**Yarning**

It is evident that Aboriginal people adopt yarning as a way of communicating, but with various connotations. Yarning among themselves, within their own community, or perhaps another Aboriginal persons' country; they use yarning as a way of greeting, hearing of local news or gossip, and in finding out what mob you

are from and what your business is in their community. To the Aboriginal person it is also about listening with respect to the Dreaming stories that the Elders tell about their history, their socio economic situation, as well as their social and emotional well-being and their health. Yarning includes the chatter with the bus or car driver when they are being transported to and from their homes to an ATSIHS. Yet this researcher has discovered that it is much more serious than that. This way of communication is unique to our Aboriginal people in that they use it to discuss serious matters either within their communities or between visiting government officials, health professionals, police, and other persons of authority. When yarning occurs in this category it is respectful that the Elder of the group commences the conversations. At the beginning of the session the Elder may talk about almost anything before the real subject is approached. It is vital, as mentioned before, that the visitor does not ask direct and forceful questions if they are hoping to achieve a real answer. They must also observe sometimes long silences while the group considers what they have been told and process the request in their own minds. It is possible, as evidenced in the observance, listening is a significant part of yarning. Receiving an answer to a request or question may take but a few minutes, a week, or a month. Yarning is part of Aboriginal culture, just as using a combination of methods to communicate is to non-Aboriginal society (Coulehan et al., 2005).

**Non-Verbal Communication**

Non-verbal communication in this context is a way which Aboriginal people signal to each other that they are not in a good mood and best to stay away from them today or use other specific signs that are only known generally to their own Aboriginal group. The signs are as simple as a raised eyebrow or a gesture of rubbing a forefinger across the nose. This is a way of sending non-verbal important messages to one another and specifically when they do not want the non-Aboriginal person to know what has been said. A participant from one of the groups stated that there are many good things passed on to one another without uttering a word. As an Aboriginal person and privileged to a small amount of this nonverbal communication the researcher has found that this is a most useful way of communicating.

Nonverbal communication and body language is a vital form of communication. When people interact with each other they continuously give and receive countless wordless messages. All of our nonverbal behaviours; the gestures each person makes, the way they sit, how fast or how loud they talk, how close they

stand to one another, how much eye contact they make send strong messages. The ATSIHS indicated that informal learning of these techniques provides them with a strategy to help them to understand their client a lot better. The participants in this research study all agreed that it is really important for them to understand that the way they listen, look, move, and react can tell the other person whether or not they care and how well they listening to their client. The nonverbal signals they send to each other either, produce a sense of interest, trust, and desire for connection or they generate disinterest, distrust, and confusion. The latter they insist is not what they want, so they learn informally from each other and in two of the ATSIHSs formal programs of nonverbal communication were utilised. This strategy is but one way to send nonverbal messages, there are also other silent ways of communicating to our Aboriginal people without a word being spoken and these are depicted in the following subjects of art, community logos, in the ATSIHS signage, and making the practice comfortable and inviting targeting Aboriginal people.

**Artwork, Logos, Signage, and Comfort**

In all four of the ATSIHSs visited it was obvious that the health service targeted Aboriginal people and their families. Each practice displayed Aboriginal artwork, each with their own story. Signage to indicate directions as to where to go was in plain and simple words. All the brochures and flyers in the health services depicted the local Aboriginal artwork with colours that included black, yellow, and ochre and some displayed green, blue, black, and white depicting the colours of the Aboriginal and Torres Strait flags. There were play places and cultural toys for the children to play with and all clients were treated with dignity and respect.

It was also evident that the clients and their children's comfort were looked after with comfortable seating and cushions which were adorned with cultural stitching and or paintings. Small chairs and tables and biscuits were available for the children with cool water for all to access. Sometimes the patients were offered refreshments in the way of a cup of tea or coffee and sandwiches if they had travelled a long distance or were elderly and frail. The waiting rooms were adorned with natural local flowers and greenery while the staff were professional, but warm and welcoming. All of these gestures communicated to the clients that this was a welcoming place and that they could feel safe and wanted in this environment. Communicating in this culturally friendly way led me to look at other means of communicating especially about their illness.

**IBERA**

Indigenous Body Education Resource Animation (IBERA) is an excellent program provided by the health services to help the client understand what part of the body is not working as it should and what the disease may look like. This program is designed with Aboriginal voices so that a male client may choose a man's voice on the computerised program to describe what he wants to know. This applies also to women and teenagers. For example, if a client is suffering from renal disease, the program will show the client where the kidney is situated in his or her body and what function it performs. It may then go on and describe what happens when the kidney fails to function correctly. This applies to all parts of the body. An excellent strategy in communicating health issues to Aboriginal people. Of course many of these strategies could not have been put in place unless the staff were culturally sensitive and had not undertaken cultural awareness training or communicated in some way with their Aboriginal clients and their community.

**Cultural Reconnection Strategy**

Being culturally aware and having undertaken cultural sensitivity training it is obvious that the staff at the ATSIHS were mindful that some of their clients had difficulty with identity and specific knowledge of their own culture and or mob. Some of the health services implemented a strategy of cultural reconnection programs and the *Tree of Life*. The running of these programs involved Elders from the client's country who taught the clients about their culture, and helped them find out who their mob was. Understanding your culture, gaining an identity, and knowing about your past is a vital internal and emotional communication tool that allows many hurtful problems to heal and provides better understanding of one's self, as well as being able to communicate these issues to their health professional. This has been evident throughout this research. Without knowledge of the past, one cannot appreciate the present or make predictions about the future.

**Cultural Awareness, Sensitivity, and Safety**

The health services in this research insisted on staff, including GPs, undertaking cultural awareness training. However, it seems apparent that to some health professionals it is more challenging to put the training guidelines into practice. Medical terms are still being used by GPs and Specialists, direct questioning continues, and if they do obtain an answer from the client it may be what the client thinks the health professional is wanting rather than what the client feels or knows.

Added to this, if the client is not accompanied to their consultation by an AHW they tend to come away not realising exactly what is medically wrong with them, what treatment they need, or what medication to take and in what dosage. This has also caused some GPs to misdiagnose the client with serious repercussions. Cultural awareness needs to uncover the less obvious including interpersonal behaviours such as displaying respect by lowering the eyes or head which may contrast with the dominant cultures way of looking a person directly into their eyes.

**Cultural Sensitivity**

It is one thing for health professionals to be culturally aware but this research has revealed that it does not always carry over to cultural sensitivity. One doctor, who recently came from the British Isles, stated that he was culturally aware of Aboriginal people but he was unable to understand what they were saying and was disgusted at the way the women patients sat with their eyes cast down and were non-compliant by remaining silent throughout the consultation. This type of occurrence is an example of both a lack of understanding of Aboriginal culture and not being culturally sensitive. These women, according to the participant in the research group, stated that it was taboo to talk about such things to a man. It is apparent that the Doctor was both culturally unaware of men's and women's business but was also insensitive to their needs as well as their cultural safety.

**Cultural Safety**

With the strategies in place in the health services within this research it is obvious that all four strive to ensure cultural safety by doing everything that has been discussed earlier in this chapter. They go to great lengths to ensure that clients are not labeled due to the perceived power of some of the health professionals. They implement strategies to ensure a culturally safe environment and engaging with clients to understand their unique needs, beliefs and ways of doing things. The health professionals of these health services ensure that they do not diminish, demeanor or dis-empower their clients and others through their speech and or actions. With these strategies in place the health professionals are able to ameliorate their communication with their clients and see to their needs in many areas of health and other issues that arise. Understanding the necessity of formulating and implementing these strategies may well be that many of the staff who are of Aboriginal culture have experienced these problems themselves or at least have some knowledge of what many Aboriginal clients may experience.

