Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
The Doctor symbol with the staff and two snakes has long represented medical societies. The symbol was derived from Asklepios the ancient mythical God of medicine. Asklepios was renowned for his gentle humane remedies and his humane treatment of the mentally ill. The great serpent is represented in Asklepios symbol and has been adopted in contemporary medicine to represent the dual role of a physician, who deals with life and death, sickness and health.

My painting depicts Asklepios snakes without the staff. I have painted two different serpents, representing two different cultures, both equally important. The organs within the serpents represent health and reproduction. I have replaced the staff with a circle representing many Aboriginal Nations and Tribes throughout Australia. I have dotted the circle red, black and yellow the colours of the Aboriginal flag.

My story begins in my dream, I saw two snakes one white and one black.

One no bigger than the other both snakes of equal power and respect, their beauty profound and glorious.

Neither snake were the same and not like the other. Their prints in the sand were alike but told different stories.

Their fate had brought them together, their journeys long and telling. They watch with silence, understanding and purpose.

Curious they studied each other gently acknowledging each other's strengths and weakness without contempt.

Finally they shared stories, they spoke of hardships and prosperity, they spoke of family and traditions, culture and love. They grew fond of each other, they celebrated, they laughed and they cried all in one night.

At the end of the night one of the serpents stopped and said 'We are so different yet so much the same'

**MORAL OF THE STORY**

We are all creatures of Mother earth, we come from different traditions and cultures, if we choose to progress forward together as one we need to open our hearts to each other's differences.

*By Artist – Peter Jensen*
Research team

University of Western Sydney

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Dr Penelope Abbott
Dr Berice Anning
Dr Ron Brooker
Dr Ruth Morgan (Research Officer)
Mr Chris Martin (Administrative Assistant)
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URBIS:

Dr Linda Kurti
Mr Julian Thomas

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Ms Ada Parry
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Suggested citation

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The research team acknowledges the key input of the following people and organisations:

- General Practice Education and Training Cultural Educators and Cultural Mentors Network who not only conceived and planned this research but provided input throughout the research;

- General Practice Education and Training who funded the research;

- General Practice Education and Training Cultural Educator and Mentor Reference Group, Ms Gaye Doolan, Mrs Rose Gilby, Mr Kym Thomas and Professor Marlene Drysdale, who oversaw the research process and the development of this report;

- General Practice Education and Training Senior Aboriginal Health Training Advisor, Professor Marlene Drysdale, and Aboriginal Health Training team members, Ms Nicole Pollock and Ms Isobel Shearman, who facilitated the research;

- Mr Peter Jensen, who created the title page art work titled "Urudh Yarswmaka" and the accompanying story describing cultural education and mentoring;

- Uncle Gabriel Bani, Wagadagum Chief, Mabiaug Island, who has given Mr Jensen the name "Urudh Yarswmaka", and provided permission for UWS to use it for this report ("Urudh Yarswmaka" describes how two traditional lugger boats are running full sail, side by side as if they are tied together with rope); and

- All the stakeholders and organisations listed in this report who contributed their time and insights to the research.
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<th>Definition</th>
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<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation</td>
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<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Service</td>
</tr>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
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<tr>
<td>AGPT</td>
<td>Australian General Practice Training</td>
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<tr>
<td>AHCWA</td>
<td>Aboriginal Health Council of Western Australia</td>
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<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council</td>
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<tr>
<td>AHRC</td>
<td>Australian Human Rights Commission</td>
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<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<tr>
<td>AIDA</td>
<td>Australian Indigenous Doctors Association</td>
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<tr>
<td>AMC</td>
<td>Australian Medical Council</td>
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<tr>
<td>AMS</td>
<td>Aboriginal medical service</td>
</tr>
<tr>
<td>CE</td>
<td>Cultural Educator</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CM</td>
<td>Cultural Mentor</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
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<tr>
<td>CRT</td>
<td>Critical reflection tool</td>
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<tr>
<td>DoHA</td>
<td>Australian Government Department of Health and Ageing</td>
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<tr>
<td>ECT</td>
<td>External clinical teaching</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
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</tr>
<tr>
<td>GPR</td>
<td>General Practice Registrar</td>
</tr>
<tr>
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<td>General Practice Supervisor</td>
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<tr>
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<td>IGPRN</td>
<td>Indigenous General Practice Registrar Network</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>IHTP</td>
<td>Aboriginal and Torres Strait Islander (Indigenous) Health Training Post&lt;br&gt;1</td>
</tr>
<tr>
<td>JD</td>
<td>Junior Doctor (also known as a Prevocational General Practice Placements Program trainee)</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine, Bachelor of Surgery</td>
</tr>
<tr>
<td>ME</td>
<td>Medical Educator</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NAIDOC</td>
<td>National Aborigines and Islanders Day Observance Committee</td>
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<tr>
<td>NCCC</td>
<td>National Centre for Cultural Competence</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>NIRA</td>
<td>National Indigenous Reform Agreement</td>
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<tr>
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<td>New South Wales</td>
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<td>Northern Territory</td>
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<td>NTGPE</td>
<td>Northern Territory General Practice Education</td>
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<tr>
<td>OSCE</td>
<td>Objective structured clinical exam</td>
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<tr>
<td>PGPPP</td>
<td>Prevocational General Practice Placements Program</td>
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<tr>
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<td>Primary health care</td>
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<td>QI &amp; CPD</td>
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<td>Royal Australian College of Physicians</td>
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<tr>
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<td>Royal Australian College of General Practitioners</td>
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<tr>
<td>RAP</td>
<td>Reconciliation action plan</td>
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<tr>
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<tr>
<td>RTP</td>
<td>Regional Training Provider</td>
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<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>UWS</td>
<td>University of Western Sydney</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>WAGPET</td>
<td>Western Australian General Practice Education and Training</td>
</tr>
</tbody>
</table>

1 The term “Indigenous” is used with reference to and respect of both Aboriginal and Torres Strait Islander peoples. IHTPs refer to training positions within a college (ACRRM/RACGP) accredited Aboriginal and Torres Strait Islander health training facility. The facilities are accredited to deliver vocational training within an Aboriginal and Torres Strait Islander health context to GPRs enrolled in the AGPT program.
Glossary

Assessment is the process of documenting, in measurable terms, knowledge, skills, attitudes and beliefs (Linn & Gronlund, 2000). In the context of cultural education and cultural mentoring in vocational training, it is the process of objectively understanding General Practice Registrar and Junior Doctor practice by observation and measurement.

Evaluation is the systematic determination of merit, worth, and significance of something or someone using criteria against a set of standards (Scriven, 1991). In this report, evaluation of cultural education and mentoring programs is the process of observing and measuring for the purpose of judging them and of determining their “value,” either by comparison to similar things, or to a standard.

Formative evaluation or assessment provides information for improvement (Scriven, 1967). Summative evaluation or assessment provides information for decision makers to make judgements about adopting, continuing, expanding or terminating a program or a practice (Scriven, 1967).
Executive Summary

Introduction

In 2012 General Practice Education and Training commissioned the University of Western Sydney, who subcontracted with Urbis, to conduct research aimed at developing the evidence base to support training in cultural competence for doctors working with Aboriginal and Torres Strait Islander people. This research is aimed to inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

Letters of support for the research were provided by the National Aboriginal Community Controlled Health Organisation and its affiliate organisations and ethics approval was received from the Human Research Ethics Committees of the University of Western Sydney, New South Wales Aboriginal Health and Medical Research Council, Northern Territory Department of Health and the Menzies School of Health Research as well as the Central Australia Human Research Ethics Committee, Aboriginal Health Council of South Australia Aboriginal Health Research Ethics Committee and Western Australian Aboriginal Health Ethics Committee.

The research was framed at all times by the research outcomes and research questions developed by General Practice Education and Training Cultural Educators and Cultural Mentors and reflected in the contract between General Practice Education and Training and the University of Western Sydney.

Research methods

A mixed methods approach was used, collecting data from a range of sources including a review of the literature, online and paper-based surveys, face to face and telephone interviews and guided discussion with the General Practice Education and Training Cultural Educators and Mentors Network members at a national workshop. All participants were provided with the ethics approved participant information statement and completed a standard participant consent form.

