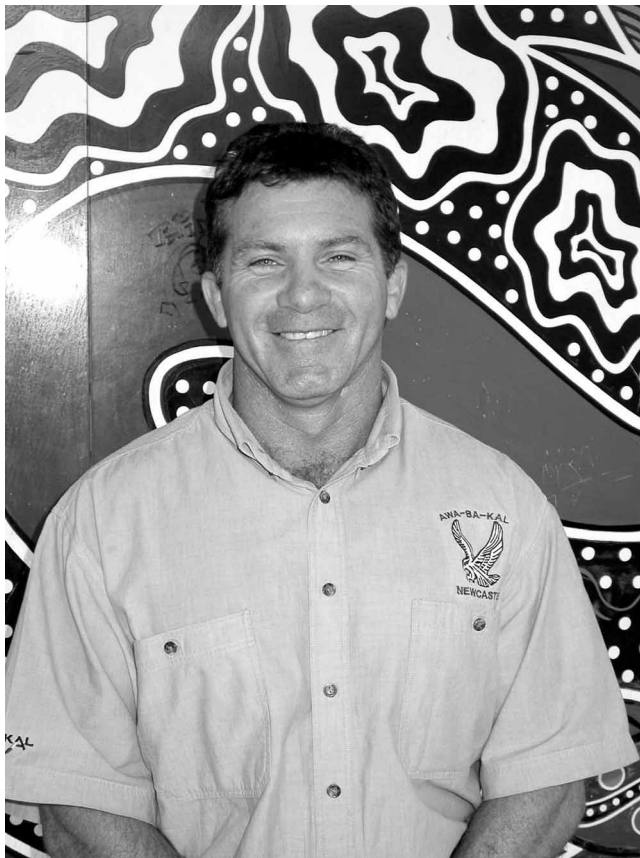


COMMUNITY VOICES

## An Interview of Darren Barton



Darren Barton is an Aboriginal programs coordinator, health worker, and audiometrist at the Awabakal Aboriginal Medical Service. He comes from the Kamilaroi (Gamilaroi) tribe, which is in his grandfather's country in the northwest of New South Wales. His grandmother is a descendent of the Yorta Yorta tribe near the Victoria New South Wales border. Barton serves as Regional Representative and Director of the state-level Aboriginal Health and Medical Research Council. He participates in teaching health professions

students and practitioners at the University of Newcastle and elsewhere. I interviewed Mr. Barton during the Network: TUFH meeting in Newcastle, Australia in 2003 and later communicated with him by email. This is an abridged, edited summary of our conversations.

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Associate Editor  
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## **Background**

The median age at death for Aboriginal people in Australia is 51 years—20 years less than non-Aboriginal Australians whose median age at death is 71 years. Dr. Sandra Eades, a distinguished young Aboriginal physician-researcher who gave a keynote address at the Network: TUFH meeting, wrote: “The current state of health of Indigenous Australians is a cause for national shame. It has its roots in the wholesale exclusion of Indigenous people from Australian society since 1788”. “No More Excuses”, the Australian Medical Association’s report about Aboriginal health, is in agreement with Eades.

The ill-health of Australian’s Indigenous people (as well as the ill health of Indigenous people in the USA, Canada, New Zealand and elsewhere) has been linked to colonists forcibly taking away their land, culture, language, and identity. Ongoing marginalization, (revealed in poor education, inadequate nutrition, fewer job opportunities, etc.), is also linked to their poor health status. Some Indigenous people cannot easily access healthcare. Others avoid mainstream services because of past, and even current, maltreatment.

The resilient Indigenous people of Australia are making progress in improving the health of their people. They have created more than 120 community-controlled, culturally sensitive Aboriginal Medical Services, such as the one where Barton works. Despite barriers, the Indigenous people have been joining the healthcare work force. They also have been working in partnership with the University of Newcastle, James Cook University, and other schools in recruiting and supporting Indigenous students and helping health professions students and practitioners understand the special strengths and healthcare issues of Indigenous people.

## **Interview**

### *How did the Awabakal Aboriginal Medical Service get started?*

About 30 years ago, a group of Aboriginal people here in Newcastle saw the need for an Aboriginal Medical Service (AMS). They realized that Aboriginal people weren’t going to mainstream services or doctors. The founding leaders of Awabakal applied for funding and got it. They hired a co-ordinator, a manager, and one health worker. They had a generous doctor who saw patients one afternoon a week in an old infants’ care building. Also, they had a health worker and a doctor working out of the boot (trunk) of a car. People weren’t coming to them, so they went to people.

