

Developing Aboriginal and Torres Strait Islander cultural capabilities in health graduates: A review of the literature

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Introduction

In 1978, Kleinman and colleagues' seminal paper on cross-cultural health care drew attention to the concept of illness and treatment being culturally shaped. They argued that understandings and responses to illness vary across cultures and as a consequence, health professionals need to respond to the individual's experience of illness and health with respect for that individual's culture (Kleinman *et al.*, 1978). It is in this early work that Kleinman made the causal link between health providers' responsiveness to cultural differences and improved patient outcomes.

In Australia, despite an increasing number of educational and training tools developed to support health professionals to provide more culturally responsive health care, progress has been slow in reducing inequitable morbidity and mortality rates between Aboriginal and Torres Strait Islander¹ people and non-Indigenous² Australians (Vos *et al.*, 2009). Aboriginal and Torres Strait Islander people are often reluctant to access health services because of discrimination, misunderstanding, fear, poor communication and lack of trust in service providers (Durey *et al.*, 2011, Sahid *et al.*, 2009). Evidence of racism in health care often goes unreported and unchallenged (Henry *et al.*, 2004; Johnstone & Kanitsaki, 2009). Studies suggest that Aboriginal and Torres Strait Islander patients are more likely to access services where service providers communicate respectfully, have some understanding of Aboriginal culture, build good relationships with Aboriginal and Torres Strait Islander patients and where Aboriginal or Torres Strait Islander health workers are part of the health care team (Durey *et al.*, 2011; Shaouli Shahid *et al.*, 2009; Taylor *et al.*, 2009).

Health providers' attitudes and behaviours towards Aboriginal and Torres Strait Islander people can undermine or enable better health outcomes. Recommendation 23 of Health Workforce Australia's *Growing Our Future* report (2011) identifies the need to enhance the skills in the health workforce to work more effectively with Aboriginal and Torres Strait Islander patients and communities. The report outlines strategies to build interdisciplinary collaborative relationships between Aboriginal and Torres Strait Islander Health Workers and other health professionals, and also calls for mandatory cultural competency curricula in vocational and tertiary training for health professionals. Higher education providers (HEPs) are responsible for educating the next generation of health professionals, so equipping graduates with the capacity to work effectively and respectfully in Aboriginal and Torres Strait Islander health contexts is absolutely crucial (Universities Australia, 2011; Grote, 2008).

International experience suggests educating non-Indigenous health professionals about Aboriginal and Torres Strait Islander issues and health care contributes positively to the health status of Aboriginal and Torres Strait Islander people and communities (Aboriginal and Torres Strait Islander Nursing Education Working Group, 2002). Although there is no concrete evidence that improving health practitioner skills, knowledge and attitudes in Aboriginal and Torres Strait Islander health translates directly to improved patient health outcomes (Ewen, 2012), there is considerable anecdotal evidence. The potential to reduce health inequities by including Aboriginal and Torres Strait Islander health curricula to support a more culturally informed health workforce is strongly recognised (Thackrah & Thompson; 2013; Flavell *et al.*, 2013; Behrendt *et al.*, 2012; Universities Australia, 2008, 2011; Grote, 2008; Nash *et al.*, 2006; Nolan *et al.*, 2008; Ranzijn *et al.*, 2007). This approach is called for across key strategic documents such as the (National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013).

The need to develop abilities to deliver health care that respect the cultural differences of Aboriginal and Torres Strait Islander peoples has been increasingly addressed in discrete health disciplines. Various undergraduate health curricula frameworks have been developed in the disciplines of medicine (Betancourt 2006, Phillips 2004), oral health (Bazen *et al.*, 2007), nursing (Papps & Ramsden 1996; Ramsden 2002), occupational therapy (Gray and McPherson, 2005), public health (PRERP, 2008), psychology (Ranzijn *et al.*, 2008; Pedersen & Barlow 2008)

¹ This paper recognises and celebrates the diversity of the First Australians. Throughout this paper, the term Aboriginal and Torres Strait Islander/ and peoples (where relevant) is used in respect of this diversity. Use of the word 'Indigenous' through this document refers to First Nation people outside of Australia.

² Throughout this paper, the term 'non-Indigenous' is used to refer to all Australians who are not Aboriginal or Torres Strait Islanders.

and recently, social work (Bessarab *et al.*, 2014). Nonetheless, efforts to integrate this approach in curricula have often been fragmented and inconsistent. Attempts have ranged from invisible/marginalised content, discrete units of study, and integrated cultural coursework (multicultural care) to streaming of embedded perspectives across all units of study (Chapman, 2008; Rigney, 2012; Bennett *et al.*, 2013). Importantly, these attempts have often been constrained by a lack of academic and institutional commitment (Charles Sturt University, 2012). As a result there has been ongoing dependence on discrete Aboriginal and Torres Strait Islander units to carry the responsibility for teaching content, often without adequate resourcing or staffing. Pedagogical principles must be renegotiated to ensure a more committed and effective process to prepare culturally responsive graduates (Williamson & Dalal, 2007).

The complexities of developing cultural capabilities in entry-level undergraduate students and the relative newness of adapting learning outcomes to practices across disciplines requires careful consideration of what to include in curricula and how (Paul, 2012). Grote (2008) developed pedagogical principles to underpin cultural competency curriculum projects by synthesising those used at the Queensland University of Technology and University of South Australia. Adapted within the key HEP Framework produced by Universities Australia (2011), Grote's principles provide an excellent resource for HEPs to begin mapping the teaching and learning elements in Aboriginal and Torres Strait Islander contexts (Attachment A).

Purpose of Review

The purpose of this literature review is to identify what helps or hinders development of curricula in the higher education sector to prepare entry level health science graduates to work respectfully and equitably in Aboriginal and Torres Strait Islander health settings. The review was undertaken to inform and support the development of an Aboriginal and Torres Strait Islander Health Curriculum Framework by Health Workforce Australia and Curtin University.

A second purpose of conducting this review is to provide stakeholders with an informative resource that can be referred to as they begin, or seek, to revise and improve activities related to implementing an Aboriginal and Torres Strait Islander Health Curriculum Framework.

Methods

This literature review was undertaken through a series of iterative searches combining traditional bibliographic, internet and catalogue searching using key words including (though not exhaustive) 'cultural competency', 'cultural safety', 'cultural awareness' and related terms, 'cultural developmental models', 'terminology', 'curriculum development', 'higher education', 'accreditation', 'Aboriginal and Torres Strait Islander', 'Indigenous Australian', 'health graduate capabilities' and 'clinical supervision'. A more targeted search strategy was also undertaken by following citation trails within individual papers relevant to the topic area. The review was completed over a period of months, to allow the authors to be responsive to information emerging in adjunct work, namely the national consultation process.

There were no distinct inclusion or exclusion criteria for this review; rather papers were included based on expertise, key stakeholder voices, or subjective assessment by authors for relevance. For the most part, papers from 1995 to current were reviewed; however, a number of earlier works have been included for their seminal role in transforming thinking.

While peer-reviewed literature comprises a large portion of material in this review, it also incorporates considerable grey literature, policy documents and occasionally references to websites. This review aimed to capture theory and practice-based information from health and education sectors, so sources were intentionally broad. Google Scholar was primarily used in addition to conventional databases to enhance access to scholarly literature.

Summary of Findings

Terminology

- Contested terminology and lack of consistency in definitions of concepts connected to cultural capabilities create complexity for higher education providers (HEPs) in mapping and assessing learning outcomes.
- There is widespread agreement in the literature surveyed that the notion of being 'competent' in Aboriginal and Torres Strait Islander health care is inappropriate due to the implication that there are a set of final learning outcomes that can be achieved.
- There is preference for the notion of developing 'capabilities', as this denotes ongoing learning, and for students/health professionals to demonstrate these capabilities in practice.

Accreditation & Professional Standards

- The role of accreditation bodies in consolidating expected graduate capabilities is central to influencing how HEPs develop student-learning outcomes linked to Aboriginal and Torres Strait Islander health care.
- Despite the widely recognised crucial role of accreditation, there has been variable progress across different health disciplines in articulating required professional standards in Aboriginal and Torres Strait Islander health capabilities.
- There is a clear need for interdisciplinary approaches in health care and particularly within the context of Aboriginal and Torres Strait Islander health care.
- Interprofessional and interdisciplinary approaches necessitate shared visions and articulation of accreditation and professional cultural standards across health professions.

Role of Clinical placements

- Clinical placements in health services and the Aboriginal and Torres Strait Islander health care contexts are central to supporting enhanced students learning outcomes.
- Coordinating and implementing placements in these contexts is extremely challenging due to a number of factors. The lack of attention by HEPs to developing mutually beneficial partnerships with their CCHS clinical placement providers is a key concern specifically raised by health providers.
- Key enablers of successful clinical placements include providing student orientation prior to placements; central coordination; longer placements; flexibility of placement; and strong attention to developing and sustaining partnerships between HEPs and their CCHS clinical partners.
- Developing and ensuring clinical supervisors have the adequate support and appropriate capabilities to supervise students in these contexts, is absolutely crucial.

Pedagogical approaches in developing cultural capabilities

- There is considerable contestation around what are appropriate pedagogies to guide specific Aboriginal and Torres Strait Islander curriculum design and implementation.
- The literature consistently highlights the following pedagogical principles as key elements for the effective implementation of Aboriginal and Torres Strait Islander curriculum:
 - Acknowledgement and exploration of power relations, white privilege and whiteness
 - Engagement with critical race theory and implementation of decolonising approaches
 - Intercultural pedagogy that aims to move learning 'beyond binaries'
 - Critical reflection and reflexivity
 - Pedagogy of discomfort³

³ Bolter describes the pedagogy of discomfort as "both an invitation to enquiry and a call to action. As enquiry, a pedagogy of discomfort emphasizes 'collective witnessing' as opposed to individualized self

- Identifying how Aboriginal and Torres Strait Islander pedagogy can inform curriculum and the non-Indigenous learning experience to 'decolonise' the educational process is of particular importance.
- Examples of Aboriginal and Torres Strait Islander pedagogy include Yunkaporta & Nakata's 'Eight ways of Learning' model (see Attachment D) and Yarning
- Learning within the local context and focusing on the learning process (as opposed to learning outcomes alone) are both core elements in Aboriginal and Torres Strait Islander pedagogical approaches.

Implementing Aboriginal and Torres Strait Islander content

- Increasing the number of Aboriginal and Torres Strait Islander staff within faculties is central to facilitating the teaching and learning of Aboriginal and Torres Strait Islander content.
- Improving the capabilities of both non-Indigenous and Aboriginal and Torres Strait Islander educators to teach this content is key to effective implementation.
- HEPs must identify how all educators can be supported to deliver content in a more culturally appropriate and safe way for both students and staff. This requires resource investment, professional development strategies, substantial planning and HEP commitment.

Models to map the development of graduate capabilities

- There is widespread preference for a combination of stand-alone units as well as vertical and integrated curriculum, embedding Aboriginal and Torres Strait Islander content throughout the life of student's higher education degree.
- Curriculum frameworks should be built around models that identify how cultural capabilities progressively develop. As most HEPs don't yet have a definition for cultural development and competency in students or staff, developmental learning models and terms have largely been taken from the health education literature.

Assessing learning outcomes

- There is widespread agreement that core student learning outcomes in Aboriginal and Torres Strait Islander curricula must be accessible and achievable for HEPs and students, including:
 - Critical reflexivity
 - Ability to respond to diversity
 - Confidence and resilience to challenge racism
 - Recognition of the importance of relationships and engagement
 - Interprofessional capabilities
- Linking Aboriginal and Torres Strait Islander and Indigenous curricula, graduate attributes and university initiatives to human rights and social justice perspectives is widely supported within the literature
- Assessing the cultural capabilities of students via measurable, definable and categorical indicators is a complex task and assessment tools remain underdeveloped.
- Defining student capabilities that recognise the ongoing, developmental journey is important in developing assessments.
- Simulation, clinical placements, and situational assessment are all key elements in assessment design, as well as the role of client/consumer feedback on the student's cultural capabilities.

Organisational readiness

- Organisational readiness and commitment is absolutely key to effective implementation of Aboriginal and Torres Strait Islander health curriculum.

- HEPs must have capacity to ensure rigor in the standards of the curriculum, to undertake cyclical organisational self-assessment and to implement strategies to develop the cultural capabilities of educators and staff throughout the organisation.

1 DEVELOPING CULTURAL CAPABILITIES: TERMINOLOGY

Developments in preferred terminology in the 1970s marked a heightened awareness of the differences between cultural groups and the implications of these differences for health care provision (Perso, 2012; Kleinman *et al.*, 1978). Since that time, a number of terms and concepts have been developed to describe the intended outcomes of health care practices enhanced by this awareness. These include cultural safety, cultural respect, cultural competence, cultural responsiveness, cultural security and more (Thomson, 2005). (Attachment B) presents a summary of many of the key concepts related to the delivery of health care to Aboriginal and Torres Strait Islander Australians and to others from culturally and linguistically diverse backgrounds. This summary highlights the lack of consensus over definitions and the considerable overlap between some of these key terms and concepts.

From mid-1980, cultural competency emerged as a preferred term in the United States to describe improvements to health care for Native American Indians (Perso, 2012; Grote 2008). Cross *et al.*'s (1989) widely used definitions of cultural competency from the Native American perspective identified the crucial link between theories about cultural differences and health care practice. Cultural competency has also been described as requiring action not just at the individual level, but also at organisational and systemic levels (Stewart 2006, cited in Perso, 2012 p. 18). In Australia, while the concept of cultural competence remains contested (Thackrah & Thompson, 2013; Universities Australia, 2011), its widespread use in health practice training and dialogue highlights the recognized shift from awareness and sensitivity to a client's culture; to the ability to work competently and safely with that client within their cultural context (Gower, Nakata & Mackean, 2007).

Culturally inclusive curriculum frameworks focusing on competency emerged in policy documents in the Australia higher education sector from the 1990s (Grote, 2008; Wyatt-Smith & Dooley, 1997). The increasing focus of developing competencies to enable more effective practice appears to have affected the preferred terminology in the sector. For example, Universities Australia's (2011) definition of cultural competence identifies content knowledge, critical reflection, proficiency of engagement (congruent with Australian and Torres Strait Islander people's expectations) and capacity to effect change as the key elements of a culturally competent individual. Highlighted in this definition, is that 'competency' must correspond to the experience and expectations as defined by Aboriginal and Torres Strait Islander people.

In Perso's (2012) review, once competency has been achieved, culturally responsive behaviour will follow. The notion of cultural responsiveness was first developed in North America as part of a multicultural focus in service delivery (Williams, 2007; Bessarab, 2012). Responsiveness describes enacting the elements of cultural competency through a dynamic process that constantly reassesses the capacity to be culturally competent at every level (system, service, individual) (Perso, 2012).

The terms 'cultural competence' and 'cultural responsiveness' are often used interchangeably (Dunbar & Scrymgour, 2009). Perso (2012) suggests 'cultural responsiveness' seems to have arisen from legislative and government requirements for services to demonstrate how they respond to the needs of culturally and linguistically diverse populations. Although government documents (such as the 2009 Victorian Government's Cultural Responsiveness Framework) have identified the proliferation and confusion of terminology in this area, the call for health care to be more culturally 'able' will be enhanced through a competent skill set in individuals, services and systems. HEPs play a critical role in preparing the future health workforce to develop the appropriate abilities. However, the challenge for HEPs is to avoid tokenism where a 'tick-box' approach to competency-based learning outcomes can undermine the effectiveness of linking knowledge to sustained and meaningful improvements in practice.

In 1991, Maori nurse Irihapeti Ramsden's seminal work (endorsed by the Nursing Council of New Zealand in 1992) shifted the focus from health provider to patient or client to assess whether the health care they received felt 'culturally safe'. Ramsden argued that colonisation had left a legacy of power imbalances between Pakeha (descendants of European settlers) and Maori that had negatively impacted on Maori health. She suggested that nurses needed to reflect on whether their attitudes and behaviours towards Maori compromised Maori health and

health care (Nursing Council of New Zealand, 2011). Ramsden deliberately chose the subjective term of 'cultural safety' to shift the power balance from the health professional to the Maori patient to determine whether they felt culturally safe in a health care context (Ramsden, 2002, p.181). Cultural safety is the term preferred by a number of Aboriginal and Torres Strait Islander peak professional bodies including the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Australian Indigenous Doctors Association (AIDA) and Indigenous Allied Health Australia (IAHA).

Despite the preference for this term in a number of settings, a study by Johnstone & Kanitsaki (2007, p. 247) exploring knowledge about cultural safety and its possible application in the Australian health context found that the term is conceptually problematic and that lack of suitable research and revision has meant that its translation and application into practice has not been 'meaningfully' applied.

The National Aboriginal Community Controlled Health Organisation (NACCHO) also supports cultural safety as defined by the recipient of care. It states that 'cultural respect ... creates cultural safety for Aboriginal peoples' (2011, p.12). Cultural respect is understood as

Recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people (AHMAC-SCATSIH, 2004, p.7)

Cultural respect can be learnt and practiced by increasing knowledge, awareness, and skills, and developing relationships with Aboriginal and Torres Strait Islander people, communities, services and staff to improve equity of outcomes (NACCHO, 2011; AHMAC-SCATSIH, 2004). This approach is also important for the provision of culturally competent, responsive, secure and safe care.

Contested terminology

Across Australia, there remains a lack of consensus around definition and use of terms when referring to cultural competence, cultural safety, cultural security, cultural responsiveness, cultural proficiency and cultural awareness (e.g. Parry *et al.*, 2013 although some key differences have been noted (AIHW, 2011, Papadopoulos, 2004. Also see (Attachment B). The lack of consistent definitions in government policies informing health care initiatives and practice is confusing. As Grante *et al.* (2013, p. 250) state:

Capacity for policy directives to effectively circumvent the potential deleterious outcomes of culturally incompetent services is only possible when that policy provides clear definitions and instructions.

Given the widely recognised lack of definitional coherence at a health service and policy level, defining learning outcomes in an educational setting is often fraught with difficulty.

Various organisations including CATSINaM (2013) have published reviews on terminology to offer more clarity about the delivery of culturally appropriate care. (Attachment C) reproduces the summary of key terms provided by CATSINaM. This document is useful for considering the strengths, limitations and outcomes of terms widely applied in the cultural capabilities space. Importantly, the CATSINaM document clarifies that it is Aboriginal and Torres Strait Islander peoples who will ultimately define what constitutes culturally safe and respectful care, and whether or not it has been achieved.

McEldowney & Connor (2011, p. 342) say:

[The] context (of culturally safe care) is expanded through identifying the three concepts of relationality, generic competence, and collectivity, which are all integral to each client-nurse encounter. Clients and nurses engage in a dialogue to establish the level of cultural safety achieved at given points in the care trajectory.

Given the diversity of Aboriginal and Torres Strait Islander communities, it is essential that health providers, education bodies and related services work with health care recipients to identify and define the elements of culturally safe and responsive practice in their local context.

Developing competencies or capabilities?

Despite contested terminology, there is general agreement that cultural knowledge and awareness on its own does not lead to attitudinal and behavioural shifts. There is also agreement that self-understanding (internal) and understanding of the organisational environment (external) are both required in the process of developing cultural competency at personal and institutional levels (Universities Australia, 2011). Universities Australia adopted the term 'cultural competence' to describe the ability to act, through a combination of behaviours, attitudes and institutional policies, to support individuals' effective engagement in the cross-cultural space (Grote, 2011). Thus individual ability and practice needs to be supported by policies and standards, in an environment that supports engagement in cultural competence (Universities Australia, 2011).

