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ORIGINAL RESEARCH

Closing the gap by increasing access to clinical dietetic services for urban Aboriginal and Torres Strait Islander people

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Abstract

Aim: Late in 2010, the dietetic clinic in a Brisbane Indigenous health service increased from one to four days/week. This article presents research to assess the impact of this on access for urban Aboriginal and Torres Strait Islander people to dietetic services.

Methods: Clinic data on referrals and attendance before and after this change are compared. Focus groups with staff and in-depth interviews with 13 patients were conducted to ascertain staff and patient experiences of the clinic changes.

Results: The additional time allowed the dietitian to develop a stronger presence in the community and clinic. This ensured that the dietetic service was culturally safe for clients and strengthened team approaches to patient care in the clinic. Despite space limitations, new referrals more than doubled and occasions of service tripled. New patients were more likely to attend an appointment with the dietitian in 2011 than in 2010 ($P < 0.001$) and the proportion of patients who did not attend appointments without rescheduling decreased significantly ($P = 0.006$).

Conclusions: Various factors contributed to improved access for Aboriginal and Torres Strait Islander people to dietetic care. These included fostering the dietitian's cultural awareness and building trust with Indigenous community members, making the dietetic service culturally safe for clients; connecting with patients through appropriate communication styles and inter-professional teamwork. Providing an expanded and culturally safe dietetic service improved the availability, acceptability and appropriateness for Aboriginal and Torres Strait Islander people.

Key words: Aboriginal and Torres Strait Islander, clinical nutrition and dietetics, cultural safety, evaluation, health services, social research.

Introduction

Poor nutrition contributes about 16% of the burden of disease in Queensland.[1] Although morbidity and mortality from diet-related conditions is higher in Aboriginal and Torres Strait Islander populations than in the overall Australian population,[2] action to address nutrition in the Indigenous population is suboptimal. The 2000–2010 National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan was not funded adequately for full implementation and has not been extended.[3] Furthermore, the Queensland workforce addressing Aboriginal and Torres Strait Islander nutrition was substantially diminished in 2012 by the State Government,[4] reversing the earlier workforce expansion to address nutrition inequalities.[5]

Aboriginal and Torres Strait Islander people experience significant problems in access to health care.[6,7] Access can be characterised by availability, affordability, acceptability and appropriateness, the latter two issues being particularly significant barriers to health-care access for Aboriginal and Torres Strait Islander people in urban areas.[6] Aboriginal people may be reluctant to use health services as a result of inappropriate care practices, distrust resulting from historical factors, past poor treatment, and lack of health professionals' knowledge and skills in working *with* Aboriginal clients.[8] Improving cultural safety of patients is important to improve access to care.[6,9] Culturally safe care involves building trust with patients, while recognising the power differentials resulting from socioeconomic conditions, history, politics and health. It requires respecting patients and ensuring that they become partners in health decision-making.[10]

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Although there is little specific information about Indigenous people's access to dietetic care,[7,11,12] a study from Fremantle, WA, indicates that Aboriginal people with diabetes were much less likely than non-Indigenous people with diabetes to have seen a dietitian.[13] Given the high burden of diet-related conditions experienced by Aboriginal and Torres Strait Islander peoples,[2] including urban populations,[14,15] the provision of accessible and culturally safe nutrition services is an important strategy for reducing the health gap between mainstream and Aboriginal and Torres Strait Islander populations.

This article outlines strategies implemented in a Brisbane Indigenous health service to increase access to dietetic services and presents research evaluating these changes. As little research has been conducted specifically on access to dietetic services by urban Aboriginal and Torres Strait Islander people, this research contributes new evidence on successful strategies to increase dietetic access at Inala Indigenous Health Service (IIHS).

In 1995, IIHS was established within a Queensland Health Community Health Centre in Inala, one of the most disadvantaged Statistical Local Area in Brisbane.[16] Beginning with an Aboriginal doctor and nurse and 12 Aboriginal or Torres Strait Islander patients, through the provision of culturally safe services, the number of patients has increased.[17] By 2012, IIHS employed 49 full-time staff and served over 6000 patients, 85% of whom are Aboriginal people or Torres Strait Islanders.

