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A Best Practice Approach to Cultural Competence Training

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Introduction

What has been commonly termed 'Cultural Awareness Training' has been a popular method utilised by organisations targeting employees, to improve the cultural appropriateness of their service delivery. Policy shifts and evaluation findings have seen the expectations and ideals of such training evolve from mere 'Awareness' to more of a 'Cultural Competence' focus, addressing not only knowledge, but also behaviour.

In an attempt to determine best practice in regards to Cultural Competence Training (CCT), the authors conducted a review of CCT – exploring the programs currently available nation-wide, the information content and mode of delivery they commonly utilised, and the 'gaps', shortcomings and areas in need for further development that have been identified. This article presents the findings of this review, setting out a proposed best practice approach to CCT.

Research Design

In order to explore the above issues and identify best practice components, a review of the relevant literature and identified programs was undertaken. Literature was located through database searches focusing mainly on health and education databases, including Medline, ATSIHealth, Health & Society, Google Scholar, Australian Indigenous Health*Info*Net, DRUG, APAIS, RURAL, CINAHL, ProQuest Health & Medical Complete, PubMed Central and Journals@Ovid Full Text databases. Literature was also located within various hard copy sources, notably public and private collections of reports relating to various Indigenous issues.

The following keywords/phrases were used in the context of Indigenous settings Australia and worldwide: cultural safety; cultural sensitivity; cultural awareness; cultural competence; cross-cultural; cultur*; acculturate*; train*; education*; teach*; and learn*. A sample of CCT programs and providers were located through literature searches, Internet searches, and personal communications.

FINDINGS

CCT in Context

From the literature it can be deduced that CCT is required to address the needs of three main stakeholders:

- Indigenous clients of an organisation;
- Indigenous employees of an organisation; and
- Non-Indigenous employees of an organisation.

In Australia, the initial policy approach to culturally competent service delivery was that of 'cultural awareness', taking its name from the cultural training programs that arose in response to *A National Aboriginal Health Strategy* and other reports dealing with Indigenous health and wellbeing (Queensland Health 2001, cited in Thomson, 2005). These training programs were developed to provide health professionals with knowledge of aspects of Indigenous culture and ultimately aimed to result in more culturally appropriate service provision (National Rural Faculty, Royal Australian College of General Practitioners (NRFRACGP) 2004).

The cultural awareness approach however has been criticised as being "a soft option that has delivered sub-optimal results", and despite being in vogue for more than 25 years, Aboriginal peoples continue to describe health services as "alienating and uncomfortable", and link this view with continuing poor health outcomes (Health Department of Western Australia, n.d., p. 2).

The 'cultural awareness' approach, focusing largely on the knowledge and experience attributes of health care providers, was in vogue until the push for a more rights-based approach in Western Australia in the late 1990s, termed 'cultural security' (Health Department of Western Australia, n.d.).

Cultural Security is built from the acknowledgement that theoretical 'awareness' of culturally appropriate service provision is not enough. It shifts the emphasis from attitudes to behaviour, focusing directly on practice, skills and efficacy. It is about incorporating cultural values into the design, delivery and evaluation of services. Cultural Security recognises that this is not an optional strategy, nor solely the responsibility of individuals, but rather involves society and system levels of involvement. Cultural Security is proposed to effect change in all elements of the health system: workforce development, workforce reform, purchasing of health services, monitoring and accountability, and public engagement.

The principles of Cultural Security have been adopted by the National Health & Medical Research Council (NHMRC) (2006) in the development of their guide titled *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation.* The guide acknowledges four dimensions of cultural competency – systemic, organisational, professional and individual – which interrelate so that cultural competence at an individual or professional level is underpinned by systemic and organisational commitment and capacity (NHMRC 2006).

The concept of cultural security does not appear to have been widely adopted on its own, however, it has recently been incorporated into a broader concept in the early 2000s, that of 'cultural respect' (Thomson 2005). In 2004, the Australian Health Ministers' Advisory Council (AHMAC) released *The Cultural Respect Framework*, stating the framework is to serve as a guiding principle for jurisdictions both in policy construction and service delivery, assisting them to develop their own initiatives to strengthen relationships between Indigenous peoples and the

health care system. Cultural respect is defined as "Recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples", noting that cultural respect can only be achieved when health service providers create an environment in which cultural differences are respected, and Indigenous peoples can feel culturally safe (AHMAC, 2004 p.6).

CCT Composition

The characteristics of CCT programs vary considerably depending on the context. CCT composition can range from web-based programs, to brief lecture and/or workshop formats, to field trips and excursions, to 'cultural immersion' activities such as supervised placements within particular environments (NRFRACGP 2004). Content and teaching techniques differ greatly, and the duration of programs varies considerably, from one-off sessions lasting a couple of hours, to ongoing programs lasting weeks.

CCT Providers

CCT is developed and delivered by a wide variety of providers, and generally falls into the following categories:

- CCT provided by Universities, TAFE and other training organisations as part of curricula;
- CCT provided by organisations (government, non-government, and private) for employees as part of professional development; and/or
- CCT provided by training providers or consultants to be accessed or contracted by interested individuals, groups or organisations

Some CCT may be delivered according to particular standards relevant to a state government directive or accredited with a particular peak body, and some may be delivered by accredited trainers who hold training qualifications.

Does it Work?