The idea of being 'competent' when delivering health care to Aboriginal and Torres Strait Islander peoples is, itself, contested, largely for its association to the idea of an achieved set of final learning outcomes that do not require further development. In the early 2000s, developmental literature frequently described 'competencies' as the outcome of the learning journey, describing a set standard of skills and knowledge that are learnt and thus able to be delivered in a specific context (Duigan, 2006). In his criticism of competency approaches in medical education, Brooks (2009) argues, "competency is not what we want to use when trying to determine if someone is a good, or even an adequate, physician" (cited in Paul *et al.*, 2012, p.322). This observation is particularly relevant to the idea of cultural competency since the complexity of culture makes the idea of assessing for competencies, or measurable learning outcomes, extremely difficult (Paul *et al.*, 2012). These critiques of 'competency' argue that not only is it misleading to suggest there are a finite set of transferable learning outcomes; but more importantly, culture is simply too complex for a set of measurable competencies to be defined, tested and measured.

The concept of 'capabilities' offers a more holistic (and realistic) approach to identifying and assessing for behaviours and understanding that go beyond particular knowledge and skills. They involve being able (i.e. having the capability) to demonstrate that what one has learnt can be appropriately applied in a cultural context (Duigan 2006). Duigan (2006) made an important distinction between competency-based and capability-based programs; the former focus on achieved performances in the past, whilst the latter focus on desirable attributes for the future and the individual's ability to engage in a process to develop those attributes. Stephenson (2000, p. 2) describes a capability as an 'all round human quality', that allows knowledge, skills and personal attributes to be applied not just in the 'known circumstances but in response to new and changing circumstances'. Capabilities are active, dynamic and constantly being tested in every new interaction, an important consideration for HEPs aiming to develop graduates who can deliver culturally appropriate care to the diversity of Aboriginal and Torres Strait Islander peoples. Clearly, the notion of developing capabilities offers not only a more holistic framework for approaching the kinds of skills, attributes and knowledges that need to be developed; but an approach that moves away from reducing individuals to tick box cultural categories and instead towards abilities that can be responsive to the diversity of Aboriginal and Torres Strait Islander peoples.

2 HEALTH & EDUCATION PARTNERSHIPS

Role of accreditation & professional standards in curriculum

The role of accreditation bodies in consolidating expected graduate capabilities is central to influencing how HEPs develop student-learning outcomes linked to Aboriginal and Torres Strait Islander health care (Ewen, 2011). In New Zealand, cultural competency⁴ has developed in accordance with the Health Practitioners Competence Assurance Act. Since its enactment, health practitioner registration bodies are developing standards of competence and processes to ensure both clinical and cultural competence. In addition, funding bodies now incorporate cultural competence into contractual requirements (Bacal, 2006). This Act has been a key driver not only in health practice standards, but also in curriculum development (particularly pedagogy), where competence to practice has become the dominant discourse in health education (Gilkison, 2013).

The crucial role of accreditation and industry-based professional standards in effecting curriculum developments is strongly recognised. However, progress across different health disciplines has been variable in articulating required standards. For example, Public Health has considerable content related to the development of cultural capabilities throughout its curricula, but it does not have an accreditation body to assess for content, or for stipulation of standards in graduates. This is a shortfall (Baba, 2012). A 2011 review of healthcare qualifications by Australian HEPs in relation to industry-based professional standards, found no overarching statement of professional entry-level threshold learning outcomes (TLOs) related to Aboriginal and Torres Strait Islander content (Australian Learning and Teaching Council, 2011). The disciplines of Public Health, Medicine and Pharmacy mention (to varying degrees) standards related to Aboriginal and Torres Strait Islander content. However, at a national level the overarching statements are fairly general, indicating that Aboriginal and Torres Strait Islander needs are not incorporated and that approaches need to be consolidated. This highlights the need for uptake and commitment at a higher level to support change.

Developments in accreditation and/or professional standards

Despite shortfalls, there have been important developments in some disciplines. For example, the cultural competence pedagogical framework and associated curriculum guidelines developed by Ranzjin *et al.* (2008a) have been endorsed by the Australian Psychological Society and now form part of the Australian Psychology Accreditation Council accreditation guidelines for the education of Australian psychologists. This means that Australian HEPs are now obliged to include instruction in 'Aboriginal and Torres Strait Islander and cross-cultural psychology' within all undergraduate programs. Those involved in developing the guidelines and curricula highlight that the endorsement of the framework and its adoption within accreditation standards has been instrumental in embedding strategies developed by the project into psychology undergraduate training. Recent developments in Social Work have led to similar outcomes. The Australian Social Work accreditation standards in Australia now state that Aboriginal and Torres Strait Islander curriculum must be embedded within any Social Work course (Australian Association of Social Workers, 2012a, 2012b). This curriculum is one of four mandatory curriculum subjects, and may be a stand-alone subject or streamed across the entire course (Australian Association of Social Workers, 2012a, 2012b).

The experience of the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework is an important indication of the crucial link between accreditation standards and commitment by HEPs in aspects of curriculum implementation. Published in 2004, the CDAMS Framework provided a set of guidelines

⁴ While the term 'competency' (as discussed in the previous section), is highly contentious, it is still widely used across the literature and most of the documents sourced for this review referred to the development of abilities in terms of competence. However, the preference by the authors of this review (in light of the literature findings) is use of the term 'capabilities'. For the remainder of this document, the term competency will still be used if particular authors who are being referenced have described development in this way; however at times, where comments have been made by the authors of this literature review, the term capabilities will be used.

for implementing Aboriginal and Torres Strait Islander content into core medical curricula and has been applied by many HEPs around Australia (Phillips; Medical Deans-AIDA, 2012). Although endorsed in 2006 by the Australian Medical Council (AMC), a recent review of the Framework highlights that stronger recognition within the AMC's Assessment and Accreditation Standards and Procedures was needed to address issues of implementation-particularly, the limitation of dedicated resources (Medical Deans-AIDA, 2012). This implies stronger recognition within the AMC's standards will lead to greater investment - and greater priority - of Aboriginal and Torres Strait Islander curricula. This review also recognises the critical role of including Aboriginal and Torres Strait Islander health expertise on medical school accreditation teams.

In 2013 Health Workforce Australia conducted an environmental scan of accreditation and professional competency standards across a wide range of health disciplines. Each discipline's standards were reviewed for specific statements supporting the development of cultural capabilities, and for information about related accreditation processes, assessment of standards and accreditor training. While most disciplines mentioned the need for culturally competent care, 40 per cent made no mention of Aboriginal and Torres Strait Islander peoples either in their Accreditation Standards or Professional Competencies. Standards that did make explicit reference to Aboriginal and Torres Strait Islander peoples gave no indication of how thoroughly they addressed Aboriginal and Torres Strait Islander health service provision, nor any explicit mention of the means and mechanisms by which accreditation standards facilitated the measurement and monitoring of health provision to these communities. Also absent were descriptions of the capabilities required for accreditors to adequately assess whether a HEP has the competency and other elements required to deliver Aboriginal and Torres Strait Islander curriculum.

The Australian Indigenous Doctor's Association (AIDA) works closely with the AMC to improve leadership and professional standards and has recognised the critical need for Aboriginal and Torres Strait Islander visibility, representation and voice in accreditation assessment and associated activities.⁵ Recent recommendations to the AMC by AIDA include an Indigenous Committee of the Council, which has cross-membership on other AMC committees, to bring Aboriginal and Torres Strait Islander expertise and membership to accreditation standards and processes, and to other aspects of the AMC's work.

Experts in Indigenous health and care should be involved in the development of assessment teams, Indigenous health issues should feature in assessment, and issues of Indigenous curriculum content, student recruitment and support and clinical training should be prominent in the accreditation process⁶

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) works in partnership with the Australian Nursing and Midwifery Accreditation Council (ANMAC) to review Nursing and Midwifery standards for elements that define culturally safe practice and to assist with the translation of these elements into curricula. This is an exemplary case of an Aboriginal and Torres Strait Islander peak body being involved in the design and implementation of accreditation standards.⁷

Clearly, the standards and industry expectations that are being set in the professional context will have a link to the graduate attributes that HEPs articulate (Oliver, 2011). HEPs play a crucial role in contributing to national productivity and responding to industry needs by developing graduate attributes that are reflective of industry requirements (Bradley *et al.*, 2008). Yet while this link between industry expectations and HEP responses is critical, strong support from key agencies within the education sector for progress will place more weight on HEPs to progress in this area. The Tertiary Education Quality and Standards Agency (TEQSA), for example, are crucial in foregrounding recommendations associated with the development of cultural capabilities from key reports (e.g. Universities Australia, 2011; Behrandt, 2012; Goerke & Kickett, 2013).

⁵ See AIDA update for the Aboriginal and Torres Strait Islander Health workforce working group, 1st April 2014.

⁶ Ibid pg 2

⁷ For example, see CATSINaM Annual Report 2012-2013 <http://catsin.org.au/wp-content/uploads/CATSIN0001-Annual-Report-PRINT-270913-4.pdf>

Interprofessional curriculum, health service & higher education partnerships

Variability in accreditation content, terminology and specificity across disciplines highlights a fundamental element of the cross-cultural accreditation landscape. Individual professions/disciplines do not deliver health care services in isolation. Instead they play a specific role in a service team, highlighting interdependency between different professions and the need for shared visions and goals in education, training and professional regulation (Task Force Two, 2006). This suggests that the accreditation of cultural capability standards must be shared within, and coordinated across, Australian health disciplines, to support interdisciplinary approaches to implementing Aboriginal and Torres Strait Islander health curriculum.

Cultural competency in practice necessitates interprofessional education, bringing health professionals together (such as doctors and nurses) with other health care providers (such as counsellors, social workers, or Aboriginal Health Workers) who may not have traditionally been part of the health care team to explore collaborative practices (Curran, 2004; Oandasan *et al* 2004). Interprofessional clinical education and student placements both contribute to enhance the cultural capabilities of health students (Oandasan *et al.*, 2004). At Curtin University, the health curriculum has been built around an interprofessional framework that interlinks client-centred service, the safety and quality of services and interprofessional collaborative practice (Brewer & Jones, 2013). This experience of articulating the key elements of health practice has facilitated tertiary and health sector partnerships as stakeholders have worked to develop a shared understanding of interprofessional education and practice.

Health service clinical placements in developing student cultural capabilities

The potential for clinical placements to enhance student's cultural understanding and learning outcomes is widely recognised (Siggins & Miller, 2012). Innovative clinical placements provide a pathway for students to bear witness in real time to the inequities and challenges facing society, particularly the impacts of social determinants of health. In Canada, clinical placements of student nurses in Indigenous contexts identified how critical awareness of poverty, inequities and marginalisation often created a dissonance and soul-searching for students critically engaged in learning. This led to a renewed commitment to social change, highlighting the potential for transformative learning and practical engagement with concepts such as social justice (Kirkham *et al.*, 2005). In Australia, the recent review of the implementation of the CDAMS framework (Medical Deans-AIDA, 2012) found some of the more effective examples of implementing Aboriginal and Torres Strait Islander curriculum were characterised by experience-based learning activities such as clinical placements in Rural Clinical Schools and Aboriginal Medical Services; cultural immersion experiences in community contexts; and reflective learning activities.

Challenges in community-based clinical placements

Although powerful learning experiences, clinical placements in these settings face a number of challenges. In Canada, a survey of clinical placements in Indigenous settings found they require more preparation than traditional clinical placements, and issues of safety in practice and sustainability are key considerations (Kirkham *et al.*, 2005). Similarly in Australia, a report from fourth year Occupational Therapy students from The University of Queensland, provided feedback to university educators about their experience in placements in Aboriginal and Torres Strait Islander contexts. The report identified a lack of dedicated course content to prepare students for these settings including the complexities of working with Aboriginal and Torres Strait Islander clients. The overall deficit approach to working in such contexts (referring to the over-emphasis on the 'chronic problems' and 'issues' facing Aboriginal and Torres Strait Islander people) also created anxiety for students (Wiseman *et al.*, n.d).

Also of key consideration in clinical placement partnerships between community controlled health services (CCHS) and HEPs is the post-colonial context in which these partnerships take place. Hamersley (2012) discusses the concept of community-based service learning (CBSL), distinguished from other service-learning programs by its

intentional engagement with issues of social justice, inequality, poverty and social determinants (also Jones, 2002). Australia's postcolonial context means that, in many instances, clinical placements within Aboriginal and Torres Strait Islander CCHS may be implicitly driven by the combined aim of improving the cultural capacity of students and creating partnerships for HEPs and students to actively engage with Aboriginal and Torres Strait Islander health from a social justice perspective.

Hammersley (2012) highlights that while CBSL has enormous potential to enhance student learning, skills and attitudes, there is a lack of research supporting claims that CBSL has mutual benefits for those involved. She argues that many CBSL initiatives fail to challenge dominant power relations and therefore perpetuate traditionally uneven partnerships. Hammersley refers to Ward & Wolf-Wendal (2000) in describing the unidirectional framework of 'doing for', rather than 'doing with', and the need for practical reciprocity where there is mutuality between service providers' and receiver's needs and outcomes. Hammersley cautions HEPs to be mindful of motivations of 'charitable' engagement with CCHS, and instead to build mutually beneficial and equal partnerships.

Improving clinical placement experiences for health services and students

ClinEd Australia (2014) highlights the crucial role of student orientation prior to placement, such as that offered by the Institute of Urban Indigenous Health in Queensland,⁸ to mitigate some of the potential challenges of clinical placements in Aboriginal and Torres Strait Islander settings. Also emphasised are the different skills and mindsets that students require to undertake placements in Aboriginal and Torres Strait Islander health contexts. The complexity of client issues and the nature of the Aboriginal and Torres Strait Islander clinical context need flexibility, patience, a degree of informality, and an essential respect for Aboriginal and Torres Strait Islander people. This can, in many ways, be more important than pre-placement learning, highlighted by Nelson *et al.*'s (2007, p. 211) experience of Occupational Therapy placements:

If you've got a person with the right attitude, who's non-judgmental, who's open, willing to accept difference, then they will learn those cultural things as they go along.

A study of clinical placements conducted across Australia and the United Kingdom found that students needed time to settle in and establish collegial relationships, which significantly influenced their experience of belonging (Levett-Jones *et al.* 2008). This process was a necessary precursor to their participation in an active learning process, and raise important considerations in shorter (i.e. less than four weeks) clinical placements. In Australia, criticisms of short-term placements in CCHS for medical electives acknowledge that longer placements are required to allow students to build relationships with community members and to make more meaningful contributions to various clients' healthcare (Weichtmann, 2013; ClinEd, 2014). Research conducted with undergraduate nursing students who participated in the Primary Health Care Intensive Programme (PHCIP) for clinical placements in far west New South Wales (Bennett *et al.*, 2013) suggests that student confidence in interactions with Aboriginal and Torres Strait Islander peoples can improve through extended immersive placements with adequate orientation and support.

Relationship building is central, not only to the student experience, but also to ensure sustainable, mutually beneficial partnerships between education providers and Aboriginal and Torres Strait Islander community-controlled organisations. In a review of Medical Specialist Training, Ewen (n.d., p. 14) highlights the lack of attention to sustainability models including how training organisations engage with CCHS:

The current capacity of (CCHS) to be training sites for more students, from more health disciplines, at more levels, creates an unsustainable burden on the Aboriginal health services. Models of engagement, which include funding agreements, need to be developed so that patients of the Aboriginal health services have increased access to expert care, not decreased access due to too many trainees not being adequately supported. These models need to be based upon a reciprocal relationship between the training needs of specialists and health needs and priorities of the community.

⁸ See http://www.clinedaus.org.au/files/resources/iuih_student_orientation_package_2013_for_portal.pdf

Ewen (n.d., p. 15) highlights the importance of a coordinated and resourced approach to clinical placements in Aboriginal and Torres Strait Islander health settings, noting that CCHS 'will not be the ideal training environment for all specialist trainees at all stages of their training'.

The Institute for Urban Indigenous Health (UIIH), a regional community-controlled health organisation, and The University of Queensland, have recently collaborated on a program to increase placement opportunities for students from diverse health professions in the final year of their degrees or in advanced level studies (Nelson *et al.*, 2013). This program is open to multiple HEPs and is a response to the need to build better, more coordinated and mutually beneficial relationships between academic institutions and CCHS whilst also addressing the challenges of student clinical placements in an Aboriginal and Torres Strait Islander context. The program has a central coordinator based at the UIIH who coordinates and oversees placements across a large region, working closely with services and HEPs to develop well-designed placement programs with explicit expectations. Successes in this program, including the significant increase in student placements, increased variety and better coordination of placements and its work in developing mutually beneficial partnerships, suggest that it could be an important model to examine (Nelson *et al.*, 2013).

An initiative at the University of Otago (New Zealand) sought to address some of the anxieties students may feel going into clinical placements in Maori settings with no prior experience interacting with Maori people. On Hauora Maori Day, Maori community members were invited to attend a health-screening clinic staffed by students at the university. Designed in collaboration with the local Maori community, the clinic provided a powerful model for expanding opportunities for students to engage with Maori people (Pitama, 2012). Simulated learning is another positive strategy used in undergraduate courses to increase student contact with Aboriginal and Torres Strait Islander patients in a controlled and safe environment where facilitators and simulated patients give feedback (MacLeod, 2012).

The need for national consistency

Educating health and human service professionals in a clinical environment is becoming increasingly complex. Changes to funding pathways, staffing issues, models of care, infrastructure and health technology increase demands not only on health service providers, but also on the role of clinical education in health graduate training (Rodger *et al.*, 2009; Layman & Bamberg, 2003). Increasing student numbers for HEPs and diversity in health professional courses are challenging. The requirement for graduates to be 'competent' in interprofessional collaboration and culturally sensitive care in diverse contexts (amongst other more clinically specific attributes) adds to the complexity, providing a key challenge in the relationship between clinical health education and health service settings (Pew Commission, 1998; McMeeken *et al.*, 2005; Humphris & Hean, 2004; Rodger *et al.*, 2009; ClinEd, 2014). Inconsistencies in Australia across jurisdictions suggest more national guidelines are needed to develop a national plan for promoting quality in clinical placements and expanding the capacity and competence of placement supervisors for all health professions (Siggins & Miller, 2012).

Clinical educators and supervision

A supervisors' 'catalyst' role influences the extent to which cultural issues are addressed in the student learning experience (Constantine, 2008). Studies have found students who have multicultural supervision (i.e. their supervisors attend to multicultural issues) develop greater confidence that translates to an increased likelihood of greater success when working with culturally diverse clients (Constantine, 2008). Other studies in psychology (Hird *et al.*, 2008; Burkard *et al.*, 2006; Yabusaki 2010), indicate that it is not only the supervisor's attention to intercultural issues, but also the supervisor's ability to model cultural responsiveness that is crucial to the student learning experience.

