Nursing Inquiry

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ORIGINAL ARTICLE

Cultural Safety: A First Nations Perspective

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ABSTRACT

Curriculum designed to promote the cultural safety of health professionals is now expected in Australia. There is, however, limited research demonstrating the relationship between this curriculum content and the ability to work in a culturally safe manner. Eleven advisory group members were recruited from various First Nations groups in Australia. Through participation in Yarns, members were invited to describe their experiences of cultural safety in healthcare and their desires regarding the education of healthcare students. Yarns were digitally audio-recorded and analysed using reflexive thematic analysis. For First Nations Peoples, cultural safety is a multifaceted, lifelong journey, marked by continuous growth and relational learning. The experience of cultural safety is unique to each person receiving care. Authentic relationships and respect for cultural protocols and responsibilities are essential. Forming genuine connections with local First Nations Communities and sustaining authentic relationships through empathy, respect and deep listening is fundamental. Structural barriers to addressing cultural safety were identified, including: constraints on the time and resources of health professionals; the enduring impact of colonial policies; the role of tertiary institutions in marginalising Indigenous knowledges and voices, and the fact that opportunities for creating respectful and direct engagement with First Nations Communities remain limited in tertiary education programmes.

1 | Introduction

The disparities in outcomes for First Nations Peoples compared to non-First Nations Peoples are evident across every social, health and well-being indicator (Commonwealth of Australia 2014; Ryder et al. 2019). Efforts to address these inequities include providing cultural education to enhance the skills of healthcare professionals and students, aiming to improve the delivery of culturally safe healthcare services to First Nations Peoples (Australian Health Practitioner Regulation Agency 2022; Commonwealth of Australia 2014; Withall et al. 2021). Strengthening cultural safety within healthcare settings for First Nations Peoples is essential for enhancing both access to services and the quality of care delivered (Australian Institute of Health and Welfare 2022). In Australia, cultural safety is now legislated within the code of conduct for registered health professionals, requiring that care be delivered in a manner that is culturally safe and free from racism (Australian Health Practitioner Regulation Agency 2022; Australian Health Practitioner Regulation Agency and National Boards 2022). Despite these actions, First Nations Peoples continue to report feeling unsafe whilst receiving healthcare services, including having individual needs dismissed

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(Australian Institute of Health and Welfare 2022; Gilroy et al. 2024; McGough et al. 2018; Nolan-Isles et al. 2021; Pinero de Plaza et al. 2023).

University health professional programmes within Australia now include information on First Nations health and cultural safety in their curriculum (Coombe et al. 2019; Deravin et al. 2018; Mills et al. 2018; West et al. 2019; Zimmerman et al. 2019), consistent with professional accreditation requirements (Nursing and Midwifery Board of Australia 2016; Occupational Therapy Board of Australia 2018). A recent scoping review by Tillott et al. (2025) identified that whilst there is some consistency in the curriculum content, there is limited research regarding how understanding of, and the practice of cultural safety, can be effectively assessed, and whether curriculum innovations are influencing the professional practice of health graduates and, crucially, the health of First Nations People.

Developing a curriculum that incorporates culturally safe practice is more complex than simply delivering content and requires careful planning and collaboration with First Nations Peoples, along with an understanding of the diversity of Indigenous culture (Zubrzycki et al. 2014). The importance of incorporating Indigenous knowledges and pedagogical approaches, including storytelling and privileging First Nations voices, was discussed in many of the studies identified in the scoping review by Tillott et al. (2025). Understanding the lived experience of First Nations Peoples' perspectives on cultural safety and how this could be taught and evaluated is critical to effective curriculum development and the promotion of culturally safe practices of health professionals (Bennett et al. 2018; Flavell et al. 2013; Forsyth et al. 2019a, 2019b; Hall et al. 2023; Kurtz et al. 2018; Paul et al. 2006; West et al. 2018).

This paper discusses the consultation process and insights gained from a First Nations Advisory Group (AG) on the topic of cultural safety within healthcare. This includes sharing of lived experiences and understanding of culturally safe care from First Nations Peoples' perspectives. This information will be used to inform curriculum development and pedagogy in the health professional programmes offered at an Australian regional university.

1.1 | Terminology

The term 'First Nations' refers specifically to Aboriginal and Torres Strait Islander Peoples and groups within Australia. This is at the request of the AG members, who collectively requested to be acknowledged as First Nations Peoples.

When referring specifically to First Nations Peoples or Communities, capitalisation (P or C) is used. When referring to people or community in general, lowercase (p or c) is used.

1.2 | Aims and Objectives

The AG was formed to gain a deeper understanding of First Nations Peoples' experiences of healthcare and perspectives of cultural safety. Regular consultations with the AG, in the form of Yarns, were held over a 3-year period, with the AG providing input in addressing the following research questions:

- What are First Nations Peoples' experiences and understanding of cultural safety?
- How could these perspectives inform the professional education of health students?

1.3 | Research Methodology

This study employed Yarning as its research methodology. Yarning is a relational methodology grounded in Indigenous epistemologies that facilitates culturally safe engagement, based on traditional practices and principles (Wain et al. 2016). Yarning prioritises the agency of participants, allowing individuals to influence and direct the trajectory of the Yarn (Barlo et al. 2020).

