LOWITJA INSTITUTE

Cultural Safety in Australia

Discussion Paper

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Use of language in relation to cultural identity

Lowitja Institute's protocol is to use the term Aboriginal and Torres Strait Islander peoples in the Australian context, unless specifically referring to Aboriginal peoples or Torres Strait Islander peoples. Where appropriate, specific nation names may be used.

The term First Nations peoples is used to refer to Indigenous peoples across the world.

The term non-Indigenous people is used for people in Australia who are not Aboriginal, Torres Strait Islander or Aboriginal and Torres Strait Islander people. When authors are being quoted, the terms in the quote will be those used by the author.

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About the artwork

Cover artwork by Jordan Lovegrove, Karko Creations

The artwork by Ngarrindjeri artist Jordan Lovegrove illustrates the concept of cultural safety for Aboriginal and Torres Strait Islander people. At its centre is a meeting place that symbolises a First Nations person, family, or community. The coloured meeting places surrounding it represent businesses, workplaces, government departments, and services. These entities work together to create a culturally safe environment, supported by smaller meeting places that signify various communities. This network ensures the health, wellbeing, and strong futures of Aboriginal and Torres Strait Islander people.

The themes of safety, security, and trust are central to the artwork. Cultural safety means that Aboriginal people feel their experiences are believed and validated. It emphasises the importance of centring and valuing Indigenous cultures in policy, research, evaluation, and service delivery, creating environments where Aboriginal and Torres Strait Islander people feel welcomed and respected.

Contents

Executive summary

Cultural safety as both a concept and practice emerged in Aotearoa New Zealand in the early 1990s through the foundational, lived experience and culturally informed work of Irihapeti Ramsden, a Māori nurse. The introduction of cultural safety into Australia for Aboriginal and Torres Strait Islander peoples was First Nations-led and also occurred through the nursing profession, initiated by Dr Sally Goold, the founder and trailblazer of the Congress of Aboriginal and Torres Strait Islander Nurses.

The purpose of embedding cultural safety at individual and institutional levels in practice and policy is to achieve justice and equity for Aboriginal and Torres Strait Islander peoples across health and human services; preferably, in all life contexts. A critical step to achieving this outcome is developing a shared understanding of cultural safety through high-quality training for all people leading and/or working in health and human services.

Learning about what cultural safety means for Aboriginal and Torres Strait Islander peoples and how to apply this learning in health and human services contexts occurs in two main ways – through tertiary education or in the workplace.

Learning through tertiary education: For students in health professions, education on cultural safety is governed by standards set by national health professional accreditation councils and supported in two further ways. First, by the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Department of Health 2014) or, where they exist, equivalent documents for other professional groups adapting or implementing this Framework or crafting their own (Australian Association of Social Workers 2023; CATSINaM 2017c; Public Health Indigenous Leadership in Education Network 2016; Ryan, Gibson & Hummel 2023).

Second, by other relevant national professional learning networks, such as Leaders in Medical Education (LIME) and Leaders in Nursing and Midwifery Education Network (LINMEN).

Learning in the workplace: Many staff in health and human services workplaces completed their tertiary education before cultural safety was a formalised part of the curriculum. Their main opportunity to undertake cultural safety education rests on the initiative of their organisations to organise cultural safety workforce development or the individual staff member seeking out this training. Therefore, a high proportion of cultural safety workforce development occurs beyond the tertiary education context. It reaches across the workforce involved in or impacting on the social and cultural determinants of health for Aboriginal and Torres Strait Islander peoples.

Apart from the original 2011 NACCHO Cultural Safety Training Standards, no standards have been developed and promoted for cultural safety training that occurs outside of the tertiary education environment. While Hunter et al. (2021) identified and acknowledged what are considered attributes of high-quality cultural safety training, they were replicated from the 2011 NACCHO standards.

The purpose of this discussion paper is to propose recommended and nationally consistent standards, set a platform for the accreditation of workplace-based cultural safety training, and propose further action that can lead to cultural safety being embedded and measured at individual and institutional levels in practice and policy across health and human services. This is congruent with the aspiration of the original 2011 NACCHO Cultural Safety Training Standards with the benefit of having gained another decade of learnings about cultural safety and cultural safety training.

Background

Introduction

In Australia, there has been increasing recognition of the critical importance of cultural safety for Aboriginal and Torres Strait Islander peoples. It is critical for improving access to quality healthcare, addressing the social determinants of health, and elevating the importance of the cultural determinants of health for Aboriginal and Torres Strait Islander peoples.

Understanding of cultural safety and related concepts has evolved over two decades in our dynamic and diverse contemporary society. Aboriginal and Torres Strait Islander health and education professionals, communities and community controlled organisations have worked to define and refine the core features of culturally safe systems, programs, and services across the social and cultural determinants of health.

This discussion paper reflects on the history of advocacy for cultural safety in Australia, and its promotion and application through cultural safety training and education, including what is currently known about the impact on participants' knowledge, skills, and subsequent actions. Cultural safety training and education is one of multiple mechanisms needed for embedding cultural safety across systems, policies, programs, and services in the pursuit of health equity and justice. Therefore, the purpose of the paper is fourfold:

- To outline key developments in the history of cultural safety in Australia.
- To clarify how cultural safety training and education differs from other types of cultural training.
- To synthesise existing understandings about cultural safety and cultural safety training and propose a revised set of nationally consistent quality standards for cultural safety training and other supportive actions.
- To link the focus on cultural safety training standards with other parallel and subsequent mechanisms that are being or can be implemented to embed cultural safety, such as health professional curriculum standards, policy, organisational change strategies, and resources to guide and assess progress with cultural safety organisational change initiatives.

The discussion paper is structured in nine parts:

SECTION 1 Executive summary

SECTION 2 Background

SECTION 3 Why is cultural safety important?

SECTION 4 Advocacy for cultural safety across health in Australia

SECTION 5 Key terms and concepts

SECTION 6 Impact of cultural safety training

SECTION 7 Components of good practice in cultural safety

SECTION 8 Resources for evaluating and strengthening cultural safety

SECTION 9 Conclusions and recommendations

Discussion paper development

This work is published and disseminated by Lowitja Institute, Australia's community controlled national institute for Aboriginal and Torres Strait Islander health research. It forms part of the Lowitja Institute Discussion Paper series, which encourages the dissemination of critical analysis and literature reviews of key issues affecting Aboriginal and Torres Strait Islander health and wellbeing research, work in progress, and research methodologies.

As outlined below, the National Aboriginal Community Controlled Health Organisation (NACCHO) initiated a project in 2010 to create national cultural safety training standards – known as the NACCHO Cultural Safety Training (CST) Standards initiative. The intent was for the standards to be recognised as a national benchmark for quality Aboriginal and Torres Strait Islander cultural safety training for the health workforce and other sectors across the social and cultural determinants of health (NACCHO 2011:2).

Two of this paper's authors, Adjunct Professor Janine Mohamed and Kathleen Stacey, were directly involved in writing a background paper (NACCHO 2011) and creating the NACCHO CST Standards through a co-design process with representatives of NACCHO's jurisdictional Affiliates. The initiative proposed a process by which training providers could achieve accreditation against the standards. As funding could not be secured in 2011, full implementation could not proceed.

In 2020, Lowitja Institute gained NACCHO's permission to lead a project to review and update the original background paper and National CST Standards. The project purpose was to reflect on cultural safety developments over the intervening years, especially cultural safety training, training standards and the evaluation of training outcomes. This became the Lowitja institute Accreditation of Cultural Safety Training (CST) Standards initiative conducted over 2021–22, led by Adjunct Professor Janine Mohamed with Kathleen Stacey as the consultant.

This discussion paper has evolved over three phases, from the initial work done at NACCHO, through to an updated background paper for the Accreditation of CST Standards initiative, and now further updated and expanded for the Lowitja Institute Discussion Paper series.

Authors and perspectives

Reflecting the values and priorities of Lowitja Institute, this discussion paper is structured within an Indigenous research paradigm that centres Indigenous perspectives in the process.

Indigenist paradigms recognise ongoing oppression, transgenerational trauma, and grief for Aboriginal communities, and facilitate decolonisation through a process of elevating and privileging Aboriginal worldviews and self-determination (Walter & Suina 2019). The epistemological position is constructivist/interpretivist, acknowledging multiple realities that must be constructed and interpreted within a social, cultural, and temporal context (Santiago-Delefosse et al. 2015).

The NACCHO CST Standards and Lowitja Institute Accreditation of CST Standards initiatives were both conducted through a partnership between Indigenous and non-Indigenous practitioners and researchers with direct policy, program, and training expertise. The authors have been immersed in advocating for cultural safety, designing and implementing cultural safety initiatives, cultural safety training, and developing cultural safety standards across curriculum and healthcare. This applied experiential tacit knowledge is incorporated into this discussion paper alongside learnings from published and grey literature.

A feature of both initiatives was working with 'critical friends' – people with long-standing experience in Aboriginal and Torres Strait Islander health, and promoting cultural safety, policy, workforce development, and delivering cultural safety training.

The critical friend role was to co-design and update standards, review and advise on the background paper, and advise on an accreditation process. Critical friends in each initiative were:

- **NACCHO CST Standards initiative:** Representing the eight NACCHO Affiliates: Ann Newchurch and Carmen Dadleh from AHCSA, Sharon Bushby from AHCWA, Gwen Troutman-Weir from AH&MRC, Erin Lew Fatt and Norma Benger from AMSANT, Mary Martin from QAIHC, Salina Bernard from VACCHO and Clare Anderson from Winnunga Nimmitjyjah.
- **Accreditation of CST Standards initiative:** Sharon Gollan, Mary Martin, Renee Brown, Karl Briscoe and Norma Benger.

Continuity between the three-phase development of the discussion paper is provided by Adjunct Professor Janine Mohamed and Kathleen Stacey.

Adjunct Professor Janine Mohamed, a Narrunga Kaurna woman and CEO of Lowitja Institute from 2019–24, has undertaken consistent work on cultural safety since 1998 when she began teaching it in university, then advocating for cultural safety across the health workforce and systems through her Aboriginal community controlled health sector roles. She led NACCHO's initial lobbying of Australian Health Practitioner Regulation Agency (Ahpra) in 2008–09 to embed cultural safety into Bill A and B of the Ahpra legislative framework and include cultural safety into health professional registration standards and codes of conduct. In 2010–11 she was manager of the original NACCHO CST Standards Project.

Embedding cultural safety has remained a sustained campaign for Janine following her time in NACCHO.

In her CEO role at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, she initiated and influenced the development of the Ahpra Aboriginal and Torres Strait Islander Cultural Safety Strategy (Mohamed 2016a). She worked consistently across nursing and midwifery to embed and improve cultural safety content into curriculum, and professional registration standards and codes of conduct.

To further support this work, she spearheaded a three-year planning and advocacy campaign that resulted in establishing the Leaders in Nursing and Midwifery Education Network, or LINMEN, in 2017. Janine also advocated for cultural safety to be the standard set during the 2016 review of the National Safety and Quality Health Service Standards. She supported a stand-alone cultural safety unit being embedded into the Enrolled Nursing qualifications, co-developing teaching and learning materials to support its delivery.

Over her Aboriginal community controlled health sector career, including her most recent role as CEO of Lowitja Institute, Janine has been directly involved in informing and shaping the successive National Aboriginal and Torres Strait Islander Health Workforce Strategic Frameworks. She played a critical role in co-developing the Implementation Plan associated with the 2021–31 Framework that has dedicated strategic directions and specific strategies focused on embedding cultural safety into health policy, systems, programs, and services. She also supported the elevation of cultural safety in the *National Aboriginal and Torres Strait Islander Health Plan*.

Kathleen Stacey, a non-Indigenous ally, was the consultant for both CST standards initiatives. In 2010–11 she supported the original NACCHO CST Standards Project, co-writing the background paper and co-developing the Standards, playing the same role in the Accreditation of CST Standards initiatives. Prior to and since 2010 she has continued to co-facilitate cultural safety training and initiatives and co-write cultural safety resources with Sharon Gollan, a Ngarrindjeri trainer and consultant known for her long-standing work in cultural safety. Kathleen has also continued development and implementation of cultural safety initiatives and advocacy work with Adjunct Professor Janine Mohamed, including collaborating on developing the Enrolled Nursing cultural safety unit teaching and learning materials, and the most recent National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework.

We acknowledge the valuable contributions of Professor Catherine Chamberlain, a palawa woman of the trawlwoolway clan (Tasmania) based in the University of Melbourne and Lowitja Institute, and Professor Naomi Priest, a non-Indigenous ally from the Australian National University. Catherine and Naomi read, reviewed, and provided critical friend commentary and suggestions during the final iteration of the discussion paper.

Scope of the literature review

A literature review was conducted to inform our applied learning and co-design process. This occurred across the three phrases of paper development, first in 2010, then was updated in 2020/21 and extended upon in 2023. On each occasion, searches were based on a review of published and grey literature using the following search phrases:

- ‘cultural safety training’
- ‘cultural safety training standards’
- ‘cultural safety training’ and ’standards’
- ‘cultural safety training evaluation’
- ‘cultural safety training” and ‘evaluation’
- ‘evaluation of cultural safety training’.

While the primary focus was on cultural safety for Aboriginal and Torres Strait Islander peoples and cultural safety training within Australia, material on other common cultural training terms was also surfaced that informed the 'Key terms and concepts' section of the paper. Information on cultural safety and/or cultural training in other countries is referred to occasionally, but not described in detail apart from acknowledging the foundational work on cultural safety in Aotearoa New Zealand by Irihapeti Ramsden (Papps & Ramsden 1996; Ramsden 1996, 2002).

Databases searched included MEDLINE, PubMed, ProQuest, CINAHL, ERIC and Google Scholar. Other known sources were searched for material on resource hubs such as the Australian Indigenous HealthInfoNet, Leaders in Medical Education (LIME), Leaders in Nursing and Midwifery Education Network (LINMEN) and the Australian Indigenous Psychology Education Project, in addition to a general Google search for grey literature. Many relevant documents found in these supplementary searches had been identified through initial searches.

Why is cultural safety important in Australia?

Why is discussing and addressing cultural safety critical in Australia? A core reason is racism and the historical and ongoing impacts of colonisation evident in the persistent health inequities experienced by Aboriginal and Torres Strait Islander peoples.

Colonisation and racism

The colonising practices implemented in Australia since 1788 are grounded in racism, as an ideology and system of oppression that creates racial hierarchies based on the socially constructed concept of race (Berman & Paradies 2010). Challenges to the reality of race were evident in the United Nations Educational, Scientific and Cultural Organization's (UNESCO) early work, five years after it was established:

> *The biological fact of race and the myth of 'race' should be distinguished. For all practical social purposes 'race' is not so much a biological phenomenon as a social myth. The myth of 'race' has created an enormous amount of human and social damage. In recent years, it has taken a heavy toll in human lives, and caused untold suffering* (UNESCO 1950:8).

Despite these challenges to the reality of race, scientific agreement that race is not a legitimate biological category and thorough discrediting of previous racially based science (Watego, Singh & Macoun 2021), racism and its impact remain real and ongoing. In the colonisation of Australia, racism has resulted in the redistribution of power and resources from Aboriginal and Torres Strait Islander peoples, as the colonised groups, to non-Indigenous Australians, in particular white Australians, as the privileged group. The concept of race, elevating white people to a position of superiority, legitimised colonial claims to sovereignty and ownership of Aboriginal bodies (Moreton-Robinson 2007). The infusion of racism within Australia's legal systems has kept these claims in place (Falk & Martin 2007).

Defining racism

Racism can be defined as organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups. Racism can manifest through beliefs, stereotypes, prejudices or discrimination. This encompasses everything from open threats and insults to phenomena deeply embedded in social systems and structures.

Racism can occur at multiple levels, including: internalized (the incorporation of racist attitudes, beliefs or ideologies into one's worldview), interpersonal (interactions between individuals) and systemic (for example, the racist control of and access to labour, material and symbolic resources within a society) (Paradies & Ben et al. 2015:2).

Racism can be characterised as operating at two intersecting and mutually reinforcing levels, individual and systemic – see Figure 1. In their cultural safety training work, Gollan & Stacey (2018, 2021a, 2021b) describe how individual racism

occurs when individuals practise ***racial prejudice*** and ***racial discrimination*** in their attitudes and behaviours towards Aboriginal and Torres Strait Islander peoples. As noted by Mohamed & Stacey (2017), the presence or absence of racism is always determined by Aboriginal and Torres Strait Islander peoples. Individual racism may also be referred to as interpersonal or everyday racism (Paradies & Cunningham 2009; Paradies, Truong & Priest 2014; Thurber et al. 2021b). It is both a manifestation of and driven by systemic racism.

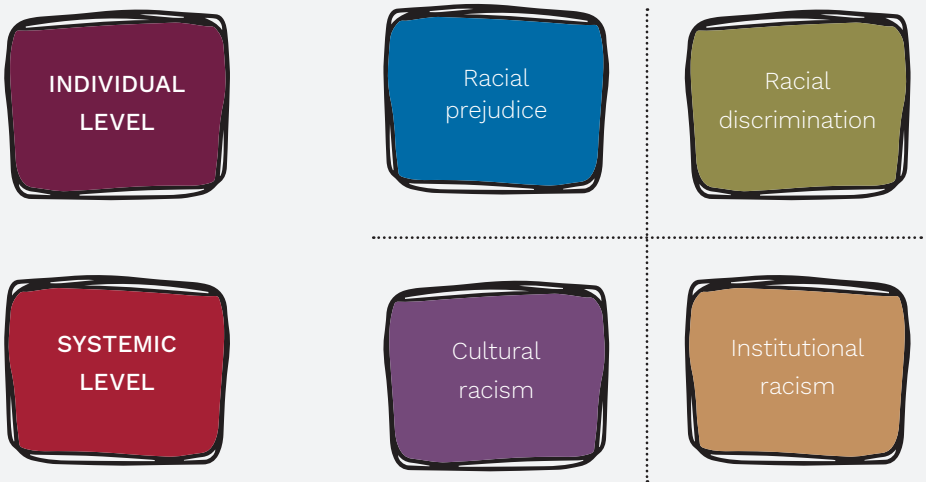
Systemic racism occurs through ***cultural*** and ***institutional racism***. In Australia, cultural racism refers to the ideas and narrative taught, learned and circulated in Australian society that diminish, distort, limit, and misrepresent Aboriginal and Torres Strait Islander peoples, both historically and currently. In a British-colonised country, such as Australia, it is essential to understand white privilege and its symbiotic relationship with racism.

Michaels et al. (2023:768) describe cultural racism as the 'widespread values that privilege and protect Whiteness and White social and economic power' that 'permeate all levels of society', and argue they shape and support all forms of racism, including institutional racism.

Institutional racism refers to the imposition and assumed superiority of white dominant culture laws, policies, and practices in how systems and organisations operate across all sectors that do not consider, allow for, or support other cultural knowledges, experiences or values. Putting this in direct terms, consider this: Who created the system? Who was it created for? Where does power sit? Who was locked out, who benefits and what are the ongoing effects?

Systemic racism may be used interchangeably with or in a similar manner to structural racism (Bailey, Feldman & Bassett 2021; Bailey et al. 2017). For example:

Figure 1: Two levels and four forms of racism



> *There is no "official" definition of structural racism – or of the closely related concepts of systemic and institutional racism – although multiple definitions have been offered. All definitions make clear that racism is not simply the result of private prejudices held by individuals, but is also produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system as well as in cultural and societal norms* (Bailey, Feldman & Bassett 2021:768).

If we only focus on individual racism and addressing racist attitudes and behaviours, which has a long history in the scholarship on race and racism, we will not be effective in combatting or eliminating it. We will not address how racism is embedded in the core structures, values, and beliefs of our society (Bailey, Feldman & Bassett 2021; Bonilla-Silva 2005; Michaels et al. 2023; Watego, Singh & Macoun 2021). By implication, non-Indigenous people cannot be 'non-racist' but can be 'anti-racist' if prepared to tackle racism in all its forms at both systemic and institutional levels (Mohamed & Stacey 2017).

