AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

The George Institute for Global Health

Cultural Safety Training:

Analysis of national survey results and literature review.

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Preface

Background

The Australian Commission on Safety and Quality in Health Care's (the Commission) role is to lead and coordinate national improvements in the safety and quality of health care. The Commission works in partnership with the Australian Government, state and territory governments and the private sector to achieve a safe and high-quality, sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.

The Commission is responsible under the National Health Reform Act 2011 for the formulation of standards relating to health care safety and quality matters and for formulating and coordinating national models of accreditation for health service organisations.

The Commission developed the National Safety and Quality Health Service (NSQHS) Standards in consultation with the Australian Government, state and territory governments, technical experts and other stakeholders. The NSQHS Standards aim to protect the public from harm and to improve the quality of health service provision.

The NSQHS Standards include six specific actions to improve safety, quality and experience of care for Aboriginal and Torres Strait Islander peoples. The User Guide for Aboriginal and Torres Strait Islander Health provides further information for health service organisations to implement the six actions. The Commission undertakes to continually improve the evidence base and resources which inform these actions and to support health service organisations to implement the actions. This report contributes to the implementation of the Aboriginal and Torres Strait Islander Action 1.21 of the NSQHS Standards, t*he health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients*.

This report explores the available literature on cultural safety training delivered by health service organisations and the attributes of high-quality cultural safety training programs. The review includes a detailed analysis of the survey results collected from health service organisations regarding their cultural safety training programs. The report concludes with recommendations to improve cultural safety training delivered by health service organisations for their staff.

Analysis of the survey data was undertaken by the Aboriginal and Torres Strait Islander Health Research team at The George Institute for Global Health and funded by the Medibank Better Health Foundation.

Key Findings

Summary of evidence

The report reviews and explores the impact of culture in healthcare and acknowledges the impact that reflective practice can have for staff across health services in fostering a culturally safe health service. The report identifies and acknowledges attributes of high-quality cultural safety training programs which includes:

- Interactive training with various forms of media, delivered in a safe learning environment
- Delivering training in partnership with or by Aboriginal or Torres Strait Islander people

- Reflective practice and exploration of pre-existing knowledge
- Identification and acknowledgement of the diversity among Aboriginal and Torres Strait Islander peoples
- Clearly naming racism and understanding the effect this has on health outcomes
- Asking participants to identify how they can implement their learnings in practice
- Identifying systemic improvements needed to foster a culturally safe culture
- Evaluating training by asking the workforce for feedback on the training as well as partnering with Aboriginal and Torres Strait Islander peoples to evaluate their experience within the health service.

The report describes a total of 14 topics for inclusion in cultural safety training as well as a process for evaluating the overall quality of training using eight quality markers.

Summary of analysis of survey data

The report analysed survey data collected from health service organisations about their cultural safety training. A total of 421 responses were collected across a range of health services with 96% reporting some type of cultural safety training was in place.

The report describes findings which indicate very few health service organisations have cultural safety training programs that include the attributes of high-quality training. The key findings from the analysis includes:

- only 11% of organisations included all 14 topics within their cultural safety training
- just four health service organisations reported having all eight quality markers
- a wide variation in timing, length, and mode of delivery for training
- half of respondents reporting that their training was delivered in partnership with or by an Aboriginal or Torres Strait Islander trainer and that in some instances, training was sourced from an external Aboriginal or Torres Strait Islander training provider, and
- just 21% of respondents reporting that their training had been evaluated.

The report outlines the evaluation of training being focused on is the knowledge and understanding of participants rather than monitoring and evaluating the impact of the training on the health service organisations delivering patient-centred cultural safety care. Health service organisations report seeking resources or direction on the implementation of knowledge learnt throughout cultural safety training both at a systemic level and at the individual level.

Recommendations for health service organisations

The authors of the report highlight general domains and made recommendations to improve cultural safety training. These include recommendations on:

- general topics and content to be included within the training curricula
- delivery of training that considers partnering with local Aboriginal or Torres Strait Islander peoples or trainers and resources or content tailored to the audience
- the framework of the training program including the timing, format and evaluation, and
- future recommendations for evaluating cultural safety training among health service organisations.

Conclusion

The information highlighted in the report provides an important overview of the attributes of high-quality cultural safety training and the impact that cultural safety in a health service organisation can have on the safety, quality and experience of care for Aboriginal and Torres Strait Islander peoples.

The analysis demonstrates that there is a gap between current health service organisation cultural safety training and the identified high-quality cultural safety training attributes. The analysis provides a foundation for the development of information which can lead to systematic improvements to cultural safety training delivered across health care in Australia.

The Commission agrees the report's recommendations would lead to improved cultural safety training. Implementation of these attributes in cultural safety training will support health service organisations to meet the requirements of Action 1.21 of the NSQHS Standards, *the health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients*.

The Commission acknowledges the limitations of the survey data. Ongoing monitoring of effectiveness of cultural training will be monitored through existing reporting structures and accreditation assessment.

The report will be used to inform the development of resources for use by health service organisations implementing Action 1.21 of the NSQHS Standards and assessors at assessment. The aim of the resources will be to drive improvements in the cultural training provided.

The report recommendations relating to the evaluation mechanisms involving local Aboriginal or Torres Strait Islander communities needs to be considered at the health service organisation level. It is not related to the systematic evaluation of safety, quality and experience of care for Aboriginal and Torres Strait Islander peoples at a national level.

Next Steps

The Commission will develop resources for health service organisations providing information on best practice cultural safety training programs. Assessors can use this information when reviewing cultural safety training programs at assessment.

Aboriginal and
Torres Strait Islander
Health Research Program

THE AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE'S NATIONAL SURVEY ON CULTURAL SAFETY TRAINING: ANALYSIS OF RESULTS

FINAL REPORT – NOVEMBER 2021

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Acknowledgement of Country

The George Institute acknowledges the Gadigal people of the Eora Nation as the Traditional Custodians of the land on which our Australia office is built and this report was written. We pay our respect to Elders past, present and emerging.

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Acknowledgements

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Acronyms

ACSQHC	Australian Commission on Safety and Quality in Health Care
AIDA	Australian Indigenous Doctors Association
APHRA	Australian Health Practitioner Regulation Agency
CATSINAM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
IAHA	Indigenous Allied Health Association
NAATSIHWP	National Association of Aboriginal and Torres Strait Islander Health Worker and Practitioners
NACCHO	National Aboriginal Community Controlled Health Organisation
NSQHSS	National Safety and Quality Health Service Standards

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Executive Summary

In 2021, the Australian Commission on Quality and Safety in Health Care (The Commission) conducted a national survey to understand the type and extent of training in cultural safety being undertaken by health service organisations. The Australian Commission on Safety and Quality in Health Care (ACSQHC) commissioned the Aboriginal and Torres Strait Islander research team at The George Institute for Global Health to conduct analyses of the national survey on cultural safety training in health care. Funding for the analyses and subsequent report was through Medicare Private.

The report is divided into three sections. **Section 1**, provides context to the national survey, with a description of concepts such as cultural awareness, cultural sensitivity, cultural competence and cultural safety, including their genesis. A particular focus is given to their importance in providing care to Aboriginal and Torres Strait Islander peoples in the Australian healthcare context. We present several cultural safety frameworks and a review of the evaluation of cultural safety training in health care. **Section 2** presents findings from the analyses of the survey. **Section 3** brings both sections together to present key implications and recommendations for future consideration. Below is a summary of each section.

Section 1 – Background to cultural safety training

The concepts of cultural awareness, cultural sensitivity, cultural competence and cultural safety continue to evolve and as such, can mean different things to different people. Originally described by Māori nurses and midwives in the early 2000s, cultural safety in healthcare calls on the health professional, their healthcare organisation and the wider health system, to reflect on their own culture, values, beliefs, attitudes, systems and power to bring about a change in the patient-provider interaction.

There are multiple programs purporting to be delivering cultural safety training in Australia, offering a wide range of content and duration. Literature recommends avoiding a “one size fits all approach” and describes characteristics of programs that achieve meaningful changes in attitudes, behaviours and processes. It is important that the focus of the training is aligned to the specific cultural needs of each community and therefore local Aboriginal and Torres Strait Islander leadership and partnership is essential. Successful training programs must achieve reflective practice and provide strategies that ensure health services are culturally safe. To achieve cultural safety in healthcare, training must occur in a health system that is held accountable to and supportive of the principles of cultural safety and that those principles are supported by system policies and procedures.

To date, evaluations of cultural training programs in healthcare have been limited and have varied by methodological design and have broadly focussed on short term outcomes, with minimal

examination of the impact on patient experiences and patient outcomes. The ACSQHC in partnership with the Aboriginal Reference Group, developed and conducted a survey to describe the type and impact of cultural safety training in which health professionals have participated in healthcare settings across Australia.

Section 2 – The survey

From 2 March 2021 to 23 April 2021, a link was distributed through multiple health care networks inviting healthcare professionals to participate in the national survey. A total of 421 respondents representing a broad range of health care settings from each of the states and territories participated in the survey. The majority of training (51%) was reported to have been introduced in 2017-2021; which coincides with the release of the most recent ACSQHC Standards. Most of the training was offered as a 'one-off' event and very few (21%) reported it having been evaluated. Outcomes of the evaluation that were conducted were primarily focussed on knowledge, with very little, if any evaluation, examining elements that align with best practice care such as reflective practice. Similarly measures reporting changes in governance or impact on patient outcomes or experiences were either lacking or absent.

Section 3 - Recommendations for consideration

An overview of the implications of findings, drawing on key elements of the literature and survey results is provided in the final section of the report. Recommendations are presented that give an overview of factors the literature reports to be associated with best practice in cultural safety training. Recommendations are divided into the content of cultural safety training for a general health audience and then includes cultural safety training content that relates specifically to the individual, the heath setting and the healthcare sector. Recommendations include consideration of the format of the cultural safety training and modes of delivery. Finally, recommendations are provided that relate to pragmatic development of a survey to measure and assess cultural safety training.

Section 1 - Background

The Australian Commission on Quality and Safety in Health Care (the Commission) engaged The George Institute for Global Health's Aboriginal and Torres Strait Islander Health Research Program to conduct an analysis of health service organisation survey data describing cultural safety training programs being delivered in the health service sector. The objective of this work is to identify the extent of the training and how training programs could be improved.

Purpose of the research

The Commission aims to improve care, treatment and partnering with Aboriginal and Torres Strait Islander people through the implementation of healthcare standards and availability of resources. It is recognised that the cultural safety of a health service organisation has a significant impact on the experience of patients, the quality and safety of care received and patient outcomes. The Commission aims to better understand training programs being delivered across health services nationally and to describe the expected parameters of cultural training expected for the system to meet the National Safety and Quality Health Service Standards (NSQHSS) (herein referred to as the Standards) [1]. In this way it is anticipated organisations can improve cultural safety, patient experience and safety and quality of care for Aboriginal and Torres Strait Islander patients.

Considering culture in healthcare

A patient's culture often determines how they define illness, disease, health and wellbeing, and determines what they value in healthcare [2-4]. Culture relates to the beliefs and practices common among particular groups of people [5]. Public health research on the patient experience of healthcare has found patient groups from cultural backgrounds, which differ from the dominant culture of the health provider, are underserved and treated negatively. This impacts on their health outcomes [6].

