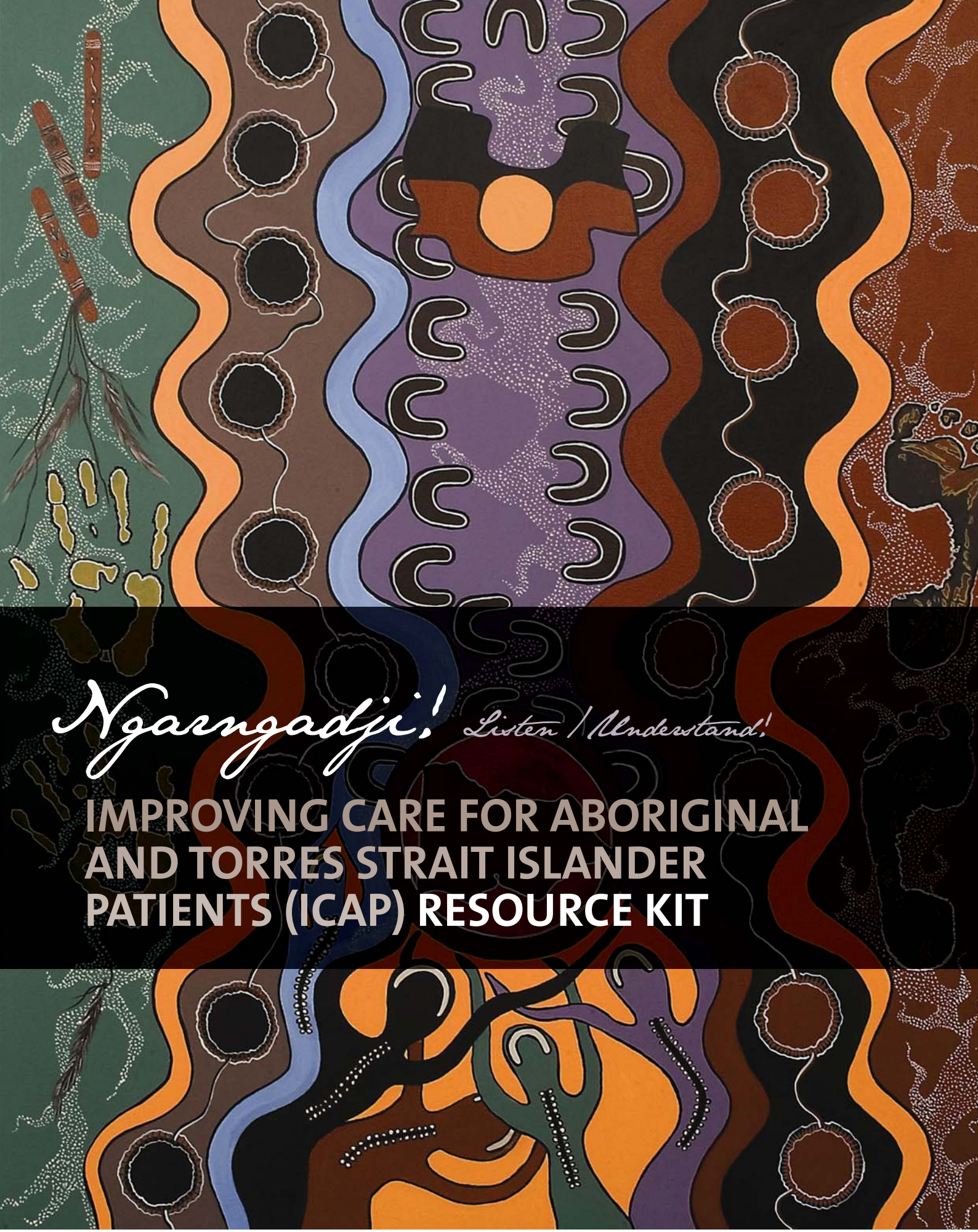

Ngarngadji! *Listen / Understand!*

IMPROVING CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS (ICAP) RESOURCE KIT

Onemda
VicHealth Koori Health Unit

StV

VACCHO Inc

A Victorian Government initiative

State Government Victoria

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Ngarngadji!

The word *Ngarngadji!*, meaning 'listen/understand!', is used here with the permission of the Traditional Owner for Woiwurrung language and the Victorian Aboriginal Corporation for Languages.

Foreword

The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program was established in late 2004 in response to research that highlighted hospitals needed to take a quality improvement approach to how they developed services to the Aboriginal Community, and that any changes needed to be undertaken in consultation and partnership with the Aboriginal Community. The ICAP program cemented that intention at the policy implementation level with a partnership between the Department of Human Services (DHS) and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) with the funding of three project officers, one within a DHS regional office, one in a metropolitan hospital and one at VACCHO. This team leads the reform process and has provided Aboriginal and non-Aboriginal hospital staff along with Aboriginal organisations, support and guidance regarding the reform.

The *Ngarngadji! Listen/understand! Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Resource Kit* brings together the good practice developed over many years within the Victorian acute healthcare system. In line with the Council of Australian Governments' commitment and investment in 'Closing the Gap', this package is a clear step in the right direction to assisting in closing the health inequality gap between Aboriginal and non- Aboriginal Victorians.

We are delighted to provide the *ICAP Resource Kit* to assist hospital staff with their efforts to improve services for the benefit of the Aboriginal Community. We need all key Victorian stakeholders, including hospitals, Aboriginal Community Controlled Health Organisations and governments to take a long term view and support sustainable change to ensure that the acute healthcare system can play its part in improving health outcomes for the Victorian Aboriginal Community.

RAY MAHONEY
A/Chief Executive Officer
VACCHO

STEVE BALLARD
Director, Aboriginal Affairs
Department of Human Services Victoria

About the Artwork

The painting that I have done is about the Aboriginal Hospital Liaison Officer Program, now called the ICAP program. It is painted to reflect the program's cultural strength and uniqueness.

There are key symbols in the painting that bring together important Indigenous messages, for example networking and communication are painted in travel lines and the 'Three Message Sticks'.

Other key symbols in the painting are ceremony, identity and spirituality, all of which are examples of the issues in Aboriginal health care, which, from a holistic view, improve Aboriginal health and wellbeing.

MARILYNE NICHOLLS, 2005

Table of Contents

Preface: The vision becomes reality

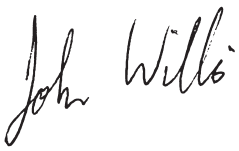
Working with hospital staff to improve services to the Aboriginal and Torres Strait Islander Community is a challenging but rewarding role. As one of the inaugural ICAP project officers employed to assist Victorian hospitals to implement the ICAP reform, I had the privilege of working alongside many dedicated Aboriginal and non-Aboriginal staff, some with many years of experience and others new to the field.

Many hospital staff stated a desire to make a difference but were unsure how to proceed. Although it was acknowledged all hospitals are different, there was a range of common issues that hospitals were facing and many requests for information on how to respond. Why reinvent the wheel if another hospital has successfully responded to this issue? What was needed was a way of 'bottling' the expertise and experience of those who had undertaken the journey of successfully developing their services and a way to make it available to those less experienced in Aboriginal health. The concept of the *ICAP Resource Kit* was developed in response to these requests.

The project brief for the resource kit emphasised the need for both Aboriginal and non-Aboriginal researchers to undertake the work to ensure the kit would be culturally appropriate and practical to use, for both Aboriginal and non-Aboriginal staff. We were very pleased with the consultants engaged to undertake the project, which involved a partnership between Onemda VicHealth Koori Health Unit, The University of Melbourne, and St Vincent's, Melbourne.

This partnership brought together extensive experience of the hospital sector from both an Aboriginal worker perspective and a management perspective of an Aboriginal health program. This combination facilitated the comprehensive collection of good ideas, stories, experiences and successful hospital policies and processes, from both an Aboriginal and non-Aboriginal perspective.

It is fabulous to see the *ICAP Resource Kit* finally completed. I would personally like to thank both Angela Clarke and Sonia Posenelli for taking on this vision and bringing it to reality. I hope that you find the kit both practical and informative to guide your practice on how to provide culturally appropriate hospital care to the Aboriginal and Torres Strait Islander Community.



JOHN WILLIS
Project Manager
Improving the Culture of Hospitals Project
La Trobe University

Who put this kit together?

THE ICAP RESOURCES PROJECT TEAM CONSISTED OF THE FOLLOWING CONSULTANTS:

- **Angela Clarke**, *Onemda* VicHealth Koori Health Unit
- **Shaun Ewen**, *Onemda* VicHealth Koori Health Unit
- **Nicole Waddell**, *Onemda* VicHealth Koori Health Unit
- **Sonia Posenelli**, St Vincent's Melbourne.

THE ICAP PROJECT WORKING GROUP MEMBERS WERE:

- **John Willis** (Chair 2007/08), Senior Metropolitan ICAP Project Officer, St Vincent's
- **Raelene Lesniowska** (Chair 2008/09), Senior Metropolitan ICAP Project Officer, St Vincent's
- **Helen Kennedy**, Health Programs Manager, Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- **Leigh Gibson**, Director Community and Integrated Care, Goulburn Valley Health
- **Ged Williams**, Director of Nursing, Maroondah Hospital, Eastern Health
- **John Stanway**, Executive Director, Royal Children's Hospital
- **Steve Ballard**, Senior Manager, Aboriginal Affairs, Department of Health Victoria
- **Leanne Andrews**, Rural ICAP Policy Advisor, Department of Health Victoria
- **Bree Heffernan**, Program Advisor, Department of Health Victoria.

The development of the kit was guided by a steering group—the ICAP Project Working Group—which included the metropolitan and rural and VACCHO ICAP Project Officers, executive-level health service managers, representatives of community-controlled health organisations and senior personnel in the Department of Human Services Victoria.

Acknowledgments

The ICAP Resources Project Team acknowledges the generous support provided by many Aboriginal and non-Aboriginal personnel in health services across Victoria who gave their time and consulted in the development of the final report and who provided material including photographs for the *ICAP Resource Kit*.

We are indebted to the members of the ICAP Project Working Group, Aboriginal Hospital Liaison Officers, hospital managers, Elders, Community members and VACCHO members who reviewed drafts and made useful contributions and suggestions.

We especially acknowledge Louise Pinazo, Lisa Braddy, John Willis and Raelene Lesniowska for contributions to the format of the kit and for material provided.

The *ICAP Resource Kit* contains resource material and photographs from a number of other publications, individuals and organisations. The ICAP Resources Project Team acknowledges and appreciates the support provided in making material available for use. Specific acknowledgments and website contacts, where relevant, are included throughout the kit.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
AHLO	Aboriginal Hospital Liaison Officer
AIMS	Agency Information Management System
AWHBU	Aboriginal Women's Health Business Unit
BADAC	Ballarat and District Aboriginal Co-operative
CEO	Chief Executive Officer
CS&HITB	Community Services & Health Industry Training Board
DOH	Department of Health Victoria
EQuIP	Evaluation and Quality Improvement Program
GP	General Practitioner
HARP	Hospital Admission Risk Program
ICAP	Improving Care for Aboriginal and Torres Strait Islander Patients
KPI	key performance indicator
KRA	key result area
NAIDOC	National Aborigines and Islanders Day Observance Committee
OP	outpatient
RCH	Royal Children's Hospital (Melbourne)
RWH	Royal Women's Hospital (Melbourne)
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
WIES	Weighted Inlier Equivalent Separation

About this Resource Kit

WHO IS THE KIT FOR?

The kit is full of information for people who are working together to realise the goals established by the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) reform. They include hospital executives and managers with responsibility for, and interest in, improving Aboriginal health programs and services within their settings. The kit is for Aboriginal Hospital Liaison Officers (AHLOs) working within mainstream settings and for staff in community-controlled health organisations working with health services (hospitals). It is for personnel who are new to their roles in acute settings and those who already have a good working knowledge of Aboriginal health.

Importantly, the kit has much to offer managers and supervisors of Aboriginal programs in acute health who are committed to improving their knowledge and skills.

THE ICAP PROGRAM

The ICAP Program was established in Victoria in 2004/05 as part of a reform that heralded a significant new approach to Aboriginal health funding and accreditation for Victorian public hospitals. The acute funding supplement for Aboriginal and Torres Strait Islander patients was increased from 10 per cent to 30 per cent in 2004/05.

THE ICAP REFORM FOCUSES ON OUTCOMES AND CULTURAL CHANGE IN HEALTH SERVICES. THESE INCLUDE:

- improved identification and health care for Aboriginal patients
- recognition that Aboriginal patients are everybody's business
- culturally aware staff
- relationships with Aboriginal communities
- improvements in discharge planning and primary care referrals.

The Department of Health Victoria (DOH) funds three project officers to assist in implementing the ICAP Program. One is based at St Vincent's and focuses on metropolitan health services. One is based in DOH, at the Ballarat office, and focuses on rural health services. The third position is based at VACCHO and has a focus on Aboriginal staff and Aboriginal Community-Controlled Health Organisations (ACCHOs).

Further information about the role of the ICAP Project Officers (and other key ICAP stakeholders) is provided in Section 3, Appendix I: A quick background guide.

THE ICAP RESOURCES PROJECT

The purpose of the ICAP Resources Project was to develop a set of resources to assist health services in implementing the ICAP Program successfully.

THESE RESOURCES AIM TO:

- enhance the effectiveness of cultural awareness training programs for health service staff
- improve the effectiveness of the ICAP Program within health services
- improve the awareness of health service management personnel about the cultural issues facing Aboriginal staff and the added complexities of operating an Aboriginal program within an acute health service.

The kit is targeted to all health service staff. Some resources are specifically targeted to managers and supervisors who have the responsibility of overseeing the establishment and implementation of the ICAP Program.

The project gathered, analysed and documented the views of key stakeholders (the end-users) about the appropriate content of the resources for the successful implementation of the ICAP Program. It also sought their recommendations regarding the development of any additional resources that may be required by health services.

HOW TO USE THIS KIT

The *ICAP Resource Kit* has five sections: the final report of the ICAP Resources Project and four additional sections, which are the resources developed and collated by the Project Team based on the key stakeholder interviews.

This kit is designed for a mixed audience, which includes hospital senior executives, AHLOs, supervisors and other hospital personnel.

THE KIT IS AVAILABLE IN THREE FORMS:

- a loose-leaf binder (hard copy)
- a CD–ROM
- on the ICAP website at <www.health.vic.gov.au/koori/icap>.

An outline of the five sections of the kit follows.

Section 1: ICAP RESOURCES PROJECT FINAL REPORT

This section contains the final report of key stakeholder interviews carried out by the ICAP Resources Project Team consultants. The report provides feedback from 44 Aboriginal and non-Aboriginal stakeholders representing 20 Victorian health services (hospitals).

Section 2: ORIENTATION GUIDE FOR ABORIGINAL HOSPITAL LIAISON OFFICERS

This section provides information for AHLOs. We encourage all new AHLOs and their program managers to adapt the information in this section to their own workplaces, experiences and needs.

The information provided is a guide only and we do not expect that it will answer everyone's questions or concerns, but we have attempted to put in as much information as we thought initially relevant.

This section has been written in such a way that it has some very basic information. Some people may find that they are already familiar with some of this, while others may find that all the information is new. Please take what you need from this section and flick over the pages containing information you are familiar with.

Section 3: ORIENTATION AND INFORMATION FOR HEALTH SERVICE MANAGERS

This section will:

- assist hospital managers and program supervisors to better understand the complexities of operating an Aboriginal program by examining human resource management issues
- build capacity to implement ICAP successfully by examining strategic issues such as partnerships with community-controlled organisations
- provide ideas for improving hospital information management practices.

The information is varied and wide-ranging and can be used for reflection, to spark discussion (between managers and between managers and AHLOs) and to develop new knowledge. The views are not intended as definitive points of view or answers.

Three areas—human resources management, integration between hospital and Community, and information management—are covered in sub-sections.

Section 4: CULTURAL COMPETENCE AND AWARENESS INFORMATION FOR HEALTH SERVICES

This section is relevant for ICAP stakeholders who are interested in developing knowledge and ideas about cultural competence—in particular, supervisors of AHLOs.

The section specifically includes:

- models of cultural competence and key definitions
- a review of the literature on cultural competence
- recommendations on cultural awareness training made by the key stakeholders who provided feedback to the ICAP Resources Project.

Material is included about the development of cultural awareness training in health services in accordance with ICAP Program objectives.

Section 5: PRACTICE EXAMPLES FROM VICTORIAN HEALTH SERVICES

This section contains a range of ICAP-related information and tools developed in the field throughout Victoria. These materials have been generously provided to the ICAP Resources Project Team for use by health colleagues. We are indebted to the contributing health services and individuals for their generosity and spirit of collaboration. The loose-leaf binder contains a summary of the examples, while the CR–ROM and the website versions of the kit contain the examples in full.

SECTION 1: ICAP RESOURCES PROJECT FINAL REPORT

This section contains the final report of key stakeholder interviews carried out by the ICAP Resources Project Team consultants. The report provides feedback from 44 Aboriginal and non-Aboriginal stakeholders representing 20 Victorian health services (hospitals).

EXECUTIVE SUMMARY

PURPOSE OF THE ICAP RESOURCES PROJECT

The purpose of the ICAP Resources Project was to develop a package of resources to enhance the capacity of Victorian health services to achieve the vision that 'Aboriginal health is everybody's business'. The project was funded by the Department of Health Victoria (DOH).

The project sought to:

- identify training and information resources that would assist health services in implementing ICAP successfully
- improve awareness of the cultural issues facing Aboriginal staff
- build capacity to manage the complexities of operating an Aboriginal program in mainstream acute settings
- identify examples of good practice activities across the field.

SCOPE

Consultations

The project documented the views of 44 stakeholders in metropolitan and rural hospitals in Victoria including Aboriginal staff and executive-level, senior and middle managers (Appendix I). Their views form the bases of this final report.

Resources

Stakeholder feedback informed the development of the ICAP Resource Kit, which comprises this final report (Section 1) and four other sections:

- **SECTION 2: ORIENTATION GUIDE FOR ABORIGINAL HOSPITAL LIAISON OFFICERS**
- **SECTION 3: ORIENTATION AND INFORMATION PACKAGE FOR HEALTH SERVICE MANAGERS**
- **SECTION 4: CULTURAL COMPETENCE AND AWARENESS INFORMATION FOR HEALTH SERVICES**
- **SECTION 5: PRACTICE EXAMPLES FROM VICTORIAN HEALTH SERVICES.**

Material that expands on themes raised by key stakeholders is included in the final report.

PROJECT FRAMEWORK

The functions, standards and criteria of the fourth edition of the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program (EQuIP 4) form the framework that underpins the focus and analysis of stakeholder input:

- EQuIP corporate functions cover standards such as strategic and governance considerations, partnerships/integration with Community and risk management

- EQuIP support functions cover standards such as human resources management (including training, learning and development) and information management (ACHS 2006).

FINDINGS

The findings cover a broad range of areas reflecting EQuIP 4 standards.

Structural arrangements

Stakeholders described a range of staffing models and reporting lines currently in operation. These highlighted the influence of historical arrangements, available funding and workforce considerations in health services' governance structures for ICAP. The importance of senior champions/executive level 'buy in' in influencing program success was an important conclusion drawn by many stakeholders. To build capacity it is also desirable to co-opt internal hospital staff who are interested and committed to Aboriginal health.

Community partnerships

Linking effectively with Aboriginal communities is proving to be challenging for some health services and, to a stronger degree, for metropolitan health services. Solid examples of good practice were found in a number of regional health services. For several health services, integration efforts between hospital and Community are underpinned by informal relationships established over time, as well as by formal partnership agreements. Regional health services generally appear to have better-developed links with Community.

Tangible recommendations were made for joint planning between hospitals and communities. They included those who should be involved in the planning processes; the need to have plans for the development of cultural competence in hospital staff and for dissemination of information to Aboriginal Community Controlled Health Organisations (ACCHOs) about hospital programs, services and processes; commitment to respect Aboriginal culture; staff development and exchange opportunities; and quality improvement processes.

AHLO orientation

AHLO orientation emerged as an important area to resource. Hospital systems are complex. There was significant consensus about the need for intensive orientation of AHLOs. Suggestions included meeting key hospital staff, addressing a range of administrative requirements, access to a mentor in human resources, orientation to hospital policies and procedures, information such as flow charts, maps or who to go to for particular information, spending time directly observing other staff performing their roles, and information on relevant meetings within the hospital and Community. Aboriginal stakeholders suggested a generic package with localised information.

AHLO competencies/training needs

In light of hospital accreditation requirements, stakeholders identified that the scope of AHLO practice, training, competency development and credentialing needs to be addressed. DOH has commissioned the Community Services & Health Industry Training Board (CS&HITB) to develop competency standards for AHLOs in acute settings. This affords AHLOs and health services the opportunity to identify required knowledge and skills.

Non-Aboriginal managers and Aboriginal staff

The need for strategies to manage differences was a key theme. Many Aboriginal and non-Aboriginal stakeholders identified the challenges and the pivotal nature of two-way learning, respect and collaboration.

Key messages from AHLOs included the importance for supervisors to understand Community expectations and norms, and that supervisors need to be prepared to take advice in this area and get to know the local Aboriginal Community as part of the supervisory role. AHLOs also highlighted the need for collaboration with local Aboriginal organisations and linking with Community members as advisors.

AHLO supervisors' learning and development needs

Supervisors of Aboriginal staff described their own learning and development generally as self-directed and ad hoc. They stressed the importance of personal and professional reflection. A critical finding was that supervisors tended to learn by trial and error and the role can be a 'journey into unfamiliar territory'.

Supervisors identified the need for culturally focused workshops for managers and peer learning arrangements. Experienced supervisors tend to use flexible and strengths-based approaches in working with AHLOs. Many said that they face challenges in managing adherence to organisational norms and accountability. They requested the development of specific human resources policies and practices to promote culturally safe and effective workplace relations, and to inform discussions and negotiations with Aboriginal staff.

Resourcing executive-level staff

Clear ideas emerged about resourcing executive-level staff, including the particular needs of executive-level staff for high-quality awareness training, for good data, and for information on the policy background and on key agencies and key contact people. Many stakeholders felt that organisational responsibilities regarding ICAP need tightening and resourcing.

Cultural awareness training

Cultural awareness training is a key result area for ICAP. Stakeholders identified the need for well-developed, standardised and health-related awareness packages. Many draw on what is available by accessing websites and other information available in the public domain. Some have developed Aboriginal health intranet sites and internal hospital presentations. Many health services have sought to create a more welcoming environment, for example through posters and artwork. Stakeholders made suggestions about the content and structure of awareness training and shared good practice examples.

Funding

Tensions were expressed by many stakeholders regarding the Weighted Inlier Equivalent Separations (WIES) Casemix funding model and co-payment. Many stakeholders asked for greater clarity and transparency regarding the funding model.

Information management

Stakeholders shared ideas and examples of good practice in:

- Aboriginal and Torres Strait Islander identification, including staff training
- how to address gaps in hospital performance
- data usage—health services identified that they tend to emphasise data related to the WIES co-payment funding. Several also use data to drive strategy, to review clinical services over time, to identify opportunities for improvement and to re-focus services.

KEY RECOMMENDATIONS

1 The *ICAP Resource Kit* should be placed on the ICAP website (through the ICAP Project Officers) and end-users provided with hard copies of the resource kit. There is an opportunity to use stakeholder feedback to develop a 'talking heads' DVD.

2 To improve outcomes such as effective ICAP and AHLO program management, health services need to consider resourcing coordination responsibilities.

3 To strengthen executive level 'buy in' to the Aboriginal health agenda, it is recommended that DOH considers the inclusion of key performance indicators in its DOH Statement of Priorities for Hospitals, in addition to existing ICAP key result areas.

4 Health services need to be able to effectively collect and report on Indigenous data. To achieve this, several important steps need to be considered:

- the involvement and delegation of responsibilities to health information services within hospitals for regular and useful Aboriginal data reporting
- consultation with ACCHOs regarding the sort of data they would like to see from a particular health service
- in the long term, DOH will need to consider how to build Indigenous capacity for analysing and interpreting data through skills development and mentoring.

5 The orientation guide for AHLOs (Section 2 of the *ICAP Resource Kit*) developed by the project should be further informed by the development of CS&HITB competencies for AHLOs in acute settings. These could be used by VACCHO to further develop orientation modules for trial and evaluation. The ICAP Management Group should consider establishing a working party (which would include VACCHO, Onemda VicHealth Koori Health Unit and several hospitals) for participation in such a process.

6 The ICAP Management Group should consider the establishment of an education and peer support program for supervisors, drawing on the project findings and resources to inform workshop content and development. Aboriginal mentors should be involved in the program.

7 Health services need to support key stakeholders (program managers and senior staff) to implement and undertake cultural awareness training. ICAP Project Officers should consult supervisors of Aboriginal programs on setting a minimum standard of training and orientation for these roles. The DOH Cultural Respect Training Program provides a solid training format for executive level and supervisory staff. Health services are encouraged to collaborate, working with an ICAP Project Officer, so as to access standardised training of this type.

8 The *ICAP Resource Kit* is a guide or beginning point, and should be reviewed by the field (ICAP key stakeholders), built upon and refined over time.

INTRODUCTION

THE ICAP PROGRAM

The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Program was introduced in Victoria in 2004 and is funded by the Department of Health Victoria (DOH). ICAP is an extension and enhancement of the Aboriginal Hospital Liaison Officer (AHLO) program, which was established in 1982. ICAP builds on the work done by AHLOs across Victoria to improve the access of Aboriginal and Torres Strait Islander people in the State to mainstream health services. The focus is on improving service provision to Aboriginal and Torres Strait Islander patients by taking a service-wide approach. All Victorian health services must produce an ICAP plan.

Commencing in the 2004/05 financial year, separately funded programs—the AHLO program and the WIES supplement—were amalgamated. This provides a single, coherent funding stream proportional to the health services' Aboriginal patient numbers. The WIES supplement for Aboriginal patients was increased from 10 per cent to 30 per cent.

Several key stakeholders are pivotal to the ICAP Program. They are:

- DOH regional offices
- ICAP Management Group
- Koori Human Services Unit
- ICAP Coordinator
- ICAP Project Officers
- Victorian Aboriginal Community Controlled Health Organisation
- hospitals and AHLOs.

The ICAP Program goals as outlined in the ICAP guidelines (DHS 2005) are to:

- ensure accurate identification to improve access for Aboriginal and Torres Strait Islander patients
- support health services to provide culturally sensitive care and appropriate referrals
- recognise that high-quality and culturally sensitive health care is a whole-of-health service quality issue
- promote partnerships between health services and ACCHOs.

Key result areas for health services are to:

- establish and maintain relationships with ACCHOs
- provide or coordinate cultural awareness training for hospital staff
- ensure that the cultural needs of Aboriginal people are addressed when referrals and service needs are being considered, particularly in regard to discharge planning
- make effective primary care referrals involving Aboriginal workers and agencies.

THE ICAP RESOURCES PROJECT

In light of ongoing requests from both Aboriginal and non-Aboriginal staff within metropolitan and rural health services, the ICAP Resources Project was funded by DOH to develop specific ICAP resources. To date, ICAP has created a website to ensure that up-to-date, relevant resources and information are readily available.

The ICAP Resources Project gathered, analysed and documented the views of key ICAP stakeholders—the end-users—about what additional resources would be useful to them.

Onemda VicHealth Koori Health Unit at The University of Melbourne was the lead organisation for the project, working in partnership with Aboriginal Health, St Vincent's Melbourne. The project was subject to a competitive tender process. Management of the project was undertaken by the ICAP Project Working Group, which includes representatives from the health service sector and VACCHO and ICAP Project Officers (see Appendix II: ICAP Project Working Group membership).

AIMS

The aims of the ICAP Resources Project were to:

1. Develop a set of training resources to assist health services in implementing ICAP successfully. The resources should address strategic and leadership considerations, partnerships with community-controlled organisations, human resources management, information management including Aboriginal and Torres Strait Islander identification, improving access and cultural awareness training.

2. Improve health service management/whole-of-health service awareness of the cultural issues facing Aboriginal people and to build capacity to manage the complexities of operating an Aboriginal program within an acute setting.

THE ICAP RESOURCE KIT

Many of the findings of the ICAP Resources Project have been used to develop an immediate set of resources based on identified needs. The *ICAP Resource Kit* consists of this final report and four resource sections:

- **SECTION 2:** ORIENTATION GUIDE FOR ABORIGINAL HOSPITAL LIAISON OFFICERS
- **SECTION 3:** ORIENTATION AND INFORMATION PACKAGE FOR HEALTH SERVICE MANAGERS
- **SECTION 4:** CULTURAL COMPETENCE AND AWARENESS INFORMATION FOR HEALTH SERVICES
- **SECTION 5:** PRACTICE EXAMPLES FROM VICTORIAN HEALTH SERVICES.

The final report identifies key stakeholder feedback on achievements to date and perspectives on challenges in successfully implementing the ICAP Program. The findings highlight many good practice examples from across Victorian health services. At the time of completing this project report, the consultants note that DOH, which funded the project, is preparing to formally evaluate the ICAP Program. This report is not intended to cut across that evaluation.

PROJECT APPROACH

Our approach to the interviews with key stakeholders at times resembled 'having a yarn'. During this process key messages were conveyed. A sample of the conversations follows. We trust that stakeholders' words reflected throughout this report and elsewhere in the *ICAP Resource Kit* will resonate, challenge and inspire—and lead to even more yarning.

On funding issues:

> *Aboriginal and Torres Strait Islander admissions happen to attract dollars. Needs are more important than the dollars. A hospital's business is about the whole of the population needing health services. This includes attending to special needs groups. Aboriginal people have arguably more need.* (Chief Executive Officer, metropolitan health service)

On developing cultural awareness:

> *We took our very cool, calm and collected Manager to the local Aboriginal Health Service. She crumbled. She was overwhelmed. Then she 'got it'—about how Aboriginal people feel when they come to hospitals.* (Aboriginal liaison officer, metropolitan hospital)

On supervising Aboriginal staff:

> *This work is much harder [than supervision of non-Aboriginal staff]. As a supervisor, it requires you to come on a journey into unfamiliar territory. It requires you to be outreaching and constantly checking in.* (Supervisor, metropolitan health service)

On engaging the hospital board:

> *In light of ICAP we linked Aboriginal health to core business and to what is seen as an advantage to the organisation. We did not make lots of dollars but we were better able to link to the Community and this was valued.* (Executive sponsor, metropolitan health service)

Our approach to developing the resources included locating useful material available in professional and public domains, and we have summarised and highlighted this in the resource kit.

PROJECT METHODOLOGY

DESIGN

The project used two main methods to achieve its aims:

- a review of relevant literature and existing documentation and material; multiple literature searches were conducted, as well as collation and review of existing key material and use of the Internet;

- interviews with key stakeholders—a qualitative methodology was used and information was obtained using semi-structured questionnaires.

Approval was received from the University of Melbourne Human Research Ethics Committee. (See Appendices III–VI for copies of the project outline, interview schedules and consent form.)

QUALITY FRAMEWORK

The functions, standards and criteria of the Australian Council on Healthcare Standards EQuIP 4 provided the underpinning framework for gathering and analysing information.

EQuIP is a set of standards and criteria relevant to all Australian health care organisations (ACHS 2006) Health services work towards achieving these standards and criteria and they assess themselves against the standards. In turn, the Australian Council on Healthcare Standards conducts periodic reviews to verify compliance and achievements. EQuIP evaluates key clinical, support and corporate functions (see Appendix VII: EQuIP 4 functions, standards and criteria).

In line with the project aims, findings focus on feedback in the areas of EQuIP corporate functions and support functions.

Important in the EQuIP corporate standard are elements such as organisational structures and processes, strategic directions, lines of communication and responsibility (including committee structures), corporate policies, workplace health and safety, risk management, clinician credentialing and the scope of practice.

The EQuIP support standard of human resources management was the major focus of the project. Human resource management, as part of the EQuIP support function, can include an organisation's learning and development system, including training, supervision and employee support and formal training for managers; workplace relations, grievance management and mediation; employee assistance programs and work–life balance; recruitment practices such as selection and orientation; policies and procedures, including rights and responsibilities; and performance development and review and position descriptions.

INTERVIEW PROCESSES

Drawing on cultural safety principles, separate questionnaires were developed for Aboriginal stakeholders, who were interviewed by Aboriginal consultants. Non-Aboriginal stakeholders were interviewed by a non-Aboriginal consultant.

The project sought the views of metropolitan and rural stakeholders, with representation from Aboriginal staff and executive-level, senior and middle managers in Victorian hospitals. Participation was voluntary.

The process was as inclusive as possible within the timeframe and budget. Key informants were targeted for representative and in-depth input on the advice of the ICAP Project Working Group. Several Aboriginal and non-Aboriginal interviewees no longer working in hospitals were included because of their prior roles and extensive experience.

All stakeholders included on the ICAP membership list in September 2007 were advised of the project and were invited to participate through surveys.

The consultants obtained progressive input from the field on several draft versions of the report and the resources packages. Two ICAP forums in late 2007 and late 2008 were used for project consultation. Prior to finalisation of the report and resources, draft versions were circulated through the ICAP Project Officers to the ICAP membership.

PROJECT SAMPLE

Forty-four stakeholders were interviewed. They represented 20 different health services, and included both Aboriginal and non-Aboriginal respondents. Of the 19 Aboriginal people interviewed, there were two Elders, eight current AHLOs working in Melbourne (some newly appointed), seven AHLOs currently employed in rural areas and two previous AHLOs from rural regions.

The 25 non-Aboriginal stakeholders who were interviewed included two ICAP Project Officers. There were also five respondents from regional hospitals and 18 from metropolitan hospitals; of these respondents, 10 were health service executives, 12 were in middle management/supervisory roles and one was a research fellow.

