CHAPTER ONE

Indigenous Australian cultural competence

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LEARNING CONCEPTS

Studying this chapter should enable you to:

1. identify the importance of Indigenous Australian cultural competence.
2. identify the historical context behind Indigenous Australian cultural competence.
3. identify the importance of skills that enable the journey of Indigenous Australian cultural competence.
4. determine strategies that promote Indigenous Australian cultural competence in practice.
5. identify your own professional plan in Indigenous Australian cultural competence.

KEY TERMS

critical reflection

culture

Indigenous Australian cultural competence

transcultural care

worldview

Introduction

Indigenous Australian cultural competence
A nonlinear process in which non-Indigenous health workers consider how their values, beliefs and behaviour influence the care they provide to Aboriginal and Torres Strait Islander peoples.

This chapter will encourage you to begin thinking about the relevance of **Indigenous Australian cultural competence**.

Throughout this chapter you will be asked to reflect on and consider what culture and cultural competence means to you as a registered nurse and/or allied health practitioner. This will involve considering what defines culture, the history and significance of Indigenous Australian cultural competence, and finally how cultural competence translates into clinical practice. Often the lifelong journey of cultural competence can be challenging. It requires us to reflect on our beliefs, attitudes and values—on the very essence of who we are as a person—and then consider how these may influence, change or enhance the care we provide to our clients. This can be an uncomfortable process. Often in times of discomfort we learn and are more inclined to retain the learning.

critical reflection
A deep form of reflective learning that creates the opportunity for our worldviews to be transformed.

This chapter will require you to reflect. Reflecting critically on yourself as a person in a diverse world and as a clinician is vital to enacting Indigenous Australian cultural competence. Case studies will be provided to encourage **critical reflection**, and links to other sections of this textbook will help to provide professional context.

The importance of Indigenous Australian cultural competence within the Australian health landscape

Historically health outcomes for Aboriginal and Torres Strait Islander peoples have been significantly worse than for non-Indigenous Australian people (Australian Bureau of Statistics, 2012, 2015). This has been addressed by many different government and non-government initiatives. The most prominent campaign was introduced in 2008 when the Australian government recognised the need to make the changes required to reduce health disparities by funding the development of the Close the Gap campaign. This campaign was, and remains, important for a variety of reasons. It showed the wider health community the gravity of health disparities in all areas of Aboriginal and Torres Strait Islander peoples' health and healthcare (Council of Australian Governments (COAG) Reform Council, 2010) and enabled an opportunity to report successes as initiatives were implemented.

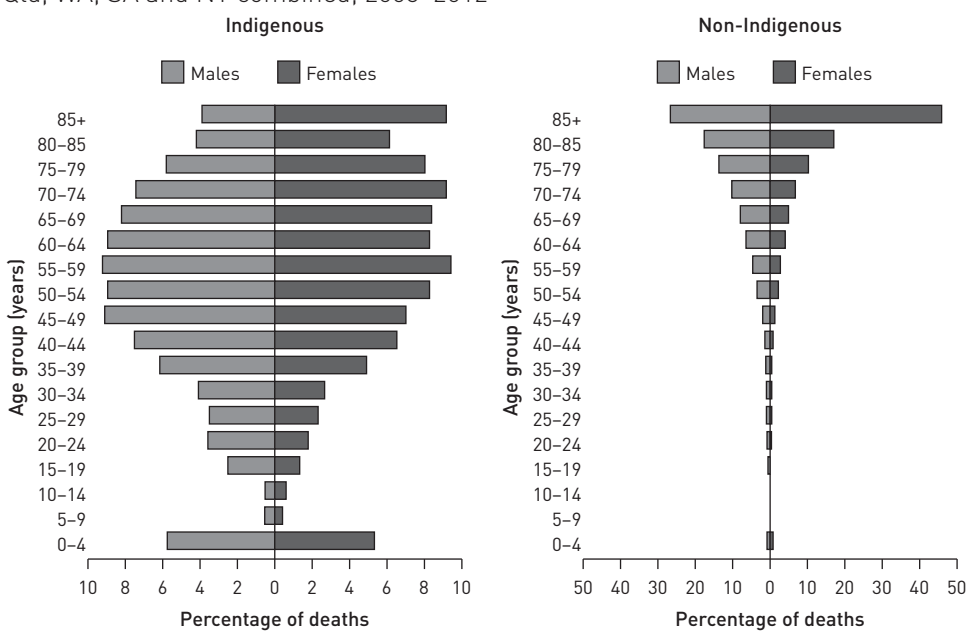
The Closing the Gap campaign was supported by the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*, which had an overarching philosophy of ensuring equality in cultural considerations in care, and of dignity and justice underpinning health. This framework was later progressed to the *National*

Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Commonwealth of Australia, 2013). This plan importantly focused on not only health priorities but also principles in healthcare delivery, and highlighted a vision for the eradication of systemic and non-systemic racism in healthcare within Australia.