The data from each of the above sources was analysed in consultation with a team of three experienced Cultural Educators/ Mentors who were part of the research team. A General Practice Education and Training convened Cultural Educator/Cultural Mentor Reference Group further advised on all aspects of the research.

Key findings

In section 3 of the report a synopsis of the key findings of the literature review, the surveys and the interviews and focus groups is presented. The more detailed reports related to each methodology can be found in three
appendices. In the discussion (section 4), the findings across all three arms of the research are integrated and key learning from the research considered.

Participants in the research included people in a range of roles in each of the 17 Regional Training Providers, including nominated representatives of 13 Regional Training Providers. Participants included Regional Training Provider delegates such as Chief Executive Officers or other senior staff such as Directors of Medical Education, Medical Educators, representatives of affiliated Aboriginal and Torres Strait Islander Health Training Posts, Cultural Educators, Cultural Mentors, and General Practice Registrars and Junior Doctors. Within Aboriginal and Torres Strait Islander Health Training Posts we consulted with Chief Executive Officers and their delegates, Aboriginal Health Workers, General Practice Supervisors and other relevant Aboriginal or Torres Strait Islander staff. Representatives of a wide range of key stakeholder organisations were also consulted. Details of the research participants are found in section 1.4 of this report.

In summary the findings of the research are:

- Cultural education and cultural mentoring are contested terms even beyond the Australian General Practice vocational training environment. Definitions provided by General Practice Education and Training are generally agreed and found to be helpful, however a range of additional understandings highlight the complexity of these activities. In addition there is great uncertainty regarding the roles of Cultural Educators and Cultural Mentors including who is appropriate to undertake this teaching and how they are best recruited, engaged and supported. The roles themselves overlap and are undertaken by a variety of people in different employment structures;

- Support for Cultural Educators and Cultural Mentors varies greatly with key strategies noted to improve support including adequate and appropriate remuneration, recognition in terms and conditions of employment of importance of family and community responsibilities, organisational support for Cultural Educators/Cultural Mentors and cultural education, and strong partnerships with Medical Educators;

- There are few opportunities for professional development and career advancement for Cultural Educators and Mentors and though engagement in these activities is not recommended to be a pre-requisite for employment, individualised plans as well as peer mentoring and national networking may enhance the sustainability of the roles. Individualised training for Cultural Educators and Mentors is recommended to include teaching and mentoring skills training relevant to the local situation, as well as knowledge about the context of General Practice Registrar/ Junior Doctor training;
• Cultural education is being delivered across all Regional Training Providers though cultural mentoring appears to be less widely available. Cultural mentoring is largely seen as being available most usually for General Practice Registrars and Junior Doctors in Aboriginal and Torres Strait Islander Health Training Posts who are either confident and proactive in seeking cultural advice or who need remediation or are seen to be making errors. Cultural education is extended in some Regional Training Providers to staff and related stakeholders, in particular General Practice Supervisors. Cultural Educators and Mentors are not as routinely involved in the development and evaluation of cultural education programs as they are in the delivery of the programs. Assessment, particularly of values and attitudes is not widely reported;

• Survey and interview participants agreed with recommendations in the literature for education to be based on adult learning principles, particularly involving experiential learning, adequate time for reflection and active engagement with Aboriginal and Torres Strait Islander people and communities. Similarly those communities and peoples are recommended to lead the determination of what should be taught and how. The importance of engagement with Aboriginal and Torres Strait Islander communities and people is well recognised by those Regional Training Providers consulted, however some find this process difficult and requested guidance on how to achieve this;

• With cultural education, learning is recommended to include history and culture and the impacts of these on health, with learning adapted to the particularities of local communities especially for cultural mentoring. In both the literature and the consultations the need for learning to reflect the learner’s needs and to build over a lifetime towards cultural competency is well noted. This presents the challenge of assessing the needs of individual learners. Some suggestions are made in this report;

• The preparation of General Practice Registrars and Junior Doctors for Aboriginal and Torres Strait Islander Health Training Posts is sometimes supported by Regional Training Providers though more often provided by the Aboriginal and Torres Strait Islander Health Training Post. Suggestions for how this may be enhanced are detailed in Section 3.2.4 of Appendix 3; and

• An effective learning approach reported in the literature and strongly reflected in the consultations is the “two-way learning” model of teaching, which in the General Practice training context, means cultural learning is equally valued compared to medical learning. This approach is most likely to be evidenced by strong and respectful partnerships between Medical Educators and Cultural Educators/ Cultural Mentors and supportive structures within Regional Training Providers.
Building Aboriginal And Torres Strait Islander Cultural Education And Cultural Mentoring Capacity

Using the evidence for best practice described in the literature as well as suggestions and recommendations of research participants, a range of recommendations is presented. Most notably these include principles that will inform the proposed *National Framework for Cultural Competence in Prevocational and Vocational General Practice Training*. The principles are presented in the following section of this report and described in more detail in section 5.

Other recommendations include:

1. improved delineation of the Cultural Mentor role to avoid the potentially unlimited scope of the role, both in terms of time commitment and availability and the expertise expected of the Cultural Mentor;

2. enhanced understanding and support of the Cultural Mentor role to make it more accessible both to Aboriginal and Torres Strait Islander people with the appropriate skills and experience as well as to General Practice Registrars and Junior Doctors who would benefit from cultural mentoring;

3. extension of cultural education to Junior Doctors as well as to Regional Training Provider staff and other stakeholders particularly General Practice Supervisors;

4. enhancement of cultural mentoring activities within General Practice training, including for General Practice Registrars who are not undertaking a placement in an Aboriginal and Torres Strait Islander Health Training Post;

5. increased opportunities for General Practice Registrars and Junior Doctors to undertake experiential learning particularly through Aboriginal and Torres Strait Islander Health Training Post placements;

6. exploration of cultural education and mentoring needs of Aboriginal and Torres Strait Islander Junior Doctors and General Practice Registrars;

7. rigorous evaluation which rises above short-term satisfaction and explores the impact of cultural training on changes in practice at the individual and organisational levels;

8. adequate long term, core funding for cultural education and mentoring; and

9. provision of guidance for Regional Training Providers including in practical strategies to promote organisational cultural competence and positive relationships with local Aboriginal and Torres Strait Islander communities, also regarding recruitment and support of Cultural Educators and Cultural Mentors.
Core principles to inform a National Framework for Cultural Competence in Vocational and Prevocational General Practice Training

Based on the research findings the following core principles are recommended to inform a new National Framework for Cultural Competence in Prevocational and Vocational General Practice Training. These core principles are explained in more detail in section 5 of this report.

Understandings of cultural education and cultural mentoring

1. In the General Practice environment, cultural education and cultural mentoring are best experienced through a two-way learning approach in which General Practice education is informed by Aboriginal and Torres Strait islander culture and knowledge as well as medical learning. In some circumstances this may mean cultural and medical teaching is delivered in partnerships between Aboriginal and Torres Strait Islander people and non-Indigenous health professionals or educators. These partnerships require and model respectful collaborative professional relationships.

2. Cultural education and cultural mentoring are carried out by Aboriginal and Torres Strait Islander people. These people may be engaged in a variety of roles both with relevant organisations and within local communities.

3. Cultural education and cultural mentoring are recognised as overlapping activities.

4. These activities may be carried out in a variety of locations, including in the Regional Training Provider offices, however they should engage community controlled health organisations such as Aboriginal Community Controlled Health Services or State or Territory Affiliates of the National Aboriginal Community Controlled Health Organisation.

5. Cultural education and cultural mentoring are enacted in different ways according to the local Aboriginal and Torres Strait Islander context.

6. Cultural education and cultural mentoring are supported by systems and organisational approaches as well as professional standards that value cultural competence. This includes a reflexive approach on the part of the organisation.

Employment and support of Cultural Educators and Cultural Mentors

1. Cultural Educators and Cultural Mentors are recognised and supported by Aboriginal and Torres Strait Islander communities and/or organisations.
2. Those engaged in cultural education and cultural mentoring are encouraged but not required to nominate themselves as Cultural Educators or Cultural Mentors. The roles and activities rather than the position titles of Cultural Educator or Cultural Mentor can be used to describe the personnel engaged in the cultural education and mentoring activities.

3. Cultural Educators and Cultural Mentors are remunerated through negotiated arrangements according to individual circumstances.

4. Employment terms and conditions include recognition of the importance of time spent with communities engaging in culturally significant activities.