2 | Methods

2.1 | Recruitment of Advisory Group Members

People from First Nations Communities were invited to participate in a series of Yarns on cultural safety. Initial invitations were extended to members of First Nations Communities, Elders, university staff and other interested individuals, who were then encouraged to share the opportunity with others in their networks. All members of the AG were known to one or more members of the research team, which assisted with the relational aspects, including establishing trust, promoting group facilitation and information sharing.

2.1.1 | Characteristics of Advisory Group

The AG consisted of 11 members, including those who were from the following Nations: Bangerang, Bundjalung, Gamilaroi, Gumbaynggirr, Pitjantjatjara, Malyangapa and Yuin.

The AG members reported being employed in various fields, including a project officer, director of an Aboriginal Corporation, researcher, PhD student, academic, manager of Aboriginal Community Controlled Health Organisation (ACCHO), student support officer, team leader of ACCHO and Community health worker.

2.1.2 | Yarning as a Research Method

Yarning is a culturally safe research method that is supportive of Indigenous culture and practices, allowing First Nations Peoples to share their story, whilst simultaneously addressing some of the power imbalances between researchers and group members (Bessarab and Ng'andu 2010; Kennedy et al. 2022). Yarning has advantages as a research tool because it allows for relaxed, open, in-depth discussions that provide rich data and descriptions on a specific topic (Bessarab and Ng'andu 2010),

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with participants given the opportunity to share their story in a safe, non-judgemental setting, focusing on strengths rather than deficits (Barlo et al. 2020). Yarning was used as a key data collection strategy with the AG, with members sharing their stories of cultural safety and healthcare over time.

2.2 | Data Collection

Data were collected from the AG through either group or individual Yarns, according to their preference. Data were collected between December 2021 and May 2024, with member checking occurring in April 2025. The lead researcher (V.T.) coordinated each of the Yarns, with topics for members to share their stories and experiences. Each of the Yarns was audio-recorded and transcribed verbatim.

2.3 | Data Analysis

Data obtained from the Yarns were analysed using Braun and Clarke's (2022) reflexive thematic analysis (RTA). RTA is particularly suitable due to its flexibility, reflexivity and alignment with decolonising methodologies. It allows researchers to honour Indigenous ways of knowing and being, emphasising storytelling and relationality, while placing members' lived experiences at the foreground (Braun and Clarke 2006, 2021; S. Wilson 2008).

Recognising that researchers are active, interpretive creators of themes, it was essential to involve multiple members of the research team and the research participants in the development of the analysis. This ensured the widest possible subjective interpretation and that the theoretical assumptions and analytical skills of the team were continually challenged at each stage of the fluid, organic coding and theme generation process. Additionally, the researchers' biases about the meaning of the data were thoroughly explored (Braun and Clarke 2021).

During the familiarisation phase, the researcher engaged with the AG, exploring their stories and listening to the recordings multiple times before actively engaging with the analysis, notes and reflections. The data obtained from the AG were peer reviewed by two other team members (T.S. and M.D.), who were both involved in the AG yarns, adding greater insight and depth of understanding to the findings. During the coding process, three separate team members, V.T., T.S. and M.D., independently completed the coding task. Discussion about perspectives, interpretation and meaning enabled further insight and deeper understanding. Team members engaged in ongoing reflection over an extended period of time as analysis proceeded from the first yarning meeting. Using an iterative process of going back and forth between the codes, patterns emerged and were further explored in collaborative and reflexive discussions between V.T., T.S. and M.D. Theme names were developed using quotes from data transcripts to maintain a close connection with the data itself. Further review and reflexive discussions about meaning-making were provided by S.B. and B.M.-S., prior to member checking. Digital recordings were reviewed throughout to ensure the accuracy of the transcript data used to substantiate themes and to verify that the context and meaning aligned with the identified themes.

Member checking involved the thematic analysis being closely reviewed by research participants to enhance the credibility, validity and trustworthiness of findings. Participants reviewed, questioned, elaborated and validated the researchers' interpretations and conclusions. This essential step ensured that the analysis of the data adequately represented and encapsulated both their experience and the understanding of their experience.

2.4 | Ethical Considerations

Two members of the research team are First Nations Peoples, who were involved throughout the analysis process. The input from these team members, along with ongoing consultation with the AG, ensured that cultural protocols were followed and that the project was conducted in a culturally sensitive manner. AG members were given a Participant Information Sheet, with each person providing consent to be involved in the project. Potential risks were identified that might occur as a result of participating in this project (National Health and Medical Research Council 2018; National Health and Medical Research Council, Australian Research Council, & Universities Australia 2007 [updated 2018]). Human Research Ethics Committee (HREC) approval was received prior to commencement (ECN 2021/106).

3 | Findings

These findings describe cultural safety from the understanding and lived experience of First Nations Peoples. These insights reflect the diversity of the AG members and highlight the complexity and multifaceted nature of cultural safety. The themes are discussed below, accompanied by substantiating quotes from individual AG members.

3.1 | Awareness and Education

Effective education and training, particularly within healthcare and academic settings, that equips individuals with the knowledge and skills necessary for cross-cultural communication and service delivery, is essential. Healthcare providers need to recognise and effectively address the health disparities between First Nations Peoples and non-Indigenous Australians (L. Wilson et al. 2022) to provide an effective service.