**Employing Aboriginal Staff**

One of the very interesting and positive strategies adopted by all four health services is to employ Aboriginal staff. This includes psychologists, accredited AHWs, registered nurses, enrolled nurses, CEOs, administration staff, transport drivers and so on. This is a positive move and it also gives the staff opportunity for advancement and as one participant of this study said, they started as an AHW and will this year qualify as a registered nurse. It not only makes the practice appear culturally friendly but gives a message that we are one of you and that we understand many things about being Aboriginal. Generally, in a community controlled health service, Aboriginal staff are recommended to the CEO by the Elders and members of the Aboriginal community. This in itself is a positive step, as the trust in this prospective employee has already been placed in him or her by the people of the community.

It is apparent that the person recommended may not be fully qualified in all areas of the work required but, has the capabilities of developing skills over time. The health services that follow this way of employing Aboriginal staff not only attract clientele, as seen earlier in this chapter, but demonstrate that they are able to offer non-Aboriginal staff the opportunity of providing better communication and health care to their Aboriginal people by providing training to develop their skills in communication and other areas of the health service.

**Flexibility**

The research has discovered the need for flexibility when employing Aboriginal staff as Aboriginal people have different needs than that of the dominant culture. These include obligations to kin as well as other cultural commitments. Most prominent is during grief and loss; Sorry Time. It obvious in the dominant society that bereavement time off is allowed but only to certain members of the direct family. However the study revealed that the family of an Aboriginal person may include up to three to five hundred relatives and or kin. If the Aboriginal person is denied this Sorry Time then it impacts on their emotional and social as well as physical well-being. In a position of employment where grief and loss is suffered by an Aboriginal person and they are required to return to work before they are ready or have carried out their cultural commitments, their work may suffer. As a result the employer being of the dominant culture and lacking the understanding of this process

may dismiss the employee. When ATSIHSs employ an Aboriginal person they utilise strategies of capacity building employment.

**Employment Capacity Building of Aboriginal Staff**

Strategies of capacity building of staff include cultural awareness, sensitivity and safety training to all staff both Aboriginal and the dominant culture. Employees are trained in the skills they require to carry out the position they have been employed to do. Continuous development of these and other skills can only contribute to future staff promotion, provide more effective communication with clients as well as better health care needs, and indirectly help clients to better communicate and to educate them in their health care problems

Some of the programs evidenced throughout the research provide the staff with the ability to maintain their cultural identity, identify goals, and determine strategies to reach those goals. The skills development program also assists the Aboriginal employee to interact more confidently and effectively with the dominant cultures as well as the government and the private sector. It is evident that these strategies, which are a human resource development, have a broader strategy at work which is improving education and employability of Aboriginal people simply by the AHWs communicating with their clients on a constant basis. It is then beneficial in the broader sense that improving education for all Aboriginal people will have long term benefits, many of which have been listed in this discussion.

**Enthusiasm and Positive Attitude**

While enthusiasm and possessing a positive attitude is not a strategy it is what these findings discovered in all staff of the four health services. This enthusiasm contained eagerness to do the right thing, not only to their clients, but to each other with respect and warmth, devotion and a passion rarely experienced at the level that this researcher experienced within these health services. The eagerness displayed on their faces when they discussed the strategies that they were implementing or under consideration to formulate was infectious. It made one feel quite excited and inspired by this teamwork and what they wanted to achieve. On questioning, they admitted that some days were harder than others but they knew that they had to find a way around every obstacle if they were to improve the communication between their people and the health professionals but also of the dominant culture as well.

There is little doubt that within these health services that the staff believe that enthusiasm is lost if one does not keep a positive attitude. All staff involved in this

study demonstrated that with exuberance. Their attitude towards constantly looking for ways to implement strategies to improve communication, connect their clients with their own culture, and help them to communicate more effectively with health professionals were demonstrated in their voices, their body language, and at a risk of repeating what has already been stated their enthusiasm for all things connected to the service they were working in. When asking the participants about this at afternoon tea (as recorded in my journal) they stated that having a positive attitude assisted them with creative, constructive thinking. It was found that they used these modes to induce optimism in their colleagues and clients, to inspire each other, and to motivate each other to accomplish goals of helping their people to experience good health and longevity equal to that of their dominant culture counterparts.

One of the things most noticeable about the staff was the high level of confidence they had in what they have set out to achieve. Elgass (2000) wrote that a positive attitude assists a person to contend more simply with the daily tasks and occurrences of life. It makes it less difficult to elude worry and negative thinking. A positive attitude can deliver constructive transformation in one's life and make each individual happier, brighter, and more successful. The author asserts that one's attitude is communicated to others in three different ways. Elgass (2000) suggests that approximately 7% is by verbalizing, 38% by tone of voice as well as 55% by posture. In this researchers mind having a positive attitude coupled with enthusiasm, as witnessed at the focus group discussions, can only lead to continual success in the task of improving communication between Aboriginal people and health professionals. It is her opinion that there are three ways of communicating what type of attitude one may have to another and that is by either being positive, negative, and or neutral. Dealing with the person projecting the neutral attitude can be most challenging. From what was witnessed during the data collection and the attitude displayed to clients while the researcher was watching, it did seem that the all staff had all aspects of positive attitude covered. They also demonstrated genuine enthusiasm towards their work and responsibilities. It is a pity that more of both enthusiasm and positive attitude is not linked together more often in all cultures and professions.

**Summary**

Looking at the ways to communicate it is evident that yarning is a significant communication within Aboriginal communities. This includes yarning about serious

community matters and a form of greeting when meeting with one of their own or an Aboriginal person from another country.

Adopting the strategy of either formally or informally learning about non-verbal body language can only lead to better understanding and communication between the health professional and the Aboriginal client. The non-verbal language which is a way of communication takes many forms such as displaying Aboriginal artwork in the health service, using comfortable seating, and Aboriginal designed literature on display. The signage to direct people is plain and simple and easy to read.

Cultural awareness, sensitivity and safety is a major strategy incorporated by the health services for all staff to ensure that they communicate well and use the right protocols when dealing with people of Aboriginal culture. It is evident that while non-Aboriginal people undertake this training they do not always put it into practice which can lead to disastrous miscommunication and even misdiagnosis.

One significant strategy is that of employing Aboriginal staff within their health service. While the CEO may use different methods in the choice of employee the fact that they do choose a person of Aboriginality is vital and ensures that when a client visits the health service they are going to be conversing with someone that is aware of their culture. This makes the client feel safe.

Flexibility in employing an Aboriginal staff member cannot be overlooked. They do have different requirements and cultural responsibilities to their mob and kin especially during Sorry Time.

While employment capacity building is carried out in all cultures it is important specifically within a position where an Aboriginal person is employed. It could, and does, inspire clients and other Aboriginal people to undertake education and or seek employment.

# CHAPTER 6

## 6. Conclusion

Figure 11. Legends of the Dreaming
Source: Roberts, A., & Mountford, C. (1975). Legends of the Dreaming. Hong Kong: Myer Publications.