Rodger *et al.*'s (2009) report on the role of clinical education, and specifically supervision, argues that educators are often selected based on availability or seniority rather than required skills (e.g. clinical expertise, effective communication, interest in students' professional growth, a sound knowledge base, effective teaching skills, commitment to supervision). In many cases, clinical educators had little or no preparation for clinical education and evaluation/assessment of students. Goals of the health sector and of educational institutions are also often quite different in relation to student placements. The risk of supervisor burnout is also a major concern. Roger *et al.*'s

(2009) report argues for the need to properly support and train clinical educators and supervisors to use more innovative clinical models of education and to understand the importance of communicating and collaborating with other clinical educators, their managers, and the tertiary environment. An interprofessional approach to health practice and student education in a culturally diverse context clearly also requires specific skills in clinical supervisors.

The National Clinical Supervision Competency Resource recently published by Health Workforce Australia (2014b) documents the required core competencies of clinical supervisors to enable them to determine professional expectations whilst contributing to interprofessional teamwork and development. This is an important document for articulating and providing benchmarks for clinical supervision expectations and performance. However, there is only one descriptor addressing cross cultural supervision issues and Aboriginal and Torres Strait Islander contexts are not specifically mentioned (p. 16), highlighting further work required.

Bessarab *et al.* (2012, p. 53, 76) argue that, in an Aboriginal and Torres Strait Islander context, it is important to distinguish between culturally responsive supervision, cultural supervision and cultural mentoring, with the following distinctions:

- i) Culturally responsive supervision - undertaken by Aboriginal and Torres Strait Islander or non-Indigenous supervisors. Reflects respectful collaborative relationships and requires that the supervisor can critically reflect upon their own cultural identity.
- ii) Cultural supervision - cannot be undertaken by non-Indigenous people, and is embedded in an Aboriginal and Torres Strait Islander space that is supportive and culturally safe for staff and students to engage in and reflect on cultural issues emerging in their practice.
- iii) Cultural mentor - someone who is Aboriginal and/or Torres Strait Islander and who is able to guide and inform a student or field educator in noticing and understanding aspects of the practice context that are culturally nuanced.
- iv) Shared supervision – multi-student placements at one time and multiple mentoring placements (the latter consisting of teams of clinical educators supervising teams of students), useful in modeling inter-professional approaches.

Clearly, strengthening and standardising the relationship between HEPs, accreditation and professional standard bodies is crucial to enhance the translation of student learning outcomes to effective-and expected- health service delivery for Aboriginal and Torres Strait Islander patients. Key to these partnerships is the role of clinical placements and education, which serve as a strategy for students to experience health care in Aboriginal and Torres Strait Islander contexts in a guided and supported way, whilst also ensuring an ongoing dialogue occurs between HEPs and the local health service contexts their students will eventually be working in. Developing national standards and frameworks to support consistency in partnerships between the higher education and health service sector is important. Ensuring enough flexibility within these standards for the unique characteristics and cultural requirements at a regional and local level to be expressed is of utmost importance.

3 PEDAGOGICAL APPROACHES TO DEVELOPING CULTURAL CAPABILITIES

Universities Australia's (2011) review of cultural competency development highlights that, over the last 15 years, pedagogical literature has expanded to include key theoretical principles of 'cultural awareness', 'whiteness', 'cultural sensitivity' and 'cultural safety', feeding these terms into a broader understanding of the elements constituting cultural competence. However, there continues to be a lack of clarity with differing interpretations of the terms 'culture' and the interchangeable use of supplementary terms such as awareness, sensitivity, proficiency and safety. As HEPs and educational institutions don't yet have a definition for cultural development and competency in students or staff, developmental learning models and terminology have largely been taken from other cultural contexts and particularly the health education literature (Grote, 2011; Bessarab *et al.*, 2012). Bessarab *et al* caution against the conflation of Aboriginal and Torres Strait Islander content into the broader pedagogical category of cross-cultural practice (2012). Contention persists about appropriate pedagogies to guide specific Aboriginal and Torres Strait Islander course design and program development (Reitmanova, 2011; Hollinsworth, 2012).

Power, privilege and whiteness

Considerable focus is placed in the literature on understanding unequal power relations (historical and current) and theories informing curricula content. There is wide recognition of the need for education in cultural competence to recognise the historical legacy of post-colonial relations between Aboriginal and Torres Strait Islander peoples and other Australians (Universities Australia 2011). The importance of acknowledging inequitable power relations between the colonisers and the colonised, and the effect that this inequity has on health and wellbeing, is a major pedagogical consideration in cross-cultural contexts. Research in Australia and other post-colonial nations draws attention to the notion of 'white privilege' as a framework for examining the power and privilege of the dominant racial and cultural group. This has been noted in research from New Zealand (Ramsden, 2002; Tuhiwai Smith, 1999), Canada (Pitner and Sakamoto, 2005; Pon, 2009; Sakamoto, 2007) and Australia (Fredericks, 2008; Moreton-Robinson, 2009; Walter *et al.*, 2013). All of these authors speak to the notion of white privilege where, according to Moreton-Robinson (2009, p xix), 'Whiteness remains the invisible omnipresent norm' against which other cultures are judged'.

Pease (2010) argues that privilege is the other side of the coin to oppression, stating that too much focus on those who are oppressed can divert attention from making the privileged accountable for their part in reproducing inequality. Reflecting on and interrogating the concept of whiteness in the context of mainstream Anglo-Australian culture requires an understanding of how specific forms of privilege are practiced and reproduced in ways that discriminate against Aboriginal and Torres Strait Islander Australians and compromise their relationships with non-Indigenous people (Moreton-Robinson, 2009; Pease, 2010). In their recent publication on the Social Work Curriculum Framework, Bessarab *et al.* (2014) argue that awareness and understanding of whiteness in the context of social work professional practice is crucial to achieving epistemological equality and changing power imbalances. As some of the core principles in culturally responsive health care, these elements are essential considerations in pedagogical design.

Nicoll (2004) reflects on her own challenge of teaching Aboriginal and Torres Strait Islander content to non-Indigenous students, suggesting that Critical Whiteness Theory (CWT) is not only a theoretical learning outcome, but a pedagogical strategy. She argues that CWT can be used to "shift the pedagogical focus from the racialised oppression of Aboriginal and Torres Strait Islander Australians to the white middle-class subject position that is a direct product of this oppression"(Nicoll, 2004. para. 1). Nicoll shows how the redefinition and focus on relations between Aboriginal and Torres Strait Islander and non-Indigenous people can be a powerful platform for interrogating and understanding whiteness in action. The application of CWT in the academy, however, is fraught with difficulty. Nicoll suggests that CRT is often approached as 'either an anachronistic and possibly dangerous development within identity politics or as the latest excess of academic "Theory"' (2004, para. 18).

Pon (2009) notes that those not part of the dominant 'white' culture in Canada are seen as 'other'. He argues that the dominant white cultural group focuses on concepts such as cultural competency where, in relation to both Indigenous Canadians and migrants, culture is defined in a way that 'forgets' inequitable power relations and racism inherent in the colonial past. He supports the notion that cultural education requires a 'self-reflexive grappling with racism and colonialism' (p. 59) to understand how knowledge of 'others' is initially constructed. Sakamoto (2007) shifts the focus from trying to understand the cultural other to interrogating the power-laden contexts in which the process of 'othering' occurs. She advocates a 'revisioning' of cultural competence that is more inclusive and open to different ways of knowing. She argues that unless ideological and theoretical influences are named and interrogated, cultural competence will be reduced to 'managing' diversity. Using different standpoints in education can create opportunities for power to shift. Ramsden's (2002) understanding that the consumer of health care will define whether health practice has been culturally safe or not is an important focus, and the pedagogy of this concept can support students to understand the notion of shifting power from provider to recipient.

Critical race theory and decolonising pedagogy

According to Pitner and Sakamoto (2005) cultural training should use racialised language and encourage students to reflect on power relations as well as their own cultural biases, assumptions and worldviews that inform their perceptions and interactions with people from different cultural and linguistic backgrounds. Sakamoto (2007) suggests that the concept of cultural competency currently views culture as neutral and devoid of power, does not theorise power, analyse whiteness nor critique systems of oppression such as racism. Critical Race Theory (CRT), a body of scholarship that interrogates the discourses, ideologies, and social structures that produce and maintain conditions of racial injustice (Delgado & Stefancic, 2001; Hatch, 2007; see also Singleton & Linton, 2006), is one approach that has been applied in many teaching and learning environments to unpack and address racism as a barrier to improving health outcomes. It is argued CRT may appropriately inform what Aboriginal and Torres Strait Islander scholars recommend as crucial to Aboriginal and Torres Strait Islander studies, particularly the unpacking and reflecting on one's own cultural position, the complexities of embedding different perspectives and knowing, teaching and learning at the cultural interface (Nakata, 2004; Phillips, 2005; Williamson & Dalal, 2007; McLaughlin & Whatman, 2007).

Bringing Aboriginal and Torres Strait Islander perspectives, knowledges and voices into the academic setting is a key element for 'decolonising'⁹ the pedagogy and shifting the power balance in education. Dudgeon and Fielder (2006) explore higher education from a de-colonisation perspective and challenge the primacy of mainstream authority in informing how Aboriginal and Torres Strait Islander culture and knowledge are represented. They describe how, across Australia, Aboriginal and Torres Strait Islander centres have created space within higher education to 'centre' or foreground Aboriginal and Torres Strait Islander culture and knowledge from their perspective and experience.

While the delivery of specific content in specific Aboriginal and Torres Strait Islander centres is a potent means of exposing students to Aboriginal and Torres Strait Islander pedagogies in an Aboriginal and Torres Strait Islander context, the increasing emphasis on embedding Aboriginal and Torres Strait Islander perspectives in the broader mainstream curriculum faces major challenges in decolonising pedagogy. It is here that the application of CRT may offer some potential. Reflecting on their experience of embedding Aboriginal and Torres Strait Islander perspectives in curricular projects, McLaughlin and Whatman (2011) discuss the need for deeper analysis of 'decolonising projects' around what embedding Aboriginal and Torres Strait Islander perspectives actually means to educational stakeholders. They argue CRT's 'emancipatory, future and action-orientated' goals provide a platform for a powerful interrogation of how academics understand, and seek to implement, Aboriginal and Torres

⁹ Smith (1999) highlights that for Indigenous people to represent their own history and reality is key to the decolonising venture whereby '[c]oming to know the past has been part of the critical pedagogy of decolonising. To hold alternative histories is to hold alternative knowledges. The pedagogical implication of this access to alternative knowledges is that they form the basis of alternative ways of doing things' (p. 34). Others such as Dudgeon & Fielder (2006), Nakata (2012) and Moreton-Robinson (2004) have critically discussed the decolonisation of the academy.

Strait Islander knowledges in curriculum. Drawing on a number of leading CRT theorists (Ladson-Billings & Tate, 1995; Dixon & Rosseau, 2005), they argue applying CRT in curricula creates a space for radical, transformative knowledge to be debated and generated - still largely untapped by a White academy.

Beyond binary pedagogies to intercultural approaches

McConaghy (2000) argues that the way culture is often discussed and ultimately understood has driven a 'cultural relativism'¹⁰ that is intertwined in how Aboriginal and Torres Strait Islander culture is represented and taught in education. The proliferation of binary thinking (that Aboriginal and Torres Strait Islander culture is opposite to Western) has resulted in a reductive approach to Aboriginal and Torres Strait Islander education and a pedagogical approach that often drives ongoing stereotyping of Aboriginal and Torres Strait Islander people and their culture. As some Aboriginal and Strait Islander academics have argued, adopting an essentialist¹¹ position within universities has been a necessary part of the decolonisation process. Taking a stand as opposite to the dominant white academic system has created space for Aboriginal and Torres Strait Islander knowledges and pedagogy to enter (Dudgeon and Fielder, 2006; Paradies, 2006).

However, some Aboriginal and Torres Strait Islander academics, have recently begun to emphasise the need to move beyond the pedagogy of Aboriginal and Torres Strait Islander cultural content as opposite to Western to embrace teaching and learning in shared 'intercultural' spaces. Nakata and colleagues (2012, p.134) resist ongoing binary cultural positioning as counterproductive in the learning experience. They support a pedagogical approach that fosters open discussion and robust inquiry. The notion of an intercultural approach avoids essentialism and definitive explanations of cultures and nurtures a more complex understanding of how cultural values and knowledge are produced and maintained. It highlights the complexity of knowledge production including the difficulty, and often contested nature, of resolving what is western and what is Indigenous in ways that avoid over-simplification and invite students to engage in a more vigorous and critical analysis (Nakata *et al.*, 2012). According to Bhaba (1990, 2012) who famously coined the term 'third space'¹² to describe this intercultural context, this level of reflection and open inquiry can lead to new positions, meanings and discourses (see also Rutherford, 1990). In educational settings, students can be supported to share their understandings with others and to explore points of difference and shared meanings. The intercultural space has also been described as the 'cultural interface' or 'contested space between two knowledge systems' (Nakata, 2007, p.9), the 'middle ground' where Indigenous and Western cultures relate (Nakata *et al.*, 2012, p.134).

Critical reflection and reflexivity

The key elements required for developing intercultural learning spaces and experiences are that both students and educators engage in critical reflection on their own positioning and construction of their social and cultural identities (Dudgeon & Fielder, 2006; Walker, 2004). Nakata *et al* (2007, 2012) also argue that intercultural spaces are developed when terms such as 'decolonisation' and 'Aboriginal and Torres Strait Islander knowledge' are critically analysed to avoid accepting simplistic explanations and to support student engagement with contemporary Aboriginal and Torres Strait Islander issues. This examination increases the capacity for *ongoing* critical reflection to explore one's responses to the shifting and complex experiences and emotions that can arise in intercultural encounters.

¹⁰ The concept of cultural relativism is widely used in sociology. It acknowledges that what is perceived as true, valued and expected in one social system may not be the same truth in another socio-cultural system. http://sociology.about.com/od/C_Index/g/Cultural-Relativism.htm.

¹¹ This term describes the view that a phenomenon and/ or a group of people (i.e. in this case, Aboriginal and Torres Strait Islander peoples) have characteristics and properties that are essential to them- underlying and unchanging elements.

¹² Bhabha's description of the third space refers to the space between cultures, the uniqueness of each individual and possibility for shared cultural elements and liminal spaces where new cultural elements can emerge. See Bhabha (2004).

While the notion of developing reflexivity during undergraduate training is not new in some health disciplines (namely nursing), it remains a complex teaching endeavor. Research from New Zealand looked at the experience of students who were involved in the practice of a reflective process in teaching and learning about cultural safety (Cultural Safety Research Group, 2006). This work highlighted the pedagogical complexities of teaching reflexivity as it is

[s]haped by the particular cultural lens and everyday lived experience of each student (p. iv)

While the Cultural Safety Research Group's review of the literature identifies a commonality in describing the elements of reflexivity e.g. awareness, description, evaluation, new awareness, learning and action (2006, p. 30), the group highlight that the pedagogy of reflexivity is context bound - particularly in relation to individual and social-political contexts. They argue that more research is required to identify effective reflexive teaching practices.

Pedagogy of Discomfort

The ability to care for self, to 'sit' in the complexity of reflecting and to experience the intercultural space (which is often uncertain, risky and inconclusive) is a key cultural capability in this context (Nakata 2007; Nakata *et al* 2012). Boler (1999) describes the 'pedagogy of discomfort' as the process of questioning beliefs and assumptions which can stimulate a suite of emotions including defensiveness, anger, and importantly, fear that one's personal and cultural identities will be lost. Boler (1999, p. 176) argues for the 'ethical aim' within the pedagogy of discomfort, the willingness to:

Inhabit a more ambiguous and flexible sense of self (to be able, as educators) to extend our ethical language and sense of possibilities beyond a reductive model of 'guilt vs. innocence'.

Boler identifies a number of ways in which discomfort, as a pedagogical strategy, can be transformative rather than traumatic. Focusing on discomfort as a call to action, she highlights emotional selectivity and the value of learning to see self in context; understanding what is to be gained through discomfort (individually and at a collective, advocacy level); and understanding differences between spectating and witnessing history and contemporary uncomfortable truths. As also argued by Nakata and colleagues (2012), Boler (1999, p. 196) draws attention to the importance of avoiding the binary traps of innocence and guilt and learning to 'inhabit ambiguous selves' the space between binary opposites, or the middle ground. The implication here is that, whilst stepping away from the safety of binary opposites into middle ambiguous spaces can be an uncomfortable learning – and teaching - experience, developing the capacity for students and educators to inhabit these spaces is ripe with transformative potential. Collaboration between Aboriginal and Torres Strait Islander and non-Indigenous pedagogical approaches, such as those articulated in Bessarab *et al.*'s (2014) framework for social workers, is key to exploring how the discomfort of the middle ground can be experienced in the teaching and learning context.

Aboriginal and Torres Strait Islander pedagogy

In order to move teaching of content into alternative and transformational learning spaces it is crucial to understand how Aboriginal and Torres Strait Islander pedagogy can inform non-Indigenous learning and decolonise the educational process. The increasing number of publications on Aboriginal and Torres Strait Islander pedagogy (Nakata *et al.*, 2012; Yunkaporta, 2009) support and reflect divergent views between both Aboriginal and Torres Strait Islander and non-Indigenous scholars about what constitutes Aboriginal and Torres Strait Islander curriculum (Behrendt *et al.*, 2012; Anderson *et al.*, 1998; Nakata, 2007b). The Australian Council for Education Research (2011) argues that Aboriginal and Torres Strait Islander pedagogy has been insufficiently theorised in the Australian context, while Nakata and colleagues call for Aboriginal and Torres Strait Islander academics to further debate the concept and production of Aboriginal and Torres Strait Islander knowledge within the academy (Nakata, 2012). There needs to be more academic attention given to Aboriginal and Torres Strait Islander pedagogies, supported by the incorporation of Aboriginal and Torres Strait Islander knowledges and terms of reference into university policies and practices (Oxenham, 2000, Rigney, 1997; Bierman & Townsend-Cross, 2008).

Eight ways of Learning & the local context

Yunkaporta (2009) writes about the use of Aboriginal and Torres Strait Islander pedagogies to equip educators in New South Wales to explore the complexities of teaching and learning at the cultural interface. Yunkaporta points out that while developments in education have aimed to shift the binary presentation of Aboriginal and Torres Strait Islander content, these have generally developed only as “organisers for Indigenised content and activities rather than pedagogy” (p. 9).

Informed by Nakata’s standpoint methodology (2007b, p. 51, Yunkaporta developed the ‘Eight Ways of Learning’ model (2009), (Attachment D) as a pedagogical framework designed to engage teachers with Aboriginal and Torres Strait Islander knowledges. Yunkaporta’s Framework offers a culturally safe point of entry for teachers to *begin* engaging with Aboriginal and Torres Strait Islander knowledge and dialogue in response to, and in relationship with, their local context. Delivery of Aboriginal and Torres Strait Islander content should not override local knowledge of place or ignore western land-based knowledge; to do so would also be to miss a powerful pedagogical opportunity for learning based in land and place (Yunkaporta, 2009; Marker, 2006).

Yunkaporta’s model has been widely adopted in learning contexts, and suggests Aboriginal and Torres Strait Islander perspectives do not come from Aboriginal and Torres Strait Islander content – rather they come through Aboriginal and Torres Strait Islander processes of knowledge transmission. A pedagogical approach built on fostering relationships and immersion in Aboriginal and Torres Strait Islander settings at the local level is highlighted through this emphasis on the process of learning, rather than on content and learning outcomes.

