Chapter 15
Embedding Cultural Competence in Faculty: A Mixed-Methods Evaluation of an Applied Indigenous Proficiency Workshop

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Introduction

One of the most pressing issues in Australian society is the gap between Indigenous and non-Indigenous health and life expectancies (Marmot, 2017). Australia agreed with the World Health Organisation’s 2008 Closing the Gap in a Generation report (WHO, 2008), spending approximately 5.6% of government expenditure towards ameliorating this gap (Gardiner-Garden & Simon-Davies, 2012), yet there have been only minimal positive outcomes (Alford, 2015; Gannon, 2018). In applied terms, this means Indigenous people are still dying younger (Anderson et al., 2016), scoring higher on psychological distress (Markwick, Ansari, Sullivan, & McNeil, 2015) and suffering poorer indices on all chronic diseases (e.g. Walsh & Kangaharan, 2016; Thompson, Talley, & Kong, 2017). The level of complexity involved in addressing these “wicked” or seemingly “impossible to solve” health problems is made worse by the lack of any pan-national strategic planning and/or intervention evaluation.
(Lokuge et al., 2017), even though there has been a plethora of programs and projects designed to improve Indigenous health (see for example, AGPC, 2016).

Leaders in health and educational institutions must consider why there is a lack of progress in closing the gap in Indigenous health and life expectancies. Addressing the inequities in Indigenous health requires a determinant of health approach (Mitrou et al., 2014), as 39% of the gap in health outcomes can be explained by social determinates (AIHW, 2017; Markwick, Ansari, Sullivan, Parsons, & McNeil, 2014). The social determinant considered to most reliably predict Indigenous poor health is racism (Kelaher, Ferdinand, & Paradies, 2014; Paradies, 2006; Paradies & Cunningham, 2009; Paradies et al., 2015; Paradies, Truong, & Priest, 2014).

**Racism and Its Effect on Indigenous Health**

Racism in Australia and Australian health care settings is often researched, with racism’s associated negative impacts on Indigenous health recognised since the 1970s (Stevens, 1974; Paradies, 2016). Paradies (2006) empirically demonstrated the link between self-reported racism and poorer health. Larson, Gillies, Howard, and Coffin (2007) also confirmed a significant correlation between experiencing racism and levels of illness in Indigenous people. Ziersch, Gallaher, Baum, and Bentley (2011) found racism predicts poor health in urban Indigenous populations, and Awofeso (2011) also identified racism as a major impediment to Indigenous health and health care. Kelaher et al. (2014) showed how racism negatively impacts the mental health of Indigenous people, and Doyle (2012) demonstrated how cultural incompetence, if not racism, can threaten the therapeutic mental health journey of Indigenous people. Racism is recognised as a barrier to accessing health care in Australia (Bastos, Harnois, & Paradies, 2018). According to Paradies (2018), there are five areas for combatting racism in organisations and institutions, and one of these is cultural competence training for health workers.

**Cultural Competence Training in the Health Sector: Changing the Cultural Landscape**

Creating cultural competence in health care practitioners would be one way to tackle the inequities in Indigenous health (Doyle, 2015a; 2015b). It is the attitudes and behaviours of health care providers and researchers that are either culturally competent or not (Stoner et al., 2015), and many frontline workers continue to acknowledge their cultural incompetence (Wilson, Magarey, Jones, O’Donnell, & Kelly, 2015). An evidenced-based program embedded into the training mechanisms of all health professionals to skill practitioners in cross-cultural proficiency would decrease
racism in health care settings (Durey, 2010; Gordon, McCarter, & Myers, 2016), by privileging the value of social justice and giving voice to Indigenous people as stakeholders in their own health (Reibel & Walker, 2010). Changing the focus of health care delivery to include cultural competence can reduce the health disparities of Indigenous Australians (Durey & Thompson, 2012).

Creating equity in Indigenous health settings needs to be a priority in health systems (Otim, Kelaher, Anderson, & Doran, 2014). It is necessary to understand the long echo of colonisation to develop a core value of social justice towards ameliorating poor Indigenous health status (Griffiths, Coleman, Lee, & Madden, 2016) and to recognise that respectful communication is the key to closing the gap in the quality of health care delivered to Indigenous people (Thompson et al., 2017). Although reorienting the culture of professional health care systems towards equity is challenging (Baum, Bégin, Houweling, & Taylor, 2009), the benefits of embedding an anti-racist approach to health service delivery are acknowledged and mandated by Australia’s peak bodies (Spencer & Archer, 2015).