Having reached the end of an enlightening, and sometimes frustrating, journey the conclusions chapter will reveal that the participants of this research study not only listened to what Aboriginal people stated that their health needs were but understood that without effective communication their client's health status would be slow to improve and the gap in longevity still below that of their dominant culture counterparts. The four Aboriginal health services in this research took major steps to improve the communication between the two entities by formulating and implementing strategies to meet this need.

This research has focussed on constructing a descriptive conceptualisation of what strategies have been implemented to decrease the barriers of communication between health professionals and Aboriginal people. The literature review revealed that there have been singular strategies implemented focussing on issues, which have been somewhat successful in what they were intended for, but many were unsuccessful. Problems with communication still exist between Aboriginal people and health professionals today.

Many of the singular strategies reported in the literature that were implemented to improve communication with Aboriginal people in general practices and hospitals and particularly within the renal care units failed due to lack of cultural awareness and training and the inability to understand the language used by their clients. It has also been found that the inability to communicate effectively with Aboriginal clients has caused misdiagnosis which has sometimes resulted in death and or major complications and at the very least the health issue that the client consulted about may not receive the correct treatment and over time the problem escalates into a major life threatening or chronic illness.

It is obvious from the beginning when the first Aboriginal Medical Service (AMS) was established in 1971 at Redfern, well before the Alma Ata Declaration and the Ottawa Charter declared that all people throughout the world had the right to seek adequate health care, that it was recognised in Australia that health care had to

be determined by Aboriginal people for Aboriginal people. Once the Redfern clinic was established other Aboriginal and Torres Strait Islander Health Services (ATSIHSs) were established in diverse areas and the Aboriginal people started to seek help for their health issues, which was a significant step for them. Nevertheless, the realisation that Aboriginal people needed their own clinics did not completely solve all the issues that inhibited effective health care with communication being the principal barrier to resolving health care needs. Investigation in to what was needed to resolve the problem revealed that through the cooperation of both staff of ATSIHSs and the Aboriginal communities which the ATSIHSs catered for, a number of problems were identified and strategies were implemented in an attempt overcome these issues.

It is concluded that the strategies revealed in this research, if adopted by other organisations, will not only go a long way in improving communications between health professionals and Aboriginal peoples but may ultimately improve their health, education, and socio economic status. This chapter emphasises that this must be a collaborative effort by both the health professional and all peoples with the interest of Aboriginal people being able to communicate effectively, not only with health professionals, but with the dominant culture as a whole.

**Conclusion**

The reluctance of many of the ATSIHSs in South East Queensland to take part in this research study was very disappointing. It made this researcher question why this was so and she was unable to form an opinion or come to any conclusions. A positive contributing factor was that the four health services that were willing to participate represented a wide area of South East Queensland that enabled the researcher to gain a more in-depth look at what each service did to decrease the barriers of communication with their clients across a broader area.

The literature review identified a number of strategies that were implemented to try to improve communication between the Aboriginal clients and health professionals. One strategy that appeared to work well was employing Aboriginal Health Workers (AHWs) and developing their skills within an ATSIHS. This strategy has been adopted by the four ATSIHSs in this research study and has proved to be a positive step not only in the communication phase but in developing trust and building good relationships with their clients.

The strategies implemented in developing AHWs skills are paramount to the success of the ATSIHSs involved in this study. Providing employment capacity, building programs that give staff the opportunity to develop their skills is pivotal to the good management of an ATSIHS. However, utilising the strategy of flexibility that may not be found in the dominant culture's general practice is crucial to maintain Aboriginal staff. Aboriginal staffs require special consideration during Sorry Time. If the staff member is not grieved by the loss of a close relative they may still have cultural obligations to the deceased's family therefore flexibility must be exercised in allowing time off to fulfil these cultural obligations.

While other major factors are making these ATSIHSs successful they would not reach the heights of achievement that they have without having AHWs ever ready to accompany clients to specialist meetings, other general practice consultations, and other institutions outside of the health arena such as Centrelink, as well as to undertake home visits. This service is not found in general practices that are generally attended by the dominant culture. The AHW trains and takes on diverse roles in Aboriginal health. These include, counselling and explaining what the health professional has told the client should they not have understood what had been said. In all the ATSIHSs in this research there are a large number of positions filled with AHWs which underpin the successful running of an ATSIHS.

Major findings in the research were that the 17 topics that arose within the thematic analysis findings all played a part, some more significant than others, in assisting the ATSIHSs in formulating strategies to improve communication between themselves and their Aboriginal clients. Some of these included ensuring that the Aboriginal clients, their families, and their communities had input into what health-care programs and or service they required. All four health services had a Board of Management however, only two ATSIHSs were community controlled while the other two used community consultation and engagement.

Nevertheless, the common factor for all four in the beginning was to establish a clientele data base as an Aboriginal Health Service. While staff of two of the ATSIHSs in the initial stages visited each home within their district, they soon discovered that while all the people they visited were Aboriginal individuals or families, there was still a language barrier.

The issue of language had to be tackled first and foremost as staff of the four ATSIHSs were all confronted with people from diverse language groups. It was

realised that most Aboriginals spoke some English and the strategy adopted by all four was to talk plainly and simply rather than to use academic or medical terms. Added to this, the strategy of having compulsory cultural, sensitivity, and safety training for all staff and the understanding that clients have a preference to yarn rather than have questions directed at them and expect the questions to be answered.

Providing transport was important because of the low economic status of many clients as well as clients with a disability who would not have been able to afford transport costs to seek health care.

Displaying Aboriginal artwork and plain signage indicating directions as well as brochures that display Aboriginal colours and designs indicated to the Aboriginal client that this practice appears to be culturally friendly. It may also communicate to an Aboriginal client that this is a health service that they can trust with their health care needs. The strategy of using Indigenous Body Education Resource Animations (IBERA), a computerised program that allows the client to view what part of their body was adversely affected, is an excellent way of communicating to clients about their health issues and what they need to do to sustain good health.

The four ATSIHSs in this study also consider women's business when talking to young mothers about child rearing and used the strategy of having Women Elders talk to the women about issues surrounding birthing and other women's topics. Reconnection to country for these women was also an important strategy as without them knowing their past they cannot be content in the present. The strategy of male Elders communicating with male patients is similar to that of the *Women's Business*, however only men's issues are discussed. This is known as *Men's Business*.

While not a strategy this researcher was simply amazed at the enthusiasm of all staff in the four ATSIHSs in not only continually searching and consulting about what future strategies that they may be able to formulate and implement but the positive attitude they demonstrated to all who cared to listen. It was only natural that some relationship building by the researcher was a requisite to elicit the data she obtained from the four ATSIHSs. However, once trust was established the participants of the ATSIHSs demonstrated their eagerness to decrease the barriers to communication not only between themselves and their clients but between their clients and the dominant culture. This, they all agreed, was the way forward to ameliorating the health of their people.

While there have been 17 strategies identified as being implemented to decrease the barriers in communication between health professionals and Aboriginal clients it is concluded that these strategies are only sections of a whole and are not successful by themselves in decreasing the barriers to communication between health professionals and Aboriginal clients. It is this researcher's findings that the four ATSIHSs in this research study have continually added strategies to assist in developing effective communication and do not use them as a singular strategy but as a combination and as a collective that will prove to be a solid tool to improve communication between health professionals and Aboriginal people. As all participants stated, they are constantly relying on their clients, families, and community for feedback and ways to develop new strategies to continually add to those strategies already developed.