In Australia there is a disparity in health outcomes between Aboriginal and Torres Strait Islander people and non-Aboriginal people [7]. Ongoing colonisation, institutional racism, implicit bias and dominance of western biomedical models of health and wellbeing by the healthcare system and health professionals, have contributed significantly to the health inequities and poorer outcomes of Aboriginal and Torres Strait Islander communities [8, 9]. Further, service delivery models, clinical guidelines and policies, continue to reinforce a western biomedical model of health and wellbeing [3].

Cultural awareness, cultural sensitivity, cultural competence, cultural security, cultural respect, and cultural safety have emerged as key ways for healthcare providers to support the treatment and care of people who were not considered to be 'part of' the dominant culture [3, 10].

It is important to acknowledge that the concepts outlined in the section below are broad, complex, and continually evolving. There are a myriad of definitions, interpretations, and applications of these terms, dependent on the literature, setting, policies, frameworks, and jurisdiction [11, 12], which leads to a lack of clarity and poor understanding of their meaning. They are often used interchangeably despite there being important differences between them. We recognise that these cultural concepts have only recently entered common usage, and trainings in these areas for health professionals are similarly new and emerging. In the Australian healthcare setting, they have arisen from health systems and healthcare organisations recognising the shortfalls in the interaction between patients and providers, and a willingness to improve health outcomes among Aboriginal and Torres Strait Islander peoples.

The general aim of these approaches in the healthcare context is for professionals to build an array of knowledge, tools and/or skills to better understand how to treat patients in a culturally appropriate way, remove barriers to treatment, and improve health outcomes [4] and for health care organisations to implement policies and practices that support best practice for the healthcare of Aboriginal and Torres Strait Islander peoples. In Australia today, healthcare professionals are increasingly required to undergo training to better understand cultural considerations and apply best practice when delivering health care for Aboriginal and Torres Strait Islander patients [3, 13].

Cultural awareness

Cultural awareness is the recognition that there are differences in the cultures of peoples across the population, such as differences in values and worldviews [3, 5]. Cultural awareness is often discussed as the first step in a journey towards building skills in cultural competence or towards cultural safety [3, 5, 14]. In the healthcare context, culturally aware health professionals recognise cultural difference among patients [3]. Cultural awareness does not necessarily involve a change in behaviour nor a reflection on cultural power imbalances and inequities, rather it is a basic understanding of difference among cultural groups [3]. Some definitions describe cultural awareness as an exploration of one's cultural background and examining assumptions and biases [14].

According to Australia's Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health (2016, p.18), cultural awareness is the demonstration of "a basic understanding of Aboriginal and Torres Strait Islander histories, peoples and cultures. There is no common accepted practice, and the actions taken depend upon the individual and their knowledge of Aboriginal and Torres Strait Islander culture. Generally accepted as a necessary first step and a foundation for further development, but not sufficient for sustained behaviour change" [15].

Cultural sensitivity

Cultural sensitivity is considered the step after cultural awareness. It is the valuing of people's right to be different and valuing differences in worldviews, knowledge, values and beliefs across different

cultures [3, 5]. It involves professionals learning about a patient's cultural background and in the process becoming sensitive to differing needs among their patients, as well as considering what has been gained from learnings in cultural awareness [3, 5].

Cultural competence

The concept of cultural competence in healthcare emerged in the United States and has multiple definitions, models and frameworks, evolving in application and interpretation over time [16]. Broadly, cultural competence entails the ability of healthcare providers working effectively with patients from different cultural backgrounds [3]. In 2002, Betancourt (p.v) defined cultural competence as "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs" [17]. According to Betancourt (2003, p.297) [4], cultural competence in healthcare is about "understanding the importance of social and cultural influences on patients' health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations." Betancourt's model breaks down cultural competence into three levels; organisational (leadership/workforce), structural (processes of care) and clinical (provider-patient encounter) [4]. Similarly, Australia's Cultural Respect Framework 2016-2026, which was developed by the National Aboriginal and Torres Strait Islander Health Standing Committee also describes cultural competence as acting upon a system and the people within that system. The Cultural Respect Framework (2016, p.18) defines cultural competence as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals to enable that system, agency or those professionals to work effectively in cross-cultural situations" [15].

Cultural competence is widely acknowledged as a continuum and a process, rather than an endpoint where one 'becomes' culturally competent [3]. It is an ongoing journey of cultural learning for healthcare professionals. For example, Campinha-Bacote's model of care to support healthcare professionals in becoming culturally competent integrates five constructs for nurses to continuously move forward in achieving the ability to work with people from diverse cultural backgrounds [18]. These five constructs include cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire [14, 18].

Cultural competence as an approach in healthcare has been criticised, as it often focuses on healthcare professionals 'acquiring' knowledge about another group's culture, without reflecting on their own culture, privilege, power or bias [12]. Simplifying cultural competence by educating oneself on the 'other' promotes the idea that people from one group are homogenous rather than diverse, leading to stereotyping and assumptions, and reinforcing differences [11, 12, 16]. Cultural competence also implies that there is a 'checklist' of behaviours that ensure competence when

working with people from culturally diverse backgrounds [3, 19]. Some education in cultural competence does, however, include learning about colonisation, power imbalances and the impact of one's own culture on a patient [3].

Cultural safety

The late Māori midwife Ramsden, conceptualised Kawa Whakaruruhau, or cultural safety in her doctorate, the notion being sparked when discussing cultural competence when one of her Māori students said 'well what about safety, what of my cultural safety' [14, 20]. From this time cultural safety has evolved as a way to achieve positive health outcomes for Indigenous peoples. Cultural safety is a departure from cultural awareness, sensitivity and competence, and is a model to achieve a transfer of power from the health professional to the patient, through organisational and systemic reflections, policies, plans and processes as well as through individual self-reflection [12]. Cultural safety relies on the health professional, their healthcare organisation and the wider health system, to reflect on their own culture, values, beliefs, attitudes and power to bring about a change in the patient-provider interaction [5, 19]. While cultural awareness, sensitivity and competence often focus on the health professional learning about people whose culture or experience differs from their own, cultural safety requires self-reflection and identification of a health professional's own culture, and to reflect on how power imbalance impacts on the healthcare interaction between a patient and provider [3, 5]. Importantly, cultural safety is only achieved when a health consumer has deemed the interaction culturally safe, rather than the healthcare professional determining that culturally safe practice has been achieved [3, 12, 15, 21]. Embedded in definitions of cultural safety is the need for the individual health consumer to be able to access services and raise concerns [15].

Similar to cultural competence, cultural safety is a process and privileges the first-hand experiences of the patient experiencing healthcare [22]. Cultural safety aims to expose how the patient and healthcare professional sit within the healthcare system and wider context, and works to produce culturally safe interactions and environments, and systemic change and decolonisation of the health service [23]. Health systems and healthcare organisations influence health professionals' practice and are thus required to engage in operationalising cultural safety, for example, through action plans, policy development, implementation of cultural safety policies and monitoring and evaluation [12, 21]. Engagement of healthcare organisations and the wider health system in cultural safety allows the health professional to apply cultural safety in their practice [12].

The most commonly cited definition is from The Nursing Council of New Zealand, however the most recent and updated definition is from that of Curtis et al., 2019, p.14:

> "Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes,

assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity.

Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment" [12].

This definition is broad and shows how cultural safety can be applied to many groups of people. It foregrounds the essential tenet of cultural safety in healthcare, i.e. the need for the patient to determine whether the healthcare provided was culturally safe.

According to Australia's Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health (2016, p. 18) the essential features of cultural safety are:

"a An understanding of one's culture

b An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s)

c It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point

d An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past

e Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver" [15].

Cultural safety and Aboriginal and Torres Strait Islander people

The cultural safety framework is the only framework which explicitly acknowledges the ongoing colonisation which Indigenous peoples experience [22]. Cultural safety has particular importance to the delivery of healthcare to Indigenous peoples [20, 22, 24]. It is a transformative approach that aims to address power imbalances and repression, and transfer power from a traditionally dominant health system to the healthcare recipient [22]. Cultural safety in healthcare means that the cultural needs and voice of Aboriginal and Torres Strait Islander peoples take a predominant role through a patient-centred approach [22]. It acknowledges that Aboriginal and Torres Strait Islander peoples have culturally different understandings of health and wellbeing compared with those of the dominant culture, as well as historically poor experiences with the healthcare system

[25, 26]. It puts the person's cultural values and norms at the centre and shifts service delivery to meet their cultural health needs [22]. For these reasons, cultural safety is considered one of the best opportunities to transforming the patient-provider relationship and improving the health and wellbeing of Aboriginal and Torres Strait Islander people [3].

Three important aspects of culturally safe health care across the literature are how it is provided, how it is experienced, and how it is accessed. These concepts form the basis for the Cultural safety in healthcare for Aboriginal and Torres Strait Islander Australians: monitoring framework [27]. Culturally safe healthcare is provided through the behaviours and attitudes of healthcare professionals, the culture of providers respecting and understanding Aboriginal and Torres Strait Islander people's culture. It is also defined with reference to the provision of care, including governance structures, policies, and practices. Culturally safe healthcare is experienced by Aboriginal and Torres Strait Islander people feeling safe, connected to culture, and having cultural identity respected [27].

There are several frameworks in Australia that relate to cultural safety in healthcare for Aboriginal and Torres Strait Islander people. See Table 1 below.

Table 1 Cultural safety frameworks

Title (year)	Organisation or agency	Definition
Cultural Safety Framework (2016)	National Aboriginal and Torres Strait Islander Health Workers Association	"Cultural safety is the 'outcome of education that enables safe services to be defined by those who receive the service' i. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. ii. Cultural safety aims to enhance the delivery of health services by identifying the power relationship between the healthcare professional and the person receiving care, and empowering the service user to take full advantage of the health care service offered. iii. Cultural safety is based on the experience of the recipient of care, and involves the effective care of a person or family from another culture by a healthcare professional who has undertaken a process of reflection on their own cultural identity and recognises the impact their culture has on their own practice. iv. Cultural safety on a continuum of care with cultural awareness being the first step in the learning process (which involves understanding difference), cultural sensitivity being a next step (where self-exploration occurs), cultural competence, and cultural safety being the final outcome of this process. This is a dynamic and multidimensional process where an individual's place in the continuum can change depending on the setting or community v." [21]
Cultural Safety Framework (2016)	Council of Aboriginal Alcohol Program Services Corp	"Cultural Safety is concerned with creating an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of 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.1" [28]

Title (year)	Organisation or agency	Definition
Aboriginal and Torres Strait Islander cultural safety framework for the Victorian health, human and community services sector (2019)	Department of Health and Human Services, Victoria	"Aboriginal and Torres Strait Islander cultural safety is defined as an environment that is safe for Aboriginal people and Torres Strait Islanders, where there is no assault, challenge or denial of their identity and experience." [29]
Western NSW Primary Health Network Cultural Safety Framework (2017)	Western Health Alliance Ltd	"WNSW PHN defines Cultural Safety in the context of a model developed in the Indigenous health care context in Aotearoa, New Zealand. This model delivers patient-centred care that extends beyond cultural awareness and cultural sensitivity and it is increasingly being used in the Australian primary health care setting. The cultural safety model focuses on the safety felt by individuals, their families and their communities in seeking health care. It aims to maximise safety through recognising and protecting the patient's cultural identity and by addressing power imbalances in the therapeutic relationship which have the potential to be detrimental to the patient's health and wellbeing. Whether primary health care provision is culturally safe is defined by the patient, his or her family and community." [30]

Embedding cultural safety in Australian healthcare

It is increasingly acknowledged there is a need for health professionals and healthcare organisations to embed cultural safety across the Australian healthcare system to improve health outcomes among Aboriginal and Torres Strait Islander peoples [31, 32]. Core accreditation requirements have been established at the Australian Medical Council, the Australian Nursing and Midwifery Accreditation Council, Occupational Therapy Council, Dietitians Associations of Australia. Accreditation requirements for cultural safety trainings aim to embed culturally safe practice among health professionals to improve the delivery of healthcare to Aboriginal and Torres Strait Islander people. The Australian Curriculum Framework for Junior Doctors by the Confederation of Postgraduate Medical Education Councils outlines learning outcomes required of doctors early in their careers [33]. The Framework identifies the need for doctors to acknowledge the impact of history on Aboriginal and Torres Strait Islander people and identify their own cultural values and how these values effect the healthcare interaction [33].