The fundamental principle of place re-orientates learning as a process that emerges through engagement with the pedagogies unique to the local context, rather than from generalised – and often stereotyped- Aboriginal and Torres Strait Islander content. This engagement requires and develops a reciprocal and emotional relatedness with the people, place, space, history and time of the local context (Bierman and Townsend-Cross, 2008), and a responsibility with non-Indigenous educators and HEPs to be in dialogue with local Aboriginal and Torres Strait Islander communities to identify and include local pedagogies (Bessarab *et al* 2012; Behrendt *et al.*, 2012).

Yarning

In the research community there has been increasing attention on the potency of adopting yarning methodologies in building relationships and collecting information from Aboriginal and Torres Strait Islander research participants in a culturally appropriate way. Bessarab & Ng’andu (2010) define yarning in the following way:

Across Australia, Aboriginal people constantly refer to and use yarning in the telling and sharing of stories and information. An internet search in 2010 using Google revealed 418,000 sites referring to yarning. When an Aboriginal person says “*lets have a yarn*”, what they are saying is, lets have a talk or conversation. This talk/conversation/yarn can entail the sharing and exchange of information between two or more people socially or more formally (p.38).

Developing capabilities in students to be able to ‘*have a yarn*’ with their Aboriginal and Torres Strait patients will be an important learning outcome of any curriculum. However, understanding yarning as an Aboriginal and Torres Strait Islander approach to information sharing is also important in exploring and adopting Aboriginal and Torres Strait Islander pedagogies in higher education. As a pedagogical approach, yarning may assist educators and students to move beyond didactic teaching models, towards interactive, relationship orientated, and place-based learning spaces.

Considerations for embedding and integrating Aboriginal and Torres Strait Islander content

Nakata argues that the inherent conceptual differences between Aboriginal and Torres Strait Islander and western knowledge systems mean:

...it is not possible to bring in Indigenous knowledge and plonk it in the curriculum unproblematically as if it is another data set for Western knowledge to discipline and test (2007, p.8)

As previously discussed, addressing the learning process, rather than just content and outcomes, is essential in shifting towards Aboriginal and Torres Strait Islander pedagogies. Yet integrating and embedding Aboriginal and Torres Strait Islander perspectives by foregrounding the process is inherently complex as curriculum frameworks, by nature, must identify teaching and learning components along with anticipated outcomes of the students learning experience. Attempts to bring Aboriginal and Torres Strait Islander knowledges and perspectives into curriculum can run the risk that teaching and learning become, as Nakata's (2004a, p.3) describes, 'corrupted' and 'impoverished', through a dilution and generalisation of content.

McLaughlin & Whatman (2007) and Williamson & Dalal's (2007) reflections on their experiences of embedding Aboriginal and Torres Strait Islander perspectives in curriculum at The University of Queensland through pedagogy and content highlight some important considerations. McLaughlin & Whatman (2007) argue that curriculum reform is needed to assist decolonisation of the Western construction of Aboriginal and Torres Strait Islander knowledges and draw attention to the extra investment of time involved for academics that are part of these curriculum projects. Similarly, Williamson & Dalal (2007) argue for a number of pedagogical principles to drive the more authentic embedding of Aboriginal and Torres Strait Islander knowledges, supporting approaches that promote engagement beyond the 'intellectual' and encourage the consistent unsettling of Western authority (Williamson & Dalal, 2007). Importantly, Nakata reminds us that the focus on unsettling this authority must not become preoccupied with resistance and rejection of Western knowledge, driving an ongoing 'counter-to' position of this content in the academy (2012, 2007).

Clearly, curriculum content needs to address broader issues of curriculum design, pedagogical approaches and assessment when considering Aboriginal and Torres Strait Islander knowledges (Williamson & Towers, 2002; McLaughlin *et al.*, 2007). Bessarab *et al.* (2014) argue for exploring new teaching and learning processes with ongoing questions about how and by whom, knowledge is being constructed. Nakata (2013) highlights the complexity of knowledges, referring to the works of Marcia Langton (2011) and Peter Sutton (2001), and the insufficient development of Aboriginal and Torres Strait Islander discourse to reflect the different intersections of knowledge and the diversity of contexts. The effective teaching of Aboriginal and Torres Strait Islander content is absolutely crucial in order to transform student-learning experiences, and in turn; contribute to the reproduction of knowledge and understanding in the contemporary Australian context.

4 IMPLEMENTING ABORIGINAL & TORRES STRAIT ISLANDER CONTENT

Embedding cultural capabilities as a graduate attribute in the specialised area of cross-cultural education is understandably complex. Few academics have the confidence, skills and ability to either teach in this context or assess students' capabilities (de la Harpe *et al.*, 2009; Nash, Micklejohn & Sacre, 2006; Flavell *et al.*, 2013). The need for investment in teachers' professional and personal intercultural capabilities is identified across a number of educational studies (see Walton *et al.*, 2014 review). Further, the dominance of non-Indigenous approaches to higher education relegates Aboriginal and Torres Strait Islander pedagogies and epistemologies to the periphery of teaching and learning (Behrendt *et al.*, 2012). Increasing Aboriginal and Torres Strait Islander staff within faculties is central to facilitating the teaching and learning of Aboriginal and Torres Strait Islander content and improves the cultural competency of the university setting (Universities Australia, 2011).

Building Aboriginal and Torres Strait Islander academic presence

Aboriginal and Torres Strait Islander employees are under-represented across all levels of the Australian higher education sector in relation to population parity (Behrendt *et al.*, 2012). Positions that are occupied are skewed away from academic research and teaching to general roles, mostly within Aboriginal and Torres Strait Islander Centres as distinct from the 'mainstream' campus. This dramatic under-representation sends negative messages to both the Aboriginal and Torres Strait Islander and mainstream community about the place of Aboriginal and Torres Strait Islander people in higher education and society more generally (Behrendt *et al.*, 2012).

The Australian Technology Network's (ATN) submission to the Bradley Review noted the recruitment and retention of high-quality academic staff is the 'single biggest issue confronting the sector over the next decade' (ATN, 2008, cited Bradley *et al.*, 2008 p.22). The '*Getting Em n Keepin Em*' (2002) report recognised that the unfamiliarity and dominant Anglo-Australian nature of the academic environment is a barrier for Aboriginal and Torres Strait Islander students to achieve learning outcomes. Behrendt (1996) highlighted the racism inherent in reproducing colonial structures within the education system that exclude and alienate not only Aboriginal and Torres Strait Islander students, but educators as well. Increasing Aboriginal and Torres Strait Islander presence in university academic staff profiles will not only help non-Indigenous staff to reflect on their own teaching practices, but be more conscious (and accountable) of how Aboriginal and Torres Strait Islander perspectives and cultural knowledges are assumed within their teaching approaches (Behrendt *et al.*, 2012).

Since 1999 government policies in Aotearoa/New Zealand have driven increasing participation of Maori in tertiary education (Durie, 2009). This has led to a point in the educational sector where Maori cultural identity is embedded within higher education and recognised as an important catalyst for cross-cultural learning (Durie, 2009). In Australia, incentives are needed to encourage more Aboriginal and Torres Strait Islander people into the higher education workforce, to retain existing staff across faculties and to develop the capacity of Aboriginal and Torres Strait Islander staff to take up leadership and professional positions across all areas of university business (Behrendt *et al.*, 2012).

Improving the cultural safety of the university environment is one strategy to increase such participation. Major challenges facing Aboriginal and Torres Strait Islander staff include responsibility for cultural matters outside their job description and duties; the dependency of family members and insufficient support to meet these family responsibilities, and racism (Behrendt *et al.*, 2012). While many HEPs have already implemented strategies to improve their activity, the Behrendt *et al.* (2012) report also identifies how the organisational culture of HEPs can reflect the inherent value attributed to Aboriginal and Torres Strait Islander students, staff and researchers. The review highlighted the need for HEPs to build their cultural understanding and competency through professional development. A whole-of-university governance approach is needed to institute strategies that address racism and improve cultural competency (see Universities Australia, 2011).

Teaching considerations for Aboriginal and Torres Strait Islander educators

While the need to increase Aboriginal and Torres Strait Islander academic and teaching positions in mainstream degrees is widely recognised, teaching Aboriginal and Torres Strait Islander material can be challenging and emotionally draining for Aboriginal and Torres Strait Islander educators (Kickett, 2014). The material they teach may reflect inequities experienced in their lives, and the sharing of stories and personal experiences may raise unresolved hurts or even be traumatic. Behrendt (1996) points out that standing in front of a class of students is risky, as the Aboriginal and Torres Strait Islander educator's own identity and value can potentially come under attack with students making often unconscious or unintentional racist remarks. Not surprisingly, Aboriginal and Torres Strait Islander academics often feel most comfortable teaching within Aboriginal and Torres Strait Islander studies centres.

Lateral violence from other Aboriginal and Torres Strait Islander people can also be an issue (Bessarab *et al.*, 2012). A recent Health Workforce Australia Report (2014, p 13) examining the context of Aboriginal and Torres Strait Islander leadership in the health sector, identified a major issue of 'tall poppy syndrome' where people moving into (or occupying) leadership positions experience lateral violence from other Aboriginal and Torres Strait Islander people. The report explains this can cause some potential leaders to stand back from leadership or publically visible opportunities because they do not want to be criticised by some members of their communities. The report turns to Aboriginal singer/songwriter, author and filmmaker Richard Frankland to explain lateral violence as coming

... from being colonised, invaded. It comes from being told you are worthless and treated as being worthless for a long period of time. Naturally you don't want to be at the bottom of the pecking order, so you turn on your own (p.14)

The HWA report also highlights:

The implications of lateral violence are important in constructing leadership development approaches that will be effective and sustainable and in considering issues of cultural safety (p.14)

Efforts to increase the numbers of Aboriginal and Torres Strait Islander people willing to teach in mainstream curriculum implementation must consider, and have strategies to support and mitigate, some of the well-known risks and challenges facing Aboriginal and Torres Strait Islander educators. These include issues of cultural safety associated with being a minority voice in a dominant white space, but also risks of lateral violence from within Aboriginal and Torres Strait Islander communities.

Teaching considerations for non-Indigenous educators

While there has been strong support for Aboriginal and Torres Strait Islander staff teaching Aboriginal and Torres Strait Islander content, there is increasing recognition that this content must be 'integrated' throughout the curricula. This requires all academic staff to be capable and confident to teach in this domain (Virdun, 2013). Yet despite much literature around content, Williamson and Dalal (2007) argue there is little published about how an educator might apply this knowledge. As Yunkaporta notes, the literature highlights the need for educators to examine their own cultural baggage, yet gives few explanations as to how this might be done (2009).

Non-Indigenous educators often feel apprehensive teaching Aboriginal and Torres Strait Islander content given the singular set of knowledge and skills required (Yunkaporta, 2009). A recent Aotearoa/New Zealand survey of

medical students' and educators' experience of the teaching Maori health curricula, found that many teachers felt underprepared to teach or assess the material (Jones *et al.*, 2013). Similarly, responses from non-Indigenous staff participating in the 'Getting it Right' survey of social workers teaching Aboriginal and Torres Strait Islander content indicated lack of confidence in effectively teaching the material. This included concerns about 'getting it wrong', not doing justice to the area, managing resistance from students and dealing with emotional triggers. Some non-Indigenous staff also felt the content should only be taught by Aboriginal and Torres Strait Islander people (Bessarab *et al.*, 2014 p.76).

Williamson & Dalal (2007) argue there is a need to move beyond intellectual engagement to a deeper, more holistic commitment by HEPs and educators to develop transformative teaching strategies. Yunkaporta (2009) provides a pedagogical framework to support educators to work with Aboriginal and Torres Strait Islander knowledge. This framework encourages a shift in educational focus from the production of material outcomes to the development of cross-cultural relations and capacity to engage in the 'cultural interface' (Nakata, 2007, p.9). Clearly, this shift requires the need for better institutional support and targeted professional development to improve teaching and learning practice (Behrendt *et al.*, 2012; Jones *et al.*; 2012). This includes the implementation of culturally sound pedagogies for teaching students from all backgrounds. Staff who are culturally competent are not only able to teach more effectively, but they also model the principles of cultural competency to students including partnerships with Aboriginal and Torres Strait Islander people, understanding of knowledge protocols and the capacity to be self-reflexive (Bessarab *et al.*, 2014).

Collaborative teaching

Individual HEPs and the tertiary sector more broadly, must identify how non-Indigenous educators can be supported to deliver content in more culturally appropriate ways. An increasingly favoured approach is institutionally supported models of collaborative teaching. Bessarab *et al.* (2014, p.38) advocate for a collaborative approach to teaching Aboriginal and Torres Strait Islander content that includes relationship building 'to bring life to the skills, values and knowledges of cultural responsiveness'. Cross-cultural teaching involving an Aboriginal and Torres Strait Islander and a non-Indigenous educator can be a powerful way to model intercultural collaboration to students (Morgan & Golding, 2010; Kickett *et al* 2014). However for this to be successful, it is not only the will of key individuals that is needed, but substantial organisational planning to support a whole-of-school approach (Bessarab, 2014).

What skills are required in educators to facilitate development of student cultural capabilities?

Creating a safe environment for students and also Aboriginal and Torres Strait Islander and non-Indigenous staff is central to effective teaching and learning of Aboriginal and Torres Strait Islander content (Thackrah & Thompson 2013). This requires developing educator skills to manage student discussions within a safe space where tension, disquiet and resistance can emerge when uncomfortable truths about Australia's shared history are discussed. Thackrah & Thompson (2013, p.20) reflect on some of the complexities of developing a safe space:

Classroom dynamics are influenced by students personalities and experiences, demographic characteristics, the program they are undertaking and, of course the skills and experience of the facilitator. The presence of Aboriginal students or an Aboriginal facilitator, for example, may not only change the dynamics considerably; but necessitate a rethink of what constitutes a safe learning environment from an Aboriginal ...perspective.

Goerke & Kickett (2013) argue that the best way for a student to develop attributes in Australian Aboriginal and Torres Strait Islander cultural competence, is to be in a learning environment where the staff they encounter model these attributes. If staff do not understand and demonstrate cultural competence, there is little chance that they will be able to support students to develop the associated attributes (Goerke & Kickett, 2013). Nakata (2007b, p.13) is unequivocal that 'educators need themselves to develop their scholarship in contested knowledge spaces of the cultural interface and achieve for themselves some facility with how to engage and move students through the learning processes. Highlighted here is the need for educators to develop their own cultural capabilities, with these capabilities observable to students in their practice.

Reflexivity

Educators need highly developed facilitation skills in combination with the practised capability to critically reflect on their own cultural positioning in order to effectively manage their own emotional responses and those that arise in the classroom. This requires educators to 'reposition' themselves so students feel safe enough to 'test' the boundaries of their own thinking, identify blind-spots and explore their own capacity to reposition (Nakata *et al.* 2012). Key concepts such as 'whiteness' and 'privilege' in the context of colonisation and Aboriginal and Torres Strait Islander and non-Indigenous relations need to be understood in order to facilitate discussions and enquiry in this area (McIntosh, 1990; Pease, 2010; Bessarab *et al.*, 2014). The educator must have the capacity to reflect on and interrogate his or her own attitudes about the cultural 'other', whilst also challenging student perceptions and managing classroom discussions around racially charged material that may be fuelled with emotion (Phuntsog 1998, Hershfeldt, 2009).

The practice of reflexivity in understanding factors informing perceptions and values is not only important for non-Indigenous educators (Pewewardy, 2003). In Hawaii, Manuelito (2003) found that Indigenous teachers working with their own Indigenous students must sometimes overcome negative attitudes (resulting from the residual effects of colonisation) about the place of Indigenous culture in the curriculum (2003). Conversely, research suggests that non-Indigenous health professionals working in Aboriginal and Torres Strait Islander health contexts can experience stigma associated with 'being white', where they prioritize Aboriginal and Torres Strait Islander experience and knowledge and devalue or dismiss their own agency in improving Indigenous health (Kowal, 2011). These elements again highlight the pedagogical complexity of reflexivity.

According to Nakata *et al.* (2012) educators need to understand how knowledge is constructed in cross-cultural education, reflect on where they position themselves in relation to the cultural 'other' and resist taking binary or opposing cultural positions¹³ which inhibit discussion and limit inquiry. However, others argue that foregrounding Aboriginal and Torres Strait Islander knowledge and culture is an important strategy to revalue that which has been so resoundingly de-valued for so long (Dudgeon & Fielder, 2006). While Nakata *et al.* (2012) support this position as an entry point, they caution against maintaining it where resorting to binary positioning can shut down inquiry (Nakata *et al.*, 2012).

Reflexive approaches include understanding what motivates educators to be involved in teaching in these types of contexts. McEldowney's (2005) doctoral research explored the voices of nurse educators involved in teaching for 'social change' in Aotearoa New Zealand. Arguing that teaching and learning cannot be politically neutral, she draws on the work of Zeichner (1995, cited in McEldowney, 2005, p.149) who says educators

[n]eed to act with greater clarity about whose interest we are furthering in our work because, acknowledged or not, the everyday choices we make as teachers...reveal our moral commitments with regard to social continuity and change.

McEldowney uses an approach called life enquiry to reflect on and explore with nurse educators their 'inside stories' to understand what influences and motivates them to teach in this area. By exploring the interconnection between life stories and shape shifting moments with participants in her research, McEldowney highlights the significance of life experiences in the decision to teach for social change. The life story methodology, argues McEldowney (2005, p. 183)

...revealed and evoked the fascinating connections between personal life as lived and the participants' stances on activism in their everyday practices within their pivotal roles as nurse educators.

Thus, a critical point of reflection for educators is to understand their own life trajectory and how it influences the way they teach and the motivations behind their pedagogical approaches and choice of content.

¹³ The binary or opposing cultural approach speaks to teaching through an 'either or' perspective. For example, Aboriginal and Torres Strait Islander culture is 'collectivist' and western culture is 'individualist'. Or, educating based on assumptions or stereotypes that all Aboriginal and Torres Strait Islander people have similar cultural and social beliefs and practices that are the opposite to western people and culture.

Models to identify and develop educator capabilities

The Linking Worlds Research Project (Frawley *et al.*, 2010) was an intercultural leadership project that identified capabilities required to work well with Aboriginal and Torres Strait Islander content. Frawley *et al.* (2010) argue that transformative teaching and learning can occur when Aboriginal and Torres Strait Islander and non-Indigenous people collaborate and develop capabilities across five core domains: personal, relational, professional, organisational and intercultural.

Subsequent iterations of this work culminated in the recent production of the report, *Relationships are key: building intercultural capabilities for Aboriginal and Torres Strait Islander students and their teachers* (Frawley *et al.*, 2013). This report presents the results of research focused on leadership styles in educational contexts that aim to enhance learning and teaching through capacity building, communities of practice and cross-disciplinary networks. It highlights the crucial role of relationships in knowledge exchange. 'Communities of practice', as forums for educators to build their capacity, and as structures for ongoing support, offer considerable potential here. Wenger, McDermott and Snyder (2002, p. 4-5) describe the notion of a community of practice as follows:

Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (As they) accumulate knowledge, they become informally bound by the value that they find in learning together. Over time, they develop a unique perspective on their topic as well as a body of common knowledge, practices, and approaches. They also develop personal relationships and established ways of interacting. They may even develop a common sense of identity. They become a community of practice.