The proof that Aboriginal people are now more than ever consulting ATSIHSs and other health professionals is evident in the increasing numbers of clientele that attend these health services. Added to this evidence is the increasing number of AHWs employed to attend to the needs of Aboriginal clients. Through these efforts of Aboriginal people it is foreseen that the future holds longevity for them equal to that of their dominant culture counterparts.

One of the ATSIHSs is actually a Brokerage and therefore is a referral service. Their strategy is not only to have an Aboriginal Board of Management, employ AHWs, and continually apply employment capacity building, but have spread their strategies into dominant culture general practices.

### 6.1 Recommendations

That further research be undertaken into what strategies are successful in decreasing the barriers of communication between health professionals and Aboriginal people (refer Appendix A) The Strategies to Improve Communication Report outlines ten of the most poignant strategies utilised by ATSIHSs in improving communication with their clients followed by five recommendations. A request to disseminate this report as widely as possible shall be forwarded to:

1. National Aboriginal Community Control Health Organisation (NACCHO);
2. Queensland Aboriginal and Islander health Council (QAIHC);

3. Queensland State Government and Federal Government Health Ministers; and
4. GP Connections and Medicare Locals.

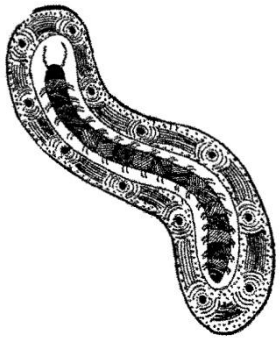

Figure 12. Millipede
Source: Close, V. (2002) Cultural Awareness Program (Unpublished)

# REFERENCES


Abbott, P., Gordon, E., & Davison, J. (2006). Expanding roles of Aboriginal health workers in the primary health care setting: Seeking recognition. *Contemporary Nurse, 27(2),* 157-164.

Aboumatar, H. (2009). *Embedding teamwork and communication improvement strategies in the work environment*. MPSC Annual Conference Solution Submission: The JHM Teamwork and Communication Program presented at John Hopkins Medicine Maryland Patient Safety Centre.

*About Australia: Indigenous programs: education, health and housing* (2008). Retrieved from the Australian Government Department of Foreign Affairs and Trade website: http://www.dfat.gov.au/facts/Indigenous_programs_education_health_housing.pdf.

Altrichter, H., & Holly, M. (2005). Research diaries. In Somekh, B., & Lewin, C. (Eds.), *Research methods in the social sciences*. Retrieved from www.ncl.ac.uk/fms/postgrad/skills/documents/Researchdiaries2008.ppt.

Anderson, K., Devitt, J., Cunningham, J., Preece, C., Cass, A. (2008). "All they said was that my kidneys were dead": Indigenous Australian patients' understanding of their chronic kidney disease. *Medical Journal Australia, 189(9),* 499-503.

Aronowitz, S. (2003). *A Mills revival.* Retrieved from http://www.logosjournal.com/aronowitz.

Ashworth, T. (1994). Different ways of talking. In Graham, D. (Ed.), *Being a Whitefella*. Freemantle, WA: Freemantle Arts Centre Press.

Atkinson, P., & Silverman, D., (1997). Kundera's 'Immortality': The interview society and the invention of the self. *Qualitative Inquiry, 3,* 304-325.

Australian Health Ministers' Advisory Council (2008). *Aboriginal and Torres Strait Islander health performance framework*. Canberra, ACT: Department of Health and Aging.

Australian Medical Association (AMA) Indigenous Report Card (AMAIRC, 2007). *Institutionalised inequity: Not just a matter of money*. Conference on 22nd May 2007 at Nunkuwarrin Yunti, Adelaide, South Australia .

Australian National Audit Office (1998). *The Aboriginal and Torres Strait Islander health program:* Canberra, ACT: Department of Health and Aged Care.

Baildon, G. & Bourke, N. (2003). Cross cultural challenges: Northern Territory experiences. *Acquiring Knowledge in Speech, Language and Hearing, 5(1),* 28-30.

Bain, M. (1992). *The Aboriginal-White encounter: Towards better communication*. Darwin, NT: Summer Institute of Linguistics.

Bassey, M. (1999). *Case study in educational settings.* Buckingham, UK: Open University Press.

Batumbil, P. & Guyulun, H. *Sharing the true stories: Improving communication in indigenous health care*. (2009, November 27) Retrieved from http://www.cdu.edu.au/centres/stts/home.html.

Baum, F. (2004). *The new public health* (2nd ed.) South Melbourne, Australia: Oxford University Press.

Bell, K., Couzos, S., Daniels, J., Hunter, P., Mayers, N., & Murray, R. (2000). Aboriginal community controlled health services. *General Practice in Australia, Commonwealth Department of Health and Aged Care, Canberra, ACT, 2004*, 75-102.

Bessarab, D., & Ng'andu, B. (2010). Yarning about yarning as a legitimate method in Indigenous research. *International Journal of Critical Indigenous Studies, 3(1),* 37-50.

Boren, M. T. & Ramsay, J. (2000). Thinking aloud: Reconciling theory and practice. *IEEE Transactions on Professional Communication, 43(3),* 261-278.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. Qualitative. Research in Psychology, 3: 77-101.

Braysich, J. (1979). *Body language.* Perth, WA: Braysich Enterprises.

Brennan, G. (1979). *The need for interpreting and translation services for Australian Aboriginals, with special reference to the Northern Territory: A research report*. Canberra, ACT: Department of Aboriginal Affairs.

Briscoe, G. (1974). The Aboriginal Medical Service in Sydney. In Hetzel, B., Dobbin, M., Lippmann, L., & Eggleston, E. (Eds.), *Better Health for Aborigines?*. St Lucia, Brisbane, QLD: University of Queensland Press.

Burt, S., & Code, L. (Eds.) (1995). *Changing methods: Feminists transforming practice*. Ontario, Canada: Broadview Press.

Cannella, G., & Lincoln, Y. (2004). Epilogue: Claiming a critical public social science: reconceptionalising and redeploying research. *Qualitative Inquiry, 10*, 298-309.

Cape, B. (1968) *Bailliere's nursers' Dictionary* (17edn) Bailliers, Tindal & Cassel : London: UK.

Carrello, C. (2009). The journey of Aboriginal health. *Department of Health, Perth, WA, 4*, 1-4.

Carspecken, P. (2004). Quality, quantity and the human sciences: The qualitative research movement and its implicit philosophical and methodological issues. *Fourth Annual Interdisciplinary Conference on Qualitative Research at the University of Michigan.*

Carspecken, P. (2005). Houston School critical ethnography; trends and themes. *Journal of Curriculum Theory Conference*. Retrieved from www.indiana.edu/~pcarspeck/Service/tabid/8266/Default.aspx.

Carspecken, P. (2008). *Can a theory of everything explain itself? Limits to knowledge in the physical and social sciences*. Rotterdam, UK: Sense Publications.

Cass, A., Lowell, A., Christie, M., Snelling, P., Flack, M., Marrnganyin, B., et al. (2002). Sharing the true stories: Improving communication between Aboriginal patients and healthcare workers. *Medical Journal of Australia, 176(10)*, 466-471.