FINDINGS OF THE INTERVIEWS

ICAP PROGRAM MODELS

Aboriginal Liaison Officer roles

The stakeholder interviews identified that the vast majority of health services employ Aboriginal staff in liaison officer roles. This reflects the historical focus of the AHLO Program, a longstanding and well-recognised program, which, in 1982, established 18 AHLO positions across Victoria. The primary emphasis is on patient support.

Aboriginal policy and planning roles

Where health services have set out—both pre-and post-ICAP—to establish Aboriginal health programs, a few have introduced Aboriginal policy, planning and development positions. Examples include the Royal Women's Hospital, Northern Health, Austin Health and Western Health. The focus of these positions has been to collect data, to develop links with ACCHOs, to provide cultural awareness training for hospital staff, and to establish strategic directions, priorities and program foundations. Many respondents from health services taking this approach said they found that they also needed to be able to respond to requests for Aboriginal liaison services from patients, families and Community organisations. Most have had to balance these requests according to available funding and their ability to recruit. Some, such as Peninsula Health and Bayside Health, have attempted a mix of patient care and program development initiatives.

Other new developments

A few health services have responded specifically to new DOH programs, such as Maternity Enhancement, Mental Health and the Hospital Admission Risk Program (HARP), with the aim of improving Aboriginal and Torres Strait Islander patient and family service provision. The Mercy Hospital for Women, Bairnsdale Hospital, Ballarat Health Services and Goulburn Valley Health are strong examples of organisations making such improvements.

Several rural hospitals, such as those at Sale and Orbost, have introduced AHLO positions since the inception of the ICAP Program. For health services with small numbers of Aboriginal and Torres Strait Islander patient episodes of care and limited funding, the ability to meet ICAP key result areas has been constrained. Nevertheless, most are working incrementally to achieve improvements.

A number of health services with long-running AHLO programs have, in light of the ICAP strategy, undertaken new program developments and enhancements. At the Royal Children's Hospital an innovative new model of Aboriginal patient and family care is being planned. At St Vincent's there has been an expansion to include more patient liaison coverage, as well as dedicated staffing for cultural awareness training, policy and planning initiatives, and for the coordination of ICAP.

REPORTING AND MANAGEMENT

Executive level 'buy in'

There was strong consensus that although health services vary, finding senior Aboriginal health/ICAP champions is essential. ICAP needs a voice at executive level and executive/ senior staff membership on the organisations Aboriginal advisory committees. Executive level 'buy in' to ICAP was apparent in most health services represented, with only a limited number of exceptions.

According to feedback, executive sponsors said that they generally focus on policy and system development. They are likely to be involved in nurturing the strategy—working with Community organisations and helping to obtain agreements and endorsements within their own organisations.

Reporting arrangements

Aboriginal liaison reporting arrangements are predominantly through social work department managers. A few Aboriginal programs have a separate governance structure and some report directly to executive directors (although not clinically). Stakeholders articulated that the link to social work has been made principally because of the clinical focus, the skills required for the AHLO roles, and for the purposes of staff support and supervision. Several stakeholders noted that the relationship had the potential for inherent difficulties because of historical issues and critiques of past practices. Others—both AHLOs and social work managers—described working relationships as effective.

Some stakeholders said that structural arrangements for both AHLO and Aboriginal policy and planning positions and for the relevant managers can be confusing if there are internal idiosyncrasies. For example, executive responsibilities may be shared between two directorates for pragmatic reasons. Most health services do not have Aboriginal health units. Many AHLOs and Aboriginal policy and planning roles have a link to, but do not report to, Aboriginal advisory committees.

Rationale for structural arrangements and linkages

Management of ICAP and Aboriginal health reporting lines is influenced by one or more of a range of factors. The rationale for structural arrangements can be influenced by strategic considerations such as interest in integration with Community, the experience and commitment of certain executive sponsors, and historical and operational reasons (and a mix of all these). There were pros and cons in all the arrangements and it was not possible to identify best practice. There was consensus regarding the importance of internal (hospital) champions:

> *It is important to co-opt people within the health service who are interested in Aboriginal health—structure is not the main consideration.* **(Executive sponsor, metropolitan health service)**

A small number of stakeholders discussed the structural links between Aboriginal staff working in a range of programs across their health services—the AHLO program, mental health, maternity enhancement positions, and community-based drug and alcohol

services. The experience to date is that these links are mostly informal or they occur through membership of Aboriginal advisory committees. Opportunities to more actively link Aboriginal staff working within health services have not yet been maximised.

In terms of the scope of practice, such as broadening AHLO coverage beyond the acute environment, only a small number of health services (generally rural) have internally funded HARP AHLO positions. AHLOs tend to focus primarily on traditional acute patient services.

ICAP and AHLO program management and growth

Very few health services have allocated specific funded resources for ICAP and AHLO program management. Several stakeholders felt that to ensure effective program management and accountability, there is a need to consider resourcing of coordination responsibilities. One commented:

> *We have now funded two days per week for ICAP coordination responsibilities because Aboriginal health program and staff responsibilities need dedicated management time.* (Executive sponsor, metropolitan health service)

GOOD PRACTICE EXAMPLES

The following examples highlight good practice in the areas of strategy, staffing and management at various health services.

The Royal Women's Hospital and the Royal Children's Hospital

The Royal Women's Hospital Aboriginal Women's Business Unit and the Royal Children's Hospital Aboriginal Unit commissioned reports pre-ICAP to inform Aboriginal health directions. The Royal Women's Hospital completed the *Right of Ways Report* in 1998 (RWH 1998) and the Royal Children's Hospital published *Lookin' after Our Own: Supporting Aboriginal Families through the Hospital Experience* in 2000 (Clarke, Andrews & Austin 2000). These are still used to inform both hospitals' work.

The role of the Royal Women's Hospital Aboriginal Women's Business Unit includes training and education, and focuses on experiences of patients, conference presentations and reconciliation in the hospital. The unit is responsible for the Associates Program, which seeks to create a critical mass of internal non-Aboriginal staff to support the work of the Aboriginal Women's Business Unit.

Western Health

The Cultural Diversity Unit has in place strategic policy developments to respond to culturally diverse populations. The unit is led by an Aboriginal manager.

St Vincent's

In addition to growth in Aboriginal liaison staffing to incorporate cultural awareness training several years ago, St Vincent's has created a part-time Coordinator of ICAP position to build capacity in Aboriginal health initiatives across the health service.

Goulburn Valley Health

At Goulburn Valley Health there is an informal but positive connection between two AHLO positions and the Aboriginal Mental Health position.

Bairnsdale, Sale and Orbost

Taking a sub-regional focus in program management and networking, Bairnsdale, Sale and Orbost supervisors and AHLOs have set up regular joint AHLO and supervisors' meetings.

HEALTH SERVICES WITH NO ABORIGINAL LIAISON OFFICER ROLE

Several stakeholders had made no staffing changes related to Aboriginal health since the introduction of ICAP. Respondents articulated commitment to improving patient access and Community interface. The issues appear to be how to effectively use limited funding, as well as other practical constraints.

One health service identified that it was aiming for a conservative approach rather than raising expectations that could not be met. Building identification and improving data collection were important. The health service had considered both a policy and planning role and a patient contact role to ensure a clear service delivery aspect.

Another health service said the plan to recruit someone to carry out an education and training strategy had to be changed in light of recruitment difficulties.

INTEGRATION WITH COMMUNITY

Stakeholder feedback indicated that health services' links to local Aboriginal communities are variable. They appear to be more strongly developed in several regional areas, while some metropolitan health services are grappling with this key result area. There is an impression from regional health service respondents that their relationships with local Aboriginal communities evolved over time and gained momentum. A long lead time and lots of 'real' and meaningful interaction seem to be essential. The process of relationship building can work very naturally:

> *We asked [the] Community what they wanted to see. This led to asking the hospital's board of management for another flag, i.e. an Aboriginal flag. This was a highly successful initiative. We received lots of positive comments from [the] Community. This led to our asking what else would you like?*
>
> *We asked any Aboriginal person we came into contact with what they would like to see.*
>
> *We consult with Aboriginal peak bodies but it is important to remember that peak bodies do not always represent the Community ... The secret of working with the Community lies in chatting quietly to [Aboriginal] people you know and meet anywhere. This is probably easier to do in a rural area.* (Supervisor, rural health service)

Aboriginal respondents highlighted the need to better promote and inform the Community about the ICAP Program:

> *The profile of ICAP needs to be raised within mainstream and Aboriginal organisations as most people are not familiar with the expectations or aims of the program.* (Rural Aboriginal worker)

> *Each hospital needs to have its own reference group made up of Aboriginal Community organisation reps, local [general practitioner], hospital [chief executive officer], DOH rep and the AHLO. People need to look at applications with a view at what skills/qualities/ qualifications people offer.* (Rural AHLO)

Suggestions were made as to how health services might best carry out joint planning between hospitals and Community. These included:

- involve the ACCHO, the AHLO, the AHLO supervisor and hospital senior staff in planning processes
- commit the organisations to joint planning
- the overall plan should include links between the hospital and the ACCHO; a program to ensure cultural competence of hospital staff (ongoing); the explanation of hospital programs, services and processes to ACCHO staff including the role(s) of the AHLO and other personnel involved in ICAP; a commitment to respect Aboriginal culture (for example, acknowledgment of land, the Aboriginal flag, NAIDOC events); staff development (for example, exchange opportunities should be outlined); clear complaint and quality improvement processes; and opportunities for support, such as accreditation compliance, between the organisations.

Findings highlighted the value of solid working relationships and formalised agreements between mainstream and Aboriginal community-controlled health services. (For further information, see Section 5: Practice examples from Victorian health services.)

RISK MANAGEMENT

Scope of practice and credentialing

There has been growing attention in recent years to the issue of clinician credentialing in health services. It is generally a requirement for those delivering patient care to have up-to-date competencies and/or professional registration or accreditation.

During the course of the project, stakeholders identified gaps such as the lack of documented policies on the scope of AHLO clinical practice and the required competencies. There is no apparent process for credentialing AHLOs involved in patient care planning. A number of stakeholders also referred to the occupational health and safety implications for AHLOs, given the often complex nature of the work and frequent role ambiguity.

How can health services ensure basic standards and competencies in the absence of formal training, with a lack of field experience programs and in the absence of a professional body representing AHLOs? These gaps warrant further attention in the field and by key ICAP stakeholders. At the time of writing this report, DOH has commissioned the CS&HITB to develop competency standards for AHLOs in acute settings. Additionally, the formation of an AHLO network or association was suggested by some stakeholders and this has commenced (March 2009).

LEARNING AND DEVELOPMENT FOR SUPERVISORS

The respondents ranged from new to experienced and very experienced personnel. Many of the stakeholders who supervise Aboriginal staff conveyed the impression of having been on a 'journey'. Much of what was said informed the development of the resources in the following sections of the *ICAP Resource Kit*. Many AHLOs conveyed the importance of supervisors' commitment and openness to new learning.

Learning processes

Many supervisors expressed an interest and commitment to Aboriginal issues and a commitment to social justice. Baseline knowledge and skill development tended to include attendance at cultural awareness workshops, reading policy material, and viewing films and documentaries on Aboriginal history and experiences.

The majority of supervisors agreed that supervising Aboriginal staff (when compared to non-Aboriginal staff) is different. The working relationship can be extremely rewarding. The role and the relationship, however, have potential for stress for both the AHLO and supervisor.

Many line managers reported that AHLOs bring essential and valued cultural knowledge. Additional training and preparation are sometimes needed for the complex hospital setting. Managers were generally not prepared for this.

Most supervisors indicated that, over time, they came to appreciate the pressures that Aboriginal staff experience when working in a mainstream hospital environment. In their personal lives, Aboriginal staff generally experience boundary issues between personal and work issues. Aboriginal staff support needs are significant, as are the occupational health and safety risks.

Almost all supervisors learned by doing—many said 'by trial and error'. Often they talked with peers about issues to try to get some perspective and to learn strategies. Some spoke with respected Aboriginal people and Elders who acted as sounding boards for information and to facilitate Community linkages.

Aboriginal mentors

Positive references were made by supervisors about support they received from the Koori Human Services Unit (pre-ICAP) and more recently from ICAP Project Officers. These stakeholders identified that ICAP workshops provide useful learning for them. Others spoke of the importance of Aboriginal mentors.

I learned through relationships with key Aboriginal women who were mentors. My credibility was established and tested in what I did, in working with AHLOs and senior staff at the Co Op. Did I turn up, did I take responsibility? I have stuffed up, I have learned, I have had the conversation. (Executive sponsor/manager, rural health service)

Many supervisors said that the best way they learned has been in working with AHLOs. Reference was made to the importance of the dialogue that occurs through the day-to-day working relationship and the two-way learning process.

Reflection, empathy, respect

Supervisors spoke of their roles as being 'unfamiliar territory' and stressed the importance of personal and professional reflection and working to develop a certain mindset and empathy. Engagement is also critical.

Recognise the impact of Community issues, illness, loss of patients, family issues on the AHLO and the negative impact on their [Aboriginal staff's] wellbeing—it is not like this for any other staff member. (Supervisor, metropolitan health service)

Put yourself in the shoes of the AHLOs. What would my life and job role be like? Everything is connected, you cannot separate yourself, you cannot quarantine the work. It's there when you walk down the street. You are public property. How difficult is this? (Manager, rural health service)

Work on genuinely connecting with Aboriginal colleagues—ask, check, deliver, keep at it. (Supervisor, metropolitan health service)

Supervisors need to be prepared to work outside their comfort zones. This includes less professional distance and taking time to build genuine relationships. (Supervisor, metropolitan health service)

One size does not fit all

Many supervisors said that they have grappled with accountability and reliability issues day-to-day and have had to work out how to meet organisational requirements while still trying to take a culturally appropriate/safe perspective. Most experience tensions in doing this.

I get to know them [Aboriginal workers], the history, the story they bring, what they have to offer ... For Aboriginal staff the expectations and boundaries of the role will need to be communicated and to be respected by them and others. You can do this through the recruitment process—say clearly, 'your employer expects', 'families expect'. (Manager, rural health service)

Decide early where you stand and why. One size does not fit all. (Supervisor, metropolitan health service)

The importance of links with Community

Aboriginal interviewees articulated the importance of respect and collaboration, recognition of the importance of AHLOs networking with Community, and the need for managers who take on the supervisor role to be committed and prepared, including making linkages with the Aboriginal Community.

> *The AHLO must be respected as a valued member of staff and not just seen as an 'add on'. We need to be appreciated for our professionalism and have our judgments valued, particularly when it comes to what Community events we are expected to attend by our Community organisations and Koori workers who are our peers and colleagues, just like non-Kooris have with their networks.* (Rural Aboriginal worker)

> *Supervisors should be interviewed for the role to demonstrate their commitment and possible expertise they bring to ICAP. Supervisors need to be aware of local services and spend time in them acquainting themselves with local services and programs being delivered by Aboriginal organisation[s].* (Rural Aboriginal worker)

> *I'm accountable to my Community and I'm clear on that but what hospitals don't realise is that they are accountable too. We are entitled to services just like anybody else out there in this society. Hospitals tend to segregate us from other services that are provided because they look for Koori money to run programs.* (Melbourne AHLO)

AHLO expectations of supervisors

Aboriginal stakeholders indicated that being respectful and open to learning, as well as leading by example, were important ways to learn and teach.

> *On having the right attitude, the best advice I could give to supervisors or any other non-Koori staff member in a hospital is 'just ask'. That's what they would expect from me but they forget to do it when it comes to learning about Koori issues.* (Melbourne AHLO)

> *Supervisors need to lead by example. When they have the right attitude it rubs off onto the other staff members. If they don't have a high regard for the Koori program, other staff don't care either and Kooris pick up on that and this causes more stress in the job than anything else.* (Melbourne AHLO)

Other human resources considerations

Supervisors articulated a range of other issues and considerations in managing the program—the time commitment required, the pros and cons of Aboriginal units, concerns about equity in program management and the AHLOs co-working with other clinicians. For details see Sections 2 to 5 of this resource kit.

Aboriginal staff made suggestions about practical resources that would be beneficial in the area of human resources management.

> *The AHLO should have a mentor in the human resources department (to be aware of hospital policies and procedures) separate to the overall supervisor.* (Rural Aboriginal worker)

An organisational flow chart needs to be developed and a line management flow chart so the AHLOs are clear and so are the managers/supervisors. Because at times it can be unclear—due to the complexities of working within a hospital system—who you go to for what issues and tasks. (Rural Aboriginal worker)

AHLO recruitment

Several mainstream stakeholders advised that Community input is important in the selection process for AHLOs. More than ever before, key local Aboriginal people and VACCHO are being asked to assist in Aboriginal staff recruitment and selection and on interview panels.

Many stakeholders suggested that it is useful to seek guidance in recruitment from the Aboriginal Advisory Committees and ICAP Project Officers or to involve the VACCHO ICAP Project Officer.

ORIENTATION FOR AHLOS

Supervisor suggestions

The importance of providing good orientation and support for AHLOs, using a strengths-based approach, and the need for creative and flexible supervision arrangements were identified. Specific suggestions included:

- longer periods of orientation, taking time to get it right
- actively assist Aboriginal personnel to develop understanding of the environment (including reporting lines and committee structures—for example, the ICAP committee)
- provide information on the organisational who's who, roles and responsibilities
- have basic policies and procedures (user friendly)
- guide communication with clinical staff ('how to')
- use direct observation of other clinical staff by the AHLO
- ensure a basic understanding of medical conditions
- provide guidance on how to manage the impact of patient deaths
- clarify role and interface arrangements—for example, with social workers and care coordinators in HARP.

See Sections 2 to 5 of this resource kit for more details.

AHLO suggestions

It would be helpful to have a generic package for hospital orientation and then add localised information. This could be done in collaboration with the local Aboriginal organisation and is a great way to start dialogue between hospital and Community. Hopefully this could be built on and be the beginning of a meaningful and productive working partnership. (Rural AHLO)

New Aboriginal staff need intensive orientation when starting in their new position. The initial orientation should at a minimum include meeting relevant hospital staff as a priority, meeting with the outgoing AHLO and working with them for at least one to two weeks to 'learn the ropes'. It's important that supports are in place at the beginning of someone starting work so the new worker should be able to connect with a Community member/Elder as a mentor or advisor. (Melbourne AHLO)

It is important to be clear and have the orientation organised prior to the AHLOs starting in the position. I think a three-week orientation is okay: for example, one week in the hospital, one week in the Community and one week in the hospital. It gives the opportunity for the AHLOs to settle in and get an understanding of the role without getting overwhelmed ... make appointments or meetings prior to the worker starting ... include some free time as well ... what meetings are happening within the hospital and in the Community that are relevant to attend? (Rural Aboriginal worker)

An orientation calendar could include a range of requirements the AHLOs need to have to access systems—for example, payroll, [information technology] access, swipe cards, [identification] card, where does the mail go and get collected from, maps of the hospital, organisational flow chart etc. (Rural Aboriginal worker)

All stakeholders need to attend training, even the AHLO, particularly if they are not from the area. Training needs to draw in Elders from local Community (and they should be paid for their time). (Rural Aboriginal worker)

Supervisors said that they would like VACCHO-run orientation and training for AHLOs. Some experienced hospital stakeholders are willing to be an active part of this.

ENABLERS AND TOOLS FOR MANAGERS

Stakeholders made suggestions about what would enable supervisors and executive-level staff to do their jobs better.

Supervisor suggestions

Suggestions from supervisors included:

- special culturally focused supervisory workshops or resources
- opportunities to network with other managers, including a 'buddy' arrangement with a manager from another health service
- the development of human resource-specific policies that inform and assist workplace relations
- the development of culturally safe mediation and negotiation skills
- an in-house support system/organisational support base.

Specific suggestions included:

> *We would have liked to have been alerted to what to expect from day one. A supervisors' workshop, for example, would have been helpful. We stumbled across issues ... the most helpful learning tools were the people resources.* (Supervisor, metropolitan health service)

> *If DOH were serious this would mean a two-day program on cultural awareness for managers, properly funded, run every year.* (Executive sponsor, metropolitan health service)

AHLO suggestions

AHLO feedback regarding the orientation of supervisors stressed the importance of supervisors being educated or 'getting educated' and having undertaken cultural awareness training. Grappling with Community politics was also raised—the need for a basic who's who and what you need to know.

> *A reasonable standard of 'cultural competence'—for example, historical understanding and a local Community understanding and awareness prior to supervising AHLOs.* (Rural Aboriginal worker)

> *Let the Community sort their politics out. There's a line non-Kooris should not cross. We know you want to understand and learn ... check in with VACCHO and do what they tell you.* (AHLO, metropolitan health service)

Many stakeholders (at all levels) said that they need a list of key players in ICAP, VACCHO and the DOH Koori Human Services Unit. Available ICAP information was seen to be good and detailed. Many said that they needed simple information—a three- to four-page overview of ICAP and key criteria behind it; what it is, who it applies to, who developed it. The project has developed this information. (See Appendix I: A quick background guide in Section 3 of this resource kit.)

Executive-level training

Executive-level staff are seen to be busy, with lots of competing demands, so training needs to be very focused. Ideas included:

- provide senior management with tight briefing documentation
- provide high-quality awareness training (many have considered using the Koorie Heritage Trust)
- provide ICAP policy information and background
- detail organisational responsibilities regarding ICAP
- identify the key local community-controlled agencies, and include introductions and discussions to identify their views and wishes
- use data (it is seen to be important to senior people).

> *At the Board planning day five to six years ago when the participants considered looming crises, for example. In cancer care, the facilitator highlighted that the data showed that there was one crisis and that was Aboriginal health and mortality and that the organisation has the largest urban Aboriginal population in metropolitan Victoria. No one present knew this; we were not aware that Aboriginal people were not using services, the extent, and there were no structures or processes to quantify this. The size of the local Aboriginal Community was a surprise.* **(Executive sponsor, metropolitan health service)**

CULTURAL AWARENESS TRAINING

Under EQuIP, health services need to make provision for consumers/patients from culturally diverse backgrounds through cultural awareness, staff training, and the organisation's human resources learning and development system. Stakeholders provided examples of what has worked for them and they made other telling comments.

Variation in hospital staff readiness

Stakeholders noted that while some hospital staff really want to know more about Aboriginal health issues, some do not view this as core training and others struggle to accept the importance of Aboriginal issues.

Examples of strategies

In tackling the need for accountability by health services in developing cultural awareness, strategies include:

- brainstorming with AHLO staff and advisory committees about suitable content
- making Community visits
- accessing available websites
- internal presentations
- developing specific resource material
- using existing audio-visual materials
- addressing attitudes and knowledge
- working with Aboriginal colleagues
- drawing on the personal experiences of Aboriginal staff (where those staff are willing to share this)
- giving presentations in generic hospital orientation programs
- taking out subscriptions and memberships to journals and publications
- creating a welcoming environment (for example, through artwork).

Key considerations in providing awareness training

Stakeholders also identified some of the main considerations in planning and delivering cultural awareness training, including content, structure and time considerations, good practice and resource examples, and tools. (See the resource sections for details.)

Issues in funding and sourcing awareness training

Stakeholders, particularly AHLOs and supervisors, gave several strong messages about issues experienced to date regarding funding and sourcing training. They said:

- AHLOs cannot be expected to routinely provide cultural awareness training
- health services generally have not set aside budget costs for external cultural awareness training
- sourcing high-quality training is difficult (even where there is an available budget).

INFORMATION MANAGEMENT

Under EQuIP, effectiveness in information management is evidenced by data capture, compliance with statutory requirements, analysis of data, transforming data into user-friendly information, reporting, records management, education of users and strategic use of data.

USING DATA EFFECTIVELY

There is a sense overall that health services generally struggle to use Aboriginal patient data to best effect.

Aboriginal and Torres Strait Islander identification and funding

All health services are required to identify Aboriginal and Torres Strait Islander patients by asking, as part of the admission process, 'Are you of Aboriginal or Torres Strait Islander origin or descent?' Most health services have specifically sought to make improvements in this key result area. (For more details, see Section 3: Orientation and Information for Health Service Managers.)

Acute Aboriginal and Torres Strait Islander admissions attract an additional funding supplement of 30 per cent under WIES. Tensions were expressed by many stakeholders regarding the WIES co-payment, with many saying this is the only thing that the health service is tracking (and the ability to use the bonus funding is constrained in reality).

Mainstream perspectives on data collection and analysis

Several executive sponsors and supervisors said that Aboriginal patient data does not have much impact beyond the calculation of WIES. Although day-to-day information, including clinical unit analysis, would be useful, feedback indicated that the resources to pull that information together are not readily available.

Nevertheless, mainstream stakeholders said that they use Aboriginal patient data for tracking for business cases (to lobby for additional/new resources), to expand or re-focus the service, for awareness training, for advocacy and in Quality of Care reports. (See Section 5: Practice Examples from Victorian Health Services).

Aboriginal stakeholder perspectives on data collection and analysis

Aboriginal staff indicated that Aboriginal and Torres Strait Islander patient data needs to be properly analysed. One respondent suggested recruitment of a Koori staff member to manage and analyse data at a regional level. Others said:

> *Remove data responsibility from AHLOs to 'let them get on with their job'.* (Metropolitan AHLO)

Data should be able to be accessed by NACCHO and VACCHO so that they can input into the distribution of funding and programs. (Rural Aboriginal worker)

These suggestions for data management were underscored by a metropolitan health service research fellow, whose suggestions are included in the resource kit section 3.

RESOURCES NEEDED

Several suggestions were made on how to improve information management. There was strong consensus that a short training video on Aboriginal and Torres Strait Islander identification is essential. DOH is working on a DVD for training frontline staff. For assistance and advice in setting up Aboriginal and Torres Strait Islander identification training, hospitals can contact the Koori Human Services Unit (email <Koori@DOH.vic.gov.au> or telephone (03) 9096 7032).

Stakeholders need ready access to guidelines for AHLO data collection. Newer Aboriginal staff and supervisors said that they needed this information early on. This is available and can be located in Section 2: Orientation guide for Aboriginal Hospital Liaison Officers.

What is the role of Medical Records/Health Information Services and information technology departments in setting up reports for Aboriginal and Torres Strait Islander identification? Beyond WIES reports, health services need to consider involving highly skilled Health Information Services professionals to take on some responsibility for routine tracking and reporting of meaningful Aboriginal patient data and for quality assurance/auditing.

Several health services were impressive. They were able to demonstrate high-quality reporting to local communities, the use of data to drive strategy and policy, data usage to review performance (in particular, clinical areas such as the emergency department) and the use of data to lobby for resource allocation. For further details on what is feasible, see Section 5: Practice examples from Victorian health services.

RECOMMENDATIONS

The project findings have been used to frame a number of recommendations. These recommendations were developed from Table 1, which shows, where possible, how the recommendations are linked to EQuIP 4 standards and criteria, and suggests responsibilities for action.

1 The *ICAP Resource Kit* should be placed on the ICAP website (through the ICAP Project Officers) and end-users provided with hard copies of the resource kit. There is an opportunity to use stakeholder feedback to develop a 'talking heads' DVD.

2 To improve outcomes such as effective ICAP and AHLO program management, health services need to consider resourcing coordination responsibilities.

3 To strengthen executive level 'buy in' to the Aboriginal health agenda, it is recommended that DOH considers the inclusion of key performance indicators in its DOH Statement of Priorities for Hospitals, in addition to existing ICAP key result areas.

4 Health services need to be able to effectively collect and report on Indigenous data. To achieve this, several important steps need to be considered:

- the involvement and delegation of responsibilities to health information services within hospitals for regular and useful Aboriginal data reporting
- consultation with ACCHOs regarding the sort of data they would like to see from a particular health service
- in the long term, DOH will need to consider how to build Indigenous capacity for analysing and interpreting data through skills development and mentoring.

5 The orientation guide for AHLOs (Section 2 of the *ICAP Resource Kit*) developed by the project should be further informed by the development of CS&HITB competencies for AHLOs in acute settings. These could be used by VACCHO to further develop orientation modules for trial and evaluation. The ICAP Management Group should consider establishing a working party (which would include VACCHO, Onemda VicHealth Koori Health Unit and several hospitals) for participation in such a process.

6 The ICAP Management Group should consider the establishment of an education and peer support program for supervisors, drawing on the project findings and resources to inform workshop content and development. Aboriginal mentors should be involved in the program. (In light of the early drafts of this report, an ICAP Manager's network was established in May 2009.) The Terms of Reference for this group are included in Section 3, Appendix III, of this resource kit.

7 Health services need to support key stakeholders (program managers and senior staff) to implement and undertake cultural awareness training. ICAP Project Officers should consult supervisors of Aboriginal programs on setting a minimum standard of training and orientation for these roles. Health services are encouraged to collaborate, working with ICAP Project Officers, so as to access standardised training of this type.

8 The *ICAP Resource Kit* is a guide or beginning point, which should be reviewed by the field (ICAP key stakeholders), built upon and refined over time.

TABLE I: SUMMARY OF RECOMMENDATIONS

ISSUE	RECOMMENDATION	EQuIP STANDARD/ CRITERIA	DEPARTMENT OF HEALTH	ICAP PROJECT OFFICERS	HEALTH SERVICES	VACCHO	OTHER
ICAP Resources Project—dissemination and implementation	Phase 1: report and resources to be placed on the ICAP website. Phase 2: provide end-users with hard copies of formatted resource material. Phase 3: consider the development of a 'talking heads' DVD (with AHLOs, supervisors and others) using project material.		√ (IT) √	√ (coordinate) √ (coordinate) √			√ Onemda
Management of ICAP and AHLOs within health services	Allocate dedicated equivalent full-time resources for coordination of strategic planning, program oversight and supervisory responsibilities.	3. Corporate 3.1.2 Governance structures and delegation practices			√ (to consider)		
The need for hospitals and ACCHOs to jointly carry out work planning/strategies	Include key elements in work plans/strategies such as planning processes, plans for cultural competence of hospital staff, for dissemination of information to the ACCHO on hospital programs, services and processes, commitments to respect Aboriginal culture, staff development and exchange opportunities and quality improvement processes.	3. Corporate 3.1.1 The organisation provides quality, safe care through strategic and operational planning and development			√		√ ACCHOs

ISSUE	RECOMMENDATION	EQuIP STANDARD/ CRITERIA	DEPARTMENT OF HEALTH	ICAP PROJECT OFFICERS	HEALTH SERVICES	VACCHO	OTHER
Aboriginal and Torres Strait Islander data management within health services	Create new responsibilities for health information services departments in hospitals re Aboriginal patient data collection.	2. Support 2.3.2 Information and data management systems meet strategic and operational needs			√		
	Consult with Aboriginal Advisory Committees and/ or local communities regarding what sort of data they would like to see.	2.3.4 Integrated approach to the planning, use and management of information			√		√ Aboriginal Health Hospital and Community Advisory Committees
	Build Indigenous capacity for analysing and interpreting data through skills development and mentoring programs.	As above	√			√	√ Koori Human Services Unit
Establish key performance indicators (KPIs) for Aboriginal health	In addition to ICAP key result areas (KRAs), consider inclusion in DOH Statement of Priorities for Hospitals		KPI Working Group Metro Health	Inform KPI development	Meet set KPIs		Onemda (consult)
AHLO competencies: 1) develop standards based on community-controlled principles, and 2) implement a package/training program to address competency development	Work with the Community Services & Health Industry Training Board (CS&HITB) to ensure that AHLOs have skills and knowledge to equip them to work in an acute setting.	3. Corporate 3.1.3 Processes for credentialing and defining scope of practice	√	√	√	√	√ CS&HITB

ISSUE	RECOMMENDATION	EQuIP STANDARD/ CRITERIA	DEPARTMENT OF HEALTH	ICAP PROJECT OFFICERS	HEALTH SERVICES	VACCHO	OTHER
Community mentors for AHLOs	Establish guidelines, training and processes.	2. Support 2.2 Human resources management supports quality health care, a competent workforce and a satisfying work environment		√	√	√	√ Local Aboriginal organisations
Supervisors and executive staff need access to tailored orientation and cultural awareness training—to meet minimum standards	Fund key staff to attend cultural awareness training. Draw on existing programs.	2. Support 2.2.4 The learning and development system ensures the skill and competence of staff					√
Supervisors need access to ongoing workshops through the ICAP Program	Establish a peer program based on the findings of the ICAP Resources Project and draw on the resources developed to inform the program. Resource payment of workshop facilitation and guest presenters.	2. Support 2.2.4 The learning and development system ensures the skill and competence of staff	√	√ (coordinate)	√ Support key staff involvement		√ Community mentors
Cultural awareness training—health services need easy access to training packages adapted to the needs of health service personnel and to presenters who have been accredited/approved to deliver the training	VACCHO and others (e.g. Koorie Heritage Trust) to consider driving the development of further training resources that have been standardised.	As above		√ (coordinate)		√	Onemda

APPENDICES

APPENDIX I: HEALTH SERVICES INVOLVED IN PROVIDING STAKEHOLDER FEEDBACK FOR THE ICAP RESOURCES PROJECT

Austin Health

Ballarat Health Services

Bairnsdale Hospital

Barwon Health

Bayside Health

Bendigo Health

Goulburn Valley Health

Melbourne Health

Mercy Hospital for Women

Northern Health

Peninsula Health

Peter MacCallum Cancer Centre

Robinvale District Health Services

Royal Children's Hospital

Royal Women's Hospital

Southern Health

South West Health Care

St Vincent's

Western Health

Wodonga Regional Health Service

APPENDIX II: ICAP PROJECT WORKING GROUP MEMBERSHIP

Project management was undertaken by the ICAP Project Working Group, which includes representatives from the health service sector, VACCHO and ICAP project staff. The membership of this group is outlined below.