Simple activities such as cultural awareness programmes run by First Nations Peoples can be an effective starting point, with 'cultural awareness programs planting a little seed into people's minds' (Possum), but are not enough. Education should start early, 'it has to start in primary school' (Tarunna), and be authentic. Students should have the opportunity to 'experience Aboriginal Community before they commence working with Community members' (Aboriginal Community Member). This may include 'participating in local events, doing volunteer

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work, and just getting to know the Aboriginal Community' (Aboriginal Community Member), and this learning should continue indefinitely, 'it's a lifelong journey' (Possum).

Although many tertiary institutions now include content on First Nations Peoples and health (Coombe et al. 2019; Mills et al. 2018; West et al. 2019; Zimmerman et al. 2019), a knowledge gap in education is identified, noting that 'students haven't had exposure to what cultural safety means' (Sista G). It is essential for students to 'experience working with our Communities…it would be strange if you have done the whole degree, and came out and experienced that for the first time' (Dylan).

3.2 | First Nations Identity

Differences in cultural practices, beliefs and priorities can lead to misunderstandings or undermining of one's cultural identity. Understanding each person's unique cultural, Community and spiritual identity is essential for cultural safety. People should be recognised beyond cultural stereotypes or preconceptions, be valued and treated with the same level of respect and sensitivity as anyone else might expect when engaging with the healthcare sector (Hole et al. 2015).

For First Nations Peoples, being able to embrace one's culture fully and authentically, regardless of the environment they are in, is seen as a part of culturally safe practice. Cultural safety is identified as 'where I can spiritually and culturally practice and be who I am, and where I am not questioned for who I am or what I am doing' (Tarunna). Engagement with bush medicine, spirituality, the Dreaming and other aspects of culture is integral to First Nations identity, and has been shown to have a link to improvements in health outcomes (Bourke et al. 2018; Parter et al. 2023). These practices, however, do not always align with the values and practices of the modern healthcare system (Momot 2024; Reese et al. 2024).

There is a strong emphasis on collective ways of living and mutual care in First Nations Communities, where the well-being of an individual is intertwined with that of the family and Community. This Community-based approach to living should inform the provision of culturally appropriate care and spaces. A healthcare professional who respects First Nations culture and the Community context creates a more personalised and welcoming care experience, making healthcare less transactional and more relational.

Respect for one's identity includes 'not feeling like I'm looked at any differently' and to be 'treated like everyone else' (Jewel), without being subject to intimidating attention. While healthcare services should value and respect the unique cultural practices and values of First Nations Peoples, the overall quality and standard of these services and associated health outcomes should be the same for everyone.

Having a positive healthcare experience is seen as an exception to the norm for many First Nations Peoples, with one member stating, 'I must have had a charmed life…I haven't had any problems as such…to look at me, you wouldn't know that I was Aboriginal'. This is further illustrated by a personal experience whereby 'my mother [a First Nations person] lived to 94 and dad [a non-Indigenous person] died at 51', acknowledging that 'this was very unusual for an Aboriginal person to live that long' (Possum).

Being part of a well-known First Nations family in a rural Community can be seen as a barrier to receiving quality care, with the desire 'to not feel like I'm looked at any differently, just because I've got [that] last name' (Jewel). These sentiments highlight the importance of not making assumptions about People's experiences of the complex factors influencing health outcomes and reflect an ongoing struggle with external judgements, suggesting that cultural safety begins with fundamental respect. They also underscore the burden of internalised expectations that First Nations People carry into spaces where they should feel respected and secure.

3.3 | Community Connections and Engagement

Forming genuine connections with the local Community is fundamental for culturally safe practice, 'you have to get that cultural connection first with whatever Country you're working on to be culturally safe' (Sista G). Simple activities such as connecting through local events, including National Aboriginal and Islanders Day Observance Committee (NAIDOC) celebrations or football games, are effective ways to develop mutual respect and understanding, helping solidify relationships.

Building trust requires long-term engagement and consistent presence within the Community. Gaining trust and acceptance within a First Nations Community is described as challenging but meaningful, reflecting the importance of respect, understanding and commitment. 'Achieving such trust…is not granted lightly but earned through genuine and consistent engagement' (Possum). This effort demonstrates the healthcare practitioner's genuine commitment to the Community beyond their professional obligations, acknowledging that healthcare practitioners 'need to stay connected to people in the Aboriginal Community, because those people will probably rely on them and might need help from them, but they'll only reach out if they know that they [healthcare practitioner] are committed. It's just knowing that we can trust them' (Julie).

Understanding cultural protocols and responsibilities, including Kinship networks and local Community practices, is are important consideration for healthcare providers (Parter et al. 2023). Knowledge gained through connections within one Community often becomes a foundation for engaging with other communities, as personal and cultural networks, customs and values may be shared, even though each Community is unique (Balnaves and Hopkins 2025). This is illustrated by one of the AG members revealing that 'one of the reasons that a First Nations person will introduce themselves by their family name, Country and Kinship, is because these connections are for building relationships, starting to identify who you are and where you are from, and to show people where we fit in in the scheme of things; and that helps us in building relationships' (Dylan).

