

Exploring, employing every endeavour to enhance the health of Aboriginal people

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LOOKING FOR ANSWERS

The challenge of impacting Aboriginal health for the better is always at the forefront of Ceduna Koonibba Aboriginal Health Service's mind. Week after week we see the effects of compounded grief on our people. We see and arrange so many funerals that our social health team has it down pat and can probably run their own funeral service. How could we as a health service improve our people's lifespan and quality of life. The average lifespan in the Ceduna area is 48 years. There is no sense in living an extra 20 years if you feel debilitated and need to be hooked up to a haemodialysis machine for 4-5 hours 3 days a week. There is no longer any spontaneity in life. You can't go on extended hunting or fishing trips. The client ends up being very stressed, disempowered, dependent on family and other services and depressed

MEASURES WE USE

CKAHS has continually been thinking beyond the obvious and has tried and are currently using the following measures:

- being part of the community
- using traditional health care
- yarnin
- co-operative work with other organisations
- thinking laterally when it comes to allied health service shortage.

Being a part of the community

The organisation counts itself as a part of the Aboriginal community. We take part in times of celebration like the National Aboriginal Islander Day Of Celebration and at funerals. We needed to be seen as part of the community, not only for a sense of belonging but also to help us know what the needs of the community are. Employees are encouraged to be part of the Aboriginal organisations. CKAHS are proactive in their cultural appropriateness and support families in their time of need with the deaths, funerals and wakes.

Using traditional health care

CKAHS know of the effect the separation policies of past government. People are left with grief from this period and with missing pieces in their culture. Ceduna Koonibba Aboriginal Health Service assists people's healing by assisting in re-unions, and using traditional methods of

healing, be they smoking, bush medicine or the use of a 'ngangkari' or traditional healer. Encouraging the hunting and gathering of traditional food which helps prevent illness. When conducting workshops we supply our participants with traditional food and that draws the people in to participate and eat healthy food.

Yarnin

Aboriginal people have a rich oral tradition and yarnin is a great tool for finding information and for healing. We have a well-being program that largely allows participants to tell their stories and find healing with the help of the group. Our well-being support worker is qualified in Narrative Therapy for Aboriginal people, incorporated in this is massages, facials, manicures and relaxation techniques to soothe the body, mind and soul.

Co-operative work with other organisations

A willingness to lend a hand to other organisations who need our assistance. For example, Transitional Accommodation Program (TAP) which is a place where people who come from traditional lands may stay while in Ceduna. It is administered by the Aboriginal Housing Authority. CKAHS aids them by providing a health clinic to the site twice a week, assisting them with social and emotional issues that come up and with their homemaker program and including them in our immunisation and screening programs. Ceduna Koonibba Aboriginal Health Service is a member of the Regional Health Service Steering Committee which is composed of the Ceduna District Health Service, Tullawon Health Service, Oak Valley Health Service, and CKAHS. Together these organisations forward plan the Allied Health Services for the area.

Thinking laterally when it comes to allied health service shortage.

CKAHS had no access to a podiatrist during working hours for our Aboriginal clients and therefore another avenue was needed. We now access her after hours and we pay her as a private practitioner. The lack of a Podiatry Service is still a significant concern for all rural health services for diabetes clients in particular. To address this situation, we had our health workers trained by the visiting podiatrist in basic foot assessment and toe nail cutting. To ensure that all our clients have access to foot care as needed, and those with problems are seen by the podiatrist with decreased waiting time.

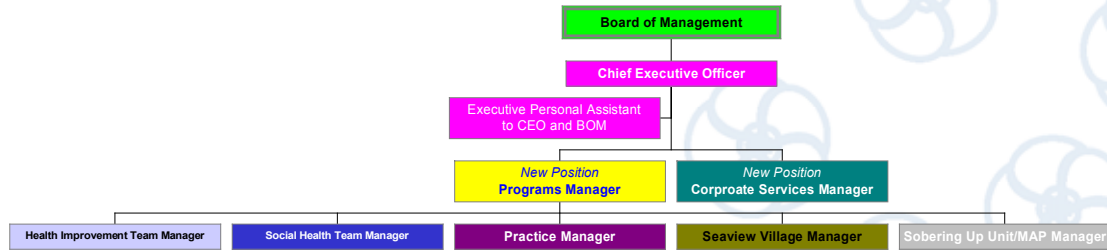
FINDING ANSWERS

Despite the measures we have employed before, people were still slipping through gaps in our health service delivery. What was the answer? If we find an answer, how could we make it core business? What about capacity building for our people?

One day at a specially convened meeting of senior staff, while trying to answer the question of where we as a health service were failing it became obvious that our GP service arm had become so demanding that the focus of the health service had shifted from that of primary health to secondary health. We were so busy dealing with the acute presentations that we had forgotten the principles of primary health. We needed to streamline our primary health care delivery.