Browne (2017:25) describes this in the Canadian context, which resonates with our own:

> *..it is critically important to understand experiences of racism described by Indigenous peoples as reflecting broader racist discourses, policies and practices, which are firmly entrenched in organizations and institutions, and in the dominant society through media, public conversations, and everyday practices. Situating these experiences in the wider socio-political landscape may preempt [sic] the denial of racism that might otherwise occur when the 'problem' of racism is constructed primarily as reflecting individual level reactions or opinions.*

A review of all research commissioned by Lowitja Institute up to and including 2020 that related to cultural safety and racism identified critical learnings in relation to racism (Stacey & Gollan 2021a):

- Racism is a frequent and regular experience for Aboriginal and Torres Strait Islander peoples and associated with significantly poorer mental health and reduced life chances (Ferdinand & Massey et al. 2019; Ferdinand; Paradies & Kelaher 2013; Gallaher et al. 2009; Watego, Singh & Macoun 2021).
- Aboriginal staff frequently experience racism in the workplace (Dwyer & O'Donnell 2013; Gallaher et al. 2009).
- Cultural safety is premised on acknowledging and addressing the reality and prevalence of racism, historically as well as in the contemporary context (Bond, Singh & Kajilich 2019; Gallaher et al. 2009).

Subsequent research in the Australian context reiterates and expands on this reality for Aboriginal and Torres Strait Islander peoples (for example, Bailey et al. 2020; Allison, Cunneen & Selcuk 2023). More information about race, racism and anti-racism is found in *Partnership for Justice in Health: Scoping Paper on Race, Racism and the Australian Health System,* another paper in the Lowitja Institute Discussion Paper series (Watego, Singh & Macoun 2021).

Racism and health inequities

Evidence of inequities between non-Indigenous and Aboriginal and Torres Strait Islander peoples in Australia across most areas of life are alarming. Health is no exception and has been a core focus of advocacy and collective effort by Aboriginal and Torres Strait Islander peoples and non-Indigenous allies for the last century, most evident in the sustained 'Close the Gap' campaign over the last two decades.

The first formal response to the campaign was in 2008 when the Government of Australia made a commitment to set national Indigenous health targets across five areas (Human Rights and Equal Opportunity Commission 2008):

- partnership between government and Aboriginal and Torres Strait Islander peoples and their representative bodies
- health status
- primary healthcare and health services
- primary health infrastructure
- social determinants of health.

This commitment was shaped into a series of 'Closing the Gap' commitments and plans at Australian and jurisdictional government levels, with the most current being the *2020 National Agreement on Closing the Gap* that has four key reforms and 19 socioeconomic targets (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & all Australian Governments 2020). It is also represented in the vision of the current *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*: 'Aboriginal and Torres Strait Islander people enjoy long, healthy lives that are centred in culture, with access to services that are prevention-focused, culturally safe and responsive, equitable and free of racism' (Department of Health 2021:6).

Despite the commitments made by successive Australian governments since 2008, the most recent report on outcomes against the targets highlight ongoing disparities as only four are on track of the 15 that can currently be assessed (Productivity Commission 2023). Although seven of the targets that are not on track are improving, outcomes are worsening for the other four target areas (Productivity Commission 2023).

Across many levels of government and society, Australia continues to struggle in its understanding of the depth, extent, operation and impacts of racism on Aboriginal and Torres Strait Islander peoples that are implicated in these outcomes (Watego, Singh & Macoun 2021). This is despite a growing body of research evidence that clearly demonstrates these impacts on health and health inequities throughout life and across generations (ABS 2016; AHRC 2011; Bailey et al. 2020; Bond, Singh & Kajilich 2019; Bourke, Marrie A. & Marrie H. 2019; Brinckley & Lovett 2022; Dunn et al. 2011; Ferdinand et al. 2019; Ferdinand, Paradies & Kelaher 2013; Grant & Guerin 2018; Henry,

Houston & Mooney 2004; Kairuz et al. 2021; Larson et al. 2007; Macedo et al. 2019; Markwick et al. 2019; McConnachie, Hollinsworth & Pettman 1988; Miller et al. 2009; Nelson et al. 2015; Paradies & Cunningham 2008, 2009; Paradies, Harris & Anderson 2008; Paradies et al. 2013; Paradies et al. 2015; Paradies, Truong & Priest 2014; Priest et al. 2011; Priest et al. 2021; Reconciliation Australia 2022; Shepherd et al. 2017; Thurber et al. 2022; Thurber et al. 2021a; Thurber et al. 2021b; Wright et al. 2022).

Another poorly recognised fact is that the health of Aboriginal and Torres Strait Islander peoples is the worst of any Indigenous people of any Western democracy (Anderson et al. 2016; Ring & Brown 2003). Indigenous people were healthier than their European counterparts as colonisation began (Gee et al. 2014). The health inequities evident today are the outcomes of colonisation and sustained racism, and how racism operates within the health sector and across the social and cultural determinants of health (Thurber et al. 2022; Priest et al. 2021).

Freedom from racism is a fundamental human right for Indigenous peoples (United Nations 2007). Addressing, preventing and eliminating racism is essential for reducing the burden of disease and increasing the quality of life of Aboriginal and Torres Strait Islander peoples. A recent paper argued that a high proportion of the gap in health outcomes between non-Indigenous and Aboriginal and Torres Strait Islander peoples relates to racism:

> *The recent report on the Closing the Gap targets from the Australian Institute of Health and Welfare...attributes 53% of the health gap between non-Indigenous Australians and Aboriginal and Torres Strait Islander people to the social determinants of health and risk factors. The remaining 47% of the health gap may be attributed to* ***institutional racism, interpersonal racism*** *and intergenerational trauma (Bourke, Marrie H. & Marrie A. 2019:613 emphasis added).*

Figure 2: What accounts for the gap in health outcomes between Aboriginal and Torres Strait Islander and non-Aboriginal Australians?

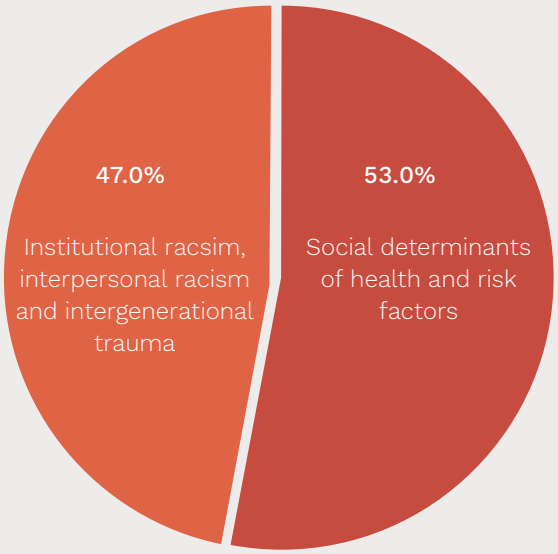


Figure 2 demonstrates the Australian Institute of Health and Welfare (AIHW) outcomes. However, as the social determinants of health include access to socioeconomic resources, which are driven by systemic racism, these outcomes understate the extent of racism's impact on health outcomes for Aboriginal and Torres Strait Islander peoples (Priest et al. 2021).

Racism and cultural safety

Cultural safety is increasingly being recognised as a pre-condition for Aboriginal and Torres Strait Islander peoples being able to access and benefit from the range of opportunities, programs and services available in our society, including in health and human services sectors. This recognition is due to the dedicated and consistent advocacy of national Aboriginal and Torres Strait Islander organisations, individual Aboriginal and Torres Strait Islander people and, in some instances, non-Indigenous allies.

The definition of cultural safety is described in detail in the 'Key terms and concepts' section below. In brief, it is understood as an experience that Aboriginal and Torres Strait Islander peoples have where the presence or absence of cultural safety can only be determined by them (Gollan & Stacey 2018; Mohamed et al. 2021; Mohamed & Stacey 2017; Walker, Schultz & Sonn 2014).

> *Cultural safety is not something that the practitioner, system, organisation or program can claim to provide, but rather it is something that is experienced by the consumer/client (Walker, Schultz & Sonn 2014:201).*

Further to this:

A culturally safe environment exists if Aboriginal and Torres Strait Islander peoples report that:

- *their experiences are believed and validated*
- *their cultures are centred and valued in policy development, research, evaluation and service design and delivery*
- *they feel welcomed and respected in policy, research, evaluation and service environments*
- *they see other Aboriginal and Torres Strait Islander people working [in positions of power and authority] within the policy, research, evaluation or service context*
- *they do not experience any form of racism in policy, research, evaluation and service contexts or processes* (Mohamed et al. 2021:6).

Cultural safety is not experienced in the presence of racism. Addressing cultural safety is not a way of avoiding engagement with racism. Addressing, preventing and eliminating racism is at the heart of cultural safety work, coupled with ensuring Indigenous ways of knowing, being and doing are recognised, valued and enacted. Therefore, eliminating racism and improving cultural safety is central to improving social, emotional, spiritual, cultural, and physical health and wellbeing outcomes for Aboriginal and Torres Strait Islander peoples. It will have positive impacts across the social and cultural determinants of health.

Critically, racism will not be addressed just through a focus on cultural safety. It will require a multi-pronged anti-racism approach to intervene across all levels and forms of racism (Priest et al. 2021; Watego, Singh & Macoun 2021). Whatever strategies are implemented, they need to be hard-wired into interlocking systems and measured to ensure accountability and the quality of the intervention (Bainbridge et al. 2015; CATSINaM 2014a; Mohamed 2016a; Tremblay et al. 2023).

A useful piece of the picture, however, is having nationally recognised standards for cultural safety ***training*** that occurs outside of the tertiary education environment and creating shared language and understanding of all forms of racism that need to be tackled across the existing health and human services workforce.

Racism and cultural safety: interlinked and interdependent

Hall et al. (2023:2) emphasise how addressing racism and cultural safety is interlinked and interdependent for Aboriginal and Torres Strait Islander peoples in the context of colonisation:

'Use of the terms Aboriginal and Torres Strait Islander Health and 'cultural safety' may more accurately represent the aspirations of Aboriginal and Torres Strait Islander peoples' perceptions of culturally safe healthcare, and thereby encompass Aboriginal and Torres Strait Islander peoples' unique experience of colonisation and subsequent racism, including pervasive contemporary institutional racism.'

Advocacy for cultural safety across health in Australia

At an individual level, Aboriginal and Torres Strait Islander people working across a range of roles in the health sector have advocated for cultural safety in health. Over time, this shaped into collective national movements. This section focuses on this national level advocacy, while acknowledging there have been long-standing and ongoing advocacy efforts at jurisdictional and individual health network or service levels.

Early advocacy for cultural safety in the health sector

Led by Dr Sally Goold of the Congress of Aboriginal and Torres Strait Islander Nurses, or CATSIN, the Indigenous Nursing Education Working Group's (2002) seminal *'gettin em n keepin em'* report on the recruitment and retention of Aboriginal and Torres Strait Islander nurses was one of the earliest national reports in Australia to directly address cultural safety. It endorsed the definition of cultural safety initially articulated by Irihapeti Ramsden, a Māori nurse, who was central to naming and advocating for cultural safety with the New Zealand Nursing Council (Ramsden 1996).

Ramsden's advocacy resulted in the Nursing Council of New Zealand approving guidelines on cultural safety in 1992 that Ramsden originally wrote in 1991. They were initially released in 1995 and updated on several occasions. These guidelines defined cultural safety as:

> *The effective nursing practice of a person or family from another culture...The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual (Nursing Council of New Zealand 2011:7).*

At this time in Australia, cultural safety was not part of nursing and midwifery or any other health professional accreditation and registration standards, although early steps towards this had been taken. The National Aboriginal and Torres Strait Islander Health Council (NATSIHC) initiated the seminal report, *A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people* (2008), under the leadership of Dr Mark Wenitong and Associate Professor Gregory Phillips, funded by the Department of Health and Ageing. It raised culturally safe learning and employment environments and cultural safety training for staff in education institutions and health services as key priorities.

In a similar timeframe the harmonisation of health practitioner registration and accreditation was occurring, leading to establishment of the National Accreditation and Registration Scheme for health professionals. During this process, the National Aboriginal Community Controlled Health Organisation (NACCHO) recommended in their 2009 submission that:

- Aboriginal and Torres Strait Islander Health Workers and Health Practitioners become part of the National Accreditation and Registration Scheme for health professionals
- cultural safety be embedded into the scheme's legislation, noting that other countries had done this work.

During the same period, the Australian Government announced the Indigenous Chronic Disease Package, and specifically an Indigenous Health Incentive within the Medicare Practice Incentives Program (PIP). In March 2010, the PIP Indigenous Health Guidelines became available and stated 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 (Department of Health 2010:3).*

The Royal Australian College of General Practitioners (RACGP) was funded by the Department of Health to develop an online course that would meet the cultural awareness training requirement to register with the PIP. Fourteen years later, the RACGP continues to offer the six-hour online cultural awareness module and the 2023 version of the Indigenous Health PIP guidelines retains the same requirement (Department of Health 2023). Simultaneously, the RACGP developed 'educational criteria' for cultural awareness education and cultural safety training (RACGP 2011), which covered program length, delivery, evaluation, and mandatory content. The criteria were linked to its continuing professional development program.

NACCHO believed that understanding what the difference was between various forms of cultural training was critical for the health sector and, further, that Aboriginal and Torres Strait Islander organisations were the ones best equipped to set training standards. This situation was a strong impetus for the original NACCHO Cultural Safety Training Standards (2011) project. As the people impacted by its absence, it is only Aboriginal and Torres Strait Islander people who can determine if cultural safety is present; hence the project was Aboriginal and Torres Strait Islander-led.

NACCHO initiated a project to create national cultural safety training standards in 2010. The goal was 'to achieve recognition of the NACCHO CST Standards as the national benchmark for quality Aboriginal cultural safety training for the health workforce and other relevant sectors' (NACCHO 2011:2). Further, it would make it more possible to measure training outcomes.

> *NACCHO and its Affiliates [wanted]...to be in a position where there are ACCH (Aboriginal Community Controlled Health) Sector developed and endorsed standards that define the minimum requirement of and conditions of cultural safety training, as...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 (NACCHO 2011:2).*

The NACCHO CST Standards initiative, as a co-design process with its jurisdictional Affiliates over 2010–11, resulted in:

- a background paper
- defining minimum requirements of and conditions of cultural safety training delivered to organisations across five elements, whether they were Aboriginal and Torres Strait Islander or non-Indigenous organisations
- proposed the process by which training providers could achieve accreditation against the standards.

At this point, no further funding could be secured to move to the next stage of implementing the accreditation process, which meant the standards were not promoted and the initiative could not reach its full potential.

Cultural safety in nursing and midwifery curriculum

In November 2014, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM 2014a) held a National Cultural Safety Summit for the profession, facilitated by Associate Professor Gregory Phillips (2015) for ANMAC, Schools of Nursing and Midwifery and Aboriginal and Torres Strait Islander nursing and midwifery leaders. At that point, ANMAC did not have a consistent approach to including cultural safety content across their accreditation standards for registered nurses, enrolled nurses, midwives, and nurse practitioners. Resolving this, along with ensuring cultural safety was understood and implemented across the profession, was the primary purpose of the summit.

The Summit resulted in a formal agreement to undertake a scoping project for a Leaders in Nursing and Midwifery Education Network (LINMEN), akin to the already established Leaders in Medical Education Network (LIME), which occurred through the leadership of Associate Professor Gregory Phillips (2015). This led to ANMAC becoming a key partner with CATSINaM, along with the Council of Deans of Nursing and Midwifery Australia and New Zealand (CDNM), in funding and undertaking a scoping project in 2015.

While LINMEN gained strong support across nursing and midwifery national bodies, with endorsement of its goal 'to improve the quality of cultural safety education and training for students and educators in nursing and midwifery' (CATSINaM 2017a), it took two years of sustained advocacy to achieve its establishment in mid-2017. LINMEN continues today.

In the interim, CATSINaM led development of a complementary document to the Aboriginal and Torres Strait Islander Health Curriculum Framework over 2016-2017, with support from ANMAC and CDNM, to enhance uptake and implementation of Aboriginal and Torres Strait Islander health, history, culture and cultural safety curriculum across Schools of Nursing and Midwifery (CATSINaM 2017c). This inspired other professions to follow suit, for example, the Optometry Council of Australia and New Zealand (OCANZ 2018).]

Advocacy in health professional curriculum

An important development in promoting action on cultural safety was the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Framework) that was released by the Federal Department of Health in September 2015 (Department of Health 2014). The Framework was designed to support higher education providers to:

> *..implement Aboriginal and Torres Strait Islander health curricula across their health professional training programs. Developed with extensive input and guidance from a wide range of stakeholders around Australia, the Framework aims to prepare graduates across health professions to provide culturally safe health services to Aboriginal and Torres Strait Islander peoples through the development of cultural capabilities during their undergraduate training (Department of Health 2014: Section 1:4).*

The Framework had a strong focus on cultural safety and advocated for specific curriculum content on cultural safety. It is not a set of standards against which programs are accredited. Rather, it provides guidance for national health professional accreditation councils who have this role, for example, Australian Nursing and Midwifery Council (ANMAC), Australian Medical Council (AMC), Optometry Council of Australia and New Zealand (OCANZ), et cetera. Over time, due to advocacy from national Aboriginal and Torres Strait Islander health professional organisations, many accreditation councils have aligned their professional accreditation standards for pre-registration education with the Framework guidelines.

Meanwhile, universities delivering pre-registration courses for health professions were encouraged to use the Framework to ensure they meet and/or exceed the accreditation and registration guidelines for their profession in relation to Aboriginal and Torres Strait Islander health and cultural safety.

More recently, the 2014 Framework (Department of Health 2014) underwent a thorough review as part of developing cultural safety curriculum content with relevance across the health professions – see Hall et al. (2023) for a detailed account. It includes a diagram that maps the journey of what is involved in developing Aboriginal and Torres Strait Islander health and cultural safety education and training in health professional curriculum, and the intersections with the National Registration and Accreditation Scheme.

Advocacy in health professional registration

A strong and consistent relationship that is vital for cultural safety to gain traction in health is the one between health professional curriculum, health professional registration, and health service standards. This section focuses on registration.

As noted above, NACCHO addressed this in its advocacy for cultural safety to be embedded in the National Accreditation and Registration Scheme for health professionals in 2009. This scheme is overseen by the Australian Health Practitioners Regulation Agency (Ahpra). National Aboriginal and Torres Strait Islander health professional bodies continued to advocate for embedding cultural safety in the following years, such as CATSINaM (2014a, 2017b), the Australian Indigenous Doctors' Association (AIDA 2013), the Indigenous Allied Health Australia (IAHA 2015), and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWA 2013).

In December 2016, CATSINaM took this a step further and directly lobbied the Hon. Sussan Ley, Minister for Health and Aged Care at the time, to embed cultural safety into health practitioner regulation law:

> *The blueprint for our accreditation and registration scheme is the 'Health Practitioner Regulation National Law Act 2009'. It is silent on cultural safety, even though concern about racism and the lack of cultural safety in health care has been formally expressed at a national level ever since the 1989 National Aboriginal Health Strategy, and legislative models from like countries were available for consideration prior to the development of the 2009 Act.*
>
> *The standout example is the 'New Zealand Health Practitioners Competence Assurance Act 2003'. It charges health profession regulation authorities with the function "to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession" (p. 95). This would systemically embed the requirement that in order to achieve and maintain registration, health professionals must provide evidence they have been trained in and can demonstrate capacity to provide culturally safe health care.* (Mohamed 2016b:1-2)

This created further impetus for Ahpra to take dedicated action on cultural safety and laid the groundwork for eventual legislative change. It was bolstered by the outcomes of an independent review into Accreditation Systems within the National Accreditation and Registration Scheme by Professor Michael Woods (2017:79) – for example:

> *Safety and quality and cultural safety and awareness are key competencies for all practitioners and should be included within competency standards. Standardised and mandated references would ensure implementation through appropriate health practitioner education and training.*

In 2017, Ahpra commenced a project that led to a national strategy to embed cultural safety within health professional registration, working closely with national Aboriginal and Torres Strait Islander health organisations, professional associations, academics, and stakeholders and facilitated by Dr Gregory Phillips (Ahpra 2020).

