



# Creating the NACCHO Cultural Safety Training Standards and Assessment Process

A background paper

May 2011

# Contents

<b>1: INTRODUCTION .....</b>	<b>1</b>
1.1 History of this project .....	1
1.2 Project plan and deliverables .....	2
1.3 Purpose of this paper .....	7
<b>2: ISSUES RELEVANT TO CULTURAL SAFETY TRAINING .....</b>	<b>8</b>
2.1 Concepts and meanings .....	8
2.2 Cultural safety and respect as a human right .....	16
2.3 Racism and cultural safety .....	20
2.4 Components of good practice in cultural safety training .....	24
2.5 Training participation, culturally safe practice and continuous improvement .....	25
<b>3: CONSIDERATIONS IN SETTING CST STANDARDS .....</b>	<b>27</b>
3.1 Focusing on standards .....	27
3.2 Existing ACCH Sector work on training standards .....	27
3.3 Minimum requirements .....	29
3.4 The appropriateness of online options .....	30
<b>4: ENDORSEMENT OF THE CST STANDARDS .....</b>	<b>31</b>
<b>5: FUTURE DIRECTIONS .....</b>	<b>32</b>
<b>APPENDICES .....</b>	<b>33</b>
Appendix A: Standards Committee Terms of Reference .....	33
Appendix B: Industry Reference Group Terms of Reference .....	35

## *Acknowledgements*

The writing of this paper was made possible through the knowledge, experience and advice provided by members of the Cultural Safety Training Standards Committee (see Appendix A), who represented the following organisations within the Aboriginal Community Controlled Health Sector:

- ④ Aboriginal Health Council of South Australia (AHCSA)
- ④ Aboriginal Health Council of Western Australia (AHCWA)
- ④ Aboriginal Health & Medical Research Council of NSW (AH&MRC)
- ④ Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- ④ Queensland Aboriginal and Islander Health Council (QAIHC)
- ④ Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- ④ Winnunga Nimmityjah Aboriginal Health Service, ACT
- ④ National Aboriginal Community Controlled Health (NACCHO)

# 1: Introduction

## 1.1 History of this project

Creating an environment of cultural safety in health services to ensure responsive and culturally appropriate care is the core business of NACCHO, State Affiliates and its Members. It was a driving force behind the establishment of Aboriginal Community Controlled Health (ACCH) Services in the early 1970s and the ongoing growth of the ACCH Sector. As NACCHO recently stated in its February 2009 submission to the Australian Government paper, 'Towards a National Primary Health Care Strategy':

*Services that are not Aboriginal community-controlled, by definition,<sup>1</sup> cannot deliver culturally appropriate primary health care. However, services that are not Aboriginal community-controlled can be encouraged to deliver healthcare that is culturally secure. A definition and program prepared by the ACCHS sector for the delivery of Aboriginal **cultural safety training** for mainstream health services should be supported.*

Work to establish a set of Aboriginal Community Controlled Health (ACCH) Sector endorsed Cultural Safety Training Standards that align with sector principles has been in progress for some time. In August 2010, the NACCHO Board made a recommendation to proceed with this particular project in order to formalise this work. Such standards would be of value to both the ACCH Sector and the mainstream health sector, as Aboriginal Peoples require services in both settings.

Following conversations with the Office for Aboriginal and Torres Strait Islander Health (OATSIH), a proposal to establish Stage 1 of a Cultural Safety Training (CST) Standards Project was submitted in March 2010. It included two main components:

- ① **Component 1:** Create the NACCHO National Standards for Cultural Safety Training and an Assessment Process.
- ② **Component 2:** Create a searchable database on Cultural Training activity and resources.

In May 2010 the Department of Health and Ageing (DoHA) supported NACCHO's proposition that the project commence with existing OATSIH funds focused on implementing COAG measures while negotiations to fully fund the project continued. OATSIH agreed to fund parts of Component 2 only, but not Component 1. The project is coordinated by the Senior Policy Officer and the NACCHO COAG Implementation Officer with assistance from *beyond...* (Kathleen Stacey & Associates).<sup>2</sup>

---

<sup>1</sup> NACCHO's definition of an Aboriginal community-controlled service is: 'An Aboriginal Community Controlled Health Service is: an incorporated Aboriginal organisation, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body which is elected by the local Aboriginal community that is delivering a holistic and culturally appropriate health service to the Community which controls it'; viewed Dec 12 2010 < <http://www.naccho.org.au/definitions/communitycont.html> >.

<sup>2</sup> Kathleen is a non-Aboriginal person who has co-facilitated cultural respect training over the past eight years in different locations around Australia with Sharon Gollan, a Ngarrindjeri woman from South Australia as part of

As this was not a sustainable situation, NACCHO continued to advocate for full funding of the project over the timeframe (see Figure 2). The imperative of fully funding this project is underscored by the advent of the Indigenous Chronic Disease Package, more specifically the PIP Indigenous Health Incentive within the Medicare Practice Incentives Program (PIP). The PIP Indigenous Health Guidelines became available in March 2010 and state that:

*To meet this requirement, at least two staff members from the practice (one of whom must be a GP) must complete appropriate cultural awareness training within 12 months of the practice signing on to the incentive. For the purposes of the PIP Indigenous Health Incentive, appropriate training is any that is endorsed by a professional medical College, including those that offer Continuing Professional Development (CPD) points, or endorsed by the National Aboriginal Community Controlled Health Organisation or one of its state or territory affiliates.<sup>3</sup>*

In late 2010, the timeframe for completion of training was extended to 12 months after the availability of an online course that OATSIH funded the Royal Australian College of General Practitioners to develop. This course became available in 2011.

NACCHO and its State and Territory Affiliates have experienced a marked increase in contact from GPs regarding training since establishment of the PIP Indigenous Health Incentive. In responding to these queries, NACCHO and its Affiliates wish to be in a position where there are ACCH Sector developed and endorsed standards that define the minimum requirement of and conditions of cultural safety training, as this can form the basis of negotiating or recommending training options with GPs as well as the broader health workforce and the workforce of other sectors whose work impacts on Aboriginal health.

## 1.2 Project plan and deliverables

### 1.2.1 Project goal and objectives

The long-term goal of the CST Standards Project is: **To achieve recognition of the NACCHO Cultural Safety Training Standards as the national benchmark for quality Aboriginal cultural safety training for the health workforce and other relevant sectors.**

There are three objectives for the first year of the CST Standards Project:

1. To establish NACCHO Cultural Safety Training Standards.
2. To establish an assessment process and guidelines for achieving endorsement against the NACCHO CST Standards.

---

an Aboriginal/-non-Aboriginal partnership.

<sup>3</sup> Australian Government, 2010, *Practice Incentives Program: Indigenous Health Incentive Guidelines – March 2010*, Medicare Australia, Canberra, p. 3, viewed Sept 27 2010 <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/indigenous-health-incentive-guidelines.pdf>>.

3. To create a publically accessible, searchable database of Cultural Training activity and resources for: the health workforce, their education and training providers; and other relevant sectors that impact on Aboriginal health.

These objectives align with the two main components of the project as follows:

- ⑥ **Component 1:** Create the NACCHO National Standards for Cultural Safety Training and an Assessment Process - Objectives 1 and 2.
- ⑥ **Component 2:** Create a searchable database of Cultural Training activity and resources - Objective 3.

### **1.2.2 Support structures**

The project is driven and overseen by a **Cultural Safety Training Standards Committee** with ACCH Sector-only membership that has responsibility to develop the NACCHO CST Standards and Assessment Process. The main role of the NACCHO CST Standards Committee is to develop the NACCHO CST Standards and assessment process, monitor the overall program process and deliverables, and develop a proposal for Year 2 of the project. Their Terms of Reference are in Appendix A.

The project also gains support and advice from a **Cultural Safety Training Standards Industry Reference Group** with a membership that includes and extends beyond the ACCH Sector. The main role/Industry of the CST Standards Industry Reference Group is to support for the project, contribute advice and feedback that supports achievement of the objectives, and promote understanding and implementation of cultural safety in their respective organisations. Their Terms of Reference are found in Appendix B.

NACCHO has the project management role, and will oversee funding contracts, project progress, reporting and deliverables. NACCHO will also inform the ACCH Sector of project process and facilitate an endorsement process to achieve the final NACCHO CST Standards.

The relationship between the two groups, NACCHO and the broader ACCH Sector is illustrated in Figure 1 on the next page.

### **1.2.3 Project steps and timeline**

A more detailed project plan was developed that outlined the steps required to address the objectives related to each of the two components, including project management.

While an initial timeline for Year 1 of the project was established based on a July 2010 to June 2011 timeframe on the assumption that full funding would be available by August 2010, as described above the anticipated funding was not forthcoming. The revised timeline is shown in Figure 2 and reflects the final process of the project. There are several steps that will now occur in the July-December 2011 period, as they are dependent on resources currently not available to NACCHO, but that NACCHO plans to procure.