IIHS established the dietitian position within its general practice in 1997. Until mid-2010, this role comprised one day of clinical dietetics and four days of community nutrition each week. Given the growth of IIHS, and the variety of nutrition-related conditions,[15,18,19] the need for dietetic services has increased and the position was split into two. A new dietitian took over the role at the time of the changes. Despite clinic space constraints, the dietitian's clinic role was expanded to four days/week from mid-2010. A full-time Community Nutritionist position was also established. There is a collaborative approach to nutrition work, with the Community Nutritionist mainly working in community primary prevention projects and the Dietitian primarily in the clinic, but also engaging in community events to provide visibility for the role.

To gather baseline information, raise clinical staff awareness about the expanded dietetic services, and begin a conversation with staff about increasing dietetic access for patients, routine clinic data on referrals by doctor and patient attendance were analysed and presented to the whole staff. Strengthening cultural awareness for the dietitian and cultural safety of the patients was also addressed.

Cultural awareness for a new dietitian included community orientation, as she had limited experience working with Aboriginal and Torres Strait Islander people or in low socioeconomic areas. A tour was facilitated by an Aboriginal Health Worker, visiting community housing, centres and shops. Introductions to the Elders and workers in community organisations established relationships with some community members. The orientation had a strong impact, providing cultural lessons that facilitated making the dietetic clinic more culturally safe for patients (see Appendix 1). Key lessons learned include the style of appropriate resources for the clinic (visual materials rather than written), having a more informal approach to communication (even in appointments) and dressing appropriately to be less threatening for patients.

The dietitian's presence in the community is maintained through participation in a variety of community events (e.g. organising healthy meals for the monthly suicide prevention meetings at the Elders' meeting room). This serves to build trust for community members and to continue learning about and engaging with community members. The dietitian's presence in the clinic was promoted through regular nutrition activities in the waiting room and the engagement of receptionists with weekly easy recipe handouts or nutrition information for patients left at the reception desk. According to a receptionist, patients love the recipes and chat about them with reception staff.

Because of space constraints, dietetic consultations may be conducted outside under a tree, in the quiet space in a hallway, at patients' houses, supermarkets or any available room in the community health centre, where the patient would feel comfortable. Patients are met by the dietitian in the usual waiting room and accompanied to whatever space is available. If necessary, they are weighed in the clinic before leaving there. A mobile 'office' comprises a folder of culturally appropriate resources, a notebook and a pen.

The research aimed to ascertain if changes to the dietetic services described above increased referrals and attendance rates and to learn from clinic staff and patients what is important to them in a dietetic service.

Methods

Ethics statement: The Inala Community Jury for Aboriginal and Torres Strait Islander Health Research gave community support for this research. Ethics approval for the study was obtained from Queensland Health's Metro South Human Research Ethics Committee.

Clinic data in the practice management software from 2010 to 2011 on patient referrals and attendance before and after the changes implemented to the dietetic service were compared using a Fisher's exact test in Stata.[20]

Qualitative approaches, useful for exploring the complexity of primary care delivery[21] and areas little represented in published research,[22] were used to provide an understanding of clinic staff and patients' perspectives on the changes to the dietetic clinic introduced during 2011. A staff member who is not part of the clinical staff facilitated focus groups and interviews in an attempt to minimise observer bias.

Two focus groups, one with general practitioners (GPs; $n = 6$, 34 minutes) and another with practice nurses ($n = 7$, 19 minutes) covered expectations of dietetic services, the impact of the increased availability of a dietitian, referral processes and patient outcomes from increased access to the dietitian. These were incorporated within staff meetings to minimise staff burden. An in-depth interview was conducted

with a senior receptionist to explore the impact of the new referral processes on reception staff and observations about patient engagement in nutrition promotion activities in the waiting room and reception. Thirteen dietetic patients participated in in-depth interviews (12–35 minutes). A parent responded in relation to the youngest patient. Purposive maximum variation sampling was used to ensure a range of patients by age (3–60 years), gender (six men, seven women), referral type, referral condition and attendance at appointments (two non-attendees, two attended only one appointment). To minimise selection bias, the dietitian did not select, recruit or interview patients. The first author selected potential participants from a complete patient list. Patients were phoned to invite participation in an interview. Although most were willing to participate, several declined because it was not convenient for them. The interviews were conducted either at the participant's house or the health service. The first author conducted interviews with an Aboriginal Health Worker from the community. Participants were thanked with a grocery voucher. Interviews covered perceptions about dietitians' work, referral to the dietitian, expectations and experiences of appointments, and suggestions for the dietetic services. We stopped interviewing after 13 interviews because the data were saturated.