In 2017 the Commission released the Standards that included a requirement for training in cultural safety and cultural competence: "1.21 The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients". [1, p.10] Assessment of these Standards is mandatory in all Australian hospitals and day procedure services.

In 2021, The Australian Medical Council began a process to review its accreditation standards, in particular to improve the health of Aboriginal, Torres Strait Islander and Māori people through culturally safe practice [34].

Training programs developed as a result of accreditation requirements are inconsistent and vary from one-off workshops to extended, integrated programs. While there is an effort to embed culturally safe practice in the Australian healthcare system through accreditation requirements and frameworks, the quality and impact of these trainings on healthcare delivery is unclear [35].

The Australian Health Practitioner Regulation Agency (AHPRA) released a Health and Cultural Safety Strategy 2020-2025, outlining Codes of conduct and Codes of ethics [36]. A recent study analysed the Codes of conduct and Codes of ethics of 16 AHPRA registered practitioner Boards after the release of the Australian Health Practitioner Regulation Agency's (AHPRA's) Health and Cultural Safety Strategy 2020-2025 [36]. Study outcomes suggested improving AHPRA Codes to achieve culturally safe practice for Aboriginal and Torres Strait Islander people.

While developing health professionals' cultural safety practice is one potential strategy, organisational-level action has also been recognised as important take place to embed cultural safety in Australian healthcare [22, 37]. Institutional support of Aboriginal and Torres Strait Islander people's health is required to make this change. Meaningful partnerships with Aboriginal and Torres Strait Islander organisations is an important part of organisational-led support, as well as Aboriginal and Torres Strait Islander people in leadership [37].

Cultural Safety Training

Best Practice

In Australia in the tertiary education landscape, the majority of health professional programs have core accreditation requirements for cultural safety training and education, such as: Australian Medical Council, Australian Nursing and Midwifery Accreditation Council, Occupational Therapy Council (Australia and New Zealand) and Dietitians Association of Australia (AMC, 2010; ANMAC, 2012; DAA, 2009; OTC, 2013). Best practice approaches in this area have also seen the Nursing and Midwifery Board of Australia [38] join with peak bodies such as the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives [39] for joint statements, codes of conduct and principles on cultural safety [40]. Additionally, extended training programs such as the Australian Curriculum Framework for Junior Doctors and the Royal Australasian College of Physicians have introduced key core clinical skill requirements of cultural safety through Indigenous strategic frameworks [41, 42].

Studies analysing curriculum development and delivery of cultural safety and cultural competency programs in Australia, Canada, New Zealand, and the United States have found that there is a wide range of programs, varying in depth of content and duration [43]. Rather than providing a specific set of instructions on how to deliver cultural safety training, expert academics have provided recommendations for the characteristics that training programs should include to achieve meaningful change in attitudes and behaviours among training recipients.

Literature suggests that one of the most important principles when designing or implementing cultural safety training is avoiding the “one size fits all” approach. As discussed earlier, developing cultural safety capabilities is a long-term process that requires a process of self-reflection which cannot be achieved through attendance at a one-off course [44]. It is important to recognise that health professionals are at different stages of the journey of working in a culturally safe way, thus evidencing the need of approaches that are tailored to each individual’s stage [45, 46]. In addition, providing culturally safe health services entails providing services that meet the cultural needs of the healthcare recipient; this means that the focus of the training needs to be tailored according to the specific cultural values, knowledge systems and therefore specific cultural health needs of each community [47]. In Australia there is great diversity within Aboriginal and Torres Strait Islander communities, each with unique cultural values, languages, health understandings and hence cultural health needs [48, 49].

Cultural training designed for health workers in Australia has been criticized for its focus on developing cultural awareness rather than cultural safety [50]. Experts in cultural safety emphasize the need to shift the training focus from teaching about Indigenous culture to examining processes of power imbalances and identity [51]. Furthermore, as discussed earlier, the extent to which a health service is culturally safe must be determined by the service recipient rather than the service provider. For this reason, literature suggests that training of health practitioners and health system transformation requires leadership and guidance from the local Aboriginal or Torres Strait Islander community who ultimately determine if the care is culturally safe [44].

Cultural safety for Aboriginal and Torres Strait Islander people within the health system cannot be achieved through cultural safety training alone. It is a whole system approach, requiring adoption of cultural safety to support practitioners in providing culturally safe health services [44]. Achieving cultural safety entails organisational leadership, engagement and accountability to ensure that system policies and procedures support the provision of culturally safe care [44].

Wylie et al’s paper “It’s a journey not a check box: Indigenous Cultural Safety from Training to Transformation” provide five key recommendations to improve cultural safety competencies in healthcare [44]:

1. Training should be introduced in the early stages of health professional education (ensuring that all health professionals receive training instead of trying to reach them when they are working, when time is limited)
2. Integration of multiple modalities of training during a health professional’s career
3. Training to include practical tools to develop competencies that align with different roles and responsibilities
4. Training to be specific to each communities’ needs rather than general information about Indigenous peoples
5. Training should be informed by lived experiences of local Indigenous people of each community to ensure care responds to local community needs.

Cultural Safety training in Australia

In Australia, training in cultural capabilities is provided to healthcare practitioners through a range of training providers. The duration of training, content, and modality of the training varies between providers. We have reviewed several training programs offered in Australia and synthesised the recommendations from several health organisations in Australia who provide cultural training programs. Although the available programs and recommendations vary in duration and modality, the focus of the content is similar, including topics such as:

- the impact of colonisation and dispossession on the current health status of Aboriginal and Torres Strait Islander people,
- power imbalances and privilege,
- racism, history, and importance of Community Controlled Health Organisations,
- cultural competency, cultural safety, and strategies to provide culturally safe services.

Most trainings available adhere to core accreditation requirements or recommendation shared by most organisations that training should be developed in partnership and delivered by Aboriginal and Torres Strait Islander people. See Table 2 for examples of trainings available and the recommendations given by main health organisations in Australia.

Table 2 Cultural safety training in Australia

Organisation	Training characteristics and/or recommendations
National bodies	
Australian Indigenous Doctors Association	• Delivered by Aboriginal and Torres Strait Islander doctors who are role models and reinforce culturally safe behaviours and practices throughout the training. • The program is delivered over 8 hours. • Learning Outcomes: - *Demonstrate awareness of personal worldviews and how these relate to clinical practice settings.* - *Understand and apply Aboriginal and Torres Strait Islander worldviews and approaches to health and wellbeing in clinical practice.* - *Understand racism and why it is a barrier to good health outcomes.* - *Recommend practical strategies to mitigate barriers and utilise enabling factors at systemic, organisational and practice level.* - *Strengthen culturally safe practices to achieve better health outcomes for Aboriginal and Torres Strait Islander Peoples.* - *Utilise techniques to improve rapport building, engagement, and communication in clinical consultations.*

Organisation	Training characteristics and/or recommendations
Royal Australia College of General Practitioners	• Provides training in cultural awareness (online) and cultural safety (face to face). • Recognises that cultural safety is determined by Aboriginal and Torres Strait Islander peoples. • Reflexive approach and learning methodologies that result in behaviour changes and practice • Curriculum: - *Cultural awareness component: Aboriginal and Torres Strait Islander culture and history, how attitudes and values can influence perceptions and behaviours in clinical setting, key issues faced by practitioners and Aboriginal and Torres Strait Islander people, consider ways to address the issues.* - *Cultural safety component: Assists Australian GPs to maintain and improve the quality of care they provide to patients and promote care to the community of the highest possible standard.*
Indigenous Allied Health Australia	• Focuses on critical self-reflective practice. • Delivered in four stages of online and blended learning • Face to Face one or two day / Online six months • Learning facilitated by lived experience of Aboriginal and Torres Strait Islander facilitators. • Content focused on how to build cultural safety and how to deliver culturally safe and responsive care and services. • Four levels: from cultural awareness, to self-aware-practice, personal action plans to embedding cultural safety into systems.
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	• E-Learning Cultural Safety Training under development. • Launching on National Close the Gap Day 2022. • Training Standards should minimum cover the learning objectives: - *knowledge of Australian history and the impact of invasion and colonisation on Aboriginal and/or Torres Strait Islander Peoples.* - *knowledge of the impact of racism on Aboriginal and/or Torres Strait Islander Peoples' health and the skills needed to address it.* - *knowledge and understanding of what cultural safety is and the importance of it to Aboriginal and Torres Strait Islander Peoples.* - *Ability to identify strategies to embed cultural safety in midwifery and other health care environments on individual, organisational and systemic levels.*

Organisation	Training characteristics and/or recommendations
Committee of Deans of Australian Medical Schools	• Assumes the student has no prior awareness about Indigenous health, cultures, or experiences. • Suggests that the proposed subject areas are taught as part of core/compulsory medical education, rather than offered only as electives. • 8 suggested subject areas (history, culture, self and diversity, Indigenous societies, cultures and medicines, population health, models of health service delivery, Clinical presentations of disease, communication skills, ethics, protocols, and research). • 10 pedagogical principles: - *Educating medical students about the health of Aboriginal and Torres Strait Islanders is unique among teachings about the health of other Australians, and we can teach medicine in a way that enhances students' understanding of Indigenous experiences and worldviews.* - *Indigenous health is an integral part of medical education.* - *Teaching from a positive strengths-based model, rather than a deficit model, is more likely to encourage effective learning environments and attitudes.* - *Planning vertical and horizontal integration is important.* - *Indigenous staff are key curriculum developers and enhancers.* - *The attitudes of all teaching, clinical and administrative staff counts towards effective learning.* - *In order to facilitate the most effective learning possible, partnerships with local Indigenous individuals, organisations, and communities will need to be developed.* - *It is important to teach Indigenous cultural safety/awareness separately to multicultural awareness.* - *Students can be important curriculum enhancers if effectively supported and encouraged, but they should not be expected or relied upon to perform this function.* - *Multi-disciplinary collaboration is likely to enhance learning outcomes.*

Organisation	Training characteristics and/or recommendations
Statewide bodies	
Victorian Aboriginal Community Controlled Health Organisation	• Four-hour (no breaks) Introduction to Cultural Safety in Aboriginal Health for frontline service providers. • Four-hour (no breaks) Introduction to Cultural Safety in Aboriginal Health for Executive and Management. • Promotes a safe environment to enable useful discussions and interactions to take place through two-way communications between participants and facilitators. • Course content: - *Aboriginal people and communities.* - *Status of Aboriginal health.* - *Impact of history on Aboriginal people.* - *Strategies to redress current issues.* - *The Victorian Aboriginal community health sector and closing the health gap.*
New South Wales Government	• In November 2011 NSW published Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health. • This Policy Directive sets out the cultural training requirements for the NSW Ministry of Health (MoH), Local Health Districts (LHDs) and other NSW Health Organisations. • Includes an E-learning component (2 hrs) and a face to face component (4-6 hrs) which includes content on generic subjects and local content. • It has different learning outcomes targeted for leadership groups, program and service managers, frontline staff, and other staff. • Participants gain information to improve their knowledge and understanding of the diverse culture, customs, and protocols of Aboriginal communities in NSW. • Participants learn how to interact positively with Aboriginal people by implementing engagement and communication strategies that will improve the way they work.

