Cultural Safety in Policy and Practice Seminar: Summary and implications

April 27th 2016
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- Professor Dennis McDermott, Co-organiser and Presenter: Director, Poche Centre for Indigenous Health and Well-being, Flinders University
- Ms Jude Barlow, Welcome to Country: Ngunnawal People
- Ms Brooke Boney, Facilitator: SBS political reporter
- Mr Craig Ritchie, Presenter: Deputy CEO, Australian Institute of Aboriginal and Torres Strait Islander Studies (AIASTSIS)
- Mr Dave Sjoberg, Presenter: Director, Poche Centre for Indigenous Health and Well-being, Flinders University
- Mr Martin Rocks: Director, Programme Management Office and Implementation Planning Section, Health Programmes and Sector Development Branch, Australian Government Department of Health
- Ms Janine Mohamed, Presenter: CEO, CATSINaM
- Dr Naomi Priest, Presenter: Fellow, Australian National University (ANU) Centre for Social Research and Methods
- Ms Nancy Laliberte and Ms Laurie Harding, Presenters and International Guests: Facilitators, San’yas Indigenous Cultural Safety Training Program, Provincial Health Services Authority in British Columbia
- Professor Roianne West, Panel Member: Professor of Indigenous Health and Workforce Development, Griffith University and CATSINaM Vice President
- Mrs Sharon Gollan, Panel Member: Director, Sharon Gollan and Associates, and Cultural Respect and Training Consultants
- Mr Rod Little, Presenter: Co-chair, National Congress of Australia's First Peoples
- Ms Kathleen Stacey, Documenter and Report Writer: beyond… (Kathleen Stacey & Associates) P/L
- Ms Leonie Williamson, Seminar Coordinator: Policy and Research Officer, CATSINaM
1: Why this seminar?

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) was founded in 1997. It is the national peak body that represents, advocates and supports Aboriginal and Torres Strait Islander nurses and midwives at a national level. CATSINaM’s 2013-2018 Strategic Plan outlines its commitment to advocating and progressing the cultural safety work occurring across the health and education sectors. This commitment is detailed in CATSINaM’s Cultural Safety Policy Position Statement (see Appendix B), along with recommended actions for the nursing and midwifery profession, education providers, Australian and State/Territory Government, and both government and non-government health industry providers.

The premise is that cultural safety is integral to improving health outcomes for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander Australians are more likely to seek access to health care, and achieve better health outcomes by utilising services that are respectful and culturally safe. For CATSINaM it is a critical component of their work on attracting and retaining more Aboriginal and Torres Strait Islander nurses and midwives within the healthcare system.

CATSINaM has implemented its commitment in a variety of ways. It offers cultural safety training opportunities for its key stakeholders, ran cultural safety and resilience professional development for its Members, held the inaugural National Summit on Cultural Safety in Nursing and Midwifery, is supporting implementation of the National Aboriginal and Torres Strait Islander Health Curriculum Framework by nursing and midwifery higher education providers, and is pursuing the establishment of a national Leaders in Nursing and Midwifery Education Network.

So, why hold this seminar? There continues to be a ‘disconnect’ in how we progress from cultural safety in policy to cultural safety in practice. Further, cultural safety needs to be more firmly and consistently embedded across policy for the health professions, higher education providers, government, and health providers. This seminar provided a forum for bringing together policy makers, educators, academics and practice leaders to examine how to consolidate cultural safety in policy and progress the practice of cultural safety within our healthcare systems.

“Cultural safety and cultural competence is at the heart of what it means to be professionally competent – it is not possible to be competent in any domain of activity, and certainly healthcare, if cultural safety is not deeply embedded in what you do as core business. There is no more pressing issue for the Aboriginal and Torres Strait Islander policy enterprise.”

Craig Ritchie: Deputy CEO, Australian Institute of Aboriginal and Torres Strait Islander Studies

2: Cultural safety from policy to practice

The first session was presented by Professor Dennis McDermott and Dave Sjoberg from the Poche Centre for Indigenous Health and Well-being, Flinders University. It drew on their experience of building cultural safety into the curriculum for pre-registration health professionals, along with Dennis’ current ‘National Senior Teaching Fellowship Activity’ that aims to create a good practice guide or model for delivering cultural safety in this context.

In his part of the presentation, Dennis acknowledged that different terms have been used for cultural training over the last 25-30 years, so it is important to recognise the differences in their focus and intent. For example:

- **Cultural awareness**: This was the initial term used and is often more familiar to people; however, this is a localised phenomenon specific to a particular Aboriginal country or nation that is delivered by Traditional Owners of that country or nation. The main focus is on Aboriginal rather than non-Aboriginal people.

- **Cultural competence**: This refers to using knowledge and skills flexibly to work effectively – to do no harm. This cannot be achieved via a checklist, but must be responsive to both individual and institutional contexts.

- **Cultural safety**: This has a deliberate focus on power, which permeates health and education experiences. Cultural safety is created in a health intervention experience where power dynamics in the health encounter are addressed and clinician cultural underpinnings are a critical focus. It invites practitioners to consider “what do I bring to this encounter – what is going on for me”. It reverses the gaze to focus on non-Indigenous people, to reflect on their own cultural identity and how this plays out in practice so they are not diminishing or disempowering Aboriginal and Torres Strait Islander people individually, collectively or institutionally.

- **Cultural ease**: This addresses the issue of non-Indigenous people not working with Aboriginal and Torres Strait Islander people to avoid getting it wrong. It works towards how Indigenous protocols and ways can be incorporated seamlessly into the health professional repertoire, i.e. “when you don’t crunch gears” as you adapt to different cultural ways.

“**What is special about cultural safety? It puts power at the centre, is a decolonising process that is regardful not regardless of who a person is, and requires health practitioners to engage in critical reflective practice. Whether or not cultural safety is experienced can only be determined by the recipient of care.”**

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being
To ensure cultural safety is embedded in policy and translate into practice we must directly engage with the following four life contexts for Aboriginal and Torres Strait Islander Australians. Each implies different mechanisms to use in developing culturally safe individual practitioners and organisations:

**Health equity/inequity:** We must both recognise and understand the social determinants of health.

**Decolonisation:** We must understand that our teaching happens in the context of a colonised country. How can we help students unlearn the so called ‘facts’ of how this country was established to become what we know today? We must disassemble existing planks of beliefs to make room for new learning.