Scott *et al.* (2008) also developed an academic leadership capability framework for effective teaching and learning leadership. The five capability domains: personal, interpersonal, cognitive, generic and role-specific, have been used at Curtin University to guide the development of teaching and learning skills for educators teaching in a discrete Aboriginal and Torres Strait Islander health science unit. In this unit, students' assumptions about Aboriginal and Torres Strait Islander people are explored and challenged. This may result in student discomfort and as such, educators require a level of emotional intelligence and the capacity to reflect on their own beliefs so as not to project them on to the student (Hafferty, 1998; Mezirow, 2000; Jones *et al.*, 2013; Goerke & Kickett, 2013; Kickett *et al.*, 2014). The unit has used Scott *et al.* (2008) & Frawley *et al.*'s (2010) capability frameworks to guide strategies to identify and develop the capabilities that educators require to manage student discomfort, support students to develop their own cultural capabilities and also take care of the needs and development of teaching staff. Yet this is no easy feat, as Boler (1999) highlights:

The educator who endeavours to rattle complacent cages, who attempts to 'wrest us anew' from the threat of conformism, undoubtedly faces the treacherous ghosts of the other's fear and terrors, which in turn evokes one's own demons (p.175)

How, and if, institutions support staff to develop the required cultural capabilities is central to effective curriculum implementation and genuine graduate attribute development. This is also central to legitimising Aboriginal and Torres Strait Islander content in health curricula and sending the message of the value of this content to students (Jones *et al.*, 2013).

5 DEVELOPMENTAL MODELS & GRADUATE CULTURAL CAPABILITIES

As the higher education sector does not yet have a national standard for developing or measuring cultural competencies or capabilities in students and staff, cultural developmental learning models and terms have largely been taken from the health education literature (Grote, 2011). The push for culturally safe and competent services for Aboriginal and Torres Strait Islander Australians has resulted in the creation of many different models and frameworks that bring together interrelated elements required to achieve cultural competency. Most frameworks identify a required set of knowledge and skills/behaviour/action. Many of the more recent versions can be traced back to widely cited developmental models from the United States that have been applied within the health care context, for example, Campinha-Bacote (2002), Bennett (1993) and Cross *et al* (1989).

The increasing preference for vertical integration, the embedding of Aboriginal and Torres Strait Islander content throughout undergraduate health science degrees, will require curriculum frameworks to be built around development models that identify how cultural capabilities are progressively acquired. This also requires HEPs to identify, define and develop student-learning outcomes across key stages of the learning journey, along with ways to measure student progress towards those outcomes. Considerable work has already been undertaken in the health service sector to refine cultural development models. It is important for health faculties to align themselves with these models, given that it is within this sector that their graduates will be required to demonstrate their cultural capabilities.

Key cultural developmental models from the health sector

One of the most influential models of cultural competence informing American and Australian health care delivery is that of Campinha-Bacote (1998; 2002) which built on earlier work by Sue (1978; Sue & Sue 1990; Sue *et al.*, 1992) see (Attachment E). This developmental model identifies both individual and service-based competencies in an ongoing process where the service responds to the cultural context of the client. The cultural 'responsiveness' of the service is reflected in the capacity of health care providers to gradually *become* more competent rather than *achieving* competence through cross cultural interactions and the acquisition of cultural knowledge. Within this model, responsive health care providers are also self-aware and reflexive; demonstrate cultural skills that are enabled through practice; have cross-cultural encounters; and importantly, are motivated to engage across all these domains (Campinha-Bacote (1998; 2002). This models' identification of the need to be motivated (externally by performance standards and requirements in the workplace or internally by the desire to develop cultural capabilities) as well as the ongoing journey of developing cultural competencies, are important contributions of Campinha-Bacote's work.

Bennett's Developmental Model of Intercultural Sensitivity (1986, 1993) is also widely utilized (Attachment E). This is a research-based framework designed to explain and map an individual's journey of cultural development using concepts from cognitive psychology and constructivism. It identifies a shift from ethnocentrism (one's culture is central to reality) to ethno-relativism (experiencing one's own culture in the context of others). Individuals develop more complex and sophisticated understandings of culture (their own and that of others) as their acquisition of knowledge and intercultural experiences provide opportunities to construe (and re-construe) their understandings over time. This framework has been used for over 20 years to develop education and training programs for intercultural competency development.

Hammer's Intercultural Development Continuum within the Intercultural Development Inventory (1999), builds on the development model proposed by Bennett. It suggests that people are not alike in their capabilities to recognise and respond to cultural differences (Attachment E). Key to this model is the identification of the part of the developmental journey (which moves from denial, to polarisation, minimisation, acceptance and finally adaptation) during which the individual feels overly critical of their own cultural values and can potentially disconnect from their

own cultural group. Another consideration in the developmental journey comes from research conducted by Kowal (2011) with non-Indigenous health professionals. Identifying the 'striking feature'(p.2) of the cohort of her 'progressive' (p.2) non-Indigenous professionals to claim any agency in working in Aboriginal and Torres Strait Islander improvement, Kowal's findings highlight how the self-silencing by non-Indigenous people of their own 'white voice' - and where this sits on a developmental journey – should be considered in developmental models in the Australian context¹⁴.

In terms of development models specifically within a post-colonial context, Terry Cross's (1989) work from the Native American Indian perspective has been very widely used (Attachment E). Cross's models understand development as moving towards a state of 'proficiency', with one of the key attributes or outcomes being the ability to advocate for equity (i.e. a human rights/ social justice approach). Important in this model is the identification of stages prior to the developmental journey, which are identified as cultural blindness, incapacity, and even destructiveness (Cross et al, 1989).

American-based cultural competency models have been adapted to the Australian context. The Victorian Government Department of Human Services (2008, p.24) have adapted Cross *et al.*'s (1989) framework to describe behaviors and attitudes on the cultural competency continuum that are specifically related to the Aboriginal and Torres Strait Islander Australian context:

- Cultural destructiveness - exemplified by policies that led to the Stolen Generations;
- Cultural incapacity - relates to the prevalence of racism and paternalism;
- Cultural blindness - no understanding of cross-cultural factors; a belief that mainstream services do not need to change to meet Aboriginal clients' needs;
- Cultural pre-competence - well intentioned actions such as employing Aboriginal staff within the organisation but without fully understanding cultural differences and approaches;
- Cultural competence – acceptance of, and respect for, cultural diversity within the organisation; service delivery is reviewed and adjusted to meet the needs of different population groups;
- Cultural proficiency – cultural diversity is highly valued, active research takes place and self-determination is promoted and supported.

Adapting development models into curriculum

Developed in the context of improving health provider's cross-cultural service delivery, Wells' (2000) Cultural Development Model (CDM) model is designed to track attitudinal and behavioral changes through cognitive and affective phases of intercultural learning (Attachment E). The CDM synthesises cultural development from other key models including the ones above. It suggests that cultural awareness, cultural sensitivity, and cultural competence do not achieve the level of cultural development necessary to meet the health care needs of a diverse population. The CDM presents cultural proficiency as a concept that extends competence to practice and involves individual and institutional behavior/commitment. Wells' model has been used to identify and map content for culturally competent curricula at Charles Sturt University and the University of South Australia (Charles Sturt University, 2010; McConnochie *et al.*, 2008; Ranzijn *et al.*, 2010).

Recent perspectives from the discipline of social work, illustrated in Bessarab *et al.*'s (2014) *Getting it Right* Framework, refer to the development of 'cultural responsiveness' in graduates. This work argues that developmental stages are not linear; rather students can potentially move backwards, or straddle multiple stages at one time due to a range of reasons. Bessarab *et al* identify these non-linear 'phases' as resistance and denial (of

¹⁴ Kowal's findings and conclusion of the reluctance in non-Indigenous people to claim agency stems from her discussion around the impact of White 'anti-racist' discourse in the era of self-determination in the Australian context. While Kowal's work does not specifically link this experience to developing cultural capabilities, her research does identify an important aspect to contemporary non-Indigenous and Aboriginal and Torres Strait Islander relations, and how this may play out within the classroom.

history and its impacts); stereotyping (and generalisation of attitudes) and glorification (where there is avoidance of challenging or engaging with attitudes and practices that may require change/ development), as part of the development towards cultural responsiveness. Bessarab *et al's* (2014) important work considers the complexities of developing cultural capabilities in graduates and of assessing whether students are moving through key stages of the developmental journey. They explain that some students may display unfavourable attributes at particular times as an essential part of the developmental process, while for other students, these same attributes may be an indication they are not developing – and therefore not able to pass- this aspect of the curriculum (Bessarab *et al*, 2014). The roles and capabilities of educators are absolutely crucial for being able to identify and assess the development of students with respect to these complexities.

What should be the assessable core learning outcomes?

Critical Reflexivity

Most developmental models emphasise critical reflection as a core skill required to develop a degree of competency in this field (Tyler, 2002). Intellectual and practical exposure to other cultural realities in the context of self-examination and critical reflexivity supports this development. Emotional engagement is also considered essential for effective reflective practice (Bhawuk & Triandis, 1996 cited in O'Byrne, n.d.). As Kleinman (cited in Faidman, 1998) argues:

If you can't see that your own culture has its own set of interest, emotions, and biases, how can you expect to deal successfully with someone else's culture? (p. 1316)

A key capability that is strongly argued for through the work of Nakata and colleagues (2013, 2012, 2007) is the capacity to be critically reflective. Students must be able to question their own positions, but also the knowledge (Aboriginal and Torres Strait Islander included) they encounter. Nakata (2013, p.9) links this capability in students to the decolonial endeavor, arguing:

...the very forms of critical analysis we utilise to critique Western knowledge practices are not engaged and applied to some of these contemporary forms of Indigenist knowledge production. The limits of such knowledge production are not considered or articulated, and students are often positioned to accept them uncritically on moral, cultural, political, and social justice grounds.

Nakata's contentious but thought-provoking argument highlights the importance of developing capacity in students to engage actively and critically with the information and experiences they encounter, so that curriculum delivery does not resort to polemics or stereotypes.

Responding to diversity

As previously discussed, Ranzijn *et al* (2005), suggest cultural competency education and training should be seen as an ongoing personal journey. They argue that cultural competence should be understood as

a process, not an event; a journey, not a destination; dynamic, not static; ...[it] involves the paradox of knowing (Ranzijn *et al.*, 2005, p. 1).

The concept of culture, defined too narrowly, can be easily conflated with other concepts such as race and ethnicity, thereby failing to capture diversity and significantly reducing the effectiveness of cultural competency strategies (Thackrah & Thompson, 2013). It is increasingly being recognised that cultural competency for one population may not necessarily translate to another (Kim *et al.*, 2006; Sue, 1999, 2003). Cultural competence needs to be regarded as an ongoing process that is developed in a particular cultural context, and this is especially relevant with regard to the diversity of Aboriginal and Torres Strait Islander cultures (Walker & Sonn, 2010), which speaks to the notion of developing the capability to be 'culturally responsive' to the unique diversity of each encounter (Bessarab *et al*, 2014). A key pedagogical strategy to support students to develop more nuanced understandings of diversity, and to meet the requirement for ongoing experiential learning, is to increase opportunities for encounters with cultural difference. As Grote (2011) highlights

As individuals consciously engage in intercultural experiences and more information is provided, their interpretation of their experiences becomes more complex, shifting from fairly simplistic understandings to more complex experiences of cultural difference (p.242)

The notion of cultural capabilities, however, may provide a framework where a set of skills and sensitivities are identified that can be transferred into any setting to *support the development* of specific knowledge and behaviors appropriate to the local setting.

Confidence & resilience to challenge racism

In a small qualitative study, Mitchell *et al.* (2011, p.330) looked at the capacity of first year undergraduate students to challenge 'everyday antiracism'. They report that social expectations to 'fit in' and the fear of provoking aggression and conflict inhibit students from speaking up. They also report that when students feel well informed and factually authoritative, they are more likely to speak up. The authors highlight that equipping students with capabilities to challenge racism prepares them to deal with the potential discomforts they might encounter. Mitchell *et al.* (2011) suggest the use of intergroup dialogue over several sessions and role-play activities in a simulated and supportive environment to explore and test the development of these skills.

Relationships and engagement

As previously discussed, work by Frawley *et al.* (2013, p.4) on developing core intercultural capabilities emphasises 'relationships as key' to both learning experiences and outcomes. Frawley *et al.* highlight the value of forming intercultural spaces focused on the teaching and learning process, spaces that create opportunities for student engagement with Aboriginal and Torres Strait Islander peoples. The focus of this body of work is that capabilities will ultimately develop through engaging in ongoing relationships. Active relationships are key to developing cultural capabilities (Walker & Sonn, 2010; Frawley, 2013). Teaching and learning strategies are required to provide ongoing opportunities for students to engage and interact with Aboriginal and Torres Strait Islander people, not only in structured learning experiences, but also in informal and unstructured 'real time' encounters.

The importance of developing relationships and partnerships with Aboriginal and Torres Strait Islander people is highlighted across multiple health sector strategic documents.¹⁵ HEPs must focus on supporting students to acquire practical skills and confidence to engage in these relationships and partnerships as core-learning outcomes. In the absence of a shared, mandated agreement across health professions on what constitutes a culturally capable health professional, principles articulated in key health sector documents (such as the Cultural Respect Framework, Queensland Cultural Respect Framework and NHMRC Guidelines)¹⁶ could be considered in mapping and articulating these core learning outcomes within higher education. Mapping alongside key health sector documents will also assist (in the absence of standardised inter-professional cultural competencies) curriculum learning outcomes to align with the current expectations of professional practice.

Inter-professional capabilities

Indigenous Allied Health Australia (IAHA) accepts the Aboriginal and Torres Strait Islander definition of health as more than the absence of disease. It also acknowledges that the poor health experienced today by Aboriginal and Torres Strait Islander peoples is often the result of complex and interrelated social, historical, political and cultural factors. An interdisciplinary holistic approach to healthcare delivery is absolutely paramount if Aboriginal and Torres Strait Islander health is going to be improved (IAHA, 2013a). Existing industry recognition of the role of inter-professional capabilities and associated frameworks hinged on the client-centered approach, offers an opportunity

¹⁵ For example, National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013; Cultural Respect Framework 2004-2009; Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2012-2033

¹⁶ For example, National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013; Cultural Respect Framework 2004-2009; Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2012-2033; NHMRC, 2003. Values and Ethics: Guidelines for Ethical conduct in Aboriginal and Torres Strait Islander Health Research. Commonwealth of Australia, Canberra.

to position the value of developing cultural capabilities for graduates working in Aboriginal and Torres Strait Islander contexts.

The notion of inter-professional education (IPE) was identified by the World Health Organisation in 1978 as an important component of primary healthcare training and has been gaining increasing recognition in the health profession literature (Salvatori *et al.*, 2007). Inter-professional collaboration is particularly important in the management of complex and chronic health conditions, a reality facing many Indigenous populations around the world (Salvatori, 2009; Byrne, 1999). In Australia, the chronic health complexities of Aboriginal and Torres Strait Islanders call for an inter-professional approach. Principle 10 of the CDAMS Framework points out that multi-disciplinary learning contributes to more rounded practitioners, and, in the case of Aboriginal and Torres Strait Islander health, may also contribute to the development of more holistic thinking and practice (Phillips, 2004). Nisbet *et al.* (2011) argue that the CDAMS Framework has great potential to be applied across disciplines to provide powerful inter-professional teaching and learning opportunities for health students and staff.

Inter-professional collaboration enhances patient-and family-centred goals and values by supporting cohesiveness between different health perspectives and care plans; provides mechanisms for continuous communication among health providers; and optimises staff participation in clinical decision-making (Curran, n.d.). Oandasan *et al.* (2004) reinforce the importance of adult learning theory in the context of inter-professional education by highlighting the need to create non-threatening learning environments and to provide opportunities for learners to develop skills as reflective collaborative practitioners, specifically through journals and small group discussion. Importantly, educators must also be capable of acting as inter-professional role models, highlighting the need for faculty development and suitable training to prepare teaching staff for their role as facilitators (rather than teachers) in this environment (Curran, n.d.).

Inter-professional patient-centred care has drawn considerable focus in Canada as an essential component for delivery of effective health care (Curran, n.d; Dector 2006). It can also enhance care in culturally diverse settings. Oandasan *et al.* (2004) highlight how patient-centred practice in culturally diverse settings requires health care providers to collaborate with other key community workers who have not traditionally been part of the health care team. The role of inter-professional clinical education and student placement is undoubtedly a key aspect, in this context, to enhancing the cultural capabilities of health students (Oandasan *et al.*, 2004).

Inter-professional models of clinical education and student placements can also demonstrate, to students, 'holistic' and client-centred practice within the context of collaborative, culturally appropriate services (ClinEd Australia, 2014). Models of inter-professional learning and education can also be transferred into curriculum design. At Curtin University, the Inter-professional Capability Framework was designed to provide a model for teaching and assessing the capabilities required for collaborative practice – in health graduates (Brewer, 2011). The framework has three core elements i) client-centred service, ii) client safety and quality, and iii) collaborative practice, of which five capabilities (communication, team function, role clarification, conflict resolution and reflection) are developed. This framework is unique in the way that these capabilities articulate with three graduate student learning levels i) the novice, ii) the intermediate student and iii) the entry practice level (Brewer, 2011). This mapping of interprofessional capabilities through different levels of the student learning experience may provide a useful model for simultaneous mapping of cultural capabilities through an integrated curriculum.

Human Rights, social justice and the link to graduate attribute statements

Links between Indigenous curricula, graduate attributes and university initiatives are increasingly being made from human rights and social justice perspectives. In the New Zealand context, Durie (2009) argues that if the university's main objective is to have a student and staff body that represents the community, then an equity framework is important. However, if the objective is to cultivate a university-wide culture that reflects the values, customs, interests, and aspirations of diverse groups within society, then a broader framework - a social cohesion framework - is necessary (Durie 2009). In America, the development of cultural competence as a graduate attribute has been linked to the human rights agenda, to the need for equity and social justice (Graves, 2007).

The process of critical reflection is a powerful tool in efforts to improve fundamental social justice outcomes for Aboriginal and Torres Strait Islander people (Walker *et al.*, 2000). It allows us to become more conscious of the power inherent in our own practice - to democratise relationships, interactions and processes and to promote culturally secure processes and environments that will improve Aboriginal and Torres Strait Islander health and wellbeing. The pedagogical model behind Ranzjin *et al's* (2008) curriculum content considers development of cultural competency as more than just awareness, skills and self-reflexivity; it also requires action and engagement in broader issues of justice & human rights, the development of strategies to address racism.

A recent review by Ma Rhea (2013) examined the extent to which Aboriginal and Torres Strait Islander matters appear in graduate attribute statements, strategic plans, policies and Reconciliation Action Plans (RAPs) in Australian HEPs. Ma Rhea (2013) reports that only six of the 39 Australian HEPs make specific reference to Aboriginal and Torres Strait Islander matters within their graduate attributes statements, and of these six:

- three have commitments to Aboriginal and Torres Strait Islander peoples in their strategic planning or policies and have a RAP;
- one has a RAP but no strategic plans or policy;
- two mention Aboriginal and Torres Strait Islander matters in their Graduate Attribute statements but have no evidence of specific policies, strategic plans or a RAP.

