



The Rural Research Capacity Building Program 2009-2011 Intake

Final Report

Aboriginal Cultural Awareness Training Evaluation

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Abbreviations

- CETI NSW Clinical Education and Training Institute
- NCAHS North Coast Area Health Service
- CAT Cultural Awareness Training
- OATSIH Office for Aboriginal and Torres Strait Islander Health
- PHN Public Health Nurses
- Aboriginal Aboriginal and Torres Strait Islander people

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Abstract

Aim:

This study aimed to determine the level of Cultural Awareness among staff in the North Coast Area Health service. This study also sought to evaluate the effectiveness of the current system for training them in Aboriginal Cultural Awareness in improving relevant Knowledge, Attitudes, Understanding and Behaviour.

Method:

Richmond Network health staff were encouraged to participate in this quantitative cross sectional study using a web based survey. During the formative phase of the survey questionnaire, consultations were made with local elders, Aboriginal Cultural Awareness trainers and Aboriginal Health Workers. Domains used in the survey were created to gather information considered relevant to the study aims.

Results:

Participants of the survey who have attended some form of Cultural Awareness training (CAT) have significantly higher Cultural Awareness scores compared to those not trained, with the effect being 2.7 points ($Z=4.219$, $P<0.0001$). Results also show that within the Richmond Network, those who attended a *full-day* course attained a higher overall score (1.3 points higher, $Z=4.211$, $P<0.0001$) than those who attended three half hour sessions ($3 \times \frac{1}{2}$ hour). However, results also show clear signs of overt racism amongst staff responses to the survey questions.

Conclusions:

The current profile of staff Cultural Awareness in the Richmond Network indicates that there is considerable room for improvement. Whilst training can significantly improve Cultural Awareness, it should be viewed as one contributing factor amongst a package of necessary strategies to deliver culturally appropriate services. It is evident from the survey results and various racist comments throughout the survey that the Area Health Service has not yet reached a high level of Cultural Competence.

Implications:

It is vitally important that the health service reassess its dependence upon, and promotion of CAT as the primary means of achieving the ongoing safety and security of its Aboriginal staff and clients.

Keywords:

Aboriginal health; Cultural Awareness Training; Cultural Competence; Cultural Respect; Cultural Safety; racism

Executive Summary

Background and Rationale

The health disparities between Aboriginal and non-Aboriginal Australians are large and significant. Aboriginal Australians experience significantly more ill health compared to other Australians, have reduced quality of life due to ill health, are more likely to experience disability and die at a much younger age.¹⁻³ According to the *2004-2005 National Aboriginal and Torres Strait Islander Health Survey*, despite poorer health, health care is not sought by many Aboriginal Australians due to difficulties in access including cost, transport or distance, cultural barriers and lack of available services.⁴

Each Area Health Service and local community-controlled health organisations have an obligation to develop a partnership agreement according to policies which advocate new ways of providing culturally appropriate services.⁵ However overall the health system still does not provide an equal level of quality of care to Aboriginal people and is often culturally inappropriate and insufficiently resourced to meet client needs.¹

In recent years there has been an increasing recognition that an effective health service should provide health care in a manner that is appropriate to the cultural needs of its clients. To this end various forms of CAT programs have been developed. Currently in the North Coast Area Health Service, CAT is mainly provided via *full-day* workshops, with content designed to increase participant understanding and knowledge of Aboriginal history and culture, as well as raise awareness of the health issues impacting on local Aboriginal communities. Recently a compressed *3 x ½ hour* CAT with similar aims to the *full-day* sessions has been introduced for staff in high demand front-line services.

This study aimed to answer the question: 'Does the current system for training NCAHS staff in Aboriginal Cultural Awareness, when delivered in either of two modes (one *full-day* and *3 x ½ hour* sessions), improve relevant knowledge, attitudes and purported behaviours of participants, in relation to providing culturally appropriate services?'

Methods

This is a quantitative study where a web based cross sectional survey was used to investigate current levels of Cultural Awareness and training history amongst health staff in North Coast New South Wales.

The survey questionnaire was designed to gather information in a number of domains including: participant demographics; type of health work including whether they worked with Aboriginal colleagues or clients; CAT history; knowledge, attitudes, understanding and behavioural questions. These domains have previously been used to assess CAT and were considered of high relevance to the study aims.⁴⁻⁸ Consultation with local elders, Aboriginal

Cultural Awareness trainers and Aboriginal Health Workers were made during the formative phase.

The analysis included univariate, bivariate and multivariate methods.

Findings

There were a total of 394 respondents to the survey representing 21.2% of the Richmond Area health staff. A number of staff who commenced the survey withdrew without completing the Cultural Awareness test section (n=107, 27.2%). Analysis revealed that these respondents were those who:

- had not previously attended any form of CAT,
- had not completed higher education,
- have management roles, or
- work alongside ATSI co-workers.

Analysis of responses suggests that those who had attended *full-day* training were able to respond more correctly to the Aboriginal Cultural Awareness questions, with better Knowledge (0.9 points, $z=3.19$, $p=0.01$), Understanding (1.1 points, $z=2.49$, $p<0.05$), Behaviour (1.0 points, $z=3.72$, $p<0.001$) and overall (2.7 points, $z=4.219$, $P<0.0001$) scores than those who have not attended training. The Attitude score was unrelated to previous CAT regardless of the format (0.5 points, $z=1.551$, $P>0.10$). Scores of attendees of $3 \times \frac{1}{2}$ hour sessions were not significantly different to those who had never trained (2.5 points, $z=1.858$, $P<0.10$).

However, the overall awareness is still poor and there are also clear signs of overt racism amongst staff responses to the survey questions. Respondents providing racist comments ranged from administrators working in Area Executive office to ward nurses and a dental worker. A range of types of racist comments were apparent, these included ignorance; the belief that all should be treated equally regardless of their cultural history; stereotyping; non caring; demeaning or patronising. An example of '*Ignorance*' is an answer to: Q.23, "Why should health workers know about *Stolen Generations*?"
-"Kevin Rudd said sorry so it is no longer an issue."

Conclusion and Recommendations

There is clearly considerable room for improvement in the Cultural Awareness of staff before Cultural Competence can be claimed. More importantly, there is an urgent need to address the broader issues of racism and Cultural Safety for service clients as identified in the 'house metaphor'.

It is recommended that:

- The full-day CAT continue to be implemented throughout the health service as a mandatory training.
- The $3 \times \frac{1}{2}$ hour trainings be used only in situations where a *full-day* training is not possible, such as where critical staff shortages prohibit *full-day* training.

- The existing set of policies and enforcement practices covering racism within the service be reviewed and strengthened.
- A committee be established as a matter of priority to review the place of CAT within the broader context of the other vital foundations of culturally appropriate practice within the service. Input from Aboriginal elders during this review process is vital towards efficacy.
- As a minimum requirement, this committee should include:
 - Area Chief Executive
 - Aboriginal Health Coordinator
 - Director of Human Resources
 - Strategic Development and Performance Coordinator, Aboriginal Health Strategic Unit
 - Director Learning and Development
 - Director of Clinical Services
 - Executive level representative of NSW Health Policy Branch

Introduction

The health disparities between Aboriginal and non-Aboriginal Australians are large and significant.

In recent years there has been an increasing recognition that an effective health service should provide health care in a manner that is appropriate to the cultural needs of its clients. To this end various forms of CAT programs have been developed.

In order to understand the context for this research it is important to also understand the various meanings and aspects of Cultural Awareness to build a complete picture that combines the most important aspects into an overall framework. This framework then provides a holistic lens through which to review how cultural difference has and is now being addressed in the international arena of health care before focusing on issues and strategies within the Australian setting. Once an understanding is gained of the broader context it is then appropriate to examine the role and value of CAT in the local context.

What is Cultural Awareness?