Despite the popularity of past Cultural Awareness Training as a means to achieving culturally appropriate service delivery, there has been relatively little systematic evaluation of its potential impact. It is also difficult to determine what aspects of such training are resulting in successful outcomes, and which approaches are more effective, as due to the variation in training composition, programs are unable to be easily compared.

Policy

Westwood (2005) reports a lack of formal CCT policy by NSW Health identified through a small-scale study conducted in South Western Sydney Area Health Service, with no formal published policies on Indigenous Cultural Awareness Training by NSW Health able to be located. Despite Cultural Awareness Training workshops being conducted in all sectors, Westwood found that the majority of staff had not attended. Lack of policy equates to lack of accountability and support for implementing meaningful change to service practices that can result in more culturally appropriate service provision.

Accessibility and Availability

Research conducted by NRFRACGP (2004) found that CCT is limited for general practitioners working in Indigenous health. Only 14% of training organisations across Australia, surveyed as part of the research, reported having delivered training for general practitioners in the period from 2002, despite the majority of organisations reporting a perceived learning need among general practitioners for CCT. Fifty percent of these programs were one-off events, and the remaining 50% were reported as repeated events. A literature review conducted by NRFRACGP (2004) also found very few studies about CCT programs/curricula available for health professionals working in Indigenous communities. A South Australian study conducted by Valadian, Chittleborough and Wilson (2000) targeting health service staff found that only 14.7% of respondents had attended CCT in the previous year.

Goals and Purpose

The evaluation of Cultural Awareness Training as delivered to NSW health staff conducted by Dench McClean (1999) highlighted that education, awareness and training are terms often used interchangeably, despite actually delineating very different things. Awareness is an end state concerned with 'knowing' (acquiring knowledge), which is education, not training. Training is the process by which people acquire the skills needed to perform a specific task or range of tasks. Dench McClean (1999) state that in order to be effective in delivering appropriate services to Indigenous clients, all NSW Health staff need:

- Awareness of important Indigenous issues, such as cultural differences, specific aspects of Indigenous history and its impact on Indigenous peoples in contemporary Australian society;
- The skills to interact and communicate sensitively and effectively with Indigenous clients; and
- The desire or motivation to be successful in their interactions with Indigenous peoples, to improve access, service delivery and client outcomes.

Dench McClean also found that the changing of attitudes held by individual participants is difficult and beyond the scope of short-term training programs, however, culturally appropriate behaviour on the other hand is within the scope of such training.

Reviews of training provision to health staff in NSW (Dench McClean 1999) and the Northern Territory (Lowell 2001) note that the overall level of CCT required to achieve effective service provision is unable to be provided by current staff training methods.

Knowledge

The NRFRACGP (2004) surveyed a total of 104 organisations across Australia regarding the provision of CCT to general practitioners. Evaluation outcomes were reported to include increased knowledge, high satisfaction levels, and increased understanding/awareness. Yaxley's (2001) evaluation of RACGP Aboriginal Health Training for GP registrars held across Australia found increased awareness of cultural issues and Indigenous health issues.

Jamrozik (1995) evaluated a CCT program which consisted of a seven-day field trip to remote Aboriginal communities and local health services in Western Australia, where medical students interviewed Indigenous people and health service providers. Findings showed greatly increased knowledge with participants answering more factual questions correctly after completing the program. Crampton et al (2003) found similar outcomes in regards to Maori cultural immersion programs for medical students in New Zealand.

Beach, Price, Gary, Robinson, Gozu, Palacio, Smarth, Jenckes, Feuerstein,

Bass, Power & Cooper (2005) reviewed the findings of studies evaluating interventions to improve the cultural competence of health professionals, and from a total of 34 studies, found excellent evidence that cultural competence training improves the knowledge of health professionals.

Attitudes

Indigenous and non-Indigenous people alike have voiced mixed views about Cultural Awareness Training. While some feel it is a positive move towards non-Indigenous peoples coming to understand how to work more effectively and appropriately with Indigenous peoples, others, such as Puggy Hunter (2001, cited in Fredericks 2003) who referred to such training as 'hug a blackie' are more cynical about their likely success at improving Indigenous health outcomes.

Research conducted by Young (1999) has provided an in-depth analysis of Cultural Awareness Training programs and the role they play, highlighting that such training typically focuses on providing non-Indigenous service providers with awareness of Indigenous issues, yet fails to foster a valuing of other cultures. Young (1999, p.212) states that Cultural Awareness Training

> *"... is an individual change strategy which relies on learning interpersonal interaction processes which, at the very best, might start a collective conscientisation process leading to change at an organisational level for the betterment of the social position of people of different cultures and backgrounds ..."*

Young asserts that Cultural Awareness Training is essentially about interpersonal interaction, and not necessarily about changing attitudes, and thus any changes in attitudes are the result of an individual's choice to do so. However, the promise lies in the ability of such training to potentially influence or support these changes.