As part of the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 [52] the APHRA is rolling out the Moong-moong-gak cultural safety training program nationally for all APHRA's committees, staff, National Boards, State and Territory Boards, Accrediting Authorities and professional associations. The training is designed to provide knowledge, skills, and abilities to develop and apply culturally safe practices. The training duration is 16 hours and is designed for health practitioners to critically reflect on their knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism to Aboriginal and Torres Strait Islander peoples. The training is in line with the definition provided by the National cultural safety strategy [52] which states that to ensure culturally safe and respectful practice, practitioners must:

- Acknowledge colonisation and systemic racism, social, cultural, behavioural, and economic factors which impact individual and community health.
- Acknowledge and address individual racism, their own biases, assumptions, stereotypes, and prejudices and provide care that is holistic, free of bias and racism.
- Recognise the importance of self-determined decision-making, partnership, and collaboration in healthcare, which is driven by the individual, family, and community.
- Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

The National Aboriginal Community Controlled Health Organisation (NACCHO) is working on a project to "**achieve recognition of the NACCHO Cultural Safety Training Standards as the national benchmark for quality Aboriginal cultural safety training for the health workforce and other relevant sectors**" [53]. As part of this project NACCHO identified components of good practice in the literature and through consultancy with Aboriginal and non-Aboriginal experts facilitating cultural safety training. According to NACCHO, good practice in cultural safety training:

- *Is an interpersonal and interactive process, i.e. needs to occur face to face and involve personal, small, and large group exercises.*
- *Explores pre-existing knowledge and participant learning hopes and expectations.*
- *Facilitates creation of a safe space for participants to explore their cultural values and beliefs, and their intended or unintended participation in racism.*
- *Asks participants to reflect on their own culture, and how their cultural values and beliefs shape their behaviour and interactions with Aboriginal Peoples or other Aboriginal Peoples, i.e. has a strong 'self-focus'*
- *Emphasises the diversity of Aboriginal Peoples and Torres Strait Islander peoples.*
- *Clearly names racism in all of its forms and explores how it is present in health and everyday experiences for Aboriginal Peoples, both historically and currently.*
- *Asks and supports participants to apply what they learn directly to their work contexts*
- *Considers what steps need to be taken at organisational and systemic levels of the health system in which participants operate, in addition to what they do at an individual level*
- *Is a minimum of a day in length.*
- *Draws on multi-media resources.*
- *Is delivered by Aboriginal people.*
- *Evaluates the experience and impact of the training at completion of the training day(s).*
- *Negotiates to undertake assessment of the training impact at an agreed time following the training.*

Evaluation

While cultural safety training programs have been evaluated, there are limitations in the design of those evaluations. One of the key limitations is that most evaluations measure short-term outcomes after the completion of the training. The study conducted by Withall et al (2021), evidenced that up to 5 years after completing cultural safety training as undergraduate students, nurses and midwives showed different degrees of demonstrated cultural safety in their work [46]. Further studies evaluating long-term outcomes are required to assess whether changes in behaviour and practice are sustained over time [11, 51]. In addition, many of the evaluations focus on checking completion

of training but have failed to measure long-term behaviours and organisational change that ensure services are culturally safe [44]. Other limitations include the lack of validation of the tools used to conduct the evaluations [54]. Most evaluation tools focus on self-assessment of change in cultural attitudes and beliefs by the health practitioner rather than evaluating the extent to which cultural safety is reflected in actual practice [35, 55-60]. There is a lack of evidence of training evaluations that measure effectivity from the perspective of healthcare recipients, which is a key tenet of cultural safety.

A systematic review of 34 studies that implemented interventions to improve cultural competence among health care providers found excellent evidence to support training improving health professional's knowledge [61]. The systematic review also found good evidence of training improving attitudes and skills, but limited evidence of training improving patient satisfaction. No studies were found evaluating health status outcomes or equity of services. Furthermore, due to the heterogeneity of the curricular content and methods of cultural safety training, the systematic review could not determine which types of training interventions were most effective on which types of outcomes. A systematic scoping review analysing intervention strategies, outcomes, and measures of health workforce cultural competency interventions resulted in similar findings. Only four studies out of 64 included validated measurement tools to assess intervention outcomes. Consistent outcomes were improved practitioner knowledge, skills attitudes, and beliefs however, there was very limited evidence of intervention impacts on health care and health outcomes [62].

While there is limited evidence to show the direct impact of cultural safety training on health outcomes, there is evidence supporting healthcare organisation and healthcare practitioners embedding cultural safety within their institutions and this impacting the service achieving better outcomes at a health service, health practitioner and patient level [63].

Outcomes at health service level

A study mapping cultural clinical indicators of best practice in mental health nursing identified culturally safe care as a key indicator of exemplary practice for Māori people [64]. Reibel and Walker found that of 42 services providing general antenatal care to Aboriginal women, only nine were identified as providing culturally responsive care and were associated with increased access and frequency of visits for Aboriginal women [65]. A study conducted in the United States found that the implementation of a culturally sensitive educational intervention using a navigator resulted in increased adherence to screening mammography guidelines among Native American women [66].

Outcomes at healthcare practitioner level

Mooney et al found that a half-day training program for practitioners resulted in a significant increase in understanding of Indigenous health issues and in forging better friendship and working relationship with Indigenous people [58]. A culturally tailored smoking cessation training program

improved health practitioner competence to deliver smoking interventions to Indigenous Australian patients [67]. A study evaluating a pharmacist-led-medicines education course delivered to Aboriginal Australian Health Workers to develop pharmacist cultural awareness found that at the end of the intervention pharmacists were more prepared to work with Indigenous people to identify health issues and enhanced the development of sustainable relationships with Aboriginal Health workers [68].

Outcomes at patient level

Cook et al (2010) implemented an educational intervention with culturally specific educational materials to provide information about disease management to Native Hawaiian patients and family members. The intervention resulted in high patient satisfaction, improvement in adverse events following percutaneous coronary intervention and decrease in readmission rates [69]. D'Silva et al (2011) studied an intervention incorporating cultural and historical characteristics, values, and traditions of the local native community to a smoking cessation curriculum. The adapted curriculum was developed based on suggestions from community members and included addition of local stories in the local language and teaching on how to use tobacco in sacred ceremonies. The intervention resulted in significant smoking abstinence at 90-day follow-up and reduction in daily smoking among the people who did not quit [70].

Regarding the implementation of strategies to embed cultural safety in the healthcare system and organisations, there is an existing framework to evaluate cultural safety in policy according to reflexivity, dialogue, power differences, decolonisation, and regardful care [71]. The Western NSW Primary Health Network has also developed a cultural safety framework and a self-evaluation tool to assist primary health service providers in assessing the degree to which the organisations adhere to each standard of the framework. This provides an opportunity for primary health organisations to demonstrate their commitment in progressing to become culturally safe health service providers [30].

Evaluation of interventions to improve cultural capabilities among healthcare workers in Australian healthcare settings

We conducted a review, including peer-reviewed papers and grey literature, to gather evidence on the evaluation of cultural safety and cultural competency interventions conducted in Australian healthcare settings. We conducted a search using key words related to cultural safety and cultural competency, training, evaluation and Aboriginal and Torres Strait Islander and the Boolean operators "AND" and "OR". The search was conducted using PubMed, Google, Google scholar and websites of relevant organisations such as: Leaders in Indigenous Medical Education (LIME), the Lowitja Institute, HealthInfonet, and the Indigenous Higher Education journal. A summary of the findings is provided in the Table 3 below.

Table 3 Summary of findings

Training modality	**Studies**
Face to Face	Chapman (2014),Kerrigan (2020) and Sinnott (2000)
Online	Downing (2011)
Studied Outcomes	**Studies**
Outcomes at health service level	Liaw (2019) and Liaw (2015)
Satisfaction and perceptions on quality and utility of training	Downing (2011), Durey (2017), Kerrigan (2020), Sinnott (2001), Vass (2015) and Hinton (2012)
Self-assessed familiarity with Aboriginal culture and attitudes and perceptions towards Aboriginal people	Chapman (2014) and Mooney (2005)
Self-assessed confidence in providing culturally safe services	Durey (2017), Hinton (2012), Dingwall (2015)
Self-assessed knowledge and skills to provide culturally safe services	Durey (2017), Liaw (2019), Vass (2015), Dingwall (2015) and Liaw (2015)
Findings	**Studies**
Health workers enjoyed the training and believed it to be beneficial and relevant for their practice	Downing (2011), Durey (2017), Kerrigan (2020), Sinnott (2001), Vass (2015) and Hinton (2012)
Change in perception about Aboriginal and Torres Strait Islander people	Chapman (2014)
Increased confidence to communicate with Aboriginal and Torres Strait Islander people	Hinton (2012), Liaw (2015) and Durey (2017)
Enhanced skills to provide culturally safe care	Vass (2015), Dingwall (2015), Durey (2017) and Liaw (2015)
Increased knowledge about Aboriginal health and cultural safety	Mooney (2005), Vass (2015) and Durey (2017).

Increase in Aboriginal posters, flags, and brochures in waiting room and increase in registrations for Indigenous practice incentive payments	Liaw (2015)
Increase in health checks for Aboriginal people	Liaw (2019)

A document containing the data extracted for each of the records included is available in a separate Excel document provided to the Commission. We located 11 records discussing outcomes after the implementation of training interventions to improve cultural capabilities among the health workforce in Australia. Overall, the findings of the review are consistent with findings of the international literature in this area. The duration of the trainings varied from two hours to one-day. Four interventions were conducted face to face [56, 72-74], one online [75] and the remainder of the studies did not specify the modality of the training [51, 58, 73, 76-79]. Only three studies used instruments that had been validated [56, 73, 80]. Of the included studies only two analysed outcomes at the health service level; one analysed access to care after the training [73] and the other studied practice physical spaces and health checks and risk factor management for Aboriginal patients in general practice [80]. Six studies focused on satisfaction and perceptions on the quality and utility of the training [50, 72, 74, 75, 77, 79]. Two studies measured self-assessed familiarity with Aboriginal culture and attitudes and perceptions towards Aboriginal people [56, 58]. Three manuscripts analysed self-assessed confidence in providing culturally safe services to Aboriginal and Torres Strait Islander people [77-79]. Five studies analysed self-assessed knowledge and skills to provide culturally safe services [73, 75, 78-80].

All studies analysing satisfaction and perception of utility of the training found that the health workers enjoyed the training and believed it to be beneficial and relevant for their practice [72, 75-77, 79]. Chapman et al's study found that cultural training changed their perception but did not affect their attitude towards Aboriginal and Torres Strait Islander people [56]. Three studies found that the training increased practitioner's confidence to communicate with Aboriginal and Torres Strait Islander people [77, 79, 80] and four studies found enhanced skills to provide culturally safe care [75, 78-80]. Three interventions resulted in increased knowledge about Aboriginal health and cultural safety [58, 75, 79]. The two studies analysing outcomes at the health service level found that after the training, clinics began displaying more Aboriginal posters, flags, and brochures in the waiting room, registrations for Indigenous practice incentive payments increased [80], and there was an increase in health checks for Aboriginal people [73].