Christie, M., & Harris, S. (1985). Communication breakdown in the aboriginal classroom. In Pride, J. (Ed.), *Cross cultural encounters: Communication and miscommunication*. Melbourne, VIC: River Siene.

Congress, C.A.A (2009) *Health introduction.* Retrieved from *http://www.caa2009.org/.*

Corbin, J. & Strauss, A. (2008). *Bascis of qualitative research*. Thousand Oaks, CA: Sage.

Coulehan, K., Brown, I., Christie, M., Gorham, G., Lowell, A., Marrjanyin., & Patel, B., (2005). *Sharing the true stories, Evaluating strategies to improve communication between health staff and Aboriginal patients, STAGE 2 Report.* Darwin, NT: Cooperative Research Centre for Aboriginal Health.

Couzos, S. (2004). Practical measures that improve human rights – Towards health equity for Aboriginal children. *Health Promotion Journal of Australia, 15*, 186-192.

Crawshaw, J., & Thomas, D. (1993). It's not enough to know about diseases: Report of the review of Aboriginal and Torres Strait Islander health care in Darwin. In Meyerhoff, G. *Injecting drug use in urban Indigenous communities: A literature review with a particular focus on the Darwin area*. Darwin, NT: Danila Dilba Medical Service.

Cresswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

Cunningham, J., Cass, A., & Arnold, P. (2005). Bridging the treatment gap for Indigenous Australians. *Medical Journal of Australia, 182*, 505-506.

Dawson, A. (2004). Asthma in the Australian Indigenous population: A review of the evidence. *Rural and Remote Health, 4(1)*, 1-18.

David, P. (2007). An Aboriginal and Torres Strait Islander oral health curriculum framework. Retrieved from www.uwa.edu.au/people/**david**.paul.

Davidson, P., DiGiacomo, M., Abbott, P., Zecchin, R., Heal, P., Mieni, L., et al. (2008). A partnership model in development and implementation of a collaborative, cardiovascular education program for Aboriginal health workers. *Australian Health Review, 32(1)*, 139-146.

De, D., & Richardson, J. (2008). Cultural safety: An introduction. *Paediatric Nursing, 20(2)*, 39-43.

Denborough, D., Koolmatrie, C., Muninggirriiij, D., Marika, D., Dhurrakay, W., & Yunupingu, M. (2006). Linking stories and initiative: A narrative approach to working with skills and knowledge of communities. *The International Journal of Narrative Therapy and Community Work, 2*, 19-51.

Denzin, N. (1998). The art and politics of interpretation. In Denzin, N., & Lincoln, Y. (eds.), *Handbook of qualitative research* (p. 322). Thousand Oaks, CA: Sage.

Denzin, N. (2000). Aesthetics and practices in qualitative inquiry. *Qualitative Inquiry, 6(2)*, 256-265.

Denzin, N., & Lincoln, Y. (2008). *The landscape of qualitative research*. London, UK: Sage

Devitt, J., Cass, A., Cunningham, J., Preece, C., Anderson, K., & Snelling, P. (2008). Study protocol – Improving Access to Kidney Transplants (IMPAKT): A detailed account of a qualitative study investigating barriers to transplant for Australian Indigenous people with end-stage kidney disease. *BMC Health Services Research, 8(31),* doi: 10.1186/1472-6963-8-31.

Devitt, J., & McMasters, A. (1998). *Living in medicine: A cultural study in end stage renal disease among Aboriginal people*. Alice Springs. NT: IAD Press.

Dollard, J., Stewart, T., Fuller, J., & Blue, I. (2001). Aboriginal health worker status in South Australia. *Aboriginal and Islander Health Worker Journal, 25(1),* 28-30.

Doumany, J. (2004). *Queensland Aboriginal and Islander health service*. Retrieved from http://www.gaihc.com.au/index.php?.

Dudgeon, G., Garvey, D., & Pickett, H. (2000). *Working with Indigenous Australians: A handbook for psychologists*. Perth, WA: Gunada Press.

Dwyer, J., Shannon, C., & Godwin, S. (2007). *Learning from action: Management of Aboriginal and Torres Strait Islander health services*. Darwin, NT: Cooperative Research Centre for Aboriginal Health.

Eades, D. (1982). You gotta know how to talk: Information seeking in South East Queensland Aboriginal society. *Australian Journal of Linguistics, 2¸93-98.*

Eades, D. (1991). Communicative strategies in Aboriginal English. In Romaine, S. (Ed.), *Language in Australia*. Cambridge, UK: Cambridge University Press.

Eades, D. (1992). Communicative strategies in Aboriginal English. In Romaine, S. (Ed.) (Rev. ed.), *Language in Australia*. Cambridge, UK: Cambridge University Press.

Eades, D. (1996). Legal recognition of cultural differences in communication: The case of Robyn Kina. *Language and Communication, 16(3),* 215-227.

Eades, D. (2001). Communicative strategies in Aboriginal English. In Romaine, S. (Ed.) (Rev. ed.), *Language in Australia*. Cambridge, UK: Cambridge University Press.

Eckermann, A. (2005). *Binan Goonj: Bridging cultures in Aboriginal health*. Armidale, NSW: University of New England.

Edis, F. (2000). Multiculturalism: Language in Aboriginal Australia: Yolngu Matha. *Speech Pathology Australia, October,* 118-120.

Eldridge, C. (2011).*Cultural awareness and safety training*. Retrieved from http://www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=1087.

Elgass, J. (2000). *How to exude positive energy:* Retrieved fromwww.ehow.com > Mental Health.

Fereday, J., & Muir-Cockrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive coding theme and development. *International Journal of Qualitative Methods, 33(5),* 4-8.

Fletcher, S. (2007) *Communities working for health and wellbeing: Success stories from the Aboriginal Community Controlled Health Sector in Victoria, Melbourne (AUST).* Melbourne, VIC: Victorian Aboriginal Community Controlled Health Organisation and Cooperative Research Centre for Aboriginal Health.

Foley, D. (2000). Indigenous Research: Differing value systems. *Australian Journal of Indigenous Education, 28(1),* 17-30.

Franks, C. (2006). "Gallinyalla": A town of substance? A descriptive study of alcohol, tobacco, medicines and other drug use in a rural setting. *Rural Remote Health, 6(2),* 491-497.

Fredericks, B. (2003). *Us speaking about women's health: Aboriginal women's perceptions and experience of health, well-being, identity, body and health services* (PhD Thesis). University of Central Queensland, Rockhampton, Australia.

Freemantle, J., Officer, K., McAullay, D., & Anderson, I. (2007). *Australian Indigenous health: within an international context*. Darwin, NT: Cooperative Research Centre for Aboriginal Health.

Gabb, D., & McDermott, D. (2007). What do Indigenous experiences and perspectives mean for transcultural mental health? Towards a new model of transcultural teaching for health professionals. In Ranzijn, R,. McConnochie, K., & Nolan, W. (Eds.), *Psychology and Indigenous Australians: Teaching, practice and theory*. Cambridge, UK: Cambridge Scholars Publishing.

Gallois, C., Ogay, T. & Giles, H. (2005). Communication accommodation theory: A look back and a look ahead. In W. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp. 121-148) Thousand Oaks, CA, USA: Sage.

Goldbart, J., & Hustler, D. (2005). Ethnography. In Somkh, B., & Lewin, C. (Eds.), *Research methods in the social sciences* (pp. 16-21). London, UK: Sage

Griew, R. (2008). *The link between primary health care for Aboriginal and Torres Strait Islander Australians*. Canberra, ACT: Department of Health and Aging.