5. Professional needs of Cultural Educators and Cultural Mentors are addressed through support for professional development activities including peer support and networking activities.

6. Cultural Educator and Cultural Mentor professional development activities are negotiated according to individual, community and organisational needs including, potentially, development of teaching and mentoring skills; understandings of cross cultural stress and impacts of cross cultural stress on non-Indigenous health professionals as well as on Cultural Educators and Mentors; and awareness of the Australian General Practice Training context including colleges’ curriculum requirements.

7. Cultural Educators and Cultural Mentors are supported to plan individualised career pathways including the achievement of additional qualifications. Additional study or achievement of qualifications is not however, a requirement for the roles.

Cultural education and cultural mentoring programs including development, evaluation and assessment

1. Local communities and/ or Aboriginal and Torres Strait Islander Health Training Posts are actively engaged in the development and oversight of cultural education and cultural mentoring programs so that these are reflective of local community experience, knowledge, values and needs.

2. Cultural Educators and Cultural Mentors work in respectful partnerships with Medical Educators in implementing two-way learning approaches that value both cultural and medical learning.

3. Cultural education programs are based on adult learning principles with a particular focus on active learning through engagement with Aboriginal and Torres Strait Islander people.
4. Increased General Practice Registrar and Junior Doctor access to well supported Aboriginal and Torres Strait Islander Health Training Posts provides the most effective and appropriate learning engagement with Aboriginal and Torres Strait Islander people.

5. Programs present cultural education as life-long learning and as a result of this, formative assessment is used to gauge knowledge, skills, attitudes and behaviours, in order to tailor learning to individual General Practice Registrar and Junior Doctor needs. As a life-long learning activity, cultural education also needs to be vertically integrated across university, vocational training and ongoing GP learning environments.

6. The Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine Aboriginal and Torres Strait Islander health curriculum statements define the learning outcomes required of General Practice Registrars. These along with the related assessment processes set the standard for cultural education and mentoring activities provided by Regional Training Providers.

7. Cultural education is extended to all stakeholders within the organisation including for Regional Training Provider staff and General Practice Supervisors as well as General Practice Registrars and Junior Doctors.

8. Effective cultural education and cultural mentoring programs require opportunities for learners and organisations to reflect on their own cultures and how these impact on their interactions and relationships with Aboriginal and Torres Strait Islander people. This is best facilitated through open and respectful communication in a culturally safe environment.
1. Introduction

The introduction to this report firstly describes the General Practice vocational training environment, with a focus on activities relating to training in Aboriginal and Torres Strait Islander health. This is followed by the context, rationale and scope of the research and an introduction to the research report.

1.1. General Practice vocational and prevocational training in Aboriginal and Torres Strait Islander health

In June 2000, as a result of the review of GP training, the Honourable Michael Wooldridge announced the establishment of General Practice Education and Training Limited (GPET). General Practice Education and Training set up a regionalised system of General Practice education and training, now delivered through 17 Regional Training Providers (RTPs) across Australia.

General Practice Education and Training manages the Australian General Practice Training (AGPT) and Prevocational General Practice Placements (PGPPP) programs on behalf of the Australian Government. The Minister for Health and Ageing identified the AGPT program as well placed to make a significant contribution to the Council of Australian Government’s (COAG) ‘Closing the Gap’ strategy by increasing Aboriginal and Torres Strait Islander peoples’ access to culturally safe primary health care. General Practice Education and Training is achieving this by providing more opportunities for General Practice Registrars (GPRs) to develop the skills and knowledge necessary to undertake quality GP training in Aboriginal and Torres Strait Islander health (GPET 2013).

Given the disparity in morbidity and mortality experienced by Aboriginal and Torres Strait Islander Australians in comparison with non-Indigenous Australians and the important role of General Practice in improving health outcomes, a key focus for GPET has been training in Aboriginal and Torres Strait Islander health (Martin & Reath 2011). Based on recommendations from reports including the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989) and the findings of the Royal Commission into Aboriginal Deaths in Custody (1991) and many subsequent reports, as well as in alignment with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) curriculum statements (RACGP 2011b, ACRRM, 2011), this training has included a strong focus on skills related to cross cultural engagement with Aboriginal and Torres Strait Islander patients and communities.

Aboriginal and Torres Strait Islander people are engaged by RTPs as well as by Aboriginal Community Controlled Organisations (ACCCHOs) to support this learning. They have generally been referred to in this work context, as Cultural Educators (CEs) and Cultural Mentors (CMs) (GPET, 2011a).
1.2. Aboriginal and Torres Strait Islander Cultural Educators and Cultural Mentors and the call for research

Cultural Educators (CEs) and CMs were first employed by the RACGP Training Program prior to 2001 and were supported by the RACGP to meet regularly to share ideas and network. GPET has expanded this networking opportunity and CEs and CMs now meet twice annually, gathering annually also with Medical Educators (MEs) who have roles in teaching in Aboriginal and Torres Strait Islander health, usually in partnership with the CEs.

Cultural Educators and Mentors have repeatedly called for improved recognition and support of their roles in General Practice training, this culminating at a meeting in Alice Springs in 2010 in the development of nine recommendations which were presented to the GPET Board and accepted in principle in 2011 (GPET 2011b).

Three actions resulted from these recommendations. The first, development of accepted definitions of cultural education and cultural mentoring, has been completed. The third is ongoing and refers to implementation of the activities related to segment 3 of the previous GPET “Framework for General Practice Training in Aboriginal and Torres Strait Islander Health” (GPET 2004b), addressing support of CEs and CMs.

The second recommendation from the 2010 meeting in Alice Springs was a call for a scoping study or survey project to determine understandings and level of cultural education and cultural mentoring activity. This research addresses this recommendation.

1.3. The research team

In 2012 GPET put out a request for tender for the provision of research expertise on “Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity”. A team of researchers from the Department of General Practice at the University of Western Sydney (UWS) won the tender and contracted with GPET to undertake the research project. The UWS researchers subcontracted with Urbis and also contracted three experienced CEs to advise on the process and outcomes of the research (Table 1).

TABLE 1: THE RESEARCH TEAM

<table>
<thead>
<tr>
<th>The Research Team</th>
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<tbody>
<tr>
<td><strong>UWS:</strong> Prof Jenny Reath, Dr Penny Abbott, Dr Berice Anning, Dr Ron Brooker</td>
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<tr>
<td><strong>UWS Research Officer:</strong> Dr Ruth Morgan</td>
</tr>
<tr>
<td><strong>URBIS:</strong> Dr Linda Kurti, Mr Julian Thomas</td>
</tr>
<tr>
<td><strong>Cultural Consultants:</strong> Associate Professor Mary Martin, Ms Ada Parry, Ms Elaine Gordon</td>
</tr>
<tr>
<td><strong>GPET Project Reference Group:</strong> Professor Marlene Drysdale, Ms Gaye Doolan, Mr Kym Thomas and Mrs Rose Gilby</td>
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</table>
The research team liaised closely with the GPET project lead Professor Marlene Drysdale (and originally Dr Ed Green). A GPET CE/CM Project Reference Group was convened to review the research as it progressed. This group comprised Professor Marlene Drysdale, Ms Gaye Doolan, Mr Kym Thomas and Mrs Rose Gilby.

The GPET CE/CM Project Reference Group was supported by GPET Aboriginal Health Training Team members, Ms Nicole Pollock and Ms Isobel Shearman.

1.4. Scope of the research

A list of stakeholders to be consulted was included in the tender document and re-iterated in the UWS contract (Table 2).