Figure 1: CST Standards Project support structure

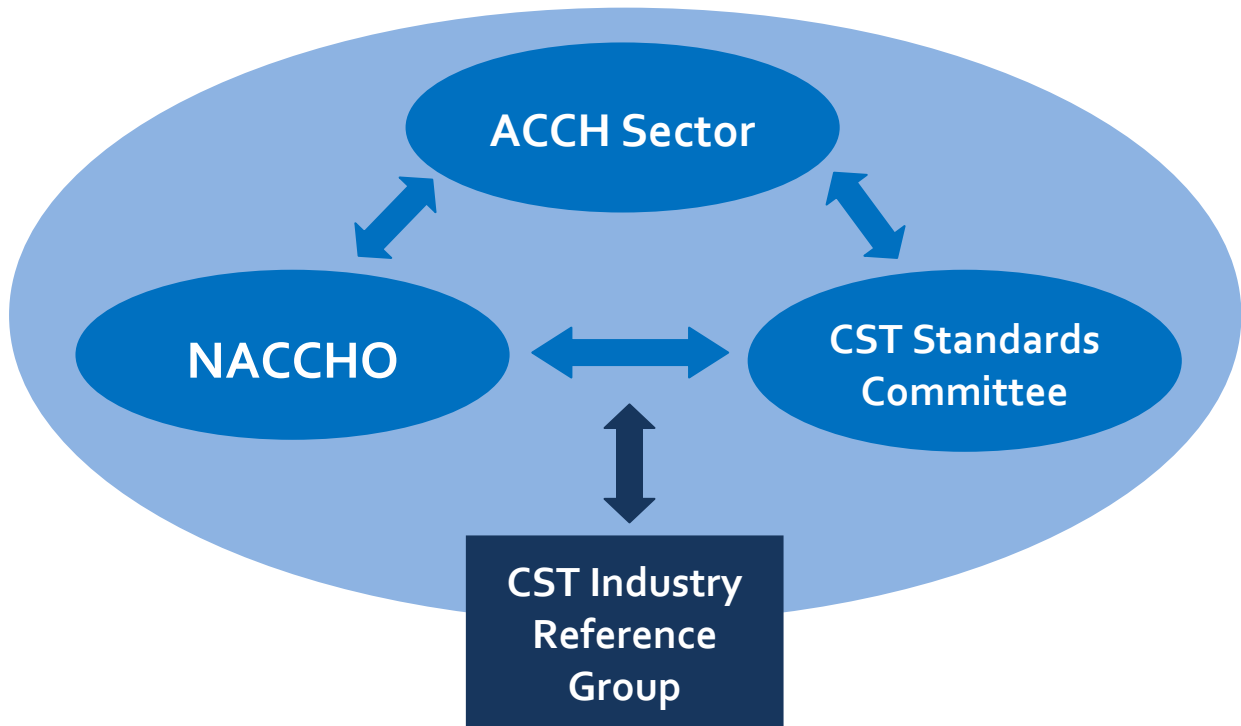


Figure 2: Project plan, steps and timeline for the NACCHO Cultural Safety Training (CST) Standards Project

STEPS	2010						2011						
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul-De
<b>Project management</b>													
1: Document project and operational plan													
2: Liaise with DoHA as needed													
3: Establish Industry Reference Group and hold meetings	7 <sup>th</sup>								9 <sup>th</sup>				
4: Establish Standards Committee and hold meetings		18 <sup>th</sup>		28-9 <sup>th</sup>	22 <sup>nd</sup>			3 <sup>rd</sup>	8-9 <sup>th</sup>	20 <sup>th</sup>			
5: Engage personnel													
6: Develop a business case for Year 2 of the project													
7: Evaluate progress													
8: Provide progress reports to NACCHO													
<b>Component 1: Create the NACCHO National Standards for Cultural Safety Training (CST) and an Assessment Process</b>													
1: Develop a background paper on cultural safety and CST													
2: Develop NACCHO CST Standards													
3: Develop NACCHO CST Standards Assessment Process													
4: Ratify NACCHO CST Standards and Assessment Process											11 <sup>th</sup>		
5: Promote NACCHO CST Standards and Assessment Process													
6: Assess submitted training events/resources (ongoing)													



STEPS	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul-De
Component 2: Create a searchable database on Cultural Training activity and resources													
1: Finalise specifications with IT													
2: Build and test database system													
3: Contact targeted organisations and compile a contacts database													
4: Develop administrative arrangements with targeted organisations													
5: Provide Affiliates with training and system admin access													
6: Launch system to training providers													
7: Organisations populate the database													
8: Hold a National Public Launch of the system and NACCHO CST Standards													
9: Monitor usage and reporting													

### 1.2.4 Deliverables for Year 1

The five deliverables or products that will be produced in Year 1 of the project will be:

- a background paper
- the CST Standards and Assessment Process
- application guidelines for training providers
- the online database
- a business case for Year 2 (and beyond), which includes the required implementation process, associated budget and other future directions.

## 1.3 Purpose of this paper

The purpose of this paper is to provide the CST Standards Committee and Industry Reference Group with an overview of issues relevant to Cultural Safety and Cultural Safety Training. This will help guide CST Standards Committee decisions on what the Standards and the CST training program assessment process should be, and the Industry Reference Group in appreciating the reasoning behind these decisions. It will not be a comprehensive paper on all research and publications relating to cultural safety and culturally safety training, but will address critical issues for the ACCH Sector to consider in achieving endorsed NACCHO CST Standards.

Therefore, this paper will cover the following main areas:

- ⊞ Issues relevant to cultural safety training:
  - concepts and meanings
  - cultural safety and respect as a human right
  - racism
  - good practice in cultural safety training
  - training participation, culturally safe practice and continuous improvement.
- ⊞ Considerations in setting CST standards:
  - focusing on standards
  - existing ACCH Sector work on training standards
  - minimum requirements
  - the appropriateness of online options

## 2: Issues relevant to cultural safety training

### 2.1 Concepts and meanings

A variety of different terms are used to describe training that could contribute to better health service experience and outcomes for Aboriginal Peoples. While they may be interchangeable in some instances, there are critical distinctions that are important to recognise.<sup>4</sup> These will be outlined below for cultural awareness, cultural sensitivity, cultural safety and/or cultural respect, and cultural competence.

Three matters were critical in approaching this section:

1. Rather than reproduce multiple definitions from a range of sources, the focus is on the shared or common meanings associated with these terms in a range of definitions.
2. The Aboriginal definition of health from the 1989 National Aboriginal Health Strategy<sup>5</sup> was kept in mind when determining whether and how these training approaches make an impact on health outcomes for Aboriginal peoples. The full text of this definition is:

*Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.*<sup>6</sup>

3. While the term 'training' is used the focus is on **facilitating learning**, in particular lifelong learning, as this fits with the birth to death philosophy of education held by Aboriginal peoples.

#### 2.1.1 Cultural awareness

This has been a frequently used training description, both by trainers/facilitators but particularly by organisations requesting training, i.e. asking for 'Aboriginal cultural awareness training'.<sup>7</sup> Cultural awareness training has also been offered since the late 1980s when the National Aboriginal Health Strategy (1989) was released.

---

<sup>4</sup> Ramsden, I, 2002, Cultural safety and nursing education in Aotearoa and Te Waipounamu, thesis submitted to the Victorian University of Wellington, viewed Oct 1 2010, <<http://culturalsafety.massey.ac.nz/RAMSDEN%20THESIS.pdf>>.

<sup>5</sup> National Health Strategy Working Party 1989, *A National Aboriginal Health Strategy*, Department of Aboriginal Affairs.

<sup>6</sup> National Aboriginal Community Controlled Health Organisation, no date, Definitions: Aboriginal health, viewed November 22, 2010, <<http://www.naccho.org.au/definitions/abhealth.html>>.

<sup>7</sup> Thomson, N, 2005, Cultural respect and related concepts: a brief summary of the literature, *Australian Indigenous Health Bulletin*, 15:4, 1-11.

Descriptions of cultural awareness commonly focus on raising the awareness and knowledge of participants about the experiences of cultures different from their own - in particular, different from the dominant culture. Therefore, cultural awareness training maintains an 'other' rather than clear self-focus for participants. It also tends to have an individual/personal rather than systemic focus. Even if racism is named the focus is on individual acts of racial prejudice and racial discrimination. While historical overviews may be provided, the focus is again on the individual impact of colonisation in this country, rather than the inherent embedding of colonising practices in contemporary health and human services institutions.

A recent review of Australian and international literature on the effectiveness of cross-cultural training, found that the majority of workplace diversity training programs in the Australian government and community sector focused on awareness and knowledge raising, i.e. were cultural awareness programs.<sup>8</sup> Please note that this review included 39 training programs in both Aboriginal/Indigenous and other culturally and linguistically diverse contexts, including but beyond the health sector. The vast majority (92%) were of one day or less duration. Responses were gained from 515 participants prior to training, immediately after training (99% response rate) and at follow-up a few months later (145 or 28% response rate).

Statistically significant positive changes were reported immediately following training, and at follow-up in three of seven areas that were tracked:

- understanding of organisational policies and issues regarding cultural diversity
- knowledge of cross-cultural communication skills
- knowledge and understanding of the customs, values and beliefs of diverse cultures.

There was no significant change in participants' self-reports of having 'confidence to work with different cultures' or the perceived 'importance of cultural competence to work performance'. Critically, the evidence of 'increased awareness of the influence of one's own culture on oneself' and the 'effect of cultural differences on interactions' was minimal and inconclusive.

Further, while 71% of participants rated their ability to transfer their learning to their work context as average or higher immediately after training (the scale options were: low, below average, average, above average and high), their actual experiences of doing this at follow-up were markedly lower. It was not clear whether any other strategies were implemented in their organisations to reinforce the training.

While there is a place for cultural awareness programs, they are insufficient in terms of achieving genuine change in Aboriginal Peoples' experience of health services and health outcomes (not just mortality rates).<sup>9</sup>

---

<sup>8</sup> Bean, R, 2005, *The effectiveness of cross-cultural training in the Australian context*. Australian Government Department of Immigration and Multicultural Affairs, Canberra.

<sup>9</sup> Western Australian Department of Health, nd, Aboriginal cultural security: a background paper, viewed Sept 29 2010, <[http://www.aboriginal.health.wa.gov.au/docs/Cultural\\_Security\\_Discussion\\_Document.pdf](http://www.aboriginal.health.wa.gov.au/docs/Cultural_Security_Discussion_Document.pdf)>.