Ma Rhea (2013) argues that there is a commonality in approaching graduate attributes about Aboriginal and Torres Strait Islander peoples. These attributes are singularly focused on developing intercultural or cross-cultural awareness, where understanding and respect for Aboriginal and Torres Strait Islander issues involves developing students' personal attitudes, expectations and understandings of the 'other' culture. Rhea (2013, p. 22) points out that the focus on graduates developing attributes in the broad category of intercultural or cross-cultural awareness means that their specific engagement with Aboriginal and Torres Strait Islander matters is a 'an optional extra and a personal choice'. Ma Rhea argues that Australian HEPs must link broader university policies, strategic plans and graduate attributes to a rights-based socioeconomic framework that reflects Australia's responsibilities as a signatory to the *Declaration on the Rights of Indigenous Peoples*.¹⁷

Government policy drivers increasingly call on services to be more culturally responsive. By using a rights-based approach, HEPs can be extremely powerful in shaping standards relating to graduate employability and professional development and can contribute to social change by producing 'postcolonial professionals' who are educated about internationally recognised human rights and economic justice mechanisms within postcolonial states (Ma Rhea, 2013). HEPs are increasingly being called to take transformative approaches to education by preparing their graduates to be citizens driven by a common understanding of humanity and universal ideals such as equity and social justice (Clifford, 2014).

Developing student cultural capabilities through an integrated curriculum

Mapping student capabilities (also referred to as 'attributes') to learning outcomes is key to implementing effective curriculum. Common approaches involve mapping within the domains of attitudes, knowledge and skills (for example, Sue 2001, Attachment E).

Research conducted with midwifery students participating in a compulsory first year Indigenous Cultures and Health unit explored learning experiences and attitudinal shifts (Thackrah & Thompson, 2013). Findings indicate that while a foundational standalone unit may have the capacity to change attitudes, transforming knowledge into practice requires on-going development and learning; students must have multiple opportunities to apply their new knowledge to real life experiences. Thackrah and Thompson's research also reflects on the development of critical thinking (2013). They suggest that a deeper level of engagement with content over time facilitates the capacity for

¹⁷ See http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

students to be ‘...in a better position to know what they didn’t know’ (p.119); students develop the ability to stand back and observe what they don’t know, moving away from the feeling that Aboriginal and Torres Strait Islander culture and perspectives is something that can be learnt in a linear and categorical fashion. The authors advocate that Aboriginal and Torres Strait Islander content be integrated throughout undergraduate degrees so that students can develop a more sophisticated understanding. Similarly, Carpenter *et al.* (2002, p. 2) highlight that embedding Aboriginal and Torres Strait Islander perspectives horizontally and vertically (as opposed to relying on a standalone unit) assists students to explore the ‘ontological and epistemological basis of relationships that underpin our understandings of race, and hopefully move to a higher order analysis of these issues in the law and justice environments’.

Mapping learning outcomes through a vertically integrated curriculum (in which, ideally, a standalone unit is also included) is clearly a complex endeavor. A number of Australian HEPs have done impressive work to map the development of cultural capabilities through learning journeys that are embedded in integrated and/or vertical curricula. Exploring examples of implementation hold powerful learnings for other HEP developing curriculum in this field.

Queensland University of Technology

Following the launch of its Reconciliation Statement in 2001, Queensland University of Technology (QUT) provided grants within the University for Faculties to embed Aboriginal and Torres Strait Islander perspectives within their curricula. Different faculties and schools used different approaches for their curriculum re-design. Here are two examples.

1. School of Humanities and Human Services: This model of curriculum design was inspired by the Alaska Native Knowledge Network and other best practice literature (Williamson & Dalal, 2007, p.52). It aims to enact principles and pedagogical approaches that recognise complexities at the cross-cultural interface for both Aboriginal and Torres Strait Islander and non-Indigenous educators. It also identifies graduate capabilities that can be demonstrated at introductory, enhanced and advanced levels. Horizontal course content was then mapped to these graduate capabilities (Attachment F). Subsequent research emerging from this project has both endorsed and challenged aspects of the curriculum framework, highlighting the need for ongoing work in this space.
2. Faculty of Health: The *Yapunya! Project* (Nash *et al.*, 2006) was heavily informed by the concept of cultural competence in the healthcare delivery models of Campinha-Bacote (1998) and Cross, Bazron, Dennis and Isaacs (1989). A series of graduate capabilities were developed to demonstrate how students would move through a learning continuum (Attachment F). The project took a whole-of-course approach, with content implemented through first, second and third year units in four major undergraduate degrees. Key elements of this program include the incorporation of Aboriginal and Torres Strait Islander content and learning activities, Aboriginal and Torres Strait Islander perspectives on assessment (theory and practicals), and clinical placements in Aboriginal and Torres Strait Islander settings (Nash *et al.*, 2008).

Embedding of Aboriginal and Torres Strait Islander perspectives has also occurred at QUT in the School of Justice Studies through a cooperative curriculum development strategy (i.e. curricula are developed with Aboriginal and Torres Strait Islander input) (Carpenter *et al.*, 2002), and in the Faculty of Education, where an outcomes-based approach was used to integrate Aboriginal and Torres Strait Islander perspectives horizontally in combination with a compulsory introductory foundational unit.

Charles Sturt University

The pedagogical framework employed at Charles Sturt University (CSU) to support the incorporation of Aboriginal and Torres Strait Islander Australian content into undergraduate programs, was originally developed by Wendy Nolan and Keith McConnochie in 2004. It builds on the notion of the ongoing development of cultural competence outlined by Cross, Bazron, Dennis, and Isaacs (1989) and Campinha-Bacote (2005). The CSU model has been further refined by Ranzjin, McConnochie, and Nolan in a project titled *Psychology and Aboriginal and Torres Strait*

Islander Australians: Teaching, Practice and Theory and subsequently adopted within the Universities Australia best practice guidelines (Universities Australia, 2011).

The model (and further developments of this model) incorporates four introductory content areas into a stand-alone Aboriginal and Torres Strait Islander Studies foundation unit, with later content integrated into other undergraduate units and finally, more developed content embedded in post-graduate programs (Attachment F). This model speaks to the developmental journey. It assumes that certain skills and knowledges are developed only after building blocks have been put in place in earlier stages. The CSU model is unique in that it has a stand-alone foundation unit combined with embedded content across the course units (CSU, 2010). Importantly, this model understands development of cultural competence as incorporating action and engagement in broader issues of justice and human rights to develop strategies to address racism - not just awareness, skills and self-reflexivity (CSU, 2010, p. 23). It also acknowledges that learning is not necessarily linear. Students begin the journey at different entry points (i.e. some are further along the continuum than others), and respond differently to different content areas.

The University of Western Australia

In 2000, The University of Western Australia (UWA) began to progressively introduce a full core curriculum in Aboriginal and Torres Strait Islander health to students in the Faculty of Medicine, Dentistry and Health Sciences (Paul *et al.*, 2006). The program uses a step-wise learning approach, mapping curricula to learning outcomes identified for each year level (Grote, 2008).

A questionnaire administered in 2003 and 2004 found significant shifts in students' perceptions of their preparedness to work with Aboriginal and Torres Strait Islander people and having a sense of social responsibility based on their levels of knowledge, attitudes and skills. Since this core unit was first implemented, work in the Faculty by the Centre for Aboriginal Medical and Dental Health (CAMDH) has been undertaken to develop a 'learning pathway' based on graduate attributes and learning outcomes, to horizontally and vertically embed Aboriginal Torres Strait Islander health into medical student curricula. Further work at UWA involved developing an Indigenous Oral Health Curriculum Framework for the Bachelor of Dental Science course, which built on, and adapted the CDAMS medical school framework (Bazen *et al.*, 2007). Paul (2012) points out that one of the strengths of the program has been the development of an evaluation tool to ascertain the impact of teaching. The tool itself has been evaluated (Carr *et al.* 2011) and adopted by a number of schools nationally and internationally for their own evaluation processes (Paul, 2012).

Assessing learning outcomes

A key concern in mapping desired capabilities and assessing learning outcomes using cultural developmental models is the implicit expectation that students will (or the educator is attempting to) move along a continuum, from awareness to sensitivity, and ideally, competency/ proficiency (Hollinsworth, 2013). As previously highlighted, the assumption here is that gaining 'cultural competence' is a linear process rather than a circuitous and often difficult journey. The challenge, when assessing whether or not students' cultural awareness is developing into cultural competence, is to avoid an approach that uses 'tick box' markers that essentialise or homogenise the diversity of Aboriginal and Torres Strait Islander experience, rather than reflecting its complexity (Hollinsworth, 2013).

Attributes related to cultural competency are poorly and rarely measured (Flavell *et al.*, 2013; Oliver, 2010). The task of assessing the cultural capacity of students via measurable, definable and categorical indicators remains complex and underdeveloped (Universities Australia, 2011). Dean (2001) critiques the idea of achieving cultural competency, arguing that the concept is unrealistic and reflects an underlying attempt by non-Indigenous people to manage and 'control' their encounters with Aboriginal and Torres Strait Islander people. Dean argues that it is unrealistic to imagine educators can develop these capabilities in students and that the idea does a disservice to the vast complexities of Aboriginal and Torres Strait Islander knowledges.

Outcomes-focused vs process-based assessment

Outcomes-focused education has been embraced across the Australian higher education sector, with learning outcomes driving course content and assessment structure. This model requires curriculum, assessment and

reporting to be structured so that they reflect higher order learning outcomes (Alderson & Martin, 2007). However, McLaughlin and Whitman's (2007) experience of integrating Aboriginal and Torres Strait Islander perspectives across four faculties at QUT suggests the outcomes-focused model of assessment is problematic in the way that it relegates such a complex area of study (i.e. Aboriginal and Torres Strait Islander perspectives) to a simplistic, outcomes focused curriculum approach.

While outcome statements may be applicable, the difficulty in assessing complex learning experiences persists. This suggests that assessment models need to shift to incorporate reflective narratives that focus on the ongoing learning process – rather than only on finite outcomes. Having assessment processes that are responsive and reflective to the ongoing, often non-linear, developmental journey is key to implementing curricula that foregrounds Aboriginal and Torres Strait Islander pedagogy. Further, the process of being assessed can be integral to challenging stereotypes and providing the opportunity for a profound learning experience (Paul *et al.*, 2012; Thackrah & Thompson, 2013). Assessment design can also impact on how the value of the content being assessed is perceived by students and other staff. Improving assessment design is an important way of raising the perceived value of Aboriginal and Torres Strait Islander content, since this body of knowledge is often seen by students (and the academy) as a 'soft science' in comparison to the more evidence-based science that is core business for health disciplines (Thackrah & Thompson, 2012). As Paul *et al.* (2012, p.322) argue:

the complexity of culture does make it more difficult to assess, yet it is the complexity of culture that warrants effective assessment.

Assessment tools

Many of the tools used to assess cultural competence have not been tested for validity or reliability. They also tend to focus primarily on knowledge as an indicator of cultural competence, rather than attitudes and behaviors (Trenerry *et al.* 2010). Many of these tools also fail to assess race-based discrimination and/or include simplistic and limited understandings of "culture" as something that "white" practitioners must deal with in their interactions with the radicalized "other" (Kumas-Tan *et al.* 2007, cited in Trenerry *et al.* 2010 p. 15).

In terms of Aboriginal and Torres Strait Islander curriculum, few validated survey instruments have been developed to assess changes in student knowledge, perceptions, values and experiences. A tool developed at CAMDAH is an exception. A survey using the Likert scale assessed medical and dental students' knowledge, attitudes and perception of their current skill and preparedness to work with Aboriginal and Torres Strait Islander clients based on their participation in a related course. Validation of the tool found the survey is likely to be sensitive enough to pick up a range of student responses. Assessing attitudinal shifts is recognised as the most difficult aspect in this process (Carr *et al.*, 2011; Paul *et al.*, 2006).

A recently published integrative review found limited literature identifying and describing tools measuring cultural competence in nursing students and nursing professionals (Loftin *et al.* 2013). The authors identified 11 instruments, four of which had been thoroughly tested in either initial development, or subsequently, with developers providing extensive details of the testing (Attachment G). Findings showed that instruments used to assess cultural competence in nurses and nursing students are self-administered and based on individuals' perceptions and are generally used to test the effectiveness of educational programs designed to increase cultural competence. No objective measure of culturally competent care from a patient's perspective was found. Comparison of instruments showed various conceptual frameworks were used and authors advised there are many factors to consider (how is competence defined; degree of self-administration and potential for biases; capacity to identify development in progress etc) when deciding which instrument to use (Loftin *et al.* 2013). This is particularly relevant when measuring complex learning that requires learners to identify their clinical reasoning.

Clinical placements and client feedback as assessment tools

As previously highlighted, simulation or clinical placements are valuable for assessing the application of complex learning and reasoning associated with cultural capabilities. The role of client and consumer feedback on the student's cultural skills is key to identifying student capacity in this context.

Echoing Ramsden (2002), the consumer's role in assessing the health practitioner's cultural capability level is being increasingly recognised. In New Zealand, Hughes and Farrow (2006) identify the client as the most appropriate person to assess cultural safety. This recognition, however, has not been included in ANMAC or NZNO's codes or standards despite nursing being expected to function in culturally safe ways since 1993.

In a systematic review of Aboriginal and Torres Strait Islander curricula, Ewen *et al.* (2012) found that none included evaluation of their impact on client outcomes. Ewen *et al.* argue that this lack of client outcome evaluation highlights the assumption that improving practitioner skills, knowledge and attitudes will automatically lead to improvements in Aboriginal and Torres Strait Islander health outcomes. While reiterating arguments from other commentators acknowledging the inherent complexities of this aspect of learning evaluation (Betancourt, 2003), Ewen *et al.* (2012) argue for a philosophical and empirical shift in how educators evaluate Aboriginal and Torres Strait Islander health from the perspective of learner experience and client outcomes. There is a clear need for objective and independent assessment of performance against standards with accurate feedback provided to students (Jeffreys, 2013). Teaching programs and accreditation and registration bodies need to develop and support competency standards that are reflected in and synergized with objective assessment practices, not only in education, but also in the workplace (Jeffreys, 2013).

Tervalon & Murray-Garcia (1998) argue for cultural humility, as opposed to cultural competence. They emphasise process rather than endpoint and recommend a form of assessment that captures the characteristics of cultural humility in individuals and institutions (see Attachment B). Using a mixed method approach, they suggest documenting an ongoing institutional process where dynamic feedback loops between the institution, its staff (and students) and surrounding communities are a key assessment method. Tervalon & Murray-Garcia's work demonstrates how student assessment processes can become part of the way that HEPs engage in broader university activities and with local Aboriginal and Torres Strait Islander communities.

Bessarab *et al.* (2014) consider Yunkaporta's pedagogical principles (see Attachment D) for guiding assessment practices. They explore ways that collaborations between local Aboriginal and Torres Strait Islander peoples and the university can inform assessment design. They suggest that better designed assessment processes that reflect Aboriginal and Torres Strait Islander ways of knowing, being and doing will be able to measure students' cultural capabilities more effectively. The assessment instrument developed by Aboriginal and Torres Strait Islander staff at CAMDH at UWA also reflects Aboriginal and Torres Strait Islander priorities (2011).

Duke *et al.* (2009) draw on the work of Benner *et al.*, (1999 & 1996) which attempts to track and assess the process of becoming more culturally competent by focussing on individual evolution through a series of stages leading to a holistic approach where decision-making and practice is situational (see also Dreyfus & Dreyfus, 1996). Duke *et al.* (2009, p.43) emphasise the importance of "involvement" as an "essential skill". They state:

[E]xistential skills...involve whole person involvement of the practitioner with their clientele....the skills of involvement are caring practices...skilled relational and practical know-how. The Benner *et al.* framework is grounded in relational practice, which is context bound and learned experientially. The competent stage of the novice to expert continuum is where the skills of involvement come to the foreground of practice.

Bringing together the work of a number of different authors, Duke *et al.* (2009, p. 44) provide a summary of generic competencies which they propose as forming the foundation for developing cultural competency. Referring to Dreyfus & Dreyfus (1996), Duke *et al.* highlight higher levels of competence are about the ability of the practitioner to cope with 'the messiness of the context and routines within it and consciously plans...' (p.45). They also draw on the work of Benner *et al.*, (1999 & 1996) to re-iterate the importance of assessing competencies around the student's relational abilities within contextually bound practice. Duke *et al.* propose a Framework (see Attachment G) where indicators of competency levels are identified and mapped to assessable learning outcomes.

Self-assessment

Self-evaluated structured surveys exploring learner-satisfaction following a teaching/ training experience is a widely used method of assessing cultural competence in health practice. Its efficacy is contested, however, due to factors such as practitioners overestimating their own abilities in relation to patient care, evaluation focusing on simple

knowledge fact outcomes rather than, for example, the individual in practice, and poorly constructed questions eliciting unreliable results (Jeffreys, 2013; Drevdahl *et al.*, 2008; Carr *et al.*, 2011). However, given it is the most widely used method of assessing cultural competence in the health practice setting; it does highlight the need to develop cohesion between the higher education and health sector in not only standardising definitions of cultural capabilities/ competence, but how these abilities are being assessed in teaching, learning *and* practice settings.

Implications from and for the health sector

A meta-analysis of approximately 120 articles reviewing approaches to Aboriginal and Torres Strait Islander cultural training for health workers described differences between training programs and the learning outcomes they aimed to achieve (Downing *et al.*, 2011). Importantly, the review highlights that there is limited evidence to indicate that cultural education of health professionals actually improves health outcomes for Aboriginal and Torres Strait Islander people (Downing *et al.*, 2011).

Paul *et al.* (2012) identify the major shortfall in cultural competency training is the lack of evidence as to whether such training actually does enhance practice and lead to improvements in patient health outcomes. While arguments for including cross-cultural elements in health education are unequivocal, there is no research identifying how this affects the quality of care or whether health care disparities have been positively affected (Betancourt, 2003; Durey, 2010). Paul *et al.* (2012) argue that teaching and learning assessment criteria must be linked to intended patient outcomes in professional practice, reiterating the need for cohesion between HEPs and the health sector in education, training and assessment. Clearly, professional standards that articulate the cultural capabilities required by health practitioners are crucial to guide HEPs on the knowledge, skills and attributes they need to be developing in graduates.

A recent review of the impacts of cultural competency training, however, did find some evidence that interventions can improve patient and health outcomes (Truong *et al.*, 2014). In Queensland, improvements to a mainstream GP service that was being poorly accessed by Aboriginal and Torres Strait Islander people included providing cultural awareness training to staff at the centre (Hayman *et al.*, 2009; Hayman 2010). Although cultural training was not the only strategy implemented, it was a contributing factor to the service undergoing a transformation in becoming more culturally appropriate, resulting in a marked increase in Aboriginal and Torres Strait Islander patient access and service satisfaction. While concrete evidence of the direct impact of enhancing the cultural capabilities of health practitioners on improved Aboriginal and Torres Strait Islander health outcomes is still to be made, anecdotal evidence unarguably highlights improving practitioner competence will enhance the clients experience and likelihood to use the service – with improved health outcomes therefore expected. It is important for mainstream health professionals to be aware of how their attitudes and behavior might promote or compromise Aboriginal and Torres Strait Islander health and wellbeing and whether the design of the service welcomes or alienates Aboriginal and Torres Strait Islander clients (Durey *et al.*, 2012; Thompson *et al.*, 2011).