In reviewing the Cultural Awareness literature a variety of meanings and aspects emerged as follows:

Cultural Awareness has been described as focusing largely on the knowledge and experience attributes of health care providers⁶ where a sensitivity towards existing similarities and differences between cultures is established and effective and appropriate communication is used.⁹ Similarly, in the *Working with Aboriginal people in Rural and Remote South Australia Handbook*, Aboriginal Cultural Awareness is described as having knowledge and understanding of the histories, belief systems, values, and experiences of Aboriginal people. It is about being aware of and accepting the differences, without the expectation of becoming an expert on Aboriginal culture.¹⁰

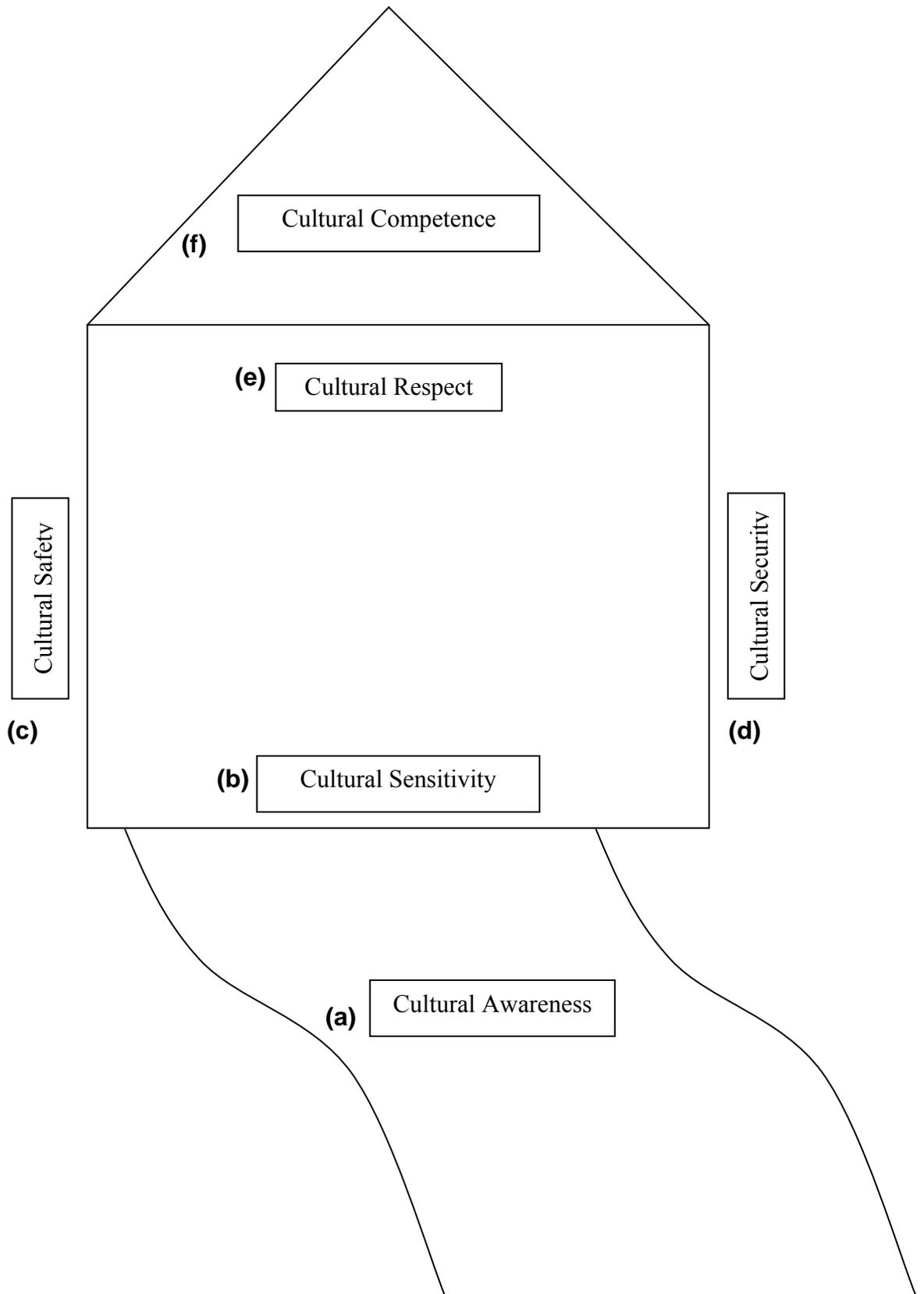
A related concept which emerged was Cultural Sensitivity, where it has been described as being aware that values, learning and behaviour are affected by existing differences and similarities in culture.¹¹

'*Cultural Safety*' is another aspect, where communication and access to health services are addressed to provide clients with the ability to contribute towards a positive and safe health service environment.^{12, 13} Extending on this is '*Cultural Security*' which is built from the acknowledgment that theoretical 'awareness' of culturally appropriate service provision is not enough. It shifts the emphasis from attitudes to behaviour, focusing directly on practice, skills and efficacy. It is about incorporating cultural values into the design, delivery and evaluation of services. Furthermore, '*Cultural Respect*' is recognising, protecting and developing the inherent rights, cultures and traditions of Aboriginal people. It is achieved when health service providers create an environment in which cultural difference are respected and Aboriginal people can feel culturally safe.⁶ Finally, '*Cultural Competence*' extends past an individual's behaviours and attitudes, establishing a culture and environment

within a business system where the respect of a person's cultural background, beliefs and values is incorporated into the delivery of health care, consequently empowering the client.¹³

In order to build a complete picture that combines the most important of the above mentioned aspects into an overall framework they have been set into the metaphor of a house such that (a) represents *Cultural Awareness*, a path leading to a more complex set of interdependent elements; (b) represents the foundations, building further on *Cultural Awareness* and developing into *Cultural Sensitivity*; (c) and (d) represent the walls of *Cultural Safety* and *Cultural Security*, building on the simpler yet essential foundations; (e) represents *Cultural Respect*, the ceiling; and (f) represents the roof, *Cultural Competence*, where a house is now complete and 'liveable' (Figure 1).

Figure 1. The Aboriginal 'Culture' House - a metaphor for the complexity and interdependence of related aspects of addressing cultural difference.



The essence of the metaphor is that if any part of the structure is omitted it becomes unstable and untenable. It provides a framework or lens through which we can consider the need for, the history of, and current approaches to addressing cultural differences in provision of health care services. It can be noted that developing an individual's cultural attitude and behaviour is important, however, CAT needs to progress and develop into a wider perspective where a whole network or system is culturally appropriate, creating a culturally safe and empowering environment for an individual.⁴

Why do we need Cultural Awareness Training in Health Services?

The 'Health Gap'

In 2006, the Aboriginal population consisted of around 2.5% of the Australian population.¹⁴ In North Coast NSW in 2006, it was estimated that of the total population of 480 675 there were 19 119 (3.98%) Aboriginal people living in the area.¹⁵

It is well documented that disparities in morbidity and mortality rates between Aboriginal people and other Australians continue. Aboriginal Australians experience significantly more ill health compared to other Australians, are typically more likely to experience disability, have a reduced quality of life due to ill health and die at a much younger age.¹⁻³ According to the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*, Aboriginal people's life expectancy is about 20 years for males and 19 years for females below that of other Australians.¹ Low birth weights and deaths of newborn babies are twice as likely for Aboriginal peoples.¹ There is also an extensively higher prevalence of diseases such as hypertension and diabetes.¹ Non-fatal injuries, mental illness, self-harm and harmful substance use is also much greater.¹ These factors highlight the need for effective health care services.

The 'Service Gap'

Since European settlement, a range of government interventions and policies have been created to 'manage' Aboriginal people. These policies included: Protection, Segregation, Assimilation, Integration, Self-determination and Self-Management.¹⁰ Many of these policies created serious and enduring problems for Aboriginal peoples across Australia. The negative social and health consequences are enormous as evidenced by the health gap described above.¹⁻³

Many issues which contribute to Aboriginal people's poorer health compared to non-Aboriginal people indicate a lack of confidence in accessing mainstream health¹ which has historically been limited by barriers such as distance and cultural and financial factors.¹⁶

According to the *2004-2005 National Aboriginal and Torres Strait Islander Health Survey*, despite poorer health, health care is not sought by many Aboriginal Australians due to difficulties in access including cost, transport/distance, cultural barriers and lack of available services.⁴

The issue of cultural inappropriateness of services, identified as a major barrier to access and delivery of effective care, has received little attention until recent years. One attempt to deal with it has been a move to Aboriginal controlled services. Australian government investment in community controlled health organisations, since the formation of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in 1994, has complemented its acknowledgment that 'mainstream' services funded by state jurisdictions also provide health care to Aboriginal people. Area Health Services in NSW were developed through legislation to promote, protect and improve health for those living in specified geographic regions and deliver necessary services to the sick efficiently. Each Area Health Service and local community-controlled health organisations has an obligation to develop a partnership agreement according to policies which advocate of providing culturally appropriate services.⁵ However, overall, the health system still does not provide an equal level of quality of care to Aboriginal people and is often culturally inappropriate and insufficiently resourced so that their needs cannot be properly met.¹ There are still a number of barriers that restrict Aboriginal people's access to quality health care. Some are socio-economic, some are due to availability and service distribution while some are clearly cultural, which includes the attitudes and practice of health service providers, communication issues, lack of cultural understanding, distrust of the system and racism.¹

How is Cultural Awareness dealt with in Health Care Settings?