Racism will be further explored in Chapter 2, but it is important to create links in this foundational chapter in relation to Indigenous Australian cultural competence. In this era we are in a position to look back and see some positive changes in Aboriginal and Torres Strait Islander peoples' morbidity and mortality. In data collated from 1998 to 2013 by the Australian Bureau of Statistics, we can see a decrease in mortality. Although this can be viewed as a positive shift, there is still much work to be done as a nation (see differences in mortality rates between Indigenous and non-Indigenous populations in Figure 1.1). The exploration of morbidity and mortality brings our attention to healthcare and healthcare outcomes. It also raises the notions of health professionals' attitudes, biases and understandings of Aboriginal and Torres Strait Islander peoples' concepts of health and connections to Australian health providers. A United Nations thematic paper highlighted the need to provide equality in healthcare for Aboriginal and Torres Strait Islander peoples (Inter-Agency Support Group on Indigenous Peoples' Issues, 2014).

Several thoughts have been raised as to why the health gap still exists, particularly with current government strategy, funding allocations and raised awareness of health disparity (Australian Institute of Health and Welfare, 2016). Various rationales have been revealed over the course of many years of research in this important area. While

Figure 1.1 Age distribution of deaths, by age, sex and Indigenous status, NSW, Qld, WA, SA and NT combined, 2008–2012



Source: Australian Institute of Health and Welfare (2014).

we continue to learn in this area, we do have some insight that health outcomes of Aboriginal and Torres Strait Islander peoples have been linked to four important areas:

- socio-economic disadvantage
- a lack of culturally appropriate healthcare resources used in mainstream health
- Western models of healthcare being the primary model of care provided within mainstream healthcare in Australia
- a lack of confidence in accessing healthcare early in a period of illness or at all due to direct and indirect racism by healthcare providers (Larson, Gillies, Howard & Coffin, 2007; Kidd, Watts & Saltman, 2008; Maher, 2013).

Therefore, our actions, thoughts and beliefs as health professionals are important in the delivery of healthcare and can result in a change in healthcare outcomes for our clients. This forms foundational thinking about the importance of Indigenous Australian cultural competence within Australia.

Studies (Durey, Thompson & Wood, 2011; Taylor, Thompson & Davis, 2010) have revealed that Aboriginal and Torres Strait Islander peoples are more likely to access healthcare when communication is respectful, where clinicians have an understanding of Aboriginal and Torres Strait Islander peoples' cultures, and where clinicians are able to work towards the development of good relationships that involve Aboriginal and Torres Strait Islander health workers as a part of the healthcare team. It is important that health professionals have the skills, attitudes and beliefs to ensure this is achievable within Australian healthcare facilities.

It has been cited by many that mandatory training in the area of Aboriginal and Torres Strait Islander peoples' health may result in better health outcomes for consumers of healthcare (Health Workforce Australia, 2011). In 2016, the release of the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Commonwealth of Australia, 2016) provided evidence and support for health practitioners embedding content into undergraduate courses (discussed further in Chapter 3). The implementation of Aboriginal and Torres Strait Islander content into courses is thought to provide much-needed training and development in the area of Indigenous Australian cultural competence. Most importantly, we must highlight that short courses have proved to have little effect on sustainable personal changes that may influence the care we provide to clients (Paul, Carr & Milroy, 2006). Therefore, models of learning need to be considered across a lengthy period of time, perhaps even a lifetime.

Case study 1.1: Nursing focus

John's story

John is a nurse employed at a major health service. He has recently been to a professional development course that focused on Indigenous Australian

cultural competence. The training consisted of an online module and a face-to-face workshop with colleagues he knows well. As he was leaving the training, a registered nurse colleague came up to him and said, 'This training is so pointless—what a waste of time! I don't care how people think or behave. As long as they get the medical treatment I am happy. The rest is just politeness, which I do not have time for. They always end up coming back anyway.' John was surprised at his colleague's attitude to care and the training program. He decided to grab himself a coffee before heading back to the ward. He wanted to reflect on the situation he had just encountered and consider its meaning in nursing practice.

CRITICAL REFLECTION QUESTIONS

- What are your initial responses to this situation?
- What are the benefits and risks raised for John (personally), to the healthcare service and to the public?
- How might John proceed in this situation? What key practice considerations arise?
- What might be other considerations when viewing this case study?

Case study 1.2: Allied health focus

Jacinta's story

Jacinta is the manager of the Allied Health Department at a major public health service. Jacinta has been tasked with reviewing the statistics of Aboriginal and Torres Strait Islander people accessing the Allied Health Department over the last two years and with providing a presentation to her manager. Jacinta decided to approach the team leaders of each allied health discipline to seek their support in putting together the statistics.

Jacinta spoke with Rob the physiotherapy team leader who said, 'This will be an easy report for the physio team as hardly any Aboriginal and Torres Strait Islander people access the physiotherapy services.' Jacinta did not reply to Rob's comments, but as she was walking to her office she started reflecting on them. Jacinta then spoke with Sarah, the occupational therapy team leader, and Sarah's comments were very similar to Rob's. Jacinta was concerned that both team leaders made very similar comments and was unsure how to proceed.

(Continued)

Jacinta decided to have a yarn with Jason, the Aboriginal community liaison officer, about both Rob's and Sarah's comments. Jason responded to Jacinta by simply saying, 'How do Rob and Sarah know if Indigenous people access the allied health services?'