**TABLE 2: STAKEHOLDERS TO BE CONSULTED IN THE RESEARCH**

<table>
<thead>
<tr>
<th>The GPET Cultural Educators and Cultural Mentors’ Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Training Providers, including General Practice Registrars and Junior Doctors</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Health Training Posts, including Chief Executive Officers, Cultural Educators, Cultural Mentors and General Practice Supervisors</td>
</tr>
<tr>
<td>The National Aboriginal Community Controlled Health Organisation and its State and Territory Affiliates</td>
</tr>
<tr>
<td>The Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>The Australian Indigenous Doctors’ Association and the Indigenous General Practice Registrar Network</td>
</tr>
</tbody>
</table>

The research objectives were framed in the contract as “to develop an evidence base that improves knowledge and understanding of what constitutes cultural education and cultural mentoring within the context of vocational and prevocational training in General Practice. In particular, to identify an accepted set of principles that can be drawn from the evidence to inform a *National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.*”

Project outcomes were stated as follows:

“The project team will deliver the following outcomes:

a. Determination of how RTPs assess cultural competence against the outcomes specified in respective Aboriginal and Torres Strait Islander health curriculum statements of the RACGP and ACRRM.

b. Identification of how RTPs develop and determine cultural education, in particular:

- reasons for this educational methodology;
- workforce used to develop and deliver this training; and
• How is this training evaluated?

c. Identification of how registrars and Junior Doctors (JDs) are prepared for working in an Aboriginal and Torres Strait Islander Health Training Post to include:

• Is cultural mentoring provided?
• Is the registrar’s experience assessed and evaluated?

d. Identification of core principles which will inform a new *National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.*

In addition 16 research questions were required to be answered (Table 3).

**TABLE 3: RESEARCH QUESTIONS**

1. What is currently understood to be cultural education?
2. What is currently understood to be cultural mentoring?
3. What practices are currently used to establish positive relationships with Aboriginal and Torres Strait Islander peoples and communities? What is needed to engage and establish partnerships?
4. When are Cultural Educators ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training?
5. When are Cultural Mentors ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training?
6. How are Cultural Educators and/or Cultural Mentors remunerated?
7. Do Regional Training Providers have formal policies in place in relation to supporting Cultural Educators and Cultural Mentors?
8. Are Cultural Educators and/or Cultural Mentors provided with the opportunity to participate in professional and cultural support and development?
9. Do Regional Training Providers run cultural education activities for staff at all levels, including medical educators and supervisors?
10. Are Registrars and Junior Doctors required to prepare for working in Aboriginal and Torres Strait Islander communities?
11. Are Registrars and Junior Doctors required to undertake formal cultural awareness training at any point during General Practice training?
12. How is Aboriginal and Torres Strait Islander health incorporated into current General Practice education and training practices?
13. Are there formal processes for feedback on cultural education and/or cultural mentoring activities?
14. Are there feedback mechanisms for Registrars and Junior Doctors who undertake an Aboriginal and Torres Strait Islander Health Training Post, and vice-versa?
15. What is needed to build sustainable cultural education and cultural mentoring capacity to meet registrar training needs?
16. What is needed to build partnerships with Aboriginal and Torres Strait Islander peoples and communities to sustain registrar training needs?
The mixed methods approach to the research (described in Section 2 of this report) was stated in the contract to include review of the literature, survey of key stakeholders as well as interviews and focus groups. The contract reflecting the UWS tender outlined how the approaches used would address the research questions above (Table 3).

1.5. Reading this report

This document reports the findings of the research. The methods section provides a detailed description of the approaches used. The results section summarises, in separate subsections, the outcomes of the literature review, the surveys and the interviews and focus groups. More detailed reports on each of the aspects of the research can be found in Appendices 1 –3. The discussion draws together key findings of the research. In the final section of this report the project outcomes as stated in the contract are presented including core principles to inform the national framework as well as recommendations related to the research process and future research in this area.
2. Methods

2.1. Overview

This research project employed mixed methods. As stated in the contract with GPET, data was collected from the following key sources:

- a review of the literature, both Australian and international;
- dissemination of online and paper-based surveys, designed for CEs and CMs, GPRs, JDs, RTPs, Aboriginal and Torres Strait Islander Training Posts (IHTPs), and other key stakeholders;
- face to face interviews and focus groups in six regions, with RTPs, GPRs and JDs, IHTPs, CEs and CMs;
- additional telephone or face to face interviews with key national stakeholders, and with seven other RTPs; and
- guided discussion with the GPET CEs and CMs’ Network members at the Perth national workshop, September 2013.

Each of the participants, including the workshop attendees, was provided with the ethics approved participant information statement and completed a standard participant consent form.

The specifics of the data analysis for each of the three research methods are described in the relevant sections below.

A number of research questions were identified in the request for tender. The research methodology was designed to ensure that the research team was able to answer each of the 16 questions. Not all research activities addressed all of the questions, but there were areas of overlap, for instance between the surveys and the interview guides, which allowed the research team to verify emerging themes through triangulating research findings.

2.2. Addressing the research questions

As noted in Table 3, a comprehensive list of research questions framed the research. Table 4 following describes how these were addressed by each of the research strategies used.
## TABLE 4: RESEARCH QUESTIONS AND PROPOSED METHODOLOGY

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Methodology/ Data collection methods</th>
<th>Stakeholders who will be consulted/interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Understanding of Cultural Education and Mentoring</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. What is currently understood to be cultural education?</td>
<td>Literature review. Online survey, interviews and focus groups</td>
<td>RTP stakeholders as noted above; IHTPs including Aboriginal Community Controlled Health Services (ACCHSs), CEs and CMs’ Network, the National Aboriginal Community Controlled Health Organisation (NACCHO) and its State and Territory Affiliates, RACGP, ACRRM, Australian Indigenous Doctors Association (AIDA), Indigenous General Practice Registrar Network (IGPRN).</td>
</tr>
<tr>
<td>2. What is currently understood to be cultural mentoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. What practices are currently used to establish positive relationships with Aboriginal and Torres Strait Islander peoples and communities? What is needed to engage and establish partnerships?</td>
<td>Online Survey, interviews, and focus groups</td>
<td></td>
</tr>
<tr>
<td><strong>Current Capacity and Roles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. When are CEs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation (including who and where) of General Practice training?</td>
<td>Survey and interviews</td>
<td>RTPs, IHTPs including ACCHSs, CEs and CMs’ Network, and NACCHO and its State and Territory Affiliates.</td>
</tr>
<tr>
<td>5. When are CMs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation (including who and where) of General Practice training?</td>
<td>Survey and interviews</td>
<td></td>
</tr>
<tr>
<td>6. How are CEs and/or CMs remunerated?</td>
<td>Survey and interviews</td>
<td></td>
</tr>
<tr>
<td>7. Do RTPs have formal policies in place in relation to supporting CEs and CMs?</td>
<td>Survey and interviews</td>
<td></td>
</tr>
<tr>
<td>8. Are CEs and/or CMs provided with the opportunity to participate in professional and cultural support and development?</td>
<td>Survey and interviews</td>
<td></td>
</tr>
<tr>
<td>9. Do RTPs run cultural education activities for staff at all levels, including MEs and General Practice Supervisors (GP Supervisors)?</td>
<td>Survey and interviews</td>
<td></td>
</tr>
<tr>
<td>10. Are GPRs and JDs required to prepare for working in Aboriginal and Torres Strait Islander communities (e.g., an informal visit to the IHTP, meeting with significant community members, ie Elders, understand local history, etc)?</td>
<td>Review curricula for GPR and JD training, survey and interviews.</td>
<td>RTPs, IHTPs including ACCHSs, CEs and CMs’ Network, and NACCHO and its State and Territory Affiliates, RACGP and ACRRM.</td>
</tr>
<tr>
<td>11. Are GPRs and JDs required to undertake formal cultural awareness training at any point during general practice training?</td>
<td>Review curricula for GPR and JD training, survey and interviews.</td>
<td></td>
</tr>
</tbody>
</table>
12. How is Aboriginal and Torres Strait Islander health incorporated into current General Practice education and training practices?

Survey and interviews.

13. Are there formal processes for feedback on cultural education and/or cultural mentoring activities?

Survey and interviews

RTPs, IHTPs including ACCHSs, CEs and CMs’ Network, and NACCHO and its State and Territory Affiliates.

14. Are there feedback mechanisms for GPRs and JDs who undertake an IHTP, and vice-versa?

Survey and interviews

Needs Assessment

15. What is needed to build sustainable cultural education and cultural mentoring capacity to meet GPR training needs?

Literature review (best practice)

Survey and interviews.

RTPs, IHTPs including ACCHSs, CEs and CMs’ Network, and NACCHO and its State and Territory Affiliates, RACGP and ACRRM, AIDA, IGPRN.

16. What is needed to build partnerships with Aboriginal and Torres Strait Islander peoples and communities to sustain GPR training needs?