**Racism:** It is essential that an examination of racism is incorporated into our training and our health services. We must name the ‘elephant in the room’, otherwise our training and attempts to be culturally safe will not work. We need well-articulated and thoughtful anti-racism teaching strategies.

**Institutional change:** Working with individual practitioners is important, but we must enable institutional change to stop these processes being stymied so we achieve overall change.

To date, nine elements or issues have emerged as essential to a good practice model, and will form the basis for the good practice guide:

1. We need more sophisticated frameworks that incorporate dialogue and exploration.
2. Approach “every clinical encounter as a cross cultural encounter” (Dr Rhys Jones, NZ).
3. Effective clinical or population health practice occurs at the intersection of population-level social determinants and personal uniqueness of identity and experience.
4. Understanding oppression must take account of structured power and privilege; it is a difficult but essential conversation for people to have.
5. Cultural competence, like all models, must evolve so we can attain desired health outcomes.
6. “Could you just listen?” Listening, hearing, then responding to what is heard is a critical starting point – this resonates with Indigenous notions of ‘deep listening’.
7. “When your belly hurts, that’s the process of self-reflection” – it is an uncomfortable process, how do we manage it so it is safe enough to keep exploring and emerge at the other end, we must build trust for people to take the journey.
8. Learning critical reflection as an essential practice skill - if we do this well in our teaching that will interrupt racism and colonial narratives.
9. Reciprocal relationships are key to facilitating trust and continue the process of addressing racism and cultural safety.
Through his fellowship work, Dennis has identified strategies to bring about change and achieve good practice at two levels. At the **sector wide level** strategies include: working through differing definitions and models of cultural training, having quality assurance frameworks and effective accreditation mechanisms (e.g. ANMAC and AMC).

At the **institutional level**, achieving organisational change requires building critical mass and capacity, ensuring all key management and staff undertake cultural safety training, and embedding faculty or organisational commitment through central plans.

To finish the session, Dave Sjoberg shared one of his approaches for building recognition of racism and an appreciation of cultural safety with pre-registration health professional students through a semester long topic about ‘Critical practice in Indigenous health’. It involved directly teaching critical thinking skills through a deconstruction exercise. It involves asking students early in the topic to write down an anonymous question about Aboriginal and Torres Strait Islander Australians that they may have always wanted to know but had been afraid to ask. Questions are then redistributed, anonymously, amongst the class.

The exercise is to examine and analyse the questions but not answer them. This involves deconstructing the language in the question, examining the assumptions and stereotypes within it, and identifying what is not being said but implied. Using resources from sociology, cultural studies and critical theory literature they learn to build a cogent argument that examines the position from which the question was asked, and identify power imbalances, inequity and privilege. This helps them learn about the social determinants of Aboriginal and Torres Strait Islander health.
3: National Aboriginal & Torres Strait Islander Health Plan, Implementation Plan

Martin Rocks works in the Indigenous Health Division of the Department of Health as Director of the Programme Management Office and Implementation Planning Section. He provided an overview of the Implementation Plan for the National Aboriginal & Torres Strait Islander Health Plan (NATSIHP); he was involved in developing the NATSIHP while seconded to Minister Fiona Nash’s Office. The NATSIHP’s vision is that:

The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.

The purpose of the Implementation Plan is to clearly articulate the specific actions that will be implemented across seven domains to make progress toward ‘Closing the Gap’: health systems effectiveness, maternal health and parenting, childhood health and development, adolescent and youth health, healthy adults, healthy ageing, and social and cultural determinants of health.

Martin explained that his Division recognises that cultural safety is a key approach to help close the gap in Aboriginal and Torres Strait Islander health outcomes, and having a thorough understanding of the social and cultural determinants of health is a key driver. The Department intends to do more detailed work on outlining the social and cultural determinants of health, so that this is reflected in the planned 2018 update of the Implementation Plan.

Martin’s current task is to engage staff from across the Department so they are all invested in the collective implementation and achievement of the deliverables. The Implementation Plan Taskforce was established in the Department in April 2016. Martin recommended that CATSINaM use this forum to keep advising the Taskforce on how we progress this area.

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4: Cultural safety: The CATSINaM experience

Janine Mohamed, CEO of the Congress for Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), shared the journey that CATSINaM has undertaken in advocating for the importance and integration of cultural safety into the health system. CATSINaM is the national peak body that represents, advocates and supports Aboriginal and Torres Strait Islander nurses and midwives at a national level. In relation to cultural safety, CATSINaM strives for:

- increased understanding and shared commitment to cultural safety in the nursing and midwifery professions
- individual non-Indigenous nurses and midwives to receive a good grounding in what cultural safety and respect is and understand that it is a life-long journey
- culturally respectful health systems where Aboriginal and Torres Strait Islander people experience cultural safety and have better health outcomes.

CATSINaM has focused on ‘cultural safety’ because it was developed from a First Nations lens through the work of Irapheti Ramsden, a Maori nurse, and her colleagues in New Zealand. In Australia, moving into greater appreciation of cultural safety within cultural training has occurred for over a decade.

There are clear reasons why CATSINaM focuses on cultural safety as a high priority:

- Aboriginal and Torres Strait Islander Australians are more likely to seek access to health care, and achieve better health outcomes by utilising services that are respectful and culturally safe places.
- A lack of cultural safety is a barrier to recruitment and retention of Aboriginal and Torres Strait Islander students, and graduate nurses and midwives.
- Under-representation of Aboriginal and Torres Strait Islander people in the health workforce is a contributing factor to the lower rates of Aboriginal and Torres Strait Islander peoples accessing health services comparative to need.

CATSINaM has been very active in addressing cultural safety over the past three years, in line with its 2013-2018 Strategic Plan. In response to the terminology discussion, as outlined by Dennis McDermott, CATSINaM developed the ‘Towards a shared understanding of terms and concepts’ paper to assist in this discussion. CATSINaM have published a policy position statement that outlines their position, the actions they will take, and the advice and expectations for different organisations and sectors in taking responsibility to improve cultural safety at individual and institutional levels. This underpins the organisation’s regular advocacy about cultural safety.

Every six months, CATSINaM offers two-day ‘Cultural Safety and Respect Workshops’ for the senior leadership of its key stakeholders. In 2015, workshops were run for Members on ‘Cultural Safety and Resilience’ to support them in managing the individual and institutional challenges they face in working within universities and health systems. This was in response to Members identifying cultural safety and resilience as a priority area for professional development.
In November 2014, CATSINaM held the inaugural ‘National Summit on Cultural Safety in Nursing and Midwifery’ that explored how the profession needs to take collective action to address cultural safety, and the mechanisms that will help achieve that. This includes establishing a ‘Leaders in Nursing and Midwifery Education Network’ or LINMEN, an equivalent network to the long-established LIME for the medical profession. Appendix B has a list of CATSINaM related resources with their website links.