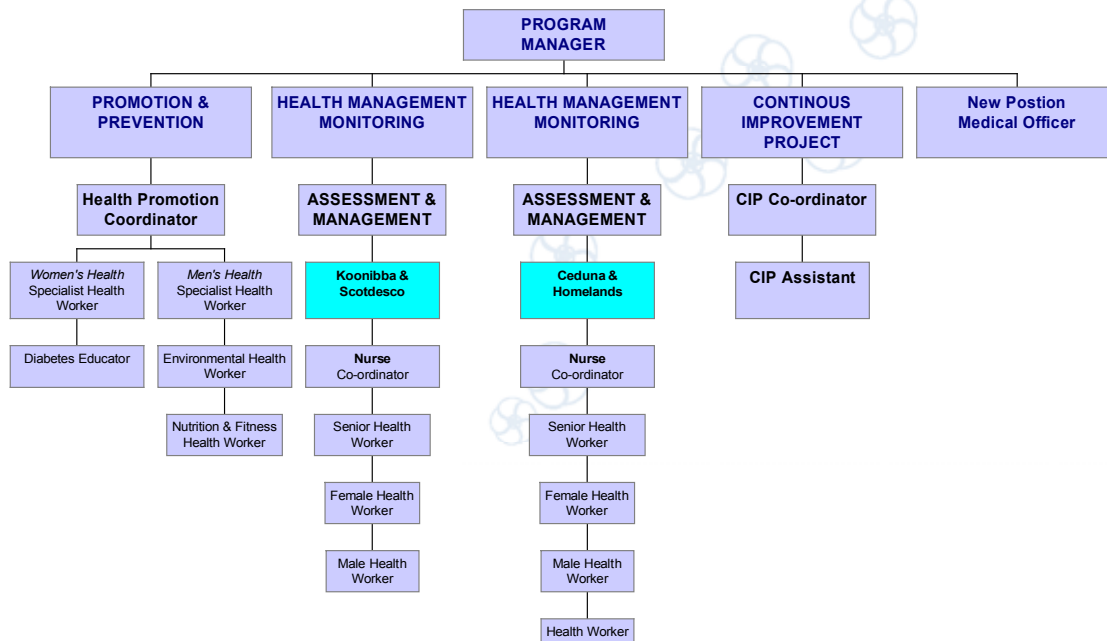
Restructuring

As our **core business** is the Early Intervention, Education and Promotion of Good Health, Early Detection, and managing Chronic Disease in Aboriginal People. It was blatantly obvious to us that primary health care principles were to be followed in order to streamline the way we do business.

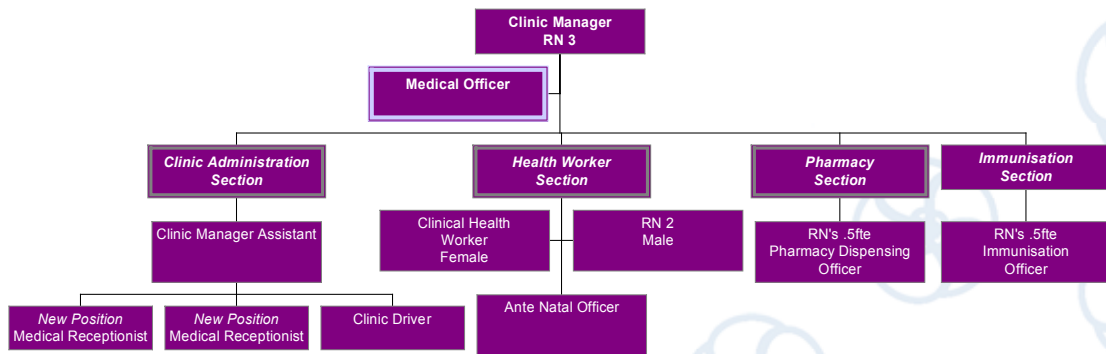


A clear delineation of the teams was needed from an administration point of view. New positions were identified and some teams renamed to reflect their fields. Resulting in health care delivery focusing on primary health care as opposed to the past focus on secondary health care presenting at the Clinic.