In her doctoral research, based on the views of a number of participants regarding Cultural Awareness Training, Fredericks (2003) notes that:

> *"... some people are happy to do the training, provided they do not have to change their practice or adopt the training or the reflection on their ideas within their normal modes of operation. This can be seen as non-Indigenous people coming to know Aboriginal people provided their personal level of comfort isn't challenged. Moreover, this means they must have a willingness to let go of old misguided stereotypes and to accept what Aboriginal peoples lives actually do encompass ... If there is no long-term commitment from individuals to making some real changes then such changes will not happen. It additionally means people can be aware and not do anything about their awareness."*

Mooney, Bauman, Westwood, Kelaher, Tebben and Jalaludin (2005) evaluated the impact of Cultural Awareness Training in South Western Sydney Area Health Service on health professionals' perceptions, familiarity and friendships, attitudes and knowledge of Australian Aboriginal peoples and the health issues affecting them utilising pre- and post-training questionnaires. Findings showed that the half-day training did not appear to have a major influence on perceptions or attitudes of participants, however it did result in an increase of participants reporting having friends who were Aboriginal and those reporting working with Aboriginal people. It also resulted in increased understanding of the complexity of Aboriginal health problems. However, it was also noted that some individuals view such training as reinforcing stereotypes or even creating resentment, evidenced by some participant comments questioning why Indigenous peoples should be viewed as being different, and why so much time should be devoted to one particular cultural group in society.

The NRFRACGP (2004) survey of Australian organisations regarding the provision of CCT to general practitioners found that reported evaluation outcomes included perceived usefulness and self-reported attitudinal change. Jamrozik's (1995) evaluation of a seven-day CCT field trip program to remote Aboriginal communities and local health services in WA for medical students, demonstrated improvement in some attitudes towards Aboriginal people. Rasmussen (2001) also evaluated a CCT field trip program for medical students and similarly found substantial change in student attitudes. Fitzpatrick and Gillies (2000) and Hayes et al (1994) also note evidence of positive changes in attitudes amongst health professionals participating in CCT.

A review of the findings of American studies evaluating interventions to improve the cultural competence of Health professionals conducted by Beach et al (2005) found that there is good evidence that cultural competence training improves the attitudes and skills of health professionals.

Behaviour and Practice

In 1999, Dench McClean's evaluation of the Cultural Awareness Training program being implemented by NSW health criticised the training for its lack of ability to extend such awareness to the provision of skills that can be applied in specific work contexts, and for typically being delivered as a one-off program, providing recipients with short exposure. It was even described by some participants consulted with by Dench McClean in the course of the evaluation as merely consisting of teaching doctors how to throw boomerangs.

Fredericks (2003) found that a number of women interviewed as part of her doctorate research acknowledged that a number of services in their communities had implemented Cultural Awareness Training for staff, however the women did not comment on whether they had noticed any changes in service provision as a result.

A review of the findings of American studies evaluating interventions to improve the cultural competence of health professionals, conducted by Beach et al (2005), found that there is good evidence to suggest that CCT impacts the skills/behaviours of healthcare providers. On an Australian front, the NRFRACGP (2004) survey of Australian organisations regarding the provision of CCT to general practitioners found that reported evaluation outcomes included predicted self-reported behavioural change, awareness of need to improve training as perceived by training providers, and self-reported improvement in skills. Valadian et al (2000) report on a South Australian study which aimed to determine the issues encountered by staff when working with Indigenous clients, and how CCT could best be utilised to address those issues. The majority of participants felt that CCT would improve the skills and knowledge of staff in working with Indigenous clients, to help address the identified issues of communication differences, cultural differences, and problems with Indigenous clients' compliance with treatment.

Indigenous Client or Patient Outcomes

None of the studies reported in the literature identified for this review had evaluated the impact of CCT on Australian Indigenous client or patient outcomes. A review of the findings of American studies evaluating interventions to improve the cultural competence of health professionals conducted by Beach et al (2005) found that there is good evidence that cultural competence training impacts patient satisfaction, poor evidence that cultural competence training impacts patient adherence, and no studies that have evaluated patient health status outcomes.

CCT Best Practice

As a result of the literature review, the following recommendations have been drawn and presented as a framework for CCT best practice:

Commitment to Achieving Cultural Competence

Cultural competence can be achieved through a commitment to achieving culturally appropriate service delivery and a culturally appropriate workplace environment. This commitment would require a focus on systemic, organisational, professional and individual levels. Within this framework, Indigenous CCT would be located as one of numerous approaches implemented across the board to achieve cultural competence. For CCT to be effective it needs to be located within a broader context of commitment to achieving cultural competence. This means a commitment to achieving culturally appropriate service delivery, and a culturally appropriate workplace environment.

Development of a CCT Policy

A CCT policy should be developed and enacted that addresses and defines factors relevant to all of the following CCT characteristics and components.

The CCT policy needs to be a statement of intentions and objectives, which defines, for example:

- What CCT will be comprised of in terms of purpose, learning objectives, content, mode of delivery, format, and duration;
- Who it will target;
- Who it will be developed, facilitated, monitored and evaluated by;
- When it is to be implemented; and
- What performance indicators can be utilised.

A CCT policy should address both Indigenous CCT and a broader based multicultural CCT.

Partnerships to Enable Development, Implementation and Evaluation

An advisory committee should be established to steer the development, implementation and evaluation of CCT within an organisation, with membership including Indigenous staff, management, Indigenous consumers, and Indigenous community representatives from each region. The advisory committee can facilitate community partnerships and involvement in the development, implementation and evaluation of CCT. These partnerships and involvement are to be ongoing.

Based on their extensive review of available national and international CCT literature, the NRFRACGP (2004) conclude that one principle of best practice in CCT is the development of genuine partnerships with Indigenous peoples that involves collaboration in the planning, implementation and evaluation of CCT programs, including local community involvement to ensure credibility and relevance. The establishment of community partnerships can help ensure that CCT programs are not only addressing the needs of the department and the staff, but of the Indigenous communities utilising its services and seeking employment.