Janine provided a brief overview of dimensions of racism that need to be examined and understood in an exploration of cultural safety: racial prejudice and racial discrimination that operate at the individual level, and cultural racism and institutional racism that operate at the socio-cultural and political level. Further, she illustrated this with examples of how this plays out in the lives of Aboriginal and Torres Strait Islander Australians.

Drawing on the recent ‘State of Reconciliation’ report by Reconciliation Australia, Janine emphasised that the pathway to reconciliation is supported by five pillars that operate at individual, organisational and societal levels – see Figure 1. For the purpose of this seminar, she drew attention to the work required to achieve historical acceptance (bottom right-hand corner).

The report states that many Australians accept facts about past injustices but are unsure of the details. So it is critical that the four in ten Australians who don’t acknowledge or know learn more about past issues, and the six in ten gain a clearer understanding of why this is fundamental to unpacking the situation that Aboriginal and Torres Strait Islander Australians face today across all areas of their lives. If this occurs, the experience of cultural safety will be stronger and more frequent for Aboriginal and Torres Strait Islander Australians.

**Figure 1: Five critical dimensions for understanding and acting on reconciliation**

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For cultural safety to be realised, it must be embedded across systems. Figure 2 illustrates CATSINaM’s recommendations on where this should occur and who need to be involved.

**Figure 2: CATSINaM’s recommendations on where to embed cultural safety and cultural respect across systems**
CATSINaM is active in addressing each of these four domains through the work they undertake or they advocate should be funded and progressed, whether by CATSINaM, other stakeholders or through shared responsibility arrangements. This work cannot be done in isolation – it will take a collective effort based on mutual aspirations.

“Champions are required – through this seminar CATSINaM hopes that more champions will step forward to work with CATSINaM, as well as lead activities that strengthen cultural safety in their own sectors and organisations.”

Janine Mohamed: CEO, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

5: Unconscious bias in healthcare and health

Dr Naomi Priest is a Fellow of the Australian National University Centre for Social Research and Methods. She has undertaken research in relation to racism, as well as Aboriginal people’s perspective on child health and wellbeing, and is currently focused on addressing child health inequities through combating racism.

Naomi commenced by acknowledging that the experience of Indigenous Australians is often conflated with Australians of other culturally diverse backgrounds, but strongly advised against doing this as the experience of Aboriginal and Torres Strait Islander Australians is distinct and requires specific attention. She also clarified that there are no biological or genetic explanations for racism, and socio-economic analyses do not fully explain the persistent inequities that Aboriginal and Torres Strait Islander Australians experience.

She provided definitions of racism drawing on published literature:

Racism is an organised system, premised on the categorisation and ranking of social groups into races, that devalues, disempowers and differentially allocates desirable societal opportunities and resources to racial groups regarded as inferior. [It is] typically undergirded by an ideology of inferiority in which some population groups are regarded as inferior to others.

Inevitably, there is a question of power and with whom it sits in a society. For example, who gets to define whether particular social and cultural differences and values are recognised while others are not? When does this occur? Where does this occur? Why does this happen?

Mechanisms in relation to racism and health were outlined:

- Institutional discrimination can restrict socioeconomic attainment and group differences in socioeconomic status and health.
- Forced removal from land and segregation can create pathogenic residential conditions.
Discrimination can lead to reduced access to essential and desirable goods and services.

Internalised racism (the acceptance of society’s negative characterisation) can adversely affect health.

Racism can create conditions that increase exposure to traditional stressors (e.g., unemployment, poverty and incarceration).

Experiences of racial discrimination are a neglected psychosocial stressor.

Naomi shared research that statistically analysed the associative strength between pairs of words that may co-occur using 10 million words from a sample of books, newspapers, magazine articles, etc. This estimated how often Americans who had reached college/university age may have seen or heard particular words paired over their lifetime. There were strong associations between black and poor, violent, religious, lazy, cheerful and dangerous; whereas strong associations with white were wealthy, progressive, conventional, stubborn, successful and educated.

This pattern of regular word association is evident in Australia. For example, associations made with Indigenous versus non-Indigenous people were investigated by Reconciliation Australia in their 2012 Reconciliation Barometer Report where they compared common stereotypes associated with Indigenous and non-Indigenous Australians based on a sample of 1,012 non-Indigenous adults. Selected outcomes are shown in Table 1.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Indigenous Australians %</th>
<th>Australians in general %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hardworking</td>
<td>20</td>
<td>71</td>
</tr>
<tr>
<td>Disciplined</td>
<td>15</td>
<td>41</td>
</tr>
<tr>
<td>Easy going</td>
<td>57</td>
<td>92</td>
</tr>
<tr>
<td>Friendly</td>
<td>55</td>
<td>86</td>
</tr>
<tr>
<td>Cooperative</td>
<td>31</td>
<td>72</td>
</tr>
</tbody>
</table>

Naomi explained that not only is there a stark difference in how frequently these descriptors are associated with Indigenous compared to non-Indigenous Australians, when compared with the National Voice Project conducted in 2013 in the USA, the frequency of negative descriptors and lack of positive descriptors associated with Indigenous Australians is far stronger than occurs for African Americans.

In the latter part of her presentation, Naomi described ‘unconscious bias’, which is evident in cultural racism and institutional racism. She explained that unconscious biases are automatically activated stereotypes and evaluations that are not always aligned with individually stated beliefs, and tend to favour one’s own in-group. They are pervasive; everyone within a culture is susceptible to them because despite our good intentions we absorb the values, attitudes, beliefs and practices of society without our active consent. While they are related to and influence explicit bias, they are distinct from explicit bias and can operate even when we think we are not being explicitly biased (i.e. being racially prejudiced and racially discriminatory).

“Unconscious bias develops early, around three to four years of age. It has real world effects on social judgement and behaviour. This is evident in policing and criminal justice, education, health, employment and workplaces, housing and public transport to name a few key locations. Unconscious bias is also increased by stress and cognitive load, which epitomises health care interactions.”