Conclusion

The concept and experience of cultural safety in healthcare has only been reported for approximately twenty years. It occurs in the context of a healthcare system that is based upon the knowledges and practices of the dominant culture which results in inequitable health outcomes

among Aboriginal and Torres Strait Islander peoples. Given its relative 'newness', understanding of cultural safety and its training continues to develop. Despite that, there is a growing body of evidence of what constitutes best practice in development and delivery of cultural safety training. The implications of these and how they are applied to the findings of the national survey on cultural safety in healthcare is presented in Section 3 of this report.

Section 2 - The Cultural Safety Training survey

Introduction

In 2021, the Australian Commission on Quality and Safety in Health Care (The Commission) conducted a national survey to understand the type and extent of training in cultural safety being undertaken by health service organisations. The survey was conducted in recognition of Action 1.21 of the National Safety and Quality Health Service (NSQHS) Standards. Action 1.21 focuses on workforce competency and states "'The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients." To date, no national survey has been developed to assess the degree to which health service organisations were applying strategies to improve cultural awareness, cultural competency and cultural safety. The aim of the survey was to have a 'snapshot' of the cultural safety training that health service organisations are conducting across the nation.

Development of the survey included the Commission's Aboriginal and Torres Strait Islander Health Advisory Group reviewing and providing advice on four iterations of the survey over a period of approximately four months. This process involved members of the Advisory Group taking the survey back to their respective organisations for input. Members of the Aboriginal and Torres Strait Islander Health Advisory Group included representation from: the National Aboriginal Community Controlled Health Organisation (NACCHO), the National Association of Aboriginal and Torres Strait Islander Health Worker and Practitioners (NAATSIHWP), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINAM), the Australian Indigenous Doctors Association (AIDA), and the Indigenous Allied Health Association (IAHA). The survey, using a mix of open and closed-ended responses, comprised a total of 30 questions and was specifically designed to be brief so as not to be too onerous for respondents to complete. (Appendix 1 presents a copy of the survey).

An invitation to participate in the electronic survey was distributed through the Commission's and the Advisory Group's networks. Contacts included State and Territory Regulators, Catholic Health Australia, Day Hospitals Australia and the Australian Private Hospital Association and those who had provided their details to the Commission through the Advice Centre. These contacts were encouraged to share the invitation with their network. The survey link was distributed and open from March 2, 2021-April 23, 2021. No reminders to complete the survey were sent out.

This section of the report (Section 2) describes the processes used to synthesise and analyse the data, provides key results from the analyses and concludes with a discussion of the survey findings.

Methods

We analysed the quantitative data using descriptive statistics and conducted deductive thematic analysis of open-ended responses.

In instances where there were large numbers of responses falling under the “Other” category, those responses were recoded either to existing options or to additional categories, which were developed to more fully summarise responses. This was most relevant for the questions relating to: the type of service the respondent was answering for; where the service was situated; when cultural safety training was introduced to the service; the format / mode of delivering the cultural safety training; and, the number of hours the cultural safety training took to complete.

Two sets of ‘training quality indicator’ variables were constructed by assigning quality markers to certain variables most likely to be associated with what the literature indicates as effective cultural safety training. The first set focussed on aggregating the total number of topics covered in the cultural safety training. The 14 variables that related to the topics covered in the training that were included in this first set of ‘training quality indicators’ relate to the following question in the survey:

What are the key topics covered in the cultural safety training? (select all that apply)

- Aboriginal and Torres Strait Islander history, peoples, cultures
- Cultural safety definition
- Contemporary context of Aboriginal and Torres Strait Islander peoples
- Racism (systemic, institutional and individual)
- Impact of historical government policies, intergenerational impact and trauma
- Interpreting and reflecting on unconscious bias
- Collaboration and partnerships with Aboriginal and Torres Strait Islander people
- Local, state, territory and national policies that are applicable to Aboriginal and Torres Strait Islander people
- Resilience and strength of Aboriginal and Torres Strait Islander communities
- The application of knowledge of Aboriginal and Torres Strait Islander culture to the assessment of the physical, emotional and
- Social factors that contribute to creating a welcoming environment
- Processes to accurately identify and record if patients are of Aboriginal and/or Torres Strait Islander origin
- The importance of an Aboriginal and Torres Strait Islander health workforce
- The role of Aboriginal and Torres Strait Islander Health Liaison practitioners

- Possible outcomes (e.g., discharge against medical advice) if cultural safety is not applied.

The second quality indicators involved recoding responses from eight questions to a “1” or a “0”. The total was then calculated. The highest possible score, therefore, was eight. The questions combined in this quality markers were:

- Question 4. Is cultural safety training available in this health service organisation?
- Question 6. Is cultural safety training mandatory in this health service organisation?
- Question 7. Is cultural safety training required as a one off or a repeated event?
- Question 8. Which members of the workforce are required to participate in cultural safety training? (select all options that are applicable)
- Question 9. Is cultural safety training included in the orientation process for new members of the workforce?
- Question 11. Has the training been primarily developed or designed with/by the local Aboriginal or Torres Strait Islander community?
- Question 17. Are there specific cultural safety training modules for different health professions?
- Question 21. Has this health service organisation evaluated the impact of cultural safety training?

Open-ended responses relating to the evaluation and impact of the cultural safety training were first coded according to the principles of cultural safety (deductive) and then themes were developed within that framework (inductive).

We used STATA 17 to conduct the quantitative data analyses and NViVO12 to synthesise the qualitative data.

Results

Category of health service by jurisdiction

A total of 421 survey responses were submitted with respondents representing a broad range of health service organisations. The following points are noted from the distribution of respondents by service category and jurisdiction (Table 4). Overall, 85.5% of respondents were from six service types. They were: public hospitals (n=179, 40%); private hospitals (n=68, 16%); community health services (n=45,11%); day procedure services (n=27, 6%); mental health services (n=23, 5.5%); and public health departments (n=18, 4%). While 28% of respondents represented NSW, not one response was received from any representatives of prisons health from that jurisdiction. Almost a quarter (23%) of respondents from the Northern Territory were from a community health service.

Table 4 Count of category of health service for which the participant responded, by jurisdiction.

Type of service	ACT	NSW	NT	QLD	SA	Tas	Vic	WA	Total
Aboriginal Community Controlled Health Service	1	1	0	0	1	0	0	1	**4**
Aboriginal Medical Service	1	0	1	0	1	0	0	0	**3**
Aged care services	0	3	0	0	2	0	1	0	**6**
Alcohol & other drugs services	0	3	0	0	0	1	1	1	**6**
Ambulance or transport service	0	1	0	0	0	0	1	0	**2**
Certifying body	0	2	0	1	0	0	0	0	**3**
Community health services*	0	7	10	7	4	1	10	6	**45**
Day procedure service	2	9	0	4	6	2	3	1	**27**
Education service	0	0	0	0	0	0	2	0	**2**
Mental health service	0	7	4	1	1	0	3	7	**23**
Non-government organisation	0	2	0	1	0	0	1	1	**5**
Primary health care	2	2	1	1	0	1	1	0	**8**
Prisons health	1	0	0	0	0	0	1	1	**3**
Private service - allied health	0	0	0	1	0	0	0	0	**1**
Private hospital	2	15	0	15	4	5	17	10	**68**
Private practice	0	0	0	2	0	0	0	0	**2**
Public dental service	0	1	2	4	1	0	1	0	**9**
Public health department	0	7	0	1	7	2	0	1	**18**
Public hospital	1	55	24	28	14	1	49	7	**179**
Workforce support	0	0	1	0	0	0	1	0	**2**
Other	0	2	0	0	1	0	2	0	**5**
Total	**10**	**117**	**43**	**66**	**42**	**13**	**94**	**36**	**421**

*Services in **bold** represent the most frequent type of service for which the participants were responding – this is where there were more than 15 responses for the service.

Location of health service

Most respondents (n=217, 52%) said their health service was situated in the metropolitan area and 131 (31%) in rural areas; 23 (5.5%) respondents said they were located statewide (Table 5). All respondents who were from public health departments indicated they were statewide.

Table 5 Where health services were situated by jurisdiction (n, %)

	ACT	NSW	NT	QLD	SA	Tas	Vic	WA	Total
International	0 (0%)	0 (0%)	0 (0%)	1 (1.5)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**1 (.2%)**
National	0 (0%)	0 (0%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	0 (0%)	2 (6%)	**3 (1%)**
Metropolitan	8 (80%)	69 (59%)	2 (5%)	36 (55%)	23 (55%)	5 (38.5%)	49 (52%)	25 (69%)	**217 (52%)**
Regional	0 (0%)	4 (3%)	0 (0%)	6 (9%)	0 (0%)	1 (8%)	1 (1%)	0 (0%)	**12 (3%)**
Remote	2 (20%)	2 (2%)	19 (44%)	8 (12%)	0 (0%)	0 (0%)	1 (1%)	2 (6%)	**34 (8%)**
Rural	0 (0%)	37 (32%)	19 (44%)	12 (18%)	15 (36%)	4 (31%)	38 (40%)	6 (17%)	**131 (31%)**
Statewide	0 (0%)	5 (4%)	3 (7%)	2 (3%)	4 (10%)	3 (23%)	5 (5%)	1 (3%)	**23 (6%)**
Total	10 (100%)	117 (100%)	43 (100%)	66 (100%)	42 (100%)	13 (100%)	94 (100%)	36 (100%)	**421 (100%)**

Was the cultural safety training available in the service?

While the majority of services said the training was easily accessible (n=123, 29%) or accessible (n=160, 38%) this differed significantly as to whether or not the service was a public or private service. Recoding of service category to “Private”, “Public” or “Other, unclear” showed that 71% of public health services were either very accessible or accessible versus 62% of private health services (χ^2=25.9 p<0.01).(Table 6)

Table 6 Availability of cultural safety training by public or private health service (n%).

	Public	Private	Other or unclear	Total
Easily accessible	57 (27%)	27 (38%)	39 (29%)	123 (29%)
Accessible	94 (44%)	17 (24%)	49 (36%)	160 (38%)
Somewhat accessible	58 (27%)	16 (23%)	38 (28%)	112 (27%)
Not accessible	4 (2%)	11 (16%)	11 (8%)	26 (6%)
Total	**213 (100%)**	**71 (100%)**	**137 (100%)**	**421 (100%)**

When was cultural safety training introduced in the health service?

There were 339 responses to this open-ended question, and responses varied greatly. The recoding of open-ended response required some judgement, for example when respondents replied “A few years ago” that was taken as three years ago, so was coded at 2018. Where respondents stated “unsure” or “years ago” this was recoded as missing. Of the 339 respondents to this question, 107 were subsequently recoded as missing. Of those where a year could be allocated, 10% indicated the training was introduced in the year 2000, or earlier; 5% from 2001-2009; 28% from 2010-2015; and 57% indicated training had been introduced since 2015 – and three quarters of those were in the last three years (from 2018 to 2021). (Table 7)

Table 7 Year that the cultural safety training was first introduced at the service

Year	Number	Percent
1979	1	0.4%
1990	3	1.3%
1995	3	1.3%
1996	2	0.9%
1998	1	0.4%
2000	14	6.0%
2001	1	0.4%
2003	1	0.4%
2004	3	1.3%
2005	4	1.7%
2007	1	0.4%
2009	2	0.9%
2010	27	11.6%
2011	4	1.7%
2012	6	2.6%
2013	6	2.6%
2014	9	3.9%
2015	13	5.6%
2016	13	5.6%
2017	19	8.2%
2018	30	12.9%
2019	40	17.2%
2020	20	8.6%
2021	9	3.9%

Is cultural safety training mandatory?

