Aboriginal and Torres Strait Islander Male Health Module for Aboriginal Health Workers

Unit 14. Networks, referral and follow-up
For the purposes of this guide, the term Aboriginal Health Worker (AHW) is used to describe Aboriginal and Torres Strait Islander allied health professionals that provide clinical and primary health care for individuals, families, and community groups. It is recognised that there are different registration requirements for the AHW workforce in different States and jurisdictions.

Acknowledgements

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Networking is about sharing information, ideas, resources and opportunities. Members of a network look to each other for advice, service pathways and contact sharing, careers and training, and client referrals. They create a support system for each other (Cowley, 2001) that can benefit the individual, family, community and the AHW greatly. Networking is always a valuable process for AHWs, whether they are new to the job or have worked in the area for some time.

Remember: “It’s not what you know and it’s not who you know, it’s what you know about who you know.”

BUILDING A USEFUL NETWORK

A first step in establishing a network is to find out:
- what client needs are likely to be (for example, listen to what the Elders and others are saying about their social, emotional, spiritual and health needs);
- what services already exist, how are they accessed by the community and are community needs being met;
- what gaps there are in the services available to the community;
- who are the major and minor service providers within the local area and the major capital city (in particular Aboriginal or Islander-specific services); and
- who are the key people within these services (including their contact details, type and level of work, availability and level of cultural competence).

As the network grows, it may branch out to include other partner services and regional and State/Territory services.

Health services are not the only ones that will be included in an AHW’s network. Because of the holistic nature of social, emotional and spiritual well-being for Aboriginal and Torres Strait Islander people, services such as counselling and mental health support services, emergency food and housing may also be relevant.

MAKING CONTACT

It is good to establish a network before there is pressure to find the right service or person to meet a client’s needs. The idea of approaching strangers and particularly health professionals such as doctors, psychiatrists, etc can be intimidating initially, but it is important that first contact is made on a human level. A phone call or email is a good way to make an appointment for a first meeting.

Meeting in person gives each person the opportunity to present themselves as individuals. This helps to establish recognition and openness in the working relationship. It is important that this human contact is made before any requests are made. Being approachable, cheerful, confident and straightforward will all help.

The other service will also want to know about the AHW’s organisation including community needs and what the organisation can offer in terms of information, contacts and ongoing support.
MAINTAINING THE NETWORK

Follow-up is essential for building on relationships. It is a good idea to follow-up on every contact with an email or phone call. This provides an opportunity to thank them for taking time to meet and remind them of the gains that can be made from collaboration. This reinforces that it is a two-way relationship.

Keeping a “Contact Book” of networking contacts (see sample contact sheet in ‘Sample Tools’) and following up at least once a month to see how things are going for them provides the opportunity for each person to ask for any leads or referrals. Referrals from other organisations could also be acknowledged in writing (eg fax, card or email) at the time of receipt and the person contacted later to let them know how it went.

Most health professionals and organisations are busy and will not be available all the time. It is important to have as many alternative options as possible. When one contact is not accepting referrals and/or has a waiting list, it is essential to have another contact with similar service or resources as a backup. Networking is continuous work, and everyone wants a fast result. It takes time to make contacts, but once you’ve made them, they are very valuable (Gillam, et al., 2001).

Traps and pitfalls of networking:
- Be sincere
- Don’t ask for (or expect) payback
- Respect other people’s time
- Follow through on promises
- Don’t over-use key contact people where possible
- Share network contacts with others as appropriate
- Don’t wait to be properly introduced – introduce yourself
- Say thank-you (a bit of common courtesy goes a long way)
- Don’t get “used”

BENEFITS OF NETWORKING

Networking has benefits for patients and AHWS, including:
- the information and resources that become available through networking can help AHWS to do their job more effectively;
- networking provides an alternative way to reach potential clients, support services, advice, guidance; and
- networks allow AHWS to present themselves and their work in a much more personal way than an advertisement, promotion, or waiting for “drop ins”.

Many AHWS do not have ready access to community services and, in some cases, deal with challenging situations. It is important that the AHW does not bear the brunt of these situations alone and has access to support.

NETWORKING ACROSS AUSTRALIA

It can be useful to make contact with the AHWS working in other parts of Australia. Also see the National Aboriginal and Torres Strait Islander Health Worker Association website for useful
Networking is sometimes done through family members, but it can also be done through more formal meetings. Sometimes it can be difficult for health services when their AHW is away at meetings, even for a few days. However, attending national meetings on occasion will also benefit the health service in the longer term if the AHW is able to bring back new ideas to improve the local service.

Some key national meetings include:

- National Aboriginal and Torres Strait Islander Male Health Convention — held in October every two years; and
- National Aboriginal and Torres Strait Islander Male Researcher Gathering — contact Mibbinbah for more information.

The role of the AHW can be very demanding — networks provide support for the AHW as well as for patients.

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1 https://www.natsihwa.org.au/
2 http://www.mibbinbah.org/
Aboriginal and Torres Strait Islander people with high support needs may require the support of a number of different services and sectors. This may involve referral to specialists and the establishment of a number of services working as part of a wider supportive team. A referral pathway provides a systematic method of accessing relevant health and other services. It also ensures that there is a consistent and coordinated response that has the patient and his or her needs as its central element.

A referral pathway is a series of steps, including clinical interventions, to be taken by local health providers in response to Aboriginal and Torres Strait Islander people’s high health support needs.

**DEVELOPING A REFERRAL PATHWAY**

A referral pathway is a process as much as a product or tool. Ideally, it is developed using a comprehensive and inclusive approach that involves the AHW, the service in which they work, and relevant health service providers and/or visiting professionals. The aim is to establish relationships and a shared understanding and to agree upon ways of working together to better address the health needs of Aboriginal and Torres Strait Islander people (Primary Care Partnerships, 2005).