Dr Naomi Priest: Fellow, Australian National University Centre for Social Research and Methods

Naomi warned against taking the position that racism is a problem of a ‘few bad apples’, which assumes it is a problem with the hearts and minds of a small group of individuals. This ignores the research on racism as a socially cultivated phenomenon that is infused into our social systems and institutions, and is evident in differential treatment throughout the health care system that leads to poorer health experiences and outcomes for Aboriginal and Torres Strait Islander Australians. Naomi offered a diverse range of examples form the research to illustrate this point.

How then do we reduce unconscious bias, and therefore cultural racism and institutional racism? Naomi put forward two types of interventions.

1: ‘Debiasing’ or reducing implicit bias can occur through:

- counter-stereotype imaging by training individuals to develop new associations through visual or verbal cues, e.g. Aboriginal people in a range of health professions
- individuation by obtaining individual information about group members to help people evaluate members of a target group based on personal rather than group attributes
- perspective taking by assuming a first person perspective and endeavoring to ‘walk in someone else’s shoes’
- evaluative conditioning or counter-stereotypical associations by pairing an attitude object with another quality that shifts attitudes in this new direction (e.g. white faces with negative descriptors or black faces with positive descriptors)
- Intergroup contact that is positive, non-competitive and sustained, although this – has to occur under conditions that account for pre-existing power differences.

2: Preventing biased decision-making can occur through:

- Increasing awareness of and insight into implicit bias, but it is important to consider who is giving the message and their relationship with the person receiving the message
- Increasing motivation to be fair as this can promote accountability and responsibility
- Fostering positive interpersonal motives through having a diversity of people in a given situation and activating norms of affiliation, group care and egalitarianism
- Improving the conditions of decision making by providing clear criteria through decision-making matrices, slowing down the process, reducing cognitive load and stress, or reducing access to information that may trigger prejudice, e.g. reviewing CVs where cultural identity is unknown
- Outlining deliberate behavioural intentions, e.g. developing if-then plans - if this occurs this is how I will behave or make a decision
- Using data to monitor whether decisions are leading to inequitable outcomes for Aboriginal and Torres Strait Islander Australians
- Accountability for achieving change by setting targets, creating incentives and ensuring there are consequences if they are not achieved (voluntary measures at the policy and organisational level do not tend to work).

Naomi offered research examples of these strategies being implemented, as well as the link to the Implicit Association Test that can be used to reveal unconscious bias and develop ways of counteracting it. There are several demonstration tests available based on different social categorisations, including race.5

Importantly, no single strategy will be sufficient; a combination from both types of interventions will be required. In addition, debiasing organisations is more effective than debiasing individuals, as individual effort alone can lead to backlash. Our requirement is to identify how we make addressing racism the responsibility of non-Indigenous providers and systems.

In a recent project, Naomi led a review of an organisational reform in the British National Health Service where a mandated workforce race equality standard was set and organisations had to meet targets in order to avoid contractual consequences. The review focused on whether or not this approach was advisable. The main learnings were that it was advisable and achievable if:6

- The core leadership support articulates diversity as an institutional priority

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5 The Implicit Association Test is found at <https://implicit.harvard.edu/implicit/>.
6 The article can be accessed at <http://www.bmj.com/content/351/bmj.h3297>. 
Multiple strategies are implemented at organisation, workplace, interpersonal and intrapersonal levels

- mandated targets or actions are set
- diversity training across the organisation (noting that it is ineffective if done in isolation)
- this results in representation of a critical mass of minority cultural groups, i.e. moves beyond tokenism
- support is provided for minority staff, i.e. psychological safety
- policies and processes support open communication without being negative.

6: What’s the harm? Disrupting stereotyping of Indigenous people in health systems through Indigenous Cultural Safety Training

Nancy Laliberte is a Cree/Metis woman originally from the Beaver River area of the territories now known as Canada, and Laurie Harding is a White Settler with Scottish and English ancestry who lives on unceded Coast Salish territory, known as Victoria, Vancouver Island in Canada.

Along with their Director, Cheryl Ward, Nance and Laurie are members of a team that developed the online San’yas Indigenous Cultural Safety Training Program based in the Provincial Health Services Authority in British Columbia, which commenced in 2009. Nancy and Laurie facilitate learning groups through the training process and support ongoing development of the program. They paid specific respect to the inspiring work of Cheryl Ward in initiating and developing San’yas, and her influence in engaging support from many people across the provincial health system.

San’yas was developed by Indigenous leaders to foster safer and more effective health services for Indigenous people. The San’yas program increases knowledge, enhances self-awareness, and strengthens the skills of those who work directly and indirectly with Indigenous people. It moves from core modules through to advanced modules, including modules focused on mental health and child welfare.

From its initial focus on British Columbia, the San’yas team have expanded their work with policy leaders across Canada and internationally to develop and implement cultural safety training in their organizations, health authorities, and professional colleges. To date 28,000 professionals in Canada have completed the core or subsequent modules.

Why cultural safety? Similarly to the reasons that CATSINaM has for focusing on Indigenous cultural safety, Nancy and Laurie spoke of the need to address inequities that are present across all aspects

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7 The San’yas Indigenous Cultural Safety Training Program is found at <http://www.sanyas.ca/training>.
of life as a result of colonisation, and the ongoing Indigenous-specific racism and discrimination occurring in Canada. They emphasised that this must be accomplished by paying attention to the historical, socioeconomic and political influences on Indigenous people and by addressing structural inequities.

Similarly to what occurs in Australia, racism and an honest account of history based on colonisation is rarely openly explored within organisations, the community and the media. Therefore, the San’yas program was designed as an intervention for the ‘elephant in the room’ – racism, colonial history, theft of land, forced removals and violence.

“Indigenous cultural safety is about knowing who we are and the people we work with, the benefits and inequities, and working together to address this... Addressing cultural safety is an ongoing process of actively working to make systems safer and more equitable for Indigenous people. The goal of cultural safety is to assess the quality of care, adapt services to better meet Indigenous people’s needs, and ultimately improve the quality of and access to services.”

San’yas Indigenous Cultural Safety Training Program Team, Provincial Health Services Authority in British Columbia

The program is underpinned by the cultural competence continuum model proposed by Terry Cross that has also been drawn upon in Australian contexts, although it uses the language of cultural competence rather than cultural safety. It suggests that people develop their capacities by moving from “cultural destructiveness” to “cultural incapacity, cultural blindness, cultural pre-competence and cultural competence” before achieving “cultural proficiency”.