Of the 339 respondents to this question, 248 (73%) indicated that the training was mandatory, 62 (18%) said it was not mandatory and 29 (9%) were unsure. There was no significant difference by whether or not the service was coded as public or private.

Is training provided as a one-off event or a repeated event and what is its duration?

Of the 248 respondents to this question, a little more than half (n=143, 58%) said that it was offered as a one-off while 105 (42%) said it was a repeated event. A greater proportion of private services than public services offered the training as a repeated event (72% versus 33%). When comparing jurisdictions, a greater proportion from Victoria (67%) indicated that training was offered as a repeated event. Only 11% of Northern Territory respondents and 27% of respondents from New South Wales indicated training was offered as a repeated event (Table 8).

The average duration reported for the cultural safety training was 4 hours. Almost half (40%) of all training was reported to be online (self-paced) and 37% of respondents reported a combination of online and face-to-face training.

Table 8 Number and proportion by state if the training was offered as a one-off or a repeated event.

	ACT	NSW	NT	QLD	SA	Tas.	Vic.	WA	Total
One-off	1 (17%)	61 (74%)	24 (89%)	20 (47%)	12 (46%)	2 (33%)	9 (25%)	14 (67%)	143 (58%)
Repeated	5 (83%)	22 (27%)	3 (11%)	23 (54%)	14 (54%)	4 (67%)	27 (75%)	7 (33%)	105 (42%)
Total	6 (100%)	83 (100%)	27 (100%)	43 (100%)	26 (100%)	6 (100%)	36 (100%)	21 (100%)	248 (100%)

Who was required to participate in the cultural safety training?

The majority (205) of respondents indicated that all members of the workforce were required to participate in the cultural safety training. Table 9 shows the breakdown by jurisdiction and Table 10 by type of health service (Public, Private, Unclear).

Table 9 Members of the workforce required to participate in the training by jurisdiction (more than one option could be selected).

	ACT	NSW	NT	QLD	SA	Tas.	Vic	WA	Total
All members of the workforce	4	71	23	38	19	6	29	15	205
Nurses	0	6	2	3	3	0	5	4	23
Other	0	7	3	0	4	0	2	0	16
Non-clinical workforce	0	4	1	2	2	0	3	2	14
Allied health	0	4	1	2	2	0	2	3	14
Managers	0	3	0	2	4	0	2	2	13
Doctors	0	3	1	1	2	0	0	1	8
Members of the workforce who identify as Aboriginal and/or Torres Strait Islander	0	2	1	1	1	0	2	0	7
Volunteers	0	1	0	0	0	0	1	0	2
Total	**4**	**101**	**32**	**49**	**37**	**6**	**46**	**27**	**302**

Table 10 Members of the workforce required to participate in the training by type of health service (more than one option could be selected).

	Public	Private	Other or unclear	Total
All members of the workforce	121	31	53	205
Nurses	11	4	8	23
Doctors	6	0	2	8
Allied health	9	3	2	14
Managers	8	3	2	13
Non-clinical workforce	8	4	2	14
Volunteers	1	0	1	2
Members who identify as Aboriginal or Torres Strait Islander	6	0	1	7

Is cultural safety training included in the orientation process?

Of the 309 respondents who answered this question, 65% said that the training is offered at orientation. This differed, though not significantly, by jurisdiction and level of remoteness. The jurisdiction with the greatest proportion of respondents saying that the training was offered at orientation was the Northern Territory (85%). Aligned with this, 71% of respondents whose services were situated in remote areas also indicated the training was offered at orientation. (Tables 11 & 12)

Table 11 Cultural safety training included at orientation by jurisdiction (n, %)

	ACT	NSW	NT	QLD	SA	Tas.	Vic.	WA	Total
No	1 (17%)	19 (21%)	0 (0%)	8 (16%)	2 (7%)	3 (27%)	19 (28%)	7 (26%)	59 (19%)
Unsure	1 (17%)	13 (14%)	4 (15%)	11 (22%)	6 (20%)	1 (9%)	10 (15%)	4 (5%)	50 (50%)
Yes	4 (67%)	59 (65%)	23 (85%)	31 (62%)	22 (73%)	7 (64%)	38 (57%)	16 (59%)	200 (65%)
Total	6 (100%)	91 (100%)	27 (100%)	50 (100%)	30 (100%)	11 (100%)	67 (100%)	27 (100%)	309 (100%)

Table 12 Cultural safety training included at orientation by where the service is situated (n, %)

	Metro.	National	Regional	Remote	Rural	Statewide	Total
No	28 (18%)	0 (0%)	1 (13%)	4 (19%)	23 (23%)	3 (20%)	59 (19%)
Unsure	30 (19%)	1 (33%)	3 (38%)	2 (10%)	10 (10%)	4 (27%)	50 (16%)
Yes	102 (64%)	2 (67%)	4 (50%)	15 (71%)	69 (68%)	8 (53%)	200 (65%)

Total	160 (100%)	3 (100%)	8 (100%)	21 (100%)	102 (100%)	15 (100%)	309 (100%)

Indicators of quality training

Two composite variables were calculated. The first focuses on the *topics* the training covered. The second on *how* the training was delivered.

The set of 14 variables from 261 responses that referred to the topics covered (listed in the methods section above) showed that only 29 (11%) of those respondents had included all 14 topics in their training. Most services had included at least 7 of the topics. (Figure 1)

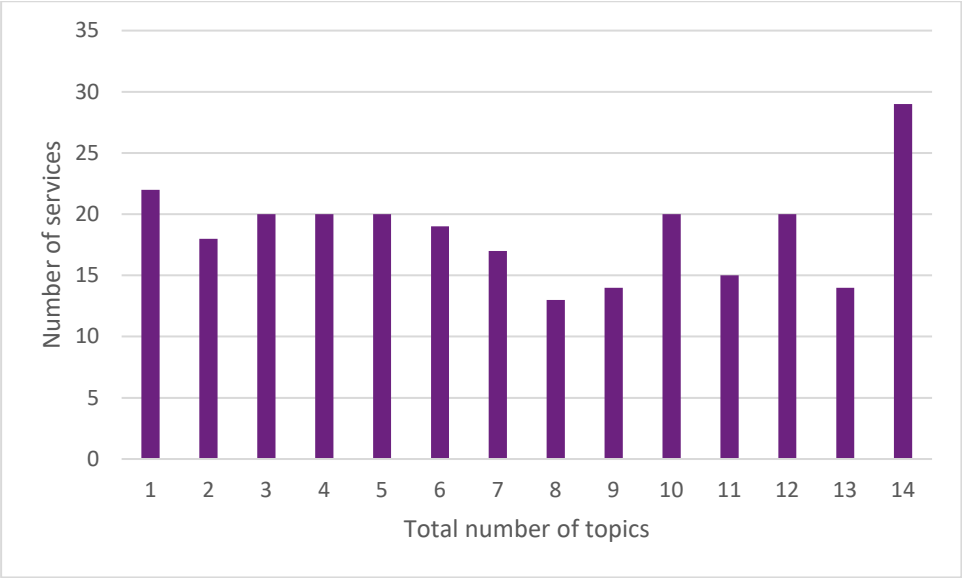

Figure 1 Total number of topics covered in the cultural safety training.

The set of eight questions recoded and combined to illustrate the extent of services offering cultural safety training that best fits current best practice indicators showed few services met all criteria. To meet all criteria, a service would have a score of 8. Only 4 services met that score. The median score was 3 which means that most services met at least three of the indicators. Note that where data were missing, services were allocated a “0” for that criteria. Excluding all services with a total “0” score raises the median score to 4 (mean 3.7). (Figure2)

Figure 2 Number of services meeting the maximum number of quality markers

What was the impact of the training? Was the training evaluated and did it affect practice?

The majority, 130 of the 274 respondents to the question "*Has this health service organisation evaluated the impact of cultural safety training?*" said they did not know if any evaluation had occurred and only 57 (21% of the 274 respondents) indicated that there had been an evaluation.

The word cloud shown in Figure 3 shows the most frequently used words (of five letters or more) that respondents used to describe the results of the cultural safety training. In word clouds, the most frequently used words are the largest in font size. From this image, we see that most frequently used words to describe the impact of the training were: cultural, Aboriginal, increased, understanding, awareness, information, knowledge. This is interesting to note, that words indicating changes in practice, consideration of regardful care were very infrequently used.

Figure 3 Word cloud showing frequency of words (of five letters or more) used in response to the question regarding the results of the cultural safety training evaluation.

Drilling through into more detail. Responses to the question about the outcome of the evaluation were coded across three main themes. The first theme was broad. This coded the type of impact respondents described as one of three areas of impact; the first was change in knowledge; the second change in collaboration and partnerships; the third, change in care delivery. The majority of responses (n=15) focused on changes in awareness or understanding. Respondents' comments included: "Staff empathy improved", "Evaluation based on awareness"; "there was limited understanding of the history of Aboriginal and Torres Strait Islander people" and "The greatest change was observed in self-reported understandings around history, power, and context of Aboriginal and Torres Strait Islander healthcare."

Examples of changes in partnership and collaboration included comments such as: "88% of respondents indicated they were likely to engage with … Aboriginal Health Service if they had any questions". Examples of changes in delivery of care included "69% indicated they applied learned knowledge and skills from the session into their professional practice" and "a shift in practice" and "Staff found it very useful and gave methods on appropriate ways to address Elders and their significance in the Aboriginal community."

Responses were then coded using two different frameworks. The first framework incorporated the six actions that relate to Aboriginal and Torres Strait Islander health in the National Safety and Quality Health Service (NSQHS) Standards; and the second were the five principles of cultural safety (decolonisation, dialogue, power, reflexivity and regardful care).

Under the NSQHS Standards, the most frequently described impacts related to partnerships, planning for comprehensive care and less frequently around governance, organisational leadership and safe environments.

The principles of cultural safety were less apparent in the data. Most frequent themes included some level of reflexivity, as well as dialogue followed by regardful care.

Additional strategies the service undertakes

Participants were asked a series of questions regarding key strategies they may or may not have incorporated into their service. Table 13 overpage presents a summary of responses by jurisdiction. The top three strategies that services have incorporated were: (i) Cultural safety incorporated into an individual's performance review processes; (ii) Recruitment of Aboriginal and Torres Strait Islander people and (iii) Members of the workforce reported the cultural safety training is of benefit.

Options to the first four questions in the table overpage included respondents ticking Yes, No or Not applicable. Of note, the majority of respondents in three of those four questions responded either, No or Not applicable. Those questions and the combined No and Not Applicable responses were:

- Measured any increase in cultural awareness in the workforce - 170 (68%) of 249 respondents indicated either No or N/A
- Received reports from Aboriginal and Torres Strait Islander community members on improved cultural safety in the organisation -180 (72%) of 250 respondents indicated either No or N/A
- Incorporated the findings from relevant adverse event and incident investigations into cultural safety training - 191 (76%) of 250 respondents indicated either No or N/A.