Developed countries such as New Zealand, Canada and the United States initially focused on Cultural Awareness, however, they have now moved on to different approaches, such as Cultural Security and Cultural Competence, addressing not only knowledge, but also behaviour. Parts of Australia have also moved on from Cultural Awareness to various other forms in an attempt to shift the focus from awareness alone to achieving real changes in the knowledge, attitudes and behaviours of our health services and workers. New Zealand shifted its attention towards Cultural Safety around 1990 on recognition that Cultural Awareness and Cultural Sensitivity were inadequate approaches in ensuring appropriate health care for Maori people.¹³ In the United States, the emphasis has been on Cultural Competence which is considered to include a number of other key components such as Cultural Awareness, Cultural Knowledge, Cultural Sensitivity, cultural understanding, cultural interaction, cultural proficiency and cultural skill.¹³

History of Cultural Awareness in Australian Context

Staff CAT has continued as a main focus of Australia's health service response to the inequalities between Aboriginal and non-Aboriginal health, to racism within the health systems and to other socio cultural issues. There are various Cultural Awareness programs throughout Australia and in North Coast NSW such as short workshops, *full-day* workshops or lectures, and ongoing programs involving field trips or excursions. However, the main focus and objectives of each program are similar, aiming to improve health professionals' attitudes, perceptions and knowledge of Aboriginal people, with

the anticipation that care delivered to Aboriginal people would be improved. Often topics covered in CAT sessions are similar, tracing the cultural, social and historical factors applying to Aboriginal peoples generally, as well as specific Aboriginal groups/communities. The training sessions also generally include current health statistics.^{5, 13}

In the article *Recognition of Cultural Awareness Training as a Core Component of Health Services*¹⁷ it is stated that though some excellent education has been provided through CAT, there has not been enough focus on the skills and motivation of non-Aboriginal health staff. Too often, it is assumed that social inequalities are developed and transformed by awareness and attitudes, hence many CAT courses concentrate on these aspects, without addressing the source of inequality and power relations. The article highlights that many health professionals lack understanding of the importance of participating in CAT and it is not pursued enough by health authorities, resulting in a lack of accountability for such programs.¹⁷

It has been noted that there have been few attempts to measure the efficacy of CATs in the Australian context either in terms of their supposed improvement in staff awareness or more importantly on staff knowledge or behaviour within the health services that provide them. A variety of literature generally encouraging the development of Indigenous cultural training for health workers is available from a range of countries, however, documentation of evidence or initiative to support this is very minimal.¹⁸

Cultural Awareness Training in North Coast Area Health Service

Currently in the North Coast Area Health Service CAT is mainly provided via *full-day* workshops, with content designed to increase participant understanding and knowledge of Aboriginal history and culture, as well as raise awareness of the health issues impacting on local Aboriginal communities. Recently a compressed *3 x ½ hour* CAT with similar aims to the *full-day* sessions has been introduced for staff in high demand front-line services.

This study aimed to answer the question: ‘Does the current system for training NCAHS staff in Aboriginal Cultural Awareness, when delivered in either of two modes (one *full-day* and *3 x ½ hour* sessions), improve relevant knowledge, attitudes and purported behaviours of participants, in relation to providing culturally appropriate services?’ This research also reflects on the relevance of this CAT to the overall complex of ‘appropriate’ services captured by the Aboriginal ‘Culture’ House metaphor described above.

Methods

Research Design

This study used a cross sectional survey design.

Ethics

Ethics approval obtained from North Coast Area Health Service Human Research Ethics Committee as a Quality Assurance study.

Sample Frame

The survey was administered to all staff in the Richmond Health Network of NCAHS.

Survey Questionnaire

The survey questionnaire was designed to gather information in a number of domains including: Participant demographics; type of health work including whether they worked with Aboriginal colleagues or clients; CAT history; knowledge, attitudes, understanding, and behavioural questions. These domains were chosen because they were considered relevant to the research question, had been used in other studies.⁴⁻⁸ These domains were also considered important by elders and local Aboriginal Cultural Awareness trainers who were consulted in the formative phase. The consultation process involved discussions around clinical scenarios where staff typically demonstrated culturally inappropriate behaviour. Examples raised during the consultation included: the situations of a death in the family, a client not taking their medications, and a client raising his voice in frustration. These scenarios were then used as a basis for questions within the survey.

Aboriginal Health staff were also given the opportunity to provide feedback and input into the survey. A draft survey was then piloted with Population Health staff before the survey was finalised and distributed. While there were no fully validated instruments available to examine this area of CAT, the wording of questions was selected to be consistent with other relevant instruments where available and the instrument constructed for this research has face validity in terms of it having been reviewed by a range of Aboriginal health workers and staff who deliver CAT.

Survey Implementation

The survey instrument (appendix 1) was uploaded onto the Area Health Service intranet site using the Select Survey ASP Advanced platform. An initial and two follow-up emails were sent to all staff and their managers encouraging participation. The offer of a draw for a double movie pass was included as an incentive. Participation was voluntary and all were assured that their responses would remain anonymous.

Data and Analysis

Data was exported to Excel where it was cleaned to check for consistency. Univariate and bivariate analyses were conducted in Excel using pivot tables, Chi square and t tests. Multivariate analysis was completed with MLwiN (*MLwiN Version 2.1*. Centre for Multilevel Modelling, University of Bristol). Univariate analysis involved frequency distributions, percentages, histograms and 95% confidence intervals for proportions according to Gardner and Altman (1986).¹⁹ Bivariate analysis was by pivot tables, chi square and two-tailed, non-paired t test. Multivariate analysis involved multiple regression. All statistical testing used an alpha of 0.05 and beta of 0.80.

Composite scores were calculated for each of the domains; Knowledge, Attitude, Understanding and Behaviour, where one point was given for each correct answer in each of the domain questions.

For Knowledge a maximum score of 11 was possible. Knowledge questions were: Q19, Q 21, Q 22, Q 23, Q 24, Q 25, Q 26, and Q 27.

A maximum of 12 was possible for Attitude, with the Attitude questions being Q 28 and Q 37 in the survey.

From the Understanding questions: Q 30, Q 32, Q 33, and Q 38, a maximum Understanding score of 24 was possible.

Finally, for Behaviour, a maximum score of 12 was possible with the Behaviour questions being: Q 29, Q 31, Q 34, Q 35 and Q 36.

To assess the representation of staff, the profile of respondents was examined using demographic questions from the survey. Secondly, comparisons of those who completed the survey to those who withdrew before completing the test questions were performed using the demographic question data. Proportions of correct responses to Cultural Awareness questions in the four domains for those who attended any CAT were then compared to those who never attended. Through using independent t tests, the mean number of correct responses given by those who attended CAT was compared to those who never attended. Finally multiple regression was used to assess the effects of training and other predictors on overall scores and domain scores of participants.

Results

Who Completed the Survey?

There were a total of 394 respondents to the survey representing 21.2% of the Richmond Area Health Staff (Table 1 shows the demographic profile and training experience). Just over three quarters (76.9%) of respondents were female. Just under two thirds (63.2%) were aged 45 or more, three quarters had completed higher education (76.9%), and four in ten (42.6%) had worked at least 16 years in health. The majority were nurses (39.3%) followed by allied health (20.1%) and administration (14.7%). Of the 394 respondents, 22 were of Aboriginal or Torres Strait Islander descent (5.6%). Just under three quarters (71.3%) reported working with other staff who were of Aboriginal or

Torres Strait Islander descent, while just over three quarters (79.2%) reported working with clients of Aboriginal or Torres Strait Islander descent. Half of the respondents (48.5%) had never attended any form of CAT. Of those who had attended training and provided the format of that training (51.8%), just under half (46.3%) had done a *full-day* training and one in six (15.8%) had attended a set of *3 x ½ hour* training sessions. Of those who recalled when their last training took place (49.5%), over half (57.4%) had attended since 2006.

The sample differed little from the profile of Richmond network staff in terms of the variables for which data was available. For gender there was no significant difference with the proportion of female staff in the sample being 76.9% compared to 73% for the Richmond network ($\chi^2=2.88$, $df=1$, $p=0.089$).

For age, the survey sample was slightly older than expected with 63.2% aged 45 or more compared with 62% for all Richmond staff ($\chi^2=0.38$, $df=1$, $p=0.54$).

Table 1. Profile of NCAHS staff Responding to Survey on CAT (n= 394)

Variable	Value	N	% of Sample
Gender	Female	303	76.9
	Male	91	23.1
Age	<45	145	36.8
	45+	249	63.2
Education level	Higher Education*	303	76.9
	No Higher Education	91	23.1
Years Worked	Up to 15yrs	226	57.4
	16+yrs	168	42.6
Profession	Nursing	155	39.3
	Allied Health	79	20.1
	Administration	58	14.7
	Management	33	8.4
	Population Health	19	4.8
	Other	50	12.7
Aboriginal	Yes	20	5.1
	And Torres Strait Islander	2	0.5
	Neither	372	94.4
Have Aboriginal or Torres Strait Islander Co-workers	Have Not/ Not Sure	113	28.7
	Have	281	71.3
Have Aboriginal or Torres Strait Islander Clients	Have Not/ Not Sure	82	20.8
	Have	312	79.2
Ever Attended CAT	No	191	48.5
	Yes	203	51.5
Type of Training (n=204 responded)	<i>Full-day</i>	88	46.3
	<i>3 x ½ hour</i>	30	15.8
	Other	72	37.9
When (n=195 responded)	2006- 2010	112	57.4
	Before 2005	83	42.6
Total Respondents			100.0

* Post high school

When the respondents sample was demographically compared to the Richmond Network workforce from which it was drawn, no significant differences were found in terms of gender or age (See Table 2).