### 2.1.2 Cultural sensitivity

Cultural sensitivity is a less frequent description for cultural training. Shared features of available definitions are that it extends beyond cultural awareness and encourages self-reflection from participants, particularly on their personal attitudes and experiences and how this may impact on how they communicate and behave with people outside of the dominant culture. It may include a focus on the emotional, social, economic, political and historical contexts in which cultural differences and personal experiences occur. Even though this starts engaging participants with the contemporary lived experiences of Aboriginal Peoples, and how that may contrast with their experiences as non-Aboriginal people, there is a stronger focus on the individual and personal, rather than the systemic and institutional nature of these contexts.

### 2.1.3 Cultural safety and cultural respect

According to Thomson, the term cultural respect grew out of the concept of cultural security initially put forward in Western Australia.<sup>10</sup> A Western Australian Department of Health paper described cultural security as:

*[A] commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.<sup>11</sup>*

Cultural security shifts the focus from individual health practitioners to the health system in which they operate. Further, to how that system ensures that the rights of Aboriginal Peoples to high quality services that result in better health outcomes are met through the consideration and incorporation of culture. While occasionally used in some jurisdictions, the terms that are more consistently used at a national level within the health sector are cultural respect or cultural safety, which are frequently used interchangeably or together. The initial work on cultural safety occurred in New Zealand and is comprehensively documented by one of its key proponents, Irihapeti Ramsden.<sup>12</sup>

At a national level within mainstream health, cultural respect has been defined and promoted through the 'Cultural Respect Framework for Aboriginal and Torres Strait Islander Health: 2004-2009' that was released in 2004 by the Australian Health Minister's Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health.<sup>13</sup> It was defined as:

---

<sup>10</sup> Thomson, *op cit.*

<sup>11</sup> Western Australian Department of Health, *op cit.*, p.2.

<sup>12</sup> Ramsden, *op cit.*

<sup>13</sup> Australian Health Ministers Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party (AHMAC-SCATSIH), 2004, *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health: 2004-2009*, Department of Health, South Australia, viewed Sept 28 2010, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-crf.htm/\\$FILE/](http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-crf.htm/$FILE/)>

*...recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples. (p.7)*

The Framework then explained that cultural respect occurs when the “health system is a safe environment” for Aboriginal Peoples and where cultural differences are respected. Further, that respect includes the right to achieve “equitable health outcomes”. The Framework emphasises three dimensions:

- knowledge and awareness
- skilled practice and behaviour
- strong relationships between Aboriginal people and communities, and the health agencies providing services to them, including Aboriginal staff.

Definitions of cultural respect and cultural safety, particularly those from the perspective of Aboriginal Peoples, emphasise that the presence of cultural safety can only be defined by those who receive health care; they will determine if their cultural identity and meanings are being respected, and they are not being subjected to discrimination. Therefore, a discussion of power and power imbalances between consumers and health care providers that includes the place of culture is needed within cultural respect/safety training. This means approaching health care services and outcomes in a political context, not just a social, scientific, ethical or legal context.<sup>14</sup> It includes understanding how that translates into the daily lived experiences of Aboriginal Peoples, which requires participants developing their self-reflection skills.<sup>15 16</sup>

Self-reflection is a critical component of this approach to learning, so that health care providers recognise both the conscious and non-conscious use of power in relationships with their Aboriginal clients at an individual and organisational level. In some instances, this training will include a focus on ‘whiteness’, and how being part of whiteness automatically leads to white people experiencing privileges and making assumptions that anyone has equal access to these privileges. This emphasises that Aboriginal people do not enjoy the same level of ‘rights’, even under our contemporary legal and policy framework.<sup>17 18</sup>

A historical perspective is usually included so that participants understand how Aboriginal people have been treated through the colonisation process, the impact at that time, and the **current** and **ongoing** impacts that are referred to as inter-generational trauma. Rather than just being a history lesson, the focus is on how this links to racism and how these experiences shape Aboriginal people’s involvement with health services now and infuse their daily lives.

For example, while Aboriginal Peoples know they have a right to access health services they need, and receive responsive, respectful and quality care, they cannot be confident they will

---

[Cultural Respect Framework.pdf](#)>

<sup>14</sup> Ramsden, *op cit*.

<sup>15</sup> Gollan S, personal communication, September 23<sup>rd</sup> 2010.

<sup>16</sup> Taylor, K & Guerin, P, 2010, *Health care and Indigenous Australians: cultural safety in practice*, Palgrave Macmillan, South Yarra.

<sup>17</sup> Gollan S, personal communication, September 23<sup>rd</sup> 2010.

<sup>18</sup> Taylor & Guerin, *op cit*.

experience this due to the frequent previous experiences of racism in the health system.<sup>19 20 21</sup> This results in elevated levels of stress, as well as a reduced likelihood of accessing needed health care that is accompanied by increased health concerns and poorer health outcomes.

An examination of how dominant culture values and beliefs shape health care practice – individually and systemically is also required. While a focus on individual attitudes, knowledge and practice is present, there is a clearer shift to addressing institutional and systemic values and practices. There is a focus on what is done, not just what is talked about.

In summary,<sup>22</sup> cultural respect means Aboriginal Peoples receive competent and skilled professional care from health workers who demonstrate consciousness that respect for different cultural values and meanings must be taken into consideration within their practice. They actively ensure culturally-informed health care decisions are made with and by the Aboriginal person and their family members, so that their rights to quality care are upheld. This includes recognition that Australian health care systems are based on the cultural values and beliefs of the dominant culture. Therefore, in order to demonstrate cultural respect, aspects of the system must be changed, adapted and/or challenged.

The demonstration of cultural respect creates cultural safety for Aboriginal Peoples – a service and space where culture is acknowledged, welcomed and drawn upon as an integral part of health care services. While physical surroundings are important, it is how health care workers operate at the individual and health system level that results in Aboriginal Peoples perceiving and experiencing cultural respect and safety. This will determine whether Aboriginal Peoples will trust a health care provider and/or service.

#### 2.1.4 Cultural competence

Cultural competence is a more recent but increasingly used term in Australia, although it has been in circulation in North America for twenty years.<sup>23</sup> Similarly to cultural respect and cultural safety, descriptions of cultural competence and cultural competence training focus on addressing attitudes, improving knowledge and changing behaviour at both individual and institutional/systemic level that result in effective care for Aboriginal Peoples as a right. It shares an emphasis on participants developing an understanding and appreciation of the impact of dominant culture on Aboriginal Peoples through past and ongoing practices of

---

<sup>19</sup> Henry, B, Houston, S & Mooney, G, 2004, Institutional racism in Australian healthcare: a plea for decency, *Medical Journal of Australia*, 180; 17 May, 517-520.

<sup>20</sup> Aboriginal Health Council and Dulwich Centre, 1995, Towards culturally appropriate services, in Reclaiming our stories, reclaiming our lives: Report of the Aboriginal deaths in custody counselling project, *Dulwich Centre Newsletter*, 1.

<sup>21</sup> Miller, S, Gibson, S, Sudano, L & Edwards, S, 2009, *Ever felt like complaining? Final report*, Health and Community Services Complaints Commission, Adelaide, <[http://www.hcsc.sa.gov.au/documents/02\\_what's%20new/h\\_EverFeltLikeComplainingReportFINALWeb.pdf](http://www.hcsc.sa.gov.au/documents/02_what's%20new/h_EverFeltLikeComplainingReportFINALWeb.pdf)>.

<sup>22</sup> These last two paragraphs draw on material written by Kathleen Stacey in the 'Aboriginal Community Controlled Mental Health Workforce Action Plan: Draft, September 2009' for the Aboriginal Health Council of South Australia.

<sup>23</sup> Thomson, *op cit*.

colonisation. This requires a strong focus on critical thinking and self-reflection by participants – as individuals and members of the dominant culture.<sup>24</sup>

There are two main differences in the cultural competence literature. First, there is greater clarity about how cultural competence is defined at different levels of the health system and what this entails. These levels can be described as:

- ① Individual - knowledge, attitudes and behaviours of health care providers.
- ① Professional – education and professional development to guide the working lives of health care providers.
- ① Organisational – skills, resources, values and evaluation of progress.
- ① Systemic – policies, procedures, monitoring mechanisms and resources.<sup>25</sup>

In practice, facilitators delivering training that is described as cultural safety or cultural respect also advocate that training is one strategy of several that organisations must implement to enable change at individual, organisational and systemic levels.<sup>26</sup> If organisations are serious about the significance and value of the training, they must be consistent with the emphasis of cultural competence on multi-level intervention and change to achieve culturally respectful services and culturally competent practice.

The second main difference is that it articulates the growth of cultural competence as a continuum. A good example is provided in a recent document from the Victorian Aboriginal Child Care Agency (VACCA) that is shown in Figure 2 (this was adapted from work done in the USA, which is acknowledged in the VACCA document).<sup>27</sup>

The continuum concept is useful, as it indicates that achieving cultural competence is a journey, and that non-Aboriginal health care providers and organisations may move back and forth along the continuum. For example, this can occur if:

- enthusiasm and commitment waivers
- staff or the organisation become complacent
- staff and/or organisational culture changes so that culturally competent practice with Aboriginal Peoples becomes a lower or no longer a priority.

The idea of being on a journey, where the travelling process not just the destination is critical, is present in some approaches to cultural safety or cultural respect training.<sup>28</sup> In fact, a continuum or step-wise progression concept in achieving cultural safety was proposed by Ramsden in 2002, i.e. developing cultural awareness to form the basis for cultural sensitivity

---

<sup>24</sup> Paradies, Y, Trenerry, B, Franklin, H & Guerin, P, 2010, *Towards culturally competent organisations*. Presentation to the Executive of SA Health, Adelaide, May 2010.

<sup>25</sup> Bean R, 2006, Cross-cultural competence and training in Australia, *The Diversity Factor*, 14;1, 2-10.