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Choosing a healthcare provider goes beyond formal qualifications, further emphasising the significance of trustworthiness, reputation and Community endorsement. Providers who have been 'vouched for' by respected Community members are seen as safer choices, adding an element of cultural validation that fosters a deeper sense of security and trust. 'I won't go to a doctor unless somebody else I know has vouched for them' (Sista G) highlights the power of Community reputation in healthcare selection. The Community's collective voice can significantly influence an individual's actions.

The concept of factionalism within First Nations Communities reflects the nuanced and multifaceted relationships among Community members. Specifically, this relates to interpersonal disagreements, which Community members prefer to handle internally, without outside interference, including 'leave the factionalism to the Aboriginal Community and stay focused on what your role is' (Aboriginal Community Member). This highlights the importance of respecting cultural protocols and responsibilities, including the unique ways members navigate relationships and disagreements.

3.4 | Building and Sustaining Relationships

Cultural safety is relational. It is not only about forming connections but also about sustaining these relationships in the long term. Mutual respect and understanding are prerequisites (Arnold-Ujvari et al. 2024), 'it's about relationships…and understanding' (Sista G). Emphasis is placed on the importance of 'empathy' and 'genuineness' (Possum), 'not assuming stuff' and focusing instead on 'active listening' (Julie), 'respect' and 'listening deeply', including 'listening to what Aboriginal patients are saying, not worrying if they bring a support person to the appointment, because they want to feel safe in a mainstream service' (Aboriginal Community Member).

Healthcare professionals who are relatable, approachable, open and willing to share aspects of themselves allow for a connection that transcends traditional patient–practitioner roles. This helps break down perceived barriers and creates a more personal, trust-enhancing environment. Practitioners who are 'vulnerable and relatable' are more effective and 'allow us to build a relationship…[by] telling us who they are' (Stuart). It is 'difficult to build connections if you have a wall up' (Dylan). These statements reflect a desire for authentic, human-centred engagement in healthcare that moves beyond transactional interactions, allowing patients to feel that they are engaging with a real person.

Positive healthcare experiences are linked to meaningful and sustained relationships with healthcare practitioners 'I know that because of the relationship I have with her [a non-Indigenous practitioner], she would not put me in that [unsafe] situation' (Julie). This further highlights the importance of health professionals establishing genuine interpersonal connections to be effective. Health professionals who 'make a commitment to stay and build a relationship' (Stuart) are highly regarded, as continuity and rapport significantly enhance comfort and trust, and minimise the need for patients to repeatedly share often traumatic information and history. An ideal world would involve having 'the same healthcare practitioner from birth throughout your whole life' (Stuart). These ongoing relationships are essential in creating a culturally safe experience.

3.5 | A Safe Space

A safe space extends beyond physical safety to embody emotional, social, cultural and spiritual safety, fostering a sense of belonging and acceptance (Hole et al. 2015). This includes spaces where people have the freedom to live authentically without being pressured to conform to Western norms or suppress one's cultural identities. There are various experiences of culturally unsafe practices, 'it was the questions that were being asked, the assumptions made' (Aboriginal Community Member), 'who is asking the questions and how. It's painful at times' (Tarunna).

Feeling safe within a healthcare setting can arise from familiarity, welcoming behaviour and a non-judgemental approach from practitioners and service providers. When patients feel they can be themselves, without fear of judgement or needing to alter their behaviour, they feel more at ease. Having a healthcare provider who is 'really welcoming and friendly and accepting' (Possum) allows people to relax and feel valued. 'She smiled and remembered my name! That's really important for us' (Aboriginal Community Member). These insights reveal the power of familiar, respectful approaches to enhance feelings of safety and belonging.

Cultural signifiers, such as Indigenous artwork or the use of Indigenous languages in culturally relevant reading materials, contribute to a sense of safety and comfort (Taylor et al. 2020). However, their presence alone is insufficient to create a fully culturally safe environment. The authenticity and depth of cultural understanding within these spaces are critical, 'it's more than having the Aboriginal poster on the wall and Koori Mail [Australian national Indigenous newspaper] in the reception area…being friendly and taking the time to introduce yourself and have a "Yarn" before the clinical part of the appointment commences will help to create a respectful space between all parties' (Aboriginal Community Member), suggesting that deeper, genuine respect and understanding are necessary for people to feel safe in an environment.

Providing healthcare in alternative and community settings, rather than centralised institutions, is emphasised as giving a greater sense of safety and freedom for many people. 'I'd rather people come into my space' (Tarunna), or 'go and sit on the riverbank' (Possum). Whilst some members appreciate having healthcare services undertaken in their home, inviting people into one's home and Community is also seen as an act of trust 'for Aboriginal People to accept non-Indigenous People into Community, that's reciprocity, that's respect and trust' (Tarunna). Other members do not view their home as the best place to meet, 'sometimes I don't want people in my place… because that's my space, that's where I'm safe' (Stuart).

The concept of neutral spaces that are culturally safe, open and non-judgemental was seen as viable alternative, 'it's not

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necessarily about your place or my place, it's about a neutral place...somewhere where we can feel safe' (Stuart). These spaces allow patients to feel secure without compromising the privacy or sanctity of their homes, thereby avoiding the feeling of being trapped in a sterile environment, such as a clinic. A neutral place is seen as 'a non-intrusive space where individuals feel they are treated respectfully' (Stuart), meeting outdoors, such as 'under the mango trees' (Stuart), or where 'there are no walls, so no one's listening' (Tarunna). Services conducted 'on Country' are usually seen as most appropriate (where feasible), allowing both the patient and practitioner to 'heal together' (Tarunna).