Focus groups and interviews

2.3. Research roles, governance and communication

The UWS-led research team included an experienced Aboriginal researcher (Dr Berice Anning) and was advised in all aspects of the research by a consultant team of highly experienced CEs. The UWS team managed and contributed to all aspects of the research and led the coordination, conduct and analysis of the interviews and focus groups. Urbis contributed expertise in all aspects of the research and led the development and analysis of surveys, and the literature review. The CE consultant team provided expert assistance in the development of survey materials, interview guides, and contributed to the analysis of the data and review of the report.

The research was further supported by a GPET CE and CM Reference Group, which provided oversight of the research project overall, endorsed the survey instruments used to gather data and reviewed the report prior to finalisation. The research team including the cultural consultant team met regularly throughout the project including four face to face meetings over five days, and five meetings by teleconference. The team also considered methodological and reporting decisions by email.

Members of the research team gave presentations on the progress of the research at the following meetings and conferences:

- GPET CEs and CMs’ and the CEs and MEs’ Workshops, September 2012 and September 2013;
Section 2: Methods

- GPET Aboriginal and Torres Strait Islander Health Training Advisory Group, November 2012 and November 2013;
- GPET CEs and CMs’ Network Workshop, April 2013; and
- GPET Board of Directors, November 2013.

2.4. Ethics approval

This research project received ethics approval from a number of Human Research Ethics Committees (HRECs):

- HREC of the University of Western Sydney;
- NSW Aboriginal Health & Medical Research Council HREC;
- Central Australia HREC;
- Aboriginal Health Council of South Australia Aboriginal HREC;
- Western Australian Aboriginal Health Ethics Committee; and
- HREC of the Northern Territory (NT) Department of Health and the Menzies School of Health Research.

2.5. Literature review

A literature review was conducted early in the project to help inform the development of research materials. The purpose of the literature review was to ensure that the research built on what was already known in the area of cultural education and mentoring, rather than covering ground that was already familiar. The literature review was primarily conducted in January through March 2013, and reviewed again in August 2013. The complete literature review is provided in Appendix 1.

The primary emphasis in the literature search was on material produced within the last ten years in Australia. Evidence was also included from other English-speaking countries where Indigenous or First Nations peoples have been a prominent focus of the health system, primarily from the United States of America (USA), Canada and New Zealand. While the search was generally confined to publications since 2000, several seminal papers or reports prior to 2000 were included because of their importance in the development of understandings of cultural competence, and the development of medical pedagogy concerning cultural competence in the clinical environment.
The databases used in the literature search were primarily the following:

- APAIS (Australian Public Affairs Information Service) Social Issues;
- APAIS Education;
- Australian Family & Society Abstracts, produced by the Australian Institute of Family Studies;
- Academic Search Complete;
- Social Sciences Citation Index (SocINDEX);
- Australian/New Zealand Reference Centre;
- Education Resources Information Center (ERIC); and
- Medline.

Since the above databases do not capture all literature, an internet search was carried out of relevant websites and search engines, including Google Scholar, the Australian Government Department of Health and Ageing (DoHA), government departments of health in New Zealand, Canada and the United States, and open source journals. We also considered the websites of key organisations, search engines and clearinghouses, such as NACCHO, RACGP, ACRRM, COAG and the Australian Indigenous HealthInfoNet.

A variety of keyword combinations were used for the searches and included General Practice, family practice, Aboriginal and Torres Strait Islander, cultural education, cultural mentoring, Indigenous health, medical training, cultural competence, cultural mentoring for medical students.

In addition, a number of unpublished reports and documents were provided to Urbis by Professor Jennifer Reath of the University of Western Sydney, and by the staff of GPET. Informal conversations with GPET staff and others also highlighted additional ideas and perspectives which were explored through a further search of the literature and the internet.

Table 5 shows the criteria used for identifying documentation for the literature review.
### TABLE 5: LITERATURE REVIEW INCLUSION CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>INCLUSION</th>
<th>EXCLUSIONS (WHERE RELEVANT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time period</td>
<td>2000-2013 (with a few exceptions)</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>English</td>
<td></td>
</tr>
<tr>
<td>Place of publication</td>
<td>Australia, United Kingdom, USA, Europe, New Zealand, Canada</td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>cultural competence in health service delivery</td>
<td>cultural competence in other policy domains</td>
</tr>
<tr>
<td></td>
<td>cultural education/mentoring/training for medical practitioners</td>
<td>cultural education/mentoring/training in other professions (with rare exception)</td>
</tr>
<tr>
<td></td>
<td>cultural education and mentoring in undergraduate, prevocational and vocational General Practice training</td>
<td></td>
</tr>
<tr>
<td>Type of publication</td>
<td>peer reviewed journal articles</td>
<td>newspaper articles</td>
</tr>
<tr>
<td></td>
<td>conference presentations</td>
<td>magazine articles</td>
</tr>
<tr>
<td></td>
<td>organisational and project reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>theoretical or conceptual papers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>training documentation and curricula</td>
<td></td>
</tr>
<tr>
<td>Rigour of research</td>
<td>systematic reviews</td>
<td></td>
</tr>
<tr>
<td></td>
<td>randomised controlled studies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>surveys</td>
<td></td>
</tr>
<tr>
<td></td>
<td>content analysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pre and post evaluations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>qualitative research</td>
<td></td>
</tr>
<tr>
<td></td>
<td>process evaluations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>theoretical and conceptual analyses</td>
<td></td>
</tr>
<tr>
<td>Findings</td>
<td>the findings are applicable to cultural competency in medical education</td>
<td>no description of findings or relevance to cultural competency in medical education</td>
</tr>
</tbody>
</table>

Ultimately, 111 documents formed the basis of the exploration of the concept of cultural competence, and the place of cultural education and cultural mentoring as means for training medical practitioners to provide culturally-appropriate care. A few exceptions to the criteria were made when a seminal article was published before 2000, and/or where an important influence to medical education was provided from the nursing literature. As indicated in the table above, while the search for evidence of best practice began by identifying evaluative and empirical studies, it was expanded to include a wide range of literature including:
• documents produced as part of medical education programs, such as published curricula, descriptions of training programs, and reports from training providers;

• theoretical and conceptual literature which seeks to define and/or propose measures for assessing cultural competence and related concepts such as cultural safety, cultural security and cultural respect;

• program documentation defining cultural education and cultural mentoring, and seeking to describe these and their impacts; and

• published reports of pilot programs and training initiatives seeking to deliver training in cultural competence.

While key themes or principles from the international literature which are applicable to Australia have been extracted, the review also sought to focus on what is already known within the Australian context, and particularly within the context of prevocational and vocational training. For that reason, although undergraduate medical education is broadly discussed, to the extent that it prepares doctors for their prevocational and vocational experiences, postgraduate or continuing medical education has been largely excluded from the discussion.

There is a significant theoretical and practical literature exploring, and seeking to assess, cultural competence. There is a smaller body of literature discussing exactly what cultural education is, how it is organised and how it is delivered, and a smaller body still of literature specifically defining or articulating cultural mentoring. Cultural education and cultural mentoring are understood to be responses to the need to equip doctors-in-training with the skills, knowledge and insight to be able to work effectively in partnership with Aboriginal and Torres Strait Islander patients and health practitioners, and the research has explored these two responses as part of a spectrum of training opportunities rather than looking at them in isolation.

It should be noted that a substantial portion of the identified relevant literature originates in the North American context, both because of the limitation of the search to English language publications, and because of the size of the USA health and educational systems. It is fair to say that the growing diversity of the USA population and the fragmentation of the USA health system have led to significant efforts by many health providers to understand how to provide health care to an ethnically diverse population without the benefits of a single, unifying national approach. Although the USA health system is very different from the Australian system, there is still much which can be learned from the intellectual, theoretical and practical work which has been undertaken to ensure that people from underserved populations are able to access health care.
2.6. Surveys

The purpose of the surveys was to gather quantitative and qualitative data that would provide insights on aspects of the 16 key research questions identified through the GPET tender brief (see Table 3 above).

2.6.1. Development of surveys

The respondents for the surveys were RTPs, IHTPs, CE/CMs and GPR/JDs.

In recognition of the differing roles, experiences and perspectives of each of these groups, tailored surveys were designed for each type of respondent. The surveys did not each address all of the research questions, with questions directed toward the expected areas of knowledge and experiences of each respondent group.

Surveys focused on the experience of delivering, receiving or supporting cultural education/mentoring programs, and did not explore the specific content of programs in different locations.