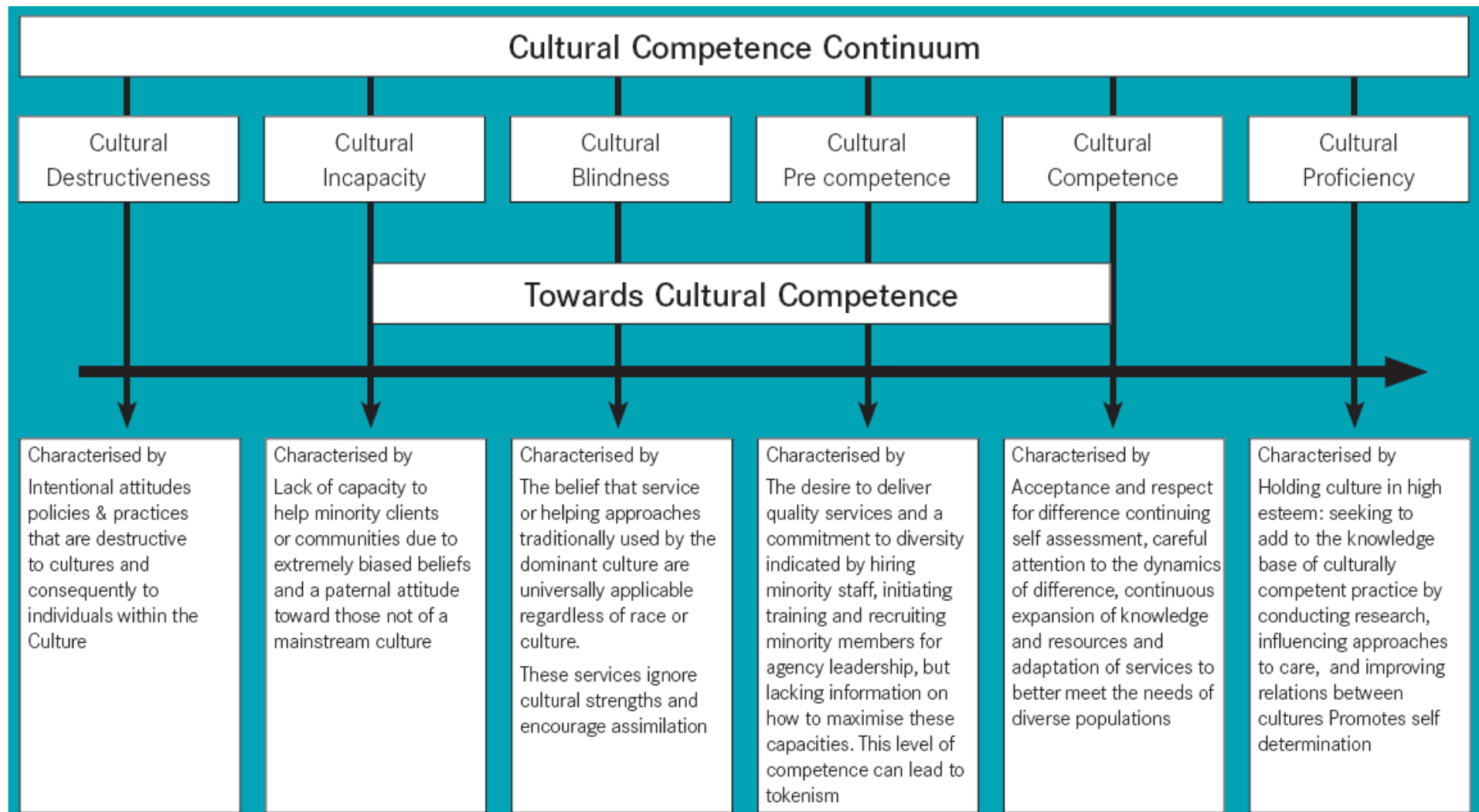
<sup>26</sup> Gollan S, personal communication, September 23<sup>rd</sup> 2010.

<sup>27</sup> Victorian Aboriginal Child Care Agency, 2008, *Aboriginal Cultural Competence Framework*, Victorian Government Department of Human Services, Melbourne.

<sup>28</sup> Gollan S, personal communication, September 23<sup>rd</sup> 2010.



Figure 2: A continuum model for cultural competence (see footnote 24)



and leading to cultural safety.<sup>29</sup> However, she strongly emphasised that these are *separate*, not interchangeable concepts. While this model was reproduced in a recent OATSIH-funded RACGP report, the fact that this was Ramsden's original work was not clearly acknowledged.<sup>30</sup>

Research outcomes are emerging for the value of cultural competence training. For example, following a cultural competence course that was facilitated as an Aboriginal/non-Aboriginal partnership, Gollan and O'Leary surveyed 69 social work students at the end of the course and held focus groups with 34 of this group (47%) four months later.<sup>31</sup> This course also incorporated all aspects of cultural safety and respect described in Section 2.1.3 above. The surveys indicated that students: became far more aware of language, power and whiteness (as this was covered in the course); started to recognise the importance of working in partnership and how to do this; understood what accountability would mean personally and professionally; and recognised the need to maintain a commitment in order to practice in a culturally competent manner.

Four months later in the focus groups, students reported that they remembered the learning gained from the course and were using it. They now paid more attention to what being a "white person" meant - how they lived and behaved in personal and work spaces – and how this is taken as normal. They described how this helped them to realise what Aboriginal people could not take for granted and therefore may experience on a daily basis. They reported an improved capacity to critically reflect on themselves and what is happening around them. However, they were conscious that they had a distance to go in breaking habits of using poor language and making assumptions as "white people" that impacted negatively on Aboriginal people.

This research contrasts with the outcomes of cultural awareness follow-up research that were described in Section 2.1.1. The areas that had strong impact for participants in the cultural competency courses were absent for participants in cultural awareness workshops, i.e. recognition of the need to maintain a commitment in order to practice in a culturally competent manner, a capacity to critically reflect on themselves as non-Aboriginal people and what is happening around them that would be different for Aboriginal people.

These areas are examples of non-Aboriginal people taking a 'lifelong learning' approach where they understand that their learning will continue far beyond the end of any training workshop or course. This difference in outcome is vital in providing direction for what the NACCHO CST project needs to do in order to achieve its goal.

---

<sup>29</sup> Ramsden, *op cit*, p.117.

<sup>30</sup> Royal Australian College of General Practitioners, 2010, *Cultural safety training: identification of cultural safety training needs*, Royal Australian College of General Practitioners, South Melbourne.

<sup>31</sup> Gollan, S & O'Leary, P, 2009, Teaching culturally competent Social Work practice through black and white pedagogical partnerships, *Social Work Education*, 28;7, 707-721.

## 2.2 Cultural safety and respect as a human right

### 2.2.1 International documents

The 1948 the United Nations Universal Declaration of Human Rights was the first internationally supported statement about the inherent rights of human beings that all countries would uphold. Article 2 of the Declaration clearly states that:<sup>32</sup>

*Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.*

These basic human rights and freedoms cover many areas, including law, employment, health and education.

Due to the treatment and experiences of Indigenous peoples across the world, the United Nations has worked over many years to develop and gain endorsement at the General Assembly on the Declaration on the Rights of Indigenous Peoples. Endorsement occurred in September 2007, although Australia only became a signatory in 2009.<sup>33</sup> Several articles are highly relevant to the CST Standards Project. Article 21(1) states that:

*Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.*

Importantly, Article 23 outlines a position consistent with NACCHO's regarding the right to self-determination.

*Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*

This is expanded in Article 24(1), which also acknowledges Indigenous peoples' rights to traditional medicines and health practices. It states that: "Indigenous individuals also have the right to access, without any discrimination, all social and health services". Part 2 of Article 24 then outlines the responsibilities of states to enable these rights to be realised:

*Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.*

---

<sup>32</sup> United Nations, 1948, *Universal Declaration of Human Rights*, viewed Nov 22 2010, <<http://www.un.org/en/documents/udhr/index.shtml>>.

<sup>33</sup> United Nations, 2007, *Declaration on the Rights of Indigenous Peoples*, , viewed Nov 22 2010, <<http://www.un.org/esa/socdev/unpfii/en/declaration.html>>.

Further to this, Article 29(3) then states that:

*States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.*

Therefore, cultural safety, cultural respect and the need for it to be present in health services have a basis in human rights, as described by these international instruments. In addition, the direct involvement of Aboriginal Peoples in developing and implementing suitable measures is consistent with the rationale for and approach to creating the NACCHO CST Training Standards and Assessment Process. It also underpins the creation of the Aboriginal Community Controlled Health Sector itself. In fact, a human rights-based approach is what Aboriginal Peoples have promoted and advocated for this since working to create the first Aboriginal Community Controlled Organisations, e.g. the establishment of the Aborigines Advancement League in 1931.

Within the health sphere, there are two seminal documents from the World Health Organisation. The first is the Alma Alta Declaration from the 1978 International Conference on Primary Health Care that sought to articulate a commitment and approach to addressing the inequalities in health status between and **within** nations, as is the case in Australia. It starts with the following statements:

*I: The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.*

*II: The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.*<sup>34</sup>

Eight years later, at the 1986 First International Conference on Health Promotion, the Ottawa Charter for Health Promotion was developed and endorsed. It names 'social justice and equity' as one of several fundamental conditions and resources for health, i.e. rights, that all health promotion must contribute to creating. Six commitments were made at the conference, two of which were:

*To move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors....*

*To respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies.*<sup>35</sup>

---

<sup>34</sup> World Health Organisation, 1978, Declaration of Alma Alta, p.1, viewed Nov 22, 2010, <[http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)>.

<sup>35</sup> World Health Organisation, 1986, Ottawa Charter, p.4, viewed Nov 22, 2010, <[http://www.who.int/hpr/NPH/docs/ottawa\\_charter\\_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf)>.