6 ORGANISATIONAL READINESS

Leadership and organisational commitment

Theorising Aboriginal and Torres Strait Islander cultural competence and determining standards for associated student learning outcomes is relatively new in the Australian higher education environment. As Universities Australia (2011) highlight, developing a culturally competent higher education setting requires leadership and executive engagement to guide a whole-of-institution approach. This includes examining individual attitudes and practice in teaching as well as management, executive, policy and strategic commitment to revise and assess capacity to implement culturally competent teaching, learning, academic, research and employment spaces. As Ma Rhea points out, organisational change requires 'cascading sponsorship' (2013, p.4), or multiple layers of investment and commitment, flowing through key layers of the higher education environment.

The recent review of the implementation of the CDAMS framework by the Medical Deans and Australian Indigenous Doctors Association (Phillips, 2004; Medical Deans-AIDA, 2012) highlights shortfalls at an organisational level affecting the efficacy of the implementation of the curriculum, including the absence of compulsory and assessable content; the limited vertical integration of content and the leadership and prioritisation at a school and organisational level required to effectively develop and integrate the overarching curriculum framework. The review highlights, amongst other things, the pivotal role of organisational readiness and commitment in order to effectively implement Aboriginal and Torres Strait Islander curriculum.

Legitimising curricula by implementing standards

Aboriginal and Torres Strait Islander curriculum and student learning must adhere to standards of excellence, ensuring that content in curricula meets the same rigorous standards required of other curricula content. It is necessary to develop an Aboriginal and Torres Strait Islander quality and standards framework to overcome the unevenness currently displayed in teaching and learning of Aboriginal and Torres Strait Islander content (Rigney cited in Behrandt et al., 2012). Ensuring rigor in the standards of the curriculum also leads to recognition of content quality and importance. This is important not only for the health sector in recognising the role of Aboriginal and Torres Strait Islander curriculum as core to health professional competency development, but also for legitimising this curriculum to students and staff in the higher education setting. Jones *et al.* (2013) report on the experience of implementing Maori health content at the University of Otago in New Zealand. They suggest that inadequate student assessment tools, concerns about capabilities of educators implementing curriculum and systemic, issues associated with lack of organisational readiness highlighted the need for Maori health to be presented as a legitimate and critical area of health education. Jones *et al.* (2013) argue for institutional commitment and action, demonstrated through reviewing of educator workloads, incentives to be involved with tangible benefits, and institutional commitment to developing educator capabilities. Similarly, in a systematic review of school-based approaches for developing students' intercultural understanding, Walton *et al.* (2013) found studies consistently called for investment in educator's professional and personal intercultural capabilities.

Organisational self-assessment

Organisations must undergo self-assessment to ensure alignment and integration between policies, programs, practice and professional development levels to provide a supportive environment for teaching Aboriginal and Torres Strait Islander curriculum (Goerke and Kickett 2013).

Building on the experience of implementing the CDAMS framework, the Critical Reflection Tool (CRT) has been developed by Knoche and Phillips from the Onemda Vic Health Koori Health Unit as a potential resource through

which schools and institutions can internally review efforts to implement Aboriginal and Torres Strait Islander curricula and diversify the student body (2007; Ewen *et al.*, 2012). This tool provides a framework for whole-of-school engagement in a process of reflection on practice and progress. It addresses broader systems and contextual issues, including barriers to success, and stimulates discussion to develop a more culturally competent teaching and learning environment (Ewen *et al.*, 2012; Bennett *et al.*, 2004). The CRT is an attempt to create 'structures that allow individuals to reflect on the larger structural picture of which they are part', examining for example, policies, evaluation activities, resource allocation and institutional slang (Hafferty 1998, cited in Ewen *et al.*, 2012, p.202).

An example of organisational readiness: Charles Sturt University

In the Universities Australia guide to developing culturally competent higher education settings, Charles Sturt University (CSU) is highlighted for its top-down approach to implementing Aboriginal and Torres Strait Islander curricula. Here, mandating the inclusion of Aboriginal and Torres Strait Islander curricula has occurred at a management and policy level (Universities Australia, 2011). Five-year review cycles are undertaken to support schools to implement changes, and to give them options as to how they can include material, with governance of the process occurring at an Aboriginal and Torres Strait Islander executive level. Central coordination is supported by senior-level investment to facilitate cohesive integration of perspectives across different units. This is extremely important for implementing curriculum on a large scale across different faculties, and for ensuring there is a pedagogical synergy around the learning outcomes that each school and course are endeavoring to achieve.

The implementation of this curriculum model at CSU has been supported by broader key developments within the university that highlight the strength of aligning university education strategies with institutional developments and organisational readiness at the highest level. CSU's Aboriginal and Torres Strait Islander Education Strategy (IES) objectives and key performance indicators align with the HEP overall strategic plan, signaling a whole-of-university commitment. The incorporation of Aboriginal and Torres Strait Islander perspectives is also outlined in university policy and a pedagogical framework to guide curriculum development and knowledge assessment has been implemented (with a dedicated Aboriginal and Torres Strait Islander Curriculum and Pedagogy Coordinator).

Universities Australia (2011) also identifies CSU's introduction in 2009 of a policy requiring all staff to undertake cultural competence training, appointments of senior Aboriginal and Torres Strait Islander staff, and participation of Aboriginal and Torres Strait Islander staff in governance and reporting structures. These commitments, amongst others, provide an example of the multi layered investment and whole-of-university commitment that is required to bring higher education settings to a point of readiness to effectively implement and legitimise Aboriginal and Torres Strait Islander curriculum.

Attachment A –Grote’s Pedagogical Principles

Grote (cited in Grote 2010, p.40) outlines the following principles of Aboriginal and Torres Strait Islander cultural competency education and training as:

1. Australian Indigenous people have distinctive needs with regard to service provision because of the unique colonial, social, cultural, economic, political, historical and contemporary experiences that set them apart from others with culturally and linguistically diverse (CALD) backgrounds. Indigenous cultural competency should therefore be set apart from multicultural cultural competency.
2. The nature of these factors and their influence on Indigenous communities need to be included in foundational content. These units need to provide opportunities for students to critique the role of their respective (future) professions in the lives of Indigenous people both in the past and the present day.
3. The provision of services to enhance the wellbeing of Indigenous people is an integral component in the education of practitioners (and researchers).
4. Foundational content on Indigenous issues should be introduced in dedicated compulsory units. When this is not possible, at the very least, foundational content on Indigenous matters should constitute half of the material covered in units devoted to multicultural or cross-cultural matters.
5. Adopting a strengths-based perspective of culture, diversity and identity can facilitate learning and reflection on attitudes and values.
6. To maximise learning outcomes the integration of Indigenous CC content in curricula should be both horizontal and vertical. Issues and concepts introduced in foundational units should be revisited and integrated into a broad range of units taken later in the course.
7. The involvement of Indigenous staff members and formalised partnerships with representatives from Indigenous organisations and communities in the development of curricula is essential. This is to ensure that the teaching of Indigenous content and the presentation of Indigenous perspectives are both appropriate and respectful of Indigenous culture. Furthermore, Indigenous and non-Indigenous partnerships provide models of effective collaboration; bolster the credibility of the program in the eyes of students as well as Indigenous communities and organisations.
8. Learning (and research) settings should aim to foster positive encounters for all Indigenous and non-Indigenous participants.
9. A wide range of teaching and learning strategies, including the use of authentic case studies should be incorporated into an Indigenous CC curriculum.
10. Different learning styles and methodologies should be taken into consideration when designing assessment instruments. Such evaluation tools should be transparent and reflect articulated learning outcomes.
11. Activities that promote the development of reflective skills, self-awareness and critical analysis should be integral components of learning and assessments.
12. Reflection and self-awareness activities should provide opportunities for non- Indigenous students to explore their understanding of their own cultural values and attitudes along with the concepts of whiteness and privilege.
13. Support needs to be provided for Indigenous and non-Indigenous staff members involved in teaching.

14. Indigenous staff members need to be provided with support and strategies to deal with racism. They should not be routinely delegated the responsibility of dealing with Indigenous matters.
15. While Indigenous students can make valuable contributions to enhance learning in the classroom with appropriate support, they should not be assigned this responsibility nor seen as representatives of Indigenous people.

Attachment B – Concepts & Terminology

Concept/terminology	Reference & Description	
Cultural Awareness	<p>Thomson, N. (2005) 'Cultural respect and related concepts: A brief summary of the literature', <i>Australian Aboriginal and Torres Strait Islander Health Bulletin</i>, 5(4), 1-11.</p> <p>Coffin, J. (2007) 'Rising to the challenge in Aboriginal health by creating cultural security', <i>Aboriginal and Islander Health Worker Journal</i>, 31(3), 22-24.</p>	<p>A health professional's awareness increases of various cultural, social and historical factors applying to Aboriginal and Torres Strait Islander peoples generally, and to specific Aboriginal and Torres Strait Islander groups and/or communities; encouraging health professionals to reflect on their own culture and acknowledge biases and the tendency to stereotype with a view to better appreciating diverse values, beliefs and behaviours. Cultural awareness has also been used interchangeably with 'cultural sensitivity' in cultural training (Smedley <i>et al.</i> cited in Thomson 2005, p.3).</p> <p>Awareness of Aboriginal cultural issues and needs but not linked to practice.</p>
Cultural Safety	<p>Ramsden, I. (2002) <i>Cultural safety and nursing education in Aotearoa and TeWaipounamu</i>, unpublished thesis (PhD), Victoria University, Wellington, New Zealand.</p>	<p>Focuses on the attitudes and behaviors of the nurse rather than the Maori patient in a bi-cultural context. Developed within Maori cultural reality with an emphasis on social justice and addressing systemic and interpersonal prejudice of British colonisers towards Maori. Acknowledged the detrimental effects of inequitable power relations in health care and on Maori health outcomes. 'Cultural Safety is a mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give the power</p>

	<p>Phillips, G. (2004) <i>CDAMS Aboriginal and Torres Strait Islander health curriculum framework</i> Melbourne: VicHealth Koori health Research and Community Development Unit.</p> <p>AIDA Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and patients.</p> <p>Eckermann <i>et al.</i> (2010) <i>BinanGooniji: Bridging Cultures in Aboriginal Health</i> (3rd edition), Chatswood, NSW: Elsevier.</p>	<p>to the consumer' (p. 6).</p> <p>Ensuring that systems and health providers delivering health care are aware of the impact of their own culture and cultural values on the delivery of services, and that they have some knowledge of, respect for and sensitivity towards the cultural needs of others (p. 8).</p> <p>Is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health. It is also about increasing numbers within and support for the Indigenous medical workforce.</p> <p>An environment that is safe for people; where there is no assault, challenge or denial of their identity or who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together with dignity, and truly listening.</p>
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<p>Cultural Respect</p>	<p>Australian Health Ministers' Advisory Council - Standing Committee for Aboriginal and Torres Strait Islander Health Working Party (2004) <i>Cultural Respect Framework for Aboriginal and Torres Strait Islander health</i>, Adelaide: Department of Health, South Australia.</p>	<p>Cultural respect is recognising and continually advancing the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples. Cultural Respect is about shared respect and is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. It is a commitment to the principle that the Australian health care system that constructs and provides services will not wittingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of Cultural Respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain protect and develop their culture and achieve equitable health outcomes (p. 7).</p>
<p>Cultural Security</p>	<p>NT Department of Health and Community Services (2002) <i>Aboriginal cultural security</i>, Darwin: Northern Territory Government.</p> <p>Coffin, J. (2007) 'Rising to the challenge in Aboriginal health by creating cultural security', <i>Aboriginal and Islander Health Worker Journal</i>, 31(3), 22-24.</p>	<p>Cultural security shifts the system's thinking from attitude to behavior where developing and providing health and community services sensitively unites Aboriginal cultural rights, views and values with the science of human services.</p> <p>Incorporates cultural awareness (awareness of Aboriginal cultural issues and needs but not linked to action) and cultural safety (health providers working with individuals or organizations though practices not standardized into policies or procedures) into cultural security (links understanding to action that is embedded in policies and procedures). Culturally secure care listens to the needs of Aboriginal people and makes sustained improvements to practice.</p>

<p>Cultural Competence</p>	<p>IHEAC, as cited in Universities Australia (2011). National Best Practice Framework for Indigenous cultural competency in Australian universities. Canberra, ACT: Department of Education, Employment and Workplace Relations (DEEWR).</p> <p>Papadopoulos, I., Tilki, M. and Lees, S. (2004) 'Promoting cultural competence in healthcare through a research-based intervention in the UK', <i>Diversity in Health and Social Care</i>, 1(2), 107-115.</p> <p>Cross <i>et al.</i> (1989). <i>Toward a culturally competent system of care</i>. Washington, DC: Georgetown University Child Development Center.</p> <p>Centre for Cultural Competence adopts Davis (1997).</p>	<p>Awareness, knowledge, understanding and sensitivity to other cultures combined with a proficiency to interact appropriately with people from those cultures in a way that is congruent with the behaviour and expectations that members of a distinctive culture recognise as appropriate among themselves. Cultural competence includes having an awareness of one's own culture in order to understand its cultural limitations as well as being open to cultural differences, cultural integrity and the ability to use cultural resources. It can be viewed as a non-linear and dynamic process which integrates and interlinks individuals with the organisation and its systems (p. 48).</p> <p>Cultural competence takes into account patients' cultural beliefs, behaviors and needs. Offers a staged approach involving cultural awareness (self-awareness, cultural awareness, ethnocentrism); cultural knowledge (including health beliefs and behaviors and stereotyping), cultural sensitivity (including empathy, communication skills, trust, acceptance and respect) and cultural competence (diagnostic and clinical assessment skills and challenging and addressing prejudice, discrimination and inequalities).</p> <p>A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations.</p> <p>Student and staff knowledge and understanding of Aboriginal and Torres Strait Islander Australian cultures, histories and contemporary realities and awareness of Aboriginal and Torres Strait Islander protocols, combined with the proficiency to</p>
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		engage and work effectively in Aboriginal and Torres Strait Islander contexts congruent to the expectations of Aboriginal and Torres Strait Islander Australian peoples. Integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis, 1997).
Cultural Responsiveness	Victorian Government Department of Human Services (2008). Aboriginal Cultural Competence Framework. Victorian Government Department of Human Services, Melbourne, Victoria.	Refers to health care services that are <i>respectful of</i> , and <i>relevant to</i> , the health beliefs, health practices, culture and linguistic needs of diverse consumer/patient populations and communities. Describes the capacity to respond to the healthcare needs of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual.
Cultural Humility	Tervalon M & Murray-Garcia J (1998) Cultural Humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. <i>Journal of Health Care for the Poor and Underserved</i> . 9(2):117-125.	a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations (p. 117).

Attachment C - CATSINaM Summary of Key Terms & Concepts

CATSINaM (2013) provide the following summary of key terms:

Term	Key Point	Utility	Outcome
Cultural awareness	Underpinning knowledge and attitudes	Not sufficient. Alone does not lead to change in behaviour or practice. Foundation for further development	A necessary initial step
Cultural Sensitivity	Underpinning knowledge and attitudes	Not sufficient. Alone does not lead to change in behaviour or practice. Foundation for further development	A necessary early step
Cultural knowledge	Fundamental to the health and wellbeing of Aboriginal and Torres Strait Islander peoples Underpinning knowledge	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 Security	Government framework document	Has been superseded	Represents a shift from attitude to behaviour
Cultural Responsiveness	Government framework document	Not Aboriginal and Torres Strait Islander specific Useful for issues relating to diversity (generic)	Provides understanding of an all of systems approach for dealing effectively with notion of diversity
Cultural Safety	A political concept: personal, institutional and system	Identifies shortcomings of cultural awareness and sensitivity, and identifies power and its consequences	Determined by care recipient
Cultural Respect	Government framework document	Aboriginal and Torres Strait Islander specific Acknowledgement of the key role of Aboriginal and Torres Strait Islander communities in determining culturally appropriate care	Advancement of inherent rights of Aboriginal and Torres Strait Islander peoples
Cultural Competence	Framework document	Not Aboriginal and Torres Strait Islander specific. Useful for issues relating to diversity (generic)	An on-going process, whereby individual, organisations and societies may plot their progress. A worthy aspiration

Attachment D - Yunkaporta's Eight Ways of Learning Framework

Yunkaporta's (2009) Eight Ways Learning Framework involves:

- Deconstruction/Reconstruction- aiming to learn the whole rather the parts
- Learning maps- using visuals and shapes to create holistic images
- Community Links- connecting the learning experience to real life community links
- Symbols and Images- symbolic meaning at the micro level of content
- Nonverbal- focus on kinesthetic and hands on learning
- Land links- relating land and place to learning, ecological learning
- Story sharing-personal narratives as knowledge sharing tools
- Non-linear process -avoiding dichotomies, finding common ground, cycle of learning

Yunkaporta's Cultural Interface Protocols for Engaging with Aboriginal Knowledge

1.	Use Aboriginal processes to engage with Aboriginal knowledge.
2.	Approach Aboriginal knowledge in gradual stages, not all at once.
3.	Be grounded in your own cultural identity (not "colour") with integrity.
4.	Bring your highest self to the knowledge and settle your fears and issues.
5.	Share your own stories of relatedness and deepest knowledge.
6.	See the shape of the knowledge and express it with images and objects.
7.	Build your knowledge around real relationships with Aboriginal people.
8.	Use this knowledge for the benefit of the Aboriginal community.
9.	Bring your familiar understandings, but be willing to grow beyond these.
10.	Respect the aspects of spirit and place that the knowledge is grounded in.

Attachment E - Cultural Developmental Models

Bennett's Developmental Model of Intercultural Sensitivity (1993)

	Ethnocentric stage			Ethno relative stage		
Stage	1	2	3	4	5	6
	Denial	Defense	Minimisation	Acceptance	Adaptation	Integration
	<p>-Cultural difference is experienced that one's own culture is the only one</p> <p>-Other cultures are avoided by maintaining physical/ psychological distance</p> <p>-May act aggressively to eliminate difference if it is impinged on them</p>	<p>- One's own culture is experienced as the only good one</p> <p>-world organised into 'we' are superior and 'they' are inferior</p> <p>-cultural difference is a threat, and other cultures are criticised</p>	<p>-Elements of one's own cultural world views are experienced as universal</p> <p>-other cultures trivialised or romanticised</p> <p>-expectation of cultural similarities (down playing of differences)</p>	<p>-One's own culture is experienced as one of many different cultures</p> <p>-not necessarily agreeing with other cultural views, but not ethnocentric</p> <p>-curiosity and respectful to other cultures</p>	<p>- Experience of another culture includes attitudes and behaviors that are appropriate to that culture</p> <p>-one worldview expanded to include constructs from other worldviews</p> <p>-ability to look through the world through 'different eyes'</p>	<p>-One's experience of self is expanded to include the movement in and out of different cultural worldviews</p> <p>-at this stage, may often experience issues related to self 'cultural marginality'</p>

Hammer's Intercultural Development Continuum within the Intercultural Development Inventory (1999)

Stage	Stage	Characteristics
1	Denial	An orientation that likely recognises more observable cultural differences (e.g. food) but may not notice deeper cultural difference (e.g. conflict resolution styles) and may avoid or withdraw from cultural difference
2	Polarisation	A judgement orientation that views cultural differences in terms of 'us' and 'them'. This can take the form of: <ol style="list-style-type: none"> 1) Defence: an uncritical view toward one's own cultural values and practices, and an overly critical view towards other cultural values and practices 2) Reversal: Overly critical orientations toward one's own cultural values and practices and an uncritical view toward other cultural values and practices.
3	Minimisation	An orientation that highlights cultural commonality and universal values and principles that may also mask deeper recognition and appreciation of cultural differences
4	Acceptance	An orientation that recognises and appreciates patterns of cultural difference and commonality in one's own and other cultures
5	Adaptation	Capable of shifting cultural perspective and changing behaviour in culturally appropriate and authentic ways
	Cultural disengagement	A sense of disconnection and detachment from a primary cultural group

Cross *et al.*'s Cultural Competency continuum (adapted by the Victorian Government Department of Human Services, 2008, p.24)

Towards Cultural Competence					
←			→		
1	2	3	4	5	6
Cultural Destructiveness	Cultural Incapacity	Cultural Blindness	Cultural Pre competence	Cultural competence	Cultural Proficiency
Intentional attitudes policies & practices that are destructive to cultures and to individuals within the Culture	Lack of capacity to help minority clients or communities due to extremely biased beliefs and a paternal attitude toward those not of mainstream culture	<p>Belief that service or helping approaches traditionally used by the dominant culture are universally applicable regardless of race or culture.</p> <p>These services ignore cultural strengths and encourage assimilation. Philosophy "I don't see colour: we are all the same"</p>	<p>Desire to deliver quality services and commitment to diversity indicated by hiring minority staff, initiating training and recruiting minority members for agency leadership, but lacking information on how to maximise these capacities.</p> <p>Proactive organisation and individuals, cultural assessment, ongoing PD, organisational adaptation. This level of competence can lead to tokenism</p>	Acceptance and respect for difference continuing self-assessment, careful attention to the dynamics of difference, continuous expansion of knowledge and resources and adaptation of services to better meet the needs of diverse populations	Holding culture in high esteem: seeking to add to the knowledge base of culturally competent practice by conducting research, influencing approaches to care, and improving relations between cultures. Promotes self-determination. Assertive and proactive agenda planning.