Surveys were iteratively developed with input from all members of the research team, including the consultant team of experienced CEs. The GPET Reference Group endorsed the surveys prior to piloting. Copies of the surveys are provided in Appendix 2.

2.6.2. Survey distribution

Survey distribution occurred over two phases; a pilot phase and a full distribution phase. The purpose of the pilot phase was to test both the form and distribution method of the surveys, with a view to ultimately improving response rates and data quality during full distribution.

2.6.3. Pilot phase distribution

The pilot phase for the surveys occurred in April and May 2013, and focused on two of the 17 RTPs nationally. A number of different strategies were employed to disseminate the surveys and recruit respondents.

The approaches selected in each case were those identified by the research team as most likely to secure a good response rate:

- RTP survey was sent directly to the CEO of the two selected RTPs with a request for a representative of the RTP to complete and return the survey;
- CE and CM survey was emailed directly to CE/CMs in the CEs and CMs’ Network by GPET, and also to the two pilot RTPs with a request to also disseminate this survey to their CE/CMs;
• IHTP survey was sent to the two pilot RTPs with a request to disseminate to their local IHTPs; and

• GPR/JD survey was made available through an online web link, and this web link was provided to the two designated pilot RTPs for dissemination to their GPRs and JDs.

The research team made minor (but non-substantive) modifications to the content of the surveys following the pilot phase, and also identified improvements to the dissemination process.

2.6.4. Full distribution

Between June and August 2013, surveys were again distributed through a variety of channels selected to maximise the response rate for each respondent group. The distribution reach on this occasion was extended to include all RTPs and associated CEs/CMs, IHTPs and GPR/JDs.

Surveys were disseminated through similar mechanisms to those utilised during the pilot phase. Direct email distribution was employed to reach RTPs, IHTPs and CE/CMs.

Distribution to GPR/JDs was again via a direct weblink to the survey; however the link was circulated to all registrars by General Practice Registrars Australia (GPRA) rather than by RTPs. Due to a GPET survey scheduled for release to registrars during the same timeframe, release of the GPR/JD survey was slightly delayed, but was still in the field for more than a month.

A number of modifications to survey distribution and related processes were designed to increase response rates. These included:

• telephone contact with organisations (RTPs and IHTPs) targeted by the survey to prime them for receipt of the emailed survey in advance of distribution;

• direct follow up with RTPs and IHTPs (in some cases) after distribution;

• direct engagement by members of the research team with their networks to encourage survey completion; and

• surveys were also held open for two weeks longer than initially planned.
2.7. Qualitative interviews and fieldwork

Qualitative data was collected through visits to six selected RTP regions and through interviews mostly by telephone with representatives of seven other RTPs as well as with IHTP representatives, CEs and CMs, MEs, GP Supervisors, GPRs and JDs across every RTP, also representatives of other key organisations. In addition a guided discussion with the GPET Cultural Educators and Cultural Mentors Network members at a national workshop assisted in informing the team in some areas where further information was required.

2.7.1. Development of the interview instruments

Interview instruments were designed to elicit data according to the 16 research questions. Interviews were conducted using a semi-structured interview guide. Originally, a suite of interview guides was developed, tailored for each respondent group (RTP staff, IHTP staff, CEs and CMS, and GPRs/JDs). However, after two pilot site visits, these were revised into two interview guides, one for CE/CMs, RTP/IHTP staff and stakeholders and another for GPR/JDs. The final interview guides were used for face to face and telephone interviews and are attached in Appendix 3 of this document.

2.7.2. Site visits

In consultation with the GPET CE/CM Reference Group, six of the 17 RTPs were selected for site visits. The sites were chosen to provide a mix of regional, rural and metropolitan locations. Two or three members of the research team visited each site, usually including one of the Aboriginal cultural consultants to the team and two non-Aboriginal researchers. The selected RTPs were Sturt Fleurieu, WentWest, Northern Territory General Practice Education, General Practice Training Tasmania, Bogong Regional Training Network and Tropical Medical Training.

A member of the research team initially contacted each site to arrange one or two days of interviews with RTP staff, IHTPs, CEs and CMs, and GPRs and JDs.

As with the surveys, the initial two site visits were considered as pilot sites, selected to provide feedback on the research tools and process from both rural and urban participants. Following the initial site visits in addition to developing a single aggregated interview guide, the recruitment process was changed slightly to include direct contact with IHTPs rather than contact via RTPs so that interviews could be arranged directly with interviewees.
2.7.3. Engagement with stakeholders and other participants

The research team conducted further interviews with representatives of seven other RTPs, as well as with IHTPs, GPRs and JDs, CEs and CMs, and with nominated representatives of other stakeholders. Stakeholders had been identified in the original research plan in consultation with GPET, to include organisations with important roles and perspectives on Aboriginal and Torres Strait Islander GP training. These stakeholders are noted in Table 2 of this report. Approaches to recruitment of interviewees included the following:

- email requests to RTPs for interview with organisational representative and request to circulate to CEs, CMs, MEs, GP Supervisors, IHTPs working with them;
- email requests for interview of organisational representatives to all the stakeholder organisations identified in Table 2 of this report;
- recruitment via the surveys – a request was made at the end of each survey form for those willing to undertake an interview to provide their contact details. These were followed up in all cases and in most were interviewed;
- recruitment at two GPET CE/CM Meetings which took place during the data collection period; and
- snowballing recruitment whereby people referred as working in related areas or with knowledge that may be useful in the research were contacted for interview.

Interviews were generally with a single participant though in some cases where the preference of the interviewee was for a group interview, this approach was taken. An additional opportunity towards the end of the interview period enabled consultation in an expanded “focus group”, with 59 CE/CM/MEs attending a GPET workshop (September 2013). To facilitate the discussions in this workshop, a discussion guide addressed particular questions where limited data had been gathered up to that point in time. Small group discussions were reported back to the wider group and the researchers took notes of the presentations and the discussions in the wider group.

2.7.4. Analysis

The analytical process began at the earliest stage of the project, with assessment of the literature and its key themes. These themes were further tested in the development of the surveys and interview guides, with questions designed to explore any gaps in knowledge and understanding. An iterative process throughout the
fieldwork of identifying themes and knowledge gaps, and testing these further in dialogue with the literature, research data, and team members, continued throughout the project.

With participant consent, all interviews but one were recorded and notes were taken during the course of the interview. One participant chose to have notes taken during the interview rather than audiotaping. Most of the interviews were transcribed verbatim. The data from a smaller number of interviews were handled through direct analysis of the audiotape recording with identification and transcription of key points only. In one case data was collected via email response to interview questions posed.

These data, together with notes taken during the interviews and at the workshop, were reviewed and themes corresponding to the research questions identified by two members of the research team in a framework approach (Pope et al 2000). At two face to face research team workshops, attended also by the cultural consultants, the themes identified were reviewed, looking for common areas of experience, considering the numbers responding and similarities and differences between respondent groups, as well as seeking divergent views and innovative approaches that may contribute to core principles informing a new National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.
3. Results

3.1. Introduction

In this section of the report the results of each of the three methods of enquiry are presented in turn – the review of the literature, the survey results and the results of the interviews and focus groups.

The results presented in this part of the report are a summary of the more detailed results presented in Appendices 1-3 of the report. References, largely relating to the literature review, are gathered at the end of the report. In reporting the results, both the research questions and the research outcomes are addressed as required in UWS contract with GPET. To assist the reader to gain a clear understanding of the research findings, these are reported under thematic headings addressing the questions and outcomes, as described in Table 6.