JOHN WILLIS (Chair 2007/08)	Senior ICAP Project Officer—Metro	St Vincent's
RAELENE LESNIOWSKA (Chair 2008/09)	ICAP Policy Advisor—Metro	St Vincent's
HELEN KENNEDY	Health Programs Manager	VACCHO
LEIGH GIBSON	Director Community and Integrated Care	Goulburn Valley Health
A/PROF. GED WILLIAMS	Director of Nursing	Maroondah Hospital, Eastern Health
JOHN STANWAY	Executive Director	Royal Children's Hospital
STEVE BALLARD	Senior Manager, Aboriginal Affairs	DOH
LEANNE ANDREWS	ICAP Policy Advisor—Rural	Portfolio Services and Strategic Projects—DOH, Grampians
BREE HEFFERNAN	Program Advisor	Portfolio Services and Strategic Projects—DOH

APPENDIX III: PLAIN LANGUAGE STATEMENT

Title:

Consultation and development of resources to assist health services in the implementation of the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Program.

Purpose:

The purpose of the study is to develop an orientation pack for health service managers overseeing the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Program. Interviews and focus groups will be held with health service managers and Aboriginal Hospital Liaison Officers to determine the scope and nature of the orientation pack. Key themes to be covered will focus on what managers and Aboriginal Hospital Liaison Officers consider should be included in a resource and orientation package. We will also be asking for examples of resources that are currently in use.

Due to the relatively small number of people involved in this area, and the use of focus groups as a method, it is not possible that participants' contributions will remain anonymous. On this basis, your participation is voluntary. Unprocessed data will remain confidential, accessible only to the researchers (subject to legal limitation), and will be destroyed after five years.

Funding:

The study is funded and approved by the Department of Human Services Victoria. Onemda VicHealth Koori Health Unit at the University of Melbourne is the lead organisation, in partnership with the Aboriginal Health Unit at St Vincent's Melbourne.

Time:

Involvement will be up to an hour of your time, either in a one-on-one interview, or participation in a focus group discussion. The questionnaire will be sent to you for consideration before the interview.

The project has been approved by the University of Melbourne Human Research Ethics Committee, application number 0720942.1

Contact:

ANGELA CLARKE (Chief Investigator): (03) 8344 0812, <clarkea@unimelb.edu.au>.
SONIA POSENELLI: (03) 9288 3179, <Sonia.Posenelli@svhm.org.au>.

If you have any concerns about the conduct of this research project ... contact the Executive Officer, Human Research Ethics, The University of Melbourne, ph: 8344 2073; fax 9347 6739

Project HREC number: 0720942.1, 12th October, 2007, Version 6

APPENDIX IV: GUIDING THEMES AND QUESTIONS FOR ABORIGINAL HOSPITAL LIAISON OFFICERS

Introduction:

Thank you for contributing to this project to develop an orientation pack for health service managers overseeing the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Program. Our focus group discussion today will plan to identify key areas which could contribute to resources for the ICAP program.

During the focus group we will be taking notes, and we will re-cap those notes at the end of the session. The notes will be used to inform the draft report, which will be sent to you for review before final submission.

Themes:

ORIENTATION AND TRAINING
What information do managers and AHLO need for effective orientation?
Are there opportunities for identifying and accessing ongoing training needs?

CULTURAL AWARENESS TRAINING
Describe what resources are already available? (what works, what doesn't)
Describe what you think would be useful?

ORGANISATIONAL STRUCTURE
Where are AHLO positions placed within your organisations?
What are the supervision arrangements?
Does this best support the work of the AHLO?

INFORMATION MANAGEMENT
Describe how you collect Aboriginal specific data regarding admissions.
Describe how you process that data.

Conclusion:

Are there any key issues or comments that you would like to discuss? (time for discussion)

Thank you for your input. We will now re-cap for you our notes of the session. A draft report will be available early December for your review.

APPENDIX V: QUESTIONNAIRE FOR HEALTH SERVICE MANAGER INTERVIEWS

Introduction

Thank you for agreeing to contribute to this study. The purpose of the study is to develop an orientation pack for health service managers overseeing the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Program. Interviews and focus groups will be held with health service managers and Aboriginal Hospital Liaison Officers (AHLO) to determine the scope and nature of the orientation pack. Key themes to be covered will focus on what managers and AHLOs consider should be included in a resource and orientation package. We will also be asking for examples of resources that are currently in use.

Due to the relatively small number of people involved in this area, and the use of focus groups as a method, it is not possible that participants' contributions will remain anonymous. On this basis, your participation is voluntary.

Demographic information

ICAP SPECIFIC

Please describe what you know about the program.
Please describe your role in the program.

ORIENTATION AND TRAINING

What orientation and training have you received about the ICAP/AHLO program?
Describe what has been useful in developing your knowledge and skills?
What in your view should be included in the orientation of staff involved in meeting ICAP requirements?

CROSS-CULTURAL AWARENESS TRAINING

Do you have cross-cultural awareness training available in your organisation?
Describe what resources are already available? (what works, what doesn't)
Describe what you think would be useful?

ORGANISATIONAL STRUCTURE

Where are AHLO positions placed within your organisations?
What are the supervision arrangements?
Does this best meet the aims of ICAP, and the health service?

INFORMATION MANAGEMENT

Describe how Aboriginal specific data regarding admissions is collected.
Describe how that data impacts management of the health service.

RESOURCES

What sorts of resources would be useful to you in your role as an ICAP manager/AHLO Program Supervisor?

OTHER QUESTIONS/COMMENTS

Time to follow up any specific areas of interest, concern and clarification of the interviewee.
General closing comments, including that a draft report will be available early December for your review.

APPENDIX VI: INFORMED CONSENT FORM

Project Title

Consultation and development of resources to assist health services in the implementation of the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Program

Researchers:

- **ANGELA CLARKE** (*Onemda*, The University of Melbourne)
- **NICOLE WADDELL** (*Onemda*, The University of Melbourne)
- **SHAUN EWEN** (*Onemda*, The University of Melbourne)
- **SONIA POSENELLI** (Department of Social Work, St Vincent's Hospital)

Purpose of study

The purpose of the study is to develop an orientation pack for health service managers overseeing the ICAP Program.

I,.....have read and understood the plain language statement, and have had any questions about the project answered to my satisfaction.

I understand that involvement in the project is voluntary and that I am free to withdraw at any time, and free to withdraw any unprocessed identifiable data supplied. Data will be stored in a secure location at The University of Melbourne. It has been explained to me that the interview or focus group will take up to one hour, and notes will be taken.

I understand that:

- This is a small study and the investigators cannot guarantee that my contributions can remain anonymous.
- Reports about the project will present the combined information from all participants. Reports will not be about each individual participant's information.
- I will have an opportunity to comment on reports from this project, and I will be able to correct any errors in them before publication.

I consent to participate in this study.

Participant's name:.....Signature:.....

Researcher's name:.....Signature:.....

Date:

Form to be retained by researchers.

ANGELA CLARKE: (03) 8344 0812, <clarkea@unimelb.edu.au>.
SONIA POSENELLI: (03) 9288 3179, <Sonia.Posenelli@svhm.org.au>.

APPENDIX VII: EQuIP 4 FUNCTIONS, STANDARDS AND CRITERIA

Table of EQuIP 4 Functions, Standards and Criteria

Mandatory criteria

1. CLINICAL	2. SUPPORT	3. CORPORATE
1.1 Consumers / patients are provided with high quality care throughout the care delivery process.	**2.1 The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.**	**3.1 The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.**
1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.	*2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.*	3.1.1 The organisation provides quality, safe care through strategic and operational planning and development.
1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.	*2.1.2 The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.*	3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.
1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.	*2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.*	*3.1.3 Processes for credentialling and defining the scope of clinical practice support safe, quality health care.*
1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.	**2.2 Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.**	3.1.4 External service providers are managed to maximise quality care and service delivery.
1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.	2.2.1 Human resources planning supports the organisation's current and future ability to address needs.	*3.1.5 Documented clinical and corporate policies assist the organisation to provide quality care.*
1.1.6 Systems for ongoing care of the consumer / patient are coordinated and effective.	2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.	**3.2 The organisation maintains a safe environment for employees, consumers / patients and visitors.**
1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.	2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.	*3.2.1 Safety management systems ensure safety and wellbeing for consumers / patients, staff, visitors and contractors.*
1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.	2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.	3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.
1.2 Consumers / patients / communities have access to health services and care appropriate to their needs.	2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.	3.2.3 Waste and environmental management supports safe practice and a safe environment.
1.2.1 The community has information on, and access to, health services and care appropriate to its needs.	**2.3 Information management systems enable the organisation's goals to be met.**	*3.2.4 Emergency and disaster management supports safe practice and a safe environment.*
1.2.2 Access and admission to the system of care is prioritised according to clinical need.	2.3.1 Records management systems support the collection of information and meet the organisation's needs.	3.2.5 Security management supports safe practice and a safe environment.
1.3 Appropriate care and services are provided to consumers / patients.	2.3.2 Information and data management and collection systems are used to assist in meeting the strategic and operational needs of the organisation.	
1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.	2.3.3 Data and information are used effectively to support and improve care and services.	
1.4 The organisation provides care and services that achieve expected outcomes.	2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).	
1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.	**2.4 The organisation promotes the health of the population.**	
1.5 The organisation provides safe care and services.	2.4.1 Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.	
1.5.1 Medications are managed to ensure safe and effective practice.	**2.5 The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.**	
1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.	2.5.1 The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research.	
1.5.3 The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.		
1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.		
1.5.5 The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.		
1.5.6 The organisation ensures that the correct patient receives the correct procedure on the correct site.		
1.6 The governing body is committed to consumer participation.		
1.6.1 Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service.		
1.6.2 Consumers / patients are informed of their rights and responsibilities.		
1.6.3 The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.		

Key:

	Mandatory criteria

July 2006.

Source: ACHS 2006.

REFERENCES

Australian Council on Healthcare Standards (ACHS) 2006, *The ACHS EQuIP 4 guide: EQuIP4* (also titled *Australian Council on Health Care Standards*), 4th edn, ACHS, Sydney.

Clarke, A., Andrews, S. & Austin, N. 2000, *Lookin' after Our Own: Supporting Aboriginal Families through the Hospital Experience*, Aboriginal Family Support Unit, Royal Children's Hospital, Melbourne.

Department of Human Services Victoria (DHS) 2005, *Improving Care for Aboriginal and Torres Strait Islander Patients: Information for Health Services in Receipt of the 30% Aboriginal WIES Supplement*, DHS, Melbourne.

Royal Women's Hospital (RWH) 1998, *Right of Ways: Working towards Improving Access and Equity for Indigenous Women in Mainstream Health Services*, RWH, Melbourne.

SECTION 2: ORIENTATION GUIDE FOR ABORIGINAL HOSPITAL LIAISON OFFICERS

This section provides information for AHLOs. We encourage all new AHLOs and their program managers to adapt the information in this section to their own workplaces, experiences and needs.

The information provided is a guide only and we do not expect that it will answer everyone's questions or concerns, but we have attempted to put in as much information as we thought initially relevant.

This section has been written in such a way that it has some very basic information. Some people may find that they are already familiar with some of this, while others may find that all the information is new. Please take what you need from this section and flick over the pages containing information you are familiar with.

APPENDICES 64

ORIENTATION

WELCOME TO YOUR NEW POSITION

Congratulations! You are starting a new job that will make a difference to the Aboriginal patients and their families who come into hospital, and as a result will generally improve the health of our communities.

Your role as an Aboriginal Hospital Liaison Officer (AHLO) is a very important one, both to the Aboriginal Community and within the hospital system. The work can be very satisfying but also very demanding because of the range of responsibilities and expectations from the hospital and Community. It will take you at least a few months to settle into the role and begin to understand all the issues and complexities.

We hope this guide will be useful for you to use as a starting point. It certainly does not have all the information you will need. It definitely will not answer all your questions.

You may want to add information that you have found to be helpful and share it with other Aboriginal staff in the future.

If you are interested in background information about the ICAP Program, the Koori Hospital Liaison Officer Program that led to it, or who's who within ICAP, please see the appendix in Section 3 of this kit.

WHERE DO I GO, WHAT DO I DO, AND WHO DO I TALK TO?

Your first few days in the job

You won't be expected to see patients in your first few days on the job. Take this time to get to know your way around the hospital and your new work colleagues.

- You will be shown around and introduced to lots of people and if you can find your own way back to your office you're doing well!
- There will be lots of paperwork (Human Resources, for example, will want to know your bank account details to pay you), organising your hospital identification badge, and reading hospital policy and procedures.
- Don't worry if you can't remember everyone's name. Nobody will really expect you to.
- You'll be meeting with your supervisor (the AHLO Program Supervisor) and there will be lots of questions and information for you to remember.
- You might want to keep a note pad handy to take notes and write questions down as you think of them.
- Your supervisor will have organised an orientation schedule for you so that in your first few weeks there will be lots for you to do and people to meet.

- Remember to introduce yourself to local Aboriginal organisations and other AHLOs if you don't already know them. Let them know that you are new to the position and might be looking for their advice and support to help you in your new role. This is important, as you may well be working together to support patients and their families and they need to know who the AHLO is. You may find that catching up regularly with other AHLOs is very beneficial for your own learning and understanding of the AHLO role, and sharing experiences and helpful hints will benefit everyone.

- It might be a good idea to call the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) on (03) 9419 3350 to find out how to contact your ICAP Project Officer and to find out what support you will be able to access through VACCHO.

- You might want to add additional visits to Aboriginal organisations/workers as part of your orientation that your supervisor didn't think of. Discuss this with your supervisor.

QUESTIONS FOR AHLOs AND SUPERVISORS TO CONSIDER AND DISCUSS

Hopefully in the first few weeks in your new job you will have lots of meeting times with your supervisor. These times are very important, as you will be getting to know each other and discussing how best to do the work that is needed. It might be the first time that your supervisor has worked with an Aboriginal person and, if this is the case, they are learning as well.

We have listed a few questions that might assist in your discussions together but there will be certainly lots of other questions that will arise. Some of the questions may not be relevant to your hospital but you may not know that until they are asked. It's quite likely that you may only discuss one or two questions each time you meet, and it's also possible that your supervisor may not know the answers to some of the questions. Don't forget that you bring an Aboriginal view to your position and understand your Community in a way that a non-Aboriginal person can't be expected to.

Workplace issues

- What is expected of me in the liaison officer role?

- Most health services have several sites and settings. Will I be providing coverage or consultation across the whole health service? If I'm not expected to, how will requests from these areas be managed?

- What does my supervisor need to learn about Koori patient needs and services and how will they get this information?

- Can I draw on external guidance, for example from a mentor who is an experienced AHLO elsewhere or Elder in the Community? How?

- Who will I debrief with? (Remember that a mentor outside the hospital may be suitable.)

- How often will I meet with my supervisor? When my supervisor is unavailable, who else can support me?
- How do I handle complaints from Community members?
- What happens if a family or Community member is in hospital and I don't feel comfortable to provide them a service? Who can I refer them to?
- What do I do if a Community member does not want me to know he/she is in hospital?
- How will I find out if there are Aboriginal patients at the hospital?
- Do I only provide a service to Aboriginal patients or do I provide a service to non-Aboriginal members of the same family?
- What do I do if I know someone is Aboriginal and he/she does not identify?
- What do I do if I know someone is not Aboriginal but has identified as Aboriginal?
- What do I do if a patient needs me out of hours?
- Am I expected to provide case management? Is training available for this?
- To what extent is the AHLO a full member of the professional team? What additional skills or training might be required that other staff have access to, either in or outside the hospital?
- How will the AHLO and social workers, and the AHLO and care coordinators, manage assessments and care planning and work together? Do we work together?
- What meetings am I expected to attend?
- How will the role of the liaison officer be promoted throughout the hospital?
- Can I speak to media at anytime?
- Is it okay for the AHLO to put up promotional materials around the hospital (for example, flyers, pamphlets)?

Administration issues

- How much is in the hospital budget for Aboriginal programs and events?
- Can I get a business card?

Training issues

- What cultural awareness training currently exists? Who organises this? Is there a budget to invite local Aboriginal workers/Elders to present?
- What training will I need and who organises it? For example, writing in medical files, computer skills and data entry. (Some AHLOs have completed medical terminology courses, which they have found helpful.)
- What will the professional development and supervision plan for me as a liaison officer involve?
- What do I need to know about (for example, hand washing) before I enter certain wards?
- How do I use the equipment? Are there identification numbers or security clearance for certain areas?
- Are there opportunities for my professional development and who do I speak to about this?

Can you think of other questions that should be considered?

.....

.....

.....

ADMINISTRATIVE MATTERS

This section looks at the administration role of AHLO positions and covers human resource matters such as your hours of work, taking leave, and who to contact when you are absent, sick or running late for work. It is important in a health service context that people can get in contact with you and know how they can contact you.

HOURS OF WORK

My usual hours of work are Monday to Friday:.....

8.30 am to 5.00 pm or *(specify other)*.....

Changes may be possible by negotiation between you and your supervisor.

WHO DO I CONTACT?

You need to let your supervisor know if you are sick, unable to be at work or expect to arrive late at work. It is important to do this because your supervisor needs to manage absences and notify other key people, including the switchboard.

Supervisor

Name:.....

Telephone number (direct):.....

Telephone and ask for pager:.....

Second-in-charge

Name:.....

Telephone number (direct):.....

Telephone and ask for pager:.....

If neither is available, please call.....
(department and reception number) and advise the receptionist or leave a message.

AFTER-HOURS WORK

AHLOs work under industrial awards, which make specific provisions about after-hours and on-call work. These provisions are in place to protect workers' health and wellbeing and to ensure adequate payment for after-hours work where this is rostered.

The AHLO Program Supervisor (or delegate) is responsible for ensuring that occupational health and safety and industrial guidelines are met by each department or program.

What should I do if there is an urgent after-hours enquiry of a significant nature?

At times, patients, families and the Community will expect you to be available after hours. Discuss with your supervisor what exceptions are possible if you feel that a situation is extremely urgent.

An urgent request for consultation may be able to be made through the switchboard to your supervisor or *(insert details)*.....

PATIENT HANDOVER

What should I do if I need to hand over information on patients while I am away?

Please speak directly with your supervisor or .....

LEAVE FORMS

You can get leave forms from .....
These can be authorised by your supervisor .....
or, if your supervisor is absent, from .....

HUMAN RESOURCES

You can contact .....on .....
for all enquiries regarding your pay and leave information.

MOVEMENT SHEET OR BOARD

When I am working outside the hospital, what do I record on the movement sheet or movement board?

Your health service will have procedures in place so that you can let people know where you are. You will need to become familiar with these procedures. You may need to discuss this with your supervisor.

Why do I need to record these details?

- Your employer has occupational health and safety responsibilities and therefore needs to know where you are when you are not at the hospital.
- A patient or family may require you urgently.

KEY CONTACTS

What is the role of the Koori Human Services Unit?

The Koori Human Services Unit, which is part of the Department of Health Victoria (DOH), is a policy and strategic planning unit and is responsible for coordinating AHLO program data.

It is important to get to know staff at the Koori Human Services Unit, as you might want to know who to contact about providing data and requesting data about hospitalisations at your hospital.

The telephone number of the Koori Human Services Unit is (03) 9096 7032.

How can I find out who the ICAP Project Officers are?

There are metropolitan, rural and VACCHO ICAP Project Officers. Details of who is in these positions can be found by calling VACCHO on (03) 9419 3350.

For more information about their roles, see Appendix I: A quick background guide in Section 3 of this resource kit.

MEETINGS

What meetings are compulsory within the hospital?

Staff/program meetings are held on .....

Attendance is also required at .....

What external meetings am I expected to attend?

Regular forums and training are provided via the ICAP Program, as well as a support network for AHLOs. These should be considered a core component of an AHLO's role and attendance is strongly encouraged. The Terms of Reference for the AHLO Support Network are provided in Appendix IX of this section of the resource kit. AHLO network meetings are held every two months.

What about Community meetings?

Discuss this with your supervisor to establish priorities and to coordinate coverage.

During the ICAP Resources Project several AHLOs said:

> *It is really important for me be with the mob.* (Metropolitan AHLO)

> *It is important to meet with organisations for introductions, exchange of information and planning regarding patient care matters.* (Rural AHLO)

The Community really appreciate seeing me at Community meetings, functions and celebrations. It sends a message that the hospital is serious about working with the Community. (Metropolitan AHLO)

You may need to attend funerals of patients and Community members. This is part of the role. Please discuss this with your supervisor.

USE OF THE MOBILE TELEPHONE AND PAGER

Am I able to use the mobile telephone for personal use?

No—the telephone is for work use only.

What should I do with my mobile phone/pager if I am on a rostered day off or leave?

These should be left with your supervisor, or delegate, or *(insert details)* .....
.....

What can I do if I need to have a message put on my pager by the hospital switchboard?

You can advise switchboard directly about this by contacting .....
or by sending an email to switchboard for absences from the hospital. Your supervisor or receptionist can assist with this.

ACCESS TO AND USE OF HOSPITAL CARS

Some AHLOs have a hospital car as part of their employment package. Others access cars from the car pool.

How can I access a hospital car?

You have access to cars for patient-related work, Community organisation visits and other work-related travel.

Bookings can be made by .....

Please note that the car should be returned to the hospital on time.

If you are running late in returning the car, please advise .....

If you are not able to arrange a car and need to travel on hospital business, please discuss this with your supervisor.

The car keys can be collected from .....

What are my responsibilities regarding use of hospital cars?

- Hospital-owned vehicles are to be used for hospital business only.
- You must provide ..... with a copy of your current driver's licence.
- You may not drive the car without a current, valid driver's licence.
- The driver is responsible for any traffic or parking infringements.
- Hospital e-tags are not transferable and must not be removed or tampered with.
- The hospital's clean air policy extends to hospital vehicles in that smoking is not permitted.

Overnight access to a hospital car

Approval to take home a hospital car may be obtained in advance by contacting your supervisor.

Vehicle log book

Every hospital vehicle contains a log book in which details of the journey must be noted by the driver at the commencement and cessation of each period of use of the vehicle. Please record the purpose (for example, 'AHLO patient transport'; 'AHLO visit to VACCHO').

Transporting patients and others in hospital cars—what are my responsibilities?

It is acceptable to transport patients and their family members on hospital business.

Hospital vehicles are for hospital business only.

Petrol, key card and account slips

The petrol card or *(insert relevant details)* ..... is kept in the car in *(insert details)* .....

Please replace it (and store the account slips) when it is used to purchase petrol.

EMERGENCY FUNDS AND PERSONAL EXPENSES

What material aid is available internally to assist patients?

There is a hospital fund called *(insert details)* .....

It is available for small loans for emergency situations. All withdrawals must be recorded in *(insert details)* .....

Amounts larger than *(example)* ..... need approval by *(insert details)*
.....

If there is no access to emergency funding, the AHLO will need to draw on Community resources. These include .....

Meal vouchers are available for patients/carers under certain circumstances *(delete if not applicable)*.

All forms of financial assistance must be preceded by an assessment. Patients provided with assistance must sign a receipt or Patient Declaration Form or *(insert details)* .....
.....

Other material aid that is available includes *(insert details)* .....

What approval is needed for staff to claim personal expenses and what is the process?

Petty cash reimbursement forms should be completed and receipts attached, and the form needs to be signed by your supervisor or .....

This can then be taken to the hospital cashier/department administration officer or .....for reimbursement.

When working outside the hospital, do I get reimbursed for travel and parking expenses?

Reimbursement for travel and parking costs occurred while on business outside the hospital should be discussed with your supervisor.

How can I requisition a cheque? Under what circumstances?

You can do this for approved patient expenses and for approved costs to attend courses or conferences.

Forms are located *(insert details)* .....

These should be signed by *(insert details)* .....

Can you think of other questions that should be considered?
.....
.....
.....
.....
.....
.....
.....
.....
.....

SELF-CARE

Being in a liaison officer job can be very stressful and tiring at times and the longer you are in the position, the more likely that you may feel this. When you are in a job where you look after patients and families, you need to remember to look after yourself. Don't feel like you are being selfish or not doing your job properly.

A lot of mainstream health workers have professional supervision and counselling to debrief on their work with another professional on a regular basis. Unfortunately, it is hard to find an Aboriginal worker whose job it is to formally do this for another Aboriginal worker. That is why it is vital to catch up with other liaison officers or health workers and talk through the issues. You'll no doubt learn that your worries are much the same as others (without breaking confidentiality).

However, you may prefer to debrief with a non-Aboriginal person and if that's your preference, then go for it.

Whatever your preference, it is important to have something in place because over time these things can wear you down and not only affect you, but your immediate family as well.

Some helpful hints:

- in your lunch break go for a walk (make sure you do have a lunch break)
- close your office door for a few minutes and take some deep breaths or have some quiet time in a quiet place when things are chaotic
- make a 'things to do' list so you don't feel overwhelmed—it feels good when you can cross off little jobs that you have done
- decorate your office with special photos or posters to make your space your own.

AHLO feedback

> *Koori workers need to be with their own mob. In-services need to happen every three months so that we can debrief and support each other. It needs to be mandatory to attend so that supervisors have to let the workers go. And there should be workshops that include drug and alcohol workers and mental health workers.* (Metropolitan AHLO)
>
> *Debriefing/counselling arrangements should be made and regular appointments with a counsellor/mentor.* (Metropolitan AHLO)
>
> *Relevant training on self-care should be a priority for AHLOs.* (Rural AHLO)
>
> *Self-care can be managed through adhering to a proper Workcare structure and the [human resources] policies and procedures that all hospital employees are accountable to.* (Rural AHLO)

There should be an annual health conference for us in Victoria where ICAP, drug and alcohol workers and emotional wellbeing/mental health workers get together and talk about our work and what needs to be done. (Metropolitan AHLO)

Constantly defending the need for an Aboriginal liaison officer and working in a large hospital you can feel very isolated; perseverance and asking lots of questions can help. Go back to visit the Community. (Metropolitan AHLO)

KOORI ADVISORY COMMITTEES

Some hospitals currently have Koori advisory committees or steering committees and they usually work very well. They are a good start to developing networks and possible partnerships. There are many advantages to having a group such as this meet. Mostly it is an opportunity for Community and hospital to discuss how best to work together to meet the needs of the local Community. These meetings can start with three or four people meeting together over a coffee and having a chat about what is working well, what needs to be improved and who else needs to be involved. This is also a good opportunity to support the liaison officer, share ideas and concerns, and work on problems and solutions together.

The meetings could sometimes be held at local Koori Community organisations, giving non-Aboriginal staff at the hospital a chance to visit and meet staff who work there.

You may also find that you are able to receive more support from the local Koori Community.

AHLO feedback

I look forward to our meetings which we have about every six weeks as I feel that I am with people who are interested and supportive of my work. They give me feedback; other times I find out about other activities happening in the hospital or the Community and it makes me feel like I am part of a team and not a lone worker. (Metropolitan AHLO)

We have a healing circle that meets every fortnight. The circle is an opportunity for patients, families, [and] workers in mainstream and Aboriginal organisations to build partnerships and network while sharing information and ideas. The circle builds partnerships between the primary health sector and acute sector and also does health education and promotion/prevention while breaking down cultural issues in hospitals. The circle was established under the consumer rights patient guidelines and links with other healing circles in the primary care sector. (Metropolitan AHLO)

SAMPLE ORIENTATION GRID

The following grid shows typical activities that a new AHLO might undertake. It also suggests a timeframe for these activities. Many of the activities in this list will need to be coordinated by your supervisor.

ACTIVITY	DAY/TIME
Meet with Program Supervisor. Introductions to other staff in the department/team. Settle into office, familiarise with telephone system, email system, pager etc.	Day 1
Contact Human Resources regarding documents, identification badge, timesheets, immunisations. Introduction to transport arrangements, fill in papers, show licence, learn how to organise a hospital car.	Day 1
Tour of the hospital. Introductions to key departments and programs and senior managers. Meet Admissions staff. Visit departments: Emergency, Outpatients, Wards, Medical Records, Media/Public Relations.	First week
Review orientation manual. Coordinate appointment with the Program Supervisor to reflect on first week.	First week
Initial visits to key local community-controlled organisations. These include *(insert details for your region)*	Within the first month
Meet ICAP Project Officer(s); review ICAP resources; visit Koori Human Services Unit and discuss data collection and *Koori Health Counts!* (a Victorian Government publication).	By end of first month
Attend hospital induction. Become familiar with the hospital structure, hierarchy and roles.	Within the first month
Identify how to access resources available for patients and families: material aid, accommodation, meals, Victorian Patient Travel Assistance Scheme (VPTAS).	Week 1
Attend training opportunity for the hospital patient administration and statistical system.	By day 10
Training in patient assessment.	In the first month
Training in planning a patient discharge.	In the first month
Training in children at risk and family violence.	By end of first month
Familiarise with hospital policies and procedures including confidentiality, duty of care and privacy legislation.	In the first month
How to locate and use community resources. Include mainstream services such as Post Acute Care Programs, Aged Care Assessment Teams, Children's Services.	In the first month

PROGRAM MANAGEMENT

This section covers program management, which explains what is expected with supervision and who to go to for advice and direction.

SUPERVISOR'S ROLE

Your supervisor's role is:

- to organise orientation
- to work with you to help develop knowledge and skills
- to support ongoing training and education
- to provide support with day-to-day matters
- to assist with administrative matters and leave
- to review statistics with you
- to provide budgetary advice
- to seek and receive advice from you on issues that involve the local Aboriginal Community and organisations.

How frequently should I meet with my supervisor?

Informal contact is encouraged. It is also useful to hold regular meetings. Discuss this and decide jointly.

Frequency and location: .....

CLINICAL SUPERVISION

The purpose of clinical supervision is to provide support, consultation and education regarding direct work with patients and their families.

Some health services may separate the clinical supervision and the manager's role.

The clinical supervisor provides a sounding board and is responsible for helping you develop required knowledge and skills for doing the job.

Who is my clinical supervisor?

Name: ..... Telehone number: .....

How frequently should I meet with my clinical supervisor?

Regularly by joint negotiation. More often in the beginning *or* .....

HUMAN RESOURCE MATTERS

This section looks at human resource matters and covers anything within your workplace that relates to information about conflict in the workplace and cultural leave.

WORKPLACE ISSUES

What should I do if I have problems with my workplace, or the people I work with?

The hospital has a grievance resolution policy and procedure in which your rights and responsibilities are outlined. You can refer to this and also ask for assistance to have it explained if needed.

To maintain positive and healthy working relationships, attention to issues should be effective, responsive and timely.

Think about discussing the issue with the person with whom you are experiencing the problem first so that they can consider the matter and respond.

You may also wish to use other colleagues and/or your supervisor to discuss matters.

If the matter is not resolved, there may need to be a joint meeting of the relevant parties.

If you are having problems with your supervisor, you may like a support person to be part of any discussions or meetings. This could be the human resources consultant from the hospital or another AHLO or Aboriginal person.

If problems persist, the matter may need to be brought to the attention of human resources and/or your union representative. Depending on the award you are paid under, you will be eligible for membership of a union.

Please check this with your human resources consultant.

Who is my human resources consultant?

Name: .....

Telephone number: .....

Using an external consultant

You may wish to enlist the assistance of VACCHO or the Dispute Settlement Centre of Victoria, which is a business unit within the Department of Justice. It is an informal, impartial, accessible, low-cost service for Victorians. More than 40 Koori mediators have been trained in both metropolitan and rural Victoria.

To contact the Aboriginal Project Officer/Mediator and Dispute Assessment Officer, telephone (03) 9603 8370 or 1800 658 528.

CULTURAL LEAVE

A cultural leave policy recognises some of the special leave requirements that enable employees to meet traditional law, custom, cultural and family obligations or to participate in ceremonial, cultural and religious activities.

Cultural leave is a provision of the Commonwealth Public Service. It is available under section 40A of the *Industrial Relations Act 1999*. It is *not* in Victoria's State awards but it is comparable to special leave without pay.

It is usually time limited—up to five days per year—and is unpaid. It does not discriminate against other leave requests for cultural reasons, as it does not supersede the category of special leave without pay.

See Appendix I of this section for suggested guidelines for eligibility.

POLICIES AND PROCEDURES FOR PATIENT CARE

This part explains policies and procedures, such as confidentiality and privacy, that are associated with your workplace and that you need to be aware of in your role as an AHLO.

CONFIDENTIALITY

Confidentiality is a matter of concern for everyone who has access to confidential information about patients, employees and hospital business. Each person accessing such information holds a position of trust and should recognise their responsibility to preserve the confidentiality of this information.

What do liaison officers need to know?

- Read and abide by the organisation's privacy and confidentiality policy and procedures.
- Safeguard all confidential information at all times and take care not to act carelessly or misuse confidential information.
- It is inappropriate for AHLOs to discuss clinical information without permission with people other than the patient and immediate family. Doing so can raise doubts with patients and visitors about your respect, and the hospital's respect, for their privacy.
- Health information must not be discussed anywhere where others may overhear the conversation—for example, at Community gatherings and social events, on public transportation, in restaurants or cafes, in hallways and elevators.

- Only collect and access confidential information that is necessary for your duties.
- Do not in any way divulge, alter or destroy any confidential information except as properly authorised.

You may be held responsible for any misuse, failure to safeguard or wrongful disclosure of confidential information.

Failure to comply with the hospital's policy on confidentiality may result in disciplinary action and termination of employment.

One ICAP Resources Project stakeholder discusses a response to inappropriate requests for confidential information:

> *If an Aboriginal Elder stops me at a Community gathering and asks me about a patient who has been in hospital, I say for example: 'Aunt, you know I can't talk about that—the hospital will not let me ...'* (Metropolitan AHLO)

PRIVACY LEGISLATION

All hospitals have policies and procedures based on the *Privacy Act 1988* (Commonwealth), *Information Privacy Act 2000* (Victoria) and *Health Records Act 2001* (Victoria).