Well's Cultural Development Model (2000, p.192)

COGNITIVE PHASE			AFFECTIVE PHASE		
Cultural incompetence	Cultural knowledge	Cultural awareness	Cultural sensitivity	Cultural competence	Cultural proficiency
A lack of knowledge of the cultural implications of health behaviour	Learning the elements of culture and their role in shaping and defining health behaviour	Recognising and understanding the cultural implications of health behaviour	The integration of cultural knowledge and awareness into individual and institutional behaviour	The routine application of culturally appropriate health care interventions and practices	The integration of cultural competence into the culture of the organisation and into professional practice, teaching, and research Mastery of the cognitive and affective phases of cultural development

Sue's multidimensional model of cultural competence (2001, p.799)

Belief/ Attitude	Knowledge	Skill
Aware and sensitive to own heritage and valuing/respecting differences.	Has knowledge of own racial/cultural heritage and how it affects perceptions.	Seeks out educational, consultative, and multicultural training experiences
Aware of own background/experiences and biases and how they influence psychological processes.	Possesses knowledge about racial identity development. Able to acknowledge own racist attitudes, beliefs and feelings	Seeks to understand self as racial/cultural being.
Recognises limits of competencies and expertise.	Knowledgeable about own social impact and communication styles.	Familiarises self with relevant research on racial/ethnic groups
Comfortable with differences that exist between themselves and others	Knowledgeable about groups one works or interacts with	Involved with minority groups outside of community events, celebrations, friends etc
In touch with negative emotional interacts towards reactions toward racial/ethnic groups and can be nonjudgmental	Understands how race/ethnicity affects personality formation, vocational choices, psychological disorders, and so forth	Able to engage in a variety of verbal/nonverbal helping styles
Aware of stereotypes and preconceived notions	Knows about sociopolitical influences, immigration, poverty, powerlessness, and so forth	Can exercise institutional intervention skills on behalf of clients.
Respects religious and/or spiritual beliefs of others	Understands culture-bound, class-bound, and linguistic features of psychological help.	Can seek consultation with traditional healers.
Respects Aboriginal and Torres Strait Islander helping practices and community networks	Knows the effects of institutional barriers.	Can take responsibility to provide linguistic competence for clients.
Values bilingualism	Knows bias of assessment.	Has expertise in cultural aspects of assessment.
	Knowledgeable about minority family structures, community, and so forth.	Works to eliminate bias, prejudice, and discrimination.
	Knows how discriminatory practices operate at a community level.	Educates clients in the nature of one's practice.

Duke et al's Framework for tracking evolving cultural competence (2009, p.46)

Benner's	Summary of Benner et al's skills	Extrapolation of skills of involvement into levels of expertise
Competent	<p>Becoming involved with the client as a person through:</p> <ul style="list-style-type: none"> -Attending to mainly objective features while learning to trust Emotions -Learning to navigate between over involvement and under involvement with clientele -Noticing the bigger picture of broader circumstances Recognising differing expressions of personal suffering and vulnerability - Identifying the choices available in a situation and the tensions and outcomes associated with them. Reflecting more on their encounters, their emotions and their personal development 	<p>Recognising the importance of culture and its effect on self and client outcomes in:</p> <ul style="list-style-type: none"> -Attending cultural competence and cultural safety educating sessions. -Acting in known ways and within available resources that keep clients culturally safe -appreciating that a culture emerges when there is a shared identity within a group which influences how they interact with others -Continuing to reflect on own culture and how it influences client relationships -Understanding the socially constructed, process oriented and political nature of culture -Assessing the significance of culture and its salience in relation to particular situations.
Proficient	<p>Qualitative shifts in 'being' involved learned from reflective engagements leading to:</p> <ul style="list-style-type: none"> -understanding how client embodies many features including culture, which influences their view of the world - 'perceptually grasping' and responding to salient features within the bigger picture of health circumstances - Becoming open to unfolding situation of possibilities while acknowledging constraints -Embodying emotional 'attunement' with increasing responsiveness and ease -allowing outcomes to guide development in practicing skills of involvement 	<p>Qualitative shifts in understanding how culture is lived in day to day experiences leading to:</p> <ul style="list-style-type: none"> - Reflecting within supervision to expressions of client and own emotions pertaining to keeping client and self culturally safe - identifying cultural needs within a dialogue with clientele understanding that cultural safety is inextricably linked with broader health circumstances and its unique importance in the world view and meaning mode of a situation - Being 'regardful' of different world views and meaning of culture for each client and family and how this may transform over time - Seeking collegial help and outside

	-Recognizing own limitations and requesting help from colleagues -	resources as necessary to respond with the shape of care that best fits cultural needs which may change as the situation unfolds
Expert	<p>Development in moral compartment now demonstrates:</p> <ul style="list-style-type: none"> -understanding of the therapeutic effectiveness of emotional attunement with clientele but discerning of level of involvement needed -expressing connection with client and family over time (short or long intervals) when discerned appropriate - protecting of dignity, personhood and close relationships of client to avoid vulnerability and enhance sense of safety in foreign milieu -noticing when capability of others not sufficient to meet needs and offers assistance in the developing of their expertise -advocating for the view of clientele even when colleagues resist stance 	<p>Understanding that achieving cultural safety for clientele is a moral endeavor which requires:</p> <ul style="list-style-type: none"> -discerning involved relationships with clients - trusting client evaluations of their cultural safety developed within dialogue to guide future culturally safe practice -recognizing de-moralisation associated with cultural unsafety, and its existential effects on perceptions of worth and wellbeing - appreciating discursive views informing how a health system operates and is resourced -broadening the sphere of influence of practice by participating in mentoring/ teaching, contributing to policy development, research and publication

Attachment F - Mapping Student Capabilities

The Queensland University of Technology School of Humanities and Human Services Graduate Capability matrix (2007, p.54)

Graduate capabilities	Introductory	Enhanced	Advanced
1. Be critically aware and capable of deconstructing their own cultural situatedness and its relationship to the construction of Aboriginal and Torres Strait Islander knowledge's, peoples, etc	Articulate an introductory understanding of the nature of their own cultural situatedness	Demonstrate a capacity to articulate and analyse their own situatedness and its relationships to the construction of Aboriginal and Torres Strait Islander peoples and cultures	Demonstrate a comprehensive and critical understanding of their own situatedness, its relationship to Aboriginal and Torres Strait Islander cultures and the implications of these issues for professional practice
2. Be critically alert to the complexities of cross-cultural understanding and the acquisition of cross-cultural sensitivity	Articulate a basic understanding of the complex issues that inform cross-cultural awareness (e.g., the culturally bound nature of particular concepts)	Demonstrate an increased capacity to address and analyse the complexities of cross-cultural understanding and the processes of acquiring cross-cultural sensitivity	Demonstrate competence and confidence in addressing the complexities of cross-cultural understanding in practical contexts and in ways that embody cross-cultural sensitivity
3. Value and engage with diverse forms of knowing and their pertinent/related practices	Demonstrate a basic understanding of the possibilities of other forms of knowledge and other ways of knowing	Demonstrate an understanding and willingness to engage with other ways of knowing and their related practices	Demonstrate confidence and competence in articulating other ways of knowing and their related practices; capacity to apply such knowledge's and practices as appropriate in professional contexts
4. Understand Aboriginal and Torres Strait Islander cultures and cultural values including the complexity and diversity of Aboriginal and Torres Strait Islander communities and their contemporary concerns	Articulate a basic understanding of Aboriginal and Torres Strait Islander cultures and cultural values	Demonstrate an increased understanding of the diversity and complexities of Aboriginal and Torres Strait Islander cultures and cultural values and a capacity to analyse the contemporary concerns of Aboriginal and Torres Strait Islander peoples	Demonstrate a deep and critical understanding of the diversity and complexity Aboriginal and Torres Strait Islander cultures and cultural values; a capacity to analyse and engage with the contemporary concerns of Aboriginal and Torres Strait Islander peoples; and an understanding of the implications of these issues within particular professional contexts
5. Actively contribute to contemporary debates on the delivery of social	Demonstrate an introductory understanding of contemporary	Demonstrate an increased capacity to understand, analyse and actively engage in debates about the delivery	Actively contribute to the delivery of social justice for Aboriginal and Torres Strait Islander peoples,

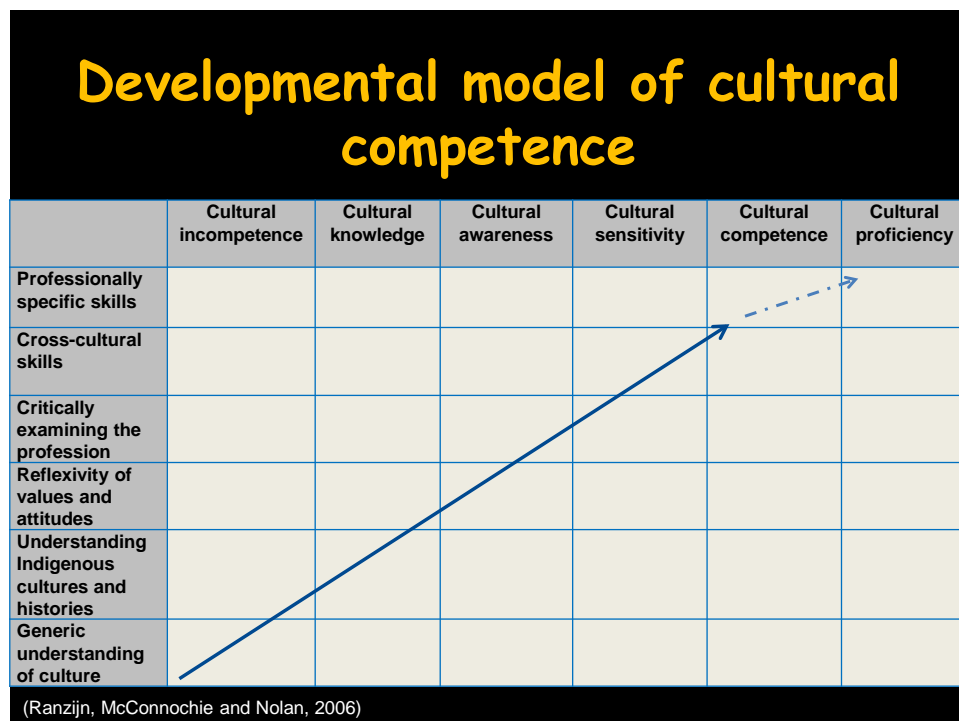
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justice for Aboriginal and Torres Strait Islander peoples	social justice debates for Aboriginal and Torres Strait Islander peoples	of social justice for Aboriginal and Torres Strait Islander peoples	particularly in the context of professional practice
6. Recognise and practice appropriate professional skills with respect to their engagement with Aboriginal and Torres Strait Islander peoples	Demonstrate an introductory understanding of the appropriate knowledge and skills for engaging with Aboriginal and Torres Strait Islander peoples	Demonstrate increased understanding of appropriate knowledge and skills for engaging with Aboriginal and Torres Strait Islander peoples in a variety of contexts	Demonstrate the capacity to engage appropriately and sensitively with Aboriginal and Torres Strait Islander peoples and their concerns in a variety of situations and particularly in the context of professional practice

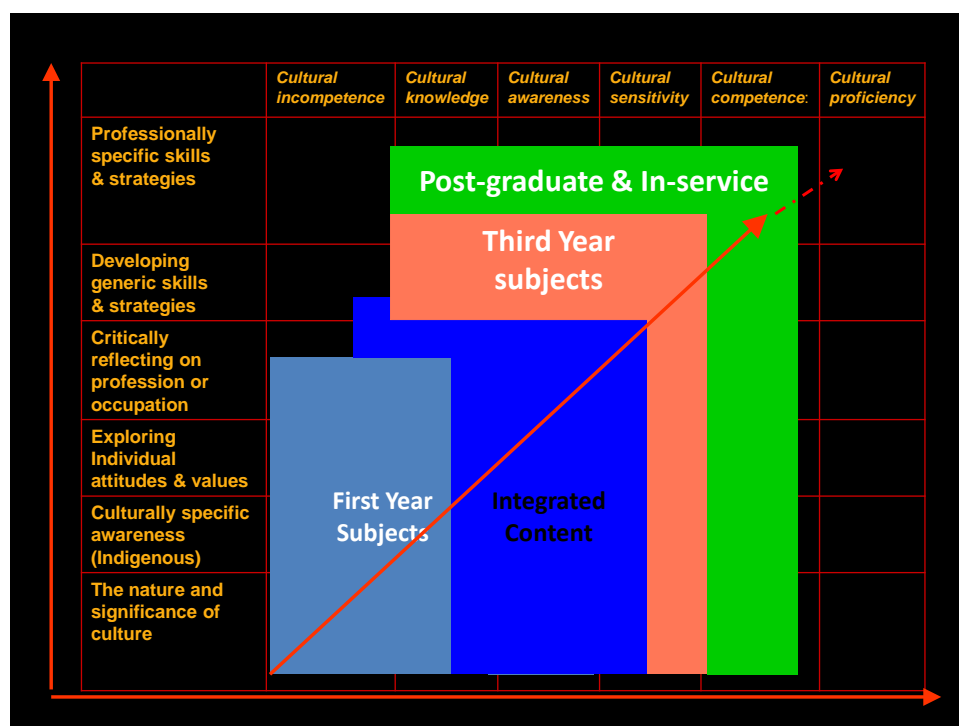
The Queensland University of Technology Faculty of Health *Yapunvah!* Project Graduate capabilities (Nash *et al.* 2006, p.316)

Level 1	Level 2	Level 3
	As for Level 1 +	As for Level 2 =
<ul style="list-style-type: none"> • Demonstrates an understanding of Aboriginal and Torres Strait Islander history, cultures and cultural values • Demonstrates an understanding of the dynamics inherent in cross-cultural interactions • Demonstrates an understanding of the epistemological construction of Western medical knowledge and how this might differ between cultures • Is able to analyse one's own cultural values and reflect on the implications for interactions with others 	<ul style="list-style-type: none"> • Demonstrates the ability to incorporate an understanding of Aboriginal and Torres Strait Islander perspectives into the provision of health care interventions relevant to the discipline area • Demonstrates the ability to question one's own assumptions as potential impediments to effective communication and accommodation of difference, particularly within the context of Aboriginal and Torres Strait Islander health • Acts in a culturally appropriate manner with peers and staff 	<ul style="list-style-type: none"> • Demonstrates a critical understanding of, and sensitivity to cultural issues in the delivery of health care for Aboriginal and Torres Strait Islander peoples • Critically reflects on one's own cultural values, their relationship to Aboriginal and Torres Strait Islander cultures and the implications for practice as a health professional • Provides culturally appropriate health care consistent with the code/s of practice relevant to the discipline area

Charles Sturt Universities Framework for mapping Indigenous cultural competence



(Ranzijn, Nolan & McConnochie, Hodgson, Spurrier, Passmore, 2008, p.20)



(CSU developed above from Ranzijn, McConnochie & Nolan, 2008)

Attachment G – Instruments measuring Cultural Competency

The instruments measuring cultural competency that were reviewed as part of Loftin et al's integrative review (2013) are:

1. Cultural Self-Efficacy Scale
 - Bernal, H & Froman, R 1993, Influences on the cultural self-efficacy of community health nurses, *Journal of Transcultural Nursing*, 4(2), p. 24–31
2. Transcultural Self-Efficacy Tool
 - Jeffreys, M & Smodlaka, I 1996, Steps of the instrument design process. An illustrative approach for nurse educators, *Nurse Educator*, 21(6), p. 47–52
3. Inventory for Assessing the Process of Cultural Competency
 - Campinha-Bacote, J 2009, *Reported reliability and validity of the IAPCC-R*, available <http://www.transculturalcare.net/iapcc-r.htm>.
4. Ethnic Competency Skills Assessment Inventory
 - Napholz, L 1999, A comparison of self-reported cultural competency skills among two groups of nursing students: implications for nursing education, *Journal of Nursing Education*, 38(2), p. 81–83
5. Cultural Awareness Scale
 - Rew, L Becker, H Cookston, J Khosropour, S & Martinez, S 2003, Measuring cultural awareness in nursing students, *Journal of Nursing Education*, 42(6), p. 249–257
6. Cultural Competence Assessment
 - Schim, SM Doorenbos, AZ Miller, J & Benkert, R 2003, Development of a cultural competence assessment instrument, *Journal of Nursing Measurement*, 11(1), p. 29–40
7. Cultural Knowledge Scale
 - Brathwaite, AC & Majumdar, B 2006, Evaluation of a cultural competence educational programme, *Journal of Advanced Nursing*, 53(4)p. 470–479
8. Cultural Diversity Questionnaire for Nurse Educators
 - Sealey, LJ Burnett, M Johnson, G 2006, Cultural competence of baccalaureate nursing faculty: are we up to the task? *Journal of Cultural Diversity*, 13(3), p. 131–140
9. Cultural Competency Instrument
 - Kosoko-Lasaki, O Cook, CT O'Brien, R Kissell, J Purtilo, R & Peak, F 2006, Promoting cultural proficiency in researchers to enhance the recruitment and participation of minority populations in research: development and refinement of survey instruments, *Evaluation and Program Planning*, 29(3), p. 227–235

10. Cross-Cultural Evaluation Tool

- Hughes, KH & Hood, LJ 2007, Teaching methods and an outcome tool for measuring cultural sensitivity in undergraduate nursing students, *Journal of Transcultural Nursing*, 18(1), p. 57–62

11. Nurse Cultural Competence Scale

- Perng, S & Watson, R 2012, Construct validity of the nurse cultural competence scale: a hierarchy of abilities, *Journal of Clinical Nursing*, 21, p. 1678–1684

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