TABLE 6: KEY RESEARCH QUESTIONS RELATED TO THEMATIC REPORTING

<table>
<thead>
<tr>
<th>Themes</th>
<th>Related Key Research Questions</th>
</tr>
</thead>
</table>
| Understanding of cultural education and mentoring, including the roles of people engaged in its delivery | 1. What is currently understood to be cultural education?  
2. What is currently understood to be cultural mentoring?  
4. When are CEs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training?  
5. When are CMs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training? |
| Employment and support of CEs and CMs | 6. How are CEs and/or CMs remunerated?  
7. Do RTPs have formal policies in place in relation to supporting CEs and CMs?  
8. Are CEs and/or CMs provided with the opportunity to participate in professional and cultural support and development? |
| Nature and extent of cultural education and mentoring programs | 3. What practices are currently used to establish positive relationships with Aboriginal and Torres Strait Islander peoples and communities? What is needed to engage and establish partnerships?  
9. Do RTPs run cultural education activities for staff at all levels, including MEs and GP Supervisors?  
10. Are GPRs and JDs required to prepare for working in Aboriginal and Torres Strait Islander communities?  
11. Are GPRs and JDs required to undertake formal cultural awareness training at any point during General Practice training?  
12. How is Aboriginal and Torres Strait Islander health incorporated into current General Practice education and training practices? |
| Development and evaluation of cultural training and cultural competence assessment | 13. Are there formal processes for feedback on cultural education and/or cultural mentoring activities?  
14. Are there feedback mechanisms for GPRs and JDs who undertake an IHTP, and vice-versa? Additional question: How do RTPs currently assess cultural competence against the outcomes specified in RACGP and ACRRM Aboriginal and Torres Strait Islander health curriculum statements? |
| The future                             | 15. What is needed to build sustainable cultural education and cultural mentoring capacity to meet registrar training needs?  
16. What is needed to build partnerships with Aboriginal and Torres Strait Islander peoples and communities to sustain registrar training needs? Additional question: What core principles that should underpin a new National Framework for Cultural Competence in Prevocational and vocational General Practice training? |
The individual questions are not addressed specifically in this section of the report, rather the results of the research are presented under the themes or “topic areas”. All the questions and outcomes will be addressed and key issues related to each identified in the discussion section of this report (section 4).

3.2. Literature Review

3.2.1. Definitions

There is no single definition of cultural competence generally or in relation to Aboriginal and Torres Strait Islander people, although a number of models have been proposed. The literature review in Appendix 1 of the report examines in more detail definitions of cultural competence, exploring the meanings and relationships between concepts of ‘cultural awareness’, ‘cultural safety’, and ‘cultural respect’. Five key aspects of cultural competence were identified. These features are that cultural competence:

- is a subjective standard of competence assessed from the viewpoint of the consumer (Downing & Kowal 2011; Eckermann et al. 2010);
- is a process of both awareness of and engagement with another culture (Dharamsi 2011; Eckermann et al. 2010; Borkan, Culhane-Pera & Goldman 2008; Wear 2008; Purnell 2000; Tervalon & Murray-Garcia 1998);
- can be defined at different (but interdependent) levels of the health system – the systemic, organisational, professional and individual – and ideally requires integrated action at all levels to create an environment which is culturally secure (NACCHO 2011; Nguyen 2008; National Health and Medical Research Council 2005; Betancourt et al. 2003);
- is a dynamic and evolving process rather than a static concept, both in relation to the cultural context within which ‘competence’ is framed and the subjective attributes and capabilities of individuals, professions, organisations and systems demonstrating cultural competence (Paul, Hill & Ewen 2012; Jenks 2011; Kleinman & Benson 2006); and
- requires ongoing self-reflection and insight on the part of clinicians, and similarly, for organisations to internally scrutinise and monitor their organisational performance (Paul, Hill & Ewen 2012; Jenks 2011; Kleinman & Benson 2006).

In general, while there is a range of literature exploring and defining cultural competence and a number of guiding frameworks developed, there is less evaluative material and therefore a lack of robust evidence base about effective strategies to create cultural competence.
3.2.2. Role of cultural education in medical education

There is very little in the evaluative literature about the impact of cultural education on patient outcomes (Lie et al. 2011). The focus of most evaluative activities appears to have been on assessment of the impact of training on participants, and these studies appear to indicate good evidence for positive impacts on knowledge, attitudes and skills (Ewen, Paul & Bloom 2012; Beach et al. 2005).

It appears clear that the institutional setting and culture in which cultural education is delivered has a significant impact on students, who learn informally through behaviours of their peers, modelling by teachers, and the degree of cultural respect demonstrated implicitly and explicitly within the learning environment (Paul, Hill & Ewen 2012; Ewen, Mazel & Knoche 2012; Jenks 2011; Rodgers 2005). This suggests that institutions themselves need to adopt a reflexive approach to cultural competence and to acknowledge the limitations of their epistemological frameworks (Ewen, Mazel & Knoche 2012; Ewen 2011; Williamson and Dalal 2007; Hart 2003). The available literature also suggests that cultural education should be delivered in a manner consistent with good practice in adult education (i.e. learner centeredness, encouraging self-direction and providing opportunity to apply knowledge and skills in practice) (Collins 2004; RACGP 2004). Educational modalities which include direct engagement with community and facilitate the application of skills in practice also are well supported in the literature (Duffy et al. 2013; Woolley et al. 2013; Murray et al. 2012; Main et al. 1998).

Development of self-awareness and an appreciation of the influence of clinicians’ own cultural standpoints on their engagement with other cultures are noted to be important (Thackrah & Thompson 2013; Paul, Hill & Ewen 2012; Dharamsi 2011; Borkan, Culhane-Pera & Goldman 2008; Fredericks 2008; Tervalon and Murray-Garcia 1998). Such insights are said to address risks associated with inadvertent reinforcement of pre-existing prejudice, propagation of stereotypes and perceptions of cross-cultural issues being a ‘problem’ located within the Aboriginal and Torres Strait Islander patient (Downing, Kowal & Paradies 2011; Jenks 2011; NACCHO 2011; Eckermann et al. 2010; Fredericks 2008). Cultural mentoring arrangements appear to be particularly supportive of reflexive practice, as they are described as providing a more tailored, one-to-one form of direct engagement and teaching (Klopp and Makanishi 2012; Murray et al. 2012; Fredericks & Thompson 2010; Johnson-Bailey & Cervero 2002).
3.2.3. Cultural education and cultural mentoring in vocational General Practice training

The focus specifically on cultural education and mentoring within Australian vocational General Practice training enabled exploration of the current structures through which this occurs both as part of core curricula and optional Aboriginal and Torres Strait Islander health clinical placements in IHTPs. In general, there was a lack of evaluative literature examining cultural education in Australian General Practice training settings, but what was available indicates the importance of ensuring that Aboriginal and Torres Strait Islander people are meaningfully engaged in planning, developing, delivering and evaluating cultural education.

Cultural Educators and Mentors appear to be reasonably well established in vocational training (RACGP 2011a; ACRRM 2011; GPET 2011a), but their specific roles could be further clarified, particularly given the interconnectedness of their roles and responsibilities as both community members and educators (Martin & Reath 2011; Fredericks 2008; Nguyen & Gardiner 2008). This complexity also points to the need to ensure that appropriate recognition, personal and professional support is available to CEs and CMs, including remuneration (McKenzie & Alberts 2002).

3.2.4. What is currently understood to be cultural education?

Cultural education is the transmission of history and knowledge of Aboriginal and Torres Strait Islander cultures, through a range of pedagogical approaches, in order to enhance the knowledge, attitudes, skills and behaviours of students and professionals. Cultural education can be perceived to take place at the system, organisational, professional and individual levels (NACCHO 2011; Nguyen 2008; Fredericks 2008; National Health and Medical Research Council 2005; Betancourt et al. 2003).

The design, delivery, evaluation and assessment of cultural education need to occur in partnership with, and be led by, Aboriginal and Torres Strait Islander people (Duffy et al. 2013, Woolley et al. 2013; Murray et al. 2012; Main et al. 1998). Cultural education may take place in a range of ways, from didactic teaching through to informal discussions and field trips (VACCHO 2001). In all cases it should be delivered by, or with, a CE who is both grounded in their own cultural identity and able to communicate across cultures, with good communication and teaching skills (Fredericks 2008; Nguyen & Gardiner 2008; GPET 2008; McKenzie & Alberts 2002; VACCHO 2001).

The content of cultural education is mediated by the teaching environment and the norms, values, language and attitudes which are modelled by the organisation and which valorise the place of Aboriginal and Torres Strait Islander culture within the medical and vocational curriculum. Medical students and doctors-in-training...
absorb both the explicit and implicit teaching of culture as it is presented through both the formal and informal or hidden curricula (Ewen, Mazel & Knoche 2012; Rodgers 2005).