In 2020, Ahpra launched its A*boriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* to achieve nationally consistent standards, codes and guidelines across all registered health practitioners in Australia in relation to cultural safety, which included the Aboriginal and Torres Strait Islander Health Practitioner Board. The plan set a clear direction and course of action for Ahpra, National Boards and Accreditation Authorities, who together regulate Australia's 740,000 registered health practitioners. The stated vision was:

> *Patient safety for Aboriginal and Torres Strait Islander Peoples is the norm. We recognise that patient safety includes the inextricably linked elements of clinical and cultural safety, and that this link must be defined by Aboriginal and Torres Strait Islander Peoples* (Ahpra 2020:7).

One of the Ahpra plan's strategies was to 'recommend and advocate change to the **National Law** to ensure consistency in cultural safety for Aboriginal and Torres Strait Islander People' (Ahpra 2020:10, original emphasis) and achieve this by July 2021. Ultimately this change in legislation occurred in October 2022, whereby cultural safety for Aboriginal and Torres Strait Islander Peoples became both an objective and a guiding principle (Queensland Government 2022a).

Cultural safety in nursing and midwifery registration standards

Prior to Ahpra's project coming to fruition, strong advocacy by CATSINaM led to the nursing and midwifery profession being the first health profession to endorse cultural safety in their national registration standards and code of conduct in 2018. This was not without challenges, as it generated a notable negative response from individual nurses and midwives in relation to the Nursing and Midwifery Board of Australia (NMBA) definition of cultural safety, which reflected the CATSINaM definition (2014b) and the recognition of white privilege (Sherwood & Mohamed 2020).

Despite this pressure, which gained national media coverage, the NMBA along with several national nursing and midwifery peak organisations and their boards stood strong alongside CATSINaM and were united in taking the professions forward. This led the way for all remaining registered health professionals nationally.

By mid-2022, all National Boards under Ahpra developed a common Code of Conduct under Section 39 of the National Law to protect the public. Principle 2 of the Code of Conduct is Aboriginal and Torres Strait Islander Health and Cultural Safety. It states that:

'practitioners should consider the specific needs of Aboriginal and Torres Strait Islander Peoples and their health and cultural safety, including the need to foster open, honest and culturally safe professional relationships' (Ahpra & National Boards 2022:4).

The new objective is:

> *..to build the capacity of the Australian workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples (Queensland Government 2022a:34).*

The new guiding principle is:

..the Scheme is to ensure the development of a culturally safe and respectful workforce that:

- *is responsive to Aboriginal and Torres Strait Islander Peoples and their health*
- *contributes to the elimination of racism in the provision of health services* (Queensland Government 2022a:34).

This has implications for all professions in terms of their Codes of Conduct and Codes of Ethics to ensure they separate conflation between a focus on cultural diversity, where Aboriginal and Torres Strait Islander people's diversity is combined with culturally and linguistically diverse communities, and cultural safety within individual and institutional health practice (Milligan et al. 2021).

Advocacy in health services

Culturally safe healthcare is essential for clinically safe healthcare; otherwise Aboriginal and Torres Strait Islander people will not stay in healthcare systems, particularly mainstream health systems. This has been regularly emphasised in recent years (Ahpra 2020; Brown et al. 2016; Gatwiri, Rotumah & Rix 2021; Geia et al. 2020; Hall et al. 2023; Sherwood & Mohamed 2020; Power, Geia & Adams et al. 2021; Power, Geia & Wilson et al. 2022; Sweet 2017). Equally, research and evaluation in health and human services must ensure a focus on cultural safety (Clark et al. 2020; Gollan & Stacey 2021a).

A significant development towards cultural safety in health services was the 2nd edition of the *National Safety and Quality Health Service Standards* (NSQHSS), released in 2017 and updated in 2021 (Australian Commission on Safety and Quality in Health Care 2017). This edition included a clearer focus on Aboriginal and Torres Strait Islander health. Once again, these inclusions were the result of strong and sustained advocacy from national Aboriginal and Torres Strait Islander health organisations and health professional associations, as well as other notable practitioners and academics (Laverty, McDermott & Calma 2017).

However, although the revised NSQHSS refer to culturally safe health services, the language used in the standards is 'cultural competency' and 'cultural awareness'. For example, 'Clinical performance and effectiveness' is one of the eight standards. Within the 'Safety and quality training' component, the stated standard is:

> *1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (Australian Commission on Safety and Quality in Health Care 2017:10).*

In the lead-up to the NSQHSS update, CATSINaM had advocated for cultural safety to be embedded in the standards (CATSINaM 2014a) and provided direct advice in 2017 on how to do this, along with later professional development on implementing the NSQHSS with a cultural safety lens. Although the NSQHSS supporting documents use the term cultural safety, the failure to use it in the standard itself contributed to existing concerns about the impact of a lack of consistency and clarity in language in the health sector (Sweet 2017).

While this opportunity to instate cultural safety within health service standards was missed, further developments in Aboriginal and Torres Strait Islander

national health policy and strategies started to turn the corner. These developments were underpinned by the policies, position statements, frameworks and/or resources of many national Aboriginal and Torres Strait Islander health organisations (AIDA 2013; CATSINaM 2014b, 2016, 2017b, 2017c, 2022; IAHA 2013, 2015, 2019; NAATSIHWA 2013). Collectively, they focus on addressing racism and strengthening cultural safety in health services, growing the Aboriginal and Torres Strait Islander health workforce and improving Aboriginal and Torres Strait Islander health outcomes.

Further, a core focus area in NACCHO's *National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023* is: 'cultural safety is embedded in organisational culture and supported through effective governance, policies and procedures' (2018:8).

During the refresh of major national strategies early in the current decade, Aboriginal and Torres Strait Islander organisations represented on the National Health Leadership Forum (NHLF) and the Coalition of Peaks advocated for cultural safety to be more prominent in strategic directions, objectives, and strategies, as well as directly naming the presence of and need to address racism that have appeared in earlier national plans (Department of Health 2013). This is now evident in the:

- *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* (NATSIHP) (Department of Health 2021)
- *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* (NATSIHWSF) (Department of Health 2022)
- *National Agreement on Closing the Gap* (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & all Australian Governments 2020).

Efforts are also being made to monitor cultural safety in healthcare, such as the Australian Institute of Health and Welfare's Cultural safety in healthcare for Indigenous Australians: monitoring framework (2023). However, there remain significant limitations and data gaps, as this work relies on existing national and state and territory level sources, which include national administrative data collections and Indigenous healthcare user surveys, as well as proxy indicators of cultural safety.

Advocacy for cultural safety training standards

NACCHO was the first national Aboriginal and Torres Strait Islander health organisation to advocate for standards that would apply to cultural safety training delivered outside of the tertiary education environment. As noted earlier, this became the original 2010–11 NACCHO CST Standards initiative. In 2020, Lowitja Institute sought to re-invigorate this work with NACCHO's permission through the Lowitja Institute Accreditation of CST Standards initiative. This was influenced by six factors:

- First, it was no longer possible to access the NACCHO CST Standards easily as they were no longer available on NACCHO's website or in any other online website location.
- Second, since 2011 there has been growth in awareness of cultural safety and cultural safety training as distinct from other forms of cultural training, developments in the evidence base for cultural safety and greater recognition of the importance of cultural safety within key national documents, as described above.
- Third, while the inclusion of cultural safety within health professional curriculum has moved ahead (see the 'Advocacy in health professional

curriculum' section), most of the workforce across health and other sectors relevant to the social and cultural determinants of health have not been impacted by these important developments in health professional curriculum.

- Fourth, despite cultural safety becoming embedded in health professional curriculum standards, assessors for national health professional curriculum authorities may not be directly trained in cultural safety, so may not be equipped to assess the adequacy of university offerings.
- Fifth, no standards have been developed and promoted for cultural safety training that occurs outside of the tertiary education environment, with exception of the Cultural Safety Training Standards for Midwifery (CATSINaM & ACM 2019), in which both primary authors were centrally involved. This contextualised the original NACCHO CST Standards (2011) for the midwifery profession, rather than for the broad health and human services workforce.
- Sixth, there is no cultural safety specific accreditation process for cultural safety training accessed across health and other sectors relevant to the social and cultural determinants of health.

In summary, reflecting on this history of advocacy for cultural safety, it is apparent that the reason behind the impetus for creating cultural safety standards, remains the reason why we still need them. Many of the early movements from the late 2000s and early 2010s have progressed, but cultural safety standards that sit outside of tertiary curriculum have not while being a large piece of the puzzle for embedding cultural safety in health and human services. Further, new cultural concept/training language has emerged throughout this period, yet confusion remains across the health and human services sectors about what exactly it means.

Key terms and concepts

While there has been growing understanding of cultural safety, different terms have been and continue to be used to describe this type of training. Training terms with currency in Australia include:

Confusion remains about the critical distinctions between these terms which are often used interchangeably (CATSINaM 2014b; IAHA 2019). This section of the paper explains the different emphasis and potential impact of these training terms. The Appendix offers another way of distinguishing between the different cultural terms that have been or are in use across Australia without specific reference to training.

Several other terms are in circulation in Australia – unconscious bias, cultural proficiency, cultural humility, and cultural ease – which are not included in this paper (Curtis et al. 2019). In brief, unconscious bias is a practice of racism that is learned via cultural racism and translated individually through racial prejudice and racial discrimination. However, the concept is ***not specific*** to racism, as it applies to other forms of power inequities or oppressions. Cultural proficiency tends to be used interchangeably with cultural competence. Cultural humility or cultural ease have greater currency in the US, although it is occasionally referred to by Australian authors and trainers.

Cultural awareness

Cultural awareness training has been offered since the late 1980s (NACCHO 2011), when the first National Aboriginal Health Strategy was being developed and released (National Health Strategy Working Party 1989). The predominance of this term continues and is often considered to be the only training required, rather than an essential but first training experience. This is despite efforts by Aboriginal and Torres Strait Islander health organisations to educate the health and human services sectors on the need to also undertake cultural safety training (for example, AIDA 2013; CATSINaM 2014a, 2014b, 2016, 2017b, 2017c; IAHA 2013, 2015, 2019; NATSIHWA 2013), and by training facilitators and advocates (for example, Gollan & Stacey 2018, 2021a; Mohamed & Stacey 2017; Mohamed et al. 2021; Phillips 2015).

Mohamed and Stacey (2017: slide 11) describe the focus of cultural awareness training as:

- *Raising the awareness and knowledge of participants about the experiences of cultures different from their own – in particular, different from the dominant culture*
- *If racism is in fact named, the focus is put on individual acts of racial prejudice and racial discrimination rather than racism as it is embedded in systems*
- *It may provide historical overviews, but the focus is on the individual impact of colonisation, rather than the inherent embedding of colonising practices in contemporary health and human services institutions*
- *It maintains a lens on the 'other' rather than a clear self-reflective focus for participants – people attend to learn about Aboriginal and/or Torres Strait Islander people and culture, not about themselves*
- *It does not usually ask non-Indigenous participants to engage in critical self-reflection about themselves, their culture and how racism is embedded at an institutional level.*

This is consistent with NACCHO's definition (2011) and other definitions found in the literature (Bainbridge et al. 2015; Downing, Kowal & Paradies 2011; Phillips 2015; Phiri, Dietsh & Bonner 2010; Walker, Schultz & Sonn 2014; Universities Australia 2011).

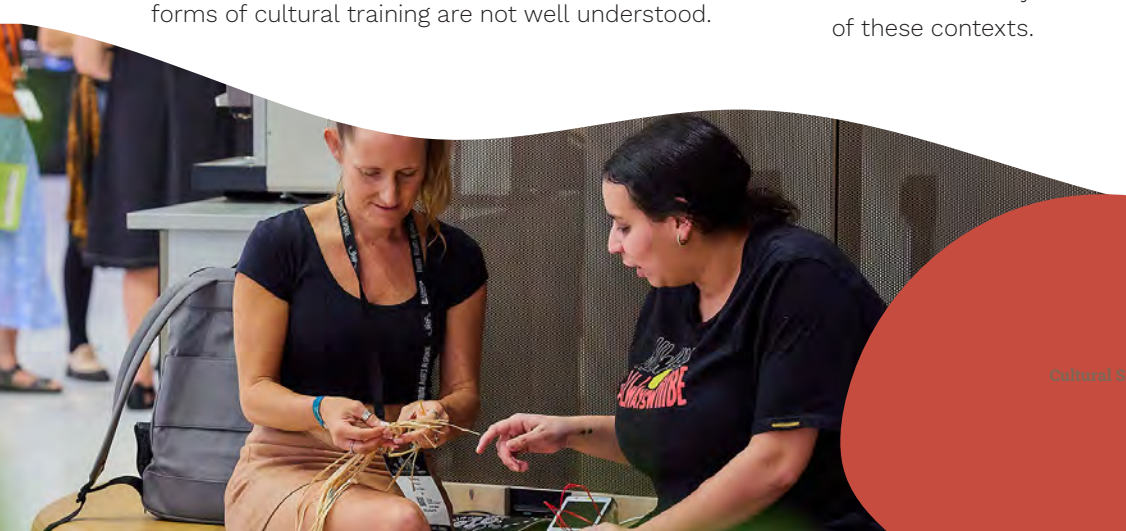
The literature confirms the experience of the authors that while cultural awareness is the most familiar term and commonly requested type of cultural training, the distinctions between this and other forms of cultural training are not well understood.

Cultural sensitivity

Cultural sensitivity is a less frequent description for Aboriginal and Torres Strait Islander focused cultural training in Australia, although Aboriginal and Torres Strait Islander cultural trainers may occasionally use the term as a stand-alone description for their training or in combination with cultural safety. The review identified it was commonly used in other countries, particularly the US and Canada, and in Australia it was mostly associated with culturally and linguistically diverse communities.

In the literature, cultural sensitivity is described as extending beyond cultural awareness. It encourages participants to engage in self-reflection, particularly on personal attitudes and experiences, biases, and prejudices they may hold, and how this may impact their communication and interaction with people outside of their culture (Bainbridge et al. 2015; Downing, Kowal & Paradies 2011; Phiri, Dietsh & Bonner 2010; Universities Australia 2011). Cultural differences are legitimated, and people must take them into account, so they provide empathic and appropriate services and/or care. This is consistent with what was identified in NACCHO's (2011) background paper.

Cultural sensitivity training 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 and Torres Strait Islander peoples, and how that may contrast with their experiences as non-Indigenous people, there is a stronger focus on the individual and personal, rather than the systemic and institutional nature of these contexts.



Cultural security

The concept of cultural security was initially put forward in Western Australia by Shane Houston (2001:3):

> *Cultural Security is a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, 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.*

It was taken up by others working in Aboriginal and Torres Strait Islander health, including Thomson (2005) and Coffin (2007). Coffin proposed that organisations should build cultural awareness so they could address cultural safety and create cultural security, and these were different concepts that should not be interchanged. Farrelly and Lumby (2009:14) emphasised that:

> *Cultural Security is built from the acknowledgement that theoretical 'awareness' of culturally appropriate service provision is not enough. It shifts the emphasis from attitudes to behaviour, focusing directly on practice, skills and efficacy. It is about incorporating cultural values into the design, delivery and evaluation of services. Cultural Security recognises that this is not an optional strategy, nor solely the responsibility of individuals, but rather involves society and system levels of involvement.*

Therefore, cultural security shifts the focus from individual practitioners or staff to the health and human services systems in which they operate, and the decisions and actions of government and non-Indigenous parties (Australian Human Rights Commission 2011; Coffin 2007). Specifically, it is how systems ensure that the rights of Aboriginal and Torres Strait Islander peoples to high quality services that result in better outcomes, are met through the consideration and incorporation of culture in policy and practice.

Cultural security is more likely to be used in the Northern Territory and Western Australia as a critical concept to operationalise (NT Health 2016a, 2016b; WA Department of Health 2015), and occasionally in other contexts (Lock et al. 2019). The Commissioner for Children and Young People WA describes cultural awareness, cultural competence and cultural safety as 'steps towards providing cultural security' (Commissioner for Children and Young People Western Australia 2018:19). There is limited information on cultural security training as such. The Northern Territory and Western Australian documents refer to cultural training, but use a variety of terms, including cultural awareness, cultural safety or cultural competence training, as strategies for working towards cultural security.

Cultural respect

When the NACCHO (2011) background paper was written, cultural safety and cultural respect were terms being used more consistently at a national level within the health sector, frequently interchangeably or together. While this continues to occur, there has been a concerted effort over the past decade to elevate the term cultural safety while acknowledging that cultural respect is critical to cultural safety being achieved.

Cultural respect remains nationally prominent as a term through the *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander*

Health (AHMAC's National Aboriginal and Torres Strait Islander Health Standing Committee 2016b). This is an updated version of a document originally developed in South Australia and adopted nationally from 2004–09 (AHMAC's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004).

The aim of the current *Cultural Respect Framework* is to 'support the corporate health governance, organisational management and delivery of the Australian health system to further embed safe, accessible and culturally responsive service' (AHMAC's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004:4). It describes the outcomes and benefits as:

> *Embedding cultural respect, through cultural safety and responsiveness, into the design, delivery and evaluation of health services supports:*
>
> - *improved health outcomes and equality*
> - *more timely, efficient and effective services*
> - *financial benefits and efficiencies*
> - *a diversely skilled and dynamic workforce*
> - *a reduction in experiences of racism and discrimination*
> - *improved consumer and community satisfaction.*

The terms cultural safety, or cultural safety and responsiveness, are used repeatedly throughout the *Cultural Respect Framework*. It advocates that adequate budget and resources are allocated to providing cultural safety and responsiveness training for health staff across all levels and disciplines.

The review showed that the term cultural respect is frequently used for training focused on culturally and linguistically diverse Australians. When it is focused on Aboriginal and/or Torres Strait Islander peoples, it is used as a stand-alone description in a few contexts by some private providers and consistently in NSW Health (Centre for Epidemiology and Evidence and Centre for Aboriginal Health 2019; NSW Ministry of Health 2015, 2020, 2022). In another context, the combined term 'cultural safety and respect training' is used but the focus is on the concepts outlined under cultural safety training (Gollan & Stacey 2018).

Cultural competence

Cultural competence first came to prominence though the work of Terry Cross and colleagues within the childcare system in the US during the late 1980s (Cross et al. 1989). They defined it as 'a set of congruent behaviors [sic], attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations' (Cross et al. 1989, cited in Thackrah & Thompson 2013:35). They viewed it as a developmental process for both individuals and organisations along a continuum of cultural incompetence to cultural knowledge, cultural awareness, cultural sensitivity, cultural competence, and cultural proficiency (Curtis et al. 2019; Walker, Schultz & Sonn 2014).

The concept of Indigenous cultural competence has and continues to have currency at national and jurisdictional levels in Australia, although it is used alongside or interchangeably with cultural awareness and cultural responsiveness, as well as cultural safety. The following are a few examples of how this occurs.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Commonwealth of Australia 2017) refers to 'culturally appropriate' services, meaning they are culturally

competent and culturally safe. It suggests that 'cultural competencies are a skill set that can be gained by experience working with Aboriginal and Torres Strait Islander people and by training module' (Commonwealth of Australia 2017:15), which can be gained by developing cultural awareness, cultural respect, and cultural responsiveness. This document also frequently refers to cultural safety and culturally safe services.

For many years, cultural competency was an element tracked in national monitoring of Aboriginal and Torres Strait Islander health, through the *Aboriginal and Torres Strait Islander Health Performance Framework* (as part of 'Tier 3: Health system performance'). This shifted in 2019 to track the experience of cultural safety for Indigenous patients and staff in the health workforce, alongside the development of the *Cultural safety in health care for Indigenous Australians: monitoring framework*, which is now in its fifth year (AIHW 2023). However, many of the same sources are used and AIHW reports that measurement is 'limited by a lack of national and state level data' (AIHW 2024:3), with a reliance on proxy measures.