This legislation is designed to safeguard privacy and gives patients, in most cases, the legal right of access to their own health information.

It is useful to discuss this as part of your orientation and discuss it in an ongoing way.

How does the legislation affect AHLOs in their day-to-day work?

AHLOs work with patients and families and they make contact with community-controlled organisations to discuss care planning and to make referrals to community services.

- Whenever possible, advise the patient about your contact with other community services.
- Obtain verbal consent to share information.
- Record this information in the patient's medical file.

AHLOs AND COMMUNITY REQUESTS FOR INFORMATION

AHLOs may be contacted by the broader Community when a patient is in hospital or be approached in a social setting for information.

Please review the guidelines on confidentiality.

It may be useful to check with the patient and/or family in advance what their wishes are regarding information requests by the Community and/or others in the patient's immediate network of family and friends.

RECORDING IN MEDICAL FILES

During the ICAP Resources Project consultancy, stakeholders gave different views about AHLO recording in medical files. They identified the general lack of clear protocols. Some expressed concerns that the information might be misinterpreted in the future by other hospital staff, which could lead to a notification to child protection.

Some minimum standards follow, but first a few words from some of the key stakeholders.

An example from a rural hospital

For AHLO recording we use the same requirements as for other Allied Health staff. There has to be a sticker on the file—that is the very least we expect. In our experience the AHLO was initially reluctant to write. This has lessened. I have asked that recording includes at least the basics—I saw the person, this is the problem, this is what I will do. Every contact.

It took the AHLO a while to do it. I prompted her if she didn't write in the file. It's important—a picture is portrayed—as it is for physiotherapists and speech pathologists and others when they record.

We set up an e-referral process for the AHLO, again as for other Allied Health disciplines. This was a real coup. It changed things a lot. It made the other hospital staff see the AHLO as a serious worker and as a part of that group of people who can assist patients and staff. We want hospital staff to know that having an AHLO is fantastic. (Manager, rural hospital)

An example from a metropolitan hospital

I am careful about writing in files because sometimes patients are nervous if they see me doing it. They might not tell me important things. I discussed it with my supervisor. We thought it would be good, if I thought a patient might be worried, to talk about writing something in their file and why I do this. I could give the patient an idea of what I was going to write and get their okay.

I work a lot with social workers and sometimes we do the recording together. We use AHLO and Social Work stickers but we only write one entry which we say is from both of us. One of us or both of us signs—it just depends. (AHLO, metropolitan hospital)

Why should AHLOs record in medical files?

All staff involved in clinical care should routinely record summary information regarding their contacts with patients/families in the patient's medical file:

- to communicate between staff involved in planning the patient's care
- to make other team members aware of the needs of patients
- to ensure that the worker's role and contribution to patient care is visible
- to fulfil accountability requirements and accreditation guidelines.

Suggested minimum standard for AHLO recording

At the first visit:

- place a self-adhesive label/sticker in the medical record
- write the date and time
- write the reason(s) for your contact
- note what you are going to do
- note any other information you feel is appropriate
- sign your entry and print your name underneath, with pager and/or extension number.

After the first visit, keep information in the medical file current and updated regularly. This should include:

- an adhesive label/sticker placed in the medical record
- the date and time of entry
- changes/updated information
- the discharge plan—information about community providers including names and contact telephone numbers
- your signature, printed name, pager and/or extension number.

For outpatient recording in a medical record:

- place an adhesive label/sticker in the file
- write the date and time of entry
- write the reason for the referral or for your involvement
- write summary notes about what you did
- sign and print your name with your pager and/or extension number.

What if I experience any uncertainty or difficulties in recording?

Let your supervisor know and then work out a plan to work on this together.

What reports do I need to complete?

AHLOs need to meet data collection requirements. Copies of relevant data collection forms are included as Appendices III—VII of this section. Not all AHLOs will need to complete each of these reports.

WORKING WITH SOCIAL WORKERS AND CARE COORDINATORS

In your day-to-day work you may find that other hospital staff are unclear about your role in patient care, care planning and discharge planning.

Is the AHLO like a social worker or a case manager?

Your role is to provide supportive contact for Aboriginal patients and families and community-controlled organisations.

The AHLO is a cultural interpreter, consultant and advocate who works with other hospital staff to assist and support Aboriginal patients and community-controlled organisations to effectively use the services that are available to assess, provide, plan and coordinate patient care.

It is necessary for hospital clinicians such as social workers and care coordinators to develop working relationships with liaison officers and to develop, in partnership, an understanding of professional boundaries and work responsibilities as these relate to patient care.

APPENDICES

APPENDIX I: SAMPLE PROCEDURE—CULTURAL LEAVE POLICY

This is a sample procedure that should be discussed and adapted by mutual agreement between the AHLO, the Program Supervisor and Human Resources. It is not derived from any particular award. We suggest that clarifying a process for cultural leave requests is a useful thing to do.

An employee who is required by custom to attend an Aboriginal or Torres Strait Islander ceremony may, subject to the employer's agreement, take up to five days unpaid cultural leave each year, which must not be unreasonably refused.

The employee must, if practicable, give the employer:

- reasonable notice of the intention to take cultural leave before taking the leave
- the reason for taking the leave
- the period that the employee estimates he/she will be absent.

If it is not practicable for the employee to give the notice before taking the leave, at the first opportunity the employee must notify the employer of:

- the reason for taking the leave
- the period that the employee estimates he/she will be absent.

In reviewing the employee's request for leave, the employer should consider at least the following:

- the employer's capacity to re-organise work arrangements to accommodate the employee's request
- the impact of the employee's absence on the delivery of customer service
- the impact of a refusal on the employee, including the employee's ability to balance his or her work and family responsibilities.

APPENDIX II: PRIVACY LEGISLATION—A BRIEF OVERVIEW

The *Health Records Act 2001* (Victoria), implemented in March 2002, establishes a set of minimum privacy standards that apply to all people in Victoria who handle health information.

The Health Records Act contains 11 Health Privacy Principles. These principles apply to health information and are restricted to that information that is physically recorded in some form, whether written, electronically stored or in some other record such as an X-ray.

The *Victorian Freedom of Information Act 1982* governs an individual's right of access to public sector health information.

Health information

The definition of health information is broad and includes information or an opinion about:

- the physical, mental or psychological health of an individual, a disability, an individual's expressed wishes about the future provision of health services to him or her or any health service provided or to be provided to an individual, or
- other personal information collected to provide, or in providing, a health service, or
- information connected with the donation or intended donation of body parts, organs or body substances, or
- other personal genetic information about an individual in a form that is or could be predictive of the health (at any time) of the individual or of any of his or her descendants.

Effectively, this definition encompasses traditional medical records collected in providing a health, mental health, disability, aged care or palliative care service. Personal information such as an individual's name, address and financial/payment details is also considered health information.

Patients should be informed that data are collected and aggregated data are routinely provided by the hospital to other bodies such as DOH, the Health Insurance Commission etc. This includes Aboriginal identification.

The organisation must take steps that are reasonable in the circumstances to ensure that the individual knows who is collecting the information, what the purpose is and the main consequences if the information is not provided.

Where information is collected from a third party, the organisation must take steps that are reasonable in the circumstances to ensure that the subject of the information is, or has been, made aware of this.

Use and disclosure of Information

An organisation must only use or disclose information for the primary purpose for which it was collected.

Secondary use or disclosure of health information by a health service provider is allowed in very limited situations, including:

- with consent given by the individual at the time the organisation collected the information or subsequently
- if it would reasonably be expected by the individual and is for a purpose that is directly related to the purpose for which it was collected
- with the consent of the individual's authorised representative, such as a guardian, where the individual is incapable of consenting
- if there is a serious and imminent threat to the life, health, safety or welfare of an individual
- if the individual is not capable of consenting and it is not reasonably practicable to obtain the consent of that person's authorised representative (or there is no authorised representative)
- where the use or disclosure is reasonably necessary for the provision of the health service
- where there is a strong public interest, for example, where there is a serious and imminent threat to the life, health, safety or welfare of any person, or for research in the public interest.

Disclosure to a family member

In some circumstances it will be appropriate to disclose information to an immediate family member. These are:

- where disclosure is necessary to provide appropriate care for the individual or is made for compassionate reasons
- where disclosure is limited to the extent reasonable for the purposes mentioned above
- where, if an individual is incapable of giving consent, disclosure is not contrary to any wishes expressed by the individual on a prior occasion, where the provider could reasonably be aware of this situation
- where a family member is under the age of 18 years, after consideration has been given to the maturity of the family member.

Disclosure to another health service provider

If an individual requests that information be transferred to another health service provider, then a copy or written summary of that information must be transferred as soon as practicable.

Where an individual does not request that information be transferred to another provider, *information may still be disclosed* in accordance with the primary purpose for which information was collected. The primary purpose of most collection will usually be the treatment or care of the individual's health.

Further reading

In 2004 the Office of the Health Services Commissioner Victoria produced a booklet, *Health Privacy—It's our business*, to help organisations apply health privacy principles in everyday or practical circumstances.

For copies please contact the office of the Health Services Commissioner, Melbourne, at <www.health.vic.gov.au/hsc/> or on (03) 8601 5200 or 1800 136 066.

APPENDIX III: AHLO DATA COLLECTION REQUIREMENTS SEPTEMBER 2009

Background

Department of Health Victoria (DOH) administrative data collections provide evidence of the poor health of Aboriginal Victorians relative to the general population. However, it is not always possible to report whether the health of Aboriginal Victorians is improving or not. This is partly due to incomplete identification and fluctuations in identification of Aboriginal people in records.

Accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are essential for DOH to plan and deliver services, monitor changes in service use and outcomes, and to account for government expenditure in this area.

Council of Australian Governments 'Close the Gap' targets

In December 2007 the Council of Australian Governments committed to improve Indigenous life expectancy, reduce child mortality, and reduce the rate of low-birth weight babies. Accurate hospital-based data is vital to measure progress against these targets. Data transmitted from hospitals is already being used to develop indicators.

Births and deaths data

The DOH Koori Human Services Unit asks that AHLOs collect and submit data on the following forms on a monthly basis:

- Koori mothers and babies form
- Indigenous deaths form

These forms are included in this section of the resource kit (Appendices IV and V) and can be completed by hand and faxed to: (03) 9096 9210. The Koori mothers and babies form can also be submitted electronically via an e-form and is available at: <www.health.vic.gov.au/koori/hospital-liaison-officer-forms>.

Koori mothers and babies form

Since 2009 perinatal data collected by midwives has included the Indigenous status of babies. This includes recording the Indigenous status of babies born to a non-Indigenous mother but an Indigenous father.

Until DOH is satisfied this data collection is accurate, AHLOs are requested to continue to complete and submit the Koori mothers and babies form for all births of Aboriginal babies. (Information on the mother need only be filled out when the mother is Indigenous.)

This data is very important to measure both the number of Aboriginal babies and their health status.

Indigenous deaths form

DOH understands it is often very difficult for AHLOs to report deaths of people they have known in their communities and is grateful for any information provided. However, although the identification of Indigenous deaths is crucial to calculating life expectancy, it is often not indicated on death registration forms. As such, DOH is heavily reliant on information from AHLOs about any Indigenous deaths they are aware of in the hospital or wider Community.

This information is not mandatory, but is requested of AHLOs as a courtesy and with complete regard to family sensitivities and concerns.

Data quality

DOH assumes processes are in place in hospitals whereby AHLOs can regularly check and arrange for any corrections of Indigenous status in patient hospital records when this is incorrectly recorded by admissions or ward staff—before this data is submitted to DOH.

Data collected by hospitals contain information on a patient's age, sex, place of residence, diagnoses, treatment, birth and death. If Aboriginal patients are correctly identified, then all this information on Aboriginal patients becomes available at a de-identified level, to tell DOH about the health of Aboriginal communities. If this is the case, AHLOs do not need to send any more information about admissions. If patients are not identified correctly, then the information is effectively lost, because DOH has no way of knowing it refers to an Aboriginal patient. If this is the case, DOH asks that AHLOs tell them.

AIMS data

As part of the National Healthcare Agreement, the DOH Health Data Development Unit requires AHLOs to collect data for the Agency Information Management System (AIMS). The provision of this data affects public health funding received by hospitals.

The AIMS form has recently been revised to cut back on the amount of information AHLOs are required to report on. This form is included in this section of the resource kit (Appendix VI), along with instructions (Appendix VII) explaining each of the six remaining areas AHLOs are required to collect data on.

AIMS data are submitted to DOH by the hospital on a quarterly basis (due on the 15th of the month after the end of each quarter) via the Health Collect Portal at <www.healthcollect.vic.gov.au>.

(AHLOs also used to send AIMS data to the Koori Human Services Unit, but this is no longer required.)

What AHLOs need to tell DOH

- Does the hospital identify Aboriginal patients correctly?
- Births.
- Deaths.
- Non-admitted patients: services to patients inside and outside the hospital.

What DOH doesn't need any more

- The number of Aboriginal admissions.
- Whether the patient was seen by the AHLO.
- Meetings and telephone calls about patients.

Further information

Further information and guidelines about AIMS data are available at <www.health.vic.gov.au/aims/index.htm>.

Assistance is also available via the AIMS helpdesk: telephone 03 9096 7743 or email <healthcollect.helpdesk@DOH.vic.gov.au>.

Further guidelines on recording Aboriginal status are provided in the *Principles of Recording Aboriginal Status in Victoria* (available at <www.health.vic.gov.au/koori/recording-aboriginality> and included as Appendix VIII to this section of the resource kit). This document should be reviewed by all hospital staff responsible for the collection of Aboriginal status data.

APPENDIX IV: KOORI MOTHERS AND BABIES DATA COLLECTION FORM

INFORMATION ON KOORI MOTHERS AND BABIES

A) MOTHER (*Koori mothers only*)

This section must be completed for all Aboriginal and Torres Strait Islander mothers.

Month (actual month of birth)

Year

1) AHLO Hospital

2) Is mother recorded as Koori by Hospital ☐ Yes ☐ No

3) Age(mother)

4) Admission date

5) Did mother receive antenatal care ☐ Yes ☐ No ☐ Few

6) Does mother have any obstetric complications/medical conditions? ☐ Yes ☐ No

If yes, please select from options:(Allows for multi selection)

- Premature rupture of membranes
- Pre-eclampsia
- Diabetes
- Cardiac disease
- Chronic Renal Disease
- Hypertension
- Other

If other is selected, please state other conditions:

7) Type of Birth

- ☐ Spontaneous cephalic
- ☐ Elective Caesarean
- ☐ Emergency Caesarean
- ☐ Vaginal Breech
- ☐ Other

If 'other' is selected, please specify.

8) Date of discharge (Mother)

9) Discharge status (Mother) ☐ Home ☐ Transfer

If transfer, please state place of transfer

Reason for transfer

10) Has mother/liaison officer contacted the MCHN? ☐ Yes ☐ No ☐ Unknown

11) Is this mother's first born? ☐ Yes ☐ No

Previous Pregnancies: **(Excluding this pregnancy)**

12) How many other births/children has mother had?

Source: Koori Mothers and Babies Data Collection form, available at: <www.health.vic.gov.au/koori/hospital-liaison-officer-forms>

APPENDIX V: INDIGENOUS DEATHS FORM

Provided by: .....

.....

Name: .....

Hospital: .....

Information on deaths in the Aboriginal Community

Please provide any information you have on deaths in the Aboriginal Community, not just deaths in your hospital/area.

NAME	AGE	SEX	DATE OF DEATH MTH/YR IF DATE NOT KNOWN	CAUSE OF DEATH	TOWN/AREA WHERE DEATH OCCURRED	IF THE DEATH WAS IN A HOSPITAL, NAME OF HOSPITAL WHERE THE DEATH OCCURRED

Adapted from: 'Information on Deaths in the Aboriginal Community, Appendix 2: Information provided by AHLOs', in *Koori Health Counts! 2006/07 Improving Care of Aboriginal and Torres Strait Islander Patients (ICAP) Program*, Department of Human Services Victoria, Melbourne, p. 79. Available at: <www.health.vic.gov.au/__data/assets/pdf_file/0010/268948/koori-health-counts06-07.pdf>

APPENDIX VI: AIMS DATA COLLECTION FORM

Public Health

Non-Admitted Patient Services **S2_116**
2009-10

AGENCY:	PERIOD:	YEAR:

Aboriginal Liaison Services		Occasions of Service
1	Services within the hospital	
	i Assisting with visits to hospital out-patient clinics	
	ii Assisting with visits to hospital Accident/Emergency Department	
2	Services outside the hospital	
	i Assisting with visits to community health and GP services	
	ii Assisting with visits to other agencies and services	
	iii Assisting with visits to specialists	
	iv Home visits	
Only public non-admitted patient occasions of service are counted on this return. Services for private patients (including compensables) are excluded.		
Signed (AHLO Manager):		Date:

Adapted from *Revised Form S2_116 Public Health Non-Admitted Patient Services*, Department of Health Victoria, Melbourne. Available at: <www.health.vic.gov.au/aims/revisions.htm>.

APPENDIX VII: AIMS DATA COLLECTION INSTRUCTIONS

Aboriginal Liaison Officer Services (Form S2_116)

The measure used for collecting statistical data is an occasion of service. An occasion of service measures volume; it is not a measure of case complexity or level of resource usage.

1. Services within the hospital

1i) Assisting with visits to hospital out-patients

Outpatient services refer to services provided to non-admitted, non-emergency department patients within designated specialist units/departments within the hospital. Outpatient services refer to services provided 'on campus', that is, services provided on a hospital site.

Include occasions of service provided to Aboriginal patients who at the time assistance is being provided, are attending a designated outpatient clinic/department within the hospital. This may be accompanying a patient to either an individual outpatient appointment or to a group session such as ante-natal class, rehabilitation session or diabetes education group.

1ii) Assisting with visits to hospital Accident/Emergency

Include occasions of service provided to Aboriginal patients who at the time assistance is being provided, have not been admitted and are attending designated emergency (or 'casualty') departments within the hospital. This includes patients treated in such departments before admission as admitted patients.

2. Services outside the hospital

2i) Assisting with visits to community health and GP services

Include occasions of service where assistance is provided to an Aboriginal patient for attending a community health service or a general practitioner (GP) appointment. This may include arranging appointments or counselling services. Community health services may include a designated Aboriginal/Koori community service, community health centre, maternal and child health service, post-natal service or Koori Community Alcohol and Drug services.

2ii) Assisting with visits to other agencies

Include occasions of service where assistance is provided to an Aboriginal patient who attends or receives other services such as home and community care (HACC), Centrelink, police, welfare organisations, DOH services such as housing, child protection, children's services or disability services, or referrals and visits to aged care residential services.

2iii) Assisting with visits to specialists

Include occasions of service where assistance is provided to an Aboriginal patient with visits to medical or surgical specialists, including assisting with visits to specialists at other hospitals such as referrals to Royal Children's Hospital, Royal Women's Hospital, Royal Victorian Eye and Ear Hospital or any tertiary hospitals or base hospitals for rural services.

2iv) Home visits

Include occasions of service where assistance is provided to an Aboriginal patient with visits to the Aboriginal patient's family home or community or other residential facility in which they live.

Adapted from 'Instructions for completing Form S2 116 Aboriginal Liaison Officer Services', in *AIMS 2009 Public Hospital User Manual (Version 16.0, July 2008)*. Available at: <www.health.vic.gov.au/aims/aims2009/ph-s2_116alos.pdf>

APPENDIX VIII: PRINCIPLES OF RECORDING ABORIGINAL STATUS IN VICTORIA

1 Scope

The Principles of Recording Aboriginal Status are applicable to all data systems that the Department of Health (DOH) mandates, whether directly or through funded agencies.

2 Purpose

Data including Aboriginal Status is collected for service planning and purchasing, policy development and research purposes, to monitor and address the many and serious health and welfare disadvantages suffered by Aboriginal people as a group.

Data is collected from all DOH direct services and funded agencies for use by the Department. Data may also be used by the agency for the purposes of providing or referring to an appropriate service.

The purpose of the data collection and persons that will have access to the data must be explained to the client at the time that he/she is asked about Aboriginal status. The client should also be informed that the answer given or refusal to answer the question would not affect the client's access to the service.

DOH also has obligations to provide data under Commonwealth/State Agreements and through protocols developed between DOH and Aboriginal community agencies such as the Victorian Aboriginal Child Care Agency (VACCA). However it should be noted that the requirements for Commonwealth reporting might in some cases not comply with the agreed national standard for recording 'Aboriginal Status'.

3 Definition

An Aboriginal or Torres Strait Islander person is defined[1] as a person of Aboriginal or Torres Strait Islander descent, who identifies as being Aboriginal or Torres Strait Islander.

The Australian Bureau of Statistics (ABS) and Aboriginal and Torres Strait Islander Commission (ATSIC) definition also requires that the person is accepted as Aboriginal or Torres Strait Islander by the community with which the person associates. DOH requires this level of identification only for persons applying for public housing through the Aboriginal Housing Board of Victoria.

1 In the National Health Data Dictionary, version 12; National Community Services Data Dictionary, version 2; and National Housing Assistance Data Dictionary, version 2 [all published by the Australian Institute of Health and Welfare, Australian Government, Canberra].

A person of Aboriginal descent is a person descended from the original inhabitants of Australia.

The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea. They do not include:

- Christmas and Cocos Islands in the Indian Ocean;
- Islands in the Gulf of Carpentaria;
- Pacific Ocean islands such as the Solomon Islands, Nauru, Kiribati, Samoa, New Hebrides, Tonga, Cook Islands or Fiji;
- Islands in Bass Strait, e.g. King or Flinders Islands.

4 Aim

The aim is for DOH to collect comprehensive and accurate data on the Aboriginal status of service users by ensuring that:

a Every Aboriginal or Torres Strait Islander person is given the opportunity on all occasions of service (both direct DOH services and funded agencies) to identify him/ herself (or person for whom responsible) as Aboriginal and/ or Torres Strait Islander.

b Processes are in place to ensure that data systems are internally consistent, i.e. that data recorded on Aboriginal status does not conflict with data on country of birth, language spoken, citizenship or other fields relating to ethnic identity. In this context it is considered very unlikely that an Aboriginal or Torres Strait Islander person accessing Victorian services will have been born overseas or speak a language other than English or an Australian Indigenous language.

The response recorded by DOH and its funded agencies will not be influenced by whether the client's Aboriginal status is endorsed by others in the Victorian Aboriginal community, except in the case of applicants to the Aboriginal Housing Board of Victoria.

5 Privacy

It is the responsibility of DOH to ensure that Departmental privacy principles are adhered to.

The Department of Human Services has an endorsed privacy policy, which applies to the handling of all personal information, within the organisation and across the funded sector. The policy contains 12 information privacy principles which ensure privacy is maintained from the time information is collected, in any subsequent use and disclosure, and in the storage, retention and disposal of the information. The principles ensure that individuals have a right to access their personal information and the opportunity to correct or comment on its accuracy. They also provide guidance on the use of unique identifiers and require privacy compliance audits. The principles are based on an individual's right to know about what happens with his/her information and to be given a choice where possible about how it is handled, while at the same time explicitly recognising other public interests. They highlight the need to demonstrate cultural sensitivity when handling information such as data on Aboriginal status, and awareness

of the historically based, legitimate concerns clients may have about misuse, stigmatisation and a loss of control over the use of this information. The DOH privacy principles can be found at <www.DOH.vic.gov.au/corpres/privacy/index.htm>.

6 Collection

a All areas of DOH and funded agencies which collect client information must collect information on Aboriginal status. This information is part of the Department's common client data standards, which require that Aboriginal Status and Country of Birth are recorded in all data collections.

b The question on Aboriginal status should be asked immediately following the question "Country of Birth". If the person was born in Australia, then information on Aboriginal status should be collected by asking the question "Are you of Aboriginal or Torres Strait Islander origin?"

The response to the question should be recorded in the format:

[Are you]	Aboriginal;	(A)
	Torres Strait Islander;	(TSI)
	Aboriginal and Torres Strait Islander;	(A/TSI)
	Not Aboriginal or Torres Strait Islander;	(not A/TSI)
	Declined to answer; or	
	*Question not able to be asked.	

It should not be possible for the response to be recorded as "not stated/ unknown/ not applicable", except as in 6i below.

*The response "question not able to be asked" should be used only:

- in an emergency situation by ambulance or hospital staff; and
- when the patient is incapable of answering questions, and
- when no other person can answer on his/her behalf and it is not possible to obtain the information later and amend the record.

This will only be available in a limited number of databases.

c Data should be aggregated in the same format as above (A, TSI, A/TSI, not A/TSI, Declined to answer).

d There should be a field in the above format on every data collection tool.

e The field should be mandatory, i.e. that it must be completed for the entry to be accepted by the system. This should be implemented as systems are redeveloped and upgraded.

f It should not be possible for the system to default to a particular response in this field.

g The information should be collected by directly asking the client at every episode of care/ occasion of service, as defined by normal practice within the program area. Where a single "permanent" record is provided through a Patient Master Index (PMI) this field should be checked at each episode (in the same way as address or next of kin would be checked).

In a situation where the client will make frequent regular visits in a short period of time, (e.g. dialysis) it is acceptable (where technically possible) to program a prompt to appear for this question so that the information must be updated periodically, e.g. weekly or monthly, rather than at every visit.

While a person's Aboriginal origin does not change over time, a person's decision to identify as Aboriginal may vary at different times. The client should be offered the opportunity to confirm or change any previously recorded identification.

h At the time of collection the client should be provided with the reason that data is collected, the destination of the data, who will have access to the data and whether it will be linked with any other data system. This includes both the collection of data for statistical purposes by DOH, and any use the agency may make of the data. If the client challenges the need for collection of Aboriginal status, the following information should be provided:

- what data is collected;
- how data is collected;
- why data is collected;
- why the data is important;
- who has access to the data.
- what safeguards are placed on the confidentiality of the data.

i The option "not stated" should not be provided in primary data collections. The only situation in which this option should be used is where data is converted from a system that has not recorded information on Aboriginal status, or has recorded it in an incompatible format.

7 Quality

a Aboriginal status should be cross-checked with Country of Birth and Language. An error should be flagged if the country of birth is other than Australia and the language spoken is other than English or an Australian Indigenous language. While neither of these situations is impossible, they are considered so unlikely that their occurrence should be cause for further investigation.

b Where it is possible for identification to be supported by reference to other data series and persons with specialist knowledge, such as Koori Hospital Liaison Officers, this verification should be sought as an additional indication of the quality and completeness of the aggregated data collection. However, rejection of identification by the external source should be cause only to check how identification was sought and whether it was recorded correctly, not to invalidate the client's identification. The only exception to this is in the case of applicants to the Aboriginal Housing Board of Victoria.

8 Community consultation

a Work on improving the collection and accuracy of Victorian Aboriginal data must occur in co-operation with the Victorian Aboriginal Community. The involvement of the Victorian Aboriginal Community is essential to improve data collection. However this cannot be achieved without community confidence in the accuracy of the data collected, and trust that information will not be abused and privacy will be protected.

b Protocols for the use of data and for returning information to the Victorian Aboriginal Community will be developed in consultation with Victorian Aboriginal Community organisations. DOH has an obligation to articulate and negotiate with the Community the benefits, safeguards and risks of such data collection.

c Different protocols will apply to different levels of data use, i.e. individual, collected and aggregated data.

d While the Department has an obligation to return data to the Victorian Aboriginal Community, only data that does not identify individuals or small communities will be made available beyond DOH, including to Victorian Aboriginal Community organisations.

9 Exceptions

a If DOH staff consider that a system should be exempt from collecting information on Aboriginal status they must prove due cause, such as:

- the difficulties of collecting data in emergency situations;
- that data on Aboriginal identification is not used presently and never will be used within DOH; or
- that collecting data would compromise service delivery.

b If an individual refuses to answer the question about Aboriginal status, he/she should be recorded as "Declined to answer". Service use of this option will be monitored closely.

If it is impossible for the question to be asked during the contact episode, Aboriginal status should be recorded as "Question not able to be asked" rather than one of "A/TSI, A/TSI or not A/TSI". (see 6b above). This option will only be available in specified databases.

If possible, further information should be sought from the client or his/her advocate and the response amended.

10 Use of data

a Aggregated data will only be used for service provision and purchasing, policy development, research and planning purposes. It will be accompanied by a statement about the accuracy of the data.

b An individual's identification as Aboriginal/ Torres Strait Islander or not Aboriginal or Torres Strait Islander will not affect the level of service available to that individual, although the type of service may vary as appropriate, e.g. referrals to a Aboriginal-specific agency may be made.

c Record linking

In order to check the accuracy and completeness of data, it may be necessary to use data identifying individuals; i.e. to use names to check the consistency of identification across systems. This will occur only while accuracy is being checked.

The Departmental Privacy Principles apply to any personal information collected. When the purpose of data collection is research the normal Departmental research protocols will also apply.

d In addition, measures to protect the privacy of a small population group, such as suppression of cells less than 5, will be taken as appropriate.

On occasions when data has been linked across systems, e.g. Aboriginal births data, the results have provided an excellent measure of accuracy of the systems.

11 Implementation

a When the Principles have been formally adopted by the Department, their implementation will become the general responsibility of relevant Koori Services strategy groups.

b A quality control group will be identified to meet as required.

c The level and distribution of resources required to implement the Principles will be determined. It is recognised that training and development will be required across the Department and its agencies.

KOORI INFORMATION PLAN STEERING COMMITTEE

February 2007

Adapted from *Principles of Recording Aboriginal Status in Victoria, April 2004*, Victorian Government Health Information, available at: <www.health.vic.gov.au/koori/recording-aboriginality>.

APPENDIX IX: AHLO SUPPORT NETWORK TERMS OF REFERENCE

AHLO Support Network Terms of Reference April 2009

Aims

To provide a support network for metropolitan Aboriginal Hospital Liaison Officers (AHLOs), to:

- Provide mutual support and cultural connection
- Share information about community and professional issues
- Share information about effective work practices and patient care
- Identify gaps that need to be addressed to enable improved care for Aboriginal and Torres Strait Islander patients
- Provide professional development opportunities

Outcomes

- Reduced isolation and increased connectedness among AHLOs
- AHLOs more informed about current issues
- Increased information, tools and skills to enable AHLOs to do their job
- Progression of ICAP issues

Participants

AHLOs/Aboriginal staff

- This network is predominantly for AHLOs employed in metropolitan health services.
- In health services that have additional Aboriginal and Torres Strait Islander staff employed to implement ICAP initiatives (for example, policy officers, community development roles etc), additional staff may wish to attend.
- To keep numbers manageable, it's recommended that only two workers from each health service should attend any one network meeting.
- Attendance at meetings is optional, though strongly encouraged at least quarterly for all AHLOs and may vary from meeting to meeting.

Other

- The VACCHO and Metropolitan ICAP project officers will attend as observers, to answer questions and record agreed action items to report back to the ICAP Management Group and AHLO managers, as deemed appropriate by the group.
- Guest participants/presenters may be invited to attend certain meetings, if agreed by participating AHLOs/Aboriginal staff.
- On occasion, the AHLO Manager's network may be coordinated to fall on the same day as the AHLO network meeting and the two groups could come together for a set period (eg: lunch) for networking and information exchange, as agreed by the two groups.

Frequency

On average, meetings will be held on a bimonthly basis, commencing on Friday 1st May 2009. Subsequent meeting dates will be: 26th June (brought forward to avoid NAIDOC week), 7th August, 2nd October and 11th December 2009 (Christmas meeting).

Duration

Meetings will be half day with catering provided accordingly.

Venue

- Meetings will be based at VACCHO unless an alternative venue is agreed by the group on certain occasions.
- One meeting per year may be held at a less formal, neutral venue for an informal network meeting, such as a lunch, as agreed by the network participants.

Administration

Administration responsibility will be determined at the end of each meeting on a rotational basis, including:

- Chairing the meeting
- Planning and circulating an agenda
- Arranging any agreed site tours/visits and guest speakers
- Typing up and circulating minutes/action items
- Booking a room and catering (and billing ICAP for catering costs). For meetings held at VACCHO, VACCHO will book the room and catering.

Agenda items

- Agenda items can be discussed at the end of each meeting, for the next meeting or submitted up to one week prior to each meeting.
- The meeting chair will discuss submitted agenda items with the person who submitted it to determine if the item is appropriate to include.
- Draft agendas will be circulated one week before the meeting.

Group rules

To be decided at first meeting and included as an attachment to (and part of) these terms.

Progression of ICAP Issues

Agreed action items raised at this network will be fed back to the ICAP Management Group and AHLO Managers, as decided by the participants at each meeting.

Review

These terms of reference will be reviewed annually.

Drafted by Raelene Lesniowska and Joanne Borg, with input and endorsement from the metropolitan Aboriginal Hospital Liaison Officers, April 2009.

APPENDIX X: THE PURPOSE OF SUPERVISION

At the ICAP Forum in October 2008, one of the ALO program managers suggested that the *ICAP Resource Kit* should include information on the purpose of supervision and that this could be included as an appendix in the Orientation Guide for ALOs. The following was developed for the kit.

Cross-cultural supervision

Introduction

In cross cultural supervision it is important to take an approach that stresses conversation and learning from each other.

Workers face a variety of job-related stresses. Unless they have help to deal with them, these may seriously affect their work and lead to a less than satisfactory service to clients and/or worker burn-out.

What is the role of the supervisor?

The supervisor ensures:

- that high quality services are provided to clients
- the development and well being of the individual worker
- the interests of the organisation are met.

Who provides supervision?

Professional supervision may be provided by the program manager and/or by another professional supervisor. Where possible access to an Aboriginal mentor is also desirable.

What is the purpose of supervision?