The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) is one of Australia’s peak bodies that support health and medical research; develop health advice for the Australian community, health professionals, and governments; and provide advice on ethical behaviour in health care and in the conduct of health and medical research. One of NHMRC’s earlier initiatives was a publication entitled Cultural Competency in Health: A guide for policy, partnerships and participation (NHMRC, 2005). This guide promoted the teaching of cultural competence for all health professionals although it is clear that health professional education had not adopted the recommendations over a decade later (Ewen, Barrett, & Howell-Meurs, 2016). As most, if not all, health professions require a bachelor degree that leads to registration, Universities Australia (UA) created a policy for tertiary institutions, intending to decrease health disparities by embedding competency-based curriculum.

Universities Australia’s Cultural Competence Training

Universities Australia is considered the peak body of the university sector and represents all Australian universities. One of its aims is to develop policy positions on higher education matters through discussing higher education issues including teaching, research, and research training. As a function of this, UA published the Guiding Principles for Developing Indigenous Cultural Competency in Australian Universities (UA, 2011). The guiding principle for teaching and learning Indigenous
cultural competence is that “all graduates of Australian universities should be culturally competent” (UA, 2011, p. 7). To this end, UA (2011) recommends that Indigenous Knowledges (IKs) and perspectives are embedded in all university curricula to provide health students with the knowledge, skills, and behaviours which underpin Indigenous cultural competence. Accomplishing this recommendation will mean the inclusion of Indigenous people at every level of governance and management, university teaching, research, and community engagement (UA, 2011).

**National Accreditation of Health Professionals**

Health care registration bodies, or boards, are the peak bodies for each of the health professions. Many of these boards require health curricula to include Indigenous cultural competence. For example, the Nursing and Midwifery Board of Australia (NMBA), Competency 2, states that a Registered Nurse “practises within a professional and ethical nursing framework … practises in accordance with the nursing profession’s codes of ethics and conduct … accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state” (NMBA, 2010, p. 3). This puts responsibility onto the tertiary providers of nursing and other health disciplines’ education to have Indigenous academics who are also registered health professionals, engaged to deliver authentic, evidence-based courseware in cultural competence. Embedding cultural competence into health courseware is intended to have health care graduates ready and able to care for Indigenous clients and thus develop cultural proficiency in their practice and their employing organisations.

While individual health care workers’ performance in their cultural proficiency journey is largely a function of professional development and assessment, workers’ attitudes and behaviours certainly affect the overall reputation for racist or non-racist interactions in the Indigenous community (Griffiths et al., 2016). The performance of health care organisations and their interactions with Indigenous people is measured by the Australian Department of the Prime Minister and Cabinet.

**The Department of the Prime Minister and Cabinet’s Aboriginal and Torres Strait Islander Health Performance Framework Reports**

The *Aboriginal and Torres Strait Islander Health Performance Framework* (“the Health Framework”) is produced every year by the Department of the Prime Minister and Cabinet (cited as CoA) and reports on three tiers of health performance with data from multiple health sources. The Health Framework considers health status and outcomes, determinants of health, and health system performance. The 2014 Health
Framework affirmed Freeman et al.’s (2014, p. 356) statements that improving the cultural competence of health care services can “increase Indigenous people’s access to health care, increase the effectiveness of care that is required, and improve the disparities in health outcomes.”

The 2016 Health Framework (CoA, 2016, p. 27) considered racism and discrimination as determinants of health, especially where “systematic or institutionalised racism is apparent in policies and practices that support or create inequalities between ethnic groups.” The 2016 Health Framework (CoA, 2016) also reported that 11% of Indigenous people had experienced discrimination from health staff within the past year. Given that word-of-mouth and being vouched for are crucial factors in working with Indigenous communities, having one in every ten Indigenous people discriminated against by health staff would give that health service a reputation for poor service, and therefore, it would be unlikely to be utilised by the people that most need it. The 2017 Health Framework reported “depression as a [function] of racism” (CoA, 2017, p. 76), thus reinforcing the importance of cultural competence in health care services (CoA, 2017, p. 162).

**The Australian Commonwealth Department of Health’s Aboriginal and Torres Strait Islander Health Curriculum Framework**

The *Aboriginal and Torres Strait Islander Health Curriculum Framework* (CoA, 2014) (“the Curriculum Framework”) was developed to address the variability among all health professions and higher education providers, in terms of the nature and extent to which Aboriginal and Torres Strait Islander curriculum is implemented. Underpinned by eight principles designed for successful curriculum delivery (see CoA, 2014, pp. 27–31), the Curriculum Framework describes the interconnected cultural capability model’s five values of respect, communication, safety and quality, reflection, and advocacy, grounded in culturally safe relationships. Each of the five cultural capabilities are aligned to a series of primary learning outcomes. These learning outcomes are adapted from Bloom’s revised teaching taxonomy (Atherton 2013) and form a continuum of novice to intermediate, then entry to practice levels (CoA, 2014, p. 35). Recognising the different health education environments, the different needs of health professions’ curriculum, and the varied resources available to faculty, the Curriculum Framework includes several models suitable for providers to adapt and use.