Moving forward

When asked to indicate the resources they would most like the Commission to provide, participants indicated the following in descending order:

- Measure for assessing the impact of cultural safety training – 204 participants
- Links to videos and podcasts – 187 participants
- Cultural safety training standards – 170 participants
- Resources on establishing cultural safety training in use by other organisations – 164 participants
- Information on available courses – 159 participants
- A sample course outline for health service organisations to follow – 155 participants
- Train-the trainer resources – 132 participants

Among the comments that 20 participants provided, additional resources included: resourcing (for NGOs); as well as additional support in increasing the frequency of training, strategies to engage with local communities, and strategies to assess patient outcomes. As one service suggested: "*Broader utilisation of the validated First Peoples Ganngaleh nga Yagaleh (GY) tool to allow for opportunities for improvement and comparisons along with looking at implementing a tool seeking Aboriginal and Torres Strait Islander peoples feedback patient / staff*".

Final comments

Of the 108 comments left by respondents at the end of the survey, responses covered the following areas:

Some respondents suggested the training should be commensurate with the proportion of Aboriginal and Torres Strait Islander patients. "*Although this should be a core aspect for every healthcare facility or organisation, applicability based on the number of patients identifying as Aboriginal and/or Torres Strait Islander should be considered when mandating the level of regulatory training (i.e. relevance based on < 1% admissions); apart from respecting cultural differences, we do not treat Indigenous patients any differently to any other race or minority i.e. the*

preoperative, admission, procedural and post op/discharge process remains the same for every patient."

However, the majority of comments were focused on the need for training, and the type of training:

- Recognition that more and regular training is warranted: "*This is such an important training which needs to be implemented into all hospitals public and private*." And "*A previous 2 day mandatory course was suddenly changed to 2 hours - how does this meet the objectives?*" There were also a few requests for the training to be standardised to avoid people having to source the training.
- Requests for additional guidance in care delivery and planning "*Would also be interested in culturally safe action plans or care models for relevant professional groups.*"
- Recognition of the importance of local context: "*Great that you are incorporating this into practice. Need to take into context that organisations need to connect to local tribes and cultures as a one size fits all approach does not work especially for rural and remote areas. Kalgoorlie has 8 different tribes here and each tribe has different requirements*".
- Suggestion of drivers for the training: "*The Cultural Respect Framework and recent changes to NSQHS standards have been significant drivers for increases uptake of the online learning module across the Department of Health*."

Table 13 Number of strategies health services identified as applying, by jurisdiction.

Strategies applied to health service	ACT	NSW	NT	QLD	SA	Tas.	Vic.	WA	Total
Measured any increase in cultural awareness in the workforce	2	28	6	11	11	4	13	4	79
Received reports from Aboriginal and Torres Strait Islander community members on improved cultural safety in the organisation	0	30	6	9	6	4	15	0	70
Have members of the workforce reported the cultural safety training is of benefit	5	53	14	26	14	3	33	7	155
Incorporated the findings from relevant adverse event and incident investigations into cultural safety training	3	26	5	6	6	3	8	2	59
Cultural safety incorporated into an individual's performance review processes	3	61	8	26	16	6	31	12	163
Cultural	4	11	2	4	7	0	5	2	35
Recruitment of Aboriginal and Torres Strait Islander people	4	61	19	23	15	2	27	11	162
Cultural coaching and mentoring	4	22	8	4	5	2	10	5	60
Sharing Aboriginal and Torres Strait Islander patient stories, with consent and to support cultural safety	3	34	7	14	9	3	14	7	91

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Section 3 Discussion

Summary of survey findings

To our knowledge, this survey is the first of its kind to attempt to take a snapshot of the type, extent and impact of cultural safety training in Australian health service organisations.

Survey generalisability

Caution is needed when interpreting these results. There are some critical 'unknowns'. The extent to which findings are representative and generalisable is unclear. The sampling strategy and recruitment approach are uncertain, consequently the number of people and organisations who received the invitation to participate in the survey is not known. Nor do we know the role/professional position of respondents. It is possible that people from different health professional roles for example, but from the same organisation, may describe the cultural safety training at their organisation very differently. We do not know *how* people responded to questions – were they responding from the personal knowledge and experience of the cultural safety training or did they collate responses and seek information for critical sources in the organisation? Finally, the survey tool itself has had limited construct validity and reliability testing. That said, in its development, members of the Advisory Group (and their member organisations) provided input and contributed to the development of the survey for face and content validation.

Key findings

Despite these limitations, there are several key findings and implications stemming from the survey. These include:

- Responses were received from 421 people answering on behalf of more than 20 different types of health service organisations across the country, resulting in a spread of voices from the private and public sectors, hospitals, community health services, peak bodies, and health departments.
- Almost all respondents (395 people which was 96%) stated they had access to some form of cultural safety training at their health service and 248 of 339 respondents (73%) said that the training was mandatory.
- There appear to be rises of when the cultural safety training was introduced associated with key drivers such as policy and standards changes. Rises were particularly noted around 2010 (post Closing the Gap in 2009) and again from 2017 (with the release of the current ASQHC Standards).

- The mode of delivery of training varied greatly with a bit more than a third having online training only and a third having a mixture of online and face-to-face training. This reliance may have been slightly influenced by the current climate of the COVID-19 pandemic that saw a strong reliance on online learning.
- There was a breadth of topics covered by the cultural safety training. All the listed topics were covered by some, while not all, training.
- A little over half (53%) of the training was reported to be delivered, at least in part, by an Aboriginal or Torres Strait Islander person.
- There was great variability in the length of the training, the number of sessions over which the training was conducted and the source of the training. Only 60 respondents indicated the training was sourced from an Aboriginal and Torres Strait Islander training provider.
- Critically, evaluations and knowledge of results of the evaluations of the training varied with only 57 (21%) of the 274 respondents to those questions indicating that an evaluation had been conducted.
- Evidence of cultural safety training impact is limited and not systematically monitored. If we think of cultural safety training as further 'down the path' from cultural awareness, cultural sensitivity and cultural competency trainings – it appears the focus of much of the current training and consequently its impact is still focused more on knowledge, attitudes and understanding generation rather than how to ensure health services provide patient-centred, culturally safe healthcare. Multiple studies exist in public health areas that show one-off training, training not supported by other factors (such as policy, opportunities for practice, environment for individual and organisational reflection) have limited capacity to lead to behavioural and practice change. While much of the training and the reported evaluations appeared to focus on knowledge and understanding, given the historical context in which our health system and health professionals are working, there is still a significant need to ensure knowledge gaps are addressed. This should not, however, be at the expense of all other elements critical to ensuring Aboriginal and Torres Strait Islander patients experience culturally safe healthcare.
- Finally, services are asking for assistance in how to enact the information learnt during the cultural safety training.

Recommendations for consideration

The following recommendations were developed by identifying first the current 'state of play' as described by the survey findings and then returning to the literature (drawn from the findings in Section 1) to identify the key elements to be considered as best practice in cultural safety training.

The second section of the recommendations relate to the more pragmatic elements when considering future survey development.

Implications for cultural safety training

Content

General topics that are included in training for the entire workforce should include but not be limited to:

- Aboriginal and Torres Strait Islander culture, knowledges, histories, peoples, lore and language and the diversity of Aboriginal and Torres Strait Islander peoples
- Tailoring of that information to reflect local knowledges, histories and impacts
- Recognition of the importance of self-determined decision-making in healthcare
- The role of taking a strengths-based approach in healthcare delivery
- Colonisation and the ongoing impact of colonisation
- Issues of trust and the impact of history, policies, practices and biases on erosion of trust
- Intergeneration trauma – what it is and the impact that can have on an individual's health and wellbeing
- Reflective practice – what it is, including reflection on one's own culture, privilege, power, and biases and how that is reflected in and influences healthcare delivery
- Understanding and recognising racism – including interpersonal, institutional and systemic racism
- Valuing the right to be different – in worldviews, knowledges, values and beliefs
- Definitions of cultural awareness, cultural competency, cultural safety, including their points of difference

As the organisations cultural safety systems grow, the clinical workforce should undertake training on topics that relate specifically to *care delivery at the individual level* including but not limited to:

- Transfer of power to the patient and their family, including how that occurs and the potential impact of action versus inaction
- Impact on power imbalances in care delivery, communication and consent
- How to communicate effectively and appropriately, for example through therapeutic yarning
- Provision of safe pathways to air concerns without any fear of recrimination or negative impact on either care delivery or relationships with staff
- Consideration of patients' own needs and advice on how to tailor care and communication to meet patients' social, cultural and linguistic needs

- Recognition, acknowledgement and incorporation of health knowledges and traditional healers such as Ngangkari into care planning

Clinical and other leaders in an organisation should participate in training that includes, but is not limited to:

- Understanding of the dominant culture's social, cultural beliefs, and knowledge influence on internal policies and practices and the potential health impacts for people who are not from the dominant culture
- The importance of leadership in determining the environment in service delivery
- Establishment of processes to ensure transfer of power to the patient
- How to incorporate elements of, or operationalise, culturally safe practice into care plans and unit/ward/hospital/service policies
- Instruction on how to promote and support patient centred care that enables service delivery to meet cultural needs
- Development of patient outcomes relevant to the patient
- Establishment, building and maintaining ongoing relationships with the local Aboriginal Community Controlled Organisations and Health Services
- How to best support and recognise the expertise of Aboriginal and Torres Strait Islander staff
- Approaches to ensure a welcoming environment and a safe space to congregate
- Development of governance structures that include Aboriginal and Torres Strait Islander people in leadership, an Aboriginal and Torres Strait Islander Reference Committee or Advisory Group that report directly to the executive and development of culturally appropriate measures of patient outcomes and experiences.

Organisations with established cultural safety systems would incorporate into their training topics including but not limited to:

- Processes to systematically implement culturally safe practice across multiple health service settings
- How to develop systematic approaches to monitor and evaluate cultural safety training
- How to measure, track and report patient concerns, patient outcomes and patient experiences appropriately and as determined by patients and their families and community
- How to develop effective partnerships with peak Aboriginal Community Controlled Health Services.

Delivery of the training

Cultural safety training needs to consider its intended audience and should be delivered over multiple approaches including:

- Incorporation of Aboriginal and Torres Strait Islander leadership and development by and with Aboriginal and Torres Strait Islander people
- Delivered by Aboriginal and Torres Strait Islander people
- Guidance and input from the local Aboriginal and Torres Strait Islander communities
- Incorporation of the lived experience, including such components as patient journey mapping and yarning
- Provision of practical tools and skills to develop competencies that align with roles and responsibilities

Format of program delivery

Cultural safety training should NOT be a 'one-off' event; it should build over time and should include:

- Multiple, varied approaches to program delivery drawing on multi-media resources (online, in person, paper based, practical application)
- Training should be tailored to individual's learning styles and experience
- Should include a whole of system approach – so that all personnel are involved in the training over sustained periods of time
- Is delivered in an environment that creates a safe place to share knowledges, experiences, values and beliefs
- Be integrated with other human resources processes, including training requirements in the roles and responsibilities of the workforce, training requirements actively considered at performance review, require individuals to develop their own action plan for the improving Aboriginal and Torres Strait Islander health
- Evaluation mechanism beyond routine participant feedback such as indicators which allow the Aboriginal and Torres Strait Islander people to report on their experience as a key measure of training effectiveness and to guide improvements to training. Alternatively, an independent Aboriginal and Torres Strait Islander organisation may be utilised to conduct an evaluation of the training program and its effectiveness.

Future survey development

The following recommendations relate to the development of future surveys to assess, monitor or track cultural safety training across multiple healthcare settings.