Supervision provides:

- time and space to reflect on the work
- an opportunity to receive information and obtain another perspective
- an opportunity to share knowledge and perspectives
- a forum to receive feedback and give feedback

Supervision seeks to:

- develop understanding and skills within the work
- validate and support the employee as a person and as a worker
- provide space to explore and express personal distress/issues which occur because of the work
- work out how to use resources better – both personal and professional
- identify the supervisees' educational/learning needs

Supervision aims to:

- ensure that the worker does not have to carry problems alone
- monitor and improve the quality of the work
- take a proactive not just a reactive approach
- ensure a two-way approach where the supervisor also engages with new learning.

SECTION 3: ORIENTATION AND INFORMATION FOR HEALTH SERVICE MANAGERS

This section will:

- assist hospital managers and program supervisors to better understand the complexities of operating an Aboriginal program by examining human resource management issues
- build capacity to implement ICAP successfully by examining strategic issues such as partnerships with community-controlled organisations
- provide ideas for improving hospital information management practices.

The information is varied and wide ranging and can be used for reflection, to spark discussion (between managers and between managers and AHLOs) and to develop new knowledge. The views are not intended as definitive points of view or answers.

Three areas—human resources management, integration between hospital and Community, and information management—are covered in sub-sections.

HUMAN RESOURCES MANAGEMENT

Human resources management is a vital function in motivating and empowering staff to achieve. A competent workforce and a satisfying working environment support the provision of quality health care and services. The ICAP Resources Project recognises that managers and program supervisors in mainstream settings require special knowledge to better manage the complexities of working with Aboriginal employees.

The information that follows was obtained through interviews with Aboriginal Hospital Liaison Officers (AHLOs), hospital managers and supervisors. Additionally, specific questionnaires and Internet searches were also used.

STAKEHOLDER FEEDBACK

Supervision of Aboriginal Hospital Liaison Officers

Respondents were asked about their roles as AHLO supervisors. The following quotes come from feedback provided by both highly experienced and newer supervisors. The material reflects a diversity of views, issues and strategies used in cross-cultural supervision and management.

On the supervisors' journey:

> *It requires you to come on a journey—a journey into unfamiliar territory. It requires you to be outreaching and to keep checking in about what is needed.* (Supervisor, metropolitan health service)

> *The AHLO—there is no one you can compare this person [role] to. It's the demands, the push and the pull. My relationship with AHLOs is very different to others I supervise. The communication is much more personal and I respond in a much more personal way.* (Supervisor, rural health service)

> *The journeys are different but there is a crossover point where you have had the dialogue, face-to-face, you have heard the stories and the history, you have heard the local history, not just from books, you have gone to the places and walked where [Aboriginal] people walked and lived.* (Supervisor, rural health service)

On boundaries and expectations:

> *The occupational health and safety issues are very difficult. Workers can refuse to abide by normal standards of self-care. There is pressure from the Community to be available 24 hours a day.* (Supervisor, metropolitan health service)

> *I know that the AHLO is going to be asked to do things that need to be avoided, so I provide my staff member with 'borrowed protection'. They simply say, 'my boss won't let me do that'.* (Supervisor, rural health service)

*What we did wrong [in setting expectations] is that we didn't have clear expectations and we didn't write them down and articulate them. (*Supervisor, metropolitan health service)

Drop the white time lines—they don't work. (Supervisor, rural health service)

On accountabilities:

How much consideration do you give for being different? It can be used as an excuse. With all the good will in the world, you have to set standards and limits. (Supervisor, metropolitan health service)

Non-Indigenous staff have family members with problems and health issues, too. I know, though, that if I do not provide adequate support for them [AHLOs], I have lost them for the next few weeks. We need to be there for AHLOs. (Supervisor, metropolitan health service)

On supervision:

Supervision arrangements are different depending on who the AHLO is. The first AHLO we had was trained, assertive and articulate and the usual arrangements worked well. I needed to change things with the staff that followed. Formal things did not work. For one AHLO, wandering in to see me when she has issues, works—it works well. (Supervisor, rural health service)

I am very aware of my body language—I do not sit opposite, I sit side by side and the door is rarely closed because two staff have been very uncomfortable with that. (Supervisor, rural health service)

Be realistic about what you may shift/change. You want to bring out the best in staff. In supervising, you need to recognise the richness of experience. Respect this. Get to know the AHLOs and their experiences. (Supervisor, rural health service)

I use a strengths-based approach, positive feedback, valuing the experience of marginalisation and I support the workers. You need to be clear about what supervision means, what is useful/what is not. It needs a joint agenda—your issues and my issues. There is a need for flexibility. There are crises and the impact of trauma and trans-generational grief and loss and the secondary impact of vicarious trauma. (Supervisor, metropolitan health service)

I believe that early and good enough supervision for AHLOs is so important. It comes down to resources. This tends to be on top of other work for supervisors. It can be intensive and not recognised. (Supervisor, metropolitan health service)

Supervision gives time to reflect, focus and develop insights. I am happy to make it as informal as possible so that it is a place where the AHLO feels it is her time, with as few interruptions as possible. I ask her to pick a day and time. If she is running around and has not eaten, then I say, 'Bring your lunch or let's have coffee while we talk'. If she's late, I call and we see what's do-able. An approximate time is okay and I say, 'come when you can'. If I have time constraints, I let her know. (Supervisor, metropolitan health service)

I have always supervised the AHLO. I set a regular weekly time—it gives a message. I have been almost universally unsuccessful on the basis of weekly attendance and I find it is used more on demand. One AHLO wrote regular monthly reports—a summary of issues—and brought this to supervision. Another AHLO popped in morning and afternoon. This was terrific, as it gave me a barometer re how she was going. Certain AHLOs needed opportunities to keep them interested, e.g. external cultural awareness sessions, analysing systems. I often deal in supervision with case-related issues (children at risk, dying, anger about a prejudiced person) and sometimes 'big picture' stuff. (Supervisor, metropolitan health service)

Supervisors can struggle with how it goes. For example, is the worker coming to supervision or not coming? What are they not telling the supervisor? Sometimes not doing what was asked or not doing what they said they would do. (Supervisor, metropolitan health service)

Had I my time over again from day one I would be sure that there was supervision twice a week, going through every case. Who is the worker seeing? What are they doing? Many AHLO staff are at welfare officer level or they do not have formal training. The cases are complex and the impact of the work can be confronting, hard and painful. (Supervisor, metropolitan health service)

Case study—shadowing an AHLO

The AHLO role is different to any other in a mainstream health service. During the course of the ICAP Resources Project, a supervisor and AHLO shared their experiences of the AHLO role, which painted a picture of some of the demanding issues that most AHLOs encounter in their work.

A few years ago our organisation reviewed the AHLO Program soon after ICAP was introduced. We had two consultants (one Aboriginal and one non-Aboriginal). VACCHO was represented on the steering committee. They suggested that it might be a good idea for one of the consultants to shadow the AHLO (follow and observe the AHLO while she did her job) to acquire a pragmatic and direct understanding of how this role played out in the workplace. (Supervisor, metropolitan health service)

The consultant spent several significant periods shadowing the AHLO as she managed her daily routine. There were also separate periods when the AHLO and the consultant met to discuss aspects of the role. This is what the consultant said:

From the outset it was clear that the AHLO was passionately committed to her Community and to her role. It was, however, immediately apparent that any expectation of having a clear daily routine was misconceived. In practice, the role was open-ended, largely crisis-driven, and the AHLO's capacity to manage time was affected by constant requests from staff members, patients and Community agencies. Each individual [who] contacted the AHLO needed or wanted an immediate response.

It was also apparent that many issues were sensitive and complex. For example, relocating an Aboriginal woman who had been a victim of violence into a safe haven, supporting patients and families facing distressing diagnoses and addressing expectations to pacify Aboriginal patients exhibiting aggressive or challenging behaviour. It was also obvious that at any time several complex situations could be occurring in parallel. The AHLO demonstrated a capacity to switch from one issue to another with an impressive grasp of detail.

In later interviews members of the nursing staff confirmed this assessment of the AHLO role being both open-ended and crisis-driven. Two statements in particular illustrated those realities: 'when you want her, you want her' and 'she is expected to do everything and be everything'.

The AHLO reported conflicting professional and personal pressures that made boundary setting difficult. This particular AHLO was assisting members of her own Community. Many of the patients were either known to her or were part of her family relationship structure, sometimes making issues of confidentiality additionally sensitive. She said that there were occasions when patients with certain diagnoses did not want her to have any details about their illness[es].

The AHLO also reported that there was an accruing personal burden of loss and grief (because of family and Community connections) when her patients were acutely unwell or when death intervened. I noticed that uninterrupted brief meal breaks did not occur. From the commencement of the working day until its closure, the pager and the incoming phone calls determined the structure and elements of the AHLO working day.

I also spent half a day with the AHLO when she attended a meeting at a Community organisation. In this context it was apparent that such visits were valued on both sides. It was also apparent that the AHLO was in many ways viewed by the Aboriginal Community members in much the same way as mainstream staff viewed her. My impression was that they had unrealistically high expectations of her depth and breadth of knowledge about extremely complex issues and of her capacity to influence management decisions within the hospital.

Some basic questions and answers: one supervisor's views

During the project, AHLOs and supervisors raised questions that need answers that are not easily put into AHLO job statements and program guidelines.

We asked an experienced health service supervisor to share her views on the following questions.

- What is an appropriate amount of Community contact for the AHLO?
- Should AHLOs transport patients and/or their family members?

- What sort of emergency material aid funding[1] should AHLOs have access to and what does this need to cover?
- What is an appropriate workload for AHLOs and should it include outpatient contact?
- How much training are AHLOs able to access each year? What are they entitled to?

This is her response:

I have been an AHLO Program supervisor for more than 10 years. I will answer the questions based on my experience, which includes lots of discussions with AHLOs. Health services are different—and they are perfectly entitled to make up their own guidelines. These are my thoughts.

What is an appropriate amount of Community contact for the AHLO?

To be effective in their roles, AHLOs need to work well with Community organisations. Good working relationships are key. Regular face-to-face contact and exchange of information are important.

While the AHLO is outside the hospital, there will no doubt be someone—a patient, family member or staff member—who needs to see [him or her] fairly urgently. The AHLO should have a mobile phone and be available for consultation.

Supervisors and AHLOs should jointly discuss and plan attendances at Community meetings so that these happen regularly.

Should AHLOs transport patients and/or their family members?

Let's look at the AHLO job description. Is this a requirement of the role? I think we should use every other option at our disposal. AHLOs are a precious resource and there are better ways to use their time. If the health service does not provide transport then you may need to assist financially with patient transport arrangements. See the next answer!

What sort of emergency material aid funding should AHLOs have access to and what does this need to cover? (What about cab vouchers?)

Every request for material aid needs to be assessed. Many patients and family members may not have enough spare money to meet costs related to hospitalisation—such as transport, meals and accommodation. You may find that there will be a need to draw on emergency relief funds—in-house or from community services. We have a Samaritan Fund but we do not provide cab vouchers at our hospital. Discuss it with the AHLO. If you need to have this option available, then plan for it.

1 Section 5: Practice examples from Victorian health services includes an example of a submission from the AHLO Program at Northern Health to hospital management for emergency relief funding. The submission was successful.

What is an appropriate workload for AHLOs and should it include outpatient contact?

The main focus of the AHLO role is patient and family support. If the AHLO is doing a range of things such as cultural awareness and Community visits, this will lessen [the] availability for patient contact. Data can tell a story and it helps managers to establish what is likely to be appropriate for the setting.

Review with the AHLO how many Aboriginal and Torres Strait Islander inpatients and outpatients the hospital treats each year.

Review the figures on the numbers of patients seen and average time spent. Remember that AHLO contact time per case can be quite lengthy.

Monitor and discuss trends in the data with the AHLO.

Use data collected over a period of time to establish some agreed targets and adjust these over time.

Outpatient work is important. Failure to attend for follow up can lead to continuity-of-care issues.

How much training are AHLOs able to access each year? What are they entitled to?

AHLOs are paid under industrial awards which outline minimum study and conference leave entitlements. It is up to the supervisor to approve or refuse leave requests on discussion with the AHLO.

AHLOs can be invited to lots of things that are interesting and may or may not be relevant to their roles, so discussion and negotiation between the supervisor and the AHLO are essential.

AHLOs should be encouraged to attend ICAP and VACCHO workshops and training. This is part of their role and support system. Personally, I think these should be separate to training needs that the AHLO and supervisor identify and decide on in the annual performance development discussion.

One of our AHLOs is at present having tutoring at work for two hours each week to work on skill building—in areas she identifies as relevant. We both saw this as important for career development and decided to set something up.

If your hospital has in-house training of any kind that is of interest to the AHLO, this should always be considered. This might include standard training such as emergency procedures, equal employment opportunity sessions, medical terminology courses.

Additional issues identified by supervisors

Responsibility for Aboriginal health and ICAP in a health service

Supervisors were asked who is primarily responsible for driving Aboriginal health. All said that ICAP is about a whole-of-health service response to Aboriginal health issues, and the AHLO alone should not be left to progress ICAP, nor should it be seen to be the responsibility of the AHLO supervisor.

A range of stakeholders identified that establishing internal working parties, in addition to advisory committees within health services, is a way to respond to this issue.

The importance of co-opting others to the effort was identified. How to most effectively involve quality managers, health information services personnel and other key stakeholders in ICAP quality improvement activities and in discharge planning was not readily answered.

The time commitment

A strong theme from supervisors was the unacknowledged amount of time it takes to manage the program. When supervisors were asked to estimate the percentage of their time spent on AHLO/ICAP Program responsibilities, several estimated an average of one day per week per AHLO staff member.

> *My AHLO/ICAP workload has doubled since ICAP was introduced.* (Supervisor, metropolitan health service)

> *I am shocked at how much time it takes [to supervise the AHLO Program]. My other staff are unhappy about the dilution of my time.* (Supervisor, metropolitan health service)

> *My role in ICAP is to help implement it. I got it because I supervise the AHLO Program. I see myself as the supervisor of the AHLO and as contributing to the ICAP Program rather than implementing it. No executive member in the health service has been nominated for ICAP.* (Supervisor, metropolitan health service)

Recruitment

Aboriginal people need to be involved on interview panels for Aboriginal positions. Several stakeholders spoke of mistakes they made in the past in setting up interview panels to recruit for AHLO and related roles. Several mainstream stakeholders said that they sought direct advice from VACCHO on options for Aboriginal representation on interview panels.

Aboriginal units

The pros and cons of having a separate Aboriginal unit were raised. It was felt that a geographically well-positioned unit helps Aboriginal people feel more comfortable. The trade off, as one supervisor noted, is that, in the unit, Aboriginal staff are more on their own, more isolated and less visible. And it is less obvious when support may be needed.

> *There are no visual cues. How do we know when the staff need support?* (Supervisor, metropolitan health service)

One team has found a way to address this.

> *We have a 'hot desk' in the department and the AHLO is encouraged to use this and often does—to get away from her centrally located office and the constant demands.* (Supervisor, metropolitan health service)

Equity issues in management practice

Supervisors said that they have to work to balance the need for culturally safe management of Aboriginal staff with their responsibilities for non-Aboriginal staff. There may be perceived equity issues. Both Aboriginal and non-Aboriginal stakeholders said that there is a need to effectively orientate Aboriginal staff to develop awareness of mainstream expectations. The importance of a flexible, open and consultative approach was also identified. The following quotes illustrate differing views.

> *Amongst other staff there can be concern about treating AHLOs more favourably—more leeway and grace compared to other employees. There is no one you can compare this role with.* (Executive sponsor, rural health service)

> *Managers need to know what is and is not appropriate leave when working in an organisation like ours. What is or is not okay. Managers are in limbo if/when they turn a blind eye—this can breed racism.* (Executive sponsor, metropolitan health service)

> *As a new supervisor be prepared to work outside normal arrangements and to support AHLOs in exceptional circumstances. You may be criticised for putting AHLOs on a pedestal or being a soft touch. Be confident—this is the way to handle it. Brief the boss.* (Superior, rural health service)

AHLOs co-working with other clinical staff

There are no clear guidelines regarding the roles of AHLOs when compared to other staff involved in the psychosocial care of patients and families. Effectively working together can require time, dialogue and a process of relationship building.

> *Most staff have no idea that AHLOs in many cases do not have professional training.* (Supervisor, metropolitan health service)

Several supervisors at metropolitan health services said that trust has to be earned, and that Aboriginal staff pick other staff they feel comfortable with.

The purpose of supervision

Several supervisors suggested that it would be useful to have an outline available on the purpose of professional supervision, which may be a new concept for AHLOs.

(See Section 2: Orientation guide for Aboriginal Hospital Liaison Officers, which includes this outline.)

Classifications and rates of pay

Supervisors (and health services) are grappling with the issue of appropriate classifications and rates of pay for AHLOs and other Aboriginal health positions.

These positions are paid under a number of different awards, including community, health professional and/or administrative awards. At the time of completing the ICAP Resources Project, a number of health services were reviewing classifications and rates of pay in consultation with each other. Support was expressed for a unified approach in the absence of a single professional association or union.

In May 2009 a support network for AHLO managers was established to discuss and progress a range of issues regarding the management of AHLOs, including some of the issues highlighted in this resource kit. The Terms of Reference for this support network are provided as Appendix III to this section of the resource kit.

USEFUL READING

Insights: Strategies for success—Indigenous and non-Indigenous people at work

Anning, K. & Saunders, H. 2001, *Insights: Strategies for Success*, Director of Equal Opportunity in Public Employment, Western Australia.

Insights: Strategies for Success is a resource tool with an accompanying CD-ROM that presents cross-cultural perspectives from Indigenous and non-Indigenous people working in the Western Australian public sector. It seeks to affirm and respect Indigenous cultural values in the workplace. Stories are presented in an innovative format, which includes cartoons, case studies, quotes, and tips and strategies for building a workplace that is continually inclusive of Indigenous staff and managers.

Readers are offered insights into commonly asked questions, from becoming an employer of choice and managing skilful staff selection to cross-cultural relating, performance management issues, and training and career development strategies.

The tool also offers practical advice for Indigenous readers about applying for positions in the public sector, how to develop a career, and how to work with non-Aboriginal managers and staff.

The publication is informed by the first-hand experiences of Indigenous and non-Indigenous people who are maintaining positive work relationships.

Sections include:

- **advertising know-how:** for example, taking the process to the Community, design tips for advertisements
- **selection:** for example, including an Indigenous panel member, involving an Indigenous selector in designing or updating the duty statement and wording the selection criteria, supporting the Indigenous panel member

- **selection techniques:** informal questioning style, skilled interviewers, an Indigenous perspective, culturally sensitive interviews

- **retention:** building a welcoming, culturally safe environment, sending staff to cross-cultural education, ensuring that Aboriginal people are employed in as many areas as possible, enhancing existing staff induction (assign a mentor, familiarise, be informal and flexible, discuss organisational culture and the way things are done)

- **communicating performance expectations:** collaborative working styles are highlighted; examples include hands-on coaching, communicating mutual trust and respect, being involved and interested and not having low expectations, managing with sensitivity (for example, in relation to dealing with Community pressure), addressing performance such as managing time and tips for doing this

- **relating:** strong cross-cultural coaching and mentoring skills emerge as key competencies in the management of a diverse workforce; this section discusses building skills (for example, customising programs, relating skills, building Community networks, personal discussion)

- **communication issues:** avoiding patronising language, the attributes of a good mentor, two-way cultural coaching, diversity of relating styles, respecting individuality and checking out what is appropriate for individuals (for example, being thanked, being assertive/passive)

- **training and development:** growing the talent within—identified positions, career development, on-the-job training, career planning, personal skills training, diverse learning styles and facilitation techniques.

One tip about ways of relating in cross-cultural relationships with Indigenous people advises:

> *Tread with humility and respect. If you do this your cultural faux pas will probably be understood and excused, quite probably with gales of laughter. The arrogance of ignorance, or of the little knowledge which is a dangerous thing, will cut you off. By all means do your cultural awareness course; it may rub off some rough edges and help you to avoid the more egregiou errors. But it will not make you an expert in 'Indigenous culture'; still less an expert in the many distinct Indigenous cultures that exist in Australia ... Some things are universal currency in doing business—honesty, openness, frankness and good humour, the ability to make or enjoy a joke at your own expense. H. Wooten (p. 30)*

A text-only version of *Insights: Strategies for Success* can be downloaded from the Office of Equal Employment Opportunity website: <www.oeeo.wa.gov.au/publications/guides/insights.htm>. The complete CD-ROM is also available via the website or by contacting the Director of Equal Opportunity in Public Employment, telephone (08) 9260 6600.

ACKNOWLEDGMENT: thank you to the Western Australian Office of Equal Employment Opportunity for permission to print this material and to include a web link.

Non-Aboriginal managers and Aboriginal employees

Nungarrayi-Price, D. & B. 1999, 'Cross-cultural Issues—A practical approach to working with and managing Aboriginal employees in the work place', paper presented to the Aboriginal Employment and Training Summit, Millennium Hotel, Sydney, 28–29 April. Accessed on 20 February 2009 at <www.jajirdi.com.au/>.

This paper outlines a practical approach to working with and managing Aboriginal employees. It was presented at the Aboriginal Employment and Training Summit in Sydney in 1999 by *Jajirdi* cross-cultural consultants Dave and Bess Nungarrayi-Price.

The material offers mainstream supervisors a basic philosophy for dealing sensitively with cross-cultural issues.

The authors draw on five principles outlined by Martin Krygier in the 1997 Boyer Lectures, 'Between Fear and Hope: Hybrid thoughts in public values'. The five principles are:

- society is complex
- life is hard
- value what works
- you're not that smart
- be careful.

One of the authors writes that in his marriage to an Aboriginal woman:

> *We continue to make mistakes and we continue to learn. It is challenging and exciting, sometimes enchanting, often downright frightening. Important is the recognition of Aboriginal humanity—which is wonderfully complex.*

He stresses two points:

- Aboriginal people share a common humanity with the rest of the Australian and world communities
- Aboriginal people express their humanity in very different, indeed often opposite, ways to what is conventional and acceptable in the mainstream:

  I once asked an Aboriginal manager of a small community enterprise what was her biggest problem as a manager. Her reply was getting the workers to work. I asked why. The answer was because they aren't related to me in the right way and won't do what I ask them to do. I don't have authority over them in the Aboriginal way. I then asked her what she intended to do about it. She answered: I'll put pressure on them until they leave and then I'll recruit young people from my own family who will work for me because I can tell them what to do.

The authors make a number of points about cross-cultural issues:

- the emphasis in Aboriginal culture is on the avoidance of public and open conflict and on the autonomy of the individual
- the right to supervise and instruct is granted in terms of kin relationship and traditionally sanctioned authority
- mainstream managers might wish to promote the notion of professional detachment and objectivity where, in Aboriginal terms, practical common sense may be both sound and ethical
- there are cultural differences in attitudes to work—professionalism involves formal training
- whitefellas are obliged to work within a particular set of unavoidable constraints applied by the law and by the marketplace and cannot be as free and flexible as they may wish to be
- effective decision making requires both objective judgments (according to a set of prescribed standards) and subjective judgments
- we should understand that some of those we are judging are operating by a different set of rules, so we have to ask if the behaviour is the logical product of a different set of rules or if it is just dysfunctional or unwise
- principles should be made explicit—learn from each other in a meaningful way. Of interest is not what is best in a moral sense but what works for Aboriginal people and whitefellas
- in terms of cross-cultural training, we should ensure that Aboriginal workers receive training on the legal and ethical basis and practical details about modern administration and business practices. Then they can make a choice on the basis of having been fully informed.

The authors sum up their approach to cross-cultural issues:

> *We should be dealing with cross cultural issues in an honest partnership of equals. We have things to learn from each other.*

The full paper is available at the authors' *Jajirdi* website (follow the 'Talk Topics' link at <www.jajirdi.com.au>).

ACKNOWLEDGMENT: thank you to Dave and Bess Nungarrayi-Price for permission to reproduce this material.

Aboriginal and Torres Strait Islander workforce, 2008

VACCHO 2008, *VACCHO Workforce Analysis and Projected Workforce Needs—Final Report 2008*, VACCHO, Melbourne.

This research collected information on the workforce situation in Aboriginal Community Controlled Health Services (ACCHSs) to identify workforce gaps in Victoria (metropolitan and rural) and to determine future health workforce requirements. Significant shortfalls exist for general practitioners (GPs), Aboriginal Health Workers, nurses, and counsellors and social workers.

Table 1 is adapted from the report. It outlines current staffing in ACCHSs and identifies existing shortfalls.

This information has implications for mainstream health services seeking to employ people in AHLO positions, indicating that for the immediately foreseeable future the availability of trained staff is likely to be limited. This fact has implications regarding orientation, support and learning needs for staff working in AHLO positions.

TABLE 1: ACCHS STAFFING LEVELS BY REGION (EQUIVALENT FULL-TIME POSITIONS) 2007

	METRO	GRAMPIANS	HUME	GIPPSLAND	BARWON SOUTH	LODDON MALLEE	TOTAL
Aboriginal Health Workers	13.1	4.0	15.8	14.2	8.4	15.8	71.3
Shortfall (number)	19.8	3.2	8.0	9.0	4.0	9.0	53.0
GPs	5.7	0.7	2.5	2.2	1.5	2.8	15.4
Shortfall (number)	6.0	2.2	3.6	2.4	1.4	2.8	18.4
Nurses	7.9	2.8	3.1	3.8	3.7	8.0	29.3
Shortfall (number)	10.5	2.2	5.0	5.0	4.2	2.0	28.9
Counsellors/ social workers	7.0	0.6	0.2	1.7	1.8	3.4	14.7
Shortfall (number)	1.6	0.2	7.1	2.2	5.8	4.0	20.9
Drug and alcohol workers	1.7	2.5	0.0	8.5	1.7	5.0	20.0
Shortfall (number)	0.0	0.0	2.0	0.0	2.0	0.8	4.8
Allied health	4.8	0.3	0.7	0.8	8.5	2.6	12.7
Shortfall (number)	9.2	1.0	1.3	1.0	4.2	1.5	18.4

The report is available from VACCHO at: <www.vaccho.org.au>, or telephone (03) 9419 3350.

ACKNOWLEDGMENT: thank you to Tyson Murphy and VACCHO for permission to reproduce this material.

Indigenous employees in the Australian Public Service, 2005

Australian Public Service Commission 2006, *Census Report: Aboriginal and Torres Strait Islander APS Employees*, Australian Government, Canberra.

This publication reported on a review and survey of 2770 Aboriginal and Torres Strait Islander employees in the Australian Public Service in 2005.

Research has shown that managers are one of the strongest drivers of employee job satisfaction and engagement within an organisation. The results of the APS survey reinforce these findings. Factors that are likely to be influenced by management are lack of job satisfaction, employees feeling valued, and lack of workplace support and poor management.

While having a good supervisor was ranked in the APS survey just outside the five most commonly nominated factors influencing job satisfaction, most of the top-five factors have a direct relation to the quality of management. The factors include good working relationships, opportunities to develop skills, flexible working arrangements, and duties and expectations being made clear.

The APS survey highlighted the views of Aboriginal and Torres Strait Islander employees on the effectiveness of their managers in relation to people management and a number of more specific areas.

From a list of 16 attributes, the survey asked respondents to choose the most important attributes they would like to see in a supervisor.

The most highly rated supervisor attributes in the APS survey were:

- demonstrates honesty and integrity
- works with staff to find solutions to problems
- respects employees as individuals
- sets realistic performance expectations
- works effectively and sensitively with Indigenous Australians
- stands up for staff
- possesses relevant job skills
- open to new ideas and ways of working
- provides quality informal feedback
- provides access to effective learning and development
- clearly articulates organisational goals
- empathic and understanding
- respectful of diverse points of view
- demonstrates passion to succeed.

Indigenous employees who participated in the survey also identified factors that negatively impact on their performances at work. These included:

- family responsibilities
- lack of effective management
- lack of clear direction, work plans and timetables
- lack of training
- stereotypes (having to deal with negative stereotypes; for example, Indigenous people are always on leave)
- expectations from Aboriginal and Torres Strait Islander clients
- issues of tokenism (feeling as if you are the 'token' Indigenous Australian in your workplace)
- unrealistic performance expectations and pressure from Aboriginal and Torres Strait Islander clients and/or family
- poor working relationship with supervisors
- poor access to information, resources and/or other technology at work
- Community responsibilities
- systems and procedures that are not culturally supportive (for example, training programs not supportive of learning styles)
- pressure only to be able to work on issues relating to Aboriginal and Torres Strait Islander people
- cultural obligations
- poor working relationship with colleagues
- racism.

The publication is available via the Australian Public Service Commission website: <www.apsc.gov.au/stateoftheservice/0405/indigenous/censusreport.pdf>.

ACKNOWLEDGMENT: thank you to the Commonwealth Copyright Administration for permission to use this material.

The Wur-cum barra employment strategy, 2002–2005

Department of Natural Resources and Environment 2002, 'Wur-cum barra Strategy', in *Wur-cum barra: Creating Employment Opportunities in the Victorian Public Sector for Indigenous People*, Department of Natural Resources and Environment, Victoria, pp. 18–37.

Figures on the Indigenous labour market participation in Victoria indicate significant levels of unemployment in Victorian Indigenous communities.

Wur-cum barra, the Victorian Public Sector Indigenous Employment Strategy, addresses the Victorian public sector's goals of addressing systemic discrimination and promoting diversity in its workforce.

The core components of the framework include Indigenous Employment Plans at an organisational and workplace level; employment targets; key result areas and performance indicators; government-wide strategies; and ministerial oversight and departmental leadership. The strategy is linked to the government's priority on Reconciliation.

The Wur-cum barra strategy framework and key result areas address:

- capacity building and pathways (existing barriers such as literacy, numeracy, post-compulsory schooling, Community social problems etc.)
- recruitment (capacity is affected by social factors that impact on work readiness and self-esteem)
- Indigenous awareness of, and perceptions of, the public sector
- induction and retention (Indigenous employees can experience a range of issues specifically related to their work roles and connection to family and Community, dealing with negative views within the broader Indigenous Community concerning past and current policies, managing personal and Community relationships, dealing with racism and stereotypical views of Indigenous people within the workplace)
- career development
- changing workplace culture (ensuring that workplaces are aware of their capacity to isolate and overwhelm Indigenous recruits and that policies and programs are developed to counter these effects)
- the Indigenous Community organisation sector (with focus on the quality and extent of relationships with Indigenous Community organisations, promoting formal and informal interchanges of staff etc.).

This document is available via the Wur-cum barra homepage on the State Services Authority website: <www.ssa.vic.gov.au/domino/web_notes/ope/rwpattach.nsf/viewasattachmentPersonal/Wur+cum+barra.pdf/$file/Wur+cum+barra.pdf>.

Wur-cum barra Toolkit. Accessed on 15 May 2009 at: <www.ssa.vic.gov.au/domino/Web_Notes/OPE/rwp553.nsf/Web+Pages/0E8C4A361C934D58CA256EBB00190845?OpenDocument>.

The Wur-cum barra electronic toolkit is a resource designed to facilitate the sharing of knowledge, experience and useful tools (for example, sample policies, strategies and resources) that will help create greater employment opportunities for Indigenous people. Sections include:

- recruitment (addressing potential barriers, job design, selection processes, advertising positions, supporting applicants, supporting selection panels)
- recruitment resources/tools
- induction and retention resources and tools (for example, when planning induction, consider/explain entitlements to various types of leave and links to supports, and educate managers and employees so that the workplace is supportive of cultural diversity)
- workplace culture (cross-cultural training, staff networks, partnerships)
- workplace culture resources and tools (for example, for cross-cultural training, seek local input, ensure that there are opportunities for constructive dialogue between Indigenous people and the training participants etc.).

The toolkit provides useful ideas for orgaisations and managers looking to make improvements.

The toolkit is available via the Wur-cum barra homepage on the State Services Authority website: <www.ssa.vic.gov.au/domino/Web_Notes/OPE/rwp553.nsf/Web+Pages/E65CC88A07E9F1A6CA256F47002A350?OpenDocument>.

Other resources

Department of Health Western Australia, Office of Aboriginal Health 2009, *Aboriginal Employment: A Guide to Better Attraction, Selection and Retention Strategies Across WA Health*, Office of Aboriginal Health, Perth. Accessed on 12 October 2009 at: <www.health.wa.gov.au/circularsnew/attachments/377.pdf>.

Provides best practice principles and strategies for attracting, recruiting and retaining Aboriginal employees across WA Health.

Australian Chamber of Commerce and Industry (ACCI) n.d., *Employing Indigenous Australians. Indigenous Employment Strategy: Framework for Industry*, ACCI, Canberra and Melbourne. Accessed on 12 October 2009 at: <www.acci.asn.au/.../Employing%20Indigenous%20Australians%20strategy.pdf>.

Developed for ACCI member associations in successfully implementing an Indigenous employment strategy.

National Aboriginal and Torres Strait Islander Health Council 2008, *A Blueprint for Action: Pathways into the Health Workforce for Aboriginal and Torres Strait Islander People*, Commonwealth of Australia. Accessed on 12 October 2009: <www.aida.org.au/pdf/Pathways/pdf>.

This paper identifies key gaps and barriers in national health workforce policy and program directions, and attempts to influence them by providing strategic advice in relation to Aboriginal and Torres Strait Islander workforce issues.

INTEGRATION BETWEEN HOSPITAL AND COMMUNITY

From the ICAP Program perspective, health services need to develop relationships with Aboriginal people and organisations. For health services, this is the key to improving cultural safety and being able to make appropriate referrals, both to the primary health system and post-discharge. From the perspective of Aboriginal people, these relationships are the basis for building confidence to attend hospital at an appropriate time and for patients to feel safe to identify as Aboriginal people.

The following section draws on reading that is available in the public domain for health services seeking to work more effectively with Aboriginal Community organisations.