Another model recommended in the Curricula Framework is Zubrzycki et al.’s (2014) *Getting it Right Framework*, which outlines the best practice for integrating cultural competence in staff and curricula in health education programs. While their framework is for social workers, Zubrzycki et al. (2014) recognise the model can be adapted across other health specialties and is useful for non-Indigenous teachers.
Given the current low numbers of qualified Indigenous health lecturers, the Curriculum Framework recognises that non-Indigenous teachers will also need to be able to teach Indigenous health and Indigenous students. The Curriculum Framework recommends that all university staff need to have a core value of respect for culture and to privilege Indigenous voices whenever possible. Applying these models and concepts requires thoughtful negotiation with colleges and communities who still live in an ongoing colonised condition, and the state of Victoria is used here as an example.

**Cultural Competence in Applied Settings: The Victorian Aboriginal Child Care Agency’s Cultural Competence Matrix**

Terry Cross, a First Nations American, created a postcolonial cultural competence model that reinforces proficiency rather than awareness and is based on a human rights/social justice approach (Cross, 1989). The model has stages of competency development, like Benner’s stages of clinical competence of novice (observer) to expert (engaged participant) (Benner, 1984; Pasila, Elo, & Kääriäinen, 2017). The Victorian Aboriginal Child Care Agency’s (VAACA) (2008) *Aboriginal Cultural Competence Matrix* adapted Cross’s (1989) framework to describe behaviours and attitudes on the cultural competence continuum that are specifically related to the Indigenous context. Cross’s (2008, pp. 278–289) model describes cultural competence as the “acceptance of, and respect for, cultural diversity within the organisation; service delivery is reviewed and adjusted to meet the needs of different population groups.” The Victorian Aboriginal Child Care Agency’s model has acceptance and respect as the core components for cultural competence in all health care (VACCA, 2008, p. 24), demonstrating the fit of Bloom’s taxonomy of three learning domains: cognitive, physical and affective, or rather, skills, knowledge, and behaviours (Cannon & Feinstein, 2014).

**Summary of Cultural Awareness/Competency Models**

Distilling the above examples of peak bodies’ recommendations for implementing Indigenous content and advice around the embedding of cultural competence in health education providers demonstrates that core values are quintessential to consider in any cultural competence conversations. Bloom’s taxonomy is used as a pedagogy, where learners’ skills, knowledge, and attitudes or behaviours are shaped by experienced Indigenous teachers. These frameworks require all staff be given the opportunity to attend training to facilitate their cultural learning.
Facilitating the Faculty

Following the UA’s recommendations to embed cultural competence into every health course would require faculty members to have some level of skills and knowledge themselves. As part of the University’s Reconciliation Action Plan, all staff members were mandated to attend a cultural “awareness” training event. In concert with this mandate was the roll-out of the embedding of Indigenous content into each course curriculum. To get buy-in from course coordinators, faculty and professional staff were invited to a workshop that demonstrated the cultural competence education given to undergraduate health students. Having faculty attend cultural competence programs can facilitate their own learning journey and demonstrate to staff an effective and Indigenist pedagogy (see Behar-Horenstein, Garvan, Su, Feng, & Catalanotto, 2016).

Pedagogy for Cultural Competence Workshops

Learning is dependent on the pedagogical approach teachers use in the classroom (Darling-Hammond et al., 2015). An adjusted model of Bloom’s three learning domains was used to underpin the learning activities of the cultural competence workshop (the “workshop”), relying heavily on the affective domain of emotions and attitude (Bloom, Krathwohl, & Masia, 1984). Overemphasising the cognitive domain when seeking attitudinal shift is often futile and risks losing the desired change in participant behaviours (Vossler & Watts, 2017). It is common to have resistance to training aimed at challenging participants’ belief systems (Betancourt, Green, Carrillo, & Park, 2017), so care must be taken ensure the participants feel safe in the workshops (Crandall, George, Marion, & Davis, 2003).