Although the Ottawa Charter has been built on by several further WHO Declarations, it remains the defining document for all health promotion practice. It is consistent with the approach to cultural safety outlined in this document.

### 2.2.2 National documents

NACCHO spearheaded the effective Close the Gap campaign together with the Human Rights and Equal Opportunity Commission (now the Australian Human Rights Commission) in 2006. The intentions were to: gain a whole of government response where Australian governments revitalised existing commitments to ending Indigenous health inequity, and placed a timeframe on achieving this for which they could be accountable; and generate a range of agreed Indigenous health equality targets around which they could coordinate their response.

In response, the Australian Government and Opposition signed a *Close the Gap Statement of Intent* in March 2008. This act commits all parties to achieving Indigenous health equality within a generation. The statement outlined nine specific commitments, two of which were:

*To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.*

*To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality.<sup>36</sup>*

To achieve this, cultural safety and respect must be present within health services, wherever they are being offered in any part of the health system. Further, as the national representative body, NACCHO must play a major role in guiding how this can occur, including through this project.

Further action has been taken through initiatives agreed by the Coalition of Australian Governments that are spelt out in the Partnership Agreements that each State/Territory Government has with the Australian Government. However, there has been a shift away from the formal Close the Gap campaign, as COAG describes their work as 'Closing the Gap'. While a subtle shift in language, it means that COAG can undertake these initiatives outside of the original intent of and commitment to the Close the Gap campaign, although COAG initiatives have recognised that the achievement of cultural safety and respect must be present for their initiatives to be effective.

Later that year, in July 2008, the Australian Health Ministers endorsed and released the Australian Charter of Healthcare Rights (the Charter), which applied to the health service system funded by State, Territory and Australian Government monies. This includes the

---

<sup>36</sup> Aboriginal and Torres Strait Islander Social Justice Commissioner and Steering Committee for Indigenous Health Equality, 2008, *Close the Gap: National Indigenous Health Equality Targets: Outcomes from the National Indigenous Health Equality Summit, Canberra, March 18-20, 2008*, Human Rights and Equal Opportunity Commission, Sydney, p.17.

mainstream public health system, GP clinics and ACCH Services.<sup>37</sup> It enshrines the rights of all consumers in the health system, which includes cultural safety and respect.

The Charter has three guiding principles:

*Principle 1: Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.*

*Principle 2: The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.*

*Principle 3: Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.*

The Charter then lists the following seven rights and provides an interpretation of what each one means: access, safety, respect, communication, participation, privacy and comment. While all rights are relevant to culturally safe services, one right specifically identifies the significance of culture in addition to the statement in Principle 3. This is the right to **respect**, i.e. 'the care provided shows respect to **me and my culture, beliefs, values** and personal characteristics' (emphasis added).

In a companion document to the Charter, 'Roles in realising the Australian Charter of Healthcare Rights', further clarification is provided on the responsibilities of healthcare providers and health service organisations in upholding these rights. A responsibility of healthcare providers in relation to the right of respect that is critical to cultural safety is to 'provide care in a manner that is **respectful of a person's culture and beliefs**, and that is **free from discrimination**' (emphasis added). The relevant responsibility for health service organisations is to "develop and sustain healthcare services that are **free from discrimination** and delivered in a manner that shows respect for patients and consumers" (emphasis added).<sup>38</sup>

This central document endorsed by Australian, State and Territory Governments makes it clear that cultural safety and respect is an unequivocal right for all peoples in Australia, even though it is not a standard experience for all peoples, in particular Aboriginal Peoples despite a long tradition of providing cultural awareness training. Therefore, cultural **safety** training is one of several essential strategies required to ensure that the right to respect is upheld.

This rights-based approach aligns with the descriptions of cultural security, cultural respect, cultural safety and cultural competence described above. It is also consistent with the approach advocated in a recent Victorian report on developing an Aboriginal Inclusion Framework; Victoria is the only state that has a state-based and legally-recognised Human Rights Charter. This document advocated a shift from a **needs**-based approach to service provision for Aboriginal Peoples, a regularly adopted approach in health services, to a **rights**-

---

<sup>37</sup> Available at the Australian Commission on Safety and Quality in Health Care site:

<<http://www.health.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-01>>.

<sup>38</sup> Available at the Australian Commission on Safety and Quality in Health Care site: <[http://www.health.gov.au/internet/safety/publishing.nsf/Content/com-pubs\\_ACHR-pdf-01-con/\\$File/17388-roles.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/com-pubs_ACHR-pdf-01-con/$File/17388-roles.pdf)>.



based approach, i.e. "Aboriginal people, just like other minority groups in our community, should be 'everyday people with everyday rights'" (original emphasis).<sup>39</sup>

## 2.3 Racism and cultural safety

The lived experience of cultural safety and cultural respect depends on Aboriginal Peoples not being subjected to and experiencing racism, where Aboriginal Peoples define whether racism has occurred. This includes individual racism - when individual health workers practise racial prejudice and racial discrimination, and institutional racism - when organisational policies and practices do not consider or make room for Aboriginal People's cultural values, meanings and protocols.<sup>40</sup>

### 2.3.1 The impact of racism on health

The undeniable presence of racism in the health sector for Aboriginal Peoples, along with the relationship between experiences of racism and health is clear in recent literature.<sup>41 42 43 44 45 46 47</sup>

48 49

This work has examined racism and health impacts on both a national and jurisdictional basis. It is also borne out in reviews of the international literature on the impact of racism in developed countries. For example, Paradies found a consistent picture of racism preceding ill health in both longitudinal and cross-sectional studies after accounting for other factors. The strongest association was between experiences of racism and poor mental health, including depression and anxiety, while racism was also associated with higher levels of smoking, alcohol and drug use.<sup>50</sup>

---

<sup>39</sup> Cooperative Change and Langton, M, 2009, *Proposed Framework to achieve Aboriginal Inclusion to lift the Cultural Competency of the Victorian Government*, Victorian Government Department of Planning and Community Development, Melbourne.

<sup>40</sup> This paragraph draws on material written by Kathleen Stacey in the 'Aboriginal Community Controlled Mental Health Workforce Action Plan: Draft, September 2009' for AHCSA.

<sup>41</sup> Bond, C, 2005, A culture of ill health: public health or Aboriginality, *Medical Journal of Australia*, 183; 4 July, 39-41.

<sup>42</sup> Durey, A, 2010, Reducing racism in Aboriginal health care in Australia: where does cultural education fit? *Australian and New Zealand Journal of Public Health*, 34;S1, S87-S92.

<sup>43</sup> Gallaher, G, Ziercsh, A, Baum, F, Bentley, M, Palmer, C, Edmondson, W & Winslow, L, 2009, *In our own backyard: urban health inequities and Aboriginal experience of neighbourhood life, social capital and racism*, Flinders University of SA, Adelaide.

<sup>44</sup> Henry, B, Houston, S & Mooney, G, *op cit.*.

<sup>45</sup> Mansouri, F, Jenkins, L, Morgan, L. & Taouk, M, 2009, *The impact of racism on the health and wellbeing of young Australians*, Foundation for Young Australians, Melbourne.

<sup>46</sup> Miller et al, *op cit.*

<sup>47</sup> Aboriginal Health Council and Dulwich Centre, *op cit.*

<sup>48</sup> Paradies, Y, Harris, R, Anderson, I, 2008, *The impact of racism on Indigenous health in Australia and Aotearoa: Towards a research agenda*, Cooperative Research Centre for Aboriginal Health and Flinders University, Casuarina, NT.

<sup>49</sup> Taylor & Guerrin, *op cit.*

<sup>50</sup> Paradies, Y, 2006, A systematic review of empirical research on self-reported racism and health, *International*

A recent Australian/New Zealand joint symposium that developed a research agenda to build our understanding of the relationship between racism and health identified that:

*Pathways from racism to ill-health may include:*

- *reduced and unequal access to the societal resources required for health (e.g. employment, education, housing, medical care, social support)*
- *increased exposure to risk factors associated with ill health (e.g. differential marketing of dangerous goods, exposure to toxic substances, Krieger 1999)*
- *direct impacts of racism on health via racially motivated physical assault*
- *stress and negative emotion reactions that contribute to mental ill health, as well as adversely affecting the immune, endocrine and cardiovascular systems; and*
- *negative responses to racism, such as smoking, alcohol and other drug use.*<sup>51</sup>

A South Australian study into Aboriginal Australian's experiences of racism in the health and social services, and whether people wished to complain about it, presented a picture of frequent and persistent experiences of racism. Over 100 people participated, either through surveys, focus groups or personal interviews, and included Aboriginal staff and community members. Examples included:<sup>52</sup>

*"I was at a hospital. I had my baby and he was at the appropriate birth weight on day 3 and therefore he and I were ready for discharge. On discharge the young midwife found out I was Aboriginal and got all flustered and went off to consult a CNC. The midwife came back and said I couldn't go as with being Aboriginal there are concerns and I was an 'at risk' person/child because of being Aboriginal."*

*"I was suffering with two ear infections and made an emergency appointment with the local clinic to see a doctor as a new client. An appointment was made, I attended and the doctor's first words were 'why didn't you go to the Aboriginal Health Service?' I was disgusted by this as I was ill and needed to see a doctor. Then without touching me or giving me a physical she diagnosed me with heart disease and diabetes. I then asked her to look at my ears as they are very painful. She looked and prescribed me with antibiotics and consultation was over. Believe me I will not attend this clinic again. I would rather drive an hour to the hospital. This experience has left a very sour taste in my mouth about this service."*

Most experiences did not result in formal complaints despite high levels of dissatisfaction with services and/or personal treatment, due to the lack of confidence that the complaints system itself would be culturally safe, as well as finding the process confusing and intimidating. There were concerns about negative consequences, such as losing access to needed services, and being dismissed by staff and perceived even more negatively.