USEFUL READING

Mainstream and Indigenous organisation partnerships

Waples-Crowe, P. & Pyett, P. 2005, *The Making of a Great Relationship: A review of a healthy partnership between mainstream and Indigenous organisations*, Victorian Aboriginal Community Controlled Health Organisation, Melbourne.

This publication reports on the apparently successful partnership between mainstream and Aboriginal organisations involved in the Victorian Indigenous Blood Borne Virus/ Injecting Drug Use Training Project.

The review set out to discover what determined an effective working model for a partnership between mainstream and Indigenous organisations—what makes for a healthy relationship, what processes work, and what steps you may need to take in your organisation, whether it is an Aboriginal or a mainstream organisation.

The following list summarises the steps that were important in the collaborative process.

- **A long timeframe:** let the relationship grow at its own pace—not a forced partnership but one built on trust. Get to know each other, work together formally and informally.
- **Building trust:** mainstream organisations need to work with Indigenous organisations in their timeframe and on their priorities, allowing the relationship to develop naturally.
- **Valuing each other:** mutual respect, valuing what each can bring to the partnership, listening to each other and respecting different points of view.

- **Get educated:** it is not up to Aboriginal people to educate the mainstream about all things Aboriginal. Before planning a collaboration, mainstream organisations need to ensure that they have allowed time and allocated funding for cross-cultural training.

- **Good planning:** a successful project is dependent on good planning, which should involve all the key stakeholders.

- **Useful product:** a collaborative project is only as good as what is produced by it.

- **Community-initiated**.

- **Identifying the partners and formalising partnerships:** identify the partners. Even better, include the partners in a formal partnership arrangement such as a memorandum of understanding—this makes all the partners equal and gives the partnership and the project a solid foundation.

- **Supportive work environments:** developing an Indigenous and mainstream collaborative project takes effort and time. For example, mainstream organisations give time and support from their workplaces to make the commitment and the health service embraces opportunities to make the health service more Indigenous friendly, from the executive board down.

- **Cultural awareness:** time to exchange ideas and values helps to build solid foundations. Cross-cultural training at the beginning of any Indigenous/ mainstream collaborative project is highly recommended.

This publication is available by contacting VACCHO, telephone (03) 9419 3350.

ACKNOWLEDGMENT: thank you to Peter Waples-Crowe, VACCHO, for permission to cite this material.

Protocols for working with the Indigenous Community

Hurley, A. 2003, *Respect, Acknowledge, Listen: Practical protocols for working with the Indigenous Community of Western Sydney*, Community Cultural Development NSW, Sydney.

Although this document was not developed in Victoria, it includes Indigenous protocols documentation (examples are outlined in Section 9 of the source document). The following suggestions are summarised from the original publication.

- **Get to know your Indigenous Community.** Make appointments to meet Community organisations and health services. You may have to organise meetings through other Indigenous people.

- **Attend, participate in and support Indigenous events** (for example, NAIDOC Week celebrations). Use Indigenous publications such as the *Koori Mail* and *National Indigenous Times*, and the ABC Message Stick website.

- **Consult:** consultation should not be tokenistic. Negotiation needs to occur for equal relationships to develop. Focus on issues that are of interest and advantage to the Indigenous Community.

Seek a facilitator or chairperson who is impartial.

When establishing a reference group or steering committee, it is important to advertise an expression of interest to allow a broad representation. Take account of issues such as language. Responses such as silence do not necessarily mean acceptance.

- **Get permission:** this includes the local Community, Elders and traditional owners according to what is required.

Copyright and moral rights are very important issues to be aware of.

- **Communicate:** the communication process requires a variety of skills (for example, respect, good listening, patience, understanding, common language, confirmation, clarification). For some good points to remember, see sections on language, Koori time, reporting back and staying in touch.

- **Ethics and morals:** confidentiality and privacy are essential—traditional customs and stories may be given to you in trust and cannot be reproduced without permission.

The integrity and trust you develop within an Indigenous Community is vital and must be maintained. Acknowledgment and attribution of clans, Elders, traditional owners, information, ideas and research has to be written into any documentation and verbalised in speeches, talks and presentations. Any advertising, media releases, news articles etc. concerning Indigenous people should only be made with the prior knowledge and agreement of the Community concerned.

- **Correct procedures:** respect and acknowledgment are common procedures for working within Indigenous communities (for example, welcomes and acknowledging traditional owners).

What to call people—some Indigenous people prefer to be called Indigenous, others prefer Aboriginal (in the same way that some people prefer Torres Strait Islander to Islander). Try and gauge how people want to be addressed.

Traditional Welcome or Welcome to Country—these are mostly performed at major events and meetings.

Paying people—if Indigenous people choose to work with you in any capacity (for example, in giving a dance performance, giving a speech, a talk or Traditional Welcome, or doing or participating in artwork or a project), it is appropriate that they be paid for time, expertise and knowledge, just as it is for any other artist or professional.

Indigenous involvement—in working with the Indigenous Community on Indigenous projects, it is vital to have Indigenous involvement throughout.

Cross-cultural training—protocols are a useful cross-cultural tool.

Respect, Acknowledge, Listen: Practical protocols for working with the Indigenous Community of Western Sydney can be downloaded from the website of Community Cultural Development NSW: <www.ccdnsw.org/ccdnsw/pdf/protocols.pdf>.

ACKNOWLEDGMENT: thank you to Anne-Marie Slzazko, Communications Manager, Community Cultural Development NSW for permission to use this material.

Cultural guides, mentors and Community resources

Alberts, V. & McKenzie, A. 2003, *Suggested Guidelines for the Development of Indigenous Cultural Mentors* (booklet), James Cook University, Townsville, Qld.

These guidelines were developed through a funded collaboration between chief executive officers and other representatives from Aboriginal Medical Services in North Queensland and the GP Training Program in North Queensland and the Northern Territory.

The main focus of this initiative was to improve cross-cultural training, undergraduate education and cultural supervision of research. It provides useful principles for mainstream services looking to develop opportunities to draw on cultural guides and mentors.

Outlined below are summaries of key points:

- the roles of cultural mentors: this may include advice on cultural matters to participate in cultural awareness programs, to be a Community contact for social events (for example, NAIDOC Week) and having input into policies and procedures
- qualifications and skills: this considers a person's standing—a person who is respected, is familiar with local health services but independent of them, has instructional skills, interpersonal skills, communication skills and broker skills, and is able to handle conflict resolution
- selection process
- boundaries and supervision
- activities of mentoring
- terms and conditions, including remuneration: adequate resourcing is important as it shows that the educational input of mentors is valued.

Suggested Guidelines for the Development of Indigenous Cultural Mentors can be downloaded from the Royal Australian College of General Practitioners website: <www.racgp.org.au/Content/NavigationMenu/Advocacy/AboriginalandTorresStraitIslanderHealth/Projectreports/20030115nationalguidelines.pdf>.

ACKNOWLEDGMENT: thank you to Val Alberts for permission to reproduce this material.

INTEGRATION WITH COMMUNITY: GOOD PRACTICE EXAMPLES

During the stakeholder interviews for the ICAP Resources Project, several regional health services demonstrated good working relationships and solid integration with ACCHS.

- **Ballarat Health Service (BHS) and the Ballarat and District Aboriginal Cooperative (BADAC)**

  The Aboriginal Health Taskforce includes the Chief Executive Officer (CEO) of BHS, the CEO of BADAC, and health unit managers. The CEO of BADAC is the chairperson.

  The location of meetings alternates between BHS and the BADAC. There is a formal partnership agreement and an annual action plan. The taskforce meets quarterly. The four agreed priority areas are women's health, men's health, psychiatric services and access to the Emergency Department at BHS. The group talks through issues, which allows opportunity for exchange of information and knowledge sharing.

- **Goulburn Valley Health (GVH) and Rumbalara Co-operative**

  The Aboriginal Health Taskforce includes the CEOs of both GVH and the Rumbalara Cooperative and two board members from each organisation, senior staff of the Cooperative, the executive sponsor from GVH, the two AHLOs, managers of other key programs and several Aunties who have remained involved over 11 or 12 years. Internal GVH expectations are that board members choose portfolios and have high profile involvement in these—Aboriginal health is one of the portfolios.

  The location of meetings rotates between the health service and the Co-operative. There is a formal partnership or Outcomes Agreement between GVH and Rumbalara (a copy of this agreement is included in Section 5: Practice examples from Victorian health services. At present the Outcomes Agreement has three agreed priority areas: data and research, health priorities, and Community relations (to increase the Aboriginal health profile, create a visible presence in the hospital and to acknowledge significant events such as NAIDOC Week and Sorry Day).

  The taskforce is looking at specific disease groups—chronic illness, diabetes, heart disease, spiritual health, and wellbeing and oral health.

INFORMATION MANAGEMENT

Improving identification of Aboriginal and Torres Strait Islander people who attend hospitals is essential to service planning and provision. Since 2004/05 the Victorian Government has funded a WIES supplement of 30 per cent for Aboriginal and Torres Strait Islander patients. Accurate identification is therefore essential to enable health services to undertake improvement initiatives.

STAKEHOLDER FEEDBACK: IMPROVING ABORIGINAL AND TORRES STRAIT ISLANDER IDENTIFICATION

The ICAP Resources Project sought stakeholder feedback on improving Aboriginal and Torres Strait Islander identification.

Training to ask the mandatory question

Many health services are focusing on training staff in first contact areas to ask the mandatory question for accurate identification—'Are you of Aboriginal or Torres Strait Islander origin or descent?' AHLOs or Aboriginal Policy and Planning Officers frequently provide face-to-face training of frontline hospital staff. They convey the need to get away from appearance-based determinations and discuss how to manage challenging patient responses.

Addressing errors in identification

> *Ask: Does the problem lie with our systems and processes or are they individual?*
>
> *AHLOs do make data changes on Patient Administration Systems. Caution—this can mask the identification problem. If patients have not been picked up, call the area, reinforce, go up to see, remind them.* (Supervisor, metropolitan health service)

Good practice examples

> *We have postcards to prompt staff to ask the question, 'Are you an Aboriginal or Torres Strait Islander?' We feel it is best to train from inside the organisation. AHLOs do this—it builds relationships and it is a more direct approach. We work hard on accurate identification. If patients are not picked up and we become aware of them later, we call the area where they first presented.* (Manager, Royal Women's Hospital)
>
> *A manager from the Monash Medical Centre described the AHLO going up to key admissions staff and asking and checking as important reinforcement: 'it creates a "drip effect" to educate and remind people'.*
>
> *You have to do the training for clerks and reinforce the information about identification again and again. At [the Royal Children's Hospital] the head of Medical Records is on board—this is important. In examining errors in identification, you need to ask is it individual, e.g. one area or clerk, or is it systemic and related to poor processes and training.* (Manager, Royal Children's Hospital)

Aboriginal health staff completed Train the Trainer courses with DOH a few years ago and they presented at the hospital's Staff Forum. Participants at the forum were surprised about the WIES impact and the dollar implications when identification data is accurate. It led to greater understanding. This and the fact that patients get extra services (like Gold Card Veterans) helps the argument that identification is a good thing. (Manager, Austin Health)

The AHLO Program runs tutorial sessions for these areas and we have developed a resources folder—we have it on line and a hard copy in the library. (Manager, Mercy Hospital for Women)

We provided frontline training to key staff. The presenters were the Koori Human Services Unit, the AHLO and a local Elder [who] gave the perspective of the patient about being asked the identification question. We also gave the same session for a group of Elders focusing on why the question is asked. (Manager, Goulburn Valley Health)

USEFUL RESOURCES

The ICAP Aboriginal and Torres Strait Islander identity poster and brochure are available for all Victorian health services and can be tailored to include photographs and contact details for AHLOs.

The ICAP Metropolitan and Rural Project Officers can be contacted regarding these materials: telephone (03) 9288 3437 (metropolitan) and (03) 5333 6043 (rural). Further information about the materials is also provided at Appendix II to this section of the resource kit.

Please contact the DOH Koori Human Services Unit for guidance and assistance in training frontline staff regarding Aboriginal and Torres Strait Islander identification: telephone (03) 9096 7032. Example training materials are also included in Section 5 of this resource kit.

GOOD PRACTICE EXAMPLES: EFFECTIVE DATA USAGE

All the health services that participated in the ICAP Resources Project appear to be tracking WIES data as a minimum. Several are using the data for service planning and improvements.

- **Ballarat Health Service (BHS)**

  BHS makes quarterly reports to the Aboriginal Health Taskforce, on which Community organisations are well represented. Data provided includes inpatient, outpatient (OP) and emergency presentations, OP failures to attend and live births. The OP failure-to-attend rate is 15 per cent for BHS patients overall, but around 35 per cent for Aboriginal patients. The OP Director and Health Unit Manager are responsible for reviewing this and considering options such as the possibility of sending an SMS reminder and/or adding a question on the discharge planning tool to let the Rumbalara Co-operative know of planned OP appointments. Outcomes are tracked and reported.

- **The Royal Children's Hospital (RCH)**

  Hospital representatives consistently spend time at the monthly Aboriginal Liaison Policy Advisory Committee considering Aboriginal and Torres Strait Islander data (for example, where patients are from and what the issues are). The information drives strategy and policy. Some years ago it was noticed that children were arriving at the hospital from the Northern Territory for cardiac surgery and many needed to have their teeth fixed before they could have the surgery. For the children and their families, this meant delays and unnecessary time spent away from communities and their families. There were accommodation problems because they could not be admitted while their teeth were being fixed.

  The hospital's experiences with five families led to a shift in processes. The AHLO went to the Northern Territory to establish processes to ensure that patients were appropriately 'worked up', including dental treatment, prior to arrival at the RCH. The cases led to collaborative work between the hospital and Aboriginal Hostels Limited, and culminated in the establishment of Aboriginal Hostel accommodation across the street from the RCH.

- **Western Health**

  Review of data on utilisation showed that the majority of Indigenous patients from the region drove past the hospital to go elsewhere to hospitals that employed AHLOs and had specialist services. For this health service, which has the highest number of diverse cultural groups of any region, cultural responsiveness is core business. The health service agreed to fund a time-limited Aboriginal health project, which has now become permanent. Data is routinely used in planning.

- **St Vincent's**

  In 2007, a review by St Vincent's Hospital Admission Risk Program (HARP) examined the extent to which Aboriginal and Torres Strait Islander patients access HARP including Community outreach programs. For example, St Vincent's at Home (home nursing service) and the Cottage, which is a short stay facility for unwell disadvantaged people.

  For the period 2006/07, a total of 85 Aboriginal and Torres Strait Islander people were linked in to at least one of these programs. Overall, these figures represent 2.7 per cent of the patients managed by this group of departments during the time period. This is a similar percentage to the health service's population overall. This indicates that these programs are accessible to St Vincent's Aboriginal and Torres Strait Islander patients.

  Aboriginal and Torres Strait Islander patient attendances in the Emergency Department over a 20-week period were reviewed. Sixty per cent of attendances occurred after hours when there was no AHLO on duty. For eight per cent of attendances, the patients left without being seen by the doctor or with an incomplete episode of care.

This information was fed back to St Vincent's Aboriginal Health Discharge Working Group. To begin with, to try to make the Emergency Department a more welcoming environment, a large Aboriginal painting was purchased and displayed in the foyer of the Emergency Department. The painting, *YIRUK (Wilson's Promontory)* is by local Aboriginal artist Ray Thomas.

The ICAP Project Officers have also provided a tip sheet regarding the use of hospital data in Section 5 of this resource kit.

AHLO STAKEHOLDER FEEDBACK: DATA REPORTS

Two Aboriginal stakeholders made a number of points on data collection. The first describes the limitations of AHLO metropolitan health service data collection on AHLO hospital work:

> *I saw 87 clients last month but could only report the five inpatients and not the 82 outpatients in the stats that got reported to DOH. The hospital only recognises the inpatient data and gives this to DOH.*
>
> *I receive only the inpatient and outpatient [Aboriginal and Torres Strait Islander] reports but not those that present in the Emergency Department.*
>
> *I am very concerned that important data is lost, which means that only part of the picture is being seen and that a holistic and true account of Aboriginal health is not being documented.*
>
> *All of this affects the program planning, strategic planning, and it is not reflective of the funding that should be included in the WIES dollars—age, gender, diagnosis is not included for outpatients and what diseases they are presenting with.* (AHLO, rural health service)

The second stakeholder said:

> *Aboriginal patient data needs to be properly analysed. Recruitment of an Aboriginal staff member to manage and analyse data could happen regionally.*
>
> *Remove data responsibility from the AHLO to let them get on with their job.*
>
> *Data should be able to be accessed by [the National Aboriginal Community Controlled Health Organisation] and VACCHO so that they can input into the distribution of funding and programs* (Aboriginal worker, rural health service).

A RESEARCH FELLOW'S VIEWPOINT ON DATA REPORTS

The ICAP Resources Project Team consultants sought the views of an experienced research fellow working in a metropolitan health service in the area of Aboriginal health. The feedback is outlined as follows.

Mechanisms are required for:

- local and State Aboriginal Community organisations to identify their data requirements and tailor reports to reflect these needs
- Aboriginal interpretation of data, both local interpretation of data and at State level
- effective communication of relevant results to AHLOs, VACCHO, local Aboriginal health services and hospitals, Divisions of General Practice and Community health centres
- accurate identification of Aboriginal patients in hospital records
- building Indigenous capacity for analysing and interpreting data through professional development and research skills, support and mentoring programs.

Other principles to consider:

- data collection should not add to the burden of work for AHLOs
- Indigenous health data analysis and interpretation is a specialised activity
- local communities need adequate time to consider data and complete and disseminate their own interpretations of local data.

Possible mechanism for data management and use:

- establishment of an Aboriginal Health Information Unit as a partnership between community-controlled State-wide organisations and hospital data units/Victorian Government allowing use of analysis of data
- establishment, funding and development of designated positions within Aboriginal State-wide bodies, whose role it is to liaise and collaborate with the Koori Human Services Unit and hospital data units regarding data analysis, interpretation and reporting.

APPENDICES

APPENDIX I: A QUICK BACKGROUND GUIDE

This appendix provides information on the Aboriginal Hospital Liaison Officer (AHLO) Program and initiatives that led to the implementation of ICAP. It also includes a who's-who of key ICAP stakeholders.

The following timeline outlines key events in the establishment of the AHLO Program and changes made prior to the introduction of ICAP. This is followed by background information covering the history of the AHLO Program's management, as well as program goals and objectives.

AHLO Program background

1980 The Working Party into Aboriginal Health was established in Victoria by the Minister of Health.

1981 *The Report of the Working Party* included a recommendation to establish an Aboriginal Hospital Liaison Officer Program.

1982 The AHLO Program was established. Aboriginal people would be employed in Victorian hospitals as a way of ensuring equitable access to mainstream health services and increased levels of awareness and sensitivity of services delivered to Koori people.

1982–86 Eighteen AHLO positions were progressively introduced into Victorian hospitals.

1989 The *National Aboriginal Health Strategy* endorsed the role and functions of AHLOs and recognised and recommended the expansion of the program in areas of high utilisation and high need.

1991 The Royal Commission into Aboriginal Deaths in Custody (report published in 1992) also recognised the important role of AHLOs. It recommended urgent program expansion, employment of Aboriginal people as health care workers, and endorsement and recognition of them as part of an effective therapeutic team.

1992 Ten years after the inception of the program, the Koori Health Unit undertook a review of the program. One key decision was to devolve responsibility for management of program delivery to the employing hospitals.

2002 Responsibility for the program was transferred to Department of Human Services Victoria (DHS, now Department of Health Victoria, DOH) regional offices. They took over program coordination and monitoring responsibilities for those programs located within their regional catchments areas, and the Metropolitan Health and Aged Care Division did so for those located in the Melbourne metropolitan region. The amendments were made in consultation with AHLOs, employing hospitals, the Koori Health Unit and regional DHS offices.

The numbers of AHLOs employed in hospitals barely altered in the next 15 years, although some hospitals established positions without new funding from government.

Program management

At its inception, the AHLO Program, known then as the AHLO Program, was managed, coordinated and monitored centrally within DHS via the former Koori Health Unit. This is now referred to as the Koori Human Services Unit. Within the Koori Human Services Unit there have been changes over the years consistent with the overall direction set by DHS/DOH.

The Unit has moved away from program delivery to policy advice, program development, program monitoring and review, and supporting regions in the implementation of programs.

Program goals

The AHLO Program had four key goals to inform the work of liaison officers:

- improve access and availability of appropriate health care services and preventive health services to Aboriginal people
- ensure the provision of resources, information and programs to Koori patients so that informed decisions concerning treatment, prevention and rehabilitation can be made by individuals and their families
- improve the ability of health care providers to meet the particular needs of Aboriginal patients and their families
- increase the sensitivity of health care providers to Aboriginal health issues.

Program objectives

There have been eight key objectives for the program:

- create a level of awareness among Aboriginal communities of the various health-related services that are available
- ensure services received by individual Aboriginal patients presenting for treatment are appropriate to their needs

- raise awareness within the Koori Community of the importance of continuity of health care
- ensure individual Aboriginal patients are aware of alternative options available to them in both treatment and health-related matters
- facilitate cross-cultural education for health care providers on the needs of Koori patients and their families
- promote an approach to holistic health care that recognises environmental, social, economic and spiritual influences
- improve the quality and accessibility of Aboriginal health statistics in Victoria
- encourage members of the Aboriginal Community to identify as Aboriginal when presenting for treatment at health care agencies, so as to improve the quality of Aboriginal health statistics in Victoria, resulting in more informed decisions about the needs of Aboriginal people.

The Aboriginal and Torres Strait Islander Hospital Accreditation Project Community Report June 2004: Summary of findings from hospital case studies and recommendations for accreditation.

The Victorian Government commissioned a project to develop a strategy for the accreditation of public hospitals with regard to the reporting of Indigenous status and the provision of hospital services for Aboriginal and Torres Strait Islander patients. The project culminated in a report published by the VicHealth Koori Health Research and Community Development Unit, at the University of Melbourne. Copies are available at *Onemda* VicHealth Koori Health Unit: telephone (03) 8344 0813 or see <www.onemda.unimelb.edu.au/publications>.

The project was undertaken through a collaborative effort between the VicHealth Koori Health Research and Community Development Unit (now *Onemda* VicHealth Koori Health Unit) at The University of Melbourne and the Centre for Health and Community Services at La Trobe University.

Key stakeholder groups that were consulted included:

- DHS (Koori Information Plan Steering Committee)
- the Victorian Aboriginal Community (regional and executive meetings of VAACHO)
- membership of the Community Steering Committee
- key Aboriginal Community members
- acute care service providers (eight hospitals).

The methods used to achieve the project aim comprised:

- case studies in eight Victorian acute care facilities
- a review and analysis of national and international literature
- the development of a *Framework for Review*—a set of quality parameters against which services can be audited
- the trial of the framework and development of an accreditation implementation strategy.

The findings for the acute care reviews showed that practices varied considerably and that there was little evidence of a systemic organisation-wide approach to address issues of accurate identification and culturally sensitive service provision.

Consequently, the *Framework for Review* was designed to assist agencies to audit roles, responsibilities and outcomes and to identify strategies for sustaining desirable practices related to the identification and provision of services to Aboriginal people.

The major areas that formed the basis for the *Framework for Review* were:

- staff values, skills and knowledge related to cultural sensitivity in the provision of services to Aboriginal people
- relationships with Aboriginal organisations and services
- inter-agency and interdisciplinary planning and evaluation processes that focus on the particular cultural and social needs of Aboriginal people
- systems and resources to support staff to make timely and relevant referrals and seek appropriate involvement of Aboriginal workers and agencies
- information technology systems that support the recording of Aboriginal and Torres Strait Islander status and communication between staff and departments
- evaluation of the effectiveness of the identification and recording system.

The framework was trialled in six of the eight acute care agencies that participated in the case studies. Generally it was found to be a useful instrument for audit purposes. The trial also confirmed the need to ensure that the identification of Aborigines and the provision of culturally sensitive services should be understood and addressed, similarly to any other 'quality' matter, and should be woven into the generic quality assurance and improvement systems that exist in hospitals. This project was a precursor to the implementation of ICAP.

The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) reform 2004

The reform heralded a different approach to Aboriginal health funding and accreditation for Victorian public hospitals.

Key elements of the reform were:

- a clear focus on the outcomes—cultural change in health services leading to improved identification and health care for Aboriginal patients
- a recognition that Aboriginal patients are everybody's business
- the establishment and strengthening of relationships with Aboriginal people and organisations
- more Aboriginal workers in hospitals
- an increase in the acute hospital funding supplement for Aboriginal and Torres Strait Islander patients from 10 per cent to 30 per cent in 2004/05
- that health services must produce an ICAP plan—the scale and cost of initiatives undertaken by hospitals should be proportional to the number of Aboriginal patients treated
- the provision of two Project Officers—one metropolitan and one rural—to assist with reforms
- VACCHO's support role for Aboriginal staff and a third Project Officer established at VACCHO.

Why was there a need for reform?

Reform was necessary because there was:

- a need to respond to the current health issues facing Aboriginal people
- a need to address the issue of under-identification and late presentation to hospitals by Aboriginal patients
- concern about the lack of equitable distribution of AHLO positions across the State, particularly in the metropolitan region
- a need to address training and support issues for AHLOs as a vulnerable, often isolated group of hospital employees.

Progress and achievement

Victorian health services were supported by the Project Officers to drive change, implement ICAP and achieve results.

There are four key result areas for hospitals:

- culturally aware staff
- relationships with Aboriginal communities
- discharge planning
- primary care referrals.

Who's-who of key players in ICAP

There are several key stakeholders that are pivotal to Victoria's Aboriginal Health Strategy. The key stakeholders are:

- DOH Koori Human Services Unit
- DOH regional offices
- ICAP Advisory Committee
- ICAP Management Group
- ICAP Project Officers
- VACCHO
- Hospitals
- Aboriginal Hospital Liaison Officers (AHLOs)
- Aboriginal Community-Controlled Health Organisations (ACCHOs).

What are their roles?

This section outlines the roles of the key stakeholders.

DOH Koori Human Services Unit

- Has overall responsibility for the ICAP Program and its implementation.
- Is responsible for the ongoing monitoring and review of ICAP implementation via reports from project officers and annual Quality of Care Reports from health services.
- Undertakes formal evaluations when required and makes recommendations to the DOH Executive regarding any changes to the ICAP program.

DOH regional offices

Through Aboriginal Planning Officers, DOH supports the ICAP Program at a regional level through funding discussions with health services. DOH regional representatives also participate in the ICAP Advisory Committee.

ICAP Advisory Committee

The ICAP Advisory Committee meets annually to address strategic ICAP planning issues and priorities and to contribute to ICAP policy development. Members include:

- the ICAP Management Group
- invited senior representatives from DOH, VACCHO, hospitals and ACCHOs
- other relevant stakeholders/advisers as identified.

Subgroups may also be formed from interested members of this committee and other key stakeholders to plan and progress specific ICAP projects.

ICAP Management Group

The ICAP Management Group consists of the three ICAP Project Officers and their respective managers (from DOH, VACCHO and St Vincent's). This group meets every six weeks to oversee the ongoing implementation of the ICAP Program, by:

- addressing operational matters
- acting as a support group for decision making by the ICAP Project Officers.

ICAP Project Officers

DOH funds three project officers to assist in implementing the ICAP Program. One is based at St Vincent's and focuses on metropolitan health services. One is based in DOH, at the Ballarat office, and focuses on rural health services. The third position is based at VACCHO and has a focus on Aboriginal staff and Aboriginal Community-Controlled Health Organisations (ACCHOs).

All three positions work together as a team and their areas of focus are not intended to exclude work in other areas.

The key responsibilities of the Project Officers are to assist health services and Aboriginal organisations in the implementation of the ICAP Program including:

- the establishment and maintenance of partnerships, and to assist in program planning and policy development at individual health services
- the creation and maintenance of a staff network and to provide support to Aboriginal staff working in health services
- documentation and dissemination of best practice examples across the sector
- creation of resources to assist health services in implementing the ICAP Program, and maintenance of ICAP resources
- taking a lead role in the planning, operation and evaluation of best practice forums and AHLO staff network meetings
- in consultation with key stakeholders, development and management of strategic projects.

VACCHO

As the key partner in the ICAP Program, along with DOH, VACCHO represents the interests of Aboriginal staff in health services and Aboriginal organisations to ensure that the ICAP Program is implemented in a culturally relevant way.

Through its Project Officer, VACCHO specifically provides:

- cultural support for Aboriginal staff in health services
- assistance in engaging Aboriginal staff in the ICAP Program
- organisation and delivery of culturally appropriate training for AHLOs that is not provided elsewhere
- joint planning and provision of best practice forums and AHLO network meetings to assist and support AHLOs in their role.

Hospitals (health services)

Health services implement the ICAP Program by employing both Aboriginal and non-Aboriginal staff to undertake quality improvement activities to meet the ICAP Key Result Areas.

St Vincent's Hospital:

- hosts the Senior Metropolitan ICAP Project Officer position
- is a member of the ICAP Management Group (as a generic hospital representative and the host of the Metropolitan ICAP Project Officer position) and ICAP Advisory Committee (as both a St Vincent's and ICAP Management Group representative).

The decision to host the Metropolitan ICAP Project Officer position at St Vincent's was based on:

- the need to ground one of the project officer positions in a hospital
- St Vincent's longstanding experience of providing an AHLO program (for 25 years as of 2008)
- St Vincent's physical proximity to and established relationships with VACCHO, DOH and VAHS.

Aboriginal Hospital Liaison Officers (AHLOs)

AHLOs play an integral role in hospital ICAP programs by providing Aboriginal patient liaison and support, improving identification of Aboriginal patients, and acting as a cultural broker and educator between Indigenous and non-Indigenous staff and services. AHLOs should also be involved in broader planning, implementation and evaluation of hospital ICAP programs, in line with the ICAP Key Result Areas.

Aboriginal Community-Controlled Health Organisations (ACCHOs)

It is important for hospitals to involve relevant ACCHOs in the planning, implementation and evaluation of their ICAP programs in order to:

- identify culturally appropriate priorities and processes
- inform and assist progress against the ICAP Key Result Areas
- validly assess outcomes for the Aboriginal Community.

APPENDIX II: GUIDELINES FOR ABORIGINAL AND TORRES STRAIT ISLANDER IDENTITY POSTER AND BROCHURE

The following information is a summary of the guidelines that were used to develop and produce an Aboriginal and Torrs Strait Islander identity poster and brochure for Victorian health services.

Introduction

Many ICAP staff feel the national Aboriginal and Torres Strait Islander identity poster and brochure produced by the Australian Bureau of Statistics (ABS) are not appropriate for Victorian health services. In response, it was agreed that a localised version of these materials would be produced as part of the ICAP Program.

Process

Initially, this project was discussed at a AHLO network meeting at VACCHO in late 2005. It was decided that a working group would be established to oversee the production of draft materials. This group consisted of five AHLOs, the then Metropolitan ICAP Project Worker and the Coordinator, Aboriginal Hospital Liaison Officer Support and Coordination Program.

It was agreed that this working group would produce a draft poster, poster, brochure and guidelines and circulate these to other Liaison Officers for comment. After reviewing comments from AHLOs, this working group confirmed the design and agreed to proceed with production.

Recommendations

The working group proposed these recommendations:

1. Each health service would have its own distinct poster and brochure but a common format would be developed including a main community photograph and photographs of liaison staff.

2. Health service responsibilities:

    a. the organising and taking of photographs

    b. gaining DOH consent from people in photographs for images to be used in an identity poster and brochure

    c. gaining approval for use of organisation logo on the poster and brochure

    d. title, position and contact details for liaison staff photographs.

3 Metropolitan ICAP Project Worker responsibilities:

a. oversee the development of each poster and brochure

b. organise and fund a limited one-off print run of posters and brochures for each health service.

Posters and brochures

Posters and brochures will be supplied to each health service (not each hospital) at no cost. Approximate poster and brochure numbers will be as follows:

- A2 (one poster)
- A3 (five posters)
- A4 (ten posters)
- 500 brochures.

If more posters or brochures or a different assortment are required, please discuss with the Metropolitan ICAP Project Officer. Additional materials and changes can be arranged upon payment from the requesting health service.

(Please note that an example poster and brochure are available in Section 5: Practice examples from Victorian health services.)

Health services with no Aboriginal staff

Health services that do not have Aboriginal staff may wish to consider developing a generic poster and brochure based on the ICAP templates, or using the ABS poster and brochure, which were updated in mid-2009. The ABS materials can be downloaded from the ABS website at <www.abs.gov.au> or ordered free of charge by calling 1300 135 070.

Assistance

For assistance with any part of this process, contact the Metropolitan ICAP Project Officer, Raelene Lesniowska on (03) 9288 3437 or 0458 399 067.

APPENDIX III: AHLO MANAGERS NETWORK TERMS OF REFERENCE, 2009

Aims

To provide a professional support network/staff business meeting for managers of metropolitan Aboriginal Hospital Liaison Staff (AHLOs) to:

- provide mutual support and advice
- share information about community and professional issues and effective work, management and program practices
- enable AHLO managers to develop competencies in cross-cultural management
- provide professional development opportunities
- identify gaps that need to be addressed to enable improved care for Aboriginal and Torres Strait Islander patients
- develop special group projects to address identified needs
- identify action items to be fed back to the ICAP Management Group (see diagram below) and AHLOs, as agreed by meeting participants.

Outcomes

- Increased support, communication and information sharing among AHLO managers.
- AHLO managers more informed about current issues and practice examples.
- Increased tools and competencies to enable AHLO managers to effectively (and culturally appropriately) do their job.
- Progression of ICAP issues and projects.