Hepworth, D., Rooney, R., & Larsen, J. (1997). *Direct social work practice: theory and skills*. Melbourne, VIC: Thomas Nelson.

Hoepfl, M. (2005). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education, 9(1),* 1-13.

Hollingsworth, H. (2001). Executive insights: An intercultural strategies for effective collaboration. *Teaching Exceptional Children, 33(5),* 4-8.

Holmes, W., Stewart, P., Garrow, A., Anderson, I., & Thorpe, L. (2002). Researching Aboriginal Health: Experience from a study of urban young people's health and well-being. *Social Science & Medicine, 54(8),* 1267-1279.

Holroyd, E. (2003). Chinese family obligations towards chronically ill elderly members: Comparing care givers in Beijing and Hong Kong. *Qualitative Health Research, 13(3),* 302-318.

Hoover, W. (1996). The practice: Implications of constructivism. *SEDL Letter Constructivism, 1(9),* 1-2.

House of Representatives Standing Committee on Family and Community Affairs (2000). *Health is life: Report on the inquiry into Indigenous health*. Canberra, ACT: Parliament of the Commonwealth of Australia.

Huberman, A., & Miles, B. (2002). *The qualitative research companion*. Retrieved from www.qualitative-research./net/index.php/fqs/article/787.

Human Rights and Equal Opportunity Commission (2005). *Achieving Aboriginal and Torres Strait Islander health equality within a generation: A human rights based approach*. Retrieved from http://www.hreoc.gov.au/social_justice/sj_report/sjreport05/index.html.

Ivey, A., & Ivey, M., & Zalaquett, C. (2007). *Intentional interviewing and counselling: Facilitating client development in a multicultural society*. Belmont, CA: Brooks/Cole.

Jackson, L., & Ward, J. (1999). Aboriginal health: Why is reconciliation necessary? *The Medical Journal of Australia, 170,* 437-440.

Johnston, E. (1991). *Royal Commission into Aboriginal Deaths in custody National report: Overview and recommendations*. Canberra, ACT: Australian Government Public Service.

Jones, K. (2006). Aboriginal cultural identity, health and ethics. *Chisholm Health Ethics Bulletin, 11(3),* 7-9.

Kellehear, A. (1990). *Every students guide to sociology: A quick and plain speaking introduction.* South Melbourne, VIC: Thomas Nelson.

Kemp, K. (2001). *Cross cultural interaction and the Northern Territory intensive care experience: Dismantling the wall* (master's thesis). University of Sydney, Sydney, Australia.

Lather, P. (19930 fertile Obsession: Validity after poststructuralism. *The Sociology Quarterly*,*34*: 673-693.

Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods*. Melbourne, VIC: Oxford University Press.

Liberman, K. (1990). Inter-cultural communication in Central Australia. *Cultural Communication and Intercultural Contact, 177*.

Lloyd, T. (2009). *Health promotion and the Ottawa Charter: Improving public health through the world wide web.* Retrieved from http://www.suite101.com/content/health-promotion-and-the-ottawa-charter-a137515.

Lowell, A., & Devlin, B. (1998). Miscommunication between Aboriginal students and their non-Aboriginal teachers in a Bilinguils school. *Language Culture and Curriculum.* Retrieved from www.eric.ed.gov.

Mackenzie, G., & Currie, B. (1999). Communication between hospitals and isolated Aboriginal community health clinics. *Australian and New Zealand Journal of Public Health, 23,* 2204-2296.

Mayo, K., & Tsey, K. (2009). *Research dancing: Reflections on the relationships between university-based researchers and community based researchers at Gurriny Yealamucka health services Aboriginal corporation*. Darwin, NT: Cooperative Research Centre for Aboriginal Health.

Maxwell, J. (1992). Understanding validity in qualitative research. *Harvard Educational Review, 62,* 279-300.

McBain-Rigg, K., & Veitch, C. (2011). Cultural barriers to healthcare for Aboriginals and Torres Strait Islanders in Mount Isa. *Australian Journal of Rural Health, 1974(2)*, 70 – 74.

McKendrick, J. (1998). Indigenous health: A cultural awareness program for medical education. *Australian and New Zealand Journal of Public Health, 22(6)*, 737.

McWilliams, C., & Sangster, J. (1994). Managing patient discharge to home: The challenges of achieving quality care. *International Journal of Health 6*, 147-161.

Mills, C. W. (1959). *The sociological imagination.* New York: Oxford University Press.

Mills, C. W., Mills, K., & Mills, P. (2000). *Letters and autobiographical writings*. CA: University of California Press.

Mitchell, M., & Hussey, L. (2006). The Aboriginal health worker. *Medical Journal of Australia, 184(10)*, 849-850.

Muecke, S. (1992). Lonely representations: Aboriginality and cultural studies. *Journal of Australian Studies, 35*, 32-34.

National Aboriginal Community Controlled Health Organisation (NACCHO) (2008). *An AboriginalMedical Service.* Retrieved from www.naccho.org.au/policies/submissions.html.

Nathan, P. (1980). *A home away from home: A study of the Aboriginal health service in Fitzroy*. Melbourne, VIC: LaTrobe University.

National Aboriginal and Islander Health Council (2003). *National strategic framework for Aboriginal and Torres Strait Islander Heath*. Canberra, ACT: National Strategic Framework for Aboriginal and Torres Strait Islander Health Council.

National Aboriginal Health Strategy Working Party (1989). *National Aboriginal health strategy*. Canberra, ACT: National Aboriginal Health Strategy Working Party.

Nelson, A., & Allison, H. (2000). Values of Aboriginal parents: Food for thought. *Australian Occupational Therapy, 47*, 28-40.

Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, 15(3)*, 259-267.

Oakley, A. (2000). *Experiments in knowing: Gender and method in social sciences*. New York, US: The New Press.

Ong, L. M., de Haes, J. C., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science in Medicine, 40(7),* 903-918.

Oxfam Australia (2009). *Close the gap: Indigenous health in crisis*. Retrieved from www.oxfam.org.au/campaigns/indigenous-health/.

Parker, M. (2001). The ethics of evidenced based patient's choice. *Health Expectations, 4,* 87-91.

Partington, G. (1998). *Perspectives on Aboriginal and Torres Strait Islander education*. Riverwood, NSW: Social Science Press.

Paterson, B. (2001). Myth of empowerment in chronic illness. *Journal of Advanced Nursing, 34(5),* 574-581.

Paterson, L., Iemma, M., Eberly, L., Ding, Y., & Hargreaves, M. (2003). *In National Aboriginal and Torres Strait Islander Health Council*. Retrieved from www.health.nsw.gov.au/pubs/2003/pdf/ar2003.pdf.

Paton, M. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage Publications.

Pease, A. (2001). *How to read other's thought by their gestures*. New Delhi, India: Sudha Publications.

Peters-Little, F. (2000). *The community game*: *Aboriginal self-definition, at the local level.* Accessed 25-01-2012 from http://epress.anu.edu.au/caper_series/no_20/mobile_devices/ch19.html.

Pulver, L., & Fitzpatrick, S. (2004). Sitting round the table of rights-based reconciliation: A health perspective. *Health Promotion Journal of Australia, 15(3),* 193-199.