---

*Journal of Epidemiology*, 35;4, 888–901.

<sup>51</sup> Paradies, Ricci & Anderson, *op cit*, p.9.

<sup>52</sup> Miller et al, *op cit*, pp.8-11.



These experiences are not unique to South Australia. Research from other locations reinforces the consistency of regular experiences of racism for Aboriginal peoples and its impact on health.<sup>53</sup> Participants in the Darwin Region Urban Indigenous Diabetes study showed a relationship between racism and depression, poor self-assessed health status and poor mental health; further it accounted for one third of the prevalence of depression and poor self-assessed health status amongst participants.<sup>54</sup> These outcomes were consistent with those from the National Aboriginal and Torres Strait Islander Health Survey, which also showed links with higher levels of diabetes, smoking and substance misuse.<sup>55</sup> Findings from the longitudinal study of the social and emotional wellbeing of Aboriginal children and young people in Western Australia, also found higher levels of smoking, marijuana and alcohol use having adjusted for both age and gender.<sup>56</sup> Another Western Australian study in a rural town demonstrated that racism was clearly linked to poorer levels of general physical and mental health, having accounted for age, gender, employment and education.<sup>57</sup>

In reviewing studies about the medical treatment of Aboriginal peoples, Paradies and colleagues found that "Indigenous patients with the same characteristics as non-Indigenous patients were a third less likely to receive appropriate medical care across all conditions as well as specifically for cancer and coronary procedures". Further, they "were only one third as likely to receive kidney transplants".<sup>58</sup>

The above outcomes on the impact of racism are borne out in another South Australian study undertaken in Adelaide study with 153 Aboriginal Australians. Experiencing racism in both informal and formal settings (including health) was repeatedly reported by participants (over 93%). Racism occurred more frequently in formal settings, although it was still very common in informal settings. Participants described having both emotional and physiological reactions to racist experiences, and almost two-thirds believed that racism affected health; for example:<sup>59</sup>

*"Oh growing up, I mean yeah it's just you feel inferior you know what I mean. People are staring at you, watching you. You just know it, and it does make you feel like, I don't know. I think it has affected my health because now I've, you know, I have a bit of nerve problems and I really think it makes me...because I'm not coping with people with racism and that you know. That's why I think, I think it has in a way affected my health, the racism that I grew up and that with you know."* (Woman, 50, full-time work)

---

<sup>53</sup> Paradies, Ricci & Anderson, *op cit*.

<sup>54</sup> Paradies, Y, 2006, *Race, racism, stress and Indigenous health*, PhD thesis, Centre for Health and Society, The University of Melbourne, Melbourne.

<sup>55</sup> Paradies, Y, 2007, *Exploring the health effects of racism for Indigenous people*, presented at the Rural Health Research Colloquium, Tamworth, NSW.

<sup>56</sup> Zubrick, S, Silburn, S, Lawrence, D, Mitrou, F, Dalby, R, Blair, E, Griffin, J, Milroy, H, De Maio, J, Cox, A & Li, J, 2005, *Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

<sup>57</sup> Larson, A, Gilles, M, Howard, P & Coffin, J, 2007, It's enough to make you sick: The impact of racism on the health of Aboriginal Australians, *Australian and New Zealand Journal of Public Health*, 31;4, 322-9.

<sup>58</sup> Paradies & Trenerly et al, *op cit*.

<sup>59</sup> Gallaher et al, *op cit*, pp.36-42.

*"Yeah I reckon it does. It plays like on your brain, on your mind. People's minds, and stress...it gets people down yeah. Makes people drink you know. Drinkin' and smokin'....escape reality." (Man, 45, unemployed)*

*"I couldn't possibly wanting to confront that every time because I'd be too tired, emotionally draining. You'd be just a wreck. Emotionally you can't do that." (Man, 46, full-time work)*

In a 2010 Sydney Morning Herald article, the current Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Gooda, emphasised the impact of racism on the daily lives of Aboriginal peoples:

*The general public needs to know that, however unintentional, however seemingly inoffensive their defenders say they are, jokes and offensive descriptions that perpetuate stereotypes actually hurt Aboriginal and Torres Strait Islander people. Real people are affected by these incidents each time they happen. Like invisible tentacles, the jibes, the put downs and the stereotypes extend to other levels, ensnaring participants along the way – in the schoolyard, in the workplace, in shopping centres and in neighbourhoods around Australia.<sup>60</sup>*

### 2.3.2 Exploring racism in cultural training

Given the impact of racism, it must be addressed early and upfront in training. Cultural training that does not directly name and address racism avoids participants developing an appreciation of the realities of Aboriginal Peoples' lives and their experiences in the health system. If racism is not named and applied to health and everyday living contexts, participants in cultural safety training will not develop the critical reflection skills required to examine and critique personal, organisational and systemic values and behaviours, or develop practical skills to recognise, prevent or address racism. While racism is more frequently addressed in cultural safety/cultural respect and cultural competence training, it is not always included or directly addressed in cultural awareness training.

The Code of Conduct documents for the public sector in State/Territory Governments typically include clauses or principles on ensuring there is no discrimination on the basis of race. These stipulations are also regularly found in health professional code of ethics. Despite these statements, experiences of racism are commonplace for Aboriginal Peoples in the health system, whether using the public sector health system or Medicare-funded system through private GP clinics.

---

<sup>60</sup> Gooda, M, June 18, 2010, *Real people affected by racist taunts*, Sydney Morning Herald, <<http://www.smh.com.au/opinion/society-and-culture/real-people-affected-by-racist-taunts-20100617-yjkh.html>>.

## 2.4 Components of good practice in cultural safety training

This section focuses on good practice *specific* to cultural safety training (CST), not on good practice in training in general. It is a synthesis of many resources identified to date in Section 2, combined with the collective wisdom of Aboriginal and non-Aboriginal people currently involved in facilitating cultural safety or cultural respect training that has been gathered through anecdotal evidence and consultation. This includes through the knowledge and experience of the CST Standards Committee Members.

The following were identified as components of good practice - cultural safety training that:

- ① is an interpersonal and interactive process, i.e. needs to occur face to face and involve personal, small and large group exercises
- ① explores pre-existing knowledge and participant learning hopes and expectations
- ① facilitates creation of a safe space for participants to explore their cultural values and beliefs, and their intended or unintended participation in racism
- ① asks participants to reflect on their own culture, and how their cultural values and beliefs shape their behaviour and interactions with Aboriginal Peoples or other Aboriginal Peoples, i.e. has a strong 'self-focus'
- ① emphasises the diversity of Aboriginal Peoples and Torres Strait Islander peoples
- ① clearly names racism in all of its forms and explores how it is present in health and everyday experiences for Aboriginal Peoples, both historically and currently
- ① asks and supports participants to apply what they learn directly to their work contexts
- ① considers what steps need to be taken at organisational and systemic levels of the health system in which participants operate, in addition to what they do at an individual level
- ① is a minimum of a day in length
- ① draws on multi-media resources
- ① is delivered by Aboriginal people
- ① has facilitators with:
  - extensive experience in service provision for Aboriginal Peoples and an understanding of the different levels of the services system that impact on Aboriginal Peoples' experiences and outcomes, i.e. on the ground services to planning, funding and policy
  - the ability to manage emotions and tension and utilise this for learning
  - the capacity and commitment to work in training partnerships, whether this involves co-facilitation with Aboriginal people or non-Aboriginal people
- ① evaluates the experience and impact of the training at completion of the training day(s)

- o negotiates to undertake assessment of the training impact at an agreed time following the training.

Many of these components focus on the **process**, not simply the content, of the training, and are also dependent on the skills and qualities of facilitators.

Another component of good practice for cultural safety training that may also occur in other forms of cultural training is a Welcome to Country and/or Acknowledgement of Country. A Welcome to Country and/or Acknowledgement of Country is a formal Aboriginal cultural practice and protocol. It is viewed as an act of recognition that you are on someone else's country. It recognises and honours the significance of the relationship that Traditional Owner Groups or Custodians have with the land on which an event is occurring. It also invites both Aboriginal and non-Aboriginal people who are visiting the country to consider the meaning of this and pay their respects.

As will be discussed in the next section, to be fully effective cultural safety training should not be a stand-alone strategy for health care services. It must be part of several integrated strategies to ensure that cultural safety and cultural respect is a right that is realised by Aboriginal Peoples in using health services, particularly mainstream health services.

## 2.5 Training participation, culturally safe practice and continuous improvement

A non-Aboriginal health care provider's participation in CST can never be a guarantee that he/she will automatically demonstrate culturally safe practice as a consequence and contribute to the creation of a culturally safe workplace.

CST is a critical opportunity and resource for an individual health care provider. His/her level of culturally safe practice will depend on how he/she engaged in the training, and then actively reflects and acts on the **learning** to improve the level of cultural safety experienced by Aboriginal clients, i.e. engages in lifelong learning. This depends on maintaining commitment at an individual level that is supported at collegial, organisational and systemic levels. Part of this commitment is a preparedness to be accountable to Aboriginal Peoples, including clients, Aboriginal colleagues and Aboriginal organisations with whom a mainstream organisation collaborates.

This is referred to as cultural accountability, which involves paying attention to:

- power relations between Aboriginal and non-Aboriginal people
- how culture is used as a central reference point in planning, decision-making and service delivery
- how people are conscious of their identity in understanding and undertaking their roles and responsibilities in the workplace.<sup>61</sup>

---

<sup>61</sup> Stacey, K & Gollan, S, 2007, *Partnership and cultural accountability: A self-check tool*, unpublished paper.