Critically however, Nancy and Laurie emphasised that people do not always move up the continuum in a smooth direction. They can move backwards and forwards, or get stuck. Any movement on the continuum is triggered by a significant event.

The original online module had approximately 20 hours of content, but this was restructured to create a ‘core module’ and then ‘advanced modules.’ Participants are advised that it takes eight weeks to complete the core module (about eight to ten hours of work is required depending on their style of learning). They must start by completing a pre-training evaluation that includes scenarios to which they respond, and there are three discussion boards and three journals to

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complete. It is self-paced training, so although 25 people commence every Monday as a group, they are often at different points in the curriculum, which is reflected in their discussion.

San’yas uses available technology to time-test participant engagement based on whether the mouse has moved or not. If participants reach the end of the module but do not do any activities, their supervisor is notified and this is followed up. Another marker is completion of the post-training evaluation that also uses scenarios to see how participants now address racist stereotypes that are presented to them.

If participants continue on to the advanced modules, they explore how they can move from being a bystander of racism to an ally who is proactively anti-racist, and unpack the colonial relationship to explore white privilege and settler privilege, i.e. benefits that have accrued to people with a settler ancestry over time from the process of colonisation.

It takes about four months to train facilitators before they take on a group. All facilitators have ongoing access to a First Nations Elder as a cultural mentor. Traditionally they had two facilitators work with a group, an Indigenous and non-Indigenous pair. They have found that this does not always work (backlash may be directed at Indigenous facilitators), so have also run groups with two white facilitators and participants that have achieved good outcomes.

Nancy and Laurie clearly stated that they see the Sany’as program as foundational, not the finishing point. Participants need to continue the journey and apply their learning on a regular basis in their work. In fact, they suggested that there would be value in having a foundation preparatory course in critical thought prior to the core training.

In 2014, the San’yas team realised they had access to an enormous amount of data that could be researched to examine patterns in how participants demonstrate engagement and resistance through the process. Therefore, they analysed participant commentary on discussion boards and journals from 2010-2014. They also wanted to explore how they facilitate a journey for participants from unlearning to learning by moving from resistance – or the growing zone – to integration and praxis.

Examples of resistance in attitudes were participants expressing: contempt, hostility, dismissiveness, avoidance, resentment, defensiveness, and stating that any individual’s opinions are ‘valid’ (even against the weight of evidence). Examples of resistance in behaviours were evident when participants: hijacked discussion boards, mobbed up or groomed others to support them, used public space, were argumentative, engaging in baiting or mocking of the topic/other participants/the facilitator, and expressed backlash.

There were always areas of predictable resistance – what they referred to as curriculum triggers. This included topics that explored race and Indigenous specific racism, colonial discourse, settler privilege and contextualising culture. As facilitators, their role is to assist participants to explore healthy guilt and shame, and to build healthy white settler identity that acknowledges the realities of what occurred in the past and what impact this has today. Nancy and Laurie explained that they cautioned participants from getting stuck when exploring colonial history, and white and settler privilege. They support them to use indignation about inequities between Indigenous and non-Indigenous Canadians to fuel the effort to address the inequities.
Nancy and Laurie explained that they have added the language of **settler privilege** and **settler fragility** to extend on white privilege. They do this when looking at the unceded land rights and laws that effect Indigenous people and are different from any other groups of people in Canada. Regardless of when people arrived in Canada, people can benefit from the privileges of being non-Indigenous people. This does not deny the journeys of recent residents from traumatic situations, but they will ultimately be gaining safety at the expense of what has occurred to First Nation’s people/Indigenous peoples in Canada. They also commented that the interest accrues exponentially to settler Canadians but the cost also builds for Indigenous people.

Another technical strategy built into the online environment is used when participants make concerning comments. There is a system to click on the comment and send a message to the participant to contact the facilitator so they can talk about the matter. Facilitators help explore where participants are at, particularly if their commentary is brief and it is not possible to deconstruct it from their online post.

They have found that people do open up and are willing to make comments in the online environment that they may not otherwise do, which creates the opportunity for direct engagement with facilitators. This aids the process of disrupting settler privilege, to challenge and support, not just to make people feel better. It can be the first time people have been challenged. They aim to make the implicit explicit, and normalise having emotions in this process. They place a strong emphasis on the need to self-reflect, because self-awareness is one of the foundations in people’s development along the cultural competence/safety continuum.

Their research has also identified how engagement occurs. Examples of **engagement in attitudes** were participants expressing: curiosity, recognition of their own ignorance, humility, empathy, self-regulation, and healthy guilt and shame. Examples of **engagement in behaviours** were evident when participants: share examples of acting on their learning, recognising and addressing racism in their work context, and talking with other participants about how they can apply the learning. They have a knowledge integration session within the module to help with this translation process; this includes using role plays and scenarios where people take up other positions to what they usually have.

The built in curriculum triggers for supporting positive engagement include exploring racist stereotyping, fostering empathy, identifying responsibility, practical activities, and supportive facilitation. The desire is to enable self-regulation, a sense of social justice and self-reflection. The intent of the San’yas program is to lead participants towards new understanding and compassion about the realities of what Indigenous people have to live with every day.

Nancy and Laurie reflected on their approach to facilitation. They focus on addressing resistance (contempt, hostility and defensiveness) and supporting engagement (responsibility, empathy, self-regulation and curiosity). They have consciously worked to orient more of their time to supporting engagement of participants who want to engage in the learning, and have a lengthy file of positive examples of translation into practice they can draw upon.

However, the concern with resistance is the ‘capacity for harm’. Currently they are working with the Provincial Health Authority on how to address this as an organisation issue. Their current phase of research with 2015-2016 data is on the extensive commentary produced through the online
The discussion forums provided 1,000's of examples of this occurring in the health authority from which to draw a random sample, combined with demographic and health role information on participants.

To date they have identified harm was experienced in 85% of situations from 380 random samples, resulting in less care to Indigenous people. The examples represented 38 different sites across their provincial health system with 32% being the emergency room. Over 92% identified as non-Indigenous and 44% were nurses. They are the people who witnessed the racism, not those committing it. This means they are seeing racism across a spectrum of workplaces, which is filtering care for Indigenous people. The learning from this research is not new but it confirms the existing literature - there is a high prevalence and spectrum of racist stereotyping resulting in violence and harm. Significantly, the violence is not described as being reported. People being inducted into accepting this situation, having the racist treatment of Indigenous people discounted and normalised.