3.6 | Gendered Nature of Cultural Safety

Gender considerations are also linked to culturally safe care. The presence of a practitioner of the same sex, particularly in sensitive situations, can make First Nations People feel more comfortable, respected and safe (Canuto et al. 2018; Fredericks et al. 2017). This preference reflects a culturally grounded understanding of the need for gendered appropriate care. 'For me [a female] it would be to be treated by an Aboriginal woman' (Tracy, Jewel); 'being a woman, if I see a woman doctor in an Aboriginal Community Controlled Services, I feel safe' (Tarunna). The separation of male and female spaces and practitioners allows individuals to feel more at ease discussing specific gendered health issues, which might otherwise not be raised (Canuto et al. 2018; Fredericks et al. 2017). Having a First Nations health worker of the same sex is also appreciated '...he wanted to make sure that the girl felt comfortable and had a female Aboriginal Health Worker with her the whole time' (Jewel).

Conversely, having someone of the opposite sex who you know, and have developed a rapport with can be seen as more comfortable than a stranger of the same sex 'if it's someone I've known my whole life, and they play an Auntie role in my life,... then I'm happy to have her around. In fact, I might even prefer it...because we actually have a relationship' (Dylan). These differences underscore that, although cultural safety is grounded in a set of core principles, individuals differ in their perceptions of culturally safe healthcare and what they require to feel safe within such environments.

3.7 | First Nations Representation in Healthcare

First Nations representation in healthcare services fosters a sense of comfort and trust among First Nations patients. Having a First Nations person deliver healthcare services fosters connection and reassurance, creating a welcoming environment that makes individuals feel understood and at ease (Taylor et al. 2020). First Nations practitioners can provide culturally attuned care, minimising the need to explain cultural nuances, reducing communication barriers and resulting in fewer misunderstandings and conflicts, as described by Julie, 'working with people from the Community is helpful because they know more about the history, and of the family'.

Aboriginal health workers play a critical role in the healthcare system, providing connection, emotional reassurance, advocacy and support for First Nations patients. It is highlighted that 'having an Aboriginal person present in healthcare when visiting a family member in the hospital, can be comforting' (Aboriginal Community Member).

Non-Indigenous healthcare service providers can sometimes create discomfort or mistrust if they do not understand culture, protocols and responsibilities, or make assumptions based on stereotypes (Williamson et al. 2019). This highlights the importance of non-Indigenous providers taking the time to get to know the individual patient, whilst simultaneously displaying respect for and understanding of cultural nuances. An example noted by one of the AG members is where a non-Indigenous doctor (working for ACCHO), who instead of listening to the patient and assessing the symptoms objectively, exhibited prejudiced assumptions, assuming that her health issue was a result of domestic violence. This led to an ongoing sense of wariness towards that practitioner 'since then, I've always been wary of that doctor, and I've had a lot of anger towards him...I didn't want to ever see him again' (Julie), demonstrating how assumptions can create mistrust.

Whilst going to an Aboriginal-led practice is preferred by many First Nations Peoples, others 'have absolutely no issues at all when going to mainstream hospital' (Dylan), or seeing First Nations practitioners at a mainstream service, 'I go to mainstream, but my doctor is Aboriginal, so that makes the difference' (Tracy). The importance of all healthcare providers having an understanding of the needs of First Nations Peoples is further illustrated by Tracy: 'if they haven't had experiences with Aboriginal People...they bring someone in who does'.

Many Aboriginal-led services are under-resourced to meet the needs of the local Community, 'they're so overwhelmed ...' (Tracy), with insufficient First Nations practitioners to meet the needs of First Nations People. This further highlights the need for all healthcare workers, regardless of cultural background, to be able to provide culturally appropriate care.

Cultural familiarity, including seeing First Nations staff or health workers, is highly significant for comfort and as a marker of safety and respect. There is a deeper need for healthcare settings to actively recruit First Nations staff and practitioners, who can offer not only through shared history and cultural understanding but also provide a sense of safety and belonging (Taylor et al. 2020). AG members generally preferred ACCHOs as these spaces are perceived as culturally safe, non-judgemental and accommodating of First Nations cultural practices. These services provide a familiar and safe environment where patients feel they will not face stereotypes or medical bias. They embody a culturally inclusive atmosphere that makes First Nations People feel safe and respected, regardless of who they are or what they look like, such as 'if you didn't have shoes on...there was no big deal, and we weren't looked at differently' (Jewel). ACCHOs are also preferred due to the alternative, holistic and culturally safe environment they provide, 'They have all the wraparound services that go with it...to me, it is culturally safe' (Sista G). Consequently, mainstream services should consider similar approaches to ensure cultural safety across all healthcare settings.

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3.8 | Challenges and Barriers for Culturally Safe Healthcare

This theme explores how historical, social and cultural dynamics intersect with systemic structures to shape First Nations Peoples' experiences and expectations of healthcare.