Interviews were digitally recorded, with permission, and transcribed professionally. Transcriptions were checked and de-identified by the interviewer before analysis. It is notable that the only transcript corrections required pertained to the use of Aboriginal English. This dialect of English, used consistently in the Aboriginal and Torres Strait Islander community, is often misunderstood by mainstream English speakers, as the transcriptions showed. NVivo software[23] was used to manage the data. De-identified transcripts were discussed by the research team and themes identified, discussed and agreed upon. Quotes representing themes were selected to demonstrate key issues voiced by participants and to ensure a range of perspectives.

Results

As expected, access to dietetic services at IIHS increased in 2011 (Table 1).

The clinic statistics show that the expanded dietitian service more than doubled referrals and almost tripled occasions of service in the first year. Notably, significant improvements from 2010 to 2011 were observed in the proportion of new patients attending appointments with the dietitian ($P < 0.001$) and the proportion of patients who did not attend without rescheduling ($P = 0.006$) (Table 1).

Table 1 Dietetic clinic statistics IIHS 2010–2011

	Year		
Dietetic clinic statistics	*2010*	*2011*	
New referrals made	100	221	
New referrals seen	32	191	$P < 0.001$
Total occasions of service	183	567	
DNA rate (did not attend)	35%	27%	$P = 0.006$

IIHS, Inala Indigenous Health Service.

Insights from interviews and focus groups on the factors that facilitated increased attendance at dietetic appointments are presented below, arranged according to the elements of access identified above: availability, acceptability, appropriateness and affordability.

Availability: The dietitian's additional availability benefits both patients and receptionists:

> 'I just can't come down the one day to see the doctor and the next day to see the dietitian. . . . so by the—having the four day clinic. It makes it a lot easier, it makes the dietitian more accessible. Before . . . [it] was on a Wednesday . . . it wasn't a good day for me.' (DA8, M, 60 years)
> 'I think it runs a lot smoother now . . . rather than the one day a week because it was just a big juggle before trying to get them in and they wouldn't come, that's all. So now there's a bit more flexibility.' (Receptionist)

Increasing the dietitian's clinic work from one to four days/week significantly increased access to dietetic services for the clinicians and patients. Patient waiting times for appointments were reduced and appointments can usually be booked on suitable days. Previously having only one day available to patient consultations was limiting, particularly for patients with inflexible work times.

The dietitian's active presence in the community broadens the reach of dietetic services, and facilitation of healthy eating activities in a variety of community groups encourages clinic attendance:

> 'And I think the community engagement is really important as well so the fact that she has a face out in the community and is doing things that are practically useful to the community . . . means people will turn up.' (Doctor focus group)

A flexible approach, including home visits or meeting with people at community venues and events, facilitates treatment for patients who would not otherwise receive any. A 20-year-old man with type 1 diabetes is one such patient. Diagnosed in hospital with type 1 diabetes, he had not returned for diabetes education. About a year later, his mother met the dietitian at a community event and mentioned her son's situation. She is a single, working mother and her son had no transport to the clinic. The dietitian's flexible and friendly approach, encompassing three home visits with cooking demonstrations, clinic visits, phone consultations and case conferences, facilitated his HbA1C decreasing from 14% to 8%:

> 'She's come out to the home, and showed me how to make these meals. . . .
> One time I was sitting [in the waiting room] – I think it was for about an hour and a half. So she came, and gave me some yoghurts, and some fruit so I wouldn't have a hypo. . . . I thought that was very nice.' (DA5)

However, availability of the dietitian in the clinic and community is not adequate to ensure access to dietetic care. Patients who had not attended appointments cited transport difficulties, work commitments and poor memory preventing them from attending appointments.