However, new themes emerged. The term “unfortunately” came up repeatedly, i.e. incidents happen due to bad fortune, not predictably or systemically, which is consistent with the assumption that we all have an equal starting place. “It happens all the time…” was commonly stated, i.e. it is normal but sad. This was linked with a lack of outrage and lack of engagement with the incident. Participants commented that “I can't do anything because…”, as if they were behind a glass screen and separated from the incident. They did not describe making a connection to their own ethical practice or connecting to the obligation to interrupt anyone being harmed in the health system. Their task as facilitators in the San'yas program is to move people along to action.

“Indigenous anti-racism is different because of the colonial context, the need to think critically, address social justice and equity, take on responsibility and expose colonial narratives.”

San'yas Indigenous Cultural Safety Training Program Team, Provincial Health Services Authority in British Columbia
7: Questions and reflections

Following the presentations, participants had an opportunity to put forward questions during a panel session. In addition to Dennis McDermott, Janine Mohamed, Nancy Laliberte and Laurie Harding, the panel included the following Aboriginal Australians with long-standing experience in training and/or addressing cultural safety: Professor Roianne West and Sharon Gollan.

Roianne West is a Kalkadoon woman who is currently Professor of Indigenous Health and Workforce Development at Griffith University, leading the ‘First People’s Health Unit’, as well as being the CATSINaM Vice President. Sharon Gollan is a Ngarrindjeri woman with a long history working in the public sector and academia, who now works as a cultural advisor, and cultural safety trainer and consultant.

Eight questions were raised; these questions along with key themes in the panel member responses are summarised here.

**Question 1: As an Aboriginal, Torres Strait Islander or Aboriginal and Torres Strait Islander Australian, what does cultural safety mean to you?**

“Connecting to my internal signs of safety. It is more than having the Aboriginal flag flying or other posters and images. It is a direct experience of feeling safe. If we are not [feeling safe] in a particular situation, then we have the opportunity to go somewhere to articulate that and believe that we will be listened to by the person to whom we speak, that they will hear and acknowledge our experience.”

Sharon Gollan: Cultural advisor, trainer and consultant

“Cultural safety is not pathologising the pain and connection to culture and people. It is recognising its reality – realising colonisation is not over. This is a step towards changing things.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

“Aboriginal and Torres Strait Islander people being able to walk as freely and comfortably on their country as their ancestors did.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

“Feeling familiar and safe in your own land. Acknowledgement that this is your land, and all the injustice that came with colonisation. Seeing another familiar face [in a health service] as I can make it through whatever is going on.”

Nancy Laliberte: Facilitator, San’yas Indigenous Cultural Safety Training Program
Question 2: What is your position on naming racism for what it is? Do you think this is a necessary part of exploring cultural safety?

“It is absolutely vital. You can’t have cultural safety without having racism addressed. From my experience, institutional racism is the most devastating form for our communities.”

Sharon Gollan: Cultural advisor, trainer and consultant

“It is absolutely important….We have to go from the top – the leadership and management and set the model for the whole organisation.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

“I commend the leadership of the NATSIHP and the Aboriginal and Torres Strait Islander Health Curriculum Framework to directly name racism. What is happening in the university and in the hospitals/health services must be consistent.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

“The reason why we need cultural safety is because of racism... The work that needs to be done is settler work about stopping the cause of the harm so people can access the health services in a respectful way. In our facilitation we have a ‘call it like it is’ approach, which is very freeing. We are conscious of how careful Indigenous people have to be in surviving through the system.”

Laurie Harding: Facilitator, San’yas Indigenous Cultural Safety Training Program

Question 3: What are important considerations in turning national/state documents that name cultural safety into practice that can be clearly seen and experienced through everyday decision-making, program and service delivery?

“It has to be a systematic and strategic approach with Indigenous leadership.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

“While non-Aboriginal people, people from the dominant culture, must have an understanding of our cultural values and beliefs, more that this they must recognise their culture, their values and their beliefs, and how that is enforced upon us to take up. We talk about cultural safety and cultural respect, but dominant culture must stop defining what that looks like - it has to be us.”

Sharon Gollan: Cultural advisor, trainer and consultant

“We are looking at policy and where it falls over – taking good intentions and motherhood statements and translating. It gets individualised, becomes about ‘lifestyle’ choices not social determinants of health. We must address what contributes to and are the drivers of inequity.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

“We need more accountability measures... a broader sweep about accountability and what is not acceptable and this is what happens if I see [racism] again in the workplace.”

Laurie Harding: Facilitator, San’yas Indigenous Cultural Safety Training Program
“We need our organisation to make change based on a cultural safety plan and action items, but when government or a health authority dictates how things will roll, people adapt it and may apply or ignore it. We have to be really hard on what the outcomes need to be and the targets.”

Nancy Laliberte: Facilitator, San’yas Indigenous Cultural Safety Training Program

Question 4: I would like the opinion of the group on face to face cultural education compared with online learning – do the panel see this as important?

“With respect to what I have heard from Nancy and Laurie, my experience of hearing that was that it was wonderful, but I also once taught in universities. I fought against online teaching of cultural safety, ways of teaching that had to look like dominant culture ways of teaching and against being part of the standard assessment process so I introduced different assessment processes, such as using practical/realistic scenarios where students presented to panels of Aboriginal community members. The effort involved was the reason why I left the university. If I was back in the system again, I would be for face to face.”

Sharon Gollan: Cultural advisor, trainer and consultant

“We talk about the online cultural safety being orientation training; really anti-racism training and then we talk about colonisation. We don’t want people’s learning to come at the expense of Indigenous people, so we have Indigenous facilitators as well and must support them through that.”

Laurie Harding: Facilitator, San’yas Indigenous Cultural Safety Training Program

“I admire what my Canadian colleagues have done, it is the most sophisticated online training, well-resourced, developed and facilitated, and I salute you for it. I have had a small experience with delivering cultural safety online with a small cohort of Masters students based in the university and larger group online based in remote communities. We had to develop mechanisms to make the contact happen across the ether, so taped all the face to face tutorials and lectures, then hold online discussions. I would always still plug for a face to face component.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

“This year we have 700 students completing the pre-survey, doing the 3 day face to face training, and then online work. I want to assess the best delivery mode to do this. Bringing research to this gives it rigour. It is good to have the experience from across the water [from San’yas].”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

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9 Sharon currently and regularly delivers face to face cultural safety to university, government and non-government organisations.
Question 5a: I would like to know whether what we hear about bullying in the medical fraternity is an opportunity to progress cultural safety or does it make it harder to push for this?