Participants

Managers

- This network is predominantly for managers of AHLOs employed in metropolitan health services.
- In health services that have additional or alternative management-level staff employed to implement ICAP initiatives (for example, policy officers, ICAP coordinators etc.), these staff may wish to attend, in addition to or in place of the AHLO manager.

- To keep numbers manageable, no more than two management staff from each health service should attend any one network meeting.
- Attendance at meetings is optional, though encouraged for all AHLO/ICAP managers and may vary from meeting to meeting.

Other

- The Metropolitan and VACCHO ICAP Project Officers will attend to answer questions, provide ICAP updates and input as required, and record agreed action items to report back to the ICAP Management Group and AHLOs.
- Guest participants/presenters may be invited to attend certain meetings, if agreed by the network participants.
- On occasion, the AHLO Managers Network may be coordinated to fall on the same day as the AHLO network meeting and the two groups could come together for a set period (e.g. lunch) for networking and information exchange, as agreed by the two groups.

Frequency

Meetings will be held on a bimonthly basis.

Duration

Meetings will be from 9 am to 11 am, including morning tea.

Venue

- The first meeting was held at St Vincent's Hospital on 8 May 2009.
- Future meetings will be rotated around participating health services, to be decided at the end of each meeting.
- One meeting per year may be held at a less formal, neutral venue for an informal network meeting, such as a lunch, as agreed by the network participants.

Administration

The host venue for each meeting will be responsible for:

- booking a room and catering (and billing ICAP for catering costs)
- planning and circulating an agenda
- arranging any agreed site tours/visits and guest speakers
- typing up and circulating minutes/action items.

Agenda items

- Agenda items can be discussed at the end of each meeting for the next meeting.
- Draft agendas will be circulated one week before the meeting for feedback and finalisation.

Progression of ICAP issues

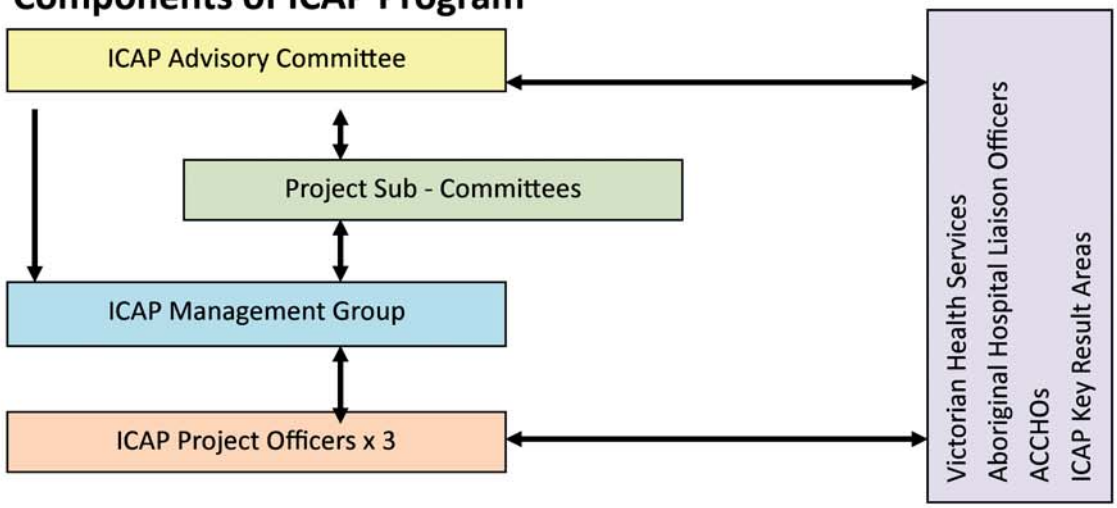
Agreed action items raised at this network will be fed back to the ICAP Management Group and AHLOs, as decided by the participants at each meeting.

Equally, issues/feedback arising from the ICAP Management Group and AHLO network will be reported and addressed via this network.

Review

These terms of reference will be reviewed annually.

Components of ICAP Program



ICAP ADVISORY COMMITTEE

Membership: Broad based including interested form ICAP Steering Committee members, specialist advisors and other key stakeholders.

Aim: To address strategic planning issues and to contribute to ICAP policy development.

Meeting Frequency: Annually

ICAP ADVISORY COMMITTEE – Sub groups

Membership: Nominated members of the ICAP Advisory Committee and other key stakeholders as relevant.

Aim: To plan and progress specific ICAP projects.

Meeting Frequency: According to project timelines.

ICAP MANAGEMENT GROUP

Membership: ICAP project officers and their respective managers. .

Aim: To address operational matters

To act as support group for decision making by the ICAP project officers

Meeting Frequency: Six weekly

ICAP TEAM

Membership: ICAP project officers (metropolitan, rural and VACCHO) .

Aim: To plan and progress activities within the ICAP work plan

To discuss emerging issues

To provide peer support

Meeting Frequency: Annually

SECTION 4: CULTURAL COMPETENCE AND AWARENESS INFORMATION FOR HEALTH SERVICES

This section is relevant for ICAP stakeholders who are interested in developing knowledge and ideas about cultural competence—in particular, supervisors of AHLOs and other hospital managers. The section specifically includes:

- models of cultural competence and key definitions
- a review of the literature on cultural competence
- recommendations on cultural awareness training made by the key stakeholders who provided feedback to the ICAP Resources Project.

Material is included on the development of cultural awareness training in health services in accordance with ICAP Program objectives.

REVIEW OF THE LITERATURE

OVERVIEW OF THE LITERATURE

There is a range of published and Internet-based material available on cultural competence. This includes general, theoretical, professional, educational and policy material.

It was beyond the scope of the ICAP Resources Project to conduct an exhaustive review and analysis of the literature. Instead, we sought to source information requested by stakeholders and material that throws light on key themes raised by those who participated in the project.

This section covers definitions, several frameworks and models of cultural competence and guidelines for delivering Indigenous content. It includes some ideas from sourced professional literature and Internet-based material on competencies needed by supervisors and managers in health services where there is cultural diversity.

CULTURAL SAFETY AND CULTURAL SECURITY

The following publications define *cultural safety* and *cultural security*.

Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand 2005, *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice*, Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand, Wellington. Accessed on 7 April 2009 at: <www.nursingcouncil.org.nz/cultural%20safety.pdf>.

In 1990 the Nursing Council of New Zealand incorporated cultural safety into its curriculum assessment process. The concept of cultural safety incorporates a broad definition that expresses the diversity that exists within cultural groups. It includes cultural groups that are as diverse as social, religious and gender groups and is in addition to ethnicity.

The Nursing Council of New Zealand's definition of cultural safety is: 'The effective nursing practice of a person or family from another culture, and [it] is determined by that person or family' (p. 4).

In relation to the application of cultural safety:

> *The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual* (p. 4).

The guidelines define culture as including but not restricted to:

- age or generation
- gender
- sexual orientation
- occupation and socioeconomic status
- ethnic origin or migrant experience
- religious or spiritual belief
- disability (p. 6).

Cultural safety is an approach that recognises diversity and individuality.

Safe service is defined by those who receive the service. Implications include demonstrating flexibility in relationships and examination of one's own realities and attitudes.

Clarke, A., Andrews, S. & Austin, N. 2000, *Lookin' after Our Own: Supporting Aboriginal families through the hospital experience*, Aboriginal Family Support Unit, Royal Children's Hospital, Melbourne.

Consideration of how to define cultural safety is provided in an extract from the book written by Aboriginal Health Unit staff from the Royal Children's Hospital.

> *There are many interpretations of cultural safety. Our interpretation developed here at the hospital when we began to sense the overwhelming need for families to feel at ease and safe. All our initiatives for the Koori program were set up to work toward making the hospital experience for our families as culturally affirming as possible.*
>
> *It is the right of our families to be able to express and be proud of their culture. We, as Kooris, acknowledge that western culture is no more or less important than our own culture. We do not force or inflict our views on others and we ask that our families be afforded the same courtesy—without the expectation that they conform to non-Aboriginal ways* (p. 76).

Houston, S. 2001, *Aboriginal Cultural Security: A background paper*, Perth Health Department of Western Australia, Perth. Accessed on 5 October 2009 at: <www.aboriginal.health.wa.gov.au/docs/cultural_security_Discussion_document.pdf>.

> *Cultural security is commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration* (p. 2).

Otim, M., Anderson, I. & Renhard, R. 2002, *Aboriginal and Torres Strait Islander Hospital Accreditation Project: A literature review*, Discussion Paper No. 9, VicHealth Koori Health Research and Community Development Unit, Melbourne.

> *In order to provide an ensure cultural security, there is a need to consult Aboriginal people when health policy is being developed so as not to compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. Hosford, Brown, Duncan (1995) argue that it is appropriate to have hospital policies developed locally and in consultation with Indigenous people because the views, values and expectations of Aboriginal people in one region in the same country may be different from those of another region within the same country.* (p. 21)

Coffin, J. 2007, 'Rising to the Challenge in Aboriginal Health by Creating Cultural Security', *Aboriginal and Islander Health Worker Journal*, vol. 31, no. 3, pp. 22–4.

This paper differentiates between cultural security, safety and awareness to demonstrate their importance in a health service context and to give practical strategies for achieving and sustaining culturally secure services.

The paper outlines a cultural security scale ranging from awareness –> brokerage –> safety –> protocol –> security –> sustainability. Let us consider two key elements that are described in the paper:

BROKERAGE – involves respect and two-way communication where both parties are equally informed and important; it must be developed with the Aboriginal community; faith and trust need to be built. One of the largest parts of brokerage is listening and yarning.

PROTOCOLS – formalise the fact that in an Aboriginal context, health care delivery and programs need to be done with Elders and key stakeholders within the particular community. Communities become partners in an equitable, culturally secure provision of service. Cultural awareness alone is not enough.

Thomson, N. 2005, 'Cultural Respect and Related Concepts: A brief summary of the literature', *Australian Indigenous Health Bulletin*, vol. 5, no. 4, pp. 1–11.

This material is based on a literature review conducted as part of a small project undertaken for a Western Australian Health Service by the Centre for Indigenous Knowledge at Edith Cowan University.

The review outlines the development and content of cultural respect and related concepts in Australia. It also summarises the development and nature of cultural safety in New Zealand and cultural competence in the United States, and explores the relations between these concepts.

The concept of cultural respect (including cultural security) has been adopted for use within Australia. The review outlines how this can be progressed at organisational, systemic and individual (including clinical) levels.

MODELS OF CULTURAL COMPETENCE

These publications and Internet-based materials provide the reader with different theoretical models and frameworks of cultural competence.

Deep listening and cultural safety

Muru Marri Indigenous Health Unit n.d., *The What, Why and How of Koorie Well-being: Developing cultural safety and cultural ease to strengthen families*, School of Public Health and Community Medicine, University of New South Wales, Sydney. Accessed 5 October 2009 at: <www.eduweb.vic.gov.au/edulibrary/public/beststart/downloads/dennis_mcdermott.ppt>.

Dennis McDermott is a Koori psychologist, academic and poet who presents on engaging Koori clients and understanding Koori ways. Previously affiliated with the Faculty of Medicine at The University of New South Wales, Associate Professor McDermott now heads Indigenous Health at Flinders University in Adelaide.

This PowerPoint presentation explores how professionals can use Indigenous ways of relating, particularly the widespread practice of 'deep listening'. This includes attending to silence and the role of disclosure and reciprocity to foster cultural safety and develop cultural ease. The following is an adaptation of the presentation.

DEEP LISTENING:

- **Dadirri:**
  - 'Inner, deep listening and quiet, still awareness ... something like what you call contemplation' (Miriam-Rose Ungunmerr-Baumann, slide 45).
  - 'Listening with your ears and heart' (Judy Atkinson, after Miriam-Rose Ungunmerr-Baumann, slide 46).
- **Ngara:**
  - 'Listen, hear, think ... (Eora, the Sydney language) to listen is simultaneously to reflect and become self-aware' (Paul Carter, slide 47).
  - 'Listening requires something of you ... you need to complete the circle. Hearing should lead to action' (Koori Peak Organisation Board Member, slide 48).
- **Binang Goonj:**
  - 'They hear, but they don't listen' (Bidjara language, south-west Queensland, slide 49).

THE ROLE OF SILENCE:

- 'If you cannot understand an Aboriginal person's silence, then you will never understand their words' (Uncle George Tongerie, Elder from South Australia, slide 50).

LISTENING INVOLVES:

- 'More than "hearing"—includes self-reflection/contemplation
- "Listening" to the silence ... to what's *not* being said ... to what's being said *non-verbally*' (slide 51).

'Indigenous listening is connection —> relationship'

- 'Through "deep listening", and appropriate self-disclosure, you become part of that person's/or community's universe
- *Now* people can deal with you—safely—and you with them' (slide 52).

FOR CULTURAL EASE WITH ABORIGINAL PROTOCOLS/WAYS, WE NEED TO:

- 'Prioritise cultural safety
- Build a service that's comfortable with Aboriginal protocols and at home with Aboriginal ways' (slide 53).

REAL COMMUNITY ENGAGEMENT:

'Little "r" respect

- What do I know about the people I am working with?
- How can I find out more?
- Meeting people in their own reality builds trust and confidence' (slide 55).

THE KOORIE WAY—COMMIT:

- 'Take time to build real relationships—the *"slow road"* may be the fastest way to get there
- So ... get involved for the long haul
- Koorie people/communities want a partner who's 'clued-in' and committed' (slide 56).

ALL THIS IMPLIES:

- *Personal challenge* [t]o existing comfort zone
- *Professional challenge* [t]o models of professional distance and non- disclosure
- *Organizational Challenge* [which] mandates organisational change
- *Political Challenge* [...] strong advocacy is politically risky' (slides 57–8).

CULTURAL SAFETY:

- Requires more than simply having some cultural awareness/sensitivity
- Requires the service provider to let go of some "power" in the relationship' (slide 35).

HOW CAN SERVICE PROVIDERS AND ORGANISATIONS MAKE A DIFFERENCE?

- *The client determines* what's comfortable—the service provider looks for guidance as to how to provide the service
- The service provider professional is encouraged to reflect on their own cultural identity and how this plays out in the way they work with the client' (slide 36)
- Cultural safety—make it a service priority.

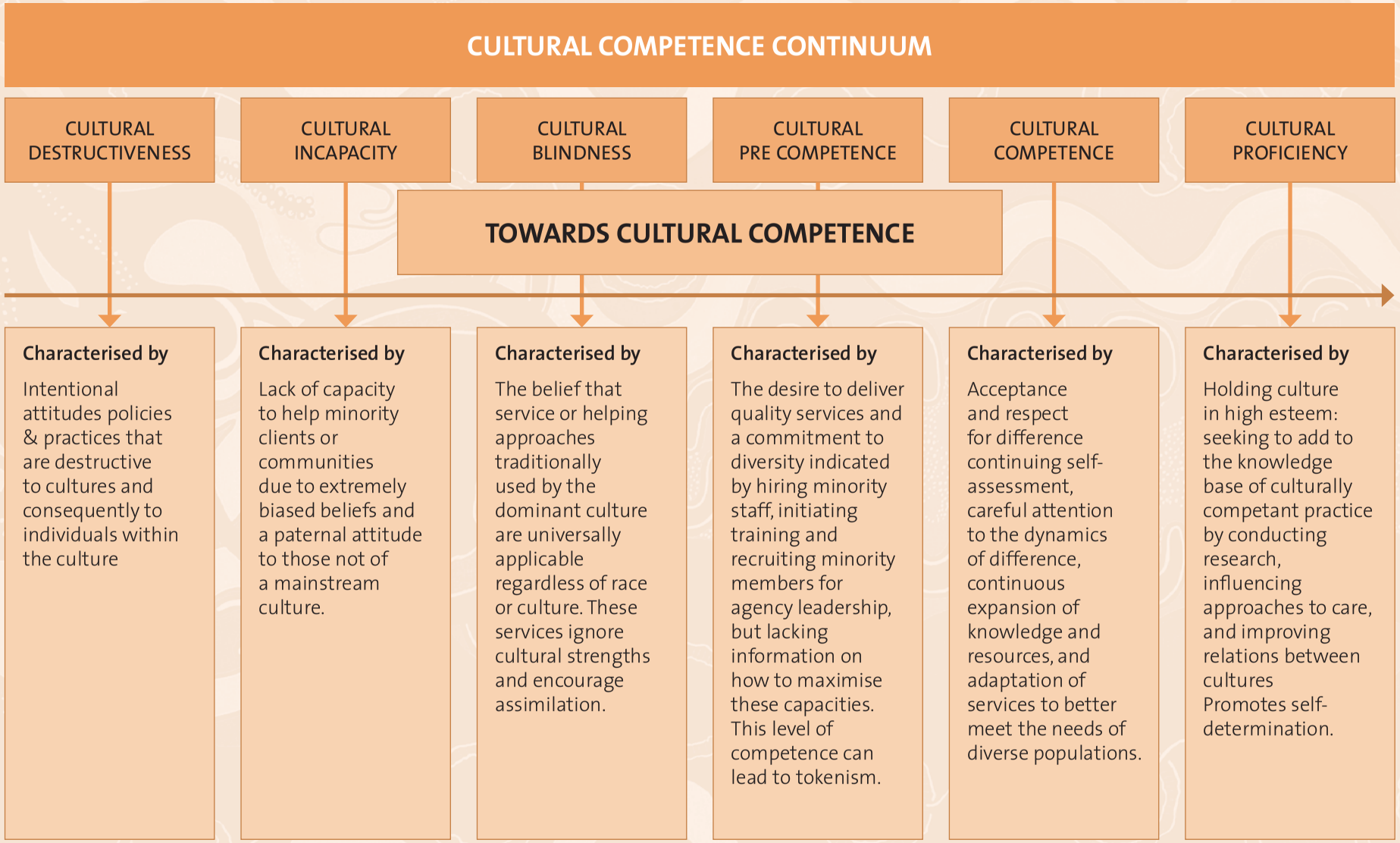
ACKNOWLEDGMENT: thank you to Dennis McDermott for permission to use this material.

Continuum of cultural competence

Department of Human Services Victoria (DHS) 2008, *Aboriginal Cultural Competence Framework*, DHS, Melbourne.

The model represented in the figure below was developed in the United States (Cross et al. 1989) and describes a range of cultural approaches and responses that might be found within a system, agency or among professionals.

REFERENCE: Cross, T., Bazron, B., Dennis, K. & Isaacs, M. March 1989, *Towards a Culturally Competent System of Care*, vol. 1, Georgetown University Child Development, Washington, DC.


CULTURAL COMPETENCE CONTINUUM
CULTURAL DESTRUCTIVENESS
CULTURAL INCAPACITY
CULTURAL BLINDNESS
CULTURAL PRE COMPETENCE
CULTURAL COMPETENCE
CULTURAL PROFICIENCY
TOWARDS CULTURAL COMPETENCE
Characterised by
Intentional attitudes policies & practices that are destructive to cultures and consequently to individuals within the culture
Characterised by
Lack of capacity to help minority clients or communities due to extremely biased beliefs and a paternal attitude to those not of a mainstream culture.
Characterised by
The belief that service or helping approaches traditionally used by the dominant culture are universally applicable regardless of race or culture. These services ignore cultural strengths and encourage assimilation.
Characterised by
The desire to deliver quality services and a commitment to diversity indicated by hiring minority staff, initiating training and recruiting minority members for agency leadership, but lacking information on how to maximise these capacities. This level of competence can lead to tokenism.
Characterised by
Acceptance and respect for difference continuing self-assessment, careful attention to the dynamics of difference, continuous expansion of knowledge and resources, and adaptation of services to better meet the needs of diverse populations.
Characterised by
Holding culture in high esteem: seeking to add to the knowledge base of culturally competant practice by conducting research, influencing approaches to care, and improving relations between cultures
Promotes self-determination.

Orlandi, M. (ed.) 1998, *Cultural Competence for Evaluators: A guide for alcohol and other drug abuse prevention professionals working with ethnic/racial communities*, OSAP Cultural Competence Series I, Department of Health and Human Services, Rockville, MD.

The Cultural Sophistication Matrix describes several dimensions of cultural competence including cognitive, affective and skills dimensions.

The approach has practical implications for the development and evaluation of cultural awareness training programs.

The author identifies:

- the importance of getting (Indigenous) people involved
- the need to distinguish between important within-culture sub-groups
- the importance of going beyond cultural competence.

The Cultural Sophistication Framework (p. 297):

	CULTURALLY INCOMPETENT	CULTURALLY SENSITIVE	CULTURALLY COMPETENT
Cognitive Dimension	Oblivious	Aware	Knowledgeable
Affective Dimension	Apathetic	Sympathetic	Committed to change
Skills Dimension	Unskilled	Lacking some skills	Highly skilled
Overall Effect	Destructive	Neutral	Constructive

Bennett's stages of cultural competence

Tesoriero, F. 2006, 'Personal Growth towards Intercultural Competence through an International Field Education Program', *Australian Social Work*, vol. 59, no. 2, pp. 126–40. Accessed 7 October 2009 at: <www.informaworld.com.ezp.lib.unimelb.edu.au/smpp/content~content=a747840795~db=all>.

This model is a highly useful one in light of the feedback provided by many of the program supervisors who participated in the ICAP Resources Project. Many supervisors described their personal and professional journeys in seeking to learn how to better manage an Aboriginal program in a mainstream setting.

Their journeys tend overall to mirror the stages described below. Those supervisors who have been Aboriginal program managers for a long time, who have taken on experiential, two-way learning, and who have engaged in personal and professional reflection evidence developing competencies, moving through ethnocentric to ethno-relative stages.

Tesoriero cites Bennett (1993). His model derives from a review of concepts in the field of intercultural communication. People move through a process of personal growth, from a position of ethnocentrism to one of 'ethno-relativism'. The process is one of stages of increasingly sophisticated recognition and acceptance of difference, with a radical shift from an absolutist view of the world to a more contextual view that accommodates ambiguity of meaning and competently engages with those who are different.

The stages and key elements are described below.

ETHNOCENTRIC STAGES

Denial:

> *In this stage, cultural difference is simply not considered, or, where it is, there are only very wide categories for cultural difference, such as skin colour* (Tesoriero 2006:133).

Isolation, separation:

> *Isolation results in cultural differences not being experienced at all. With separation, barriers are erected to maintain distance from the different...* (Tesoriero 2006:133).

Defence:

> *'Defence' is a position where, recognising cultural differences, a person postures themselves so that they may counter the impact of those differences, which they see and experience as threatening* (Tesoriero 2006:134).

Denigration, superiority:

These are:

> *Indicative responses to cultural differences [where the person is] defensive of the differences confronting [him or her, where they] either negatively evaluate what they see or take a slightly difference focus and positively evaluate [their own cultural] status* **(Tesoriero 2006:134)**.

Minimisation:

> *This is the final way to preserve one's own worldview as central and normal. Here cultural difference is acknowledged but not negatively valued, just somewhat lost within a focus on similarities... Moving beyond this stage requires somewhat of a quantum leap from relying on absolutes and dualistic thinking, to an appreciation of relativity and ambiguity* **(Tesoriero 2006:135)**.

ETHNO-RELATIVE STAGES

> *These stages assume that cultures can only be understood contextually... 'In the ethno-centric stages difference is experienced as threatening... [In the ethno-relative stages] difference is non-threatening... Cultural difference is more likely to be enjoyable and actively sought after... (Bennett 1993, pp. 46–47)' ... cultural differences are acknowledged and respected, considered inevitable and a preferred human condition* **(Tesoriero 2006:136–7)**.

Adaptation

> *The adaptive ethnorelativist nurtures a deep appreciation and respect for the integrity of cultures, including one's own culture, values and world view. Adaptation is not the assimilation of two world views into one melting pot* **(Tesoriero 2006:137–8)**.

> *Culture is a process... It is something one engages with* (Tesoriero 2006:138).

Bennett's model reflects stages of personal and professional growth and the process of developing increasing cultural competence.

> *Here empathy is central... It is achieved if one can imagine or comprehend the perspective of the other and imaginatively participate in it* (Tesoriero 2006:138).

Cultural competency in health

NHMRC 2005, *Cultural Competency in Health: A guide for policy, partnerships and participation*, NHMRC, Canberra. Accessed on 7 April 2009 at: <www.nhmrc.gov.au/publications/synopses/_files/hp19.pdf>.

The guidelines outline a four-dimensional model for increasing cultural competency in the health sector.

Integral to the model is the need for:

- capacity and conviction at systemic and organisational levels to direct, support and acknowledge culturally competent practice at an individual or professional level; and

- clear delineation of levels of responsibility and the interrelationship between these levels (p. 30).

The model acknowledges four dimensions of cultural competency (based on Eisenbruch, M. *et al*. 2001, *Nursing Education in a Multicultural Context*, Higher Education Unit, Department of Education, Training and Youth Affairs, pp. 1–12: <www.desat.gov.au/highered/programmes/nursing/reports.htm>).

- Systemic—effective policies and procedures, mechanisms for monitoring and sufficient resources are fundamental to fostering culturally competent behaviour and practice at other levels. Policies support the active involvement of culturally diverse communities in matters concerning their health and environment.

- Organisational—the skills and resources required by client diversity are in place. A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels.

- Professional—over-arching the other dimensions, this level of cultural competence is identified as an important component in education and professional development. It also results in specific professions developing cultural competence standards to guide the working lives of individuals.

- Individual—knowledge, attitudes and behaviours defining culturally competent behaviour are maximised and made more effective by existing within a supportive health organisation and wider health system. Individual health professionals feel supported to work with diverse communities to develop relevant, appropriate and sustainable health programs (p. 30).

Indigenous Health Curriculum Framework

Phillips, G. 2004, *CDAMS Indigenous Health Curriculum Framework*, VicHealth Koori Health Research and Community Development Unit on behalf of the Committee of Deans of Australian Medical Schools. Accessed on 4 May 2009 at: <www.medicaldeans.org.au/pdf/CDAMS%20Indigenous%20Health%20Curriculum%20Framework.pdf>.

> *In 2002, the Committee of Deans of Australasian Medical Schools (CDAMS) partnered with the Office of Aboriginal and Torres Strait Islander Health (OATSIH), within the Commonwealth Department of Health and Ageing, to establish and implement the CDAMS Indigenous Health Curriculum Development Project. The University of Melbourne, through the VicHealth Koori Health Research and Community Development Unit ... [hosted] the Project ...*
>
> *The purpose of this curriculum framework is to provide medical schools with a set of guidelines for success in developing and delivering Indigenous health content in core medical education ... This document seeks to enunciate the basic components of a functional curriculum for delivering Indigenous health effectively* (p. 5).

Of relevance are the guiding principles, which include, for example, that Aboriginal and Torres Strait Islander people have a diversity of cultures, which should be reflected in the design, delivery and evaluation of curricula; Indigenous views on health and wellbeing are both valid and critical to the delivery of culturally appropriate, and safe, medicine and health care; health outcomes are governed more by the historical and social determinants of health than by inherent Aboriginality; Aboriginal and Torres Strait Islander people require equity of access not only to mainstream services that are free of racism and other forms of discrimination, but also to services that are specific and culturally appropriate. (See p. 7 for additional information.)

The material suggested key subject areas, which make up the learning about the health of Aboriginal and Torres Strait Islander people, and also lists the attributes and outcomes students might be expected to achieve as a result of the delivery of this content.

Suggested key subject areas are history; culture, self and diversity; Indigenous societies, cultures and medicines; population health; models of health service delivery; clinical presentations of disease; communication skills; and working with Indigenous peoples—ethics, protocols and research. Included are recommendations on the delivery and formats—lectures, tutorials, case studies, self-guided workbooks, multimedia tools, talking circles where Elders are empowered to share their experiences, reflective discussions, field visits, experiential learning camps, community visits, problem-based learning scenarios, simulated patient training, and community clinical placements. (See p. 23.)

Ten key pedagogical principles and an approach are outlined, along with strategies, examples and cautions for teaching, and implementation approaches. These are worthy of close review.

Some of the principles include teaching from a strengths-based perspective, including positive examples of successful programs in Indigenous Australia.

Examples include:

- facilitate positive learning experiences and interactions with Aboriginal Australians based on real world contexts
- teach discrete compulsory subjects to lay a foundation; Indigenous people should be included in the design, delivery and evaluation, as they are key developers and enhancers
- content should be locally accurate, and partnerships will need to be developed
- teach Indigenous cultural safety/awareness separately to multicultural awareness—Indigenous Australians are the First Australians and their experience is distinct from the migrant experience.

For further details see pp. 13–22 of the guidelines.

ACKNOWLEDGMENT: thank you to *Onemda* VicHealth Koori Health Unit for permission to use this material.

SOME IDEAS FROM THE PROFESSIONAL LITERATURE

The following information represents a brief review of the main findings of several literature searches on the competencies needed for supervisors and managers in health services where there is cultural diversity.

Key words for the searches included cultural competence, cultural safety, cultural sensitivity in organisations and administration, human resources management, employment relations, Aboriginal staff/employees, orientation and supervision. The purpose was to identify knowledge based on research, theory and practice.

Ronnau, J. P. 1994, 'Teaching Cultural Competence: Practical ideas for social work educators', *Journal of Multicultural Social Work*, vol. 3, no. 1, pp. 29–42.

The article describes strategies for teaching cultural competence that have been successfully employed in social work practice classes.

The author says that to develop cultural competence we need commitment (admit lack of knowledge and commit to learning); we need to become aware and accept that significant differences exist between people of different cultures and to not recognise this can become a stumbling block. Readers are reminded that we will need to get in touch with our own values, standards and messages, which have been passed on by families and communities.

Strategies used by the authors in practice classes include our own cultural profiles comprising historical perspective, guiding principles and values, family structure, beliefs and strengths. Cautions are given that while profiles can provide useful information, they can also perpetuate stereotypes.

Cultural guides: it is suggested in the article that samples of food, art, music and language represent people's culture as they view it.

The author outlines that, prior to presentations, participants are asked to submit questions to provide an opportunity to check out prejudices and biases that might not be verbalised.

Weaver, H. N. 1998, 'Teaching Cultural Competence: Application of experiential learning techniques', *Journal of Teaching in Social Work*, vol. 17, no. 1 & 2, pp. 65–79.

The article focuses on experiential learning and learning for understanding. It looks at direct participation in activities combined with personal observations and reflections as a major source of learning. Self-reflection and exposure to different types of people are critical in the development of cultural competence.

Two experiential learning techniques are discussed in depth:

- the buddy system (which can include any activity that allows partners or buddies from different cultures to talk with each other) and keeping a journal to evaluate learning

- interactions in cultural communities (attending events and celebrations, spending time in a neighbourhood) and examining feelings, reactions and behaviours.

Magnusen, S., Norem, K., Jones, N. K., McCrary, J. C. & Gentry, J. 2001, 'The Triad Model as a Cross Cultural Training Intervention for Supervisors', *The Clinical Supervisor*, vol. 19, no. 2, pp. 197–210.

This paper features a description of an experiential exercise designed to increase sensitivity of supervisors-in-training to the subtle ways cultural experiences affect interactions between supervisors and supervisees.

The authors found readiness to engage in discussions about cultural differences was lacking in this limited enquiry. They draw a primary conclusion endorsing the importance of training supervisors to recognise and address cultural issues. They also encourage supervisors to adopt a process of continuous and intentional efforts towards a process of cultural self-awareness and examination.

Leong, T. L. & Wagner, N. S. 1994, 'Cross Cultural Counseling Supervision: What do we know? What do we need to know?', *Counselor Education and Supervision*, vol. 34, no. 2, pp 117–31.

The article provides a critical review of the theoretical and empirical literature on cross-cultural counselling supervision. Conclusions include that much remains untested. The authors write that it seems empirically safe to conclude that:

- race can have a profound influence on the supervisory process, particularly in terms of trainees' expectations for supervisor characteristics like empathy, respect and congruence

- race can influence a trainee's perception of supervisor liking.

The authors make recommendations to:

- encourage researchers to focus on supervisory relationship factors and elements of the interaction between supervisors and supervisees, as well as isolated characteristics of both participants (including interactions between personality dynamics and cultural dynamics)
- consider implications at an organisational/institutional level
- encourage diverse practicum and internship placements.

Larkin, C. & Buckskin, M. 1995, 'Aboriginal Liaison Officers: Breaking down the barriers', *Aboriginal and Islander Health Worker Journal*, vol. 19, no. 6, pp. 26–8.

This article describes the experience of a social work manager in the Australian Capital Territory who worked with several social workers at Woden Valley Hospital in an action research project exploring issues of racism. They worked on this with two Aboriginal women who shared their experiences and understanding. Their deliberations led to their advocating for the appointment of an AHLO. The Aboriginal women subsequently became a support group for the AHLO (Mary Buckskin). The AHLO noted in the article that she was supervised by the social work manager—showing that commitment starts at the top.

The AHLO role is described as different to social workers. It involved contact with lots of wards and it was sporadic. The group worked together and with the hospital's medical committee, local health service workers and consumers to present a Grand Round hypothetical.

The article highlights the importance of an open and supportive working environment and staff working to change themselves and their institutions to break down barriers.

Sherwood, J., Costello, M., Congoo, E., Cohen, T., Duval, T., Gibbs, G., Kelaher, B., Kelly, T., Marshall, C., Tabuai, G. & Winsor, J. 1999, 'Indigenous Management Model', *Aboriginal and Islander Health Worker Journal*, vol. 23, no. 5, pp. 16–19.

A group of Bachelor of Health Sciences (Aboriginal Health and Community Development) students from the Yooroang Garang Centre for Indigenous Health Studies, University of Sydney, was unable to identify an Indigenous management theory through their research efforts. They worked together to define a management model that they felt would sit well in their communities.

The group identified, through 'intense negotiation', the essential skills that are needed when managing 'the mob'. Considering past, present and future models, the group identified policies and procedures and cultural values and beliefs impacting on quality assurance, communication/line management, ethics and law, 'managing our mob', professional development and training.