The SA Health (2017) *Aboriginal Cultural Learning Framework*, which remains the current guiding document in that state, refers to both cultural awareness and cultural competence, although includes elements regularly associated with cultural safety training. Both terms were included in the revised 2nd edition *National Safety & Quality Health Service Standards* (ACSQHC 2018) within the 'Clinical performance and effectiveness' section, despite advocacy at the time to focus on cultural safety, as outlined in the 'Advocacy in health services' section of this paper.

The Australian Commission on Safety and Quality in Health Care (ACSQHS) approach has impacted on other new tools designed to improve Aboriginal and Torres Strait Islander health outcomes through individual health staff and health systems changes. For example, the NSW Ministry of Health (2020) released an *Aboriginal Cultural Engagement Self-Assessment Tool* that is mapped to the 2nd edition *National Safety & Quality Health Service Standards*.

In 2011, Universities Australia adopted it for its N*ational Best Practice Framework for Indigenous Cultural Competency in Australian Universities*, applying it across themes such as governance, teaching and learning, research capacity, human resource management and external engagement. This document incorporated cultural safety as part of the process of developing cultural competence, but it was unclear whether it engaged with both the individual and institutional application of cultural safety.

This positioning appeared to be influential, as Indigenous or Aboriginal and Torres Strait Islander cultural competence was adopted within university curriculum and professional development for existing professionals, especially for health and human services professions (for example, Flavell, Thackrah & Hoffman 2013; Fredericks & Bargallie 2016; Jongen et al. 2017). It was also applied to working with a diverse range of cultural groups, consistent with its US roots (Fialho 2013). Achieving cultural competence was described as requiring a strong focus on critical thinking and self-reflection by training participants – as individuals and members of the dominant culture (Universities Australia 2011, Walker, Schultz & Sonn, 2014). Walker, Schultz and Sonn (2014:201) commented how this includes engaging with concepts of white privilege and whiteness. They also believe 'while cultural competence contributes to a service recipient's experiences, cultural safety is an outcome'.

A decade since releasing the *National Best Practice Framework for Indigenous Cultural Competency in Australian Universities*, Universities Australia, via the *Indigenous Strategy: 2022–2025* (2022), has made a shift towards cultural safety, which may have a similar influential impact. The strategy includes three

racism and cultural safety commitments with the first two being:

- *Universities develop and implement an Indigenous-specific anti-racism strategy*
- *Cultural safety training provided to all staff, which includes addressing impacts of dominant culture on Indigenous people and addresses more subtle forms of racism* (Universities Australia, 2022:49)

There is a variation of opinion in Australia and Aotearoa New Zealand about the utility and appropriateness of the term cultural competence compared to cultural safety (Curtis et al. 2019; Department of Health 2014; Flavell, Thackrah & Hoffman 2013; McMillan 2013; Nakata 2007; Phillips 2015). The critique is less focused on the content and more on framing the goal as competence.

One line of critique is that cultural competence is not specific to First Nations people. It is commonly applied in a culturally and linguistically diverse context in Australia (Federation of Ethnic Communities' Councils of Australia 2019; Jongen et al. 2017). This can result in conflation between the distinct experiences and needs of Aboriginal and Torres Strait Islander peoples as a consequence of colonisation, compared to people from culturally and linguistically diverse backgrounds outside of the dominant culture who have come to live here since invasion and colonisation.

Another line of critique is that non-Indigenous people becoming culturally competent in Aboriginal and Torres Strait Islander cultures is not a realistic goal.

There is enormous diversity amongst Aboriginal and Torres Strait Islander peoples. Cultural competence implies that competence can be achieved. This contrasts with the understanding that working towards cultural safety is a life-long journey (Sherwood & Mohamed 2020) and overlooks the significant interruption to cultural practices and knowledges caused by colonisation, where some aspects of culture have been lost for some or many Aboriginal and Torres Strait Islander nations. Thus, aspiring to cultural competence within their own cultures can be challenging for Aboriginal and Torres Strait Islander peoples. It is impossible for non-Indigenous people to achieve this (CATSINaM 2014b; Taylor et al. 2014).

Critical distinction between cultural competence and cultural safety

Aotearoa New Zealand-based academics Curtis et al. (2019:1) state a critical distinction between cultural competence and cultural safety that is equally relevant in the Australian context:

'Health practitioners, healthcare organisations and health systems need to be engaged in working towards cultural safety and critical consciousness. To do this, they must be prepared to critique the "taken for granted" power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming "competent" in the cultures of others'.

Cultural capabilities

The term cultural capabilities in the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Department of Health 2014, updated in 2021:2) refers to 'behaviours and understanding that go beyond particular knowledge and skills'. Following a review of the literature on developing Aboriginal and Torres Strait Islander cultural capabilities in health graduates (Taylor et al. 2014), five graduate cultural capabilities were identified: respect, communication, safety and quality, reflection, and advocacy.

This language was chosen in contrast to cultural competencies because:

> *..having cultural competencies can imply a finite set of learning outcomes that can be transferred across a range of different cultural contexts. Yet this is unrealistic, as Aboriginal and Torres Strait Islander cultures are too nuanced for a set of measurable competencies to be either defined or applicable to the diversity of Aboriginal and Torres Strait Islander cultural contexts* (Department of Health 2014, updated in 2021:2).

The *Aboriginal and Torres Strait Islander Health Curriculum Framework* describes 17 curriculum content themes. Two themes are 'Cultural safety in health care: Terminology and definitions' and 'Culturally safe communication' (Department of Health 2014:2). Several desired learning outcomes are to "enhance cultural safety" in health service delivery. In fact, cultural safety for Aboriginal and Torres Strait Islander students, staff, and clients during placements is discussed at length in the section on implementation of the Framework. There are adaptations of the Framework customised for a specific professional group that shift from cultural capabilities to describing curriculum content linked to the core elements of cultural safety (for example, CATSINaM 2017c; OCANZ 2018).

Cultural capabilities have and continue to be used in the context of professional development training, which features strongly across Queensland Government. For example, the 2020-2033 Queensland Health *Aboriginal and Torres Strait Islander Cultural Capability Framework* (2010:9) defines cultural capabilities as "skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner". While the document refers to cultural safety and cultural respect, it describes an 'Aboriginal and Torres Strait Islander Cultural Capability Learning Program'. This was later codified into a training strategy across government (Queensland Health 2016), with the language and approach becoming evident in other sectors, such as education (Queensland Government 2022b; Queensland Government 2022c).

The Queensland cultural capability training strategy was modelled on the 2015 *Aboriginal and Torres Strait Islander Cultural Capability Framework* (Commonwealth of Australia 2015). This Commonwealth Framework provides 'a basis for building the cultural capability of the Commonwealth public sector' and 'explains the skills, knowledge, and practices that employees need to perform their duties in a culturally informed way' (Commonwealth of Australia 2015:1). It remains in use and is intended to guide senior executives, managers and human resource staff in developing practical strategies for their staff, including professional development. The predominant language is 'culturally appropriate' and 'cultural capability', as well as showing 'sensitivity' and 'respect'. The term 'cultural safety' is not used and both 'racism' and 'safe' are used only once.

Cultural responsiveness

The term cultural responsiveness appears to have arisen from government policies that aim to address and accommodate matters relating to diversity in the broadest of senses, where diversity includes gender, sexual preference, disability, age, religion, race, and ethnicity. As defined by the Victorian Department of Health, 'cultural responsiveness describes the capacity to respond to the healthcare issues of diverse communities' (2009:4). In other words, to the health beliefs and practices, culture and linguistic needs of diverse populations and communities – not specifically the unique needs of Aboriginal and Torres Strait Islander peoples or the challenges they face as a direct consequence of the history of colonialism.

This term appears in national contexts less frequently compared to cultural safety or cultural competence. When it does, it is often used in conjunction with cultural safety (AHMAC's National Aboriginal and Torres Strait Islander Health Standing Committee 2016b). The main jurisdictional link for using cultural responsiveness in the health context is Victoria for the *Koolin Balit Aboriginal Health Strategic Directions 2012-2022* and *Koolin Balit Aboriginal Health Workforce Plan 2017–2027* (Victorian Department of Health 2012, 2017).

> *Cultural responsiveness has emerged strongly in the allied health context and more recently in psychology (Australian Psychology Accreditation Council 2023). It is advocated by Indigenous Allied Health Australia or IAHA through its Cultural Responsiveness in Action: An IAHA Framework (IAHA 2015, 2019:4), which describes its relationship with cultural safety:*
>
> *If cultural safety describes the state we are aiming to reach – safe, accessible, person-oriented and informed care – cultural responsiveness is the practice to enable it. Cultural responsiveness has cultural safety at its core. Cultural responsiveness is what is needed to transform systems; how individual health practitioners work to deliver and maintain culturally safe and effective care. It is innately transformative and must incorporate knowledge (knowing), self-knowledge and behaviour (being) and action (doing).*

Strong engagement with cultural responsiveness has also occurred in education. At a national level, the Australian Institute for Teaching and School Leadership (AITSL) has produced an Indigenous culturally responsive toolkit, which consists of an Indigenous cultural responsiveness self-reflection tool, continuum and capability framework (AITSL 2022a). This work is an outcome of enacting several recommendations from a preceding project whose purpose was 'to build the Indigenous cultural competency of the teaching workforce with the goal of increasing cultural safety in schools' (AITSL 2022b:8).

While the project acknowledged that the term cultural competence/competency is 'contentious' and different terms are in currency, it is used consistently in the project report and toolkit. At the same time, the material adopts a similar approach to IAHA, where cultural responsiveness is viewed as the pathway to cultural safety. While several elements characteristic of cultural safety training are described in the material, others such as dominant culture, power, institutional racism, and white privilege do not or rarely feature. This approach is replicated in state education documents, such as the SA Department for Education (2022).

Cultural safety

Cultural safety is derived from Indigenous thought leadership

The foundational work on cultural safety occurred in Aotearoa New Zealand through the leadership of Irihapeti Ramsden, a Māori nurse. It was a strategy to equip Pakeha (white) nurses to improve the care provided to Māori (Papps & Ramsden 1996; Ramsden 2002).

In 1990, cultural safety was mandated in the New Zealand standards for nursing and midwifery registration. Papps and Ramsden (1996) highlighted the central position of power that was written into the 1992 Nursing Council of New Zealand guidelines for nursing and midwifery education:

> *Being a member of a culture surrounds each person with a set of activities, values and experiences which are considered to be real and normal. People evaluate and define members of other cultural groups according to their own norms. When one group far outnumbers another, or has the power to impose its own norms and values upon another, a state of serious imbalance occurs that threatens the identity, security and ease of the other cultural group, creating a state of disease* (Nursing Council of New Zealand 1992, cited in Papps & Ramsden 1996:493).

Following in Ramsden's footsteps, the Nursing Council of New Zealand continues to define cultural safety as:

> *The effective nursing practice of a person or family from another culture…The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact of his or her culture on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual (*Nursing Council of New Zealand 2011:7).

In Australia, the concept of cultural safety has been adopted and adapted to reflect the experiences, knowledges, and aspirations of Aboriginal and Torres Strait Islander peoples. It started to gain traction at a national level (AHMAC's National Aboriginal and Torres Strait Islander Health Standing Committee 2016a; Department of Health 2013). However, it has been used interchangeably with or been seen as inclusive of other terms used outlined in this section – for example:

> *Cultural safety involves an understanding that there are power relations in and between all cultural groups and at all levels. From this basis, services are able to work on addressing cultural inequities in health in safe ways… It includes cultural awareness, cultural sensitivity, cultural knowledge, cultural respect and builds the cultural capabilities of the health workforce* (Commonwealth of Australia 2017:15).

The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (NATSIHP) (Department of Health 2021:3) states that Aboriginal and Torres Strait Islander people have 'a right to culturally safe and responsive health care, free of racism and inequity'. Emphasis on culturally safe healthcare, service environments and workplaces are apparent throughout the document. Another example of national recognition is the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*, which states as its vision:

> *Aboriginal and Torres Strait Islander peoples enjoy long, healthy lives that are centred in culture, with access to services that are prevention-focussed, responsive, culturally safe and free of racism and inequity. Achieving this vision requires a locally qualified and skilled Aboriginal and Torres Strait Islander health workforce across the health system, to lead the delivery of culturally and clinically safe health services for Aboriginal and Torres Strait Islander peoples regardless of where they access health care* (Department of Health 2022:9).

In addition to being a First Nations-developed concept, another critical difference for cultural safety is identified by Phillips (2015:40):

> *Cultural safety in Australia has been used to refer to structural and systemic reform to better enable Indigenous participation in education, professions and health care... [T]he knowledge, skills, attitudes of individual health care workers are critical, but so too is the respectful application of these principles in institutional practices, policies and systems.*

In translating this into training on cultural safety, Mohamed and Stacey (2017:slide 9) describe how cultural safety training involves an analysis of power relations, characterised by:

- *Recognising, understanding and responding to racism at an: a) individual level, and b) the social-cultural and institutional or systemic level*
- *Understanding how dominant culture values and beliefs shape health care practice and attitudes – individually and systemically*
- *Encouraging critical self-reflection for non-Aboriginal people [the gaze is inward rather than outward]*
- *Exploring 'whiteness' and white privilege and how it shapes the lives of white people, and Aboriginal and Torres Strait Islander Australians, and Australians who are not white but are not Aboriginal and Torres Strait Islander people*
- *Learning that cultural safety is the experience of the recipient of care, it is not defined by the caregiver*
- *Understanding [historical truth telling, inequity and] the impact of colonisation and dispossession, and the historical and ongoing effects in Aboriginal and Torres Strait Islander people's everyday lives.*

Working towards cultural safety is usually described as a 'lifelong journey' rather than a destination (Gollan & Stacey 2018; Mohamed & Stacey 2017; Mohamed et al. 2021; Sherwood & Mohamed 2020). Cultural safety training assists participants to progress on their journey and gain tools for the ongoing learning journey.

Cultural safety training has been offered by several training providers for some time across a range of sectors, including health. One of the reasons for the original NACCHO CST standards initiative was to ensure that what was described as cultural safety training reflected a full understanding of what cultural safety means.

A strong emphasis in cultural safety training is placed on identifying and exploring power inequities at multiple levels and how this can be addressed, both individually and institutionally. This requires approaching healthcare services and outcomes in a political context, not just a social, scientific, ethical, or legal context (Ramsden 2002), and how that translates into the daily lived experiences of Aboriginal and/or Torres Strait Islander peoples. This includes recognition that Australia's systems

across a broad range of sectors and professions are based on the cultural values and beliefs of the dominant culture (Gollan & Stacey 2021a; Mohamed et al. 2021).

Cultural safety will only be experienced if the system is changed, adapted and/or challenged to incorporate respect for 'Aboriginal and Torres Strait Islander ways of knowing, being and doing' (IAHA 2019:2). Further, the presence of cultural safety can only be defined by those who receive healthcare; that is 'cultural safety is not something that the practitioner, system, organisation or program can claim to provide, but rather it is something that is experienced by the consumer/client' (Walker, Schultz & Sonn 2014:201). Aboriginal and/or Torres Strait Islander people will determine if their cultural identity and meanings are being respected, they are not being subjected to racism, and they feel valued, safe, and trusted.

A critical learning from a recent review of cultural safety research and resources is that cultural safety training 'must include a focus on white privilege' (Stacey & Gollan 2021a, p. 1). For example, Bond, Singh and Kajilich (2019) emphasised that anti-racism action and working towards cultural safety means exploring whiteness through colonisation and the contemporary context. The focus on 'whiteness' or 'white privilege' assists participants to recognise how being part of whiteness automatically leads to white people experiencing unearned benefits and making assumptions that everyone has equal access to these privileges that they usually see as 'rights' (Gollan & Stacey 2018; Mohamed et al. 2021; Taylor & Guerin 2019), which contrasts with the reality for Aboriginal and Torres Strait Islander peoples. Examining white privilege can debunk the myth of meritocracy that is embedded in dominant culture.

Cultural safety training participants engage in 'transformative unlearning' (Mills et al. 2021; Ryder, Yarnold & Prideaux 2011) through critical self-reflection so they recognise both the conscious and non-conscious use of power in relationships with Aboriginal and Torres Strait Islander people at individual and organisational or institutional levels. As an ongoing learning journey, this involves steps backward as well as steps forward for non-Indigenous people. Transformative unlearning requires accepting that mistakes will occur, learning from them and continuing the journey.

Despite growth in recognition of cultural safety as important over the past two decades and its increasing use in national Aboriginal and Torres Strait Islander health-focused documents, confusion about its conceptualisation is also evident (Australian Human Rights Commission 2011; Freeman et al 2014; Phiri, Dietsch & Bonner 2010). For example, viewing cultural safety as applying only to individual knowledge, attitudes, and skills, or that having cultural awareness will translate into cultural safety.

To reiterate, a vital element of cultural safety is understanding the need to move beyond the individual and focus on systems at an institutional level that are based on the values and beliefs of the dominant culture, which results in institutional racism. Creating and embedding cultural safety requires tackling power relations at a systemic level and disrupting the status quo. This is the point of difference raised by Phillips (2015) and evident from the New Zealand experience (Curtis et al. 2019).

A core reason why many national Aboriginal and Torres Strait Islander health organisations prefer the term cultural safety is that it was developed by First Nations peoples and therefore reflects the experiences of Aboriginal and Torres Strait Islander peoples as First Nations peoples of Australia. Finally, it focuses on whether Aboriginal and Torres Strait Islander peoples ***feel culturally safe*** rather than non-Indigenous peoples judging whether they are culturally competent.

Summary of key differences in cultural training terms

Having outlined the key terms and concepts in the Australian context over the past few decades, the key differences between the most common training terms are summarised in Figure 3.

Figure 3: Summary of key differences in cultural training terms

Cultural safety is unique as a First Nations-led approach and gaining traction as facilitating individual, organisational and institutional change.

Key focus areas include analysis of power racism, ongoing effects of colonisation and white privilege. It emphasises how working toward cultural safety is a lifelong journey.

Cultural competence training was developed in response to cultural and linguistic diversity, not First Nations peoples.

While it shares some content with cultural safety training, the framing is problematic, as it suggests non-Indigenous people can be competent in the diversity of Aboriginal and Torres Strait Islander cultures.

Cultural responsiveness training is more common in allied health and education contexts.

It shares some content with cultural safety training although does not examine power and white privilege.

Cultural responsiveness is described as the practice required to achieve cultural safety.

Cultural respect and cultural security as stand-alone terms are more common in two jurisdictions – WA and NT.

The exception is the *National Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health*.

Cultural awareness is the most familiar term and requested type of cultural training.

The primary focus of cultural awareness training is on Aboriginal and Torres Strait Islander people, rather than non-Indigenous people critically reflecting on themselves.

Impact of cultural safety training

A core thread throughout the work to name and promote action on cultural safety in Australia is cultural safety training. It is an essential but not singular mechanism to upskill the health and human services workforce in what cultural safety is, how to embed it in individual practice and systems, and how to recognise, address and prevent racism in all its forms.

When the original NACCHO CST Standards (2011) were developed, limited information was available about the outcomes of different forms of cultural training. Since then many reports have identified the need to learn more about the impact of cultural training in both the short and long-term (for example, Downing, Kowal & Paradies 2011; Durey 2010; Ewen, Paul & Bloom 2012; Thackrah & Thompson 2013; Lowitja Institute 2014; Paradies, Truong & Priest 2014).

Literature on the outcomes of cultural training or education has increased over the last decade in both university curriculum and the workplace, with most based on training or education delivered in health, human services and higher education environments. However, data on the longer-term impact of cultural training on individuals or the organisations in which they work remains limited (Hunter et al. 2021). This section provides an overview of this evaluation work, both prior to and after 2011.

Evaluation of cultural training by 2011

An early and comprehensive review of Australian and international literature on the effectiveness of cross-cultural training found most workplace diversity training programs in the Australian government and community sector focused on awareness and knowledge raising; that is, were cultural awareness programs (Bean 2005).

This review included 39 training programs in ***both*** Aboriginal and/or Torres Strait Islander and other culturally and linguistically diverse contexts, including the health and human services sector. The vast majority (92%) were one-day, or less, in 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).

Statistical evidence of 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 statistical evidence of 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. While 71 per cent of participants rated their ability to transfer their learning to their work context as average or higher immediately after training (scale options were: low, below average, average, above average and high), their rates of doing this at the follow-up point were markedly lower. It was unclear whether their organisations implemented other strategies to reinforce the training.