Table 2. Demographic comparison of survey respondents to Richmond Network health workforce.

Variable	Value	n Workforce	% Workforce	n Respondents	% Respondents	χ^2	p	Sig ₁
Gender	Female	1829	72.8	303	76.9	2.88	0.09	n/s
	Male	682	27.2	91	23.1			
Age	<45	965	38.4	145	36.8	0.38	0.54	n/s
	45+	1546	61.6	249	63.2			

There was a significant difference in professional profiles with over representation of Allied Health, Administration, Management and Population Health staff and under representation of nursing staff ($\chi^2= 85.21$, $df = 4$, $p < 0.0001$) (See Table 3).

Table 3. Breakdown of respondent survey sample by profession compared to Richmond Network health workforce.

Variable	Value	n Workforce	% Workforce non missing	n Respondents	% Respondents non missing	% Deviations ¹
Profession	Nursing	1363	50	155	39	-27.5
	Allied Health	229	08	79	20	82.2
	Admin	312	11	58	15	11.4
	Management	171	06	33	08	14.9
	Pop. Health	25	01	19	05	206.8

¹ Respondent sample compared to expected value from chi square table

A number of staff who commenced the survey ($n=394$), withdrew from the survey before completing the Cultural Awareness test questions ($n=107$, 27.2%). This introduced the possibility of bias in the sample of respondents who completed the survey. To detect such bias, the proportion who completed was analysed in terms of the demographic and training history information that all respondents provided (See Table 4 and 5).

This analysis indicates that respondents more likely to withdraw from the survey before attempting the test questions compared to their counterparts were those who:

- had not previously attended any form of CAT,
- had not completed higher education,
- have management roles, or
- work alongside Aboriginal or Torres Strait Islander co-workers.

There were no differences relating to gender, age and years worked in health or having clients with Aboriginal or Torres Strait Islander descent.

Table 4. Summary of comparison between those who completed the test section (n=287) and those withdrew before completing the test questions.

Variable	Value	n Completed	% Completed	n Not Completed	% Not completed	χ^2	p	Sig ¹
Gender	Female	216	71.3	87	28.7	1.61	0.21	n/s
	Male	71	78.0	20	22			
Age	<45	104	71.7	41	28.3	0.15	0.70	n/s
	45+	183	73.5	66	26.5			
Attended training	Have	157	77.3	46	22.7	4.28	0.04	*
	Have not	130	68.1	61	31.9			
Ed. Level	Higher Ed.	241	79.5	62	20.5	29.73	0.00	*
	No Higher Ed.	46	50.5	45	49.5			
Years Worked	Up to 15yrs	121	78.1	34	21.9	3.52	0.06	n/s
	16+ yrs	166	69.5	73	30.5			
Aboriginal or Torres Strait Islander co-workers	Have Not/Not sure	91	80.5	22	19.5	4.73	0.03	*
	Have	196	69.8	85	30.2			
Aboriginal or Torres Strait Islander clients	Have Not/Not sure	54	65.9	28	34.1	2.56	0.11	n/s
	Have	233	74.7	79	25.3			

¹ n/s not significant; * indicates p value <0.05

Table 5. Breakdown of respondent survey sample by profession (in terms of completing the survey) compared to Richmond Network health workforce ($\chi^2=14.46$, df = 4, p = 0.006)

Variable	Value	n Completed	% Completed	n Not Completed	% completed Not	% Deviations ¹
Profession	Nursing	119	76.8	36	23.2	-12.9
	Allied Health	63	79.7	16	20.3	-24.1
	Admin	31	53.4	27	46.6	74.6
	Management	25	75.8	8	24.2	-9.1
	Pop. Health	15	75.0	5	25.0	-6.2

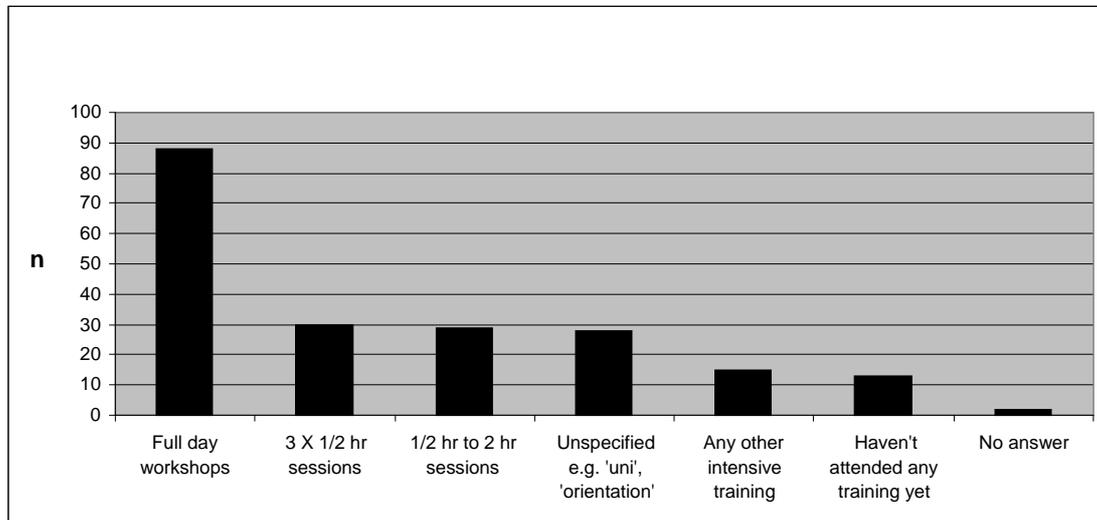
¹ Respondent sample compared to expected value from chi square table

Training in Cultural Awareness?

Of the 394 respondents, 210 (51.5%) reported having attended some form of CAT. A range of formats were reported by those who had attended (Figure 2).

These included *full-day* workshops (42.9%), three half hour sessions (14.6%) and half hour to two hour sessions (14.1%).

Figure 2. Frequency distribution of type of previous CAT of survey respondents.



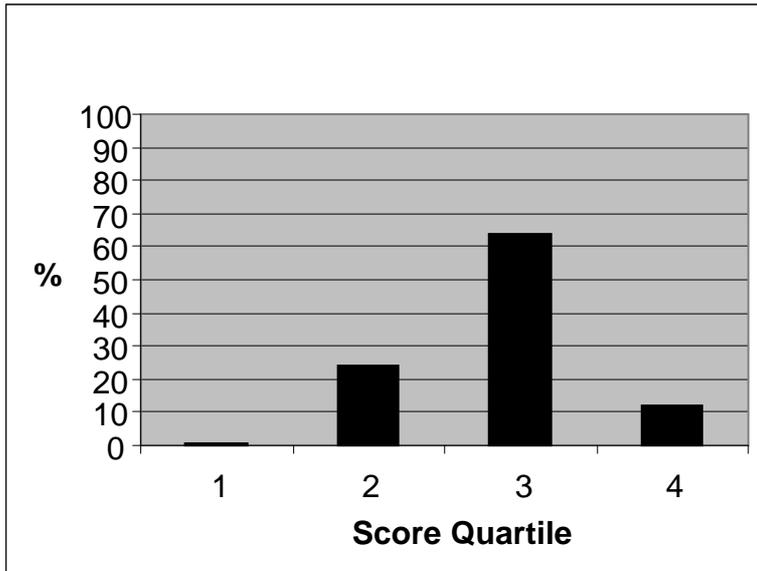
What is the Current State of Cultural Awareness in Richmond Staff?

The survey provided a snapshot of current Cultural Awareness amongst Richmond staff. The following section describes this first in terms of the overall Cultural Awareness score and then by key sub dimensions of Cultural Awareness that were measured. These were Knowledge, Attitude, Behaviour and Understanding.

Overall Score

The highest overall score possible was 59, however, the highest overall score achieved by any respondent was 44. Only 11.8% of respondents attained a score in the highest quartile of possible scores with just under two thirds (63.7%) scoring in the second highest quartile (Figure 3).