3.8.1 | History and Trauma

Historical injustices, marginalisation and cultural biases have profoundly shaped First Nations People's perception of, and relationship with, the healthcare sector. The notion of a 'shared history' refers to the collective experiences of historical injustices, marginalisation and cultural biases that First Nations Peoples have faced since colonisation over the last two and a half centuries (Reynolds 2020). This history influences how individuals perceive and interact with healthcare services. The ongoing effects of colonisation, the disruption of First Nations' models of health by Western medical models and the dismissal of Indigenous knowledge systems have contributed to a prevailing distrust of healthcare providers (Murray et al. 2025; Wright et al. 2021). These injustices have created intergenerational trauma, promoting a pervasive mistrust of healthcare providers and institutions (Gee et al. 2014).

Racism remains a barrier for First Nations Peoples in accessing culturally safe healthcare. Contemporary healthcare institutions can perpetuate stereotypes, prejudices or systemic inequities, also known as medical bias, which can result in inadequate care and negative patient experiences (Durey and Thompson 2012). Medical bias manifests as assumptions and practices rooted in colonialism and scientific racism. In this context, Barlo (2023) introduces the term 'White Noise' to describe the persistent awareness of racism, vilification and mistreatment that First Nations People carry into healthcare settings. This 'White Noise' is referred to as the constant background noise, representing the cumulative emotional, social and spiritual burden shaped by both historical and contemporary experiences of trauma and racism that Aboriginal People constantly have in the back of their mind, which can increase or decrease depending upon past or current experiences (Barlo 2023). White Noise is identified as 'impacting Aboriginal People's experiences in healthcare settings' (Stuart), noting that judgements, stereotypes and a lack of spiritual recognition are common experiences. This emotional and psychological burden carried by First Nations People when engaging with services, shaped by generations of mistreatment, perpetuates feelings of alienation, mistrust and misunderstanding (Williamson et al. 2019).

The lingering impact of historical trauma shapes First Nations People's relationship with healthcare today, for example, Tarunna explains 'I'm not talking about something which is 50 years old…I'm talking about something which is 200 years old'. Cumulative negative experiences and family history affect healthcare-seeking behaviour, 'what happened in childhood, what happened to my family members, it all adds up…it's the build-up of experiences…it is about my grandmother, it is about my mother, it is about my Community' (Tarunna).

The distrust that arises from historical experiences with health institutions often leads First Nations Peoples to avoid healthcare services altogether 'I never go to the doctors…it's the build-up of experiences' (Tarunna), 'they avoid it because they don't feel comfortable going in there' (Aboriginal Community Member). This deep-seated mistrust is further compounded by generational narratives of mistreatment and medical bias (Quigley et al. 2021), including First Nations People being discharged without a thorough examination or appropriate treatment (Mayes 2020). As one member explains, 'I have known women who have gone to the doctors and sent home with a packet of Panadol [paracetamol] and died' (Tarunna). First Nations' specific health concerns are often over-simplified or inadequately addressed, indicating the prevalence of negative experiences and systemic shortcomings in addressing First Nations' health, 'for every good story, I could probably tell 100 bad, bad stories' (Stuart). The trauma of having serious health concerns not taken seriously undermines willingness to engage with healthcare services (Murray et al. 2025).

3.8.2 | Systemic and Structural Barriers Within Healthcare

Issues such as inadequate healthcare resources and biases create a challenging environment for First Nations People seeking healthcare (Wylie and McConkey 2019). Concerns include time constraints, impersonal treatment and a perceived lack of prioritisation. The failure of the healthcare system to meet the needs of First Nations People further impacts the ongoing cycle of avoidance and distrust (Woodall et al. 2025). Systemic issues, including brief appointment slots, reflect a model that fails to meet the needs of First Nations Peoples, 'you cannot build a relationship in a standard 15-minute appointment…and you cannot gain an understanding necessary for culturally safe care…there needs to be more time' (Stuart). The frustration of having to 'fit in' with mainstream expectations further marginalises First Nations Peoples (Gollan and Stacey 2021).

The value of relational, holistic care that considers emotional and spiritual health alongside physical well-being has been emphasised. There is a recognition that holistic and alternative approaches, integrating spiritual, cultural and Community aspects, are crucial for genuine well-being, trust and a sense of safety (Gollan and Stacey 2021).

3.8.3 | Access to Care

Limited access to services and logistical issues, such as transportation, are substantial barriers to accessing healthcare (Woodall et al. 2025). Transport issues, especially in regional or remote areas, are seen as a significant barrier, with Possum describing how 'travel and accommodation services are needed to allow Aboriginal People to get to specialist appointments out of town, as a lot of people don't have the money or capacity to get to these'.

3.8.4 | Stereotypes, Judgements and Biases

Stereotypical assumptions, such as 'you [a First Nations person] are getting something for nothing' (Stuart), create an

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instant barrier that First Nations patients must navigate. Negative interactions create an atmosphere of tension and defensiveness, detracting from care experiences, 'how she spoke to him made him feel so uncomfortable. He went really quiet with his responses and was nervous' (Aboriginal Community Member). Conversely, non-judgemental care prioritises understanding and respect, creating an environment where people feel valued for who they are as individuals (Ly and Crowshoe 2015).