Any organisation engaging in CST has the responsibility to consider and implement complementary strategies to gain the maximum value from CST, and ensure commitment and cultural accountability is present. For example, this approach could include implementing several of the following recommended strategies:<sup>62 63</sup>

- a clear leadership stance on cultural respect, anti-racism and non-discrimination
- inclusion as a priority area in policy and strategy documents
- practising Welcome to Country and/or Acknowledgement of Country
- having the Aboriginal flag in prominent positions
- the inclusion of a responsibility to provide cultural safety in job and person descriptions and a review of this through performance management processes
- ongoing debriefing and reflection on practice within work teams
- clear codes of conduct regarding anti-racism and non-discrimination, and willingness to act on breaches
- pro-active recruitment and retention strategies for Aboriginal staff
- creation and review of active and constructive partnerships with Aboriginal communities and organisations
- recognition and promotion of good practice
- making an Aboriginal Impact Statement an essential component of new program and policy development, and program and policy review
- formal evaluation and review of Aboriginal Peoples' service experiences and outcomes.

While this approach can be advocated through CST, its implementation sits with the organisations choosing to engage with CST. If organisations did this, then they would be ensuring that cultural safety is part of their overall approach to continuous quality improvement, which is an increasingly valued and required element of managing and strengthening health service organisations in the contemporary health environment.

At the macro level the integration of CST into organisational and systemic frameworks could include, but not be limited to, conditions of funding agreements, a core component of organisational and professional accreditation, and an element of registration for health professionals.

---

<sup>62</sup> Gollan S, personal communication, September 23<sup>rd</sup> 2010.

<sup>63</sup> Paradies et al, *op cit*.

## 3: Considerations in setting CST Standards

### 3.1 Focusing on standards

In this project NACCHO is focused on **standards** for cultural safety training, not on the specific details of what constitutes culturally safe and competent practice in any individual health service. Culturally safe practice within individual health services cannot be approached in a 'formulaic' or 'one size fits all' manner. This is most likely to result in a lack of cultural safety, as it would fall into the all too common practice of approaching Aboriginal Peoples as if they are all the same, i.e. homogenous, rather than a diverse group of nations.

NACCHO acknowledges there are shared principles of cultural safety that should be reflected in training. These principles are guided by the Aboriginal definition of health and a human rights approach to health (as outlined in Section 2.2). Participants need to leave with a range of questions to ask themselves and their organisations on an ongoing basis, and cultural considerations they need to make in planning, delivering and reviewing services. However, there will always be variations in practice between individual health services depending on their locations, and the Aboriginal communities and nations utilising the service.

NACCHO also acknowledges that with the uptake of CST an organisation can experience many benefits that go beyond positively affecting relationships and health outcomes for Aboriginal Peoples.

### 3.2 Existing ACCH Sector work on training standards

All NACCHO Affiliates have previously delivered, are currently involved in delivering or are planning to offer cultural training, although different terms are and have been used for this training, i.e. cultural safety, cultural awareness. Discussion and documentation of quality cultural safety work and possible **standards** are also occurring within Affiliates. This work has been discussed and considered by the CST Standards Committee.

In summary, the following seven Affiliates actively involved in the CST Standards project have taken the following actions or decisions:

- ① **AHCSA – South Australia:** AHCSA has reviewed other's work in cultural safety in order to inform their approach to providing training and/or support through the GP Education and Training Officer. This work has not been formalised into standards. With the advent of the NACCHO project, AHCSA chose to work with and support a national approach to guide their state work.
- ① **AHCWA – Western Australia:** AHCWA, in conjunction with NACCHO, have designed a cultural safety training package that gained national endorsement from the ACCH Sector. AHCWA have delivered this training, and also trained other people across Australia to deliver it. However, they also decided to wait on the NACCHO project before going down a path of creating standards for their state, as they would prefer to support and be aligned with nationally endorsed standards.

- ⑥ **AH&MRC – NSW:** AH&MRC offer cultural training that is accredited through their Aboriginal Health College, and is therefore consistent with VET standards for training but not cultural safety standards. They want to contribute to and support the NACCHO CST Standards in guiding their state-based work.
- ⑥ **AMSANT – Northern Territory:** AMSANT does not have any jurisdictional standards for the delivery of CST training, but wish to contribute to the creation of the NACCHO CST Standards to set a frame for their work in the Territory.
- ⑥ **QAIHC – Queensland:** QAIHC draws on RACGP and Australian College of Rural and Remote Medicine (ACCRM) Aboriginal Health Curriculum Statement<sup>64</sup> and delivers a range of cultural training. They are participating in the NACCHO CST Standards project to identify how it will align with their existing work, as well as how they can support the use of the Standards.
- ⑥ **Winnunga – ACT:** Winnunga does not have any standards and does not regularly provide training, but wishes to contribute to and support creation of the NACCHO CST standards.
- ⑥ **VACCHO:** VACCHO are working toward the creation of CST training standards, and have shared their interim draft to assist the CST Standards Committee, while being very interested in the outcome of the NACCHO CST Standards project to guide the next steps with their work.

## VACCHO CULTURAL SAFETY INTERIM STANDARDS

*The primary health care experience occurs in a personal relationship setting. Cultural competence requires knowledge, skill and an appropriate and effective two way communication with the patient and a relationship with their community and within a community setting context.*

*Benchmarks for appropriate cultural competence training:*

- *It outlines health of Aboriginal Peoples (National, state, local);*
- *Introduces the history, culture and practices of Aboriginal Peoples;*
- *Develops understanding of local Aboriginal history and the development of Aboriginal Community Controlled Health Organisations (ACCHOs);*
- *Creates appropriate opportunities for ongoing mentoring and cultural coaching;*
- *Develop links with and understanding of Aboriginal community organisations and the Aboriginal health service sector (ACCHO & mainstream);*
- *Develops skills around communicating with Aboriginal Peoples including slang, body language, turn of phrase style potential barriers and facilitators;*
- *Develops an understanding of the impact of racism on health.*

---

<sup>64</sup> This statement is found through a link on the following website: <<http://www.racgp.org.au/aboriginalhealth>>. It is currently being revised but has not been released.



Therefore:

- It cannot be online;
- It must have a local component;
- It must engage with local Aboriginal Peoples;
- It must link to an understanding of local health services for Aboriginal Peoples;
- It **must** build relationships.

*In line with principles of collaboration and partnership as highlighted in the 'Statement of Intent', VACCHO acknowledges that sector authorities such as the RACGP set the standards for General Practice, but the NACCHO and Affiliates set the standards for the Aboriginal Community in health and are custodians of the cultural representation and any discussion in respect to cultural standards on behalf of the Aboriginal communities.*

### 3.3 Minimum requirements

It is clear from Section 2 that cultural awareness is insufficient to achieve genuine change in attitude, knowledge and practice/skills. For example, this is the term used in the PIP Indigenous Health Incentive Guidelines. There is a persistent critique in the health sector that while important in their own right, a positive change in cultural awareness or cultural sensitivity do not result in improved health outcomes for Aboriginal people.<sup>65</sup>

Therefore, there is a danger in offering 'entry-level' programs that meet the PIP requirements that are run along cultural awareness lines and do not directly address racism or engage participants in critical self-reflection. These programs will not result in culturally safe and respectful experiences for Aboriginal Peoples, culturally competent practice by health care providers and services, and therefore are unlikely to contribute to better health outcomes. If health care providers are unprepared to accept this position, then it places a question mark over their motivation to engaging in training, i.e. is it to tick the box on the training requirement in order to access PIP payments, or a genuine intention to improve their individual and organisational practice so that Aboriginal Peoples experience improved health care experiences and health outcomes.

Consideration needs to be given to what are minimum requirements, particularly on the basis of what constitutes good practice in cultural safety training (see Section 2.4). For example, one of those requirements will be the time required to adequately address the elements of cultural safety, as it is not simply about imparting knowledge, but engaging participants in critical self-reflection regarding personal and organisational values and practices.

---

<sup>65</sup> Australian Indigenous Doctors Association, 2004, *An Introduction to Cultural Competency*, The Royal Australasian College of Physicians, viewed Oct 1 2010, <<http://www.google.com.au/search?hl=en&q=aida+An+Introduction+to+Cultural+Competency&btnG=Google+Search&meta=&aq=f&oq=>>>.



### 3.4 The appropriateness of online options

Online options have either been mooted or are currently being developed as a response to meet the requirements of the PIP Indigenous Health Incentive Guidelines. As outlined in Section 2.4, to uphold the cultural integrity and quality of CST programs they must occur in-person within a group environment, and be interactive and experiential so the facilitator can assess participant engagement (verbally and non-verbally, and behaviourally and attitudinally). In other words, it needs to be experiential learning, which is consistent with adult learning principles.

Cultural safety is created or compromised by a non-Aboriginal health service provider's in-person, in the moment words and actions with Aboriginal Peoples. If the cultural safety training program does not involve in-person, in the moment experiences, then it will minimise what non-Aboriginal health service providers learn. They will not increase their capacity to provide culturally safe services. Therefore, requiring interpersonal exposure to Aboriginal Peoples within the learning framework is essential. Participants need to be in the situation, not removed from direct experiences and what both facilitators and other participants share 'in the moment'. This approach also aligns with Aboriginal approaches to learning, which should be evident in any cultural training.

On-line learning has significant limitations in providing in-person, in the moment experiences that emulate the realities of health service delivery. There is also no accountability for the time spent on engaging with resources and reflective processes. Further, it cannot be ascertained that the person claiming recognition through an online option has been the person to complete it, even if there are assignments or tasks that need to be submitted as evidence of completion. There is also the issue of who reviews and assesses these assignments or tasks, and if the people doing this are qualified to do so.

Given these challenges and the poor accountability in this process, combined with the complexity and sensitivity of the topics covered in quality cultural safety training programs, the online format is better suited to being a gateway for promoting and/or a resource for cultural safety training. It cannot constitute the training program itself. Therefore, an online course is not an appropriate approach to providing quality cultural safety training. As outlined above, cultural awareness training is not adequate to the task of increasing cultural safety for Aboriginal peoples and therefore online cultural awareness training is also not appropriate.