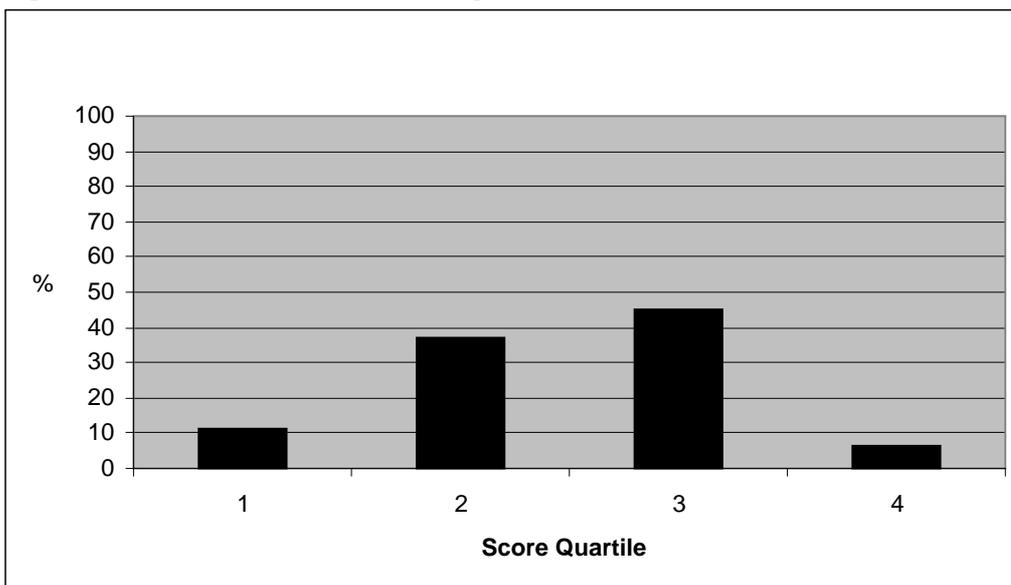
Figure 3. Distribution of Overall Cultural Awareness Scores.



Knowledge

A total of 10 (maximum possible score being 11) was the highest score achieved for Knowledge by any respondent. Only 6.6% scored in the highest quartile, while 45.3% of respondents scored in the second highest quartile (Figure 4).

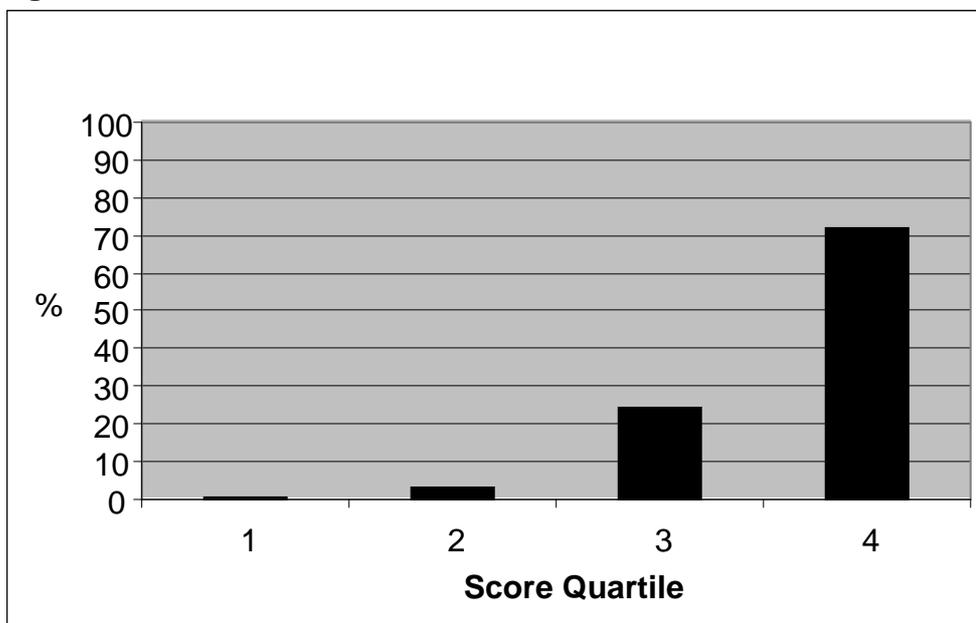
Figure 4. Distribution of Knowledge Scores.



Attitude

The highest score achieved in Attitude was 12 (from a maximum possible score of 12) by any respondent. Just under three quarters (72.1%) of respondents scored in the highest quartile, with 24.4% scoring in the second highest quartile (Figure 5).

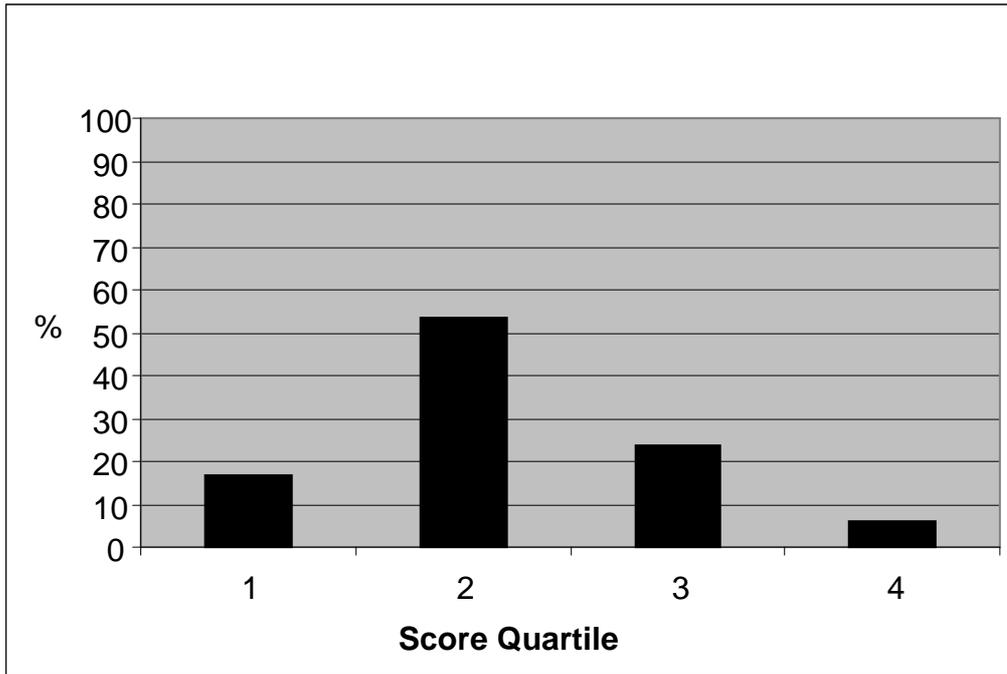
Figure 5. Distribution of Attitude Scores.



Understanding

A score of 15 (maximum possible score being 24) was the highest score achieved by any respondent. In the highest quartile, only 5.9% of respondents achieved this position, while just under one quarter (23.7%) scored in the second highest quartile (Figure 6).

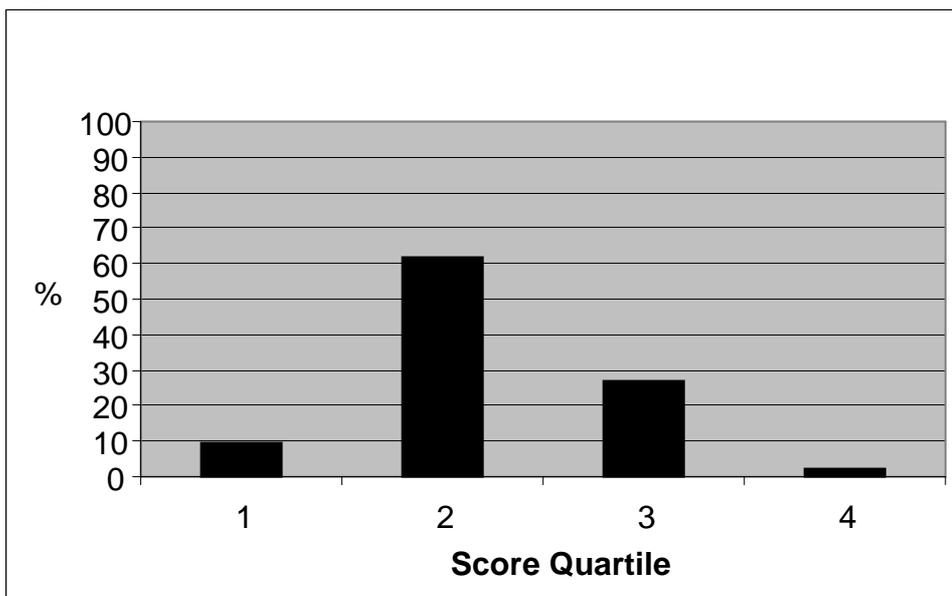
Figure 6. Distribution of Understanding Scores.



Behaviour

The highest score by any respondent was 11 (with a maximum possible score of 12), however only 2.1% of all respondents scored in the highest quartile, while just over one quarter (26.8%) of respondents scored in the second highest quartile (Figure 7).