It is essential to identify all the different services and sectors that will meet the needs of the Aboriginal and Torres Strait Islander community. For each of these services, it is useful to determine:

- whether they are available locally (and if not how are these types of services delivered in the community);
- the name of the service, contact details; and
- the target groups of each of these services and their referral processes.

Most services have specific entry and access processes. Understanding these boundaries and processes is essential to being able to access the appropriate services quickly and effectively (International Union for Health Promotion and Education (IUHPE), 2000).

Undertaking this mapping process can help establish where the service gaps are within your community.

**ROLES AND RESPONSIBILITIES**

It is helpful to have a clear understanding of the roles and responsibilities of everyone involved in providing care to an Aboriginal and Torres Strait Islander person or family with high health and well-being needs. The roles and responsibilities of different service providers will vary depending on:

- the needs of the client;
- the types of resources available in the community; and
- the types of supports and services that the person needs to access.

AHWs are integrally involved with ongoing care and support of Aboriginal and Torres Strait Islander patients. They generally work with a GP who coordinates the multidisciplinary care that a patient receives. The roles of the other staff within the health service are determined in
terms of their responsibilities within the multidisciplinary team. There may also be many other service providers involved.

There are several ways that the AHW can effectively support a community member with high support needs (Roussos & Fawcett, 2000). These can include:

- providing shared care in collaboration with GPs, nurses, allied health professionals, Aboriginal and Islander-specific services and specialists;
- formulating care plans and case conferencing to facilitate collaborative care;
- facilitating referral to other services and acting as a point of contact and advocate for the person and their family in dealing with the health system;
- providing case management by coordinating the input of other professionals and facilitating the person's access to health services; and
- ensuring that an Aboriginal and Torres Strait Islander patient receives optimal care.

The AHW’s role should be clearly expressed and clarified (when necessary), as changes occur.
One of the most valuable contributions of the AHW is in providing the level of follow-up necessary to maintain the good work done by the health promotions, screenings, and treatment of Aboriginal and Torres Strait Islander patients. For example:

- it does little to promote a new immunisation if there is no follow-up to remind people when and where to take advantage of the promotion or to explain just who should be immunised and who should not, why and what possible side effects can be expected;
- if a patient undergoes health tests or X-rays to determine the cause of pain or illness, unless there is appropriate follow-up to explain the results and if necessary, arrange further testing or treatments, there was little point in undertaking the testing in the first place; and
- if medicine is prescribed but not taken or taken inappropriately the consequences could prove fatal.

While doctors and nurses can provide explanations in these circumstances, the AHW may be able to do so in a more accessible way and may be easier to approach with questions and concerns for Aboriginal and Torres Strait Islander patients.

The AHW is in a good position to obtain the correct information from the doctor or other health professional and translate from “doctor speak” into comfortable language which the Aboriginal and Torres Strait Islander patient, or their carer, is able to follow and ask for more information and feel no “shame” for doing so.

**HOSPITAL DISCHARGE**

As an Aboriginal and Torres Strait Islander person is discharged from hospital, their discharge plan should have been made in consultation with the AHW to ensure that appropriate and timely follow-ups are factored into that plan. The AHW can assist Aboriginal or Torres Strait Islander patients to understand:

- the limitations of recovery;
- what happens next in relation to their treatment;
- any medicines are fully explained;
- that related appointments have been made and are listed in the follow-up schedule;
- that support services have been planned where necessary; and
- that family have been notified and made aware of the individuals circumstances upon discharge (where permission to do so has been given by the patient).

The community AHW would than follow-up with the patient and/or their family members (as appropriate), to monitor their recovery and provide referral or assistance as the needs of the patient change.

It is this level of direct intermediary contact between the health service and Aboriginal Torres Strait Islander person that is the essential value of the AHW. All future health service provision to Aboriginal or Torres Strait Islander communities, families and individuals must be based upon this partnership if they are to be at all successful in meeting the challenge of reversing poor health outcomes for our people.
**DOCUMENTING TESTS AND TREATMENTS**

Administration (paper work) is an important part of follow-up for Aboriginal or Torres Strait Islander patients who may require further tests and/or treatment as well as support services. By recording what you have provided to the person during a follow-up session will enable you and others to track the patients health and treatment progress, identify any gaps, and plan for similar health needs for future Aboriginal or Torres Strait Islander clients with similar needs. Also, health professionals are better able to evaluate the health support needs of their patients and adjust their treatment accordingly. When it comes to arguing for more resources to perform your duties as AHWs, this paperwork will also act as documentary evidence to support your application/arguments.

Both AHWs and Aboriginal and Torres Strait Islander patients frequently move between communities. This can mean that it is easy to lose track of a patient’s progress and the supports provided. If this occurs, no follow-up will occur unless the patient tells the AHW or the health service. It is therefore absolutely necessary to document all the services you provide to Aboriginal and Torres Strait Islander patients. When AHWs move between employers they also need to ensure the transfer of information and documentation to either the replacement worker or the health service to ensure appropriate care and follow-up for patients to ensure that they have completed their treatment and/or been seen by other health providers as required.

Documents and a transfer of patient-related information needs to occur to maintain the level of support and follow-up care to provide maximum support for their health.
REFERENCES


BACKGROUND READING AND RESOURCES


NATSIHWA, the National Aboriginal and Torres Strait Islander Health Worker Association. See: www.natsihwa.org.au

Primary Care Partnerships (PCPs). Victorian Government Health Information website provides information about PCPs, a major reform in the way services are delivered in the primary care and community support services for integrated health promotion and chronic disease. Available from: www.health.vic.gov.au/pcps

A range of other PCP resources and publications can be found at: www.health.vic.gov.au/pcps/publications/index.htm