COMMENTARY

Aboriginal and Torres Strait Islander health practitioners in rural areas: credentialing, context and capacity building

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Introduction

Recent health workforce initiatives in Australia have recognised that more equitable, accessible, efficient and effective care can often be achieved through intermediate-level workers such as health assistants and health workers[1]. In many Indigenous settings, particularly in rural and remote areas, the intermediate-level Aboriginal and Torres Strait Islander Health Workers (AHWs) have been recognised as contributing to improving health outcomes[2], as facilitating access to the health system for Aboriginal and Torres Strait Islander people[3] and as the backbone of Aboriginal community-controlled health services[4]. Likewise in the mental health area, Aboriginal and Torres Strait Islander Mental Health Workers (AMHWs) have been recognised as key service-providers for health promotion and treatment in Aboriginal mental health services in community contexts[5].

Not surprisingly, the issue of the training and credentialing of AHWs and AMHWs has increasingly been an issue of interest, even beyond the current national focus on registration and credentialing of health professions in general. While discussion about this issue has existed for decades[6,7], the recognition that AHWs and AMHWs potentially play a strategically important role in 'closing the gap' in Indigenous health care has further fuelled interest in such credentialing.

Since July 2012, the roles of AHWs have been incorporated into the new profession of Aboriginal and Torres Strait

Islander Health Practitioner (ATSIHP), which has been registered under the *Health Practitioner Regulation National Law Act 2009*. Replacing the varied requirements across states and territories, the Aboriginal and Torres Strait Islander Health Practice Board of Australia has now set the professional standards that practitioners must meet to be registered, and a new National Aboriginal and Torres Strait Islander Health Worker Association has been incorporated. These shifts have substantial implications for credentialing, training and capacity building, as well as considerable consequences for responsiveness to local contexts.

While there has been important discussion regarding the skills and training required for the AHW[3] and AMHW[8] workforce, the issue remains largely unresolved[1,9]. In the case of the new role of ATSIHPs, the Board has specified completion of a particular Vocational Education Training (VET) Certificate IV qualification as the eligibility requirement for registration. Currently the process of skills assessment, credentialing, recognition and up-skilling prior to registration is being formally investigated and determined. A key consideration in this process will be the precedent of established training for ATSIHPs in some settings, which is competency-based and delivered within the VET sector through a series of complementary Primary Health Care certificates[10]. Such competency-based learning is often associated with the performance of delegated tasks within a rule-based structure. The recently identified need for a national skills assessment initiative (currently under way, commissioned by Health Workforce Australia) suggests that for ATSIHPs, the emphasis on credentialing, the content and the method of training for such workers, particularly those working in remote communities, is a matter of considerable interest. More importantly, the response to this issue has bearing on the quality and nature of services, and on the wellbeing of people in Indigenous communities, particularly remote communities.

In this brief commentary we suggest that this emphasis on credentialing might be informed by drawing attention to the following: (a) that the model of service delivery for Indigenous and particularly remote Indigenous communities is the comprehensive primary health care (CPHC) model, (b) that the context of service delivery in Indigenous and particularly remote Indigenous communities is complex, and (c) that this model and context are well suited to a critical thinking and reflective practice approach to workforce development.

Comprehensive primary health care

It is now well established that the model of choice for Indigenous and particularly remote Indigenous communities, is CPHC[11]. This approach aims to improve health outcomes through providing better access to services, and by addressing underlying social determinants of health[12]. In rural communities, CPHC has been found to result in instances of improved processes of care, increased community participation, increased utilisation, and lead to new population health programs[13]. Further, the CPHC approach has been identified as best practice for remote Indigenous communities[13]. Typically, CPHC services include primary clinical care, preventive and health-promotion activities, as well as community-focused education, capacity building and development.

The array of skills required for such a broad model of service delivery requires careful consideration and has substantial implications for workforce training and governance. To fulfil the array of functions required to work under such a model in rural Indigenous communities, ATSIHPs will not only require clinical and technical competencies, but will also have to be able to work autonomously, and have considerable problem-solving skills.

Complexity and Indigenous health

The complex nature of Indigenous health is widely acknowledged, with the recognition that this complexity has numerous consequences and contributing factors[14]. Due to an array of factors including racism, neglect, and social, historical, systemic, medical, financial and other issues, the welfare of Indigenous communities and particularly the

manifestations of sickness, injury and health in these communities are highly complex. Complexity is evident in terms of the multiple interconnections between chronic disease and Indigenous healthcare issues[15]. However, it is even more clearly exemplified in the social, economic, cultural, behavioural, attitudinal and other issues that impact on Indigenous health service delivery[16].

In light of this complexity, a key challenge is determining an appropriate workforce response. Fortunately, the study of complexity is now well established in health care[17,18], and numerous extrapolations can be made, based on experience in dealing with complexity in other settings. Most importantly, it is clear that complex health issues involve many layers (from the medical to the financial and social), and that responses to such complex issues require the capacity to apply multiple strategies, use different forms of response, and usually require the capacity to work in many contexts and with many stakeholders[19,20].