Figure 7. Distribution of Behaviour Scores.



Has Training made a Difference?

Bivariate Analyses

Bivariate comparisons were conducted to see if those who had previously attended any form of CAT were more likely to return correct answers to test questions with true or false categories, than those who had never attended (Table 6). This Chi square analysis of responses suggests that those who had attended training were able to respond more correctly to the Aboriginal Cultural Awareness questions posed. On six of the eleven test questions, attendees were significantly more likely to return a correct answer. In the most extreme case, (question 19) almost two thirds (61.1%) of attendees answered correctly compared to only one third for non attendees (33.1%). For three of the remaining five questions, a higher proportion of those who attended returned correct answers compared to those who didn't attend but the results were not significant.

Table 6. Comparison of proportions of correct responses to Cultural Awareness Knowledge test questions for those who attended CAT compared to those who never attended.

Variable	Proportion Correct		χ^2	p	Sig ¹
	Never attended	Attended			
Q19. What does Koori mean?	0.331	0.611	21.32	0.00	***
Q21. What is local nation?	0.431	0.573	5.22	0.02	*
Q 24. What is close the gap?	0.791	0.885	4.00	0.05	*
Q27. What was the Exemption Certificate?	0.523	0.688	7.46	0.01	**
Q29. How do you tell if a client is ATSI?	0.785	0.873	3.35	0.07	n/s
Q22. Tribe	0.154	0.217	1.44	0.23	n/s
Q25. Eye Contact	0.512	0.631	2.91	0.09	n/s
Q26. Diabetes	0.554	0.537	0.03	0.87	n/s
Q28. Quality	0.470	0.599	4.14	0.04	*
Q37. Complex	0.512	0.638	3.17	0.08	n/s
Q31 Speaks Loudly	0.923	0.892	0.49	0.48	n/s

¹ n/s not significant; * 0.05=> p > 0.01; ** 0.01=> p > 0.001; *** p = < 0.001

Bivariate comparisons were also conducted to see if those who had previously attended any form of CAT provided more correct responses to test questions requesting as many correct responses as the respondent could think of, than those who had never attended (Table 7). This t test analysis suggests that those who had attended training provided more correct responses to the Aboriginal Cultural Awareness questions posed. While the mean number of responses for those who attended were only marginally higher than for those who had not attended on eight of the nine test questions, attendees provided significantly more correct responses.

Table 7. Comparison of mean number of correct responses given by those who attended CAT compared to those who never attended.

Variable	Mean n correct responses		t	p	Sig
	Never attended	Attended			
Q20. Understanding	2.54	2.88	-3.29	0.00	**
Q23. Stolen	1.32	1.47	-1.44	0.15	n/s
Q30. Aspects Unsettling	1.24	1.65	-3.11	0.00	**
Q32. Staff Pressures	0.79	1.21	-4.23	0.00	***
Q33. Not Taking Meds	1.18	1.50	-3.01	0.00	**
Q34. Client Support	0.82	0.98	-2.98	0.00	**
Q35. Staff Advice	0.94	1.15	-2.86	0.01	**
Q36. Client Death	0.82	1.31	-4.02	0.00	***
Q38. Life Expect	2.12	2.68	-3.42	0.00	***

¹ n/s not significant; * 0.05=> p > 0.01; ** 0.01=> p > 0.001; *** p = < 0.001

The final set of bivariate analyses tested for effects of training on each of the dimensions of Cultural Awareness measured by the survey as well as the overall survey score. Results indicate that those who have attended training have better Knowledge, Understanding, Behaviour and overall scores than

those who have not attended training (Table 8). The overall score of attendees was on average four points higher than that of non attendees representing a 17.1% higher score.

Table 8. Comparison of summary scores between those who have attended CAT and those who have never

Variable			t	p	Sig
	Never attended	Ever Attended			
Knowledge	4.12	5.06	-4.56	0.00	***
Attitude	9.51	9.90	-1.70	0.09	n/s
Understanding	5.32	7.04	-5.19	0.00	***
Behaviour	4.28	5.20	-4.72	0.00	***
Overall Score	23.23	27.20	-6.03	0.00	***

¹ n/s not significant; * 0.05=> p > 0.01; ** 0.01=> p > 0.001; *** p = < 0.001

When a similar analysis was done comparing those who had never attended training, to those trained on the North Coast in a *full-day* session, the later scored significantly higher on all dimensions except for Attitude (Table 9). In this case the overall score was 19.1% higher.

Table 9. Comparison of summary scores between those who never attended training and those who attended a full-day training in NCAHS

Variable			t	p	Sig
	Never attended	Full Day in NCAHS			
Knowledge	4.12	5.15	-3.41	0.00	***
Attitude	9.51	10.11	-1.78	0.08	n/s
Understanding	5.32	6.96	-3.55	0.00	***
Behaviour	4.28	5.46	-4.20	0.00	***
Overall Score	23.23	27.67	-4.74	0.00	***

¹ n/s not significant; * 0.05=> p > 0.01; ** 0.01=> p > 0.001; *** p = < 0.001

When dimensional and overall scores of respondents trained on the North Coast in three half hour sessions were compared with those trained in a *full-day* session, no significant differences were found (Table 10).

Table 10. Comparison of summary scores between those who have attended 3 x ½ hour training sessions and those who have attended a *full-day* session in NCAHS

Variable			t	p	Sig
	3 x ½ hr training	Full Day in NCAHS			
Knowledge	4.72	5.15	-0.96	0.34	n/s
Attitude	9.78	10.11	-0.63	0.53	n/s
Understanding	6.94	6.96	-0.02	0.99	n/s
Behaviour	5.22	5.46	-0.49	0.65	n/s
Overall Score	26.67	27.67	-0.70	0.49	n/s

¹ n/s not significant; * 0.05=> p > 0.01; ** 0.01=> p > 0.001; *** p = < 0.001

Multivariate Analyses

When a more detailed multivariate analysis was performed to test for an effect of any previous CAT on overall survey score a significant effect was again found. This effect was 2.7 points after adjustment for other covariates (Table 11, Model 1). Significant covariates included gender, with females scoring higher than males; age group, with older respondents scoring higher than younger ones; and education level such that those with more education scored higher than those with less education.

When a multivariate analysis was performed to test for an effect of CAT within the North Coast on overall survey score a significant effect was again found. This effect was 3.1 points after adjustment for other covariates (Table 11, Model 2). Significant covariates included gender, with females scoring higher than males; and education level such that those with more education scored higher than those with less education.

When multivariate analysis was performed to test for differences between overall scores of those not trained and those trained in the two different formats provided on the North Coast (i.e. 3 x ½ hour sessions and *full-day* course) only scores of attendees of *full-day* sessions were significantly higher than those who had never trained. (Table 11, Model 3). Significant covariates included gender, with females scoring higher than males; and education level such that those with more education scored higher than those with less education.

Multivariate analysis was then performed to test for differences between scorings on each of the four dimensions of Cultural Awareness (Knowledge Attitude, Understanding and Behaviour), for those trained in the two different formats provided on the North Coast (i.e. 3 x ½ hour sessions and *full-day* course) compared to those not trained at all.

Those who had *full-day* training showed significantly higher Knowledge scores than those with no training. Those with more education had significantly higher Knowledge scores.

The Attitude score was unrelated to previous CAT regardless of the format. Those with more education had significantly higher Attitude scores.

Those who had *full-day* training showed significantly higher Understanding scores than those with no training. Older participants scored higher than younger participants. Those with more education had significantly higher Understanding scores as did females compared to males.

Compared to those with no training, participants who had been trained in either format showed significantly higher Behaviour scores. Those with Aboriginal or Torres Strait Islander clients showed significantly higher Behaviour scores as did females compared to males.

Table 11. Results of multiple regression analyses on the effect of any previous CAT on overall survey score.