- The next iteration of the survey should undergo psychometric assessment including construct validity and reliability testing prior to release.
- Survey items (questions) and scales should be consistent. For example, responses offered should reflect directly to the item; this nuanced difference of meaning is seen in item 4 which asks about “availability”, yet responses refer to “accessibility”. Similarly item 3 asks where the service is situated and may lead some participants to interpret that as physical location while others may interpret that as a question about scope of care delivery.
- Inclusion of definitions associated with items and scales to ensure consistency of interpretation – for example item 3 could include definitions regarding the response options. Consider alternate options such as Metropolitan, Inner regional, Outer regional, Remote, Very remote.
- Setting limits linked to responses so key items, where appropriate, can only be answered with a numeric or scale response, for example in item 5.
- Consideration be given regarding who the respondents should be (administrators, health care providers) and develop a sampling and recruitment strategy, or that items are introduced to capture this data.
- Future questions could ask about governance processes, including cultural governance, care delivery and working in partnership with local Aboriginal communities.
- Questions regarding outcomes of program evaluation could incorporate both open-ended and closed-ended responses.

Opportunities for targeting future cultural safety training

The following list present a summary of implications relevant to the broader findings from the analyses of the survey:

- The possible link associated with increases in cultural safety training programs being offered and key policy or standards requirements present opportunities to leverage the current Standards further to ensure that the training addresses concepts around cultural safety and provision of culturally safe care.
- Consider development of cultural safety training standards (according to evidence and recommendation by peak bodies and representatives of Aboriginal Community Controlled Health Organisations) so training providers adhere to them and health service organisation can use them as reference when choosing a training provider. These could include aspects such as the topics training should cover (emphasis in components of cultural safety) and community leadership and participation.

- Services are requesting support in adopting stronger approaches in care delivery, organisational policy, and engagement with local services – there is an opportunity to develop resources, embedded in principles of cultural safety, to meet this need.
- Support health service organisations to engage with local community leaders and representatives to develop strategies to increase the degree to which the organisation and service provision adheres to cultural safety standards.
- Develop or recommend the use of existing validated evaluation tools to assist practices in assessing the degree to which the organisation adheres to cultural safety standards and is reflective of the needs of the community for which the health service serves.
- Develop resources and other approaches (policy templates, models of care) that reflect principles of cultural safety.

Final summation

The development, provision and evaluation of cultural safety training is relatively new and emerging work in healthcare. At its essence, cultural safety training and the provision of culturally safe care, attempt to decolonise care delivery and focuses care so that it is patient-centred. The national survey conducted in mid-2021 on cultural safety training in healthcare settings found that the trainings are diverse, focussed primarily on knowledge and rarely were they reported to have been done in any way (through content, process and mode of delivery) that reflected what is currently known about best practice in cultural safety training. Recommendations from the survey findings are presented that draw on the current literature on cultural safety training, what it is, what it should be, and how it should be developed and delivered.

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Appendices

Cultural safety training survey

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Survey on cultural safety training by health service organisations

Cultural safety leads to improved care and outcomes for Aboriginal and Torres Strait Islander patients. The level of cultural safety comes from the delivery of training and ongoing self-reflection by all staff in the health care system.

The Australian Commission on Safety and Quality in Health Care (the Commission) is committed to ongoing and evolving culturally safe practices, which are developed in consultation with, and determined by, Aboriginal and Torres Strait Islander communities.

To this end, the Commission is keen to understand the type and extent of training in cultural safety being undertaken by health service organisations.

Action 1.21 states 'The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients'.

Workforce training has been identified by Aboriginal and Torres Strait Islander communities as an effective, safe and positive strategy. Evidence supports this approach.

You are invited to complete this short survey on cultural safety training in your health service organisation. It should take you no more than 10 minutes to complete. The information will be used to understand current practice and to develop resources to support future training by health service organisations.

Deidentified survey results will be collated and published on the Commission's website.

Sea urchin design: Ms Tanya Taylor is a Worimi artist (mid-north coast of New South Wales) who is drawn to the underwater world through a deep connection with her saltwater heritage. Tanya's design is inspired by the patterns found in the sea urchins, corals and sea creatures found in the ocean.

The Commission uses the following definition of cultural safety:

Identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes. Cultural safety is not defined by the health professional, but is defined by the health consumer's experience—the individual's experience of care they are given, ability to access services and to raise concerns. The essential features of cultural safety are:

a) An understanding of one's culture

b) An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s)

c) It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point

d) An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past

e) Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.[1]

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[1]National Aboriginal and Torres Strait Islander Health Standing Committee of the Australian Health Ministers' Advisory Council (2016). Cultural respect framework 2016-2026 for Aboriginal and Torres Strait Islander health. Canberra, AHMAC.

* 1. What category of health service organisation are you responding for?

- O Public hospital
- O Private hospital
- O Day procedure service
- O Public dental service
- O Community health service
- O Mental health service
- O Ambulance or transport service
- O Prisons health
- O Alcohol and Other Drug Services
- O Aboriginal Community Controlled Health Service
- O Aboriginal Medical Service
- O Other (please specify)

* 2. In which state or territory is this health service organisation located?

- O Australian Capital Territory
- O New South Wales
- O Northern Territory
- O South Australia
- O Tasmania
- O Queensland
- O Victoria
- O Western Australia

* 3. Where is this health service organisation situated?

- O Metropolitan
- O Rural
- O Remote
- O Other (please specify)

* 4. Is cultural safety training available in this health service organisation?

O Easily Accessible

O Accessible

O Some what Accessible

O Not Accessible (selecting this will take you to the optional contact details page and then to the end of the survey)

* 5. When was cultural safety training introduced in this health service organisation?

* 6. Is cultural safety training **mandatory** in this health service organisation?

O Yes

O No

O Not sure

* 7. Is cultural safety training required as a one off or a repeated event?

O One off

O Repeated

* 8. Which members of the workforce are required to participate in cultural safety training? (select all options that are applicable)

☐ All members of the workforce

☐ Nurses

☐ Doctors

☐ Allied health

☐ Managers

☐ Non-clinical workforce

☐ Volunteers

☐ Members of the workforce who identify as Aboriginal and/or Torres Strait Islander

☐ Other (please specify)

* 9. Is cultural safety training included in the orientation process for new members of the workforce?

- O Yes
- O No
- O Unsure

* 10. How is the cultural safety training primarily delivered in this health service organisation?

- O Online (self-paced)
- O Face to face
- O Combination of online and face to face
- O E-learning (instructor led)
- O Other (please specify)

* 11. Has the training been primarily developed or designed with/by the local Aboriginal or Torres Strait Islander community?

- O Yes
- O No
- O Don't Know

12. Who leads/facilitates the delivery of the training?

- O Aboriginal and/or Torres Strait Islander person/people
- O Neither Aboriginal and/or Torres Strait Islander person/people
- O A combination - Aboriginal and/or Torres Strait Islander person/people with non Indigenous people
- O Not applicable as not led/facilitated by an instructor
- O Don't know

* 13. Who is the primary target audience for the cultural safety training? (select all that are appropriate)

- ☐ All members of the workforce
- ☐ Clinical workforce
- ☐ Management
- ☐ Executive
- ☐ Non-clinical workforce
- ☐ Governing body
- ☐ Other (please specify)

* 14. How long does the cultural safety training generally take to complete? (in hours)

* 15. Over how many sessions is the cultural safety training delivered?

* 16. How often is the cultural safety training conducted?

- ○ More than once a year
- ○ Every year
- ○ Every two to three years
- ○ Every four or more years
- ○ Other (please

* 17. Are there culturally specific safety training modules for different health professions?

- ○ Yes
- ○ No
- ○ Don't know

* 18. Where does this health service organisation source its cultural safety training?

- ☐ Accessed from the internet
- ☐ Accessed from a commercial training provider
- ☐ Accessed from a Non Government Organisation training provider
- ☐ Accessed from an Aboriginal and Torres Strait Islander training provider
- ☐ Provided by state or territory health department or government body
- ☐ Locally produced
- ☐ Don’t know
- ☐ Other (please specify)

19. Please add contact details or internet address of the provider delivering cultural safety training in this health service organisation

* 20. What are the key topics covered in the cultural safety training? (select all that apply)

☐ Aboriginal and Torres Strait Islander history, peoples, cultures

☐ Cultural safety definition

☐ Contemporary context of Aboriginal and Torres Strait Islander peoples

☐ Racism (systemic, institutional and individual)

☐ Impact of historical government policies, intergenerational impact and trauma

☐ Interpreting and reflecting on unconscious bias

☐ Collaboration and partnerships with Aboriginal and Torres Strait Islander people

☐ Local, state, territory and national policies that are applicable to Aboriginal and Torres Strait Islander people

☐ Resilience and strength of Aboriginal and Torres Strait Islander communities

☐ The application of knowledge of Aboriginal and Torres Strait Islander culture to the assessment of the physical, emotional and social factors that contribute to creating a welcoming environment

☐ Processes to accurately identify and record if patients are of Aboriginal and/or Torres Strait Islander origin

☐ The importance of an Aboriginal and Torres Strait Islander health workforce

☐ The role of Aboriginal and Torres Strait Islander Health Liaison practitioners

☐ Possible outcomes (e.g discharge against medical advice) if cultural safety is not applied

☐ Other (please specify)

* 21. Has this health service organisation evaluated the impact of cultural safety training?

○ Yes

○ No

○ Don't know

* 22. What did the evaluation of the cultural safety training show?

* 23. Has this health service organisation:

Area	Yes	No	Not applicable
Measured any increase in cultural awareness in the workforce	○	○	○
Received reports from Aboriginal and Torres Strait Islander community members on improved cultural safety in the organisation	○	○	○
Have members of the workforce reported the cultural safety training is of benefit	○	○	○
Incorporated the findings from relevant adverse event and incident investigations into cultural safety training	○	○	○

* 24. What other cultural safety strategies does this health service organisation have in place? (Select as many as apply)

☐ Partnering with local Aboriginal and Torres Strait Islander communities to develop local strategies

☐ Cultural safety incorporated into an individuals performance review processes

☐ Recruitment of Aboriginal and Torres Strait Islander people

☐ Cultural coaching and mentoring

☐ Sharing Aboriginal and Torres Strait Islander patient stories, with consent and to support cultural safety

☐ Other (please specify)

* 25. If the Commission produced additional resources or supports related to cultural safety training, which of the following would be most useful? (select all that apply)

- ☐ Cultural safety training standards
- ☐ A sample course outline for health service organisations to follow
- ☐ Information on available courses
- ☐ Train-the trainer resources
- ☐ Links to videos and podcasts
- ☐ Resources on establishing cultural safety training in use by other organisations
- ☐ Measure for assessing the impact of cultural safety training
- ☐ Other (please specify)

26. Please provide any general comment you have relating to cultural safety training.

Contact details

You are invited to provide your contact details* should the Commission need to follow up regarding your feedback, however providing your contact details is optional.

27. Name

28. Health service organisation

29. Email Address

30. Phone Number

*Privacy Statement

The Australian Commission on Safety and Quality in Health Care (the Commission) collects personal information when the information is necessary for, or directly related to, the Commission's functions or activities. The personal information is required in order for the Commission to contact you to seek clarification on the feedback you provided in your survey.

All personal information is held securely. The Commission treats all personal information in accordance with the Australian Privacy Principles under the Privacy Act 1988 (the Act) and the Commission's Privacy Policy. The Commission does not disclose personal information to other organisations unless it is required to do so under the Australian law or tribunal/court order. The Commission's Privacy Policy is available from the Commission's website at www.safetyandquality.gov.au.

Thank you for your response

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