Jacinta thanked Jason for his time and advice, and decided to go away and reflect on his comments before speaking with Rob and Sarah again.

CRITICAL REFLECTION QUESTIONS

- What are your initial responses to this situation?
- How might Jacinta proceed in this situation? What key practice considerations arise?
- What might be other considerations when viewing this case study?

The history of Indigenous Australian cultural competence

To understand cultural competence it is important that we consider where cultural competence was first developed and why. The term first emerged in the 1980s in the USA. It was particularly prevalent with teachers, social workers, and health and welfare workers as they were seeking ways to better meet the needs of multicultural communities. Although the term has been used within literature for some time, the implementation of cultural competency skills has been varied.

In the context of health, there was significant evidence that revealed people from ethnic and racial minorities experienced significantly poorer health outcomes than people from the majority/dominant culture (Betancourt, 2003; Brach & Fraser, 2000). While a range of biomedical models have explored why this may have occurred, it has taken time to shift our thinking from the 'problem patient' to what we can do, say, be or change to adapt our practice to each individual client and respond to their cultural, spiritual, social and physical needs. The concept of 'cultural competence' has since been a focus in Western English-speaking countries with Indigenous populations. A vast amount of literature about cultural competence has been generated mainly from the USA and Canada (Truong, Paradies & Priest, 2014; Clifford, McCalman, Bainbridge & Tsey, 2015), with an increasing body of work from Australia.

The literature indicates that while the term is used frequently, there remains confusion over the definition. Within healthcare a consensus has not been reached over the definition of 'cultural competence'. However, many definitions share key elements (Betancourt, Green & Carillo, 2002). These elements include but are not limited to the following: valuing diversity; having the capacity for cultural self-assessment; being

conscious of the dynamics inherent in cross-cultural interactions; institutionalising the importance of cultural knowledge; and making adaptations to service delivery that reflect cultural understanding (Humphery, 2000; Ranzijn, McConnochie, Day, Nolan & Wharton, 2008). In other words, there are many models that suggest ways that nursing and allied health practitioners can become more culturally competent.

The language of cultural competence has created discussion. The very nature of the language assumes that the journey and learning have an end point (competence), and requires certain parameters to be obeyed. However, more recent models within Australia have indicated that cultural competence does not have an end point, and nor is it linear—instead, it is reliant on skill attributes and transformative learning. It has been shown that the journey is complex, occurs across a career and stimulates a change in an individual's viewpoint (Biles, Coyle, Bernoth & Hill, 2016). There are many ways that one can learn cultural competence skills and the learning can occur in many different ways. What seems to be common across the literature is that the cultural competence needs to be viewed as a journey that may never reach an end point (Hains, Lynch & Winton, 2000).

Models of cultural competence

As suggested earlier in this chapter, there are many ways that one can learn cultural competence. Models have been developed over time to assist in the delivery of cultural competence within undergraduate degrees. These models can focus on individual approaches as well as institutional approaches to the journey of cultural competence (Cross, Bazron, Dennis & Isaacs, 1989; Campinha-Bacote, 2002) to bring much-needed training in the area of cultural diversity. It would be useful to explore your own university's take on cultural competence.

Other Western nations such as America and Canada have a specific perspective on cultural competence. There seems to be a focus on both institutional and individual competence. These models emphasise that the development of cultural competence involves a two-way learning process. The process may be between the organisation and the individual or between the health professional and client (Campinha-Bacote, 2002). Cultural competence is much more than awareness; rather it is a philosophical approach to healthcare that influences the delivery of health services (National Health & Medical Research Council, 2005).

Wells (2000) writes from an American perspective and explains cultural competence via a continuum. The continuum is represented through a matrix that can guide the practitioner and their institution through a range of stages that are thought to promote competence. The matrix views the continuum as culturally incompetent to culturally proficient. Cultural proficient is detailed as being at the top of the matrix and does allude to an end point of competence. Many Australian universities embrace the Wells model of competence. Ranzijn et al. (2008) outline the important implications of the Wells model, explaining that the practice of cultural competence is about being

sequential and fluid (able to move through stages at any time), highlighting that 'one-off' cultural awareness workshops are ineffectual.

Recent research in Australia has indicated that cultural competence training has resulted in an increased preparedness to work with Aboriginal people (Paul et al., 2006; McRae, Taylor, Swain & Sheldrake, 2008), a greater understanding of health challenges for Aboriginal and Torres Strait Islander peoples (Mooney, Bauman, Westwood, Kelaher, Tibben & Jalaludin, 2005) and improved relationships between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, all of which can enhance access to services (Si, Bailie, Togni, Abbs & Robinson, 2006). Education of Australian health professionals in cultural competence is believed to be paramount (Hunt, Ramjan, McDonald, Koch, Baird & Salamonson, 2015).

Professions play a key role in the development and understanding of cultural competence (Ranzijn et al., 2008). For example, the Australian Nursing & Midwifery Accreditation Council (2015) has mandated the inclusion of a core subject in all undergraduate Bachelor of Nursing courses. It can be argued that the inclusion of a core subject requires educators to be on a journey of cultural competence. The onus is on educators providing learning opportunities to educate and prepare nurses for delivering their services in culturally appropriate ways, as well as preparing themselves to deliver education in a culturally responsive way. Achieving this requires support at an organisational level (Grote, 2008), something which many universities are still striving to achieve. Consider the opportunities that are presented to you as a current university student.