Today Awabakal employs 80 full-time staff, including doctors, nurses, and health workers. It provides programs in a variety of areas to meet community needs, for example, medical and dental services, children’s and youth services, disability services, housing and elder services.

*That's terrific. Who oversees your organization?*

A community controlled organization. Awabakal has a board of seven directors who are elected by the community and know the needs of the community. The local community controls its own affairs because the board operates in accordance with whatever protocols and procedures are determined by the community.

*What are your administrative responsibilities at Awabakal Aboriginal Medical Service?*

As the Program's Coordinator I'm responsible for coordinating preventative health programs and ensuring that the AMS provides a range of services and programs that meet the current and future needs and expectations of Aboriginal clients within the local area. The role involves working with communities to identify current health issues and delivering programs that will raise the level of the community's awareness of health improvement initiatives.

I also look after the programs that we've been funded to provide, such as mental health, drug and alcohol, the otitis media hearing health program, and the Bringing them Home program.

*Could you say more about the Bringing Them Home program?*

The Bringing Them Home Program (Mur-rone or Healing) seeks to make contact with "stolen generations" survivors—people who were forcibly removed from their families when they were children. The Stolen Generation worker helps survivors link up with their families and understand their culture. The worker also helps them get the services they need to help in their social and emotional healing. It's really important for these people to know who they are and to be supported in this long journey.

*I've heard that for many decades, in an attempt to assimilate Indigenous people, Indigenous children were forcibly taken from their homes, placed in mission schools, foster homes, and adoptive homes. Their names were changed and they were punished for speaking their own language. They weren't told about their families or their heritage. Is it true that this horrible practice was legal and continued until the early 1970s?*

Yes. We've had young people who have been brought up by non-Aboriginal families. You really feel for them because they are lost in a sense. They don't feel like they belong anywhere until they find their family. These people have issues, even mental health issues, that can be passed on generation after generation unless they get help.

*What a tragic situation. It's wonderful that you're reaching out to these people. It sounds like health workers are key to the success of Bringing Them Home and your other programs.*

Yes, we are advocates for Aboriginal people dealing with mainstream services. We liaise between the community and mainstream health providers. We need

to be jack-of-all trades. We can't just concentrate on one area. We look at health in a holistic manner. We need to wear many hats.

*If you're caring for someone and sense that he has some special issues, might you try to link him with appropriate resources?*

Yes, we link people with the appropriate health worker or services. We also work with people and their doctors in following up on their care. If doctors tell patients they need to have speciality care, that might not happen unless the health worker gets involved.

*You are the Regional Representative and Director of the Aboriginal Health and Medical Research Council. What is the council and what are its responsibilities?*

The Aboriginal Health and Medical Research Council (AH&MRC) is the peak body representing Aboriginal Community Controlled Health Services in the state of New South Wales (NSW). It advises the NSW government on Aboriginal health policy, programs, needs, and resources. It assists community-controlled health services and supports community controlled initiatives and liaises between mainstream agencies. AH&MRC is also a member of the National Aboriginal Community Controlled Health Organization (NACCHO).

It's a very important organization with some very clever people. There's an ethics committee that looks at all research proposals that universities and the like want to do in Aboriginal communities. A lot of proposals come through. Sometimes you shrug your shoulders and think, we must be the most researched people in the world. We need to look after the communities.

*Make sure they aren't exploited?*

Yea. This has been going on too long. Researchers get all of this information out of the community, and the community is still left with nothing. Sometimes the community has expectations. Then when nothing happens, it's like a further loss. We also have to make sure that the research doesn't stigmatize our people in any way.

*That's very important.*

*Indigenous people are greatly underrepresented in the healthcare force. Do you and/or your colleagues participate in recruiting Indigenous students into the health professions?*

At every opportunity we try to encourage young Aboriginal people to enter the health professions. In 2001, a scholarship fund for a medical student's training was set up in recognition of one of the founders of Awabakal AMS. There are five or six other scholarships set up through Rotary International to encourage Aboriginal students. We also try to encourage non-Aboriginal medical students to take an interest in Indigenous health issues and to seek

to practice at Awabakal or any other Aboriginal medical service in Australia.

Hunter Area Health, in partnership with Awabakal Newcastle Aboriginal Coop, participates in an Aboriginal Employment Strategy 1998–2003. The strategy is aimed at promoting Hunter Health as a prospective employer, helping current Aboriginal staff develop new skills, and increasing the number of Aboriginal staff employed through targeting positions.

*What roles do you and others in the organization play in educating health professionals?*

Occasionally, depending on the workload of our doctors, we take on young Aboriginal and non-Aboriginal doctors-in-training. The doctors-in-training work with our doctors in caring for patients, and they consult with us about community and cultural issues.