Pyett, P., Waples-Crowe, P., Van der Sterren, A. (2009). Engaging with Aboriginal communities in an urban context: Some practical suggestions for public health researchers. *Australian and New Zealand Journal of Public Health, 33(1),* 51-54.

Ramanazoglu, C. (2002). *Feminist methodology: Challenges and choices*. London, UK: Sage.

Redfern Aboriginal Medical Service 1971 – 1991: Twenty years of community service. (1991). AMS, Redfern, NSW.

Reid, J. (1978). Aboriginal medical services, Perth, Western Australia. *Medical Journal of Australia, 1*, 53-55.

Reinharz, S. (1992). *Feminist methods in social research*. NY: Oxford University Press.

Ring, D., & Brown, N. (2002). Indigenous health: A chronically inadequate response to damming statistics. *Medical Journal of Australia, 177*, 629 – 631.

Ring, D., & Firman, M. (1998). Reducing Indigenous mortality in Australia: Lesson from other countries. *Health Promotional Journal, 7*, 235-238.

Roberts, A., & C, Mountford (1975), *Legends of the Dreaming*. Hong Kong: Myer Publications

Robertson, B., Demosthenous, C., & Demosthenous, H. (2005). Stories from the Aboriginal women of the yarning circle: When cultures collide. *Hecate, 31(2)*, 34-44.

Rose, M., & Jackson Pulver, L. (2004). Aboriginal health workers: Professional qualifications to match their promotion roles. *Health Promotion Journal of Australia, 15(3)*, 34-44.

Saggers, S., & Gray, D. (1991). *Aboriginal health and society: The traditional and contemporary Aboriginal struggle for better health*. Sydney, NSW: Allen and Unwin.

Saggers, S., & Gray, D. (2007). Defining what we mean. In Carson, B., Dunbar, T., Chenhall, R., & Bailee, R. (Eds.). *Social determinants in health*. Melbourne, VIC: Allen and Unwin.

Sargent, M., & Nilan, P., & Winter, G. (1997). *The new sociology for Australians.* Melbourne, VIC: Longman.

Schwandt, T. (2007). *Dictionary of qualitative inquiry*. Melbourne, VIC: Longman.

Shahid, S., Finn, L., & Thompson, S. (2009). Barrier to participation of Aboriginal people in cancer care: Communication in a hospital setting. *Australian Medical Journal, 190(10)*, 574-579.

Shannon, B. (1994). Social and cultural differences after medical treatment. *Australian Family Physician, 23(1)*, 33-35.

Shaw, S. (1991). Self-harm among criminalised women: *Journal of Indigenous Scholarship, 4(2)*, 6-19.

Si, D., Bailie, R., Togni, S., d'Abbs, P., & Robinson, G. (2006). Aboriginal health workers and diabetes care in remote community health centres: a mixed method anaylsis. *Medical Journal of Australia, 185,* 40-45.

Somekh, B., & Lewin, C. (2005). *Research methods in the social sciences*. London, UK: Sage.

Stewart, M. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal, 152,* 1423-1433.

Summers, J. (2006, May 14). The deciders. *New York Times,* p. 39.

Sumner-Dodd, P. (2001). Consolidating partnerships. *National Aboriginal Community Controlled Organisation Annual Report, 2003 -2008,* 29.

Taylor, K., & Guerin, P. (2010). *Health care and Indigenous Australians: Cultural safety in practice*. South Yarra, VIC: Palgrave Macmillan.

Thomson, N. (Ed.) (2003). *The health of Indigenous Australians*. South Melbourne, VIC: Oxford University Press.

Torrance, H., & Pryor, J. (2001). Highlights of recent epistemology. *British Educational Research Journal, 27(5),* 615-631.

Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor-patient communications in the Aboriginal community: Towards the development of educational programs. *Patient Education and Counselling, 62*, 340-346.

Trudgen, R. (2000). *Why warriors lie down and die: Towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact : Djambatj Mala* . Australia: Aboriginal Resource and Development Services Inc.

Tsey, K. (2001). Making research more relevant to the needs and aspirations of indigenous Australians: The importance of research capacity development. *Aboriginal and Islander Health Worker Journal, 25(1),* 19-24.

Vallance, R., & Tchacos, E. (2001). Research: A cultural bridge. *Paper presented at the Australian Association for Research in Education (AARE) Conference,* Freemantle, 2-6 December 2001.

Watts, E., & Carlson, G. (2002). Practical strategies for working with Indigenous people living in Queensland, Australia. *Occupational Therapy International, 9(4),* 277-293.

Westone, G. (2011). *Communicating with Aboriginal and Torres Strait Islander patients/carers*. Retrieved from

http://www.westone.wa.gov.au/toolboxes/cybertots/toolbox12_11/shared/resources/html/r...

Westwood, B., Atkinson, N., & Westwood, G. (2008). Recognition of cultural awareness training as a core component of health services. *Aboriginal and Islander Health Worker Journal, 32(1),* 27-29.

Williams, C. (1999). Marginalised identities in relation to the discourse of OHS. *Journal of Occupational Health and Safety: Australia and New Zealand, 15(6),* 114-127.

Wooldridge, M., Fisher, M., Huget, M. P., & Parsons, S. (2002). *Model checking multi-agent systems with MABLE*. Liverpool, UK: Department of Computer Science, University of Liverpool

World Health Organisation (WHO) (1986). *The Ottawa Charter for health promotion*. Ottawa, Canada: World Health Organisation.

Yammiyavar, P., Clemmensen, T., & Kumar, J. (2008). Influence of cultural background on non-verbal communication in a usability testing situation. *International Journal of Design, 2(2),* 31-40.

# APPENDIX A

Report into the strategies to improve communication between health professionals and Aboriginal people

# REPORT INTO THE STRATEGIES TO IMPROVE COMMUNICATION BETWEEN HEALTH PROFESSIONALS AND ABORIGINAL PEOPLE 2011

# TABLE OF CONTENTS

# INTRODUCTION

Research was carried out in South East Queensland into the strategies that were implemented to decrease the barriers of communication between health professionals and Aboriginal peoples. Four Aboriginal and Torres Strait Islander Health Services (ATSIHSs) were involved in focus groups which allowed the researcher to illicit information. One of these ATSIHSs differentiated from the other three in that it was a brokerage and therefore a referral service that covered great distances. The results that were obtained from these ATSIHSs evidenced that strategies in this report, if adopted, can decrease the barriers in communication between the two entities and therefore improving Aboriginal health.

The findings of the research will facilitate health professionals to communicate more effectively with Aboriginal peoples. A major finding was the inclusion of Aboriginal peoples' perspective and input as well as the significance of employing Aboriginal Health Workers (AHWs). The full dissertation will be available on request or it can be accessed on line. Historically, miscommunication between Aboriginal people and health professionals have been responsible for many Aboriginal people not seeking health care, for misdiagnosis, and other health issues with severe repercussions including death. Many Aboriginal people have a lack of trust in governments and institutions and specifically Australian health services. This report is intended to assist in rebuilding that trust and to decrease the barriers of communication between health professionals and Aboriginal people.

# SUCCESSFUL MAJOR STRATEGIES

There were seventeen successful strategies discovered in use by ATSIHSs, however this report will cover the ten most significant strategies followed by recommendations.