In 2009, Farrelly and Lumby summarised what had been learned so far about outcomes of what they described as 'cultural competence training' but was inclusive of cultural awareness training and cultural immersion experiences. They concluded there was limited systematic evaluation of the impact of training, although they found evidence of participant satisfaction and, in some instances, a flow-on effect to patient satisfaction (Farrelly & Lumby 2009).

Gollan and O'Leary (2009) conducted a qualitative study with fourth year social work students four months after they completed a one-week intensive course on 'Indigenous Australians and the Human Services' facilitated through a 'black–white partnership teaching' approach – Aboriginal/non-Aboriginal partnership – and based on a cultural respect and safety training approach. In total, 69 students completed a written narrative response survey two months after completing the intensive and 34 (50%) also participated in a focus group. Two of the four survey questions focused on what students learned and found helpful. The other two focused on the teaching partnership and its relevance to engaging with Aboriginal colleagues and community members.

Four consistent core themes emerged from the surveys:

- Students gained greater awareness of language, power, identity, and the implications of whiteness in their personal and professional lives, including new insights into racism, and how it was important to develop partnerships with Aboriginal and Torres Strait Islander peoples.
- Students valued the black–white partnership teaching approach in supporting their learning, although this ranged from students emphasising this gave them 'differing perspectives' to understanding 'the value of "witnessing the black–white partnership in action"'
- Students developed a clearer understanding of accountability as a non-Indigenous person, especially as a white person; students reported the most valuable aspect was the black–white partnership being modelled, debriefed and deconstructed 'live' during the course and how they could apply this to their own practice.
- Students recognised the importance of maintaining a commitment to being more aware, responsive and active so they integrate learnings into their everyday practice. (Gollan and O'Leary 2009:716)

The focus groups allowed a deeper and conversational exploration of student learning, with three areas reiterated:

1. Paying greater attention to whiteness and moving from being emotionally confronted to accepting its reality.
2. Understanding there was a 'white role' in black-white partnerships, with some students demonstrating an understanding of what it was.
3. Expressing an intention to remember and act on their learning.

All students participating in the surveys and focus groups were clearly on a transformative learning journey, although it was evident that some had progressed further over the four months, emphasising the individual journey involved in working towards cultural safety. Prior to 2010, Gollan and O'Leary's (2009) work was one of the few studies available with follow-up data on the impact of cultural training.

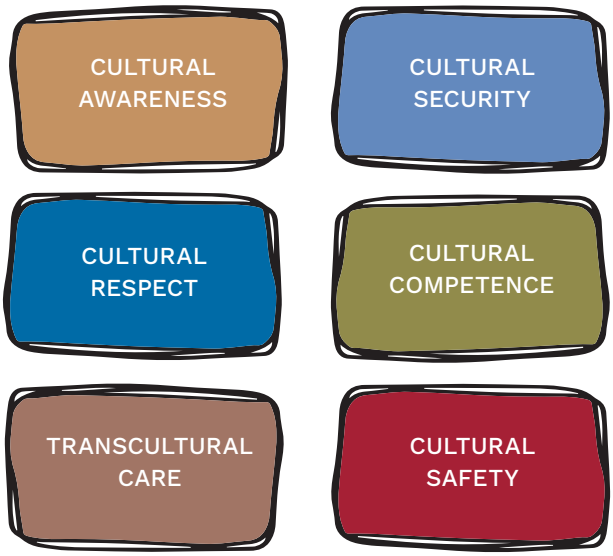
A study of cultural competence curriculum delivered from 2006–10 in a Western Australian School of Nursing and Midwifery examined how it was experienced and contributed to cultural competence in graduates (Flavell, Thackrah & Hoffman 2013). Most students found the topic motivating and were satisfied with their experience. However, students experienced challenges as the content addressed the cultural perspective of students from the dominant culture in Australia and examined racism and white privilege. Flavell and colleagues reported that the cultural competence curriculum helped develop other required graduate capabilities, such as communication and reflective skills.

Although published in 2020, Gray et al.'s research on the impact of cultural safety training for allied health students represented the 2007–11 period. The curriculum approach taken was a one-day workshop in first year with a second one-day workshop in fourth year. Prior to delivery, teaching staff received training on 'key messages and ways of responding to difficult situations' that may arise and were offered post-workshop debriefing sessions. The paper reports the quantitative component of student pre-post survey outcomes for both the first and fourth year workshops, although qualitative survey data was also gathered. It frames the results in terms of change in student cultural awareness and competence.

Both first and fourth year students indicated they needed to develop greater self-awareness of their own cultural identity and values to feel confident in working with Aboriginal and Torres Strait Islander people. Both cohorts indicated increased understanding about 'the importance of their own cultural identity in interactions with people from different cultural backgrounds' (Gray et al. 2020:15). By fourth year, students reported greater confidence in working with Aboriginal and Torres Strait Islander people post-workshop, although 'confidence does not necessarily equate to safety' (Gray et al. 2020:16).

Gray et al. (2020:16) concluded that greater integration of cultural safety education throughout undergraduate training was needed, with an increasing focus on culturally safe practice in later years, rather than general knowledge (that is, 'one off workshops may not be sufficient for promoting ongoing knowledge and attitudinal changes required for culturally safe practice').

A review of 'Indigenous cultural training' in Australia as of 2011 (Downing, Kowal & Paradies 2011) identified six training models in use:



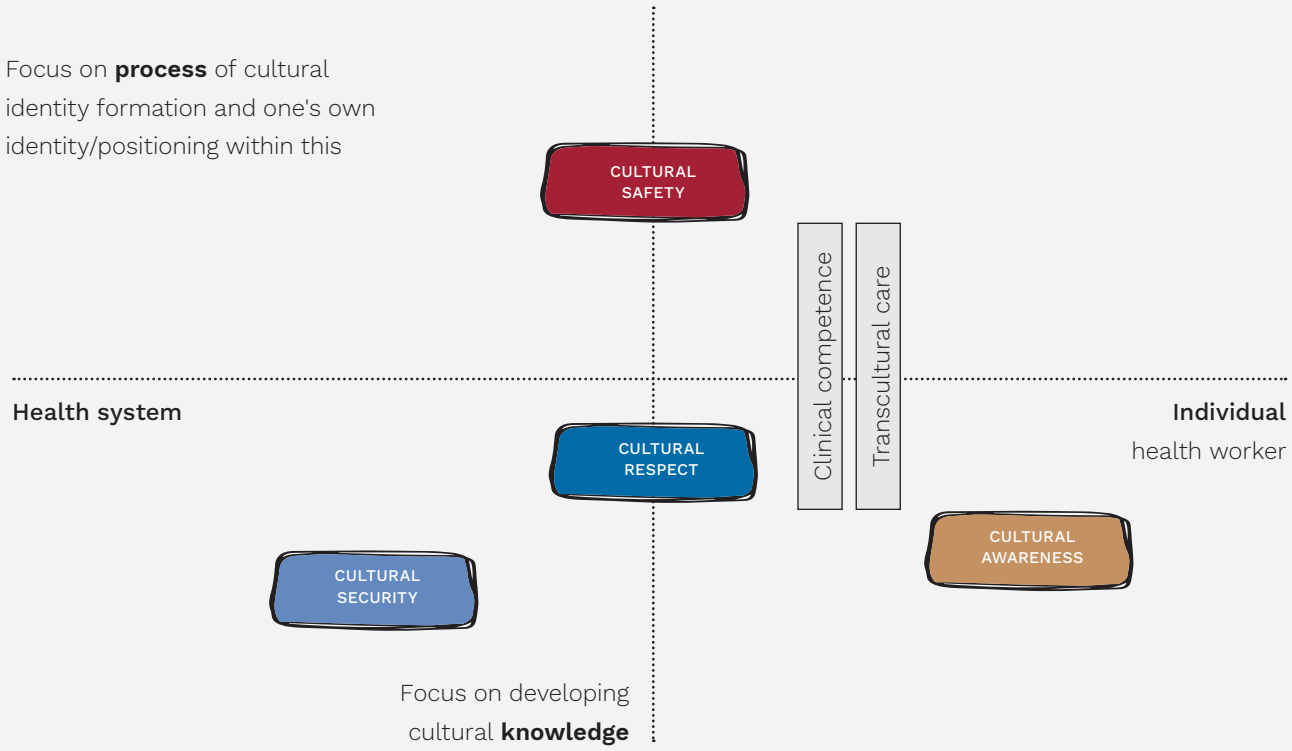
They mapped the models on two axes – see Figure 5. The horizontal or individual/systemic axis contrasts training focused on individual compared with systemic behavioural change. The vertical or process/knowledge axis contrasts training that supports participants to develop an understanding of their own culture and identity formation processes versus understanding the culture of others.

Downing, Kowal & Paradies (2011) reported that the most common training model at that time in Australia was cultural awareness training. They identified nine published evaluations of training programs for health workers, six related to a specific training program they had experienced and three in relation to health workers' view of cultural training they had previously undertaken.

Three studies assessed change in participant knowledge and attitudes, two of which reported positive change for intended behaviour following the training and satisfaction with the training experience. The one study to use a control group did not demonstrate an effect.

> *The essence of this critique is that Indigenous cultural training informed by a cultural awareness model has limited potential to create a culturally safe health care system. In order to respect and protect a person's cultural identity, health workers must be able to understand the processes by which cultural identity is created and shaped... Cultural training based on a cultural safety model may provide the answer. As it is informed by post-colonial theory, a cultural safety framework works to explicitly and critically explore issues of power imbalance and social inequality (Downing, Kowal & Paradies 2011:254).*

Figure 5: Cultural training models mapped against an individual/systemic and process/knowledge axis (Downing, Kowal & Paradies 2011:249)



They went on to state:

> *Training advocated by a cultural safety model does not focus on learning a culture, but rather focuses on assisting health workers to practice the reflexivity needed to examine their own identity and cultural beliefs, and the way in which these might manifest in their interactions with those they are caring for. By shifting the focus of training away from trying to teach about 'indigenous culture', toward examining processes of power imbalance and identity, a cultural safety model appears to be our best option for delivering indigenous cultural training that will produce lasting change among health staff and systems (Downing, Kowal & Paradies 2011:255).*

Evaluation of cultural training since 2011

Evaluation activity has escalated since 2011, with a high percentage of available information based on university experiences of cultural safety education within the curriculum. This appears to be influenced by the developments outlined in the 'Advocacy' sections on cultural safety within health professional curriculum and health professional registration.

EVALUATION OF CULTURAL TRAINING IN UNIVERSITY CURRICULUM

The University of Western Australia's Courageous Conversations About Race (CCAR) program was evaluated by Fialho (2013). This program included a strong focus on racism in relation to Aboriginal and Torres Strait Islander people but equally focused on people from culturally and linguistically diverse communities. The CCAR program formed part of a training package negotiated with the university's School of Indigenous Studies that included an 'Indigenous perspectives workshop' and a 'cultural immersion, on country experience' (Fialho 2013:10).

Results from psychometric assessments administered in the two weeks prior to and post the one-day program for small cohorts of academics from three different universities were variable, with some indication the program had a small positive effect on academic attitudes and behaviours. The analysis of qualitative feedback data indicated the program encouraged 'a deep engagement with race within a privilege conceptual framework' (Fialho 2013:20). Based on how it was gathered and presented in the report, it was difficult to ascertain the consistency with which this and other reported themes occurred, and how many participants the analysis represented.

Evaluation of and research about cultural safety education has been consistent at Griffith University since 2017, focusing on both academics and students. A Griffith University study reported on a cultural safety education program with a small cohort of midwifery academics, involving two interactive half-day workshops followed by five yarning circles over 12 weeks (Fleming, Creedy & West 2017). Evaluation consisted of pre-post surveys, including self-assessment of cultural safety, perceptions of racism and the Awareness of Cultural Safety Scale (ACSS) developed by the authors (Milne, Creedy & West 2016), as well as workshop and yarning circle satisfaction ratings and participant journals.

Of 13 participants, nine completed all surveys at pre and post points and attended one or both workshops and two or more yarning circles; therefore, all participants did not experience the full learning opportunity. A positive and statistically significant change occurred on the ACSS but not the other scales by the end of the program. Qualitative data indicated the program was impactful, although

participants needed more time to process and apply their learnings about racism and white privilege. The authors concluded that, while the program had promising outcomes, understanding cultural safety must be framed as a long-term commitment backed by institutional support.

In response to participant feedback, a series of five further yarning circles were offered over three months (Fleming, Creedy & West 2019b). Ten of the 13 academics from the initial program participated, with seven undertaking formal interviews about the learning experience, growing their awareness of cultural safety and how they were applying their learnings. Interview analysis identified that the reflective and yarning or conversational approach facilitated learning and transformation of understanding, knowledge, and attitudes, with evidence that participants were transferring this learning into practice.

This study verified the value of providing structured time in a supportive environment to assist cultural safety training participants to continue critical self-reflection on challenging material (that is, white privilege), and apply their learnings. It also illuminated how, after six months, participants were at different stages of 'transformative change'. Some still struggled with identifying the relationship between power and white privilege, particularly at a personal level and how they are implicated in rather than separate from dominant institutional structures, and still engaged in 'othering' Aboriginal and Torres Strait Islander peoples. This was evident in another study by the same authors examining awareness of cultural safety in the midwifery profession:

> *Transformation occurs when alternative perspectives are called into question and challenge previously held beliefs and assumptions. There was evidence of transformation as participants in the current study reflected on previously held beliefs and values and developed new insights. However, such transformative changes did not occur equally across all members of the group, highlighting the individual and life-long nature of the journey towards becoming culturally safe* (Fleming, Creedy & West 2019b:183).

The variation between participants in transformational change was identified again in an analysis of student journeys in learning about cultural safety principles in a third year semester-long First Peoples health and cultural safety course as part of their nursing degree (Mills & Creedy 2019).

Other Griffith University research has included development of a 'Cultural Capability Measurement Tool' (West & Wrigley et al. 2017) to assess student cultural capabilities as defined in the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Department of Health 2014). A statistically significant and positive result occurred when the tool was used to evaluate the impact of a First People's health course on student cultural capabilities, with 87 matched completed pre-course/post-course surveys from a 297 total student cohort (West & Mills et al. 2019). The authors noted that research on whether this change is sustained over time would be important.

The authors supplemented this work with development of the 'Student Emotional Learning in Cultural Safety Instrument' (Mills et al. 2021). This tool examines any shift in 'the emotional mechanisms that may contribute to, or inhibit, transformative learning' (Mills et al. 2021:2) in cultural safety learning. It draws on Boler (1999) who articulated a pedagogy of discomfort when students are asked to critically examine their values and beliefs as shaped by the dominant culture, which is a vital feature of cultural safety training.

The tool was later applied to a cohort of 395 students completing the Griffith University First People's health course (Mills et al. 2022). Statistically significant increases were achieved for students moving from being disconnected from Australia's historical truth (spectating) to a greater understanding of how they have been shaped by and are connected to it (witnessing) for the 102 completed pre-course/post-course surveys. Positive but not statistically significant change was evident for being able to manage the discomfort this generated, which Mills et al. (2022) considered was connected to how students found engaging with self-reflexivity a challenging experience. Without further support for their learning journey, disconnection between students' learning and feelings, and translation of this into intended cultural safety practice may increase.

Merritt et al. (2018) reported on the evaluation of 'cultural safety training' for tutors in a medical school, who were also clinicians. A half-day workshop was delivered by two Aboriginal facilitators to help prepare 18 tutors for their role in the upcoming semester. Nine participated in a focus group or interview six months later to reflect on the workshop and how it assisted their tutoring role and contributed to their 'cultural competency'. The outcomes indicated tutors found the workshop helpful, while their commentary indicated they were still readily engaging in 'othering' Aboriginal and Torres Strait Islander people. They also did not directly name and explore racism and demonstrated limited 'self-reflexivity' in their tutoring role to assist student learning by modelling critical reflection on their own cultural identity and its impact on patient experience.

For example, the authors as well as tutors used the terms 'cultural biases' and 'culturally sensitive issues' as euphemisms for racism. They concluded that:

> *..a key perspective missing from the tutor group as a whole, and from their engagement with the students, was their own stance – their own cultural position and identity and how it might impact upon their position and view as a tutor and as a clinician. This resistance reflects their comfort (or discomfort) in dealing with culturally-sensitive issues and, consequently, impacts upon the role and approach they assume in PBL [problem-based learning] tutorials when such issues arise. Alternatively, individuals may not acknowledge their cultural perspective because it is taken for granted (Merritt et al. 2018:18).*

In an examination of nursing academics' understanding of cultural safety and ability to teach it, Doran, Wrigley and Lewis (2019) identified similar concerns based on 15 staff completing a survey, with eight also participating in an interview (two were Aboriginal and/or Torres Strait Islander staff). While 10 (67%) believed they had undertaken cultural safety training, only three reported training on white privilege and two on anti-racism. More commonly they had undertaken cultural awareness, cultural sensitivity, or cultural competence training. Interview data indicated while they were at an early stage of understanding cultural safety, they were often confused about what it meant and most felt ill-equipped to teach students about culturally safe healthcare: 'Participants did not seem to engage with key aspects of cultural safety such as critical self-reflection, white privilege, colonisation and racism' (Doran, Wrigley & Lewis 2019:166).

EVALUATION OF WORKPLACE CULTURAL TRAINING

A systematic review of 19 reviews focused on the impact of workforce development on improving cultural competence of staff in health organisations (Paradies, Truong & Priest 2014). It included international studies and was not specific to Aboriginal and Torres Strait Islander or First Nations peoples in other countries. Most reviews reported there was a moderate improvement from cultural competency interventions for healthcare provider outcomes, and service access and utilisation, but less evidence or poor availability of evidence of improvements in client outcomes.

Seven of the 19 reviews focused on cultural competency interventions for health staff, predominantly through training. A complexity noted in the paper was that the type of training varied in its description from cultural awareness to cultural competency. With insufficient information to be confident about which form of training was used, it was not possible to identify which training interventions were more effective, including for specific groups or outcomes. However, there was sufficient information for the authors to conclude that:

> *Cultural awareness alone is inadequate for addressing the effects of structural and interpersonal racism on health disparities. Cultural awareness training has been criticised for increasing stereotyping and reinforcing essentialist racial identities. Reflexive anti-racism training is a promising alternative to cultural awareness training that reflects upon the sources and impacts of racism in society whilst avoiding essentialism and negative emotional reactions associated with White guilt* (Paradies, Truong & Priest 2014).

The NSW Ministry of Health (2015) evaluated their department-wide cultural training strategy in 2013, which had a cultural awareness model and cultural respect focus. They identified delivery areas to improve, such as better supporting Aboriginal health staff who delivered the training with facilitation skills and managing participants when they feel challenged, a common and predictable feature of cultural training. A core concern expressed was limited evidence of whether learning gained was translating into workplace application, behavioural change, and organisational cultural change. Over time, the Ministry has sought to address these matters through promoting workplace tools (NSW Ministry of Health 2024) and revising and updating the training package to reflect a cultural safety approach (NSW Ministry of Health 2022).

A paper prepared for the Closing the Gap Clearinghouse examined the impact of interventions to improve cultural competency (Bainbridge et al. 2015). It included papers from Australia and several other predominantly colonised countries: the US, Canada, and Aotearoa New Zealand. It considered interventions that included but were not limited to training. Of the 28 evaluations, 11 were focused on Aboriginal and/or Torres Strait Islander peoples. Overall, 10 of the 28 studies demonstrated notable improvements in healthcare outcomes linked to cultural competency interventions.

The authors emphasised that working towards cultural competence 'involves a sustained multi-strategy approach encompassing knowledge, awareness, behaviour, skills and attitudes, and the sustained embedding of a cultural shift towards cultural proficiency within organisations' (Bainbridge et al. 2015:18). Promising interventions that produced improvements included workforce development for health professions (that is, training), and embedding cultural content into health professional curriculum.