We work and liaise with the General Practice training organization (Valley to Coast) based in Newcastle. GP registrars rely on our doctors and Aboriginal health workers to provide information about Aboriginal health issues. We also talk with them about cultural awareness and provide information on how to best deliver services to Aboriginal people.

Some of us participate in the compulsory unit in Aboriginal health at the University of Newcastle. We are on panels at the medical school where we address all of the first-year students in medicine, nursing, occupational therapy, speech pathology, physiotherapy and nutrition and dietetics. We talk with students about Aboriginal health and some of the services that we provide. We also talk about some of the myths about Aboriginal people.

*What is an example of a myth?*

They think that we get more money on the dole (through unemployment benefits) than any other people. They think we get a house, a car, and money. They think we're all drunks. A young student told me that her family believes we're all thieves. It's really hard. I don't know why people think these things.

We try to tell our life experiences—what it was like for us growing up. I grew up in a very poor family. A lot of days, I couldn't go to school because we had no food. I don't know how we survived, but we did.

I liked school until about the 5th class. One day I returned to school after being out several days because we didn't have food. The teacher stood me up in front of the class. He said, "You're all the same. You're just like your cousin (my cousin is darker skinned than I am). You're behind in your work. You probably sit up all night watching the idiot box. You'll never become anybody".

*That's so awful. But you did become someone!*

*Can you describe how you got involved in the important work you're now doing?*

Yes. My interest in Indigenous health care was awakened from my experience working as an assistant in nursing at an aged care facility in Gunnedah. One of my mates, who was a senior health worker, asked if I wanted to take up an Aboriginal health traineeship to help our people. I jumped at the chance.

*What kind of preparation did you have for your work as a health worker?*

We were taught how to develop, implement, and evaluate health programs within our communities. We also looked at the different health issues in our communities and which funding bodies and mainstream services to tap to try to improve the health of our people.

At that time, like a lot of Aboriginal people, we didn't realize how poor our status was. When I started reading different reports about our health, it made me more determined to try to help my people. The money isn't great in health services. We're here because we want to help our people. We've been through what the younger generation is going through now. We want them to have a better life style.

*When you talk to medical and other health professions students, do you talk about ways they can be more culturally sensitive?*

We tell them about eye contact. We say, "A lot of Aboriginal people won't look people in the eyes, especially doctors who they see as people in high positions". We say, "Don't think these people are ignorant. They are listening to you. They just aren't looking at you all the time".

Also, we say, "If someone doesn't understand something, they will keep nodding their head and say, 'Yes.' You need to use easy language that they can understand. Then check to make sure they understand. Drawing simple pictures on paper is also a good way to communicate".

We tell them, "Always try to find out more about patients. They might just come in about the sore on their toe, but they might have other health issues. Many Aboriginal people don't go to the doctor very often, so when they are there, try to get the most out of that visit".

When we talk with students and doctors, we also talk about the importance of making mainstream services more culturally appropriate so Aboriginal people will feel easy and welcome. One way to do this is to have more young Aboriginal people working in these services. We have a lot of young people now doing health worker administration courses. So there are qualified kids out there. You just have to give them a go in mainstream services.

*What suggestions do you make to health professions educators regarding how to best prepare health professional students to meet the needs of Aboriginal people?*

We tell them that the most important thing is to prepare health professionals who listen to the community and individuals and hear what their needs are.

Health professionals shouldn't go into communities and say, "We're going to do this and that". We say, "If you and your students are going to work in an Aboriginal community, don't go in with your own agenda. Also, work with an Aboriginal health worker, an elder, or someone else who knows and is trusted by the community. You need to gain the community's trust. Once people trust you, they'll come to your services and clinics".

When we get new doctors, they don't see a lot of patients at the start because the community are a bit of "Wonder what he's like?". Once they trust the doctor, the doctor is inundated with patients.

*Many of our readers are health professions educators who want their students to learn to be more sensitive to the needs of their communities. Do you have any recommendations for them?*

I recommend that in dealing with Indigenous people, and in particular Aboriginal people, health professionals listen to the stories and life experiences of their clients, that they be empathetic and non-judgmental in their dealings. It's important that they allocate more time to engage with their clients as the clients will have barriers that need to be broken down. It's important to establish rapport with the client and to respect that client. It is also important to be opportunistic when dealing with clients and to treat as many problems at a time, because some people may have multiple underlying health issues but be unlikely to return for care in the near future.

*Many thanks for sharing your experiences and ideas!*

## **References**

EADES, S. (2000). Reconciliation, social equity and Indigenous health: A call for symbolic and material change. *Medical Journal of Australia*, 172, 468–469.