Weick, A., Rapp, C., Sullivan, W. O., Kishardt, S. & Saleeby D. 1989, 'A Strengths Perspective for Social Work Practice', *Social Work*, vol. 34, pp. 350–4.

The *strengths perspective* is an approach that draws on principles and methods to create opportunities for professional knowledge building. The article is a benchmark article that coined the term *strengths perspective*. This perspective promotes a mindset to approach people with a greater concern for their strengths and competencies and to mutually discover how these personal resources can be applied. It encourages engaging people as equals and giving positive feedback. It reflects an approach to building relationships and resiliency.

The core ideas of the strengths perspective are empowerment, membership, regeneration, healing within, synergy, dialogue and collaboration. The dialogue includes empathy, and identification with and inclusion of the other person.

Strengths include what people have learned about themselves and others and their world; personal qualities; traits and virtues people possess; what people know about the world around them; the talents people have; cultural and personal stories and lore; pride; and the community.

Briskman, L. 2007, 'Confronting Complicity and Moving On', in L. Briskman, *Social Work with Indigenous Communities* (pp. 12–24), Federation Press, Sydney.

This chapter promotes the value of critical social work practice. In this framework the social worker is a partner in action rather than an outside expert. It is important to recognise the limitations of our knowledge and not to reinforce patterns of domination. We need to incorporate Indigenous voices, affirming Aboriginal knowledge and expertise, while not totally discarding professional expertise. Indigenous knowledge is not less relevant. Social workers need to avoid taking a defensive stance when hearing critiques of past and present practice, maintain their commitment to social justice and human rights, and be willing to challenge current social and power relationships.

This approach is a necessary precursor to effective engagement with Indigenous people. It is necessary to go through personally confronting experiences, accepting the position of learner, and engaging with uncertainty and discomfort. A useful first step is to recognise Aboriginal co-workers as mentors and decision makers. This can assist in breaking down traditional hierarchies of supervision, creating more reciprocal relationships.

Tesoriero, F. 2006, 'Personal Growth towards Intercultural Competence through an International Field Education Program', *Australian Social Work*, vol. 59, no. 2, pp. 126–40.

This excellent article discusses an international field education program at the University of South Australia. Of interest is the conceptualisation of the program within a developmental framework identifying stages of personal growth from ethnocentrism to 'interculturality' or intercultural sensitivity. The framework, alongside the use of a clear ethical perspective and the reflective practice process, is a useful resource to identify the level of sophistication of cross-cultural competence. Milton Bennett's model of intercultural sensitivity is described earlier in this section.

The author also discusses Fook's approach to reflective practice. This promotes questions that include interrogating one's experience and accounts of them in terms of emerging themes and patterns; one's feelings, thoughts, actions, interpretations and explanations of an event; the underlying assumptions and where these assumptions derive from; gaps and biases in the explanations; cultural positions. This reflective interrogation of one's practice experiences, when used in conjunction with human rights-based approaches such as empowerment and anti-oppressive practice, builds knowledge and fosters personal change.

Betancourt, J. R., Green, A. R., Carillo, J. E. & Ananeh-Firempong, O. 2003, 'Defining Cultural Competence: A practical framework for addressing racial/ethnic disparities in health and health care', *Public Health Reports*, vol. 118, July & August, pp. 293–302.

The authors reviewed relevant literature of academic, foundation and government publications to develop a definition of cultural competence, identify key components for intervention, and describe a practical framework for implementation of measures to address racial/ethnic disparities in health and health care. A framework of cultural competence interventions—organisational (leadership/workforce), structural (processes of care) and clinical (provider–patient encounter)—emerged as important strategies to address racial/ethnic disparities in health and health care. The article covers United States literature and scenarios, but is a useful article.

On two-way learning

Langton, Marcia 1993, *Well, I Heard it on the Radio and Saw it on the Television ... An essay for the Australian Film Commission on the politics and aesthetics of filmmaking by and about Aboriginal people and things*, Australian Film Commission, Sydney.

Points are made about the importance of intercultural dialogue between Indigenous and non-Indigenous people. Langton argues that in these instances of exchange/dialogue, the individuals involved will test imagined models of the other, repeatedly adjusting the models as the responses are processed, to find some satisfactory way of comprehending the other.

A key to cultural competence is understanding the importance of connecting and relationship building for Indigenous people. In these interactions, cultural difference is explored, power relations negotiated and relationships established.

CULTURAL AWARENESS TRAINING AND RELATED RESOURCES

TIPS AND EXAMPLES FROM VICTORIAN HEALTH SERVICES

It is well recognised that training is needed to enable health professionals and other service providers to deliver appropriate care for Aboriginal and Torres Strait Islander people.

One of the key outcomes for the ICAP Program is whether health services support the development of staff values, skills and knowledge related to cultural sensitivity in the provision of services to Aboriginal people.

Cultural awareness training can be useful in facilitating knowledge development about cultural issues and may enable health care providers to make improvements in providing culturally appropriate care.

Health service stakeholders who participated in the ICAP Resources Project made a range of suggestions about cultural awareness training.

General suggestions

- Use available websites.

  The DOH ICAP website has baseline information and the Internet is a source of useful specific information. Aboriginal websites are useful for special event days such as NAIDOC Week and Sorry Day. I often go looking for text on websites, e.g. standard Welcome to County, where the information is set out and noted [as] 'please feel free to use as a resource'.

  I look for permission and authorisation. (Executive Director, metropolitan health service)

- Use education materials and packages.

  A great package is essential. We commissioned a package. A series of different AHLOs used it in their own way. It included good visual material—maps, family groupings, statistics and graphs. (Program supervisor, metropolitan health service)

- Make internal presentations and resource material accessible by putting them on the hospital's intranet site.

- Community visits are useful, including Aboriginal cultural centres, local tours and visiting agencies.

  Take people to a different environment. Go to Aboriginal Community social events. We took a table at the NAIDOC Ball. **(Executive sponsor, metropolitan health service)**

- Use audio-visual materials.

  Useful DVD's include:

  - *Liyarn Ngarn*, motion picture/DVD (see <antar.org.au/liyarn_ngarn>)
  - *Lousy Little Sixpence*, 1982, motion picture, Resource Services, Division of Services, NSW Department of Education, North Sydney (Ronin Films)
  - *BabaKiueria*, 1986, DVD, Australian Broadcasting Corporation and Moorabbin College of TAFE
  - *Land Bilong Islanders*, 1989 (Ronin Films)
  - *Bringing them Home*, 1997, DVD (free), Human Rights and Equal Opportunity Commission Sydney Publication Unit
  - *Land of the Little Kings*, 2000, DVD (Ronin Films)
  - *The Stolen Generations*, 2000, DVD (Ronin Films)
  - *Remembering Country*, 2000, video/DVD (Ronin Films)
  - *Rabbit-proof Fence*, motion picture, 2002 (Australian Film Commission)
  - *Bush Mechanics*—The Series, 2003, DVD (ABC Shop)
  - *Ten Canoes*, 2006, motion picture, Five Senses (ABC Shop)
  - *Why Me?*, 2007, video/DVD (Ronin Films)
  - *First Australians*, 2008, DVD (ABC Shop).

- Brainstorm with AHLO staff and advisory committees about the planned content of awareness sessions.

  Our Advisory Committee said that local content was very important. It was essential that the local history of Aboriginal people and the developments of Aboriginal services in the area around the hospital should be included. **(Supervisor, metropolitan health service)**

- Think about how to work on knowledge and attitudes.

  We need to win hearts and minds—using an appeal based on evidence. Put the life expectancy figures up, the health issues of Aboriginal people compare with the general population. Make a clear and compelling case on why we should target the Aboriginal population in health care. **(Executive sponsor metropolitan health service)**

- Draw on the personal experiences of Aboriginal staff (if they are willing to share their stories).

  When Aboriginal staff share their own and their families' life journey in an educative way this engages and can help to engender empathy. **(Supervisor, metropolitan health service)**

- Aboriginal and non-Aboriginal staff working together is one of the best ways for cultural awareness to be developed.

- Present at the hospital's general staff orientation—simple, brief and targeted information.

- Subscribe and take out memberships (for example, the *Koori Mail* and the Koorie Heritage Trust's Vision 2020).

- Create a welcoming environment. Most health services are using ICAP posters and pamphlets, signage and artwork in reception areas, and are funding the refurbishment of spaces where Aboriginal patients and families can feel more culturally safe.

Suggestions about content

- Aboriginal people should deliver cultural awareness training.

- When you do a presentation, include at least 15 minutes for questions.

- Do some preliminary work—gauge needs, questions and knowledge levels *before* doing a presentation.

- Tailor the content for health, including the concept of wellbeing.

- Invite people to ask the hard questions.

  Sometimes there is a need to address questions such as 'what's so special about Aboriginal people', 'Aboriginal people get so much'. It's hard to answer and Aboriginal people should not have to address these comments on their own. **(Program supervisor, metropolitan health service)**

- Draw on non-Aboriginal staff to talk about their own learning curves.

- Use different presenters, including sharing/partnering Aboriginal and non-Aboriginal presenters.

- Use audio-visual material such as DVDs on communication or snapshots of patients talking about their experiences.

- Use a health-related educational package.

  We have struggled to get a good package. It should include things staff want to understand—family networks, the local area, health issues in our area, communication (family unit—what is it, visiting hours, the need for flexibility). Some do's and don'ts. **(Program supervisor, metropolitan health service)**

Suggestions about structure

- Embed awareness programs—incorporate them as part of existing *departmental/unit professional development programs*.

  We should be more explicit about asking managers to book in for a minimum commitment. Not an extra thing, it is special, not just token. We need to identify and articulate the importance/rationale for getting behind Aboriginal health education. **(Program supervisor, metropolitan health service)**

- One type of session does not fit all—consider modules.

- Bring together like (staff) needs with like.

- Work your way through every unit and department.

- Be a part of overall hospital orientation. Do a snapshot; for example, a basic overview—facts on Aboriginal health disadvantage—and information on internal liaison programs/services.

- Use external presenters if you want it done really well, but this does have budget implications.

Funding and sourcing awareness training

- At the ICAP Forum held on 12 November 2008, participants commented that they generally struggle both with sourcing training and accessing funds for cultural awareness training.

- Practical issues in making payments to Community presenters include not only the lack of available funds but also that making payments can be time consuming and complicated.

  At times we invited/asked Elders to be involved in training. If presenters do not have an ABN number, a 47 per cent tax on top of the cost of the presentation is incurred. **(Supervisor, metropolitan health service)**

VACCHO AWARENESS/CULTURAL SAFETY PROGRAM

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is a Registered Training Organisation and the peak ACCHO for Victoria. An accredited cultural awareness program has been developed for people who work in health and who work with Aboriginal clients and organisations. The VACCHO Cultural Safety Program is based on a nationally recognised unit of competence, 'Work Effectively with Aboriginal and/or Torres Strait Islander people'.

The program may be delivered in a flexible mode based on a self-paced learning kit (hard copy); and can also be adapted to include a half-day facilitated workshop for groups and organisations. In October 2009, the cost was $300 per head.

For fully self-paced delivery, participants are expected to be working in a partnership arrangement or to establish a connection or relationship with an ACCHO.

For further information contact VACCHO on (03) 9419 3350.

KOORIE HERITAGE TRUST CULTURAL AWARENESS PROGRAMS

The Koorie Heritage Trust runs one day and half-day cultural awareness training programs, including executive-level training. These can be tailored according to the particular needs of the audience. The following provides an overview of a full-day program.

Full-day Cultural Awareness Program

DURATION: seven hours
PRICE: From $4800 (in October 2009)
Minimum 10 participants
Maximum 25 participants

Morning session

- Welcome to Country/acknowledgment by Elder/Senior representative.
- **The Building Blocks of Identity**
  - Aboriginality and identity
  - Definitions
- **The Building Blocks of Aboriginal Identity—Pre-Colonisation**
  - Language Groups
  - Relationship to Land
  - Creation Stories/Dreaming
  - Lore/Law

- **The Building Blocks of Aboriginal Identity—Post-Colonisation**
    - Missions and Reserve and Impacts
    - Major Government Legislation and Policies and Law
- **The Building Blocks of Aboriginal Identity—The Aboriginal Community Today**
    - Statistics

Afternoon session—Lunch and potential Community centre tour

- **Working with the Indigenous Community—Community Partnerships**
    - Overview of Aboriginal Community Structures
- **Community Partnerships**
    - Working in Partnership with the Aboriginal Community
- **Working Effectively with Indigenous Staff and Indigenous Colleagues**
    - Practical workshop/activity including potential Scenarios
- **Internal Policy**
    - Strategy/initiatives overview
    - Dialogue/conversation opportunity for participants.

ACKNOWLEDGMENT: thank you to Jason Eades, Chief Executive Officer, Koori Heritage Trust, telephone (03) 8622 2600: <www.koorieheritagetrust.com>.

CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES (CATSIN) CULTURAL RESPECT PROGRAM

This program aims to provide a resource for health professionals to gain information, create an understanding and improve working relationships between professionals. It is a vehicle to share information about key issues.

The program is comprehensive and includes introductory and learning modules:

- introduction
- overview of contemporary Aboriginal Australia
- human rights and social justice
- health
- what is Australia doing to improve the health of Aboriginal and Torres Strait Islander people?
- work practice in relation to Aboriginal clients/patients (challenges, nursing, communication, community protocols).

SOURCE: Hardcastle, L. & Bradford, V. 2007, 'Congress of Aboriginal & Torres Strait Islander Nurses (CATSIN)', *Aboriginal and Torres Strait Islander Health Worker Journal*, March/April, no. 2.

In late 2009, the ICAP Resources Project consultants were advised that this material will soon be available to the broader health field. Contact CATSIN for details: website <www.indiginet.com.au/catsin>, email <catsin@bigpond.net.au>, telephone (07) 3410 7236, fax (07) 3410 7235).

MAKING TWO WORLDS WORK KIT

This kit was developed as a partnership project between Mungabareena Aboriginal Corporation and Women's Health Goulburn North East, and supported by Upper Hume Primary Care in partnership with the Wodonga Regional Health Services.

The kit was developed and designed by Aboriginal and non-Aboriginal workers. Sections of the audit tool include creating a welcoming environment; engaging with Aboriginal clients and Community; developing cultural competence; staff training; and working collaboratively and respectfully with Aboriginal organisations. The tool supports agencies to audit their practices and make small changes that can make a big difference to providing better care.

SOURCE: Women's Health Goulburn North East 2008, 'Making Two Worlds Work'. Accessed on 20 September 2009 at: <www.whealth.com.au/ourwork/making_two_worlds_work.html>.

ABORIGINAL CULTURAL COMPETENCE FRAMEWORK

The *Aboriginal Cultural Competence Framework* was published by the Victorian Government Department of Human Services in November 2008. It is designed to help community service organisations define the vision and realities of cultural competence in the services they deliver. Key message about cultural competence are very useful.

SOURCE: Department of Human Services (DHS) 2008, *Aboriginal Cultural Competence Framework*, DHS, Melbourne. Accessed 7 October 2009 at: <www.cyf.vic.gov.au/indigenous-initiatives/publications2/aboriginal-cultural-competence-framework>.

CROSS-CULTURAL AWARENESS TRAINING: A SAMPLE MODULE

The material in this section is drawn from the following training manual:

- Tracey Whetnall Consultancy and South Coast Regional Initiative Planning Team (for and on behalf of the Department of the Environment & Heritage and the Department of Agriculture, Fisheries and Forestry) 2005, *Natural Resource Management Cross-Cultural Awareness Training Framework*, Commonwealth of Australia, Canberra. Accessed on 8 May 2009 at: <www.nrm.gov.au/publications/frameworks/indigenous-ccat.html>.

What follows is a small sample module, which may be of relevance for Aboriginal staff in health services offering cultural awareness training. This module provides examples of how to deal with some of the 'hard questions' that may be asked during awareness training.

How to deal with difficult questions

> *During most Cross-Cultural Awareness Training sessions there will be times when certain participants may ask you difficult questions that you may not be able to answer. Always remember that you are a FACILITATOR and not a teacher, therefore you don't always have to have an answer. Whenever you do come across this situation, the best response is to say that you don't know but will find the answer for them. When you say this you must ensure that you do the follow up.*
>
> *If you are in this situation it is always better to try and get someone else in your group to respond, this way it gives you some more time to consider your response. An example could be, after you have been asked a question, ask others what they think. 'That is an interesting question Peter, do you have any comments Sharon?'. You may find that when others answer you get time to think about your response and someone else's response may trigger your memory.*
>
> *Often when we are faced with difficult questions or racist statements we get angry and take on the issues or the person asking the question or making the comment. Responding to these statements by asking the participant where they got their information or if they are speaking from personal experience, can often make them reconsider their position—especially if they are not speaking from experience* (p. 33).

Common questions asked by Indigenous peoples about non-Indigenous people

SOME QUESTIONS INDIGENOUS PEOPLE MAY ASK ABOUT NON-INDIGENOUS PEOPLE DURING TRAINING COULD INCLUDE:

Why do non-Indigenous people only have small families?

Why do non-Indigenous people put their elders into nursing homes?

Why do non-Indigenous people appear to have money all the time?

Why don't non-Indigenous people visit their families as often as we do?

Why don't non-Indigenous people share their belongings like we do?

Why are non-Indigenous people so strict about time and appointments?

Questions asked by non-Indigenous about Indigenous people

SOME COMMON QUESTIONS ASKED BY NON-INDIGENOUS PEOPLES ABOUT INDIGENOUS PEOPLES COULD BE:

Why do Indigenous people get more benefits then we do?

Why do Indigenous people live in large family groups?

Why do Indigenous people get cheap housing loans?

Why do Indigenous people get special university entry?

How can Indigenous people, who haven't lived on their traditional lands, know how to Care for their Country?

How can Indigenous people be traditional owners of their country if they didn't even grow up there?

What do Indigenous people think about Land Rights and Native Title?

How can a person with blond hair and blue eyes claim they are Indigenous?

When can I ask an Indigenous person about the 'dead' without offending? (p. 32)

ACKNOWLEDGMENT: thank you to Tom Smith, Department of the Environment, Water, Heritage and the Arts for permission to use this material.

USEFUL WEBSITES

www.eniar.org/health.html

www.onemda.unimelb.edu.au/publications/index .html

www.vaccho.org.au

www.crcah.org.au/research/impriving_culture_hospitals.html

www.healthinfonet.ecu.edu.au

www.oxfam.org.au/campaigns/indigenous-health

www.health.vic.gov.au/koori

www.indigenousalliedhealth.com.au

www.whealth.com.au/ourwork/making_two_worlds_work.html

www.reconciliationvic.org.au

www.humanrights.gov.au/about/publications/index.html

www.healthissuescentre.org.au

http://www.georgetown.edu/research/gucchd/acc/index.html

www.koorieheritagetrust.com

www.diversityatwork.com.au

www.naidoc.org.au (to order NAIDOC posters)

SECTION 5: PRACTICE EXAMPLES FROM VICTORIAN HEALTH SERVICES

This section contains a range of ICAP-related information and tools developed in the Victorian health field. These materials have been generously provided to the ICAP Resources Project Team for use by health colleagues. We are indebted to the contributing health services and individuals for their generosity and spirit of collaboration.

Although efforts have been made to ensure included examples reflect current, positive ICAP practice, each example would need to be carefully reviewed in consultation with relevant Aboriginal stakeholders before applying it in other health services. Additionally, material should not be duplicated without full acknowledgment of the original sources.

Further ICAP practice examples and clinical tools are available on the ICAP website (www.health.vic.gov.au/Aboriginal/icap) or from the ICAP Project Officers:

RURAL	(03) 5333 6043
METROPOLITAN	(03) 9288 3437
STATE-WIDE	(03) 9419 3350

The table that follows (pages 164 to 171) lists the name and description of each of the 45 practice examples, which are divided into six sections:

DATA COLLECTION AND USE
CULTURAL AWARENESS
RELATIONSHIPS
STRATEGIC PLANNING
STAFF RECRUITMENT: POSITION DESCRIPTIONS
STAFF RECRUITMENT: JOB ADVERTISEMENTS

The loose-leaf binder contains a summary of the examples, while the CD-ROM and the website versions of the kit contain the examples in full.

PRACTICE EXAMPLES

PRACTICE EXAMPLE NO.	TITLE	DESCRIPTION
DATA COLLECTION AND USE		
1	'Asking the question' presentation: *Are you of Aboriginal or Torres Strait Islander origin?*—presentation, Department of Health Victoria	This PowerPoint presentation was developed by staff in the DOH Koori Human Services Unit and was updated in August 2008. DOH has used this presentation to conduct training with frontline hospital staff in relation to asking patients whether they are of Aboriginal or Torres Strait Islander descent. The presentation has also been used by some AHLOs, other hospital staff and the ICAP Project Officers as a basis to customise their own presentations to suit the needs of different hospitals and staff.
2	'Asking the question' handout: *Recording Indigenous Status*—Department of Health Victoria	This handout was developed by the DOH Koori Human Services Unit and updated in August 2008. The handout is designed to be used in conjunction with DOH (or other) training on identifying Aboriginal patients (see Practice Example 1).
3	'Asking the question' presentation: *Are you of Aboriginal or Torres Strait Islander origin?*—Royal Women's Hospital	This postcard was developed by the Royal Women's Hospital (RWH) Aboriginal Women's Health Business Unit (AWHBU) in 2007 in consultation with other hospital staff and the Aboriginal Women's Advisory Committee. It explains when, why and which patients are asked about Aboriginal identity and where to get further information and advice about 'asking the question'. As with the RWH Aboriginal artwork postcard (Practice Example 18), it was developed to disseminate during RWH staff training on 'Asking the question' (and other training) and is also widely accessible during promotional events and to new staff via staff orientation and the RWH Human Relations department. The style of the postcard is of similar format and design to the Aboriginal artwork postcard to signify a suite of complementary information. The postcard will be reviewed in late 2009.

4	'Asking the question: *Are you of Aboriginal or Torres Strait Islander Descent?*' script and training aid—Royal Women's Hospital	The script and training aid were developed by the AWHBU in 2008. The information is provided to all outpatient staff in conjunction with the 'Asking the Question' postcard (Practice Example 3) to improve identification of Aboriginal patients.
5	'Asking the question' *Support for Aboriginal and Torres Strait Island Patients at Western Health* presentation—Western Health	This PowerPoint presentation was developed by the AHLO based at Sunshine Hospital, Western Health, in 2009. The AHLO uses this presentation to provide training to frontline hospital staff about identifying Aboriginal patients. The presentation draws on factual information provided by DOH and includes personal photographs and local data to highlight local trends and provide greater insight into Aboriginal cultural identity.
6	'Asking the question' script—Western Health	This script was developed by the then Aboriginal Policy and Planning Officer at Western Health. It provides scripted quest This brochure is based on a template available to all health services via the ICAP Program. The purpose is to prompt staff and advise patients in relation to asking about Aboriginal patient identification. ions and responses for staff to refer to when asking patients whether they are of Aboriginal or Torres Strait Islander descent. It also includes the Planning Officer's contact details and referral process.
7	ICAP Aboriginal patient identification brochure: *Are you of Aboriginal or Torres Strait Islander descent?*—St Vincent's	This brochure is based on a template available to all health services via the ICAP Program. The purpose is to prompt staff and advise patients in relation to asking about Aboriginal patient identification.
8	ICAP Aboriginal patient identification poster—St Vincent's	This poster is based on a template available to all health services via the ICAP Program. The purpose is to prompt staff and advise patients in relation to asking about Aboriginal patient identification.
9	*Hospital data tip sheet*—ICAP Project Officers	This document was written by the ICAP Project Officers in 2009. It provides examples of how hospitals can use data about Aboriginal and Torres Strait Islander patients to inform service planning, development and review.

10	Quality Improvement Scorecard—St Vincent's	The Aboriginal Health Quality Improvement Scorecard is used by all St Vincent's departments and programs to monitor key performance indicators based on hospital accreditation standards. These indicators were developed in mid-2007 in consultation with the Aboriginal Cultural Awareness and Training Officer.
CULTURAL AWARENESS		
11	Royal Children's Hospital Clinical Guideline: *Engaging and working effectively with Aboriginal children and their parents*—Royal Children's Hospital	This example comprises intranet site material for Royal Children's Hospital (RCH) staff. It includes a clinical guideline on engaging and working effectively with Aboriginal children and their parents. It also includes information on the Aboriginal Family Support Unit, identification of Aboriginal people and general information on Aboriginal health.
12	Cultural awareness module: *Working with Aboriginal & Torres Strait Islander Patients*—Royal Women's Hospital Aboriginal Women's Health Business Unit	This PowerPoint presentation was developed by staff from the RWH AWHBU. It is regularly updated and adapted for use with different groups of non-Indigenous RWH staff as part of cultural awareness training sessions. The session is delivered by staff from the AWHBU, who can also be commissioned to provide this training on a fee for service basis to other health services and other organisations (such as universities).
13	Cultural Awareness Package, Aboriginal cross-cultural webpage—Royal Children's Hospital	Developed by the RCH Koori Mental Health Liaison Officer (KMHLO). Used for staff training.
14	Awareness module on local Community: *Aboriginal Fitzroy. A visual journey*—St Vincent's	This PowerPoint presentation was developed by the Aboriginal Liaison and Training Officer (ALTO) at St Vincent's in 2009. It provides a visual tour of sites and services of significance to the Aboriginal Community in Fitzroy and surrounds. The ALTO uses this presentation to provide localised cultural awareness training to mainstream hospital staff as part of a broader suite of presentations to address different aspects of cultural awareness.
15	Request for Wurundjeri Council Welcome to Country ceremony—Wurundjeri Council	Self-explanatory—referral/request form

16	Acknowledgment of traditional owners and Welcome to Country staff card—Royal Women's Hospital	This staff card was developed by the RWH AWHBU in 2008. The card promotes the RWH policy and suggested wording for acknowledging traditional owners and Welcome to Country protocol. The card also promotes the AWHBU and is designed to be attached to staff identity card lanyards. When re-printed, the card will have some changes, including adding the Aboriginal flag.
17	Aboriginal Women's Health Business Unit postcard—Royal Women's Hospital	This postcard was developed by the RWH AWHBU in 2007. It promotes the services of the AWHBU and complements information provided in the RWH 'Asking the question' postcard (Practice Example 3).
18	Aboriginal artwork (by Kylie A. Bird) postcard—Royal Women's Hospital	This postcard was developed by the RWH in 2008 to promote and explain Aboriginal artwork displayed in the main foyer. The artwork was launched during NAIDOC Week 2008 to provide a welcoming physical environment for Aboriginal and Torres Strait Islander patients. The artwork includes a painting by Kylie Bird, a map of traditional placenames in the lands of the Kulin Nation and an acknowledgment of the Kulin Nations as the traditional land owners of the Country on which the RWH stands.
RELATIONSHIPS		
19	*Memorandum of Understanding in Respect of the Partnership between the Victorian Aboriginal Health Service, Koori Kids and Adolescent Mental Health Network and Women's and Children's Health, Royal Children's Hospital Mental Health Service* —Royal Children's' Hospital and the Victorian Aboriginal Health Service	Self-explanatory—formal agreement between hospital and Community.

20	*3rd Health Partnership Agreement for the Improvement of Aboriginal Health in the Goulburn Valley*—Rumbalara Aboriginal Co-operative and Goulburn Valley Health	Self-explanatory—formal agreement between hospital and Community.
21	*Partnership Agreement for the Improvement of Koori Health Status in the Grampians Region*—Ballarat and District Aboriginal Co-operative and Ballarat Health Services	Self-explanatory—formal agreement between hospital and Community.
22	*Introduction to Dispute Settlement of Victoria* presentation—Dispute Resolution Centre of Victoria	This presentation outlines information on a skilled, culturally specific dispute resolution service available to mainstream services.
STRATEGIC PLANNING		
23	Aboriginal Health Action Plan: *Implementation Plant 2007–2009 for Maroondah Hospital*	This plan was developed by the then Senior Metropolitan ICAP Project Officer in conjunction with the Aboriginal Health Working Party at Maroondah Hospital in early 2007. This working party is chaired by the Social Work Manager and includes the Director of Allied Health, Patient Relations Manager, Operations Manager, Human Resources Manager, representatives from Mental Health and Indigenous service staff. The plan was developed in response to the ICAP reforms in 2006. It is used as a record of activities and outcomes and is reviewed regularly by the working party as part of Eastern Health's quality plan. It was last reviewed in March 2009. For further information about this document, contact: Penelope Vye, telephone (03) 9871 3516 or <penelope.vye@easternhealth.org.au>.
24	*Aboriginal Health Taskforce Action Plan—Ballarat and District Aboriginal Co-operative and Ballarat Health Services*	This action plan was developed by BHS in conjunction with the Ballarat and District Aboriginal Co-operative, and guides ongoing priorities and actions of the Ballarat Health Services ICAP Program.

25	Western Health ICAP Strategy	This strategic plan was developed in 2007 when Western Health implemented the ICAP Program. It outlines a vision statement, priorities and outcome measures for the program.
26	ICAP *Strategy Development for 2009–2012* presentation—Western Health	This PowerPoint presentation was developed by the Manager, Cultural Diversity and Aboriginal Health at Western Health. It was used to inform an ICAP strategic planning meeting in March 2009.
27	ICAP presentation—Senior Metropolitan ICAP Project Officer	This PowerPoint presentation was developed by the Senior Metropolitan ICAP Project Officer in June 2009. It was presented to identified 'ICAP champions' within Melbourne Health to encourage and inform progression of the Melbourne Health ICAP Program. The presentation covers the ICAP Program background, rationale and political context and the role of health services and AHLOs in the ICAP Program. This presentation was complemented by data and other information specific to Melbourne Health. The presentation has also been adapted and presented to other groups of staff at Melbourne Health and other hospitals for similar purposes.
28	*Koori Mental Health Program Steering Committee Terms of Reference*—Royal Children's Hospital	This outlines the terms of reference for the RCH Koori Mental Health Program Steering Committee.
29	*Work Plan and Budget Proposal 2008*—AHLO Northern Health	This ICAP work plan and budget proposal was written by the Site Manager, PANCH Health Service, Northern Health, and the Aboriginal Hospital Liaison Officer, Northern Health, in 2008. It was presented to senior hospital management staff and resulted in the provision of a $15,000 grant for basic welfare needs for Aboriginal and Torres Strait Islander patients. (For example: toiletries, transport tickets, meal vouchers etc.). Ready access to this type of welfare support for Aboriginal patients is typically problematic for AHLOs and can be a significant barrier to service access and compliance for Aboriginal patients.

30	*Aboriginal Women's Health Associates* program overview—Royal Women's Hospital Aboriginal women's Health Business Unit	The Aboriginal Health Associates program was developed in 2000 by the RWH AWHBU. The program provides a direct link between the Aboriginal Community health workers and the RWH staff from all patient service areas. This helps build and support more effective partnerships between the RWH and Aboriginal communities. As a consequence, enhancement of service provision and continuity of care for Aboriginal women using RWH services should follow. Aboriginal Health Associates are available to all staff via the RWH website and wear identification badges. The Associates are often accessed by staff from the AWHBU to assist with service access for women. The Associates program continues to grow, with over 40 Aboriginal Health Associates in 2009 (compared to 20 in 2004). The AWHBU runs forums for the Associates throughout the year to provide ongoing training and support and identify areas of development.
31	*Aboriginal Women's Health Associates* program membership list—Royal Women's Hospital	This is a list of the job titles and departments of the Aboriginal Women's Health Associates at the RWH as of June 2009 (see Practice Example 30).
32	Example business case for an AHLO appointment—Senior Metropolitan ICAP Project Officer	This example business case was developed by the Senior Metropolitan ICAP Project Officer in August 2009, with the assistance of health service staff. It is based on a business case that was successfully used to secure approval for the appointment of a full-time, ongoing AHLO at a Victorian health service. The case draws on Indigenous health statistics and the policy context at the time of writing to highlight the importance of AHLOs in helping to meet the objectives of the ICAP Program.
33	ICAP organisational structure—Melbourne Health	This flow chart illustrates the organisational structure in place for the ICAP Program at Melbourne Health.

STAFF RECRUITMENT: POSITION DESCRIPTIONS		
34	Position description: Aboriginal Family Support Worker/Hospital Liaison Officer—Mercy Hospital for Women (Mercy)	These position descriptions have been developed by a range of hospitals to support the recruitment of AHLOs and other ICAP-related positions.
35	Position description: Koori Social and Emotional Well-being Worker—Royal Children's Hospital	Further information about employment of AHLOs, including example Key Selection Criteria, is provided in the ICAP Guidelines, available on the ICAP website (www.health.vic.gov.au/koori/icap).
36	Position description: Aboriginal Policy and Planning Officer—Western Health	
37	Position description: Aboriginal Hospital Liaison Officer—St Vincent's	
38	Position description: Aboriginal Liaison and Training Officer (ALTO)—St Vincent's	
39	Position description: ICAP Coordinator—St Vincent's	
STAFF RECRUITMENT: JOB ADVERTISEMENTS		
40	Senior Koori Liaison Officer—Latrobe Regional Health	These advertisements have been developed by a range of hospitals to support the recruitment of Aboriginal Hospital Liaison Officers and other ICAP-related positions.
41	Aboriginal Hospital Liaison Officer—Southern Health	
42	Aboriginal Support and Liaison Officer (ASLO)—Maroondah Hospital	
43	Aboriginal Health Unit Team Leader and Aboriginal Liaison Officers (ALOs)—Mildura Base Hospital	
44	Aboriginal Liaison and Training Officer (ALTO)—St Vincent's (in *Koori Mail*)	
45	Aboriginal Liaison and Training Officer (ALTO)—St Vincent's (in *The Age*)	