> *Promising evidence-based strategies are systems-reform interventions that incorporate the development and integration of cultural competence performance indicators with clinical indicators, auditing and continuous quality improvement approaches. At health practitioner levels of care, useful interventions are offered by assessments of practitioner cultural competence and cultural safety training, education, frameworks and guidelines (Bainbridge et al. 2015:22).*

They also suggested following the pathway of the US and Aotearoa New Zealand in embedding cultural competency principles within legislation and/or policy, as this would stimulate increased efforts to achieve positive change for Aboriginal and Torres Strait Islander peoples. Ahpra's work described in the 'Advocacy in health professional registration' section is a step in that direction by embedding cultural safety into health professionals' registration requirements, as is the inclusion of cultural competency to achieve culturally safe health services in the 2nd edition *National Safety and Quality Health Service Standards* (ACSQHC 2017) described in the 'Advocacy in health services' section.

Consistent with previous evaluation work on the limitations of cultural awareness only for sustained individual behaviour and systems change, the authors found that:

> *Cultural awareness training is not enough in itself. While such training might be expected to impart knowledge upon which behavioural change will develop, it has generally not been enough when it is delivered in isolation or rapidly delivered over short timeframes (Bainbridge et al. 2015:3).*

This learning continues to be played out in different locations across Australia. Two recent examples are Northern Territory based. Evaluation of 27 training sessions with 621 participating health professionals in the Top End of the NT identified that participants appreciated access to a one-day cultural awareness training session but were keen to learn more (Kerrigan et al. 2020). The authors concluded cultural awareness training was a valuable entry point that needed to be extended into further training opportunities, particularly those that 'address unconscious bias and institutional racism through critical self-reflection… to improve the delivery of culturally safe care for Aboriginal and Torres Strait Islander healthcare users' (Kerrigan et al. 2020:9).

Similar outcomes emerged from evaluation of a one-day cultural awareness course delivered in Central Australia for health professionals and students (Rissel et al. 2022). While 123 people participated in the pre-test and 122 at post-test, by the two-month follow-up the participation rate was 15 per cent. While positive change was evident immediately post-program, this was not sustained at follow-up using a refined but previously validated scale aimed to assess attitudes that shape cultural safety (Ryder et al. 2019). The authors included that while of value, cultural awareness training is insufficient by itself to facilitate the transformative unlearning and critical self-reflection that can generate greater cultural safety knowledge, skills, and practices.

In 2018, Gollan and Stacey (2018) presented evaluation outcomes from two decades of delivering cultural safety training (a two-day program) that utilises a variety of interactive training methods. Programs are delivered in organisational contexts and apply an organisational cultural change strategy through initially engaging senior staff, equipping them to support the ongoing training process and encouraging them to develop and/or strengthen complementary organisational change strategies. Participants complete an evaluation form with two open-ended questions for narrative responses on program completion: 1) how were the presentations and exercises useful to you? and 2) how did the workshop contribute to your thoughts about your work role?

In 2018, independently analysed qualitative data from 128 workshops across the 2004-2018 period involving 2,453 participants (return rate of 84.5%) were available.[1] While it does not address the issue of assessing longer-term impact, it provides a large cohort of data at the post-session point from the same type of cultural training delivered in a consistent manner by the same co-facilitators; this is rare in other available literature. The headline consistent themes described by participants about the impact of the training experience were:

- they had greater capacity and/or commitment to create culturally safe services and environments as an individual work practice – reported by 89 per cent. In addition, 13 per cent indicated they had greater capacity and/or commitment to do this in organisational policy and practice
- they found it a personal and professional journey of self-awareness, new insights, and self-reflection – reported for 59 per cent, with 8 per cent of this group noting specifically and unprompted that, while it was challenging and confronting, this was important for moving forward and beyond other cultural learning they had undertaken
- they shifted their perspectives, beliefs and understanding of what Aboriginal and Torres Strait Islander people have and continue to experience when interacting with the dominant culture, both historically and currently – identified by 25%. Through this they were unlearning racism and how they conceptualised Aboriginal and Torres Strait Islander people.

To understand whether and how this contributed to cultural safety being strengthened for Aboriginal and Torres Strait Islander people working in and utilising these services, a series of organisational case studies is needed. For example, studies of participating organisations that made long-term commitments to training staff complemented by designing and implementing a range of other strategies over several years, combined with Aboriginal and Torres Strait Islander people sharing their direct experience of the organisation.

A small five-year follow-up study of 10 nursing and midwifery students who experienced cultural safety education in their undergraduate degree was done by Withall et al. (2021). It demonstrated how, as noted above, learning about how to practice and enable cultural safety is a lifelong journey. They identified a notable variation in the degree to which the participants had incorporated and extended on their learnings to demonstrate they understood cultural safety principles and knew how to manage barriers to culturally safe care in their practice and work context.

Hunter et al. (2021) undertook a survey of a broad range of health services nationally: 421 in total, on behalf of the Australian Commission on Safety and Quality in Health Care (ACSQHS). The survey was designed to assess whether the cultural safety training offered within health service organisations aligned with 'attributes of high-quality cultural safety training', predominantly those defined by the original NACCHO cultural safety training standards (NACCHO 2011). It is the only known survey of its kind so described at length.

A definition of cultural safety was provided in the lead-in to the survey, however, what qualified as cultural safety training was left to the discretion of health services, which was in part the purpose of the survey. As noted in the 'Advocacy in health services' section, Action 4.1 in the ACSQHS national standards states cultural awareness and cultural competency rather than cultural safety, although it refers to culturally safe healthcare in other sections and documents related to the standards.

1 This is an ongoing project; further data has been analysed with a total representation of 214 workshops representing almost 3,700 participants, but the final analysis has not been published.

Questions included the content covered in cultural training and how it was delivered, although a smaller proportion of health services answered these questions (~260-270 as response numbers were not always reported clearly). Hunter et al. (2021) reported that only 11 per cent of the 261 health services answering this question reported that all recommended topics were covered. Very few services met the eight recommended delivery elements, with less than 20 per cent meeting six or more and less than 2 per cent meeting all elements. Health services reported limited knowledge of any evaluation of the training – 47 per cent did not know and only 21 per cent reported some form of evaluation occurred.

In addition to the survey, they did a review of available literature on the evaluation of cultural safety and other forms of cultural training (nationally and internationally), which included some literature included in this paper. They reached similar conclusions, specifically, that cultural safety training consistently led to improved participant knowledge, skills attitudes, and beliefs. Further, evaluation that focused on longer-term participant outcomes and whether actions implemented by organisations created meaningful organisational change was less available. Limited data was available on whether Aboriginal and Torres Strait Islander staff and clients experienced a notable and positive difference in their cultural safety. Despite this, they stated that:

> *While there is limited evidence to show the direct impact of cultural safety training on health outcomes, there is evidence supporting healthcare organisations and healthcare practitioners embedding cultural safety within their institutions and this impacting the service achieving better outcomes at a health service, health practitioner and patient level (Hunter et al. 2021:24).*

This aligns with repeated calls, noted earlier in this paper, to increase the availability of cultural safety training, with its focus on racism, power, and white privilege. For example, following their exploration of how well cultural safety is understood in midwifery care, Brown et al. (2016:202) concluded that:

> *Strengthening training with cultural safety as a core concept would align better with the Australian National Competency Standards. Ensuring cultural training was an assessable component of practice and recognition that it is as important as the physical aspects of care for the women would be a positive approach for improving the experiences of the women and supporting midwives in practice.*

A recent rapid review of evidence recommends training as an essential although one of several strategies for anti-racism work to be effective:

> *While cultural competence and implicit bias training are becoming ubiquitous, evidence suggests they have limited if any effectiveness without explicit focus on race, racism and power and without accompanying systemic and institutional level action. It is critical that health and education professionals receive specific training in race and racism and build racial literacy in order for racism and racial discrimination present via interpersonal encounters within health care settings and classrooms [to be addressed], as well as to engender commitment to advocating for structural change and anti-racism action within communities and institutions (Priest et al. 2021:48).*

Summary of key learnings

Although more evaluation outcomes have emerged since 2011, further work is needed to identify the impact of cultural training in terms of participant learning outcomes, its influence on organisations taking on cultural safety change initiatives and the outcomes of this work, as well as the health and human services experiences and outcomes for Aboriginal and Torres Strait Islander peoples. Given those constraints, the current literature points to training in cultural safety, versus other approaches, as having more potential to result in improvements in both sets of outcomes.

Our colleagues in Aotearoa New Zealand, who have a longer history with cultural safety as a concept, have reached a similar conclusion that the required approach is 'a transformative concept of cultural safety, which involves a critique of power imbalances and critical self-reflection' (Curtis et al. 2019, p. 15).

Training by itself cannot address racism in all its forms and strengthen and embed cultural safety in policy and practice. To achieve a sustained improvement in Aboriginal and Torres Strait Islander peoples' health and human services experiences and outcomes, training needs to be accompanied by other committed and long-term organisational cultural change strategies (Bainbridge et al. 2015; CATSINaM 2018a, 2018b; Doran, Wrigley & Lewis 2019; Fleming, Creedy & West 2017; Gollan & Stacey 2018, 2021c, 2021d; Hunter et al. 2021; Mohamed & Stacey 2017; Pederson et al. 2003; Priest et al. 2021; Sherwood & Mohamed 2020). It is only through such an approach that cultural safety is not only strengthened but embedded as the 'business as usual approach' in health, human services, and educational institutions.

Key learnings on the impact of cultural training

- Literature on the outcomes of cultural education in university curricula and cultural training in the workplace has increased since 2011. Most literature reflected health and human services and higher education environments.
- Data on longer-term impacts of cultural training on individuals or the organisations in which they work remains limited.
- While some evaluated training was titled cultural safety or intended to improve participant capacity for culturally safe healthcare, the training content resembled cultural awareness training.
- Based on available evidence, outcomes from cultural awareness, cultural respect and cultural competence training are mixed, unclear, or not sustained. Improvements appeared to relate to the degree to which the content resembled key elements of cultural safety training.
- When evaluated training had a closer fit with the description of cultural safety training, stronger positive outcomes were reported.
- Tools for assessing the impact of cultural training and education are starting to be developed and tested.
- The literature points to cultural safety training as an approach with more potential to result in improvements in both health and human services experiences, and outcomes for Aboriginal and Torres Strait Islander peoples.
- While training is a vital strategy, it is only one of several strategies required to address, reduce and prevent racism, strengthen and embed cultural safety, and achieve sustained improvement in Aboriginal and Torres Strait Islander peoples' health and human services experiences and outcomes.

Elements of good practice in cultural safety training

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2021-2031* (Department of Health 2022) states that a supportive, culturally safe health and education system will enable the Aboriginal and Torres Strait Islander health workforce to grow.

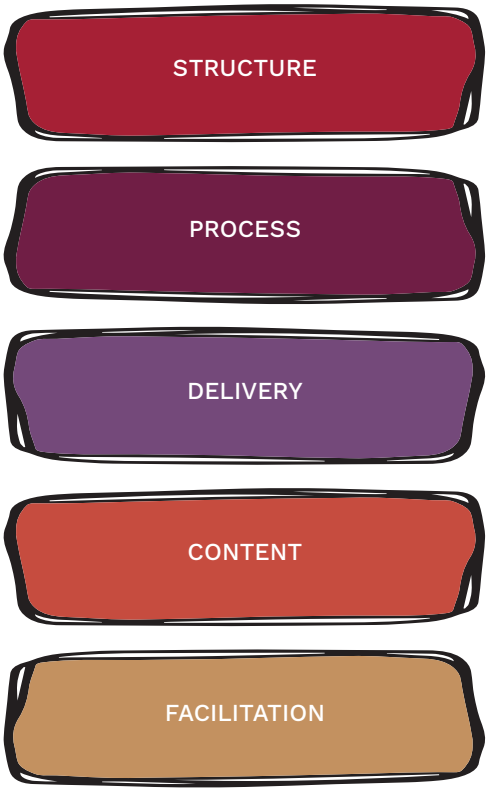
Reflecting the guidance and advocacy of national Aboriginal and Torres Strait Islander organisations over time, the Framework notes this will require significant improvements to strengthen cultural safety, including:

- sector-level change in education and training
- training across the health and community services workforces
- training for professionals across the whole health system to ensure Aboriginal and Torres Strait Islander peoples experience culturally safe and responsive healthcare
- measuring behaviours and experiences to ensure that cultural safety training and development is translating into improved cultural safety outcomes.

Therefore, it is imperative that the elements of good practice in cultural safety training can be articulated. The original NACCHO CST Standards (2011) represented what the Aboriginal community controlled heath sector viewed as good practice in cultural safety training at that time.

These were reiterated and expanded upon in the Lowitja Institute-led 2020 Accreditation of CST Standards initiative. Many of these elements have been identified by other authors in describing good practice in cultural training.

This section outlines the five elements of CST standards developed through these combined initiatives to propose a contemporary set of national standards. It provides the rationale for them based on the literature and the knowledge and experience of the critical friends involved in both initiatives.



Element 1 – Structure

Standard 1.1: Program description

Essential: CST programs are clearly described as cultural safety training and/or are focused on achieving culturally safe environments and experiences.

Standard 1.2: Program length

Essential: The total length of CST programs comprises a minimum of seven hours, not including breaks, pre-program, or post-program activities, which may occur over one or more sessions.

Highly recommended: CST programs are offered over a greater number of hours, preferably the equivalent of two days.

Standard 1.3: Learning outcomes

Essential: CST programs have clear learning outcomes for participants that cover, at a minimum:

- improved ability to explain the impact of racism on Aboriginal and Torres Strait Islander peoples' health
- greater knowledge of Australian history and the treatment of Aboriginal and Torres Strait Islander peoples
- greater understanding of the ongoing impact of this historical legacy
- greater capacity to understand white privilege and how it influences Australian society and impacts on Aboriginal and Torres Strait Islander peoples' lives
- improved ability to explain what they need to do in their role to create cultural safety and why
- improved ability to explain what needs to change in the organisation or system they work in to create cultural safety and why.

RATIONALE

Given the ongoing confusion about cultural training terms outlined in the 'Key terms and concepts' and 'Impact of cultural safety training' sections of the paper, alignment between the title, focus of the training program description and the stated learning outcomes is vital, which can then be verified against *Element 4: Content*.

Regarding length, Farrelly and Lumby (2009) emphasised that short-term programs of a day or less had limited impact, so training that is frequent, long-term, and ongoing was preferable. A more recent effort to offer medical tutors cultural safety training through a half-day workshop recognised this single 'cultural-diversity training event to be helpful but insufficient' (Merritt et al. 2018:21). In their experience of cultural competence training for university staff, Fredericks and Bargallie (2016) would have preferred to offer a two-day program but had resistance from the leadership. Research by Fleming, Creedy and West (2019a:556) found that 'those who attended a [cultural safety] workshop for one or more days (56%) reported significantly higher awareness of racism compared to those who had not'.

Element 2 – Process

Standard 2.1: Welcome to Country or Acknowledgement of Country

Essential: CST programs commence with an Acknowledgement of Country, and recognition of Traditional Owner Groups, Custodians, Nations, or Tribal Language Groups.

Highly recommended: CST programs commence with the conduct of a Welcome to Country by a representative of Traditional Owner Groups, Custodians, Nations, or Tribal Language Groups who is paid a fee for this role. CST facilitators demonstrate they understand the significance of this protocol.

Standard 2.2: Participant pre-knowledge and expectations

Essential: CST programs have a process or activity conducted prior to or at the beginning of the CST program that identifies:

- what participants know about cultural safety prior to the workshop
- what their learning expectations are for the workshop.

Standard 2.3: Evaluation and program development

Essential: CST programs require participants to evaluate their experience and learnings at completion of the program. Outcomes are analysed and used to refine the program.

Standard 2.4 Knowledge translation and application

Essential: CST programs promote or undertake follow-up activities that evaluate participant and/or organisation progress with applying their learnings (for example, three or more months later). Outcomes are analysed and used to refine the participants' or the organisation's approach to cultural safety.

RATIONALE

Welcome to Country and Acknowledgement of Country have increasingly become a standard protocol in many health and human services environments to commence meetings, workshops, forums, and other gatherings. Given the purpose of CST, it is essential that this occurs.

It is abundantly clear from the 'Impact of cultural safety' section that despite an increase in evaluation over the last decade since the original NACCHO CST standards (NACCHO 2011) there is much more work to be done in the evaluation of CST as one of multiple strategies needed to facilitate systemic change for a racism-free and culturally safe environment. Therefore, the critical friends of the Lowitja Institute Accreditation of CST Standards initiative extended this focus in the proposed national standards.

Element 3 – Delivery

Standard 3.1: Learning environment

Essential: CST programs have a process or activity that helps participants work together in safe ways to discuss sensitive and challenging areas that will be covered in the workshop content.

Standard 3.2: Delivery strategies

Essential: CST programs include a range of interactive delivery strategies to ensure learner engagement.

Highly recommended: CST programs are supplemented or complemented by other strategies; for example, follow-up activities based on recommendations from the facilitators, including readings, visual and online resources.

Standard 3.3: Delivery modality

Essential: CST programs are delivered through one or more modalities, such as face-to-face, online and/or connected learning with interactive elements.

Highly recommended: CST programs are delivered face-to-face.

Standard 3.4: Critical self-reflection

Essential: The activities within CST programs require participants to engage in critical self-reflection regarding:

- how dominant culture values and beliefs shape their behaviour and interactions with Aboriginal and Torres Strait Islander peoples at an individual level
- what they can change and do to improve their interactions with and responses to Aboriginal and Torres Strait Islander peoples, and identify one thing they will implement within the next month
- what strategies need to be developed and implemented to ensure the organisations and systems they work within embed cultural safety.

Standard 3.5: Range of program materials

Essential: CST program facilitators:

- support program delivery through a range of program materials and methodologies that participants use within or following the training
- emphasise that participants respect the intellectual and cultural property of Aboriginal and Torres Strait Islander peoples that is shared by facilitators.

Highly recommended: CST programs promote the use of resources and references endorsed by Aboriginal and Torres Strait Islander organisations. Wherever possible, these will be authored or created by Aboriginal and Torres Strait Islander peoples.

RATIONALE

The concepts and topics covered in cultural safety training are often confronting and challenging to non-Indigenous participants. Creating a safe environment is necessary to enable 'transformative learning' (Gollan & O'Leary 2009; Mills et al. 2021) through both modelling and facilitating critical reflection or reflexivity for participants as a core teaching method. This was strongly advocated by critical friends for the CST initiatives and repeated emphasis on its value and importance was evident in the literature and associated with more effective programs.

Critical self-reflection or reflexivity is a means of assisting participants to discuss and process the discomfort they experience in order to disrupt complacency, rejection or defensiveness regarding content such as racism and white privilege, re-assess their personal identity and values, and recognise what steps they need to take in creating cultural safety (Babacan 2013; Fredericks & Bargallie 2016, 2020; Gollan & O'Leary 2009; Gollan & Stacey 2018; Kowal, Franklin & Paradies 2013; Wilson et al. 2015).

Mills and Creedy (2019) referred to the 'pedagogy of discomfort', a necessary process as students undertake critical inquiry or critical self-reflection on their personal values and beliefs on the pathway to developing a sense of responsibility to act. Through an analysis of students' critical reflective essays during a First Nations health and cultural safety course, they examined how students worked through the discomfort they experienced as they 'acknowledged preconceived ideas', named and started to process 'uncomfortable emotion', and demonstrated 'fragile identities' as they had to re-understand who they were or thought they were. At this point in their journey, students were divided between 'spectating' (that is, there is a problem out there, but they were not implicated, nor did they need to take responsibility for it), and 'witnessing' (that is, there is a problem, I am part of it, and can do something to address it).

The experience of cultural safety for participants facilitates cognitive dissonance, disrupts confirmation bias, and highlights the need to manage one's fragility. Therefore, psychological, sociological, and educational theories have been utilised in developing effective approaches to training delivery and facilitating learning, combined with Indigenous ways of knowing being and doing. The former is evident in who is cited in the different papers referenced through this and the 'Impact of cultural safety training' section, such as Boler (1999), Ahmed (2013), Macdonald (2002), Moreton-Robinson (2000) and as far back as Luft and Ingham (1955).