4 | Culturally Safe Practice

4.1 | Definition and Understanding

Cultural safety is complex, nuanced and challenging to define. It may look different for every person, every environment and every situation (Balnaves and Hopkins 2025). AG members agree that cultural safety is determined by the person receiving the care, which is consistent with the definition of cultural safety adopted by the Australian Health Practitioner Regulation Agency (2020). It includes being in 'a safe space where people are accepting me value free without judgements' (Tarunna), and 'being respected, and not judged because of my cultural background' (Julie).

Cultural safety will also look different from one Community to another, 'even Aboriginal People aren't experts on it....I'm a visitor here [on the Country of another First Nations Community], and like other non-First Nations Peoples I have to learn and respect the protocols of this Country' (Tarunna).

Cultural safety is a 'lifelong journey, marked by continuous growth and relational learning, that relies on authentic relationships and respect for cultural protocols and responsibilities' (Stuart). It is an ongoing process that demands humility, respect, openness to change and embracing cultural inclusivity. 'The term "competent" should not be used when discussing cultural safety, as it implies an end point' (Stuart), which is not the case, and even First Nations People 'aren't experts in cultural safety' (Tarunna). 'Understanding the intricacies of the 250 different Nations, Communities, languages, culture, and respect is always evolving, and different from one country to another' (Tarunna).

Cultural safety is consistently described as a 'feeling', an instinctive sense of comfort and acceptance in spaces where First Nations Peoples' perspectives are valued (Latimer et al. 2018). Rather than being defined by policy or procedure, cultural safety is recognised through an emotional and spiritual response, identified by whether an individual feels truly safe, respected and understood within a particular space. First Nations People 'sense it straight away' (Aboriginal Community Member) because they have 'deeper connections with their emotions, environment and Country' (Tarunna). Cultural safety is more than a construct or policy; it is instinctual and deeply personal. The notion that 'you just feel it when people want you around' (Aboriginal Community Member), and 'I'd know from my gut feelings' (Tarunna) reflects the importance of incorporating relational aspects with evaluating one's capability within this space.

4.2 | Cultural Safety Frameworks, Policies and Implementation

Frustration is expressed with many policies aimed at achieving cultural safety, perceiving them as superficial, tokenistic and lacking an accurate understanding (Miller et al. 2025). Cultural safety is often reduced to a 'tick-the-box' exercise that fails to address the deeper, relational and contextual needs of First Nations individuals, whereby 'they do this test on a computer, but they have not spent time with even a single Aboriginal person...that will never help us, it will not contribute to our health and wellbeing outcomes' (Tarunna). Another member revealed that 'many [healthcare] organisations are grappling with cultural safety' (Tracy), particularly with how it is understood and operationalised, which results in 'muddy waters' (Sista G) and inconsistency in the implementation of policies and practices. There is ongoing resistance to overly formalised, clinical and corporatised checklist approaches to cultural safety, instead advocating for a more relational, lifelong and holistic process of reflection and evaluation, reinforced by Julie, 'we need to look at it in a different way [to the western medical model] and be more holistic'. These insights highlight the need for healthcare organisations to work in partnership with First Nations Peoples, reflect on current practices and advocating for systems that move beyond tokenistic practices towards environments where cultural safety and respect are deeply embedded and practised authentically (Australian Commission on Safety and Quality in Health Care 2021).

4.3 | Evaluation of Capability

There is a need for comprehensive education and assessment of the cultural capability of healthcare students, including ensuring they gain a deep understanding and connection to the local culture, with reports that 'they [students] haven't had any exposure to what being culturally safe means' (Sista G).

Frustration is expressed with the superficial and/or tokenistic measures of cultural safety, where paper based certification and benchmarks, without firsthand experience, are prioritised over authentic engagement and understanding, 'it's not about getting a piece of paper and saying I'm culturally safe, my environment is great, and I have a token Aboriginal person as a cultural worker' (Tarunna). Cultural safety is far deeper than a checklist, which fails to capture the essence of relationships, respect and lived experience that constitute actual cultural competence. Ironically, many online courses grant 'cultural competence' certification without any meaningful engagement with First Nations Communities, 'registering attendees as experts in the field' (Tarunna), 'You come out culturally competent with a certificate that says that you're good' (Stuart).

The evaluation of cultural safety requires relational work that reflects lived experience and continual learning, and relationship-building (Balnaves and Hopkins 2025; McCartan et al. 2020), which is 'not usually accounted for during the development and training of courses' (Tarunna). This highlights the gap between theoretical cultural awareness and practical, meaningful cultural safety that requires time and presence. It is suggested that real cultural safety requires healthcare

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professionals to immerse themselves in, and be an integral part of the Community, 'for me to work with a Community, I have to physically move in and share my roles and responsibilities for using the space' (Tarunna). This sentiment reinforces that cultural safety must go beyond checklists and paper-based certifications to encompass active, engaged relationships.

Furthermore, cultural safety requires individuals to take an empathetic approach, striving to understand the lived experiences and challenges of First Nations Peoples and Communities. Rather than assuming cultural safety can be taught or measured in isolation, genuine relationships, patience and openness are required to create culturally safe spaces. The ability to work in a culturally safe manner requires practitioners to 'put themselves in the shoes of an Aboriginal person' (Aboriginal Community Member). The importance of familiarity and relational trust is integral, noting that when practitioners do not judge or stereotype, it fosters a sense of safety and openness, 'I've known her for a long time, she really listens…I feel safe' (Julie). This suggests that empathy and a non-assumptive attitude are foundational in building cultural safety, requiring practitioners to go beyond policies and certifications to genuinely invest in understanding First Nations' perspectives.