Professional organisations and Indigenous Australian cultural competence

Importantly, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives was established in 1997 with aims to address the health gap between Indigenous and non-Indigenous Australian people. The Congress has been responsible for many policies and recommendations guiding the development of nursing curriculum and best practice. The Congress released a statement in 2017 supporting the ongoing development of cultural safety of staff, students and healthcare services, recognising that this does rely on parity in the nursing and midwifery workforce (CATSINaM, 2017, pp. 11–12). It can be suggested that there is an interrelationship between cultural safety and cultural competence. To be cultural safe, practitioners need to be responsive to culture and on a journey of cultural competence.

Indigenous Allied Health Australia (IAHA) was established in 2009 from a network of allied health professionals, and in 2013 registered as a company. IAHA believes that Aboriginal and Torres Strait Islander health professionals play a major role in healthcare. In order to make a difference in health outcomes, the health workforce needs to be culturally responsive (IAHA, 2017).

> [IAHA] asserts that a culturally responsive health workforce is imperative in order to ensure Aboriginal and Torres Strait Islander people receive the healthcare required to significantly improve health and wellbeing outcomes. IAHA views culturally responsive care as a cyclical and ongoing process, requiring regular self-reflection and proactive responses to the person, family or community with whom the interaction is occurring.
>
> IAHA (2015, p. 1)

We can assume that if we have a body of health professionals each on a journey of Indigenous Australian cultural competence, we can move forward as a culturally responsive workforce.

The following Australian definition of cultural competence has been drawn from the *Ngapartji-Ngapartji Yerra* report of the Indigenous Higher Education Advisory Council (IHEAC, 2007), a council that provides advice to the Australian government on higher education, research and training (IHEAC, 2007). This is currently the most widely accepted definition used in Australia:

> Cultural competence is the awareness, knowledge, understanding and sensitivity to other cultures combined with a proficiency to interact appropriately with people from those cultures in a way that is congruent with the behaviour and expectations that members of a distinctive culture recognise as appropriate among themselves. Cultural competence includes having an awareness of one's own culture in order to understand its cultural limitations as well as being open to cultural differences, cultural integrity and the ability to use cultural resources. It can be viewed as a non-linear and dynamic process which integrates and interlinks individuals with the organisation and its systems.
>
> IHEAC (2007, pp. 5, 34–38, and amended in 2011, IHEAC meeting and endorsed by the IHEAC Chair and Deputy Chair)

Cultural competence and cultural safety

Within Australia, the terms 'cultural competence' and 'cultural safety' are at times used interchangeably. In New Zealand, the term 'cultural safety' is often used in preference to 'cultural competence'. Cultural safety, as defined by Eckermann, Dowd, Chong, Nixon, Gray and Johnson (2006, p. 213) is:

> An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening.

The introduction of this term into nursing education stimulated a national review of cultural safety in New Zealand in the early 1990s (Ramsden, 1990) and resulted in the embedding and recognising of cultural safety as a foundation tool in nursing practice. The focus of this concept is primarily on the experience of the client, empowering

the model to be considered from both an institutional and individual level involving specific skills. This has been well detailed by Eckermann et al. (2006).

Essentially, cultural safety can be defined by the experiences of the recipient of care rather than being a tool for a practitioner to embed (Eckermann et al., 2006). It is seen to require the skill of reflecting on one's own cultural identity and then the recognition of the impact one's culture has on practice.

The Australian Health Practitioner Regulation Agency (2018) has defined cultural safety in Australia as 'the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal health care for Aboriginal and Torres Strait Islander peoples', while the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (2018) defines cultural safety as:

> a philosophy of practice that is about how a health professional does something, not [just] what they do … It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health … Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care.

Within Australia, it is paramount that we are able to provide services of care that are culturally safe. Cultural safety should be deemed 'safe' by the client—not the institution. Within health services it is also paramount that we have well-equipped health professionals that acknowledge their own position in the world and are on a journey of individual cultural competence. This enables a workforce that is culturally responsive to the needs of Aboriginal and Torres Strait Islander peoples.

How to start the lifelong journey of Indigenous Australian cultural competence

In order to commence your journey in Indigenous Australian cultural competence, an understanding of five major terms is vital: non-linear learning, culture, worldview, discomfort and critical reflection. These five components will provide context in how you may decide to progress your learning journey. Importantly, this is not a recipe for cultural competence; however, these five major terms may assist your development in this space.