For these reasons, the workshop used historical events of significance to Indigenous people (e.g. Cook’s landing, frontier wars, stolen generations, and government policies such as the requirement for Indigenous people to have identity papers), along with personal narratives, to share an Indigenous experience with participants that invited them to consider the impact of colonisation without the taking on feelings of guilt and shame (Willen & Kohler, 2016). Guilt and shame are not life-affirming responses and do not contribute to closure of the health gap (Torino, 2015), whereas reflection of self and what informs one’s stereotypes is necessary in one’s cultural proficiency journey (VACCA, 2008).
Creating a Three-Dimensional Model to Embed Cultural Proficiency Skills in Health Professionals

The workshop was designed for health care academics and professional staff to demonstrate the courseware offered to students and to embed a desire for cultural competence in workplace behaviours. The workshop model for cultural proficiency uses Benner’s (1984) novice to expert competency model wrapped around Bloom’s taxonomy of skills, knowledge, and attitudes/behaviours (Forehand, 2010), to explain the process of “assess, plan, implement and evaluate” (APIE) and the ladder of self-reflection (see Fig. 15.1).

Aunty Kerrie’s model allows the clinician to maintain therapeutic integrity using the APIE system and foster culturally proficient skills through a set of self-reflection behaviours. The main aim of this model is to facilitate a client-centred journey in paralogy with clinicians or practitioners. This was the model used in the faculty workshops.

The Cultural Awareness Workshops

The term cultural “awareness” is contentious (Truong, Paradies, & Priest, 2014) and not recommended by the UA. As Fredericks (2008, p. 11) points out, Indigenous-specific cultural awareness training in the health sector reinforces a deficit model by holding “Indigenous people, as being under serviced, needy and problematic to non-Indigenous people to some degree,” or attempts to fix Indigenous people (Bourke, Humphreys, Wakeman, & Taylor, 2010). The deficit approach, even if it is “well-meaning”, is based in a racist framework (Freeman et al., 2016, p. 99). Nonetheless,
there was pressure from the organisation to advertise the workshops as “cultural awareness workshops”.

The workshops, entitled “Cultural Awareness for Staff”, were advertised via Eventbrite to all staff in the health colleges. There were 312 “hits” on the site, with 95 participants (60 staff and 35 higher degree research students) choosing to attend one of the nine workshops. Workshop times and days were staggered during the academic semester to facilitate attendance by staff.

Methodology and Results

A Qualtrics e-survey was sent post-workshop to the 55 participants in the first workshop, with 40 participants completing the survey. In order to maintain anonymity of respondents from a small campus, no demographics were collected. Participants were asked to score their opinion from 0 to 100 on seven items (see Fig. 15.2):

1. The content of the workshop was interesting,
2. I felt safe in the workshop,
3. The content was useful to my role at the university,
4. I can discuss the Indigenous history of Australia,
5. I understand the impact of colonisation on the social determinants of health,
6. This course gave me tips on communicating with Indigenous people, and
7. My students would benefit from this course.

Findings

A simple thematic analysis was conducted on the comments of participants $(n = 35)$. These comments were categorised into two emergent themes: personality of presenter and need for more education (Table 15.1).

Discussion

While the majority of participants considered the workshop to be a positive experience, some participants might have felt uncomfortable or confronted by the material and for this reason, felt that they could not confidently discuss the Indigenous history of Australia. This might be a function of the initial “shock” of hearing stories regarding local history; for example, participants had heard of Murdering Gully Road in Victoria but had not realised it was named after the massacre of the local Aboriginal people (see Barker, 2007; Broome, 2005; Clark, 1995; Tatz, 2012).

It was also evident that some participants did not see the relevance or importance of being able to effectively communicate across cultures or considered their particular
workspace as not requiring an understanding of Indigenous Australia. Selling cultural competence to science disciplines can be challenging even though scientists may recognise the importance of IKs (Doyle, 2017).

The findings from the comments indicate that some participants recognised the limitations of a single workshop and that they needed “more” education before considering themselves competent. The second finding was based around the charisma or acceptability of the presenter to the participants: this aspect might have positively skewed the data but not necessarily meant a change in attitudes or behaviours towards Indigenous people. Having equivocal results such as these makes replicating the core components of this workshop challenging. A second workshop with a different presenter might have made the findings more robust. Results that can be considered ambiguous can make translating research into practice challenging.