5 | Discussion

The complex factors influencing First Nations People's experiences and understanding of cultural safety range from the historical and structural to deeply personal and highly individualised (Murray et al. 2025). Understanding how historical trauma, racism, discrimination, cultural and logistical barriers may be impacting a person's utilisation of healthcare services involves taking time, building genuine Community engagement and respect. Providing healthcare that is relational rather than transactional and tokenistic has many implications. These include the influence and leadership of First Nations health professionals (Arnold-Ujvari et al. 2024; Stroud et al. 2021) and non-Indigenous health professionals stepping outside their comfort zone to genuinely engage and collaborate with First Nations Communities (Australian Commission on Safety and Quality in Health Care 2021).

Working in a culturally safe manner is a mandated requirement for registered health professionals in Australia (Australian Health Practitioner Regulation Agency and National Boards 2022). Educating healthcare students with the knowledge and skills to deliver culturally safe care is essential for shaping a future health workforce that upholds the required professional standards (Australian Health Practitioner Regulation Agency and National Boards 2022; Commonwealth of Australia 2014). Cultural safety is essential for eliminating discrimination within the healthcare system (Hall et al. 2023). This is vital for fostering trust and participation among First Nations Peoples in healthcare, while simultaneously ensuring the delivery of high-quality, culturally appropriate care. This requires time, connection and moving beyond theoretical cultural awareness to genuine understanding and respect. Despite including First Nations health content in the tertiary education of many healthcare students, opportunities for respectful, direct engagement with First Nations Communities remain limited (Tillott et al. 2025). Tertiary education institutions and programmes may lack strong Community connections or the necessary expertise and engagement to navigate the relationships required to make this possible.

In the past, tertiary education institutions have not effectively navigated important protocols surrounding Indigenous knowledges, Community engagement and the dimensions of knowledge sovereignty (Sebastian and Giovanangeli 2023). There are also systemic, structural and logistical barriers in higher education consistent with Western models of knowledge, education, which may pose difficulties with coordinating and providing meaningful opportunities for students to engage directly with First Nations Peoples and knowledges (Balnaves and Hopkins 2025; Hall et al. 2023; Hunt 2013; Ngunyulu et al. 2020).

Challenges also arise in the healthcare system where many practitioners report being time poor, under-resourced and working to clinical protocols based on Western understanding of health and well-being (Rauf et al. 2024; Teucher 2010; Wright et al. 2021). These constraints make it challenging to achieve the longer-term benefits of more effective healthcare on morbidity and mortality (AbdulRaheem 2023).

The wide variety of First Nations language groups and cultures, and how these factors influence cultural safety, is different for each person. Cultural safety is an ongoing journey of attunement, inquiry and informed sensitivity, characterised by a willingness to avoid assumptions and judgements, while remaining flexible and open. This is not necessarily consistent with the current emphasis on Quality Standards and Accreditation in healthcare or Ahpra's cultural safety strategy, which requires healthcare practitioners to work in a culturally safe manner that is free of racism (Australian Commission on Safety and Quality in Health Care 2019, 2021; Australian Health Practitioner Regulation Agency 2020).

5.1 | Limitations

These findings cannot be generalised beyond the participants of this qualitative inquiry. However, the detailed nature of the findings allows readers to explore and consider the relevance of the findings for other First Nations Peoples.

6 | Conclusion

Yarns with a First Nations AG highlighted that cultural safety is complex, nuanced and ongoing. The experience of culturally safe and unsafe healthcare varies across individuals, communities and contexts, and is dependent on a complex array of historical, structural, logistical and personal factors. For First Nations Peoples, feeling culturally safe is an innate and deeply personal experience, often discerned through emotional and spiritual responses.

Culturally safe healthcare is founded not in procedural competency, but in relational trust, commitment and genuine respect for First Nations Peoples and Communities. It is grounded in authentic relationships that honour cultural

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protocols and are built on ongoing engagement with First Nations Communities.

Developing a workforce that can deliver culturally safe care requires continuous growth, humility and openness to change. Future healthcare professionals need not only theoretical knowledge but genuine opportunities to connect with and learn directly from First Nations Communities.

Whilst there are genuine attempts to ensure that healthcare practitioners understand and work effectively with First Nations Peoples, healthcare services are not always delivered in a culturally safe manner. These insights highlight the need for organisations to reflect on their current practices and to work in partnership with First Nations Peoples. Healthcare must move beyond tokenistic practices to environments where culturally safe practices are deeply embedded and practised authentically.

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Ethics Statement

This study was approved by Southern Cross University Human Research Ethics Committee (ECN 2021/106).

Conflicts of Interest

The authors declare no conflicts of interest.

Note Regarding Capitalisation

When referring specifically to First Nations Peoples or Communities, capitalisation (P or C) is used. When referring to people or community in general, lowercase (p or c) is used.

Data Availability Statement

De-identified data are available from the corresponding author upon reasonable request.

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