Acceptability: Sociocultural barriers to health care can be more significant than geographical barriers for urban Aboriginal and Torres Strait Islander people.[9] Cultural understanding, acceptability of service provider attitudes and practice, communication styles, and a system that clients can trust contribute to providing acceptable, culturally safe health services.[6] Flexibility is essential, as highlighted by the frequent rearrangement of appointment times by some patients. The additional clinic time has enabled the dietitian to take time with consultations, conduct home visits, provide practical examples of available healthy food by educating patients in nearby food outlets, and establish a stronger presence in both the clinic and the community, which is particularly important for this population group, as one patient explains:

> 'It is really important for community to see you because they can see that you're just normal like them. So you come from a normal house, you're not stuck up. You're not—you know, you don't think you're better than anybody else and you get stuck into stuff in the community as well. And that's very, very important for other people to see that.' (DA12, F, 39 years)

Participants mentioned the following factors that made them feel safe with a dietitian: not feeling judged (DA1, 8, 12, 13); the dietitian taking time to make a personal connection and being 'genuine', 'friendly', 'honest', 'supportive', 'flexible', 'dependable' and 'respectful' (DA1, 2, 8, 9, 10, 11, 12); culturally accessible materials (DA2, 4, 5, 6, 7, 8, 9, 13); clear explanations (DA4, 5, 8, 9, 10, 13); and practical education (DA4, 5, 8, 11). Keeping in touch with patients by emailing additional recipes and providing support via phone or Facebook are also important to some patients (DA4, 7, 12, 13). The nurses reiterated these points in their focus group and added that looking beyond individuals to the family and keeping focus on the affordability of foods recommended also helps patients engage with the dietetic advice. A negative example of this comes from a patient who did not receive information she found acceptable and subsequently disengaged:

> '. . . because it's like there's no point in me going [to the dietitian] and not being able to buy food until like next year. . . . she'll give me a list and stuff, what to buy, I was like I don't even eat this stuff.' (DA3, F, 19 years)

Engaging with patients is vital when working with Aboriginal and Torres Strait Islander people; however, expectations of a dietitian appointment may prevent clients from attending. While several participants in the present study simply expected the dietitian to give them dietary advice, many expressed negative expectations, including being scared, expecting a reprimand or deprivation of preferred foods. Past negative experiences with a dietitian create reluctance to attend appointments, but positive contact can encourage engagement, as the following experiences demonstrate:

> 'I really didn't want to meet her. When they said to me, 'Oh we've got a new dietitian, Auntie,' you know. 'I'd like you to go and see her,' and I went 'Yeah, righto', and it was, like, 'If I have to'. I just thought, 'Well, I'll go in respect [of referring doctor] but I don't have to keep continuing'. So I went and, yeah, she said who she was and her name and what she does and told me a lot about herself. And then she asked me about myself and things. . . . She just didn't push herself onto you. . . . She makes me feel very comfortable. . . . She's got so much respect for everybody . . . because I've met dietitians before and I've never [returned]. Not that they were rude or anything but they were dietitians. That's it. It was just like from the book.' (DA9, F, 58 years)
>
> 'I expected to be spoken down to, treated like a child. . . . she spoke to me nice.' (DA5)

Connecting with patients encourages them to return for further treatment and support. A teenager from a troubled background, with limited clinic engagement, indicated that her engagement with health professionals depends on 'what sort of person they are' (DA4, F, 15 years). She appreciated the dietitian following her up, sending recipes by email.

Common courtesy, treating patients as people first and showing care (e.g. offering a cup of tea if a patient is waiting a long time, greeting patients in a corridor or in a waiting room) encourage attendance at appointments, or rescheduling if necessary:

> 'They care enough to make the call and say, "Oh, baby's sick, can we move [appointment] to next Tuesday?" And I'll go, "Oh, I'll just see if she's up there, you want to have a quick hello?" "Yeah, that'd be good." ' (Receptionist)

The receptionist noted that patients refer to the dietitian by name, which is unusual. When health professionals do not establish a presence in the community, they are more likely to be referred to by a generic label like 'the lady'. This personal connection with patients facilitates improved attendance at the clinic.

As community is a central aspect of Indigenous health services, the clients are not all strangers, as they may be in a mainstream clinic. Several participants talked about sharing information about the dietitian in the community as well as sharing resources that they found useful.