“I am not sure it makes it harder, but it highlights when the system is under stress and under-resourced, things are more likely to happen. It is not just the medicos. We work in a School of Nursing and Midwifery where equally there is a bullying, command and control, chip on the shoulder culture. We have to help health professionals of all stripes to know they can do their job efficiently and be a human being where they empathise and connect. You can do both things at once.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

Question 5b: Does the medical profession having to address the bullying culture in the medical fraternity shift the focus away from cultural safety in an Aboriginal and Torres Strait Islander context, or is it part of shifting the entire culture?

“Absolutely, if we can work out how to get this right for the most vulnerable group in Australian society, you can work this out for everybody. We have to work consciously and deliberately, rather than robotically if working with people of your own culture.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

“If bullying is the misuse of power, then cultural safety is about recognising power and how it operates. It has a lot to offer the wider workforce.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

Question 6: I notice the intensive fear of the word racism in my work with schools. People may consider their own privileges but when put in the context of racism they find it hard to accept. How can we address this in education so it is not so problematic to talk about racism?

“It is not just about educators managing the process. It is also for the community. Racism doesn’t get named enough in our wider community. When it does get named it gets changed to another word or given other names that flip outside our mouth more easily e.g. preferring to talk about bigotry. This won’t change until we have racism spoken about in the way Naomi discussed that sexism can be, and we make space to talk about bullying and homophobia. In relation to racism, it gets silenced. It gets silenced by the media, which has a lot of influence and they don’t even want to talk about it. It is about how people in the non-Aboriginal community can name and call it.

There have been many opportunities in recent times, such as through the terrible experience of Adam Goodes, which was racism. But the focus was on the wrong person, not on media personalities who continued expressing racism towards Adam Goodes. We had an opportunity to put the spotlight on this but Aboriginal people, and Adam as an Aboriginal person, had to suck it in.
How many non-Aboriginal people could have got up and said something publically? It was a golden opportunity. Another one occurred with the NRL State of Origin game. Non-Aboriginal people need to speak it up. Not just the educators, not just Aboriginal and Torres Strait Islander people.”

Sharon Gollan: Cultural advisor, trainer and consultant

“CATSINaM’s response is multi-level and there is no single answer. An acute issue is watching our kids’ experiences. I was involved in the Health Heroes campaign that was informed by social research when we asked Aboriginal kids what they thought they could be when they grew up. They said they could be a netballer or AFL player, but were not smart enough to be nurses, midwives or other health professionals. So we have to decolonise ourselves so we can open up to our options.”

Janine Mohamed: CEO, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

“I think about TV growing up. There were no representations of me or other Aboriginal people, so I think the media plays a very important role in reflecting our society. The way we see ourselves is filtered through the TV, what we read and listen to. If you are a little black kid and can’t see yourself reflected in any of this, you probably don’t think you can do it. You don’t think you can go to university or that you are smart enough.”

Brook Boney: SBS political reporter

Question 7: What would culturally safe policy and policy-making look like?

“It is policy that is developed and led by Aboriginal and Torres Strait Islander people. It is really simple - you should involve people who are most effected by the outcomes of it.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

“In looking at the genesis of the National Aboriginal and Torres Strait Islander Health Plan, it seemed to break with the past at putting culture at the centre and naming racism. It came from strong Aboriginal and Torres Strait Islander academics, leaders of organisation leaders etc who worked hard to pressure the system. There are policy actors and bureaucrats who do not rock the boat and are scared of Indigenous perspectives coming in. Sometimes it is said to be political will, but this is also about bureaucratic capacity to put this into practice, to address the gate-keeping function of policy bureaucrats.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

“Recently we have had a policy analyst on our team. Their plan is to comb through all existing policies and find a way to ‘Indigenise’ them. It is new to have a staff member just focused on the meaningful involvement of Indigenous people in policy. We also have the First Nations Health Authority that has a policy department and have been rolling out their own policies from an Indigenous lens.”

Nancy Laliberte: Facilitator, San’yas Indigenous Cultural Safety Training Program
“When leading policy development, it shouldn’t sit in isolation, such as occurred with the NATSIHP and Aboriginal and Torres Strait Islander Health Curriculum Framework. I just did our First People’s Health Strategic Plan at Griffith University and got little resistance, but reached the end of the process and thought something is not right.

The minute we call it the First People’s Health Strategic Plan, it will just be the role of the First People’s Health Unit to do the work, so we have shifted the name to Griffith University. It was an important lesson - it mustn’t be isolated in a separate document. It must be embedded in core organisational documents.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University

“Policy is looked at in terms of its impact on many fields, so why don’t we have policy impacts against ‘Close the Gap’ - in every policy, not just health? We already see what it looks like. We have examples of what it looks like. Aboriginal Community Controlled Health Services work, hospitals who take this on seriously at an organisational level achieve a difference Aboriginal people accessing their service.”

Janine Mohamed: CEO, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

**Question 8: Where does cultural safety training belong best, who is best to deliver it? When you think of students in higher education settings, it is an institution with a colonial legacy that has been used as a tool of oppression. Students may move to another classroom and then cultural safety is absent. What is the role for civil society and community groups to make sure cultural safety is continued?**

“That is a great and difficult question. Most universities have someone fairly high in the academic food chain such as a Deputy Vice Chancellor for Indigenous Affairs, a position that is beginning to have more clout, but they can’t change the whole university. Every university is becoming more corporatized, taking away Boards and Senates to reduce staff and student representation so it is a more streamlined corporate culture, quicker decisions but for what? To go down a particular path. We need to support these positions, but it has to be embedded right across the universities and get this through all faculties.”

Professor Dennis McDermott: Director, Poche Centre for Indigenous Health and Well-being

“It has to be everywhere, in all environments, strategic and systematised, even though there are boundaries and Indigenous leaders have to rise above a lot so all sectors are addressing the matter. It underpins all health education. There should not be a space where people go in this country where cultural safety isn’t taught.”

Professor Roianne West: Professor, Indigenous Health & Workforce Development, Griffith University
8: Closing thoughts

The seminar was brought to a close by Rod Little, Co-Chair of the Congress of Australia’s First Peoples. Rod encouraged participants to share their wisdom, experience and openness to learning with their colleagues who were unable to attend.