STRATEGY ONE:

Staff of one of the ATSHSs implemented the strategy of having an Aboriginal Board of Management to advise and direct the primary health care unit of what was required to improve communication and to deliver holistic health care to Aboriginal clients. Elders and members of the community were involved in the delivering of programs. This allowed the Aboriginal community to realise self-determination and control of their health needs. It provided the staff of the ATSIHS with the vital information required to formulate and implement strategies that would not only improve communication, increase the number of Aboriginal people who sought health care, and built trust but also to form better relationships with health professionals from all cultures. This strategy is known as community control.

STRATEGY TWO:

Members of two ATSIHSs preferred to use community consultation and engagement. Staffs then were able to build rapport, trust, and relationships within the Aboriginal community. However, with this strategy the staff made the decisions on what advice they used to formulate and implement strategies and programs. This method also resulted in a successful strategy and led to other strategies being formulated and implemented for their clients.

STRATEGY THREE:

All four ATSIHSs ensured that they employed Aboriginal staff and utilised employment capacity building. They are also mindful of the necessity to be flexible when an employee has to fulfil cultural obligations in *Sorry Time* (grief and loss).

STRATEGY FOUR:

The importance of having Aboriginal Health Workers (AHWs) on staff sent a message to the clients that this health service was a place they could trust and where they felt safe.

STRATEGY FIVE:

One of the most significant findings was that one of the community controlled health services, with the assistance and participation of State Government, was actually a Brokerage which handled referrals for Aboriginal people over a vast area where ATSIHSs were non-existent. This brokerage was also community controlled as it engaged an Aboriginal Board of Management and took advice from AHWs from the field.

STRATEGY SIX:

The Brokerage ensured that all areas under their jurisdiction employed AHWs in each district whom the Aboriginal people could contact if they required a health professional. The brokerage also canvassed a large number of therapists and General Practitioners (GPs) and selected those that were culturally friendly and sensitive to the needs of Aboriginal clients.

STRATEGY SEVEN:

AHWs are of major importance to all ATSIHSs and GPs as they will, on request, accompany a client to the clinic or specialist and assist them in every way necessary to ensure that there can be no dire consequences such as misdiagnosis or miscommunication.

STRATEGY EIGHT:

The AHW will also assist in transport ensuring that the client is able to keep appointments.

STRATEGY NINE:

Language also has to be considered as English may be an Aboriginal persons third or fourth language so it is important that plain words are used instead of medical terms.

STRATEGY TEN:

The use of the program Indigenous Body Education Resource Animation (IBERA) which is a computerised program and explains body parts and disease in an Aboriginal woman's, man's or teenagers voice is an excellent strategy in communicating health needs of the client.

# RECOMMENDATIONS

RECOMMENDATION ONE:

That further research is undertaken into the use of the Brokerage system. This system may ensure better access to health professionals particularly for Aboriginal people in rural areas. The use of culturally friendly GPs can only improve communication and trust with the dominant culture which could result in better health for Aboriginal people.

RECOMMENDATION TWO:

That consideration be given by GPs in employing AHWs and provide Employment Capacity Building Programs for their staff.

RECOMMENDATION THREE:

That all health professionals undertake cultural and sensitivity training and be educated in using that training within their health service.

RECOMMENDATION FOUR:

It is recommended that this study be replicated to include both Aboriginal and Tors Strait Islanders participants. Obtaining both cultures perspectives that relate to decreasing the barriers of communication between health professional and Australia's First People is a way of giving them a voice.

RECOMMENDATION FIVE.

Further recommendation is that health professionals develop an understanding of cultural protocols and the importance of utilising plain words rather than medical terms.

A request to disseminate this report as widely as possible shall be forwarded to:

5. National Aboriginal Community Control Health Organisation (NACCHO);
6. Queensland Aboriginal and Islander health Council (QAIHC);
7. Queensland State Government and Federal Government Health Ministers; and
8. GP Connections and Medicare Locals.

# APPENDIX B

Original text of declaration of Alma-Ata (in part)

## ORIGINAL TEXT OF DECLARATION OF ALMA-ATA (in part)

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

### I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

### II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

### IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

### V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

### VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally (WHO UNICEF, 1978).

# GLOSSARY

| | |
|---|---|
| ACCHS | Aboriginal Community Controlled Health Service |
| ALS | Aboriginal Legal Service |
| AMS | Aboriginal Medical Service |
| AMS - WS | Aboriginal Medical Service –West Sydney |
| ANAO | Australian National Audit Office |
| ATSIHS | Aboriginal and Torres Strait Islander Health Service |
| ATSIHS - WS | Aboriginal and Torres Strait Islander Health Service – West Sydney |
| ATSICCHS | Aboriginal and Torres Strait Islander Community Controlled Health Service |
| AHS | Aboriginal Health Service |
| AHAACSC | Australian Health Minister's Advisory Council Standing Committee |
| AMARC | Australian Medical Association Report Card |
| AHW | Aboriginal Health Worker |
| CAT | Cultural Awareness Training |
| CCC | Cross Cultural Training |
| CHD | Coronary Heart Disease |
| CSTSC | Cultural Safety Training Standards Committee |
| DHA | Department of Health and Aging |
| GP | General Practitioner |
| GGT | Greater Green Triangle |
| GGT – UDRH | Greater Green Triangle-University Department of Rural Health |
| HP | Health Professionals |
| HREOC | Human Rights and Equal Opportunity Commission |
| MCWA | Middle Class White Australians |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NAH | National Health Strategy |
| NAHSWP | National Aboriginal Health Strategy Working Party |

| | |
|---|---|
| NSWDH | New South Wales Department of Health |
| QAIHC | Queensland Aboriginal and Torres Strait Islander Council |
| QAIHF | Queensland Aboriginal and Torres Strait Islander Forum |
| RDH | Royal Darwin Hospital |
| SAE | Standard Australian English |
| SEQAB | South East Queensland Aborigine [sic] |
| WHO | World Health Organisation |

## DEFINITIONS

| | |
|---|---|
| Aboriginal Community | This dissertation defines community or Aboriginal community as an area where a number of Aboriginal people reside in association with each other and are generally from the same language group (Peters-Little, 2000). |
| Country | Australian Aboriginal people refer to their language group or the area in which they were born as country. Refer map p.22. |
| Dominant culture | Dominant culture is one that is able, through economic or political power, to impose its values, language, and ways of behaving on a subordinate culture or cultures. This may be achieved through legal or political suppression of other sets of values and patterns of behaviour, or by monopolising the media of communication (Kellehear, 1990). |
| Aboriginal Elder/s | This dissertation refers to 'Elders' as Aboriginal men and women who are respected as leaders who impart their wisdom, traditions and knowledge on to the next |

| | |
|---|---|
| | generation. They also work for the betterment of their people and their community (Peters-Little, 2000). |
| Ischaemic disease | The heart muscle deprived of blood (Cape, 1968). |
| Joint Commission | The Joint Commission on Accreditation of healthcare facilities and organisations conducts accreditation programs for many healthcare Facilities in the United States of America. This is to ensure the status and wellbeing of their First Nation People. http://www.jointcommission.org/standards_information/prepublication_standards.aspx Retrieved 27-01-2012. |
| Renal disease | Renal refers to the kidneys. Renal disease is a disease of the kidney/s (Cape, 1968). |
| Verstehen | An empathic understanding from personal experience which permits a researcher to a greater degree a social problem, an idea or a relationship between objects (Kellehear, 1990). |