> 'So you know when you go to people and they judge you and you go, 'I won't be going back there again, will I?' . . . Well, that [non-judgmental approach of dietitian] makes me feel comfortable and I'll always go back and recommend as well, you know?' (DA12, F, 39 years)

Aspects of communication with Aboriginal and Torres Strait Islander patients which improve acceptability of a dietetic service include showing respect towards Elders by addressing them as 'Aunty' or 'Uncle', using an informal

'yarning' style in consultations, taking time to make introductions and learn about patients, making people comfortable by being friendly, interpreting medical jargon into everyday language, being non-judgmental and providing practical examples:

> '. . . she's even taken me one day over to the shopping centre. And we walked around and she sort of told—showed me the types of food that I should be looking to buy. And what I should be looking on the labels when I'm reading the—you know, what's in the ingredients inside these food types.' (DA8, M, 60 years).

Appropriate communication styles break down cultural barriers:

> 'She got to your level, she didn't judge you, she'd understand you.' (DA13, M, 26 years)

Appropriateness: Health-care services often do not meet the needs of Aboriginal and Torres Strait Islander people in relation to complex and multiple health conditions.[6] Appropriate health care deals with this complexity. Both patients and doctors spoke of the importance in the dietitian's flexibility to deal with complex problems:

> 'I thought it'd be all about just talking about the diet and eating habits and problems and getting on the scales. I didn't think it'd be anything about smoking or stress management; I thought that they'd refer me to a psychologist for that. . . . I had a couple of moments where, like, where I could have thrown it in the too hard basket and said I just want to give up, and [dietitian] kept me on the level and said don't give up. I've got to where I am now, after six to eight months, and I'm really proud of my achievements [weight loss, improved eating habits and cooking].' (DA2, M, 26 years)
>
> '. . . one particular example where that sort of engagement [home visits] made the difference between the person being seen or not. . . . Very complicated patients with complicated health problems, adolescents, [dietitian] tried very hard with them. . . . I've got an adolescent who very much needed to be seen and would not have been seen any other way.' (Doctor focus group)

For a dietitian to work effectively with urban Aboriginal and Torres Strait Islander people, there must be a work environment in which: staff are supportive of the dietitian role; inter-professional teamwork is valued and communication channels facilitate collaboration between the dietitian and other clinic staff; there are appropriate, efficient ways of making referrals and appointments; and there is adequate clinic space to meet with patients and enough clinic time for the dietitian to make a difference. As one of the doctors observed:

> 'You can't have a really able dietitian doing her stuff and working with patients well if the system's not set up for it.'

Staff mentioned the value of having the dietitian write thorough patient notes:

> 'I think having a dietitian working in the clinic using the same software makes it a much better team approach than a dietitian that writes a letter that's then stored.' (Doctor focus group)

Integrating the dietitian role within the staff team promotes discussions among the staff about food and nutrition, reminds doctors to refer patients, enables nurses and doctors to introduce the dietitian to referred patients, provides opportunities for the dietitian to work with other professionals in the clinic, and facilitates consistent dietary messages for patients and patient engagement:

> 'But if I'm having a problem with something, I'll often go and say to [dietitian], "I'm really worried about this," or "I've got a patient at the moment who's lost a lot of weight," and if he comes in, [dietitian] always ducks down with a few more sachets of various things for him to try to see if it can build him up a bit.' (Doctor focus group)
>
> '. . . one of the clients that I've got now. [Dietitian] and I work hand in hand with him. She'll see him here [clinic], but she's also part of [Chronic Disease group], . . . for this six weeks, she'll see him [there] as well. But [patient], he is talking to me outside in the men's groups, we'll get together, we'll talk. He's telling me how great things are going with his diet. Come back here, he sees [dietitian], he gets driven again by all that sort of stuff.' (Nurse focus group)

Case conferencing involving the dietitian with other clinicians facilitates consistent treatment and patients being more willing to attend follow-up appointments:

> 'What I've noticed is there's not only an increase in the number of patients that are seeing her, but there's an increase in the number of patients who are coming back more than once.' (Nurse focus group)

Good integration of the dietitian's work within the clinic improves the appropriateness of the health care offered to patients.

Affordability: Affordability of the dietitian service for both the patients and the clinic is important. Having a salaried dietitian is beneficial as one of the doctors explains in relation to the dietitian's community activities:

> 'all the extra things that are not paid for by Medicare—couldn't be done by a visiting/part time dietitian.'