Model	Intercept	Predictor variables					r ²
		Predictor 1	Predictor 2	Predictor 3	Predictor 4	Predictor 5	
1. Overall score by Trained anywhere	β =14.908 SE=1.865 Z=7.994 P<0.0001	Attended	Gender	Age	Education		0.221
		β =2.705 SE=0.641 Z=4.219 P<0.0001	β =-2.171 SE=0.735 Z=2.954 P<0.01	β =-0.078 SE=0.032 Z=2.438 P<0.05	β =2.089 SE=0.394 Z=5.302 P<0.0001		
2. Overall score by Trained in North Coast	β =18.776 SE=1.156 Z=16.242 P<0.0001	Attended	Gender	Education			0.214
		β =3.091 SE=0.691 Z=4.473 P<0.0001	β =-2.139 SE=0.789 Z=2.711 P<0.01	β =2.027 SE=0.404 Z=5.017 P<0.0001			
3. Overall score by Training modes in North Coast	β =18.954 SE=1.270 Z=14.924 P<0.0001	<i>3x1/2hour</i>	<i>Full-day</i>	Gender	Education		0.217
		β =2.482 SE=1.336 Z=1.858 P<0.10	β =3.769 SE=0.895 Z=4.211 P<0.0001	β =-1.674 SE=0.845 Z=1.981 P<0.05	β =1.860 SE=0.445 Z=4.179 P<0.0001		
4. Attitude by Training modes in North Coast	β =8.570 SE=0.465 Z=18.430 P<0.0001	<i>3x1/2hour</i>	<i>Full-day</i>	Education			0.034
		β =0.202 SE=0.500 Z=0.404 P>0.10	β =0.518 SE=0.334 Z=1.551 P>0.10	β =0.352 SE=0.167 Z=2.108 P<0.05			
5. Knowledge by Training modes in North Coast	β =3.268 SE=0.449 Z=7.278 P<0.0001	<i>3x1/2hour</i>	<i>Full-day</i>	Education	Aboriginal or Torres Strait Islander clients		0.133
		β =0.319 SE=0.430 Z=0.742 P>0.10	β =0.924 SE=0.290 Z=3.186 P<0.01	β =0.464 SE=0.143 Z=3.245 P<0.01	β =-0.484 SE=0.305 Z=1.587 P>0.10		
6. Behaviour by Training modes in North Coast	β =3.879 SE=0.283 Z=13.707 P<0.0001	<i>3x1/2hour</i>	<i>Full-day</i>	ATSI clients	Gender		0.113
		β =0.709 SE=0.410 Z=1.729 P<0.10	β =1.030 SE=0.277 Z=3.718 P<0.001	β =0.766 SE=0.294 Z=2.605 P<0.01	β =-0.624 SE=0.261 Z=2.391 P<0.05		
7. Understanding by Training modes in North Coast	β =0.698 SE=1.174 Z=0.595 P>0.05	<i>3x1/2hour</i>	<i>Full-day</i>	Gender	Age	Education	0.228
		β =1.017 SE=0.674 Z=1.509 P>0.10	β =1.125 SE=0.452 Z=2.489 P<0.05	β =-0.866 SE=0.423 Z=2.047 P<0.05	β =0.057 SE=0.020 Z=2.850 P<0.01	β =0.883 SE=0.223 Z=3.959 P<0.0001	

(Variable values: Attended 0=no, 1=yes; Gender 0=female, 1=male; Age 30=25-34, 40=35-44, 50=45-54, 60=55-64, 70=65-74, 80=75+; Education 1=Years 6 or less, 2=Year 7 to 10, 3=Year 11 to 12; Aboriginal or Torres Strait Islander clients 0=no, 1=yes)

Racist Responses

Whilst reviewing the qualitative responses to open ended questions, it became apparent that some clearly expressed racist viewpoints. Twelve respondents submitted responses of this nature of which there were 19 individual comments in total. Respondents ranged from administrators working in Area Executive office to ward nurses and a dental worker. A range

of types of racist comments were apparent, these included ignorance; the belief that all should be treated equally regardless of their cultural history; stereotyping; non caring; demeaning or patronising.

Examples classified as 'Ignorance' included:

Answers to:

Q.23, *"Why should health workers know about Stolen Generations?"*

- "I didn't think it was relevant"

- "Why should we accept political correctness over the reality of recorded history, this issue needs further examination."

- "Kevin Rudd said sorry so it is no longer an issue."

Examples of 'treated equally regardless of cultural history'

Answers to:

Q 23, *"Why should health workers know about Stolen Generations?"*

- "It is history and should be told just the same as the stolen "white" children."

Q 36, *"An Aboriginal client dies whilst in hospital. What arrangements should be made to ensure the deceased and family are treated respectfully?"*

- "They should be treated the same as anyone."

Examples of 'Stereotyping' included:

Answers to:

Q 38, *"List three main reasons why Aboriginal people might have a lower life expectancy than other Australians?"*

- "Alcohol, bad diet habits" (sic)

Q 33, *"An Aboriginal person is not taking their medication, why might that be?"*

- "Not to be taken with alcohol."

Examples of 'Non-caring' attitude' included:

Answers to:

Q 33, *"An Aboriginal person is not taking their medication, why might that be?"*

- "How would I know"

Q. 23, *"Why should health workers know about Stolen Generations?"*

- "Why should they, what purpose does it serve?"

Examples of 'Demeaning or Patronising' responses include:

Answers to:

Q 32, *"What additional pressures do Aboriginal health staff commonly face when compared with non Aboriginal staff?"*

- "Hygiene and alcohol and smoking uses."

Q 33, *"An Aboriginal person is not taking their medication, why might that be?"*

- "Thinking they can 'heal' themselves with nature."

Discussion

This study aimed to answer the question: 'Does the current system for training NCAHS staff in Aboriginal Cultural Awareness, when delivered in either of two modes (one *full-day* and 3 x $\frac{1}{2}$ hour sessions), improve relevant knowledge, attitudes and purported behaviours of participants, in relation to providing culturally appropriate services?'

This research found that those who had attended some form of training had significantly higher Cultural Awareness scores compared with those not trained. Bivariate analysis indicated that whilst the differences may appear adequate in terms of the training received, they are modest in terms of scores achieved by the most culturally aware members of staff (ranging from 3.3% for Attitude to 11.5% for Understanding). The same was true when comparing those trained on the North Coast to those not trained at all. Multivariate analysis confirmed these findings, however, it showed them to be an overestimate of true differences due to training.

Within Richmond Network those who attended a *full-day* course attained a higher overall score than those who attended *3 x ½ hour* sessions. This was mainly due to increased Knowledge, Understanding and Behaviour. Those with Aboriginal or Torres Strait Islander clients showed significantly higher Behaviour scores than those without. Females scored higher than males; older respondents scored higher than younger ones; and those with more education scored higher than those with less education. Those who attended *3 x ½ hour* sessions returned scores that were not statistically different to those with no training. This may well reflect a small sample size, and the fact that the mean scores were consistently higher than those who had not been trained suggests that with a larger sample these changes might well be significant.

In spite of CAT being implemented throughout the NCAHS, including the Richmond Network for over a decade, the current profile of staff Cultural Awareness in the Richmond Network indicates that there is considerable room for improvement. In terms of overall scores, only one in eight (11.8%) are currently achieving a score in the top quartile of possible scores. The situation is particularly poor for the Knowledge, Understanding and Behaviour dimensions with only one in fifteen (6.6%), one in seventeen (5.9%) and one in fifty (2.1%) attaining a score in the top score quartile. There are also clear signs of overt racism amongst staff responses to the survey questions.

Strengths and Limitations

One of the strengths of this study was that the instrument was grounded in the lived experience of Aboriginal clients of the health service. Deploying it via an intranet based platform with internal email reminders meant that a large cross section of staff were reached. While the response rate might have been higher, the overall sample size was more than adequate for addressing the main research question.

Comparison with staff profiles suggests that surveyed respondents were fairly representative of staff in the area with respect to age and gender if not their profession. Another possible limitation was the withdrawals that occurred after respondents started completing the survey form the test questions. Analysis indicated that these respondents were more likely to be in management roles and less likely to have attended any form of CAT. This may mean managers are not giving Cultural Awareness sufficiently high priority.

While the analysis suggests that CAT is associated with a range of improvements in staff Cultural Awareness it should be noted that the findings are based on a cross sectional survey. Compared to a longitudinal (pre-post) study, it is difficult to attribute with any certainty, a causal relationship between attending CAT and the outcomes of interest. The findings are therefore indicative rather than inferential and are best considered in the context of other published findings on the subject.

Comparison with other Studies

It's important to consider the findings in the research in the light of other studies published in the literature.

A study in South Western Sydney Area Health Service evaluated the impact of CAT on "health professionals' perceptions, familiarity and friendships, attitudes and knowledge of Australian Aboriginals and the health issues affecting them." As with the present study, differences were small, with data showing some improvement in knowledge and understanding of disease risks, however attitudes and beliefs were unchanged, the researcher concluded that brief CATs are not alone sufficient in changing attitudes and beliefs towards Indigenous health.⁵

In Canada, a study was undertaken to "determine the effectiveness of cultural sensitivity training on the knowledge and attitudes of health care providers, and to assess the satisfaction and health outcomes of patient's from different minority groups with health care providers who received training." Through this small study it was concluded that benefits of cultural sensitivity training were noticeable. Again this is consistent with the modest differences detected in the present study. Here the researchers concluded that training could potentially assist in the reduction of cultural discrepancies in the health system however it was also noted that changing attitudes is a long-term process.²⁰

A similar study was designed and conducted with public health nurses (PHN's) in Ontario to "determine the effects of the (instructional) course on PHNs' perceived cultural competence." Findings indicated that the levels of PHNs cultural competence, 'behaviour and clinical practice' could be improved through short-term courses.⁷ Further research in Australia might do well to use these findings as a starting point.