Juanita Sherwood and Lynore Geia, Aboriginal and Torres Strait Islander nurses, academics, and researchers, highlighted the importance of critical self-reflection skills for nurses and other health professionals:

> *The stories that health practitioners learn about Aboriginal and Torres Strait Islander health – whether through the media, or through school, families or connection to communities – influence the ways in which they work with Aboriginal and Torres Strait Islander clients. At the level of patient care, the ways in which nurses think about, talk about and deliver care to Aboriginal and Torres Strait Islander people will depend on the narrative being played in their heads. Is that story positive or negative? Is it one of hope or hopelessness? Nurses make value judgements about their clients – whether they intend to or not – and these judgements invariably influence the ways in which they deliver patient care (Sherwood & Geia 2018:8).*

Confidence in critical self-reflection as a pathway to transformative action was also expressed by Hall et al. (2023:1):

> *..the ongoing critical reflection and prioritising of equalised relationships with the oppressed, inherent within critical consciousness theory, is the most effectual pathway to promoting cultural safety for Aboriginal and Torres Strait Islander peoples and genuine allyship.*

Training delivery through multiple methods and interactive approaches were features of several evaluated cultural safety training programs. In their exploration of effective cultural safety training approaches for staff in tertiary health education, Gladman, Ryder and Walters (2015) tailored different approaches and activities for clinical, academic, or professional staff around core content. Farrelly and Lumby (2009:19) outlined what they believed to be good practice in training in relation to delivery strategies and program materials, which is consistent with the recommendations of the CST initiatives critical friends who had long-standing experience in delivering cultural safety training:

> *..training should adopt a learner-centred, reflective learning, solution-focused approach, and utilise a variety of training methods, including experiential learning, two-way learning, presentations, group discussion, case studies, small group learning, role plays, participant observation, problem-based learning using scenarios, games, and the use of audio-visual material.*

Element 4 – Content

Standard 4.1: Aboriginal and Torres Strait Islander Countries and Peoples

Essential: CST programs emphasise the shared and unique aspects of the cultural values, beliefs, protocols and languages of different Countries of Aboriginal peoples and Torres Strait Islander peoples, including the variations that may exist within countries.

Standard 4.2: Historical truth-telling

Essential: CST programs provide a truthful account of Australian history and how it has impacted and influenced relationships between Aboriginal and Torres Strait Islander peoples and non-Indigenous peoples, including historical truth-telling about or from the local context. This account covers the impact of colonisation following invasion (that is, laws and policies enacted against Aboriginal and Torres Strait Islander peoples), and Aboriginal and Torres Strait Islander peoples' advocacy to regain their rights.

Standard 4.3: Localised context

Essential: CST programs reflect the experiences and priorities of the Traditional Owners or Custodians.

Highly recommended: CST program providers promote that organisations undertake additional training with Aboriginal peoples from the local area. Wherever possible, these include Traditional Owner Groups, Custodians, Nations or Tribal Language Groups, or people involved with Aboriginal community controlled services.

Standard 4.4: Racism and its impact on health

Essential: CST programs clearly identify and name racism in all its forms, and explore:

- the impact it has on the health status of Aboriginal and Torres Strait Islander peoples
- how it occurs in healthcare systems and everyday experiences for Aboriginal and Torres Strait Islander peoples, both historically and at present
- the need for affirmative action to redress it.

Standard 4.5: Dominant culture and white privilege

Essential: CST programs explain what dominant culture means and explores the meaning and implications of white privilege in the Australian context.

Standard 4.6: Aboriginal and Torres Strait Islander health

Essential: CST programs:

- share the National Aboriginal Health Strategy and NACCHO definitions of Aboriginal health
- provide clear and accurate information on the factors contributing to Aboriginal and Torres Strait Islander peoples' health status.

Standard 4.7: Aboriginal community controlled health services

Essential: CST programs provide clear information on:

- the history and evolution of the Aboriginal community controlled health (ACCH) sector
- why ACCH services are effective at meeting the needs of Aboriginal peoples, including how ACCH services are based on a) the philosophy of self-determination and a human-rights based approach, b) the concept of community control, and c) comprehensive primary healthcare (holistic healthcare).

RATIONALE

In an early paper examining the components of cultural training, Hollinsworth (1992) emphasised that addressing ideological racism (also known as cultural racism) and institutional racism, were essential requirements in recognising, addressing and combatting racism. He described 'anti-racist training' as meeting this criterion. He noted a significant risk that, in cultural awareness training, 'cultures tend to be essentialised and cultural difference and consequent misunderstanding are seen as the problem' (Hollinsworth 1992:42). In contrast, the focus of anti-racist training was 'on the power relationships inscribed in both structures and processes of domination and subordination, and in the ideological discourses which reproduce and legitimate those relations as "natural" or "commonsense"' (Hollinsworth 1992:42).

Based on research about the experiences of Aboriginal and Torres Strait Islander women in a nursing context, Fredericks (2006) argued that cultural awareness or cross-cultural awareness training needed to extend or be followed by anti-racism training and address white privilege. In research on Aboriginal and Torres Strait Islander peoples' experiences of racism, Gallaher et al. (2009) emphasised that examining white privilege, through historical truth-telling and contemporary realities, was critical to the success of anti-racism strategies, including training.

Gollan and O'Leary (2009:710) described the importance of training that:

> *..explicitly names, explores and deconstructs dimensions of racism. This is coupled with an expectation that non-Indigenous students identify and understand whiteness, and develop their capacity to be accountable for the white privilege afforded them through their membership of the dominant culture.*

Durey (2010:S90) described how cultural education should include:

> *..opportunities for participants to reflect on their own culture and how their beliefs and practices intersect with those from other cultural backgrounds. Despite good intentions that 'I am not racist, I treat everyone the same', the reality can be different. Programs encouraging participants to reflect on their own culture can lead to identifying their experiences and understanding how their actions impact on those from different cultural backgrounds. This process can be confronting as participants realise they may be part of the problem rather than the solution.*

Based on a review of strategies to strengthen cultural competence among GPs, Watt, Abbot & Reath (2016:9) recommended that 'increased training focus on non-conscious bias, anti-racism training and self-reflectiveness is required'. Fleming, Creedy & West (2019b:183) stated that: 'It is not possible to discuss Cultural Safety without discussing racism'. Bond, Singh and Kajilich (2019) emphasised that anti-racism strategies and working towards cultural safety requires exploring whiteness through colonisation and the contemporary context. Kerrigan et al. (2020:9) stressed that health services staff needed training that would 'address unconscious bias and institutional racism through critical self-reflection'.

In their grounded theory study of how mental health professionals develop their ability to provide culturally safe care to Aboriginal and Torres Strait Islander clients, McGough, Wynaden and Wright (2018:211) reported how unprepared most mental health professionals felt to do this, and that organisations must develop explicit and committed strategies to achieve this, including through training. They recommended:

> *Recognising the level of racism occurring, and reflections on attitudes and positions of power and white privilege, are essential in providing cultural safety... Clinicians are accountable for their own attitudes and practices and therefore must examine their assumptions in order to critically reflect on whether current practices promote or compromise health and wellbeing. Clinicians are encouraged to explore cultural safety training as part of ongoing professional and personal development.*

Work on cultural safety in Canada echoes this position (Churchill et al. 2017; Elliot et al. 2019; Ward, Branch & Fridkin 2016); for example, 'the most effective programs strive towards cultural safety, and curriculum focuses on power, privilege, equity, de-colonization and anti-racism' (Elliot et al. 2019:39).

All cited published work was consistent with the long-standing experience of the critical friends in the CST initiatives, including this recent statement:

> *Contemporary approaches in cultural safety education require the inclusion of a broader focus on power differentials, institutional racism and 'whiteness' in the delivery of safe, accessible and responsive healthcare free of racism (Hall et al. 2023:5).*

Element 5 – Facilitation

Standard 5.1: Facilitators

Essential: CST programs are delivered by Aboriginal and Torres Strait Islander facilitators and may involve non-Aboriginal co-facilitators over the duration of the program.

Highly recommended: CST programs are delivered through a partnership between Aboriginal and Torres Strait Islander facilitators and non-Aboriginal co-facilitators over the duration of the program.

Standard 5.2: Facilitator cultural integrity and critical self-reflection

Essential: All CST program facilitators can demonstrate cultural integrity, cultural insight, emotional intelligence, and critical self-reflection in working with Aboriginal and Torres Strait Islander peoples.

Standard 5.3: Managing a sensitive learning environment

Essential: All CST program facilitators are experienced in facilitating group learning and complex group dynamics successfully.

Highly recommended: CST program facilitators have relevant qualifications and/or lived experience in training facilitation, teaching or the delivery of educational activities.

Standard 5.4: Facilitator safety

Essential: CST program training providers consider the safety of facilitators and implement a range of support strategies to address facilitator safety.

Highly recommended: CST programs are run by two (or more) facilitators.

Standard 5.5: Facilitator self-assessment

Essential: CST program facilitators undertake formal self-assessment processes with reference to participant evaluation data (Standard 2.3) so they can:

- identify opportunities to strengthen their facilitation process
- improve the workshop structure and content.

RATIONALE

The critical friends in both CST initiatives viewed facilitation as a crucial factor in successful cultural safety training. Their recommendations for facilitator standards were consistent with available literature on effective cultural safety training described below and for *Element 3 – Delivery*, specifically in relation to critical self-reflection.

In reflecting on the role that facilitators must take, McDermott (2012:15) emphasised that:

> *Developing new frameworks of thinking may require disassembling existing planks of belief: a transformative unlearning. Good cultural-safety education generates disquiet, but makes the uncomfortable comfortable enough, through sensitive classroom facilitation in a*

mutually respectful environment. When an Indigenous health curriculum includes analyses of the health consequences of racism – as it needs to – it struggles against non-recognition of racist acts and systemic discrimination. The challenge, then, is twofold: to make the invisible visible, and to facilitate a 'manageable' disquiet.

Facilitating cultural safety training can be challenging and draining for facilitators. Having two facilitators shares the role of managing participants' emotional struggles and/or resistance, and supports debriefing on a shared experience (Fredericks & Bargallie 2016). Participant struggles and resistance can have more impact for Aboriginal and Torres Strait Islander facilitators, for whom racism and white privilege is a daily reality. This can be reduced or buffered by non-Indigenous co-facilitators in two ways: 1) taking responsibility to respond to participants during and after the workshop, as negotiated with their Aboriginal and Torres Strait Islander co-facilitator, and 2) checking in with and supporting the Aboriginal and Torres Strait Islander co-facilitator in the debriefing process (Gollan & O'Leary 2009; Gollan & Stacey 2018).

In a university context, Flavell, Thackrah & Hoffman (2013:52) focused on the importance of a facilitation partnership between Aboriginal and non-Aboriginal people in delivery of cultural safety and/or cultural competence education:

Key to the success of the unit, however, was that it was designed and delivered in a partnership with Aboriginal and non-Aboriginal academics underpinned by a Memorandum of Understanding foregrounding Aboriginal Terms of Reference. Relationship building and reciprocity were key elements in the partnership... recognising Aboriginal knowledge as a 'way of being' linked strongly to spirituality, land and community rather than content to be inserted into curriculum... These elements are crucial, particularly in a unit aimed at developing Indigenous cultural competency, as the recreation of colonial structures would not model appropriate cultural sensitivity or create cultural safety.

An Aboriginal and Torres Strait Islander/non-Indigenous partnership is considered a core requirement for success by facilitators with long-standing experience in cultural safety training in a broad range of contexts. Gollan and O'Leary (2009:711) call this 'black–white partnership teaching' that offers 'practical ways of demonstrating... accountability' to students regarding the benefits of white privilege. They describe:

..black–white partnership teaching as an experiential and transformative approach to learning about injustice and privilege. It requires the Indigenous and non-Indigenous academics to develop and demonstrate trust, goodwill, respect, responsibility and partnership, and commit to an ongoing project based on a shared and transparent purpose.

There is a specific role for the white, non-Indigenous facilitator where they take responsibility for the learning process as negotiated with the Aboriginal and/or Torres Strait Islander facilitator, while also respecting and privileging the voice and leadership of the Aboriginal and/or Torres Strait Islander facilitator:

In black–white partnership teaching, white teachers demonstrate accountability and awareness of what whiteness means by stepping into classrooms to model the white role and white responsibility while working with black teachers. This assists students or already qualified practitioners to take the learning gained from the course content, process and teaching partnership model into the field where they work with Indigenous colleagues, clients and communities (Gollan & O'Leary 2009:712).

This outcome was observed in Gollan and O'Leary's (2009) qualitative study where students described the black-white teaching partnership as critical to their learning experience and understanding how to undertake their future role in a safe and respectful manner. Gollan and Stacey (2018) also noted that this facilitation approach is commented upon spontaneously by participants in the evaluation of cultural safety training as notable learning, giving them a model of how they can apply cultural safety concepts in practice.

The value of Aboriginal and Torres Strait Islander/non-Indigenous facilitation partnership was verified in the evaluation of a cultural safety program for midwifery academics:

> *A partnership model for program development and facilitation is paramount to acknowledge First Peoples participation, knowledge(s) and expertise. The facilitators (preferably First Peoples) need to be trusted, respected and capable of supporting yarning that promotes reflexivity and facilitates challenging conversations (Fleming, Creedy & West 2019b:183).*

Further and ongoing support for partnership models as the practice and demonstration of allyship was expressed in another recent paper:

> *To facilitate authentic allyship non-Indigenous academics must critically reflect, to challenge their own notions of privilege and 'whiteness', their identity as an academic, vested interests, reputation and career risks. There is much to be gained from working through these challenges, by taking the opportunity to contribute to a larger body of knowledge of how non-Indigenous academics can work collaboratively within an Aboriginal and Torres Strait Islander led approach that genuinely impacts on, and benefits, the lives of Aboriginal and Torres Strait Islander people (Hall et al. 2023:9).*

Allyship

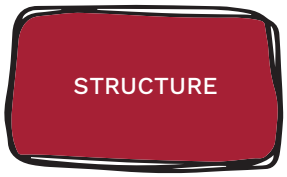
'An ally is an individual or a group who possess structural power and privilege and stand in solidarity with peoples and groups in society without this same power or privilege' (Gollan & Stacey 2021:17).

'Being an ally is an ongoing strategic process of critical reflection, education, listening, and action, both of oneself and the environment and structural factors that have helped create social inequity and systemic racism' (Mohamed et al. 2022:34).

The use of the term 'allyship' has grown in Australia over the last decade and is vital to the future expansion of cultural safety so there is a larger pool of well-equipped non-Indigenous people who can be co-facilitators. In practical terms, having done cultural safety training, developing the skills to become a co-facilitator and support the expansion of cultural safety training and practice is a way that non-Indigenous people can give back or reciprocate for the learning they have gained.

This represents non-Indigenous people moving from transformative learning to enacted learning. Other words that can be used to describe this growth are moving from being 'unconsciously incompetent' to 'consciously incompetent', 'consciously competent' and finally 'unconsciously competent' (Department of Health and Human Services 2019b).

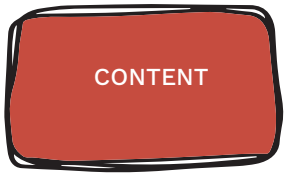
Overview of revised National Cultural Safety Training Standards



1.1: Program description
1.2: Program length
1.3: Learning outcomes

2.1: Welcome to Country or Acknowledgement of Country
2.2: Participant pre-knowledge and expectations
2.3: Evaluation and program development
2.4: Knowledge translation and application

3.1: Learning environment
3.2: Delivery strategies
3.3: Delivery modality
3.4: Critical self-reflection
3.5: Range of program materials



4.1: Aboriginal and Torres Strait Islander countries and peoples
4.2: Historical truth-telling
4.3: Localised context
4.4: Racism and its impact on health
4.5: Dominant culture and white privilege
4.6: Aboriginal and Torres Strait health
4.7: Aboriginal community controlled health services

5.1: Facilitators
5.2: Facilitator cultural integrity and critical self-reflection
5.3: Managing a sensitive learning environment
5.4: Facilitator safety
5.5: Facilitator self-assessment

Resources for strengthening, embedding and evaluating cultural safety

Cultural safety resource development that can support assessment of learnings from cultural safety training and their translation into action has expanded since the original NACCHO CST Standards initiative (NACCHO 2011). This section provides a brief overview of resources that have emerged since 2010 in these three categories:

- Guidance on culturally safe practice
- Assessment of cultural safety knowledge, practices, attitudes and/or commitments
- Planning and/or evaluation of cultural safety initiatives and their impact.

This overview is informed by a Lowitja Institute-commissioned review of research related to cultural safety (Stacey & Gollan 2021a) which included an environmental scan of resources available for translating cultural safety knowledge into policy and practice.

Guidance on culturally safe practice

Resources providing guidance on culturally safe practice at individual and/or organisational levels usually take the form of frameworks:

- **National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) Cultural Safety Framework:** This Framework (NATSIHWA 2013) outlines eight domains for organisations to focus on if they want to strengthen cultural safety: Country and community, local cultural contextuality, recognising and valuing the role of Aboriginal and Torres Strait Islander health workers and practitioners, individual reflection, systemic reflection, equity and sustainability, collaboration and cooperation, and monitoring and evaluation. Within each domain, core standards, knowledge and practices are described, as well as enablers, performance indicators and monitoring and evaluation considerations.
- **Indigenous Allied Health Australia (IAHA) Cultural Responsiveness Framework:** There are six interconnected capabilities in this framework (IAHA 2015, 2019): respect for the centrality of cultures, self-awareness, proactivity, inclusive engagement, leadership, and responsibility and accountability. It describes how an individual or organisation would demonstrate their 'knowing', 'being' and 'doing' for each capability. It also outlines the outcomes that could be achieved at organisational and individual (person or practitioner) levels if each capability was being demonstrated well.
- **Western NSW Primary Health Network (PHN) Cultural Safety Framework:** This regional organisational framework (Western NSW PHN 2016a) outlines six standards to guide the commissioning of health services and sets a standard to be met by organisations seeking funding through the PHN. It is complemented by a self-assessment and evaluation tool for organisations seeking funding from the PHN (Western NSW PHN 2016b).

- **Department of Health and Human Services (DHHS) Cultural Safety Framework:** This Victorian Framework (DHHS 2019a) is mapped across three domains: 1) creating a cultural safety workplace and organisation, 2) Aboriginal self-determination, and 3) leadership and accountability (see more below).
- **Australian Evaluation Society (AES) First Nations Cultural Safety Framework:** This framework (Gollan & Stacey 2021a) focuses on culturally safe evaluation. It outlines principles of culturally safe evaluation, provides practical guidance on the roles and responsibilities of different stakeholders in the evaluation process, and what contributes to culturally safe evaluation across all phases of evaluation. It also identifies outcomes that could be achieved if the Framework is implemented in full.

Assessment of cultural safety knowledge, practices, attitudes and/or commitments

This set of resources supports the assessment of cultural safety training on participants and/or assessing the development of cultural safety knowledge, practices, attitudes and/or commitments over time for individuals or organisations.

- **National Centre for Education and Training on Addiction Indigenous Workforce Development Checklist:** This checklist (Bates, Weetra & Roche 2010) focuses on cultural safety for Aboriginal and Torres Strait Islander workers in both Aboriginal and Torres Strait Islander and non-Indigenous organisations. It has a Yes/No/Not applicable response to use for included questions, as the basis for discussion about cultural safety and support for Indigenous workers and what strategies organisations need to have or strengthen.
- **Institutional racism matrix:** This matrix (Marrie & Marrie 2014) was used to audit all Queensland's 16 health and hospital services (Marrie 2017), as well as do a follow-up audit on one health and hospital services (Bourke, Marrie & Marrie 2019). It was designed to 'only use publicly available information provided by hospitals and healthcare organisations (notably annual reports, health service agreements, strategic and operational plans) in the assessment process' (Bourke, Marrie & Marrie 2019:614). It has 13 criteria covering five domains: governance, policy implementation, service delivery, recruitment and employment, and financial accountability. This results in an overall score to determine the level of institutional racism in the organisation.
- **Awareness of Cultural Safety Scale (ACSS):** The ACSS (Milne, Creedy & West 2016:23) is a 12-item tool designed to 'assess awareness of cultural safety and foster purposeful

consideration of ways in which nursing and midwifery academics can improve Indigenous student success in higher education'. It is specific to cultural safety education in universities or higher education settings.