Purpose, Goals and Learning Objectives

Decide what the purpose and goals of the CCT program will be for the organisation, and what the learning objectives will be for participants. It is recommended that the purpose and goals be to enable positive changes in knowledge and attitudes of staff which can then facilitate culturally appropriate workplace environments and service provision. It is recommended that the learning objectives for CCT participants be:

- Greater appreciation of the role of history and racism on contemporary Indigenous society
- Increased knowledge of Indigenous cultures
- Dispelling of myths and misconceptions
- Self-reflection on own cultural values, beliefs and attitudes and how they impact on interaction with people from other cultures
- Increased understanding of white race privilege
- Anti-racism and anti-discrimination strategies
- Skills in cross-cultural communication
- Skills and strategies to enable better working relationships with Indigenous colleagues
- Skills and strategies to enable better service provision for Indigenous clients
- Positive changes in attitudes towards Indigenous peoples and cultures, and confidence in working effectively with Indigenous colleagues and clients.

Use of Self-Directed Learning Resources

A self-directed learning component, such as a web-based CCT program, should be incorporated as deemed appropriate for particular participant groups, addressing particular training components, as an adjunct to other modes of delivery. For an organisation, there are many time and money-related benefits of utilising such a component. Westwood (2005) notes that best practice indications from the literature include the utilisation of available information technology to provide for self-directed learning, such as web-based programs, as an adjunct to face-to-face interaction. A number of studies also indicate that participants value the use of a variety of learning methods (Bennett & Wellard 2003, Rasmussen 2001, Yaxley 2001).

Use of Workshops

Workshop components should be incorporated as deemed appropriate for particular participant groups, addressing particular training components, as an adjunct to other modes of delivery.

Valadian et al (2000) identified that potential CCT participants reported a preference for the workshop as opposed to other modes of delivery. Workshops have been reported in the literature to have provided high levels of participant satisfaction as well as other positive outcomes (Bennett & Wellard 2003, Fitzpatrick & Gillies 2000, Hayes et al 1994, Dench McClean 1999). Particular attention should be given to the environment in which workshops are to be provided, and the mix of participants. The workshop environment should be appropriate, safe and comfortable for both participants and facilitators, allowing for positive and safe interaction (NRFRACGP 2004).

Use of Field Visits and Cultural Immersion

Field visits and cultural immersion through visits, placements, and staff exchanges should be incorporated as deemed appropriate for particular participant groups, addressing particular training components, as an adjunct to other modes of delivery.

Field trips including trips to Aboriginal communities, and trips to Aboriginal organisations, have been shown to achieve significant positive change in participant attitudes (Jamrozik 1995). Cultural immersion activities involving longer term visits to Aboriginal communities, placements in Aboriginal organisations or other environments providing experience working with Indigenous colleagues and clients, and staff exchange programs have particularly displayed such success (Rasmussen 2001, Crampton et al 2003, Kamaka 2001, Kavanagh 1998).

Morgan (2006) describes a CCT program for general practitioner registrars which includes a site visit to the community in which the health professional will be working a month or two prior to the placement, allowing the registrar to gain an introductory understanding of the complex cultural and other dynamics in the community, as well as appropriate communication styles and protocols. Once the registrar has commenced their post, a local community-based cultural mentor may be established. Registrars are also given the opportunity to talk to colleagues who have undertaken a similar placement, and provided with a list of key resources relevant to the community area.

Use of Mentoring and Other Follow-Up Activities

Mentoring and other follow-up activities such as involvement in Indigenous celebrations and events, should be incorporated as deemed appropriate for particular participant groups, addressing particular training components, as an adjunct to other modes of delivery.

Cultural mentoring arrangements for staff can be achieved using a number of different arrangements depending on which is most appropriate for the staff members concerned. Indigenous mentors may be external consultants, or may be Indigenous employees in other organisations (mainstream or Aboriginal) that can form a symbiotic partnership with the organisation, whereby staff from both organisations serve as mentors for each other.

Mentoring has been successful in CCT for general practitioner registrars across Australia, producing increased awareness of cultural issues and Indigenous health problems and culturally appropriate communication skills, with participants reporting high levels of satisfaction with the opportunity to interact with Indigenous peoples (Yaxley 2001).

Other follow-up activities to CCT may include staff involvement in local Indigenous celebrations or events, and the development and implementation of Aboriginal community engagement strategies.

CCT Duration

CCT should be frequent, long-term and ongoing, so as to provide staff with long-term exposure to aspects of Indigenous culture and required skills to achieve culturally appropriate service delivery. CCT should be modularised, to enable flexible delivery over a number of sessions. As much as possible, CCT principles are to be integrated into workplace practice.

The available evidence shows that such short-term programs typically fail to achieve any real outcomes relating to knowledge and behaviour change. For example, Mooney et al (2005) note that while there may be difficulty in arranging longer periods of time off work for staff to attend longer training programs, evidence shows that the half-day Cultural Awareness Training program currently being implemented by NSW Health in the South Western Sydney Area Health Service is failing to have any significant effect in changing beliefs and attitudes of participants. CCT that involves a time frame of a week or longer, typically as field trips or other cultural immersion activities, show significant positive changes to participant attitudes (Jamrozik 1995, Crampton et al 2003; Kamaka 2001, Kavanagh 1998).