Workforce training implications of a comprehensive model and complex context

The question of how to build the capacity of the ATSIHP workforce in keeping with the CPHC model[21] and in light of the complexity of health issues[22] is clearly very important. First, as has been noted[11], one of the key challenges facing workers within the CPHC model is how to assist community members to become agents of change. Likewise, contemporary understandings of ways to respond to complex issues[19,20,23-26] indicate that skills must be drawn from multiple and diverse sources, and that the capacity for collaboration with many stakeholders across sectors and disciplines is vital. As a case in point, the growing emphasis on chronic disease (particularly in Aboriginal populations) and the shift towards chronic disease self-management in health services underlines the necessity for PHC practitioners to reflect similar skills[27]. In these settings, workers' capabilities must emphasise collaborative approaches to care, the identification of

consumer's strengths and capacities, and psychosocial competence.

It has been suggested that empowerment through life skills development[11] must be part of the training for ATSIHPs, as well as part of the training they provide through their CPHC service delivery. Promoting community engagement in health issues and building linkages to achieve community health outcomes is a fundamental challenge of this approach[21], for which workers must be equipped. If health services are to address complex issues in the community, broad 'capacity building' rather than narrow skills training of workers is vital[28]. It would appear that such capacity building should be empowerment based[29] and community focused[30], emphasising community development skills[29]. Importantly it has been recommended that building workforce capacity, both for CPHC[28], and in the context of complexity[17-19], should emphasise that reflection, critical thinking and reflective practice are crucial elements.

Theoretical and practical links between the concepts of cultural safety, CPHC and interprofessional collaborative practice have the potential to enhance positive health outcomes as well as provide a strategic framework for training[31]. Cultural safety requires service providers to engage in dialogue with their clients, reflect on power relationships and systems that may continue to colonise and disempower already marginalised people, and to use reflective processes to minimise the risks associated with dominance and powerlessness[32,33]. The positioning of ATSIHPs as key professionals in the system of care necessitates that they have a high level of skill in cultural communication, and for all types of knowledge to be acknowledged and valued[31]. They are also likely to be dealing with non-Indigenous practitioners who are new to the concept of cultural safety or at least at different stages in their journey towards culturally safe practice. Indigenous health workers need to be skilled at the 'both ways' approach to communication and education. This exchange of learning approach involves them in the education of their clients, and also in the education of non-Aboriginal health professionals,

who make up most of the contemporary system of health care.

Training in 'reflective practice' has been advocated as a means of fostering an appropriate degree of autonomy and problem solving, as well as thinking across boundaries, and understanding patients[34,35]. Reflective practice includes the ability to conceptually analyse and interpret, consider multiple perspectives, ask good questions, challenge assumptions, make inferences and identify implications[36]. It is important to multidisciplinary healthcare because it transcends and complements discipline-specific content[37]. The importance of reflective practice/critical thinking has been noted for rural health settings[38,39], and it may assist workers to integrate clinical aspects of their learning into the day-to-day workplace.

Reflection helps workers to develop a broad understanding, which can be applied to other settings and problems, and to explore new possibilities when dealing with other complex situations[40]. An emphasis on reflective practice is not only consistent with cultural safety and approaches to decolonisation[31], but it may also assist ATSIHPs to better understand their own experience and that of the people they work with. Critical reflection would help workers develop skills to define a problem in a situation and think about the decisions to be made, the goals, and the steps to take[41]. In this way, the capacities for dealing with healthcare complexity are quite consistent with those required for working in CPHC. Training strategies developed to build on their experience may equip Indigenous health workers at all levels to develop practical and creative ways of working in complex and changeable environments.

Complexity theory suggests that building the capabilities of ATSIHPs may assist them in dealing with the complex reality of negotiating community-based support for people living with complex care needs, with psychosocial issues, with socioeconomic challenges and related complex disadvantages. To address complex healthcare issues there is substantial need for skills in networking, liaison, mediation and advocacy, which again is highly consistent with the skills required for CPHC. As a result we suggest that a major part of the challenge for training and credentialing ATSIHPs might be an emphasis on fostering reflection and critical thinking. Such an approach is in keeping with an integrated or holistic model of competence, which takes a practitioner's 'judgements-in-context' and their critical reflections on those as essential elements for learning and developing professional competence[42].

In this commentary we have attempted to draw attention to features of the practice of ATSIHPs in order to inform new approaches to preparing and credentialing these workers. In particular, we have highlighted the model of comprehensive primary health care, the complex context of service delivery in Indigenous and remote Indigenous communities, and the critical thinking and reflective practice approaches required. Holistic models of capacity, beyond narrow rule-based approaches, allow for the incorporation of these key features into contemporary workforce development initiatives. They also provide a foundation on which ATSIHPs might enhance their skills if they choose to transition from 'assistant' to 'professional' roles. A potential first step towards establishing more holistic models of competence might be to conduct an audit or appraisal of current and future training and workforce development initiatives, to document their alignment with these features.

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