Our study and those described above suggest that in-service training to promote Cultural Awareness may have small to modest impact on cultural appropriateness of service delivery and require a long-term approach. In developing this project, one of the issues repeatedly raised by Aboriginal health staff responsible for CAT, is the time and effort it takes out of their substantive role to provide actual client care. This begs the question of relative value. Who should take the responsibility for the cultural safety of Aboriginal clients of the service and in what way? While this study cannot answer this question in full, it does highlight the fact that such responsibility should be shared across managers in every part of the service.

The paper, *Putting Indigenous Cultural Training into Nursing Practice*, explored how six hospital-based nurses from a hospital in Darwin consider the role of “Indigenous cultural training and the impact it has had on their practice.” Through this study it was highlighted that “cultural training can only present a starting point or background for health workers wanting to develop their skills and ability to provide culturally safe care”. It also became apparent that providing culturally safe care is dependant on an individual wanting to learn and provide care in such a manner. The researchers concluded that relying solely on cultural training to solve all barriers in health provision is unrealistic. It was also argued that without support by the health organisation and structural change, an overall culturally safe and competent health service is unattainable and an unrealistic burden on health workers.^{21, 22}

Implications

The results from this research project in North Coast NSW indicate that people who have attended a CAT have shown some improvement in certain aspects of their Cultural Awareness. When this is considered in terms of the ‘house metaphor’ described in the introduction, CAT is obviously an important step. However it is clearly a very small step in the overall picture when we think of its relative importance compared to the other vital components of the house, including Cultural Sensitivity, Safety, Security, Respect and Competence. In order to achieve these other key components, strategies well beyond CAT need to be implemented throughout the health system (and in the broader community) including experiential learning, effective policy, robust legislation and consistent enforcement.^{8, 23}

From this perspective it is vitally important that the health service reassess its dependence upon, and promotion of CAT as the primary means of achieving the ongoing safety and security of its Aboriginal staff and clients.

The survey results and various racist comments throughout the survey make it evident that the Area Health Service has not yet reached a high level of Cultural Competence. While it is hard to determine how much of the gap in health between Aboriginal and non Aboriginal people is due to culturally inappropriate delivery of health services the current situation can not be helping to reduce it.

Conclusions

The current profile of staff Cultural Awareness in the Richmond Network indicates that there is considerable room for improvement. Those who have attended some form of training have modestly higher Cultural Awareness scores compared with those not trained. However, there is substantial room for further improvement in Cultural Awareness, even after training.

Those who attended a *full-day* course attained a higher overall score than those who attended *3 x ½ hour* sessions. Cultural Awareness represents only

a small component of the necessary comprehensive approach to achieving the safety and security of Aboriginal staff and clients of the service.

Recommendations

It is recommended that:

- The full-day CAT continue to be implemented throughout the health service as a mandatory training.
- The 3 x ½ hour trainings be used only in situations where a *full-day* training is not possible, such as where critical staff shortages prohibit *full-day* training.
- The existing set of policies and enforcement practices covering racism within the service be reviewed and strengthened.
- A committee be established as a matter of priority to review the place of CAT within the broader context of the other vital foundations of culturally appropriate practice within the service. Input from Aboriginal elders during this review process is vital towards efficacy.
- As a minimum requirement, this committee should include:
 - Area Chief Executive
 - Aboriginal Health Coordinator
 - Director of Human Resources
 - Strategic Development and Performance Coordinator, Aboriginal Health Strategic Unit
 - Director Learning and Development
 - Director of Clinical Services
 - Executive level representative of NSW Health Policy Branch

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Appendices:

Appendix 1:

Enter the draw for a FREE double movie pass

At the completion of this survey you will be redirected to a page where you can fill in some contact details and go into the draw for one of 6 double movie passes we are giving away
If you choose to enter the draw - you're details will in no way be linked to your response to this survey

We're seeking your help in completing this survey to ensure that the North Coast Aboriginal Cultural Awareness Trainings in 2010 are of the highest quality.

We do not need to know who you are so all your responses will be anonymous.

Thanks for assisting us with this evaluation. If you have any queries please contact Tiahna Franks on 66207268 or Eric van Beurden on 66202553.

Details

1. Do you work in a site within the Richmond network (including Area staff)?*
This survey is for people in the Richmond network (including Area staff).

Yes No

2. Name of your Work Site*
The site where you work most hours

3. Gender*

Male Female

4. Age Group*

16-24 25-34 35-44 45-54 55-64 65-74 75+

5. Highest level of education*

Year 6 or less
 Year 7 to 10
 Year 11 to 12
 Trade certificate
 Higher Education

6. In what calendar year did you finish school education?*

7. In what calendar year did you first work for NSW Health?*

8. How many years in total have you worked in NSW Health?*

9. What is the main type of work you now do in Health? *
(eg. Trade work, Nursing, Management etc.)

- Administrative
- Allied Health
- Maintenance
- Hotel Services
- Information Technology
- Management
- Medical Staff
- Nursing Staff
- Other Patient Support
- Project Staff
- Security
- Aboriginal Health
- Population Health
- Other, please specify

10. Are you of Aboriginal or Torres Strait Islander descent?*

- Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander
- Neither

11. Have you ever worked closely with Aboriginal workers?*

- Yes No Don't know

12. Have you worked closely with Aboriginal clients?*

- Yes No Don't Know

13. Have you ever attended a Cultural Awareness training?*

Yes No (go to Q. 17)

14. If yes, was your most recent training:

- A full day workshop
- 3 half hour sessions within your site
- I haven't attended any training yet
- Other, please specify

15. Where was your most recent training?

16. When was your most recent training?
mm/yyyy

17. If you have never attended a Cultural Awareness training, what have been the reasons?

18. What do you think would make it easier for staff to receive Cultural Awareness training?*

Your Understanding of Cultural Awareness

19. The word Koori can mean...*

- A traditional dug out canoe
- An Aboriginal person from anywhere in Australia
- An Aboriginal person from Queensland
- An Aboriginal person from NSW
- All of the above

20. How would you rate your current understanding of local Aboriginal culture?*

- Very poor Poor Moderate Good Very good

21. Which Aboriginal Nation is recognised as the Traditional Owners in the place of the main facility in which you work?*

22. What is the name of the tribal group that are the traditional owners there?*

23. Why should health workers know about Stolen Generations?*

24. What is 'Close the Gap'?*

- A) A movie about closing the Stanley Chasm to tourism for cultural reasons.
- B) A campaign to raise life expectancy of Aboriginal people.
- C) A book about lack of appropriate housing for Aboriginal people.
- D) None of the above
- E) A, B, and C

25. If an Aboriginal client does not look you in the eye when you are discussing a health issue, what is it most likely to mean?*

Choose the two most likely reasons.

- They don't believe you
- They are showing respect.
- They are ashamed.
- They are lying.

26. The rate of developing diabetes mellitus in local Aboriginal people, compared to non-Aboriginal people is: *

- A bit less
- About the same
- Two to four times higher
- Ten times higher
- Don't know

27. An Exemption Certificate for an Aboriginal person allowed them to...*

- Prove their Aboriginality
- Be exempt from having to go to war
- Live outside designated communities
- Get groceries without needing money
- None of the above

28. An understanding of Aboriginal culture has little to do with delivering quality health care for Aboriginal people.*

- Strongly disagree
 Disagree
 Neutral
 Agree
 Strongly agree

29. When a patient is first admitted to hospital, how might a health worker tell if the person is of Aboriginal or Torres Strait Islander descent?*

30. What aspects of the hospital system might an older Aboriginal woman find unsettling?*

31. An Aboriginal man has been admitted to a hospital ward. His son is visiting and is trying to find answers for the reason he is in hospital. He starts raising his voice as he is confused and concerned. What would be your first course of action?*

- Call security
- Try to find the cause of his confusion
- Take control by telling him to sit down and be quiet.
- Tell him anything just to calm him down
- Reassure him and explain the situation, or find someone who can.

32. What additional pressures do Aboriginal health staff commonly face when compared with non Aboriginal staff?*

33. An Aboriginal person is not taking their medication, why might that be?*

34. If an Aboriginal client needs cultural support and no Aboriginal health staff are available, what might you do?*

35. If you felt that you needed more cultural advice in relation to your work with a client, who might you talk to?*

36. An Aboriginal client dies whilst in hospital. What arrangements should be made to ensure the deceased and family are treated respectfully?*

37. Compared to non-Aboriginal clients, Aboriginal clients tend to have more complex problems both socially and physically.*

Strongly Disagree Disagree Neutral Agree Strongly Agree

38. List three main reasons why Aboriginal people might have a lower life expectancy than other Australians?*