- **Cultural Safety Continuum Reflective Tool for the Victorian health, human and community services sector:** This Victorian Cultural Safety Framework (DHHS 2019a) has a linked reflection tool outlining the four stages of learning towards cultural safety (DHHS 2019b:6) with both an individual and organisational focus. The set of reflection questions assists individuals or organisations to identify where they sit in their learning journey across each of three domains, that is, from being unconsciously competent or unaware, consciously incompetent, or emerging, consciously competent or capable and unconsciously competent or proficient in cultural safety. It is intended as a reflective process with a set of possible actions that may address the individual's and organisation's responses that can inform what cultural safety strategies they may need to implement.
- **Aboriginal Cultural Engagement Self-Assessment Tool:** This tool, originally created in 2020, 'aims to identify ways of strengthening cultural engagement between NSW Health organisation staff and their Aboriginal stakeholders by bringing a continuous quality improvement cycle to cultural engagement' (NSW Ministry of Health 2020; 2024:3) and to help assess whether cultural safety and accessible care is available. It has 54 items in total across five areas rated according to whether they are/are not met in current practice, which are cross-referenced to both the 2nd edition of the *National Safety and Quality Health Service Standards* (ACSQHC 2017) and the NSW Ministry of Health (2012) *Aboriginal Health Plan*.
- **Student Emotional Learning in Cultural Safety Instrument (SELCSI):** The SELCSI (Mills et al. 2021:2) examines any shift in 'the emotional mechanisms that may contribute to, or inhibit, transformative learning' in cultural safety learning in a higher education context. It has two scales – a 12-item 'Witnessing' scale and an eight-item 'Comfort' scale. The authors anticipate the tool may generate greater understanding of how students learn to practice in culturally safe ways in their professional roles. They have since used it with a cohort of health professional students to assess their progress after a semester long cultural safety university course (Mills et al. 2022).
- **Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing Study scales:** The Mayi Kuwayu research team (Thurber et al. 2021b) both developed and field tested a brief self-report eight-item instrument designed to capture experiences of discrimination in everyday life and a four-item instrument focused on experiences in healthcare. Their work noted and was designed to complement an earlier 'Measure of Indigenous Racism Experience' tool (Paradies & Cunningham 2008, 2009). Both instruments ask respondents whether they think any discrimination is 'because you are Aboriginal/Torres Strait Islander?' The team proposed the instruments could be 'used to enable valid measurement of discrimination's prevalence, in order to identify priority targets for action, quantify discrimination's contribution to health and health inequities, monitor trends, and evaluate interventions' (Thurber et al. 2021b:9). This tool could be utilised as one of several measurement tools for organisations undertaking cultural safety initiatives.
- **Cultural Safety Audit Tool for Individuals:** This audit tool (Gollan & Stacey 2021b) is designed to assess an individual's level of development

in understanding critical elements of cultural safety and working towards creating culturally safe experiences for Aboriginal and Torres Strait Islander peoples. It can be used by both non-Indigenous and Aboriginal and Torres Strait Islander people working in a broad range of organisations and used on a regular basis, such as every six or twelve months. Individual staff can complete it as a self-assessment, although it is possible for individuals to be assessed by another person. It is available from Lowitja Institute as a commercial resource.

- **Cultural Safety Audit Tool for Organisations:** This audit tool (Gollan & Stacey 2021c) is designed for whole of organisation use to assess the commitment to and level of development in embedding cultural safety across an organisation according to eight core focus areas for all organisations and an additional two focus areas for higher education contexts. It can be done in two ways – as a self-assessment conducted by staff or by external stakeholders, or through a combined group or staff and external stakeholders (the latter is the recommended approach). It is designed to be repeated on a regular basis, such as every 6 or 12 months, to track an organisation's progress with embedding cultural safety and to guide ongoing planning and strategy implementation.
- **Australian Reconciliation Barometer:** Reconciliation Australia commissions research on this barometer biennially (Polity Research & Consulting 2022). It uses a weighted process to represent the balance of both non-Indigenous and Aboriginal and Torres Strait Islander people on age, gender and geographical location, modelling this from the most recent Australian Bureau of Statistics census data. This provides a broad indication of the experiences and opinions of involved participants about relations between and Aboriginal and Torres Strait Islander and other Australians, and matters that affect progress with reconciliation, rather than being specific to cultural safety.

Other tools may exist that are not publicly available at present or are undergoing further development for direct application to cultural safety training (for example, Rissel et al. 2021; Ryder et al. 2019).

Planning and/or evaluation of cultural safety initiatives and their impact

A notable outcome from the Lowitja Institute-commissioned review (Stacey & Gollan 2021a) was that no tools existed that provided guidance on how to design, monitor and evaluate an organisational cultural safety strategy initiative to ascertain its impact over time. Therefore, Lowitja Institute commissioned development of a tool that could support organisations to do this.

Through its involvement with development of the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* (Department of Health 2022), Lowitja Institute was aware that the impetus to do this had started to extend beyond the sustained advocacy of Aboriginal and Torres Strait Islander individuals and organisations. The first two strategies under 'Strategic Direction 3: Aboriginal and Torres Strait Islander people are employed in culturally safe and responsive workplace environments that are free of racism across health and all related sectors' read:

> *3.1 Government and non-government organisations undertake cultural safety reviews and remedial actions to address the legacy of institutional racism in the health, education and training sectors.*

3.2 Government and non-government organisations develop, implement and evaluate cultural safety initiatives to eliminate all forms of racism and improve cultural safety in the health, education and training sectors (Department of Health 2022:48).

The **Cultural Safety Initiative Planning and Evaluation Template** (Stacey & Gollan 2021b) is a tool commissioned by Lowitja Institute that was originally developed in late 2021 and has a planned public release date of late 2024. The tool consists of a set of customisable documents across four elements of the planning and evaluation cycle that will be available as a commercial resource within the Resources section of the Lowitja Institute website. It is informed by four sets of knowledges, which are integrated to support organisations to achieve better outcomes from their cultural safety initiative: planning, cultural safety, organisational cultural change, and evaluation.

The resource is designed to:

- provide direction on what to include in an organisational cultural safety initiative
- streamline an organisation's work in planning an organisational cultural safety initiative
- guide how to evaluate progress and achievements of the initiative over time.

If all four elements of the template are used, an organisation will create four documents or sets of documents:

1. A cultural safety initiative plan to guide its work over a three-year period
2. A program logic poster that illustrates its initiative in one page and can be used to explain the initiative within and beyond the organisation
3. An evaluation strategy to monitor progress over the initiative timeframe
4. Several customised evaluation tools for implementing the evaluation strategy.

The template is complemented by the Cultural Safety Audit Tools for Individuals and Organisations, described earlier in this section. The Cultural Safety Audit Tool for Organisations can be used early to set a baseline for and inform the cultural safety initiative plan, then repeated over time as one of the evaluation tools for tracking progress. The individual tool can also be used on an organisation wide basis for the same purpose of setting a baseline and tracking change over time.

Conclusions and recommendations

Conclusions

Cultural safety was developed in a First Nations context based on First Nations knowledges (Ramsden 2002) and has been both adopted and adapted to the Australian context to advocate for justice and equity for Aboriginal and Torres Strait Islander peoples across health and human services. Cultural safety training seeks to address how racism operates, and the individual and institutional/systemic changes required to address, reduce, prevent and eliminate racism. It directly engages with equity, historical truth-telling and the ongoing effects of colonisation – it requires and promotes critical self-reflection, and clearly explores power relations and white privilege (Mohamed et al. 2021).

This paper has confirmed Lowitja Institute's consistent position that a focus on cultural safety is required if Australia is to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples, and that training needs to extend beyond cultural awareness to incorporate cultural safety training with a focus on lifelong learning. Further, the learning generated through cultural safety training must be translated into planned, implemented, and evaluated cultural safety initiatives that are institutionally supported and resourced so cultural safety becomes embedded into systems.

The work on cultural safety and cultural safety training that has occurred over the last decade-and-a-half indicates that updating and strengthening NACCHO's original national cultural safety training standards is warranted to reflect what has been learned over this time. The recent national survey of cultural training or cultural safety training delivered in health services (Hunter et al. 2021) made a recommendation of direct relevance to the focus of this discussion paper:

> *Consider development of cultural safety training standards (according to evidence and recommendation by peak bodies and representatives of Aboriginal Community Controlled Health Organisations) so training providers adhere to them and health service organisations can use them as reference when choosing a training provider. These could include aspects such as the topics training should cover (emphasis in components of cultural safety) and community leadership and participation (Hunter et al. 2021:49).*

This is exactly what occurred through the Lowitja Institute Accreditation of CST Standards initiative, which expanded on the original NACCHO CST Standards initiative (NACCHO 2011) with NACCHO's permission. The revised standards in the 'Elements of good practice in cultural safety training' section of this paper represent the historical and contemporary literature on good practice in cultural safety training. Along with others, Lowitja Institute has pursued the development of resources that can maximise the translation of learnings from cultural safety training into change at systemic, organisational, policy and practice levels.

Recommendations

UNDERSTANDING CULTURAL SAFETY AND CULTURAL SAFETY TRAINING

Recommendation 1: All national bodies with power and influence across health and human services clearly articulate the differences in definition and benefits between cultural awareness and cultural safety.

Recommendation 2: The revised National Cultural Safety Training Standards are promoted widely to achieve a shared understanding of what cultural safety training involves.

ACCREDITATION AND IMPACT OF CULTURAL SAFETY TRAINING

Recommendation 3: An accreditation body and process for assessing cultural safety training against the revised National Cultural Safety Training Standards is established, implemented, and supported to provide guidance on quality cultural safety training for health and human services organisations and other accreditation and registration bodies.

Recommendation 4: A system of reciprocity across relevant accreditation bodies is explored to achieve alignment with the revised National Cultural Safety Training Standards.

Recommendation 5: Opportunities to incorporate the National Cultural Safety Training Standards under the Tertiary Education Standards and Quality Agency (TESQA) are explored and Universities Australia utilise the standards to support further direction and resources as they implement and refresh their current Indigenous Strategy (Universities Australia 2022).

Recommendation 6: The development of tools for assessing the impact of cultural safety training is continued, expanded, and made available for widespread use across health and human services organisations.

PLANNING, MEASURING AND REPORTING IMPACT OF ORGANISATIONAL CULTURAL SAFETY INITIATIVES

Recommendation 7: The development of tools to plan, measure and track the impact of organisational cultural safety initiatives on the cultural safety of Aboriginal and Torres Strait Islander staff and clients is continued, expanded, and made available for widespread use across health and human services organisations.

Recommendation 8: Health and human services organisations commit to collation of their cultural safety impact at an individual and systemic level for accountable reporting; this includes reporting to the people with responsibility for overall governance of their organisation and transparent reporting to the public.

DATA ON CULTURAL SAFETY

Recommendation 9: National and comparable data sets on cultural safety are developed for supporting the accountability and evaluation of cultural safety commitments under national strategies and agreements, including the *National Aboriginal and Torres Strait Islander Health Plan 2021-2031, National Aboriginal and Torres Strait Islander Workforce Strategic Framework 2021-2031* and the *2020 National Close the Gap Agreement.*

Recommendation 10: Data sets are designed to measure the performance of systems, not Aboriginal and Torres Strait Islander people, and include data on Aboriginal and Torres Strait Islander people's experience of cultural safety in health and human services systems.

FURTHER RESEARCH AND REVIEW

Recommendation 11: Lowitja Institute is funded to undertake ongoing research into the application and improvement of cultural safety training and organisational initiatives on a national basis, which can inform the next review of the National Cultural Safety Training Standards and how Indigenous data governance and sovereignty is being managed for cultural safety data.

Recommendation 12: The next review and update of the National Cultural Safety Training Standards occurs prior to key national health strategies and agreements lapsing in order to inform their refresh or redesign process.

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Glossary

TERM	MEANING
Cultural determinants of health	The cultural determinants of health are anchored in Aboriginal ways of knowing, being and doing, centred upon the relationship of self to Country, kin, community, and spirituality. They are rights-based, as they hinge upon the inherent right to practice one's Aboriginal culture, including through connection to Country, family, kin and community; Aboriginal beliefs and knowledge; cultural expression and continuity; Aboriginal language; and self-determination and leadership (Salmon et al. 2019).
Cultural racism	'A form of racism expressed as a set of ideas based on social myths about other racial or ethnic groups, including First Nations peoples. This forms a narrative that repeated and reinforced at a socio-cultural level through many parts of our lives, including through families, schooling and in the media. It devalues and blames Aboriginal and Torres Strait Islander peoples for differences from dominant culture values and practices' (Gollan & Stacey 2021a:39).
Cultural safety	Cultural safety is an Aboriginal and Torres Strait Islander specific concept in Australia. It is an experience that Aboriginal and Torres Strait Islander peoples have and its presence or absence can only be determined by them (Bond, Macoun & Singh 2018; Bond, Singh & Kajilich 2019; Gollan & Stacey 2018; Mohamed & Stacey 2017). A culturally safe environment is created when Aboriginal people report that: • their experiences are believed and validated • their cultures are centred and valued in policy development, research, evaluation and service design and delivery • they feel welcomed and respected in policy, research, evaluation and service environments • they see other Aboriginal and Torres Strait Islander people working in the policy, research, evaluation or service context • they do not experience any form of racism in policy, research, evaluation and service contexts or processes (Mohamed et al. 2021).
Dominant culture	The set of values, beliefs, standards and systems that are considered the 'norm' and govern and organise every aspect of our lives in Australia (Gollan & Stacey 2021a:39).
Equity/inequity	Equity is the absence of unfair, avoidable, or remediable differences among groups of people (World Health Organization 2024); in Australia, this is often among Aboriginal and non-Aboriginal people. Health inequities then are unfair differences in health status or in the distribution of health resources between different population groups (World Health Organization 2018).

TERM	MEANING
Institutional racism	'Institutionalised racism is different from the repressive laws of the past that served overtly to oppress marginalised peoples. For Aboriginal people in Australia there is ample evidence of active oppression in past government legislation and practices that controlled people's lives. In contemporary times, however, institutionalised racism persists in the institutions and systems that exclude and discriminate against Aboriginal people. In contemporary times, society's institutions have the power to develop, sustain and enforce specific racialised views of people. The way that a society's economic, justice, educational and health care systems are applied can disadvantage certain groups of people when these systems do not cater for, or consider the cultural values or marginalisation of, members of those groups and thereby become forms of institutionalised racism. Institutional racism is embedded in these systems' (Dudgeon et al. 2014:16).
Intergenerational trauma	'This occurs when trauma is transmitted from one generation to the next. Australian First Nations people have a history of being systematically oppressed. This experience of historical trauma becomes accumulative and has psychological and physical effects that become repeated across generations through both epigenetic and socio-cultural means, which is exacerbated through contemporary experiences of trauma due to ongoing racism (Atkinson 2002; Atkinson et al. 2014)' (Gollan & Stacey 2021a:40).
Knowledge translation	Knowledge translation is 'the series of interactions we have with people...to connect research or evaluation outcomes to making needed changes in policy, programs and practice' (O'Donnell & Stacey 2022:31).
Meritocracy	A system, organisation or society in which people are chosen and moved into positions of success, power, and influence on the basis of their demonstrated abilities and merit (Merriam-Webster 2024).
Racial discrimination	Behaviour, whether it is overt or covert or intended or unintended, which disadvantages people who are identified on the basis of their real or assumed membership of a racial or cultural group (Gollan & Stacey 2021a:40).
Racial prejudice	'Attitudes expressed, whether in thinking or speech, towards people classified on the basis of their physical or cultural characteristics. Once identified as members of a particular racial or cultural group, people are judged according to presumed characteristics' (Gollan & Stacey 2021a:40).

TERM	MEANING
Racism	'...organised systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups. Racism can manifest through beliefs, stereotypes, prejudices or discrimination. This encompasses everything from open threats and insults to phenomena deeply embedded in social systems and structures. Racism can occur at multiple levels, including: internalized (the incorporation of racist attitudes, beliefs or ideologies into one's worldview), interpersonal (interactions between individuals) and systemic (for example, the racist control of and access to labor, material and symbolic resources within a society)' (Paradies & Ben et al. 2015:2).
Social determinants of health	Social determinants of health refer to the material conditions of people's lives that are shaped by structures beyond their personal control (Carson et al. 2007). They are non-medical factors that influence health outcomes. For Aboriginal and Torres Strait Islander peoples, racism is a social determinant of health in addition to those commonly acknowledged by the World Health Organization, such as income, education, employment, job security, housing, food security, early childhood development, transport and social support and exclusion.
Systemic	'In terms of racism, systemic refers to the history, ideology, culture and interactions of institutions and policies that work together to perpetuate inequity' (Australian Human Rights Commission 2021:3).
Transformative unlearning	A process of unlearning knowledge, which starts with appreciating accumulated knowing, reflecting positively on its contribution, and opening to the threat of undoing our identity. This process is a journey of personal growth and discernment, involving activities of receptivity, recognition and grieving. These activities require active dialogue with the self and with informed and trusted colleagues (Macdonald 2002).
White privilege	The implicit, unearned social advantages afforded to white people compared to non-white people, which in Australia have been instated and reinforced through invasion, colonisation and the historical and contemporary practice of racism (Pearson 2022; Pearson & Verass 2016; Phillips & Klugmann 2016).

Appendix: Differences between cultural terms

The following table, reproduced from CATSINaM (2014b:13), offers a useful approach to distinguishing between the different cultural terms that have been or are in use across Australia.

TERM	KEY POINT	UTILITY	OUTCOME
Cultural awareness	Underpinning knowledge and attitudes	Not sufficient for sustained behaviour change, a foundation for further development	A necessary initial step
Cultural sensitivity	Underpinning knowledge and attitudes	Not sufficient for sustained behaviour change, a foundation for further development	A necessary early step
Cultural knowledge	Underpinning knowledge that is fundamental to Aboriginal and Torres Strait Islander people's health	Enabled through engagement with Aboriginal and Torres Strait Islander individuals and communities	Remains the property of Aboriginal and Torres Strait Islander groups and communities
Cultural safety	A political concept: personal, institutional and system	First Nations peoples specific – emphasises institutional and historical contexts, and identifies power and its consequences	A critical requirement for achieving accessible and equitable healthcare services
Cultural respect	Government framework document	Aboriginal and Torres Strait Islander specific – acknowledges key role of Aboriginal and Torres Strait Islander communities in determining their healthcare	Respect for and advancement of the inherent rights of Aboriginal and Torres Strait Islander peoples
Cultural security	Government framework document	Has been superseded	Represents a shift from individuals to systems
Cultural responsiveness	Government framework document	Not Aboriginal and Torres Strait Islander specific – useful for issues relating to diversity generically	Understanding of an all of systems approach for effectively addressing diversity in general
Cultural competence	Framework document	Not Aboriginal and Torres Strait Islander specific – useful for issues relating to diversity generically	A worthy aspiration and on-going process, whereby individual, organisations and societies plot their progress

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ABOUT LOWITJA INSTITUTE

Lowitja Institute is Australia's only national Aboriginal and Torres Strait Islander community controlled health research institute named in honour of its co-patron, the late Dr Lowitja O'Donoghue AC CBE DSG. It is an Aboriginal and Torres Strait Islander organisation working for the health and welling of Australia's First Peoples through high-impact quality research, knowledge exchange and by supporting a new generation of Aboriginal and Torres Strait Islander health researchers. Established in January 2010, Lowitja Institute operates on key principles of Aboriginal and Torres Strait Islander leadership, a broader understanding of health that incorporates wellbeing and the need for the work to have a clear and positive impact.

The history of Lowitja Institute dates back to 1997 when the first Cooperative Research Centre for Aboriginal and Tropical Health was established. Since then, Lowitja Institute and the CRC organisations have led a substantial reform agenda in Aboriginal and Torres Strait Islander health research by working with communities, researchers and policymakers, with Aboriginal and Torres Strait Islander people setting the agenda and driving the outcomes.