**Fig. 15.2** Participants’ scores on workshop content
**Table 15.1** Thematic analysis

| Category          | Personality of presenter                                                                 |
|-------------------|------------------------------------------------------------------------------------------|
| Examples of items | • This workshop was informative, valuable and entertaining—the impact and knowledge will stay with me and I will pass onto my grandchildren  |
|                   | • Aunty Kerrie’s presentation was very informative. So glad I attended                     |
|                   | • An overwhelming wonderful session! Auntie Kerrie, you are a dynamic story teller, everyone should do this session. Thank you |
|                   | • Excellent presenter, engaging and compassionate                                          |
|                   | • I would like to say big thank you for this amazing workshop                             |
|                   | • Aunty Kerry is an amazing source of knowledge. Her lessons in cultural awareness extend well outside of the training—I learn from her each time I see her. She is such a role model to me! Thanks Aunty |
|                   | • Thank you for giving us the opportunity to learn more about “our” history Aunty Kerrie. Attending your workshop was a special and touching experience for me that has added to my knowledge and ability to teach others about the past and its repercussion still felt by people today |
|                   | • I learned a lot from this workshop since we have a great and brilliant Indigenous teacher |

| Category          | Need for more education                                                                 |
|-------------------|------------------------------------------------------------------------------------------|
| Examples of items | • Thank you for taking the time to run this very interesting workshop. Have you thought of running workshops in 2018 with additional information? |
|                   | • I think I still have a lot to learn and feel very grateful to have heard the stories you told |
|                   | • Thought provoking and a timely reminder of past events                                   |
|                   | • I would like to know more; can we have deeper conversations/lectures/teaching? This was a great start but not enough! |
|                   | • Fantastic course. It would be great to have something similar as part of the curriculum for all vocational courses. Point 4 and 5 = not a reflection on the course, but the history and impact are broad and complex. I’m sure I can discuss them better than previously, but there is still much to learn! |
|                   | • I think a post grad elective/course in Indigenous health would be useful as a course across programs and disciplines |

**Translating Research Into Practice**

Measuring cultural competence in health care settings is usually inferred by the behaviour of its Indigenous service users, using variables such as self-reporting on patient experience or being discharged against medical advice, and employment of Aboriginal and Torres Strait Islander health workers (CoA, 2017). Some researchers measured the patients’ perceptions of health care professionals’ level of cultural competence and deem proficiency as a perceived skill (Truong, Paradies, & Priest, 2014), or measure critical thinking and correlate that to cultural competence (see Garneau & Pepin, 2015). Deeming a health service to be culturally competent is more complex than considering Indigenous user satisfaction rates (Paradies et al., 2014) as it is difficult to measure the effectiveness of interventions to address cultural competence in health care for Indigenous people (Truong, Paradies, & Priest, 2014; Clifford, McCalman, Bainbridge, & Tsey, 2015). The lack of accepted indices of
success in health care delivery makes measuring success in university settings just as equivocal. Should we canvas Indigenous students to see if they feel the lecturers have adopted the core values of cultural competence? Should we measure the students’ skills, knowledge, and attitudes pre and post their university degrees to see if the cultural competence in their university courses resulted in a change in their perspectives? Should we undertake longitudinal studies on health alumni? Should we partner with a clinical facility to survey Indigenous patients, to allow for subjective assessment of health care staff? These are the questions that need to inform the next round of authentic research, to discover whether health and university executives have the political will to view the results through an Indigenous lens and operationalise cultural proficiency in all staff at all levels. Mandating this skill will contribute to a decrease in institutionalised racism and help close the health gap.

Conclusion and Recommendations

The gap between Indigenous and non-Indigenous people in terms of health status seems intractable, even with an annual government budget of millions of dollars. There is a plethora of projects aimed at increasing the health of Indigenous people, yet there has been no meaningful change in Indigenous people’s health status (see DPM&C, 2018). One reason for the lack of movement in the health bridge is because there has been no meaningful change in racism—that most salient social determinant of health. Having academic and health service staff able to operationalise a culturally proficient framework would surely contribute to a decrease in institutionalised racism. Having health professions with graduate attributes that include social justice facilitation, with university courses designed to include the embedding of this attribute, would also contribute to cultural proficiency. Universities have generic graduate attributes that might need to consider the ability of all students to be able to communicate effectively with Indigenous people.

There is a need to have multiple approaches at multiple levels for effective cultural competence facilitation (Truong, Paradies, & Priest, 2014). Educators, for example, will need different approaches to cultural competence than health workers, and even then, different disciplines will have specific cultural competence needs as well. For this reason, one workshop cannot cover all comers. Specifically designed workshops need to cater for the needs of the participants and be delivered by qualified Indigenous health, or other, professionals. Regardless of the target audience, adopting a humanistic approach from core values such as social justice and dignity is the most appropriate starting point.
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