A series of national workshops were held in 2010 to review the approach to the orientation and ongoing education and training of the new Aboriginal health workforce, being funded through recent COAG measures. They were attended by representatives from the Aboriginal Community Controlled Health Sector (State Affiliates and members), Divisions of General Practice, State/Territory Departments of Health, Registered Training Organisations and DoHA. On-line training options were discussed in the workshops, and a clear position emerged across all jurisdictions that they were **complementary** to other modes, i.e. a support mechanism, not a recommended stand-alone option within Aboriginal health. This is further reinforcement of how online options should be used.

## **4: Endorsement of the CST Standards**

Achieving endorsement of the NACCHO CST Standards followed the existing process for endorsing national positions for the ACCH Sector. The responsibilities and work of the CST Standards Committee was the first step, as each NACCHO Affiliate were invited to nominate an appropriate person to represent them in developing the CST Standards (see Appendix A).

The second step involved Affiliate CST Standards Committee members presenting the final draft of the CST Standards to their senior management and Board. In each instance, the Board either moved a motion to endorse or give 'in principle' support to the final draft CST Standards, prior to them being presented to the NACCHO Board. Each Affiliate is directly represented on the NACCHO Board.

The third and final step was presenting the final draft CST Standards to the NACCHO Board for review and endorsement, which occurred at the May 2011 meeting. Endorsement enables NACCHO to proceed with launching and promoting the CST Standards over the remainder of 2011, and inviting interested training providers to be assessed against them.

## 5: Future directions

In recognising the importance of cultural safety training in contributing to the effort to 'Close the Gap', maintaining cultural integrity is critical. Therefore, consistent with Aboriginal Peoples rights, as enshrined in the United Nations Declaration to which Australia is now a signatory, NACCHO must set the national standards that result in ACCH Sector-endorsed CST and CST providers, and quality assurance process for their ongoing accreditation. This is the benchmark to be used by all other sections of the health sector.

There is more work that needs to happen to support the ongoing implementation of the CST Standards and Assessment Process, which would be a critical part of Year 2 of the project. This will be outlined in the document providing the business case for Year 2 and beyond, so that the NACCHO CST Standards are ongoing, evidence-informed and nationally respected. The following matters are an indication of what will be considered and described in the business case:

- ④ resourcing the CST Standards Assessment Process and the linked database of Cultural Training activities
- ④ utilising material in this paper to create NACCHO Cultural Safety resources
- ④ ongoing monitoring and review of the CST Standards and Assessment Process
- ④ researching elements of CST that contribute to maintaining quality training and facilitators, e.g. how trainers sustain their capacity to do CST, given its demands.

The NACCHO CST Standards have been developed by the Aboriginal Community Controlled Health Sector in response to the NACCHO Board's long-standing recognition of the need for culturally-informed and Sector-driven standards for culturally sensitive service development and provision. Aboriginal Peoples are the owners of this knowledge and custom. Only they are endorsed at local, state and national levels through the process of validated community control and community representative arrangements based on self-determination to develop such standards and conduct such work.

As the peak bodies in Aboriginal health, NACCHO and Affiliates are entrusted to represent the needs and interests of Aboriginal health, and therefore have a responsibility to ensure cultural integrity is upheld. This authority extends to the development of national Cultural Safety Training Standards.

# Appendices

## Appendix A: Standards Committee Terms of Reference

Name	Cultural Safety Training Standards Committee
Reporting to	NACCHO Chief Executive Officer
Secretariat	NACCHO CST Project Officer
Project objectives: Year 1	<p>1: To establish NACCHO National Cultural Safety Standards.</p> <p>2: To establish an assessment process for cultural safety training programs against the NACCHO Standards and guidelines for submitting training programs for NACCHO endorsement.</p> <p>3: To create a publically accessible, searchable database of Cultural Training activity and resources for the health workforce, their education providers and the workforce of other sectors whose work impacts on Aboriginal health.</p>
Membership	A representative from each NACCHO Affiliate
Membership criteria	<p>Members must be:</p> <ul style="list-style-type: none"> <li>▪ from NACCHO and/or Affiliates</li> <li>▪ an Aboriginal person, Torres Strait Islander person, or an Aboriginal and Torres Strait Islander person</li> <li>▪ have experience with cultural safety training.</li> </ul> <p>In summary, they must meet <b>all three</b> criteria.</p>
Committee responsibilities	<p>1: Monitor project progress and completion of project deliverables</p> <p>2: Develop the NACCHO Cultural Safety Training (CST) Standards for ratification by the ACCH Sector and consider:</p> <ul style="list-style-type: none"> <li>▪ existing information and evidence about CST and the context in which it is undertaken</li> <li>▪ content, delivery process and the people delivering the training</li> <li>▪ if there should be certification or quality 'levels' within the CST Standards and how many would be appropriate.</li> </ul> <p>3: Design the CST Assessment Process that will be used to assess applications by training providers of training programs against the CST Standards, which includes:</p> <ul style="list-style-type: none"> <li>▪ who should undertake the assessment</li> <li>▪ what information or evidence needs to be provided for assessment</li> <li>▪ how the assessment is made, e.g. evidence guide</li> <li>▪ the length of time for which a trainer and/or training program is</li> </ul>

	<p>certified.</p> <p>4: Develop support materials to explain how the CST Standards (and their different levels) can be achieved.</p> <p>5: Develop a proposal for the ongoing implementation of the CST Standards with support from the CST Standards Industry Reference Group.</p> <p>6: Support the agreed endorsement process for the NACCHO CST Standards and Assessment Process.</p> <p>7: Inform the CST Standards Industry Reference Group of the final NACCHO CST Standards and Assessment Process.</p>
<b>Meeting frequency</b>	Every one-three months over Year 1 of the project.
<b>Review</b>	<p>The Terms of Reference will be reviewed at the first 2011 meeting to ensure they reflect the project and role of the Committee.</p> <p>The project and role of the Committee will be formally reviewed toward the end of Year 1 of the project.</p>
<b>Participants</b>	<p>AHCSA: Ann Newchurch and Carmen Dadleh</p> <p>AHCWA: Sharon Bushby</p> <p>AH&amp;MRC: Gwen Troutman-Weir</p> <p>AMSANT: Erin LewFatt and Norma Bengner</p> <p>QAIHC: Mary Martin</p> <p>VACCHO: Salina Bernard</p> <p>Winnunga: Clare Anderson</p> <p>NACCHO: Janine Engelhardt, Maurice Shipp and Renee Williams</p>

## Appendix B: Industry Reference Group Terms of Reference

Name	Cultural Safety Training Standards Project Industry Reference Group
Reporting to	NACCHO Chief Executive Officer
Secretariat	NACCHO CST Project Officer
Project objectives: Year 1	<p>1: To establish NACCHO National Cultural Safety Standards.</p> <p>2: To establish an assessment process for cultural safety training programs against the NACCHO Standards and guidelines for submitting training programs for NACCHO endorsement.</p> <p>3: To create a publically accessible, searchable database of Cultural Training activity and resources for the health workforce, their education providers and the workforce of other sectors whose work impacts on Aboriginal health.</p>
Membership	<ul style="list-style-type: none"> <li>▪ One representative from each NACCHO Affiliate</li> <li>▪ RACGP, ACRRM and RACP</li> <li>▪ Pharmacy Guild of Australia</li> <li>▪ Aboriginal Health Professional Associations</li> <li>▪ ATSIHRTONN</li> <li>▪ NACCHO Secretariat</li> <li>▪ Department of Health &amp; Ageing</li> </ul>
Membership criteria	<p>Members must be from <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>▪ a NACCHO Affiliate</li> <li>▪ an organisation involved in setting standards and/or accrediting training in the health sector</li> <li>▪ the funding body.</li> </ul>
Responsibilities	<p>1: Provide advice on the overall project plan and direction.</p> <p>2: Contribute information and knowledge from respective organisations to support achievement of the project objectives.</p> <p>3: Promote understanding and implementation of the NACCHO Cultural Safety Standards within their respective organisations by:</p> <ul style="list-style-type: none"> <li>▪ sharing learning and progress of the project</li> <li>▪ canvassing views to provide feedback to the project</li> <li>▪ influencing uptake of the NACCHO Cultural Safety Training (CST) Standards</li> <li>▪ facilitating relationships/links between their websites and the NACCHO website where the CST Standards, and CST and related resources are located</li> </ul>

	<ul style="list-style-type: none"> <li>▪ ensuring mandated integration of the NACCHO CST Standards with existing CPD and/or accredited training relevant to their organisation and/or stakeholders (i.e. Royal Colleges)</li> <li>▪ reviewing whether and how they reflect a commitment to cultural safety within key policies, plans, partnership agreements and practices.</li> </ul> <p>4: Provide feedback that reflects respective organisational perspectives on project products.</p> <p>5: Respect agreements on what information remains confidential until the CST Standards and Assessment Process is ratified by NACCHO.</p> <p>6: Support the CST Standards Committee in developing a proposal for the implementation of the CST Standards.</p> <p>7: Advocate for the National Cultural Respect Framework 2004-2009 to be updated in line with the outcomes of the CST Standards project.</p>
Meeting frequency	At least three meetings over Year 1 of the project.
Review	<p>The Terms of Reference will be reviewed at the first 2011 meeting to ensure they reflect the project and role of the Industry Reference Group.</p> <p>The project and role of the Industry Reference Group will be formally reviewed toward the end of Year 1 of the project.</p>
Participants	<p>Royal Australian College of General Practitioners</p> <p>Australian College of Rural and Remote Medicine</p> <p>Pharmacy Guild of Australia</p> <p>Aboriginal and Torres Strait Islander Health RTO National Network</p> <p>National Aboriginal and Torres Strait Islander Health Worker Association</p>