Rod acknowledged that, collectively, we gained enormous material from the day. Addressing cultural safety and racism is a national and international challenge, one that we must accept. We must move past denial, such a common reaction when we challenge truths. Why is it so hard to accept what happened in Australia when it has happened elsewhere as well, such Canada? We require a collective approach to policy development that opens up hearts and minds, where we say, “Let’s do this together”.

“Non-Indigenous Australians must learn to appreciate the discomfort that is a daily experience for Aboriginal and Torres Strait Islander Australians. You can’t experience what we feel every day, but you can accept it is real. You can sit with and use this experience of discomfort in this learning to enable much needed change. Change oneself, and then apply those principles to work in policy development and service delivery.”

Rod Little, Co-Chair of the Congress of Australia’s First Peoples

Today there was a call for courage and being champions. Rod suggested that the room was full of champions. We must inform ourselves through experience and resources, as was shared during the seminar, there is plenty of information. We must move to asking “What am I offering to the solution to this?” Although the journey has not and will not be smooth, it is necessary.

Rod emphasised the similarities occurring across the waters and that we need the unity of First Peoples, along with our non-Indigenous colleagues and civil society because that is where some of the power will come from for continuing much needed change. Commendable people, words and actions can be reflected in everyday realities.

“I commend CATSINaM for this work, I worked in the health sector for 15 years. It feels like you are on this path, this journey that is going to change. There was much wisdom, experience and knowledge I heard today - the growth is enormous.”

Rod Little, Co-Chair of the Congress of Australia’s First Peoples
9: Implications for action

This seminar has reinforced that cultural safety is critically important for Aboriginal and Torres Strait Islander Australians. The following implications are underpinned by the assumption that once non-Indigenous Australians recognise that cultural safety is important, they will choose to be part of the solution rather than part of the problem. How does that shape action on cultural safety in policy and practice?

The NATSIHP provides a shared platform for action, as the vision is that by 2031 the ‘Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable’. How do we realise this?

As highlighted repeatedly during the seminar, ‘let’s do this together’ and adopt a collective approach to policy development and translation into practice. This is an approach where Aboriginal and Torres Strait Islander people have clear and respected authority and leadership roles, and non-Indigenous people take responsibility for supporting and enabling implementation. This must be reflected in how the policy development process is designed, as well as the policy itself, along with implementation and accountability mechanisms.

We must all take responsibility for health inequity. Particularly for non-Indigenous Australians, change requires a personal process of critical reflection, questioning unconscious bias and engagement in racism whether at individual or institutional levels. If we are to be better policy officers, academics, educators, health professionals and community members, then our role includes changing ourselves. We need to have the courage to ‘name the elephant in the room’. It is undeniable that racism causes harm. Becoming better at naming racism is foundational to achieving cultural change in health systems, education systems and beyond.

We must use the available resources, knowledges and skills available to understand what cultural safety means and apply cultural safety principles in policy development and service delivery. A strong body of work is available, such as the resources and experts highlighted at the seminar and included in this summary paper. If we do not draw and act on this body of work, we perpetuate health inequity despite the stated intention of the NATSIHP to end racism.

On this basis, having made their intention public and combined with the government sponsored ‘Racism: It stops with me’ campaign, the Australian Government must show greater leadership in demanding anti-racism actions from State/Territory Government and the full range of health services in line with the NATSIHP Implementation Plan. Further, they must set targets and measure outcomes in order to strengthen accountability mechanisms across the health system, and require staff to name and address racism.

Training and mentoring remain important workforce development strategies for resourcing health system staff to do this. However, National Cultural Safety Training Standards are a missing element of the landscape, as they would embed a consistent and measurable approach within the system. There is an existing body of work on which such standards could be easily developed, and
CATSINaM is willing to lead in this process in partnership with other national Aboriginal and Torres Strait Islander organisations, as they are the people qualified for setting such quality benchmarks.

Finally, we need champions. Specifically, we need more non-Indigenous champions to work alongside Aboriginal and Torres Strait Islander Australians in leading, implementing and monitoring change. Non-Indigenous Australians need to reduce the burden of responsibility for challenging and addressing racism, and educating people about cultural safety. Too often this is left to Aboriginal and Torres Strait Islander people. Non-Indigenous people need to and can take up a stronger role in facilitating change that will bring an end to racism and unjustifiable health inequities.

“I don’t hold the present generation responsible for the past but I will hold it responsible for the present and the future because it is its responsibility and mine to change things for the better” [xxiv]

The late Oodgeroo Noonuccal, quoted in Watson (2006)

## Appendices

### A: Seminar program agenda

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<tr>
<th>Time</th>
<th>Agenda</th>
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<tr>
<td><strong>Arrival 9:45</strong></td>
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<tr>
<td>10:00</td>
<td>Welcome to Country</td>
<td>Ms Jude Barlow</td>
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<td>Welcome to the Seminar</td>
<td>Mr Craig Ritchie, AIATSIS</td>
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<tr>
<td>10:20</td>
<td>Cultural safety from policy to practice</td>
<td>Professor Dennis McDermott and Mr Dave Sjoberg, Poche Centre for Indigenous Health &amp; Wellbeing</td>
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<td>11:15</td>
<td>National Aboriginal and Torre Strait Islander Health Plan (NATSIHP) Implementation Plan</td>
<td>Mr Martin Rocks, Department of Health</td>
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<td>11:40</td>
<td>Cultural Safety: The CATSINaM experience</td>
<td>Ms Janine Mohamed, CATSINaM</td>
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<td><strong>Lunch 12:30</strong></td>
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<td>1:00</td>
<td>Unconscious bias in healthcare and health</td>
<td>Dr Naomi Priest, Australian National University</td>
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<td>1:45</td>
<td>What’s the harm? Disrupting stereotyping of Indigenous people in health systems through Indigenous Cultural Safety Training</td>
<td>Ms Nancy Laliberte and Ms Laurie Harding, San’yas, Provincial Health Services Authority, British Columbia</td>
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<td>2:45</td>
<td>Panel Session: Questions and reflections.</td>
<td>Professor Roianne West (Griffith University), Ms Sharon Gollan (Gollan &amp; Associates), Ms Nancy Laliberte and Ms Laurie Harding (San’yas), and Professor Dennis McDermott (Poche Centre)</td>
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<td>3:50</td>
<td>Summary and close</td>
<td>Mr Rod Little, National Congress of Australia’s First Peoples</td>
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<td>4:00-4:30 Afternoon tea and networking</td>
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B: Links to CATSINaM cultural safety related resources

The following resources can assist with exploring cultural safety and its application further:


