Chapter 15
Embedding Cultural Competence in Faculty: A Mixed-Methods Evaluation of an Applied Indigenous Proficiency Workshop

Kerrie E. Doyle, Lauren Zarb, Kyar Wilkey, Kayla Sale, Chris Pitt, and Dein Vindigni

Introduction

One of the most pressing issues in Australian society is the gap between Indigenous and non-Indigenous health and life expectancies (Marmot, 2017). Australia agreed with the World Health Organisation's 2008 *Closing the Gap in a Generation* report (WHO, 2008), spending approximately 5.6% of government expenditure towards ameliorating this gap (Gardiner-Garden & Simon-Davies, 2012), yet there have been only minimal positive outcomes (Alford, 2015; Gannon, 2018). In applied terms, this means Indigenous people are still dying younger (Anderson et al., 2016), scoring higher on psychological distress (Markwick, Ansari, Sullivan, & McNeil, 2015) and suffering poorer indices on all chronic diseases (e.g. Walsh & Kangaharan, 2016; Thompson, Talley, & Kong, 2017). The level of complexity involved in addressing these "wicked" or seemingly "impossible to solve" health problems is made worse by the lack of any pan-national strategic planning and/or intervention evaluation

K. E. Doyle (✉)
School of Medicine, Western Sydney University, Sydney, NSW, Australia
e-mail: AuntyKerrie.Doyle@westernsydney.edu.au

C. Pitt
Aboriginal Health and Wellbeing Clinical Academic Group, University of NSW, Sydney, NSW, Australia

K. Wilkey · K. Sale
Translational Health Research Institute, Western Sydney University, Sydney, NSW, Australia

D. Vindigni
School of Health and Biomedical Science, Royal Melbourne Institute of Technology, Melbourne, VIC, Australia

L. Zarb
School of Nursing and Midwifery, La Trobe University, Melbourne, VIC, Australia

J. Frawley et al. (eds.), *Cultural Competence and the Higher Education Sector*,
https://doi.org/10.1007/978-981-15-5362-2_15

(Lokuge et al., 2017), even though there has been a plethora of programs and projects designed to improve Indigenous health (see for example, AGPC, 2016).

Leaders in health and educational institutions must consider why there is a lack of progress in closing the gap in Indigenous health and life expectancies. Addressing the inequities in Indigenous health requires a determinant of health approach (Mitrou et al., 2014), as 39% of the gap in health outcomes can be explained by social determinates (AIHW, 2017; Markwick, Ansari, Sullivan, Parsons, & McNeil, 2014). The social determinant considered to most reliably predict Indigenous poor health is racism (Kelaher, Ferdinand, & Paradies, 2014; Paradies, 2006; Paradies & Cunningham, 2009; Paradies et al., 2015; Paradies, Truong, & Priest, 2014).

Racism and Its Effect on Indigenous Health

Racism in Australia and Australian health care settings is often researched, with racism's associated negative impacts on Indigenous health recognised since the 1970s (Stevens, 1974; Paradies, 2016). Paradies (2006) empirically demonstrated the link between self-reported racism and poorer health. Larson, Gillies, Howard, and Coffin (2007) also confirmed a significant correlation between experiencing racism and levels of illness in Indigenous people. Ziersch, Gallaher, Baum, and Bentley (2011) found racism predicts poor health in urban Indigenous populations, and Awofeso (2011) also identified racism as a major impediment to Indigenous health and health care. Kelaher et al. (2014) showed how racism negatively impacts the mental health of Indigenous people, and Doyle (2012) demonstrated how cultural incompetence, if not racism, can threaten the therapeutic mental health journey of Indigenous people. Racism is recognised as a barrier to accessing health care in Australia (Bastos, Harnois, & Paradies, 2018). According to Paradies (2018), there are five areas for combatting racism in organisations and institutions, and one of these is cultural competence training for health workers.

Cultural Competence Training in the Health Sector: Changing the Cultural Landscape

Creating cultural competence in health care practitioners would be one way to tackle the inequities in Indigenous health (Doyle, 2015a; 2015b). It is the attitudes and behaviours of health care providers and researchers that are either culturally competent or not (Stoner et al., 2015), and many frontline workers continue to acknowledge their cultural incompetence (Wilson, Magarey, Jones, O'Donnell, & Kelly, 2015). An evidenced-based program embedded into the training mechanisms of all health professionals to skill practitioners in cross-cultural proficiency would decrease

racism in health care settings (Durey, 2010; Gordon, McCarter, & Myers, 2016), by privileging the value of social justice and giving voice to Indigenous people as stakeholders in their own health (Reibel & Walker, 2010). Changing the focus of health care delivery to include cultural competence can reduce the health disparities of Indigenous Australians (Durey & Thompson, 2012).

Creating equity in Indigenous health settings needs to be a priority in health systems (Otim, Kelaher, Anderson, & Doran, 2014). It is necessary to understand the long echo of colonisation to develop a core value of social justice towards ameliorating poor Indigenous health status (Griffiths, Coleman, Lee, & Madden, 2016) and to recognise that respectful communication is the key to closing the gap in the quality of health care delivered to Indigenous people (Thompson et al., 2017). Although reorienting the culture of professional health care systems towards equity is challenging (Baum, Bégin, Houweling, & Taylor, 2009), the benefits of embedding an anti-racist approach to health service delivery are acknowledged and mandated by Australia's peak bodies (Spencer & Archer, 2015).

The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) is one of Australia's peak bodies that support health and medical research; develop health advice for the Australian community, health professionals, and governments; and provide advice on ethical behaviour in health care and in the conduct of health and medical research. One of NHMRC's earlier initiatives was a publication entitled *Cultural Competency in Health: A guide for policy, partnerships and participation* (NHMRC, 2005). This guide promoted the teaching of cultural competence for all health professionals although it is clear that health professional education had not adopted the recommendations over a decade later (Ewen, Barrett, & Howell-Meurs, 2016). As most, if not all, health professions require a bachelor degree that leads to registration, Universities Australia (UA) created a policy for tertiary institutions, intending to decrease health disparities by embedding competency-based curriculum.

Universities Australia's Cultural Competence Training

Universities Australia is considered the peak body of the university sector and represents all Australian universities. One of its aims is to develop policy positions on higher education matters through discussing higher education issues including teaching, research, and research training. As a function of this, UA published the *Guiding Principles for Developing Indigenous Cultural Competency in Australian Universities* (UA, 2011). The guiding principle for teaching and learning Indigenous

cultural competence is that "all graduates of Australian universities should be culturally competent" (UA, 2011, p. 7). To this end, UA (2011) recommends that Indigenous Knowledges (IKs) and perspectives are embedded in all university curricula to provide health students with the knowledge, skills, and behaviours which underpin Indigenous cultural competence. Accomplishing this recommendation will mean the inclusion of Indigenous people at every level of governance and management, university teaching, research, and community engagement (UA, 2011).

National Accreditation of Health Professionals

Health care registration bodies, or boards, are the peak bodies for each of the health professions. Many of these boards require health curricula to include Indigenous cultural competence. For example, the Nursing and Midwifery Board of Australia (NMBA), Competency 2, states that a Registered Nurse "practises within a professional and ethical nursing framework … practises in accordance with the nursing profession's codes of ethics and conduct … accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state" (NMBA, 2010, p. 3). This puts responsibility onto the tertiary providers of nursing and other health disciplines' education to have Indigenous academics who are also registered health professionals, engaged to deliver authentic, evidence-based courseware in cultural competence. Embedding cultural competence into health courseware is intended to have health care graduates ready and able to care for Indigenous clients and thus develop cultural proficiency in their practice and their employing organisations.

While individual health care workers' performance in their cultural proficiency journey is largely a function of professional development and assessment, workers' attitudes and behaviours certainly affect the overall reputation for racist or non-racist interactions in the Indigenous community (Griffiths er al., 2016). The performance of health care organisations and their interactions with Indigenous people is measured by the Australian Department of the Prime Minister and Cabinet.

The Department of the Prime Minister and Cabinet's Aboriginal and Torres Strait Islander Health Performance Framework Reports

The *Aboriginal and Torres Strait Islander Health Performance Framework* ("the Health Framework") is produced every year by the Department of the Prime Minister and Cabinet (cited as CoA) and reports on three tiers of health performance with data from multiple health sources. The Health Framework considers health status and outcomes, determinants of health, and health system performance. The 2014 Health

Framework affirmed Freeman et al.'s (2014, p. 356) statements that improving the cultural competence of health care services can "increase Indigenous people's access to health care, increase the effectiveness of care that is required, and improve the disparities in health outcomes."

The 2016 Health Framework (CoA, 2016, p. 27) considered racism and discrimination as determinants of health, especially where "systematic or institutionalised racism is apparent in policies and practices that support or create inequalities between ethnic groups." The 2016 Health Framework (CoA, 2016) also reported that 11% of Indigenous people had experienced discrimination from health staff within the past year. Given that word-of-mouth and being vouched for are crucial factors in working with Indigenous communities, having one in every ten Indigenous people discriminated against by health staff would give that health service a reputation for poor service, and therefore, it would be unlikely to be utilised by the people that most need it. The 2017 Health Framework reported "depression as a [function] of racism" (CoA, 2017, p. 76), thus reinforcing the importance of cultural competence in health care services (CoA, 2017, p. 162).

The Australian Commonwealth Department of Health's Aboriginal and Torres Strait Islander Health Curriculum Framework

The *Aboriginal and Torres Strait Islander Health Curriculum Framework* (CoA, 2014) ("the Curriculum Framework") was developed to address the variability among all health professions and higher education providers, in terms of the nature and extent to which Aboriginal and Torres Strait Islander curriculum is implemented. Underpinned by eight principles designed for successful curriculum delivery (see CoA, 2014, pp. 27–31), the Curriculum Framework describes the interconnected cultural capability model's five values of respect, communication, safety and quality, reflection, and advocacy, grounded in culturally safe relationships. Each of the five cultural capabilities are aligned to a series of primary learning outcomes. These learning outcomes are adapted from Bloom's revised teaching taxonomy (Atherton 2013) and form a continuum of *novice* to *intermediate*, then *entry to practice* levels (CoA, 2014, p. 35). Recognising the different health education environments, the different needs of health professions' curriculum, and the varied resources available to faculty, the Curriculum Framework includes several models suitable for providers to adapt and use.

Another model recommended in the Curricula Framework is Zubrzycki et al.'s (2014) *Getting it Right Framework,* which outlines the best practice for integrating cultural competence in staff and curricula in health education programs. While their framework is for social workers, Zubrzycki et al. (2014) recognise the model can be adapted across other health specialties and is useful for non-Indigenous teachers.

Given the current low numbers of qualified Indigenous health lecturers, the Curriculum Framework recognises that non-Indigenous teachers will also need to be able to teach Indigenous health and Indigenous students. The Curriculum Framework recommends that all university staff need to have a core value of respect for culture and to privilege Indigenous voices whenever possible. Applying these models and concepts requires thoughtful negotiation with colleges and communities who still live in an ongoing colonised condition, and the state of Victoria is used here as an example.

Cultural Competence in Applied Settings: The Victorian Aboriginal Child Care Agency's Cultural Competence Matrix

Terry Cross, a First Nations American, created a postcolonial cultural competence model that reinforces proficiency rather than awareness and is based on a human rights/social justice approach (Cross, 1989). The model has stages of competency development, like Benner's stages of clinical competence of novice (observer) to expert (engaged participant) (Benner, 1984; Pasila, Elo, & Kääriäinen, 2017). The Victorian Aboriginal Child Care Agency's (VAACA) (2008) *Aboriginal Cultural Competence Matrix* adapted Cross's (1989) framework to describe behaviours and attitudes on the cultural competence continuum that are specifically related to the Indigenous context. Cross's (2008, pp. 278–289) model describes cultural competence as the "acceptance of, and respect for, cultural diversity within the organisation; service delivery is reviewed and adjusted to meet the needs of different population groups." The Victorian Aboriginal Child Care Agency's model has *acceptance* and *respect* as the core components for cultural competence in all health care (VACCA, 2008, p. 24), demonstrating the fit of Bloom's taxonomy of three learning domains: cognitive, physical and affective, or rather, skills, knowledge, and behaviours (Cannon & Feinstein, 2014).

Summary of Cultural Awareness/Competency Models

Distilling the above examples of peak bodies' recommendations for implementing Indigenous content and advice around the embedding of cultural competence in health education providers demonstrates that core values are quintessential to consider in any cultural competence conversations. Bloom's taxonomy is used as a pedagogy, where learners' skills, knowledge, and attitudes or behaviours are shaped by experienced Indigenous teachers. These frameworks require all staff be given the opportunity to attend training to facilitate their cultural learning.

Facilitating the Faculty

Following the UA's recommendations to embed cultural competence into every health course would require faculty members to have some level of skills and knowledge themselves. As part of the University's Reconciliation Action Plan, all staff members were mandated to attend a cultural "awareness" training event. In concert with this mandate was the roll-out of the embedding of Indigenous content into each course curriculum. To get buy-in from course coordinators, faculty and professional staff were invited to a workshop that demonstrated the cultural competence education given to undergraduate health students. Having faculty attend cultural competence programs can facilitate their own learning journey and demonstrate to staff an effective and Indigenist pedagogy (see Behar-Horenstein, Garvan, Su, Feng, & Catalanotto, 2016).

Pedagogy for Cultural Competence Workshops

Learning is dependent on the pedagogical approach teachers use in the classroom (Darling-Hammond et al., 2015). An adjusted model of Bloom's three learning domains was used to underpin the learning activities of the cultural competence workshop (the "workshop"), relying heavily on the affective domain of emotions and attitude (Bloom, Krathwohl, & Masia, 1984). Overemphasising the cognitive domain when seeking attitudinal shift is often futile and risks losing the desired change in participant behaviours (Vossler & Watts, 2017). It is common to have resistance to training aimed at challenging participants' belief systems (Betancourt, Green, Carrillo, & Park, 2017), so care must be taken ensure the participants feel safe in the workshops (Crandall, George, Marion, & Davis, 2003).

For these reasons, the workshop used historical events of significance to Indigenous people (e.g. Cook's landing, frontier wars, stolen generations, and government policies such as the requirement for Indigenous people to have identity papers), along with personal narratives, to share an Indigenous experience with participants that invited them to consider the impact of colonisation without the taking on feelings of guilt and shame (Willen & Kohler, 2016). Guilt and shame are not life-affirming responses and do not contribute to closure of the health gap (Torino, 2015), whereas reflection of self and what informs one's stereotypes is necessary in one's cultural proficiency journey (VACCA, 2008).

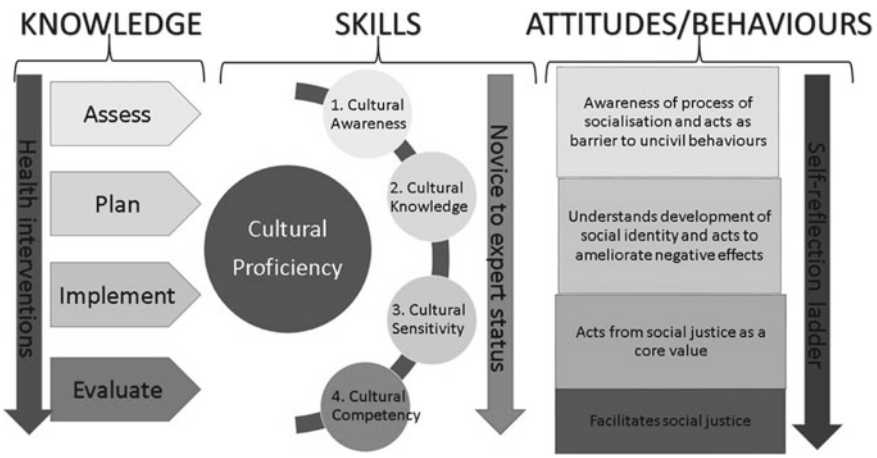

Fig. 15.1 Aunty Kerrie's wrap-around model of cultural proficiency

Creating a Three-Dimensional Model to Embed Cultural Proficiency Skills in Health Professionals

The workshop was designed for health care academics and professional staff to demonstrate the courseware offered to students and to embed a desire for cultural competence in workplace behaviours. The workshop model for cultural proficiency uses Benner's (1984) novice to expert competency model wrapped around Bloom's taxonomy of skills, knowledge, and attitudes/behaviours (Forehand, 2010), to explain the process of "assess, plan, implement and evaluate" (APIE) and the ladder of self-reflection (see Fig. 15.1).

Aunty Kerrie's model allows the clinician to maintain therapeutic integrity using the APIE system and foster culturally proficient skills through a set of self-reflection behaviours. The main aim of this model is to facilitate a client-centred journey in paralogy with clinicians or practitioners. This was the model used in the faculty workshops.

The Cultural Awareness Workshops

The term cultural "awareness" is contentious (Truong, Paradies, & Priest, 2014) and not recommended by the UA. As Fredericks (2008, p. 11) points out, Indigenous-specific cultural awareness training in the health sector reinforces a deficit model by holding "Indigenous people, as being under serviced, needy and problematic to non-Indigenous people to some degree," or attempts to fix Indigenous people (Bourke, Humphreys, Wakerman, & Taylor, 2010). The deficit approach, even if it is "well-meaning", is based in a racist framework (Freeman et al., 2016, p. 99). Nonetheless,

there was pressure from the organisation to advertise the workshops as "cultural awareness workshops".

The workshops, entitled "Cultural Awareness for Staff", were advertised via Eventbrite to all staff in the health colleges. There were 312 "hits" on the site, with 95 participants (60 staff and 35 higher degree research students) choosing to attend one of the nine workshops. Workshop times and days were staggered during the academic semester to facilitate attendance by staff.

Methodology and Results

A Qualtrics e-survey was sent post-workshop to the 55 participants in the first workshop, with 40 participants completing the survey. In order to maintain anonymity of respondents from a small campus, no demographics were collected. Participants were asked to score their opinion from 0 to 100 on seven items (see Fig. 15.2):

1. The content of the workshop was interesting,
2. I felt safe in the workshop,
3. The content was useful to my role at the university,
4. I can discuss the Indigenous history of Australia,
5. I understand the impact of colonisation on the social determinants of health,
6. This course gave me tips on communicating with Indigenous people, and
7. My students would benefit from this course.

Findings

A simple thematic analysis was conducted on the comments of participants ($n = 35$). These comments were categorised into two emergent themes: *personality of presenter* and *need for more education* (Table 15.1).

Discussion

While the majority of participants considered the workshop to be a positive experience, some participants might have felt uncomfortable or confronted by the material and for this reason, felt that they could not confidently discuss the Indigenous history of Australia. This might be a function of the initial "shock" of hearing stories regarding local history; for example, participants had heard of Murdering Gully Road in Victoria but had not realised it was named after the massacre of the local Aboriginal people (see Barker, 2007; Broome, 2005; Clark, 1995; Tatz, 2012).

It was also evident that some participants did not see the relevance or importance of being able to effectively communicate across cultures or considered their particular

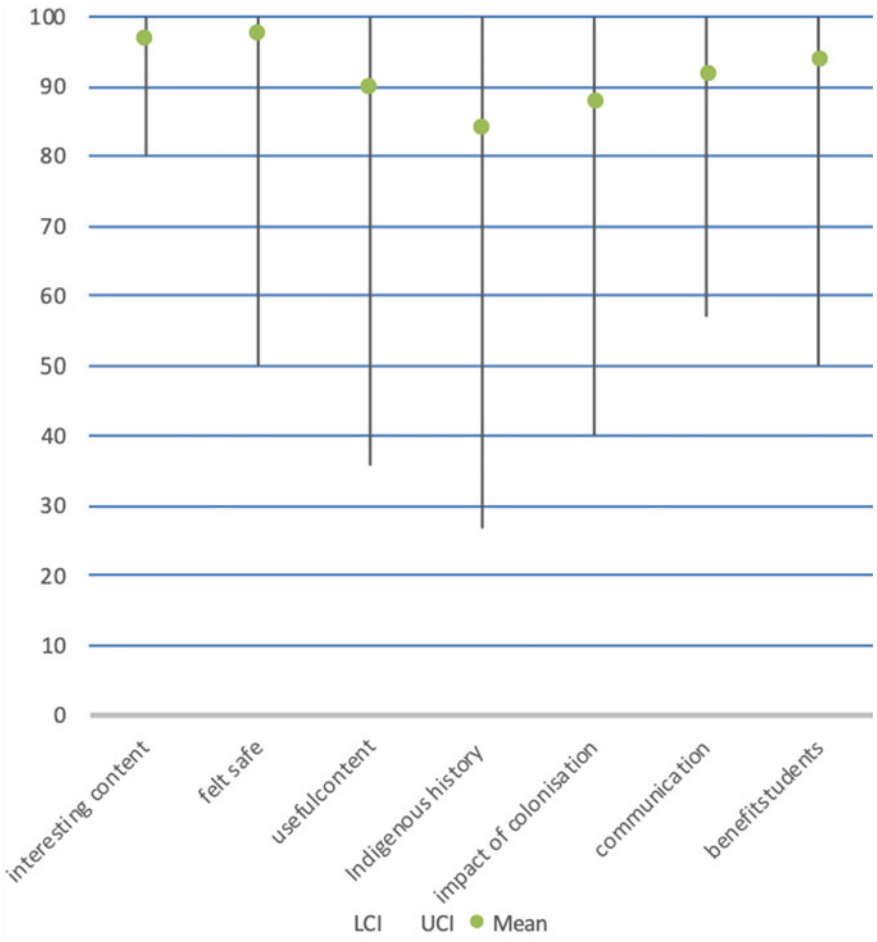

Fig. 15.2 Participants' scores on workshop content

workspace as not requiring an understanding of Indigenous Australia. Selling cultural competence to science disciplines can be challenging even though scientists may recognise the importance of IKs (Doyle, 2017).

The findings from the comments indicate that some participants recognised the limitations of a single workshop and that they needed "more" education before considering themselves competent. The second finding was based around the charisma or acceptability of the presenter to the participants: this aspect might have positively skewed the data but not necessarily meant a change in attitudes or behaviours towards Indigenous people. Having equivocal results such as these makes replicating the core components of this workshop challenging. A second workshop with a different presenter might have made the findings more robust. Results that can be considered ambiguous can make translating research into practice challenging.

Table 15.1 Thematic analysis

Category	*Personality of presenter*
Examples of items	• This workshop was informative, valuable and entertaining—the impact and knowledge will stay with me and I will pass onto my grandchildren • Aunty Kerrie's presentation was very informative. So glad I attended • An overwhelming wonderful session! Auntie Kerrie, you are a dynamic story teller, everyone should do this session. Thank you • Excellent presenter, engaging and compassionate • I would like to say big thank you for this amazing workshop • Aunty Kerry is an amazing source of knowledge. Her lessons in cultural awareness extend well outside of the training—I learn from her each time I see her. She is such a role model to me! Thanks Aunty • Thank you for giving us the opportunity to learn more about "our" history Aunty Kerrie. Attending your workshop was a special and touching experience for me that has added to my knowledge and ability to teach others about the past and its repercussion still felt by people today • I learned a lot from this workshop since we have a great and brilliant Indigenous teacher
Category	*Need for more education*
Examples of items	• Thank you for taking the time to run this very interesting workshop. Have you thought of running workshops in 2018 with additional information? • I think I still have a lot to learn and feel very grateful to have heard the stories you told • Thought provoking and a timely reminder of past events • I would like to know more; can we have deeper conversations/lectures/teaching? This was a great start but not enough! • Fantastic course. It would be great to have something similar as part of the curriculum for all vocational courses. Point 4 and 5 = not a reflection on the course, but the history and impact are broad and complex. I'm sure I can discuss them better than previously, but there is still much to learn! • I think a post grad elective/course in Indigenous health would be useful as a course across programs and disciplines

Translating Research Into Practice

Measuring cultural competence in health care settings is usually inferred by the behaviour of its Indigenous service users, using variables such as self-reporting on patient experience or being discharged against medical advice, and employment of Aboriginal and Torres Strait Islander health workers (CoA, 2017). Some researchers measured the patients' perceptions of health care professionals' level of cultural competence and deem proficiency as a perceived skill (Truong, Paradies, & Priest, 2014), or measure critical thinking and correlate that to cultural competence (see Garneau & Pepin, 2015). Deeming a health service to be culturally competent is more complex than considering Indigenous user satisfaction rates (Paradies et al., 2014) as it is difficult to measure the effectiveness of interventions to address cultural competence in health care for Indigenous people (Truong, Paradies, & Priest, 2014; Clifford, McCalman, Bainbridge, & Tsey, 2015). The lack of accepted indices of

success in health care delivery makes measuring success in university settings just as equivocal. Should we canvas Indigenous students to see if they feel the lecturers have adopted the core values of cultural competence? Should we measure the students' skills, knowledge, and attitudes pre and post their university degrees to see if the cultural competence in their university courses resulted in a change in their perspectives? Should we undertake longitudinal studies on health alumni? Should we partner with a clinical facility to survey Indigenous patients, to allow for subjective assessment of health care staff? These are the questions that need to inform the next round of authentic research, to discover whether health and university executives have the political will to view the results through an Indigenous lens and operationalise cultural proficiency in all staff at all levels. Mandating this skill will contribute to a decrease in institutionalised racism and help close the health gap.

Conclusion and Recommendations

The gap between Indigenous and non-Indigenous people in terms of health status seems intractable, even with an annual government budget of millions of dollars. There is a plethora of projects aimed at increasing the health of Indigenous people, yet there has been no meaningful change in Indigenous people's health status (see DPM&C, 2018). One reason for the lack of movement in the health bridge is because there has been no meaningful change in racism—that most salient social determinant of health. Having academic and health service staff able to operationalise a culturally proficient framework would surely contribute to a decrease in institutionalised racism. Having health professions with graduate attributes that include social justice facilitation, with university courses designed to include the embedding of this attribute, would also contribute to cultural proficiency. Universities have generic graduate attributes that might need to consider the ability of all students to be able to communicate effectively with Indigenous people.

There is a need to have multiple approaches at multiple levels for effective cultural competence facilitation (Truong, Paradies, & Priest, 2014). Educators, for example, will need different approaches to cultural competence than health workers, and even then, different disciplines will have specific cultural competence needs as well. For this reason, one workshop cannot cover all comers. Specifically designed workshops need to cater for the needs of the participants and be delivered by qualified Indigenous health, or other, professionals. Regardless of the target audience, adopting a humanistic approach from core values such as social justice and dignity is the most appropriate starting point.

References

Alford, K. A. (2015). Indigenous health expenditure deficits obscured in closing the gap reports. *Medical Journal of Australia, 203*(10), 403–404.

Anderson, I., Robson, B., Connolly, M., Al-Yaman, F., Bjertness, E., King, A. … Pesantes, M. A. (2016). Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): a population study. *The Lancet*, *388*(10040), 131–157.

Atherton, J. S. (2013). *Learning and teaching: Bloom's taxonomy*. Retrieved from http://www.learningandteaching.info/learning/bloomtax.htm.

Australian Government Productivity Commission, (AGPC). (2016). *Overcoming indigenous disadvantage: Key indicators 2016*. Canberra: Government Printers.

Australian Indigenous Health *InfoNet* (2017). *Overview of Aboriginal and Torres Strait Islander health status 2016*. Retrieved fromhttp://www.healthinfonet.ecu.edu.au/health-facts/overviews.

Awofeso, N. (2011). Racism: A major impediment to optimal Indigenous health and health care in Australia. *Australian Indigenous Health Bulletin, 11*(3), 1–8.

Barker, B. (2007). Massacre, frontier conflict and Australian archaeology. *Australian Archaeology, 64*(1), 9–14.

Bastos, J. L., Harnois, C. E., & Paradies, Y. C. (2018). Health care barriers, racism, and intersectionality in Australia. *Social Science and Medicine, 199,* 209–218.

Baum, F. E., Bégin, M., Houweling, T. A., & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health, 99*(11), 1967–1974.

Behar-Horenstein, L. S., Garvan, C. W., Su, Y., Feng, X., & Catalanotto, F. A. (2016). Assessing cultural competence among Florida's allied dental faculty. *American Dental Hygienists Association, 90*(3), 192–196.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2017). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*(2), 499–505.

Bloom, B. S., Krathwohl, D. R., & Masia, B. B. (1984). *Taxonomy of educational objectives, the classification of educational goals. Handbook II: Affective domain* (2nd ed.). New York, NY: Addison-Wesley Publishing Company.

Bourke, L., Humphreys, J. S., Wakerman, J., & Taylor, J. (2010). From "problem-describing" to "problem-solving": Challenging the "deficit" view of remote and rural health. *Australian Journal of Rural Health, 18*(5), 205–209.

Broome, R. (2005). *Aboriginal Victorians: A history since 1800* (pp. 76–79). Melbourne, VIC: Allen & Unwin.

Cannon, H. M., & Feinstein, A. H. (2014). Bloom beyond Bloom: Using the revised taxonomy to develop experiential learning strategies. *Developments in Business Simulation and Experiential Learning, 32,* 109–115.

Clark, I. (1995). *Scars in the landscape: A register of massacre sites in western Victoria, 1803–1859*. Canberra, ACT: Aboriginal Studies Press.

Clifford, A., McCalman, J., Bainbridge, R., & Tsey, K. (2015). Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: A systematic review. *International Journal for Quality in Health Care, 27*(2), 89–98.

Commonwealth of Australia (CoA). (2014). *Aboriginal Health Performance Framework, 2014*. Canberra: Australian Government Printers.

Commonwealth of Australia (CoA). (2016). *Aboriginal health performance framework, 2016*. Canberra: Australian Government Printers.

Commonwealth of Australia (CoA). (2017). *Aboriginal Health Performance Framework, 2017*. Canberra: Australian Government Printers.

Commonwealth of Australia. (2018). *Closing the Gap Prime Minister's report 2018*. Canberra: Department of the Prime Minister and Cabinet.

Crandall, S. J., George, G., Marion, G. S., & Davis, S. (2003). Applying theory to the design of cultural competency training for medical students: A case study. *Academic Medicine, 78*(6), 588–594.

Cross, T. L. (2008). Cultural competence. *Encyclopedia of Social Work*, *20*, 487–491.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center.

Darling-Hammond, L., Barron, B., Pearson, P. D., Schoenfeld, A. H., Stage, E. K., Zimmerman, T. D. … Tilson, J. L. (2015). *Powerful learning: What we know about teaching for understanding.* Wiley.

Doyle, K. E. (2012). Measuring cultural appropriateness of mental health services for Australian Aboriginal peoples in rural and remote Western Australia: A client/clinician's journey. *International Journal of Culture and Mental Health, 5*(1), 40–53.

Doyle, K. E. (2015a). Australian Aboriginal peoples and evidence-based policies: Closing the gap in social interventions. *Journal of Evidence-Informed Social Work, 12*(2), 166–174.

Doyle, R. (2015b). Links between soil science, indigenous landscape knowledge and society-examples from New Zealand and Australia. *International Union of Soil Sciences Bulletin, 127,* 40–42.

Durey, A. (2010). Reducing racism in Aboriginal health care in Australia: Where does cultural education fit? *Australian and New Zealand Journal of Public Health, 34*(s1), S87–S92.

Durey, A., & Thompson, S. C. (2012). Reducing the health disparities of Indigenous Australians: Time to change focus. *BMC Health Services Research, 12*(1), 151–162.

Ewen, S., Barrett, J., & Howell-Meurs, S. (2016). Health disparity and health professional education: A new approach. *Medical Science Educator, 26*(2), 247–253.

Forehand, M. (2010). Bloom's taxonomy. *Emerging Perspectives on Learning, Teaching, and Technology, 41*(4), 47–56.

Fredericks, B. (2008). The need to extend beyond the knowledge gained in cross-cultural awareness training. *The Australian Journal of Indigenous Education, 37*(S1), 81–89.

Freeman, T., Baum, F., Lawless, A., Labonté, R., Sanders, D., Boffa, J. … Javanparast, S. (2016). Case study of an Aboriginal community-controlled health Service in Australia: Universal, rights-based, publicly funded comprehensive primary health care in action. *Health and Human Rights*, *18*(2), 93–103.

Freeman, T., Edwards, T., Baum, F., Lawless, A., Jolley, G., Javanparast, S., et al. (2014). Cultural respect strategies in Australian Aboriginal primary health care services: Beyond education and training of practitioners. *Australian and New Zealand Journal of Public Health, 38*(4), 355–361.

Gannon, M. (2018). Indigenous health: Closing the gap—10 year review. *Australian Medicine, 30*(3), 25.

Gardiner-Garden, J., & Simon-Davies, J. (2012). *Commonwealth Indigenous-specific expenditure 1968–2012: Background note.* Retrieved from http://parlinfo.aphgov.au/parlInfo/download/library/prspub/1944093/upload_binary/1944093.pdf;fileType=application%2Fpdf.

Garneau, A. B., & Pepin, J. (2015). Cultural competence: A constructivist definition. *Journal of Transcultural Nursing, 26*(1), 9–15.

Gordon, W. M., McCarter, S. A., & Myers, S. J. (2016). Incorporating antiracism coursework into a cultural competency curriculum. *Journal of Midwifery & Women's Health, 61*(6), 721–725.

Griffiths, K., Coleman, C., Lee, V., & Madden, R. (2016). How colonisation determines social justice and Indigenous health—A review of the literature. *Journal of Population Research, 33*(1), 9–30.

Kelaher, M. A., Ferdinand, A. S., & Paradies, Y. (2014). Experiencing racism in health care: The mental health impacts for Victorian Aboriginal communities. *The Medical Journal of Australia, 201*(1), 44–47.

Larson, A., Gillies, M., Howard, P. J., & Coffin, J. (2007). It's enough to make you sick: The impact of racism on the health of Aboriginal Australians. *Australian and New Zealand Journal of Public Health, 31*(4), 322–329.

Lokuge, K., Thurber, K., Calabria, B., Davis, M., McMahon, K., Sartor, L., et al. (2017). Indigenous health program evaluation design and methods in Australia: A systematic review of the evidence. *Australian and New Zealand Journal of Public Health*. https://doi.org/10.1111/1753-6405.12704.

Markwick, A., Ansari, Z., Sullivan, M., & McNeil, J. (2015). Social determinants and psychological distress among Aboriginal and Torres Strait islander adults in the Australian state of Victoria: A cross-sectional population-based study. *Social Science and Medicine, 128,* 178–187.

Markwick, A., Ansari, Z., Sullivan, M., Parsons, L., & McNeil, J. (2014). Inequalities in the social determinants of health of Aboriginal and Torres Strait Islander People: A cross-sectional population-based study in the Australian state of Victoria. *International Journal for Equity in Health, 13*(1), 91–120.

Marmot, M. G. (2017). Dignity, social investment, and the Indigenous health gap. *The Medical Journal of Australia, 207*(1), 20–29.

Mitrou, F., Cooke, M., Lawrence, D., Povah, D., Mobilia, E., Guimond, E., et al. (2014). Gaps in Indigenous disadvantage not closing: A census cohort study of social determinants of health in Australia, Canada, and New Zealand from 1981–2006. *BMC Public Health, 14*(1), 201–219.

National Health and Medical Research Council (NHMRC). (2005). *Cultural competency in health: A guide for policy, partnerships and participation*. Canberra: Commonwealth of Australia.

Nursing and Midwifery Board of Australia, (NMBA). (2010). *National competency standards for the registered nurse*. Melbourne, VIC: NMBA

Otim, M. E., Kelaher, M., Anderson, I. P., & Doran, C. M. (2014). Priority setting in Indigenous health: Assessing priority setting process and criteria that should guide the health system to improve Indigenous Australian health. *International Journal for Equity in Health, 13*(1), 45.

Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35*(4), 888–901.

Paradies, Y. (2016). Colonisation, racism, and indigenous health. *Journal of Population Research, 33*(1), 83–96.

Paradies, Y. (2018). Racism and indigenous health. In *Oxford research encyclopedia of global public health*. Retrieved from https://oxfordre.com/publichealth/view/10.1093/acrefore/9780190632366.001.0001/acrefore-9780190632366-e-86.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A. … Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PloS one*, *10*(9), e0138511.

Paradies, Y., & Cunningham, J. (2009). Experiences of racism among urban Indigenous Australians: Findings from the DRUID study. *Ethnic and Racial Studies, 32*(3), 548–573.