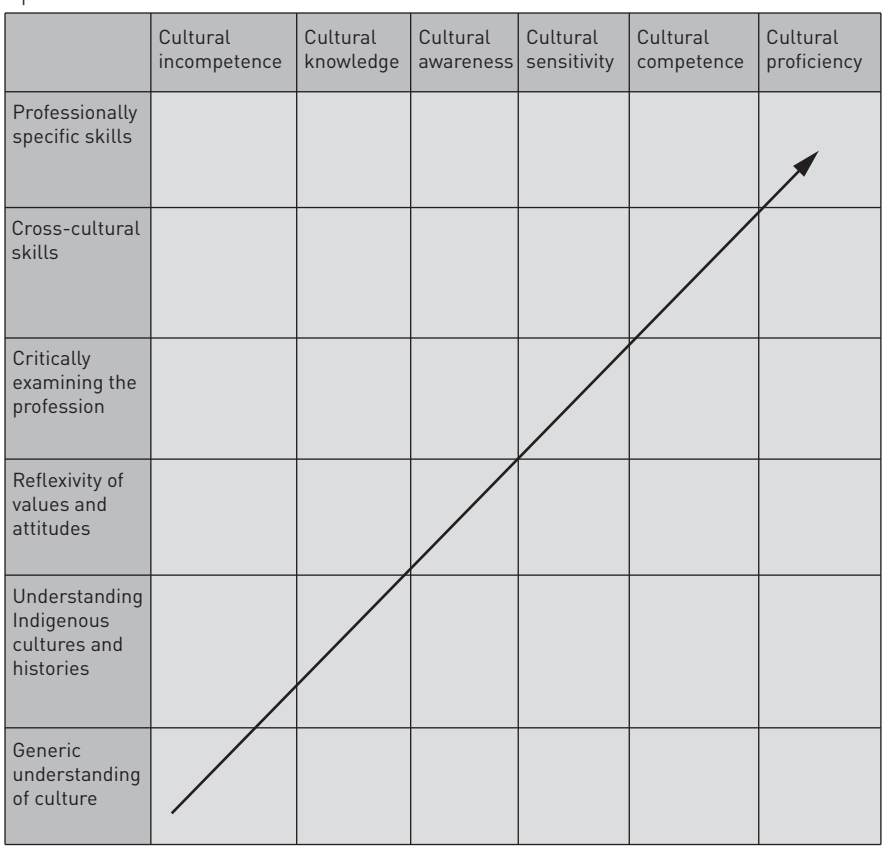
Non-linear learning

As discussed earlier, a range of models have attempted to explain and provide examples of how we 'do' cultural competence in healthcare (Biles et al., 2016; Campinha-

Bacote, 2002; Ranzijn et al., 2008). All of these models are evidenced as assisting the development of skills, values and behaviours. Importantly, what is apparent is that the journey seems to be non-linear. There are times when we will be faced with challenging circumstances that create a rapid shift in our thinking—circumstances that detract from prior learning—and we see a decline in our skills and/or a considered meaningful approach to learning Indigenous Australian cultural competence. This is important to note. The learning journey may not be a perfect linear progression and that is okay. We all have unique experiences and challenges that shape who we are as clinicians, and this is essential given the diverse population of Australian health. The important aspect to remember is that the journey must be across a lifetime. Culture shapes society and identity and is not static; therefore, our journey in Indigenous Australian cultural competence will always be moving and will not have an end point. Our journey is also shaped by the infrastructure in which healthcare is delivered (this will be further discussed in Chapter 3).

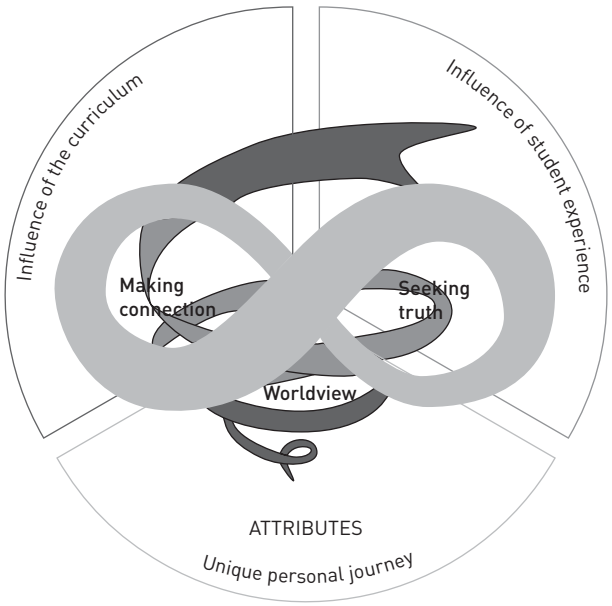
Figure 1.2 and Figure 1.3 present two models of learning Indigenous Australian cultural competence.

Figure 1.2 The Ranzijn, McConnochie, Day, Nolan and Wharton model of cultural competence



Source: Ranzijn et al. (2008).

Figure 1.3 The Biles, Coyle, Bernoth and Hill model of learning cultural competence in nursing



Source: Biles (2017).

Culture

culture A set of common beliefs, attitudes and norms shared by a group.

When considering Indigenous Australian cultural competence, it is important to first consider our own **culture**. Culture has been defined as a set of common beliefs, attitudes and norms shared by a group (Ranzijn et al., 2008). Its definition moves culture beyond social rituals and traditions like artistic expressions and beliefs as being important to our worldview (discussed later in this chapter). Cultural groups shape their worldview and make the way that members live their lives 'right' for 'us' and different to others (Jenkins, 2006). Take a moment to consider your own culture.

Worldview

worldview How we see, are and react to the world around us.

Indigenous Australian cultural competence implores us to spend time navigating our own culture prior to being able to consider the cultural influences of another person. We are then in a position to reflect on our cultural position as a nurse or allied health professional. How we see the world shapes our **worldview**. Consider how you explore your own culture. Perhaps it is through discussion with your peers, reading a book, discussing your family ties or even through university study.

Worldview has been defined as a theoretical construct (Underhill, 2009), meaning that definitions of our worldview have been theorised and built upon over many decades shaping how we see, are and react to the world around us. There are many influences

on our worldview that shape our norms, and often we are unaware that they exist until we experience difference. Difference may be around cultural norms, traditions, perspectives or gender, to name just a few (Best & Fredericks, 2014). Our worldview shapes how we see the world, how we engage with others and how we see difference (Payne & Payne, 2004). Our culture has the ability to influence our worldview.

Sociological perspectives around worldview suggest that the way in which we see ourselves in the world relates to cultural difference (Payne & Payne, 2004). An example of this is a specific dominant cultural group as discussed by Payne and Payne (2004), or other dominant groups such as male, heterosexual, white and middle class. Unconsciously, we often group together with others who share our sense of worldview and identity with the world. This can be challenging when considering difference and can promote the concept of 'othering' (Young, 2000). Othering is a challenging situation when we cluster towards our worldview groups and experience difference. We see the difference as 'other' and at times threatening to our sense of the world. It takes bravery to see the world in a different way and also it requires an element of discomfort.

Discomfort

There have been times when we have all felt discomfort. Perhaps the discomfort was during a dental appointment or a social situation where we were not comfortable with the group we were conversing with. Discomfort, which is not to be confused with distress, is an emotion where we feel unsettled, unnerved or slightly anxious (Merriam-Webster, 2017). Social theorist Megan Boler (2000) has discussed that this feeling of discomfort can promote an opportunity to feel and reconsider our own worldviews. The space where learning becomes uncomfortable can be a place where we reconsider the lens in which we see the world. Consider a workplace learning experience where you have felt discomfort. Did the experience enhance your learning and shift your thinking around a certain area?

When this occurs, it has the potential to enable us to reconsider and evaluate our own inner values. This space is important in Indigenous Australian cultural competence, where an Aboriginal or Torres Strait Islander person's view of health and wellness may differ from the personal view of a registered nurse or an allied health practitioner. Recognising these steps in your learning journey will assist not only in your practice but also in how you can relate to others in both your personal and professional world.

1. Consider a time that you have felt uncomfortable in both your personal and professional world. Record your memory of the feelings and the outcomes in your reflective journey.
2. List times that you have felt uncomfortable during clinical placement. Reflect on these situations and consider your learning during the situation.

Critical reflection

Critical reflection is a skill that is well recognised as being vital to both registered nurses and allied health practitioners (Jayatilleke & Mackie, 2013). Critical thinking has been defined as a metacognitive process requiring 'purposeful, insightful judgment that involves the development and effective utilisation of multiple dimensional cognitions to interpret and analyse a situation' (Facione & Facione, 2013, p. 6), arriving at an appropriate way to respond, act or reach a conclusion to a problem (Kaddoura, Van-Dyke & Yang, 2016). Both nursing and allied health practitioners have a range of models available to promote the use of critical thinking (Cottrell, 2017). Critical thinking has been shown to bring precision, accuracy and relevance to any given situation (Cottrell, 2017). It requires us to mindfully focus our attention on a situation, observe, identify key points, analyse and respond with the desired message (Cottrell, 2017).

Critical reflection is said to be a deep form of reflective learning that creates the opportunity for our worldviews to be transformed (Mezirow, 1981), linking with Indigenous Australian cultural competence. Mezirow (2010) describes transformative learning as the moment in time when you reconsider how you see the world, and also describes it as having the ability to challenge personal assumptions that may have an impact on professional worlds. For some learners it may be a particular learning experience such as clinical placement, and for others it may be a slower, more considered journey as they navigate their way through their undergraduate degree. Critical reflection is a vital competence in Indigenous Australian cultural competence. It creates the nexus to shift our thinking from our own norms and to start to think about the world through a different lens. Consider a learning experience that you have undertaken that has promoted a 'light bulb' moment. Perhaps the experience was through a conversation with a peer, a tutorial topic, a book or even a workplace learning situation. How did you feel and how did this influence your leaning?

Transcultural care—where does this fit?

transcultural care
Knowledge, skills and behaviours that are responsive to the delivery of healthcare to more than one culture.

Often when discussing Indigenous Australian cultural competence, the notion of **transcultural care** is raised. So, importantly, we must highlight where we see that it fits. This may assist your learning as an undergraduate student.

In the 1960s transcultural care was founded. Essentially transcultural care forms the knowledge, skills and behaviours that are responsive to the delivery of healthcare to more than one culture (Leininger, 1975; Leininger, 2002; Purnell & Paulanka, 2003). Leininger (2002) has written on the essence of nursing being 'care', and from this she links care to her model of transcultural nursing: the cultural care theory. This model has been used extensively in the development of nursing curricula (Leininger, 2002). Leininger (1975) suggests, and her model indicates, that the phenomenon of 'care' had

cultural contexts that were often not valued in the nursing profession. Leininger was foundational in nursing practice, raising attention on how culture influences the care we give and receive.

The purpose and goal of the cultural care theory is to provide culturally congruent, safe and meaningful care to clients of diverse or similar cultures (Leininger, 2002). The model is linear, cross-cultural and focuses on cognition, suggesting assessment techniques that are inclusive of 10 principles that practising clinicians should consider as a guide for practice (Leininger, 2002). Of interest, the model has been reinvigorated in teaching cultural competence in American nursing schools since the New York twin towers attack of 2001 (Leininger, 2002). One particularly important aspect in the cultural care theory is that it is believed that registered nurses and allied health professionals require an inner desire to practise transcultural nursing (Leininger, 1975). This is important and determines the success of the model's application.

Another model of transcultural nursing is the Purnell model of cultural competence. It originated in Canada and consists of 12 domains that are important for the nurse to consider, and relies on the nurse being able to assess using the domains within practice (Purnell & Paulanka, 2003). The Purnell model claims to have transcultural applications; however, the practice-based approach of the model reveals major assumptions that the underpinning of all cultures have similarities (Purnell & Paulanka, 2003), which does not always represent best care in all cultural contexts and is reliant on both organisations and individuals working together.

Transcultural care is important in Australian healthcare systems. There are similarities between the journey of Indigenous Australian cultural competence and the transcultural model of care. The skills in Indigenous Australian cultural competence are transferable to many cultural groups. The journey is driven from within the health professional.

IMPLICATIONS FOR NURSING AND ALLIED HEALTH PRACTICE

As registered nurses and allied health professionals we often experience situations with our clients when they are at their most vulnerable. It is important that our behaviours, skills and practices reflect diversity and respect the client's worldview rather than our own. Locate the Nursing and Midwifery Board's *Registered Nurse Standards for Practice* (2016) or your specific professional standards that relate to Indigenous Australian cultural competence. Review the standards and consider which standards you feel are appropriate to your learning journey.

Developing a professional plan will assist in your application and progression in Indigenous Australian cultural competence. As discussed earlier, the journey in Indigenous Australian cultural competence is across a lifetime. It may involve a range of activities that can be uncomfortable, and require critical reflection that promotes a sense of cultural identity in the world and an understanding of personal worldviews.

A professional plan evidences commitment, intention and thought into a specific area. It can align with professional standards or form a personal connection between ideas, thoughts and activities that are undertaken in a professional career. Consider what a professional portfolio may look like in your discipline area. Table 1.1 depicts one method of capturing professional goals in the area of Indigenous Australian cultural competence. A professional plan can be used in a professional portfolio, which is a requirement of all health practitioners in Australia and demonstrates that you are self-regulating your learning needs in a specific area.

Table 1.1 Professional plan for Indigenous Australian cultural competence

Professional standard	Personal activity	Professional activity	Reflective diary entry

Case study 1.3: Nursing focus

Sally's story

Sally is a student in an undergraduate nursing program in Australia. Sally has moved from a regional location to a metropolitan city to attend university. She lives on campus in shared accommodation and has made a large network of friends. Sally has been advised by her lecturers that her second placement is at a large metropolitan Aboriginal Health Service. She has recently completed a subject on Aboriginal and Torres Strait Islander peoples' health in her nursing degree program and obtained a credit in the subject. She enjoyed the learning, but struggled to grasp why it was required in a nursing degree. Now Sally needs to prepare herself for the placement. She has mixed emotions of excitement and apprehension. She shares some of her feelings with her friends, who do not understand her apprehension. Sally is confused by her feelings and has decided to complete some additional study on her own to prepare for her placement.

CRITICAL REFLECTION QUESTIONS

- What are your initial responses to this situation?
- What are some strategies for Sally?
- How might Sally proceed in this situation? What are the key considerations?
- What might be other considerations when viewing this case study?

Case study 1.4: Allied health focus

Brian's story

Brian is a second year allied health student who is in his second week of a five-week placement in a regional city hospital. Brian attended a professional development (PD) session presented by an Aboriginal Community Liaison Officer (ACLO) at the start of his placement. The ACLO mentioned that it should be everyone's business who works at the hospital to make sure that the hospital is culturally safe for all clients accessing the services. Since this PD session, Brian has started to reflect on his role as an allied health professional in ensuring that the allied health department is a culturally safe environment for the clients accessing the services. Brian is unsure if the allied health department is culturally safe for the clients as he reflects on a subject that was delivered in his first year at university that spoke of Indigenous clients not being comfortable or safe accessing mainstream health organisations. Brian decides to speak with his supervisor regarding the questions he has.

CRITICAL REFLECTION QUESTIONS

- What are your initial responses to this situation?
- How might Brian proceed in this situation? What key practice considerations arise?
- What might be other considerations when viewing this case study?