All services are provided free through the clinic; however, in 2011 approximately 35% of IIHS dietetic service occasions were eligible for Medicare funding, under either item number 10954 or 81320. Item 81320, the only Medicare item number that specifically links Aboriginal or Torres Strait Islander and dietetic service, is for people who have an Aboriginal and Torres Strait Islander health assessment (item 715) with referral to a dietitian.[24] It depends on referral from a GP, but is not extensively used, as Table 2 shows. In 2011–2012, IIHS recorded almost 40% of Queensland and 20% of Australian services against this item number. These Medicare items are available and could be used more widely.

Table 2 Medicare services processed for item 81320 July 2011–June 2012

State									
NSW	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*Total*[(a)]	*IIHS*[(b)]
324	31	458	1	9	11	18	38	890	177

[(a)] Source: MBS Item Reports.[24]
[(b)] Source: Inala Indigenous Health Service General Practice records.
IIHS, Inala Indigenous Health Service.

Discussion

This is a small study that highlights issues that are important for providing good access for urban Aboriginal and Torres Strait Islander people to much-needed dietetic care. In Australia, allied health referrals are usually made to professionals external to GP practices,[25] however, this fragmenting of care has drawbacks. People are less likely to see a dietitian beyond their general practice for weight loss, for example.[26] Given the high burden of diet-related disease among Aboriginal and Torres Strait Australians, a much higher priority needs to be placed on addressing nutrition-related disorders among this group.[27] The inclusion of dietitians in multidisciplinary health-care teams contributes to improved access to appropriate health care and improved chronic disease outcomes for Aboriginal and Torres Strait Islander groups,[28] as with other Australians.[25,29] As we have seen, some patients in the present study talked of prior reluctance to engage with dietetic services.

This research demonstrates that when dietetic services are available, affordable, acceptable and appropriate, Aboriginal and Torres Strait Islander people engage with dietetic care and health improvements follow. To achieve this, adequate and culturally safe dietetic care needs to be well integrated in the health service. As work situations are rarely ideal, flexibility in service delivery, including readiness to see patients when it suits them, also improved access. Training dietitians in the provision of culturally safe dietetic services is therefore important.

Many Aboriginal health services do not have access to full-time dietitians and instead have either a regular part-time, occasional or no dietetic service.[30] This research shows that engaging with the community builds trust and increases access to dietetic services. Inter-professional teamwork also contributes to improved access. The importance of having a culturally safe service cannot be overemphasised as this is what makes people initially see the dietitian, return for follow-up appointments and engage with strategies to improve their nutritional health.

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Conflict of interest

None.

Authorship

W. Foley conceived the research, drafted the protocol, prepared ethics application, selected study participants, conducted interviews, and led data analysis and drafting the text of this article. A. Houston participated in research planning discussions, presented the proposed research to the Community Jury, provided patient list for selection, discussed de-identified data, and contributed to thematic analysis and write-up.

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Appendix

Appendix 1 Reflection on working in a city executive health practice versus a suburban Aboriginal and Torres Strait Islander community

On the community tour I was amazed at the small, run-down houses and community centres I was shown. I couldn't believe that a suburb of Brisbane had such poor housing. Not only had I never worked with Aboriginal and Torres Strait Islander people, but I had come from working in the inner city, seeing affluent clients in an executive health practise. I had to change my practise completely, taking into consideration new challenges like different health profiles and standards of living, food insecurity, and the need to consider family circumstances that have emerged from intergenerational discriminatory policies applied to this population group, including dispossession and enforced living in missions, the stolen generation, and the social, mental, emotional and physical effects. This was a big change from my city clinic priorities which included individual-oriented education, time management, over-indulgence, jet lag, etc.

The tour was crucial for me as a new employee in the area. Coming into the community as a middle class 'white girl', how could I understand the patients' needs and struggles without listening to their stories and exploring their way of life? This helped me to become more empathic toward their needs, and modify my practise accordingly. The things that struck me the most with this patient group was their consideration of and attachment to their family. I had to adjust my assessment and treatment to include family groups—not just the individual. The contrast between the needs of clients in these two different kinds of Brisbane dietetic practice could not have been greater.