Paradies, Y., Truong, M., & Priest, N. (2014). A systematic review of the extent and measurement of healthcare provider racism. *Journal of General Internal Medicine, 29*(2), 364–387.

Pasila, K., Elo, S., & Kääriäinen, M. (2017). Newly graduated nurses' orientation experiences: A systematic review of qualitative studies. *International Journal of Nursing Studies, 71,* 16–27.

Reibel, T., & Walker, R. (2010). Antenatal services for Aboriginal women: The relevance of cultural competence. *Quality in Primary Care, 18*(5), 251–268.

Spencer, C., & Archer, F. (2015). Paramedic education and training on cultural diversity: Conventions underpinning practice. *Australasian Journal of Paramedicine, 4*(3), 1–15.

Stevens, F. S. (Ed.). (1974). *Racism: The Australian experience: A study of race prejudice in Australia* (Vol. 1). North Ryde: Australian and New Zealand Book Company.

Stoner, L., Page, R., Matheson, A., Tarrant, M., Stoner, K., Rubin, D., et al. (2015). The indigenous health gap: Raising awareness and changing attitudes. *Perspectives in Public Health, 135*(2), 68–70.

Tatz, C. (2012). Genocide in Australia. In S. Totten & W. S. Parsons (Eds.), *Centuries of genocide: Essays and eyewitness accounts*. New York: Routledge.

Thompson, G., Talley, N. J., & Kong, K. M. (2017). The health of Indigenous Australians. *The Medical Journal of Australia, 207*(1), 19–20.

Torino, G. C. (2015). Examining biases and White privilege: Classroom teaching strategies that promote cultural competence. *Women & Therapy, 38*(3–4), 295–307.
Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research, 14*(1), 99–112.
Universities Australia (UA). (2011). *Guiding Principles for Developing Indigenous Cultural Competency in Australian Universities.* DEEWR: Canberra
Victorian Aboriginal Child Care Agency. (2008). *Aboriginal cultural competence matrix.* Melbourne: Victorian Government Department of Human Services.
Vossler, J. J., & Watts, J. (2017). Educational story as a tool for addressing the framework for information literacy for higher education. *Libraries and the Academy, 17*(3), 529–542.
Walsh, W., & Kangaharan, N. (2016). Aboriginal and Torres Strait Islander cardiovascular health 2016: Is the gap closing? *Heart, Lung and Circulation, 25*(8), 765–767.
WHO Commission on Social Determinants of Health, & World Health Organization. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*. Geneva: World Health Organization.
Willen, S., & Kohler, A. (2016). Cultural competence and its discontents. In P. J. Brown & S. Closser (Eds.), *Understanding and applying medical anthropology* (pp. 353–365). Abingdon: Taylor & Francis.
Wilson, A., Magarey, A., Jones, M., O'Donnell, K., & Kelly, J. (2015). Attitudes and characteristics of health professionals working in Aboriginal health. *Rural and Remote Health, 15*(1), 27–39.
Ziersch, A. M., Gallaher, G., Baum, F., & Bentley, M. (2011). Responding to racism: Insights on how racism can damage health from an urban study of Australian Aboriginal people. *Social Science and Medicine, 73*(7), 1045–1053.
Zubrzycki, J., Green, S., Jones, V., Stratton, K., Young, S., & Bessarab, D. (2014) *Getting it right: Creating partnerships for change. Integrating Aboriginal and Torres Strait Islander knowledges in social work education and practice. Teaching and learning framework.* Sydney: Australian Government Office for Learning and Teaching.

Kerrie E. Doyle is the inaugural Professor of Indigenous Health in the School of Medicine at Western Sydney University, and leader of the Aboriginal and Torres Strait Islander Clinical Academic Group at the Sydney Partnership for Health, Education, Research and Enterprise. She is a social scientist and mental health clinician, has over 40 years' experience working in Indigenous health and communities and has various research interests including her collaboration in the Global Burden of Disease project.

Lauren Zarb is a New Zealand-trained Registered Nurse with an extensive work history in cancer nursing. She works as a lecturer in nursing at La Trobe University and remains committed to improving outcomes in cancer care. Lauren is currently undertaking a PhD investigating the role of nurse leadership in cancer nursing.

Kyar Wilkey is a Ngarrindjeri woman from South Australia. Her educational background includes a Bachelor of Psychological Science (Honours). She is a Research Assistant at Western Sydney University with the Translational Health Research Institute and Maridulu Budyari Gumal. Kyar's research interests relate to Aboriginal and Torres Strait Islander health and well-being.

Kayla Sale is a student as well as Research Assistant at Western Sydney University, working within Sydney Partnership for Health, Education, Research and Enterprise. She is a third-year podiatric medicine student with an interest in diabetes complications, musculoskeletal disorders, and the health of Indigenous and culturally and linguistically diverse groups.

Chris Pitt is a Project Officer within Maridulu Budyari Gumal and works closely with Aboriginal and Torres Strait Islander researchers. He has qualifications in psychology and public health. His research interest is in the field of health informatics and Indigenous Health.

Dein Vindigni OAM is a chiropractor with over 35 years' clinical and academic experience. He was recently the lead in the Chiropractic Program with the School of Health and Biomedical Sciences at Royal Melbourne Institute of Technology (RMIT) University. Dein's primary research interests are Indigenous Health, aged care, and assisting vulnerable and marginalised communities.