Working towards a reconciliation framework

'Reconciliation' is a term that means something different to each individual. As defined by the *Oxford Dictionary of English* (Stevenson, 2017), it is the act of bringing together. Many groups within Australia have a unique and individual focus on reconciliation in regard to Australian people. Key bodies such as the Council for Aboriginal Reconciliation (2000) and Reconciliation Australia (2016, 2017a) all have slightly differing definitions and approaches to reconciliation. Some scholars claim that reconciliation has had a lengthy timeline in Australia with initial steps being taken over 25 years ago via political activity around native title and land rights (Reconciliation Australia, 2017a). The Council for Aboriginal Reconciliation (2000), now superseded by Reconciliation Australia, was foundational in building relationships between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian people. The historic People's Walk for Reconciliation across the Sydney Harbour Bridge in 2000, following the

submission of reconciliation recommendations to the Australian Government, has been described as a pinnacle moment in the Council's history with over 250,000 Australians taking part in the walk (Council for Aboriginal Reconciliation, 2000). Reconciliation Australia is a non-government organisation within Australia with a primary aim to provide a framework for organisations to build capacity and respect (Reconciliation Australia, 2017b). Share our Pride (Reconciliation Australia, 2016), funded by Reconciliation Australia, is a website designed to provide initial thoughts about building better relationships with Aboriginal and Torres Strait Islander peoples.

In 2017, Reconciliation Australia focused on a five-step reconciliation action plan. The five steps involve race relations, equality and equity, institutional integrity, unity, and historical acceptance. One government response to this plan was the bipartisan development of the Referendum Council to consult with Aboriginal and Torres Strait Islander communities on meaningful recognition. Constitutional reform was a focus area recommended. While dialogue still continues, preliminary responses to this suggestion were not in favour of constitutional change (Reconciliation Australia, 2017a).

The Australian Health Practitioner Regulation Agency (AHPRA) (2017) and the national professional boards have often taken a combined approach in defining reconciliation. Reconciliation planning began in 2015 with AHPRA initiating discussion between professional bodies. The overall approach was aimed at professional health bodies seeking ways to close the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. While the plan is still in its infancy, we can conclude that health professional boards in Australia deem reconciliation to be a priority.

A small application of reconciliation was adopted in this textbook. As discussed in the introduction, the development of this textbook involved both an author who identified as Aboriginal and/or Torres Strait Islander and non-Indigenous writers. The journey of the writing team has had both intrinsic and extrinsic opportunities in bringing together health professionals.

Conclusion

The future of nursing and allied health professions requires us to respond to and engage with a variety of cultural groups. To ensure that this response to healthcare is safe for practitioners and clients, we need to encourage all professions to be on a pathway to Indigenous Australian cultural competence. This chapter has provided an exploration of the role of Indigenous Australian cultural competence as a way of working towards a united and unified Australia.

SUMMARY

Throughout this chapter, you have been encouraged to consider models of cultural competence while exploring ways to develop skills in cultural competence. Indigenous Australian cultural competence is a lifelong journey that requires commitment and a willingness to explore the worldview of others.

Learning concept 1

Identify the importance of Indigenous Australian cultural competence: Indigenous Australian cultural competence is a lifelong journey undertaken by health professionals. Indigenous Australian cultural competence encourages us to consider our own bias, worldview, attitude and beliefs. Studies have revealed that Indigenous Australian people are more likely to access healthcare when communication is respectful, where clinicians have an understanding of Indigenous Australian culture, and where clinicians are able to work towards the development of good relationships that involve Indigenous Australian health workers as a part of the healthcare team. It is important that health professionals have the skills, attitudes and beliefs to ensure this is available within Australian healthcare facilities.

Learning concept 2

Identify the historical context behind Indigenous Australian cultural competence: The term 'cultural competence' first emerged in the 1980s in the USA. It was particularly prevalent with teachers, social workers, and health and welfare workers as they were seeking ways to better meet the needs of multicultural communities. Understanding the history assists us to understand contemporary Indigenous Australian cultural competence.

Learning concept 3

Identify the importance of skills that enable the journey of Indigenous Australian cultural competence: Indigenous Australian cultural competence is a lifelong journey with many skills that may influence the journey of individuals. This text provides examples via five major terms: non-linear learning, culture, worldview, discomfort and critical thinking. These provide context in how you may decide to progress your learning journey.

Learning concept 4

Determine strategies that promote Indigenous Australian cultural competence in practice: Acknowledging the journey as involving the concepts of non-linear learning, culture, worldview, discomfort and critical thinking can assist the development of Indigenous Australian cultural competence.

Learning concept 5

Identify your own professional plan in Indigenous Australian cultural competence: Developing a professional plan will assist in your application and progression in Indigenous Australian cultural competence.

REVISION QUESTIONS

1. In your own words, explain why the history of cultural competence is important to understand.
2. Explore why Indigenous Australian cultural competence requires health professionals to be reflective practitioners.
3. Consider your profession and the skills required to be a culturally responsive practitioner.
4. Consider how you would contribute to your personal and professional journey in Indigenous Australian cultural competence. Develop your own professional plan.
5. Consider Reconciliation Australia's five-step action plan. Review each criterion and make suggestions on how you can personally and professionally contribute to reconciliation within Australia.

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