As a result of an extensive literature review regarding CCT for general practitioners, the NRFRACGP (2004) concluded that one principle of best practice for CCT was the allowance of a realistic time frame. Another was that training should be modularised, and thereby flexible, allowing for training to be delivered at different times rather than all in one session. Bennett and Wellard (2003) also recommend the development of a flexible program which caters for participants who are unable to commit to attending CCT over consecutive days. Mooney et al (2005) suggest that instead of making the CCT program longer, consideration should be given to a training model that integrates principles of cultural competence with workplace practice.

Acknowledgement of Heterogeneity of Indigenous Cultures

CCT programs need to be based on an acknowledgement of the heterogeneity of Australian Indigenous cultures. This means that training needs to be specific to the local areas in which they are relevant or being delivered.

The consensus from the available literature emphasises the need for CCT to be based on local content, and involve input from local knowledge holders. This approach has the benefit of providing participants with the knowledge and skills that are specific to the region and communities in which they work, as well as the necessary connections and networks with local Indigenous individuals and organisations.

Care needs to be taken to ensure that Torres Strait Islander culture, peoples and issues are also included in their own right in CCT programs. Knowledge of community demographics in terms of particular cultural groups can assist in targeting program design and development.

Models of CCT Implementation

CCT can be comprised of 3 modules:

1. A generic module for all staff, initially targeting all staff until compliance has been reached, and then for use as part of orientation upon commencing employment. This generic module could utilise self-directed learning resources and workshop modes of delivery. The generic module would be mandatory for all staff and management.
2. Specialised modules customised for particular staff levels, based on their roles within the organisation, and locally-specific. These modules would ideally be flexible in delivery, and occur regularly, providing longer exposure for participants, as well as include refresher sessions. Specialised modules could utilise workshop and field visit modes of delivery, as well as staff exchanges, placements, mentoring, and involvement in other follow-up activities. These modules

would be mandatory for all relevant staff.

3 Highly specialised modules customised for particular needs or interests, which would be available for staff to nominate attendance voluntarily. These modules could utilise a wide range of modes of delivery, and may also include longer-term cultural immersion activities.

Based on their review of the literature, the NRFRACGP (2004) conclude that a principle of best practice for CCT is the development of a generic component, accompanied by specialised components that allow for local- and role-specific adaptation. Westwood (2005) recommends several models of CCT implementation within NSW Health: inclusion as a mandatory component of staff orientation with regular reinforcement; a particular focus on front line staff for specific Indigenous CCT as well as broader based multicultural CCT; and a performance management approach where CCT is evaluated along with other competencies on a regular basis.

Mandatory v Voluntary

Generic and specialised modules of CCT should be mandatory for all staff and management, both Indigenous and non-Indigenous. The availability of highly specialised CCT modules for voluntary attendance should be considered.

Fredericks (2006) notes that some staff are unwilling to participate in CCT for numerous reasons which impact on how they participate if mandated. One participant in Fredericks' doctorate research (2003) indicated that there was a notable difference between those that voluntarily undertook CCT and those that were directed to. The risk in enabling attendance at CCT to be voluntary is that those who generally fail to attend are the ones most in need of the training. Generic modules of CCT should be mandatory for all staff, including management. Specialised modules of CCT should also be mandatory for respective staff and management. More highly specialised CCT modules, should be considered for availability to staff on a voluntary basis.

Indigenous staff should also undertake CCT with reasons including the fact that some Indigenous staff may have only become aware of their Indigenous heritage later in life and be unaware of historical and current factors affecting Indigenous people in their region, as well as the need to make Indigenous staff aware of the issues faced by Indigenous people in the region who know little about their Indigenous heritage and may have difficulty being accepted in the local Indigenous community.

Participants

CCT participants should be grouped according to employment role or work location as much as possible. Separate generic module sessions for Indigenous and non-Indigenous staff should be held. Specialised modules can combine staff again.

Bennett and Wellard (2003) recommend that CCT workshops should involve participants who work together. Fitzpatrick and Gillies (2000) also recommend a homogeneity of participants – this would assist in program delivery as activities such as case scenarios and role plays could be customised to suit the participant group.

A number of studies report on evaluations of training that involved a combination of both Indigenous and non-Indigenous participants (Bennett & Wellard 2003, Fitzpatrick & Gillies 2000, Rasmussen 2001, Campton et al 2003, Kamaka 2001). Bennett & Wellard (2003) note that a deliberate recruitment strategy aimed to achieve a participant mix whereby one-third of participants were Indigenous. This was based on prior experience with the training program which had found that the interaction and outcomes of workshops were optimised when there was a good balance of Indigenous and non-Indigenous participants. However, they also recommend that facilitators be prepared for potentially disruptive participants. This highlights the concern that combining Indigenous and non-Indigenous participants may be stressful for Indigenous participants in regards to potential negative interaction with other participants. Conducting separate generic modules for Indigenous and non-Indigenous staff can enable the module content to be adapted slightly to be more appropriate for each group, and would avoid the potential for Indigenous staff to be exposed to negative attitudes or discussions from non-Indigenous participants. Combining Indigenous and non-Indigenous participants for the specialised modules can enable the benefits of interaction between both groups in a context that may hold less potential for negativity.

Training Methods

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

Based on the findings taken from a review of the literature, NRFRACGP (2004) propose that best practice training methods for CCT include the use of multiple teaching/learning methods was recommended, with a number of techniques advocated including learner-centred and solution-focused approaches such as reflective or active learning, and experiential learning strategies, incorporating principles of adult learning.

Group work has the advantages of sharing and learning from others' experiences – utilising collaborative learning, which is a type of problem-based learning which relies upon the combined abilities of participants to analyse and solve issues relating to a problem (Australian National Training Authority 2004). It also provides an effective environment for experiential learning. Experiential techniques can be effective in demonstrating how 'cultural conditioning' occurs and can shape an individual's view and interpretation of the world (Wano 1999). However, with group work comes the potential for avoidance of sensitive issues and inhibition of full exploration of personal attitudes and beliefs, which can block further learning (Cameron & Limberger 2004).

For this reason, reflective learning through self-directed learning activities complements group work effectively. Reflective learning is well-suited to CCT because of the personal nature of the material and the fact that it is based so much on an individual's beliefs and assumptions, conscious and subconscious (Cameron & Limberger 2004). This approach allows for experimenting, exploring, and putting theory into practice (Moon 1999 cited in Cameron & Limberger 2004). However, self-reflection can be confronting for some participants, and care should be taken to ensure that the environment in which self-reflective

activities are conducted allows adequate support and psychological safety.

Facilitators

The delivery of generic modules outside of self-directed learning modes of delivery should utilise the facilitation skills of external Indigenous consultants, who are qualified, skilled and experienced in training, and have expert knowledge of Aboriginal history.

The delivery of specialised and highly specialised modules should utilise the skills of suitably qualified, skilled and experienced external Indigenous consultants who have consulted and worked in partnership with local Indigenous knowledge holders, and should also involve the facilitation skills of these local Indigenous community members. Indigenous staff members of the organisation may also play carefully designed and well-supported roles in the facilitation of specialised and highly specialised modules.

Dench McClean (1999) note that NSW Health Cultural Awareness Training utilises NSW Health Aboriginal Health Workers who have been given specific training, as facilitators. The Illawarra-South East Regional Coordination Management Group (2007) highlights that such staff facilitating training will inevitably be subjected to various forms of ignorance and racism from participants who may well be their colleagues and even managers. This is also mentioned by Bennett & Wellard (2003) and Fitzpatrick & Gillies (2000). For this reason, utilising existing Indigenous staff to train their peers or managers is not an ideal arrangement.

A review of the literature conducted by NRFRACGP (2004) concluded that best practice requires the training be delivered by Indigenous facilitators who have also been involved in the planning of the program, and include local community representatives. It is recommended that Indigenous community members, cultural facilitators, and representatives of Community Controlled Organisations and local communities play an integral role in every stage of CCT delivery.

Needs Assessment

Assessment of staff and management's needs should be conducted prior to the development of the CCT program by means of surveying staff and management, and consulting with Indigenous consumers, carers and other community members. Needs assessment findings should be utilised to inform training content.

Dench McClean (1999 pp.8-9) note: *"Individuals being targeted for [training] will obviously vary as to their specific needs for improving performance. They will have different levels of knowledge about Aboriginal people, history and cultures, as well as varying levels of confidence and commitment in interacting with Aboriginal clients and of ability in being successful in doing so effectively."*

Dench McClean (1999 p.9) recommend assessing whether "... participants need to understand more about the key issues and how to deal with them, or whether they need a major change in attitude, or both".

The NRFRACGP (2004) also identified a need for prior assessment of prospective participants' learning needs to ensure relevance of CCT programs. A number of studies have done such assessments, surveying participants for pre-existing attitudes and knowledge, previous contact with Indigenous peoples and perceived problems in their communication and interaction experiences (Bennett & Wellard 2003, Fitzpatrick & Gillies 2000; Jamrozik 1995; Rasmussen 2001). Such prior assessment can also be of use in evaluation measures, forming a basis for pre- and post-training testing.

Content of Generic Module

The CCT generic module intended for all staff and management should include the following content:

- Indigenous history in Australia – pre-colonisation
- Indigenous history in Australia – post-colonisation
- Impact of government legislation on Indigenous peoples
- Influence of colonisation and government legislation on the current situation of Indigenous peoples today
- Overview of current national Indigenous demographics and other relevant statistics
- Contemporary Indigenous issues
- Overview of Indigenous cultures and protocols
- Common myths and misconceptions
- Anti-racism training
- Strategies for positive cross-cultural communication and interaction
- Strategies for increasing cultural safety in the workplace.

While some CCT components lend themselves to a generic approach, others need to be tailored to include local and role-specific content. The generic module is intended for all staff, and therefore content is limited to that which is general and applicable to all roles.

Content addressing racism, bias and discrimination needs to be included in the generic module of CCT to be undertaken by all staff and management. This can occur either in workshop or self-directed learning modes of delivery. In a review of the literature pertaining to evaluations of cultural competence training, Beach et al (2005) found that there is concern and potential for such interventions to promote stereotyping of Indigenous peoples. The authors suggest that the inclusion of content addressing racism, bias and discrimination within training components (which was absent from the majority of training interventions they reviewed) may reduce the likelihood of such negative outcomes.

Fredericks (2006) notes that the creation of awareness does not lead to the needed structural changes, recognition of Indigenous rights nor understanding of white race privilege. She recommends that CCT be extended to more comprehensive Anti-Racism Training, exploring white race privilege in terms of white advantage and Indigenous disadvantage, and incorporating anti-racism strategies. This framework would encourage participants to address their own positioning with regard to white race privilege in society, in the workplace environment, and in service provision.

Content of Specialised and Highly Specialised Modules

The CCT content for role-specific specialised and highly specialised modules needs to be local- and role-specific, with content including:

- Demographics and other relevant statistics pertaining to the local Indigenous community
- Aspects of local Indigenous history, and impact on contemporary situation
- Information on Indigenous cultures and protocols applicable in local community
- Local- and role-specific myths and misconceptions

- Information on working partnerships with Indigenous groups, and the importance of consulting with these communities in order to provide appropriate services
- Strategies for engaging the Indigenous communities of the local region, and establishing working relationships and partnerships
- Cultural understandings pertaining to particular roles and locations, in terms of more specific effects of colonisation and government legislation, particular service delivery issues, communication and interaction, contemporary issues, etc.
- Role-specific examples of best practice
- Learning and practicing appropriate behaviours and strategies
- Strategies for culturally appropriate service delivery
- Opportunities to apply newly gained knowledge and skills in practice situations

In their review of NSW Health Cultural Awareness Training, Dench McClean (1999 p.16) state:

> *"A knowledge of the history and government policies and their impact on Aboriginal people, particularly the last 50 years, is important to understand why Aboriginal clients might be thinking and acting as they do: on its own though, it does not provide the complete solution to the problem of achieving effective interface between clients and the health system. The missing ingredients are the skills needed by non-Indigenous staff to perform their duties with maximum effectiveness and efficiency."*

Specialised and highly specialised modules provide the opportunity to customise training that is local- and role-specific, providing participants with knowledge and skills that are particular to their individual situation and needs. This content would build on the foundations laid in the initial generic modules of the CCT.

In this context, cultural immersion activities such as field visits, staff exchanges, and placements can assist participants to see what the statistics mean in terms of real people, as well as provide them with the opportunity to put their newly acquired knowledge and skills into practice, through working directly with Indigenous clients, and working alongside Indigenous colleagues. Guest speakers and community panels would be useful in specialised and highly specialised modules. 'Meet and greet' sessions with local Indigenous organisations and service providers are also recommended, enabling participants to network with Indigenous peers and form useful community links.

Monitoring and Evaluation

Establish effective mechanisms which allow for comprehensive and timely monitoring and evaluation of CCT. Monitoring and evaluation mechanisms are to ensure Indigenous involvement in their design and implementation. Monitoring of CCT against practice standards should occur periodically. Process, impact and outcome evaluation methods and measures should be utilised, assessing performance indicators including:

- Participant satisfaction
- Facilitator satisfaction
- Achievement of learning objectives
- Changes in knowledge and attitudes
- Assessment of predicted impact on behaviour and practice
- Changes in outcomes relating to Indigenous employees and Indigenous clients

Methods should include:

- Self-report surveys, interviews, questionnaires
- Session debriefings with facilitators
- Focus groups
- Pre-post attitude questionnaires
- Pre-post knowledge questionnaires
- Review of relevant employment data
- Review of relevant client access data
- Review of relevant client outcomes data

NRFRACGP (2004) found that many of the CCT programs they reviewed were not well evaluated. One of the programs they reviewed in the literature or by survey across Australia undertook follow-up evaluation to measure the sustained impact of training. Relatively few programs used pre-post testing. Evaluation was typically conducted immediately at the conclusion of the training, and limited to assessing performance indicators such as satisfaction levels, achievement of learning objectives, and changes in knowledge and attitudes, relying mostly on self-reporting as opposed to other more objective measurement. The review also found that Indigenous involvement in CCT program planning, implementation and evaluation needs to be enhanced, particularly in the area of evaluation.

REFERENCES

Australian Health Ministers' Advisory Council (2004) *Cultural respect framework* for Aboriginal and Torres Strait Islander Health 2004-2009. Department of Health South Australia.

Australian National Training Authority (2004) *New practices in flexible learning – Interactive ochre: Enhancing Indigenous cultural awareness among service professionals. Presenters' Resource.* Australian Flexible Learning Framework, National Vocational Education and Training System.

Beach, M.C., Price, E.G., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A., Smarth, C., Jenckes, M.W., Feuerstein, C., Bass, E.B., Power, N.R. & Cooper, L.A. (2005) Cultural competence: A systematic review of health care provider educational interventions. *Medical Care* 43 (4) 356-373

Bennet, J. & Wellard, R. (2003) *Evaluation of the Aboriginal and Torres Strait Islander Health Projects* South Melbourne: National Rural Faculty, RACGP.

Cameron, H. & Limberger, J. (2004) Online learning: Cross-cultural development in time poor environments. *Journal of European Industrial Training* 28 (5) 429-439

Crampton, P. et al (2003) Combating effects of racism through a cultural immersion medical education program. *Academic Medicine* 78 (6)

Dench McClean (1999) *Report to NSW Health regarding the effectiveness of cultural awareness training.*

Fitzpatrick, L. & Gilles, C. (2000) *Cultural awareness: Implementation considerations.* Toowoomba: Queensland Health, Cunningham Centre.

Fredericks, B.L. (2003) *Us speaking about women's health: Aboriginal women's perceptions and experiences of health, well-being, identity, body and health services.* Thesis submitted to Central Queensland University for the degree of Doctor of Philosophy, School of Health and Human Performance, Faculty of Arts, Health and Sciences.

Fredericks, B. (2006) Which way? Educating for nursing Aboriginal and Torres Strait Islander peoples. *Contemporary Nurse* 23 87-99

Hayes L. et al (1994) Attitude change amongst nursing students towards Australian Aborigines. *International Journal of Nursing Studies* 31 (1) 67-76

Health Department of Western Australia (n.d.) *Aboriginal cultural security: A background paper.*

Illawarra – South East Regional Coordination Management Group (2007) *Aboriginal cultural respect training framework.* Illawarra – South East Regional Coordination Management Group. Retrieved 23 June 2008 from: http://agen.org.au/?page_id=8

CANCER COUNCIL QUEENSLAND
Doctoral Scholarship in Indigenous Cancer Control

The Cancer Council Queensland invites applications from suitably qualified research students who will be commencing full-time doctoral studies through James Cook University in 2009, or who are currently in their first year of doctoral studies. Applicants must normally be resident in Queensland, and will be based in Brisbane at the Queensland Institute of Medical Research and the Cancer Council Queensland. Indigenous and non-Indigenous Australians are encouraged to apply. One Doctoral Scholarship will be offered.

The avenue of research to be undertaken includes a dedicated project within a larger National Health and Medical Research Council funded study. This exciting new study is the first to investigate the supportive care needs of Queensland Indigenous cancer patients and explore the role of health workers in meeting these needs.

The primary project supervisors will include senior investigators from Cancer Council Queensland, Queensland Institute of Medical Research and James Cook University.

The value is $23,500 per annum for up to three years (the amount to be indexed annually to CPI). The Cancer Council Queensland scholarships are intended to provide financial support for the student only.

For further information about the project please contact:
Associate Professor Anna Hawkes at the Cancer Council Queensland
Phone: 07 3258 2305 Email: AnnaHawkes@cancerqld.org.au.

The scholarship application form can be obtained from:
Gillian Yap at the Cancer Council Queensland
Phone: (07) 3258 2313 Email: GillianYap@cancerqld.org.au
Or download the application form from:
http://www.cancerqld.org.au/research/qcf_grants/qcf_researchGrants.asp

All applicants NOT already enrolled in doctoral studies at James Cook University must submit an additional application form to undertake doctoral studies at James Cook University. For information regarding JCU application procedures please contact:
Barbara Pannach at James Cook University
Phone: (07) 4781 4735) Email: Barbara.Pannach@jcu.edu.au
Alternatively the application form can be found at the following address:
http://www.jcu.edu.au/grs/JCUDEV_015302.html

The closing date for a is 5pm Friday, 7th Augu

CLOSING DATE EXTENDED
Contact Anna Hawkes
AnnaHawkes@cancerqld.org.au

Jamrozik, K. (1995) Going bush–Helping medical students learn from Aboriginal people. *Medical Journal of Australia* 163 (4)

Kamaka, M.L. (2001) Cultural immersion in a cultural competency curriculum. *Academic Medicine* 76 (5)

Kavanagh, K.H. (1998) Summers of no return: Transforming care through a nursing field school. *Journal of Nursing Education* 37 (2)

Lowell, A. (2001) Cultural education programs for service providers in Aboriginal health care. In Cooperative Research Centre for Aboriginal and Tropical Health (Ed) *Communication and cultural knowledge in Aboriginal health care.*

Mooney, N., Bauman, A., Westwood, B., Kelaher, B., Tibben, B. & Jalaludin, B. (2005) A quantitative evaluation of Aboriginal cultural awareness training in an urban health service. *Aboriginal & Islander Health Worker Journal,* 29 (4)

Morgan, S. (2006) Orientation for general practice in remote Aboriginal communities: A program for registrars in the Northern Territory. *Australian Journal of Rural Health* 14, 202-208

National Health & Medical Research Council (2006) *Cultural competency in health: A guide for policy, partnerships and participation.* Canberra: Commonwealth of Australia.

National Rural Faculty, Royal Australian College of General Practitioners (2004) Review of cultural training for GPs working in Aboriginal and Torres Strait Islander health.

Rasmussen, L. (2001) *Towards reconciliation in Aboriginal health: Initiatives in teaching medical students about Aboriginal issues.* Parkville, Victoria: Vichealth Koori Health Research and Community Development Unit, The University of Melbourne.

Thomson, N. (2005) Cultural respect and related concepts: A brief summary of the literature. *Australian Indigenous HealthBulletin* 5 (4) 1-11

Valadian, J., Chittleborough, C. & Wilson, D. (2000) Aboriginal cross-cultural awareness perceptions among staff employed in the health sector. *Health Promotion Journal of Australia.* 10 (2) 156-158

Wano, K. (1999) Cross cultural awareness training. Paper presented at the *Best Practice Interventions in Corrections for Indigenous People Conference*, Australian Institute of Criminology and Department for Correctional Services SA, Adelaide 13-15 October 1999

Westwood, B. (2005) Cross-cultural training for Aboriginal health issues South Western Sydney Area Health Service. *Aboriginal & Islander Health Worker Journal* 29 (3) 22-25

Yaxley, L. (2001) *Aboriginal health: An evaluation of the implementation of the curriculum.* Melbourne: RACGP, Training Program, Quality Improvement Unit.

Young, S. (1999) Not because it's a bloody black issue! Problematics of cross cultural training. In B. McKay (ed) *Unmasking whiteness: Race relations and reconciliation.* Brisbane: Queensland Studies Centre, University of Queensland Press.