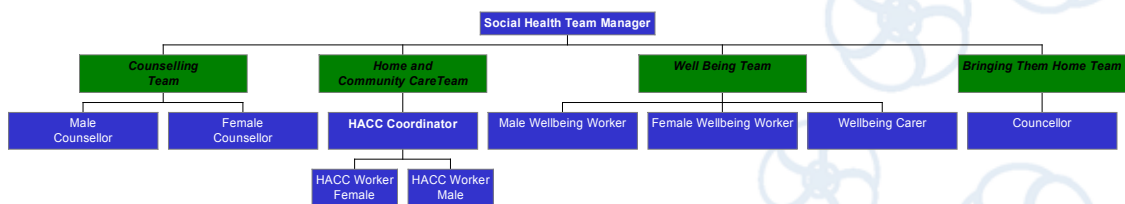
The team displayed below for impact purposes, was renamed the Health Improvement Team or HIT and is one of our biggest team. The focus of this team is health promotion and prevention of chronic disease, early intervention and detection through assessments – at all the schools in Ceduna, Koonibba and of young people and adults in surrounding homelands and Case Managing and Monitoring of people with a Chronic Diseases.



The Clinic or GP Service became an adjunct to the delivery of Primary Health Care rather than the means of delivering health care.



The Social Health Team is a separate unit that works co-operatively with the other teams. They provide specialised education, counselling and support services in the fields of mental health and social and emotional well-being.



Core business

With the restructure, the principles of primary health care are once again embedded in the core business of the health service. The structure automatically reminds us of what we are in business for. This makes our Core business clear for the health workers and clearer for the community. What we are on about is making sure that Primary Health Care Principles underpin every program and activity of the health service. It is a way of drawing together the various piecemeal funding received from the government like eyes, hearing, sexual health and others, so that they fitted smoothly into the structure and service delivery of the organisation.

Capacity building

Capacity building means we as a health service are not solely reliant on government funding for resources that will ensure we deliver the best health care to our people. The restructure has enabled us to identify the resources needed to deliver this service both in manpower and equipment. It is enabling us to access funding sources outside the regular government grants. We are able to generate funds through the Health Insurance Commission's Enhanced Primary Care Items to pay for some of the very sorely needed positions in the organisation like the Assessment and Management Team Co-ordinator and a senior male health worker.

We may not agree with the EPC items being available only for clinical conditions, because it should be extended to meet social/emotional conditions as well, but it's what we have been given and we use it to the advantage of the people we serve. The health service has decided to use these extra sources of revenue to meet acknowledged needs and also know that we are meeting some of the health needs of the community and closing some the perceived gaps in health care delivery.

APPLYING THE ANSWER

The Health Improvement Team is the main team of the health service in delivering core business. How does it all work?

Health promotion and prevention

This section of the team is involved in education and health promotion activities that seeks to stop our people from developing chronic diseases or at least delay its onset. We deliver health education packages to community groups, schools and homelands. Health promotion activities are held on the main street to coincide with health education activities relevant to that week i.e. Breast Cancer Week, Diabetes Awareness week etc. we run community days to promote knowledge and ability of our people to recognise symptoms and management of common diseases and how to stay healthy.

Workers in this team are also qualified to run Chronic Disease Self Management Courses to help people with Chronic Diseases live as healthy as possible, **building the capacity of our clientele to be better able to take care of themselves.**

Early detection/early intervention/management

The immensity of the workload that these three areas generated and the desire to see no people slip through gaps in health service delivery, has moved the organisation to a system of **case management**. It does not mean that one worker is solely responsible for delivering all health care to the client, but it does mean that there is one person that the client can go to and know that their concerns are heard and steps are taken to deliver the care required. This systematic approach meant that there is a person in particular and a team in general who will see to it that they are being assessed, having appointments made for necessary interventions, they are being educated in groups or one on one, their health status is being monitored and assistance is being extended to them to better manage their health. Members of these teams are also skilled in running Chronic Disease Self management courses. Should the need of the client extend beyond the capabilities of the individual or the team, then relevant referrals are made for what ever measures are needed to other teams within the organisation or outside the organisation.

Expertise is sought particularly from the Social Health Team in dealing with social and emotional issues that majority of our clientele have. The ngangkari program is particularly useful in not only linking people back with their culture but also as a means of opening up an avenue for healing the underlying causes of illness that leads self destructive behaviour which in turn leads to chronic illness, or violence and death.

We have counsellors and support workers who have different areas of expertise but all work together provide assistance with client's perceived needs. One worker is qualified in Narrative Therapy for Aboriginal People, another is a Social worker, one is a Counselling Psychologist, one is a Family counsellor and a support worker in substance misuse.

Continuous Improvement Project

This is a 2-year funded project by the Office of Aboriginal and Torres Strait Islander Health to help ensure that the early detection and management of chronic diseases follows **continuous improvement principles which are: plan, study, do and act**. Needs are identified, strategies to meet these needs are planned, carried out and evaluated. This position has identified a lot of gaps in the health service delivery that we are now addressing via the restructure.

RECOMMENDATION

We believe this model of Health Care Delivery would work well in similar Aboriginal Health Organisations who have dedicated and skilled health workers with a passion to see health improvements in their community.