For this reason, educational institutions need to continuously engage in a process of critical reflection and analysis of the degree to which the organisation is culturally competent (Ewen, Mazel & Knoche 2012; Ewen 2011; Williamson and Dalal 2007). Cultural education should be embedded in all aspects of the curriculum, and not considered as an adjunct or optional course (Murray et al. 2012; Paul, Hill & Ewen 2012; Kripalani et al. 2006). In keeping with this, medical schools and RTPs themselves need to reflect the cultural diversity of the community and should be modelling, at an institutional level, the kinds of culturally appropriate behaviour they wish to inculcate in their students and registrars (Kripalani et al. 2006). Medical schools and training institutions wield a great deal of power in shaping their students’ values, attitudes, and cultural priorities. Increasingly, academics working in this area are calling on educational institutions to acknowledge the importance of providing ‘socially accountable’ education, including the recognition of the medical schools’ own role in transmitting norms of privilege and power (Murray et al. 2012).

At present, it appears that much cultural education at the pre-vocational level falls back on developing cultural awareness as this is something which can be readily assessed, for instance through surveys and questionnaires. At the vocational training level, in addition to the cultural education provided in workshops, seminars and block release activities, there are further opportunities for experiential or immersive training, particularly through IHTPs or placements in Aboriginal Community Controlled Health Services (ACCHSs), although these are optional.

Cultural competence requires assessment in practical, applied environments just as any other required competence, and there have been some attempts to measure the impact of cultural education on students (Blue et al. 2005). Assessing culture as a ‘competence’ also presents a challenge in deciding how and what is assessed, and there is some evidence in the literature that in presenting culture as a competence, cultural education faces a danger of presenting culture as static and monolithic, rather than evolving and dynamic (Thackrah & Thompson 2013; Paul, Hill & Ewen 2012; Jenks 2011; Kleinman & Benson 2006). Correspondingly, it is important to acknowledge that cultural competence is assessed not by the individual service provider but by the Aboriginal and Torres Strait Islander patient (Downing & Kowal 2011; Eckermann et al. 2010), and although not explicitly discussed in the literature, who can assess cultural competence is another important issue to be considered.

A fundamental skill which underpins cultural competence is the capacity for self-reflection and reflexive practice on the part of clinicians (Klopp & Nakanishi 2012; Eckermann et al. 2010). At its core, this requires an understanding of the complexities of the interaction of cultures and refutation of the simplistic and fallacious
notion that cultural competence is needed in order to deal with ‘problems’ causatively attributed to the patient (Fredericks 2008; Downing et al. 2011; Jenks 2011; NACCHO 2011; Eckermann et al. 2010). Training which does not incorporate reflexive content is unlikely to create the insight necessary to challenge pre-existing prejudices and runs the risk of reinforcing racial stereotypes (Beach et al. 2005). It follows that cultural education needs to focus on supporting doctors to develop an awareness of the cultural content they bring to their practice and skills in reflexively moderating how they engage with Aboriginal and Torres Strait Islander people (Wain et al. 2013; Farrelly & Lumby 2009; Fredericks 2008).

3.2.5. What is currently understood to be cultural mentoring?

Cultural mentoring is a more focussed and personal process than cultural education. A CM has been described as ‘a teacher, counsellor, parent, historian, politician, anthropologist and psychologist’ (McKenzie & Alberts 2002:3). Unlike cultural education, which can be provided in groups or for individuals, and in a range of settings, cultural mentoring takes place between two people within the mentee’s professional environment. This places a large responsibility on the CM to assist the mentee to negotiate across cultures, and to provide a confidential and knowledgeable ‘sounding board’ for the mentee to reflect on his/her experiences in working with Aboriginal and Torres Strait Islander people.

Mentors (and educators) may come from a variety of backgrounds including in some cases employment as an Aboriginal Health Worker (AHW) (WAGPET 2009). It is suggested that as Aboriginal and/or Torres Strait Islander people who are representing their community, they need to have a specific knowledge and skillset including connection to local community and an understanding of its local issues and politics, communication skills, and an understanding of ACCHS and other HTPs and the context in which registrars are working.

Where the mentoring role is seen to deliver benefits to community, Aboriginal and Torres Strait Islander people are willing to provide their expertise (Martin & Reath 2011; Nguyen & Gardiner 2008; Fredericks 2008). However, the cumulative and at times conflicting pressures associated with mentors’ roles as teachers and as community members mean that the vocational training organisations need to ensure that they are valued (including in the tangible, remunerative sense), and personally and professionally supported (McKenzie & Alberts 2002).

As with any mentoring relationship, there may be challenges with two people learning to work together when they come from different backgrounds and experiences, and the mentor will require organisational support and backing, to assist them to facilitate the mentee’s reflection and learning. Adequate professional and personal support is required to enable a CM to be effective in a role which may require the discussion of challenging emotional and social issues (Fredericks 2008; Nguyen & Gardiner 2008; VACCHO 2001).
The role of CMs, as defined and delivered within GPET, appears to be unique, as there is little mention in the literature of other explicit Indigenous mentoring programs. At the same time, little appears in the literature about the Australian Aboriginal and Torres Strait Islander cultural education model as well, so it may be that people in this and other countries are undertaking similar processes but not writing about them. If this is the case, then sharing the experiences of the CMs working in Australia will be an important contribution to the literature.

Notwithstanding the relative development of cultural mentoring within vocational training, there remains a need to clarify the roles of Aboriginal and Torres Strait Islander mentors (and educators), particularly given the interaction and integration with their roles and responsibilities as senior community members. Clear definition of their functions and responsibilities as mentors rather than supervisors may be appropriate (McKenzie & Alberts 2002), as the latter carries connotations of vicarious responsibility for the practice of the mentee – and has significant implications for the mentor as a community member.

### 3.2.6. What is known about best practice in cultural education and cultural mentoring?

Cultural competency is demonstrated at systemic, organisational, professional and individual levels. These layers are inter-dependent and each influences how the others are able to implement culturally competent practices. While each layer may have a different degree of impact on an individual patient’s experience, ultimately, it is the combination of the systemic, organisational, professional and individual competency that will determine the experience of cultural competency and cultural safety (NACCHO 2011; Nguyen 2008; National Health and Medical Research Council 2005; Betancourt et al. 2003).

The importance of cultural education and cultural mentoring for individuals should be supported by professional standards and cultures which value attainment of cultural competence (Rodgers 2005; Betancourt et al. 2003). It will be reinforced in practice through enabling policies and practices which facilitate and enact cultural respect at the systemic and organisational levels (NACCHO 2011; Nguyen 2008; National Health and Medical Research Council 2005).

This means that educational institutions which are delivering or coordinating cultural education (and who are propagators of professional values and culture) must engage meaningfully with Aboriginal and Torres Strait Islander people at the institutional level, particularly in the design and delivery of curricula, and valuing and respecting the contributions of CEs and CMs (Murray et al. 2012; Universities Australia 2011a; NHMRC 2005; AHMAC 2004).
There is also a need for a theoretical framework to guide the development, implementation and assessment of cultural education, including both formal training and mentoring. Some frameworks do already exist, both from the USA and here in Australia (NACCHO 2011; Ranzijn, McConnachie & Nolan 2008; Borkan, Culhane-Pera & Goldman. 2008; Nguyen 2008; Coffin 2007; National Health and Medical Research Council 2005; Tervalon and Murray-Garcia 1998), and these could form the basis for designing a framework for curriculum development, which could include identified competencies at each stage of a developmental continuum. This could inform both course planning and ongoing student assessment.

Specific cultural education activities should adhere to the accepted principles of adult education, including learner-focussed teaching, autonomy and self-direction of the student, collaborative learning and sharing of ideas (Collins 2004; RACGP 2004). These activities should also engage the learner in interactive learning with Aboriginal and Torres Strait Islander communities (Klopp & Nakanishi 2012; Murray et al. 2012; Fredericks & Thompson 2010). They should preferably be offered regularly over a longer period of time to allow for consolidation and implementation of learning, rather than as brief, one-off events (Farrelly & Lumby 2009; WAGPET 2009).

The literature, both in Australia and internationally, is particularly clear regarding the critical need for reflexivity by learners, to better understand their own cultural stance and the ways in which their own culture (which may not be visible to them) may be perceived by others (Fredericks 2008, Farrelly & Lumby 2009). Cultural education and mentoring for JDs and GPRs needs to incorporate such learning methods as self-reflection, journaling and mentoring, to assist students to develop self-insight.

Finally, the nature of cultural competence as a dynamic process of growth and change over time suggests that individual clinicians need to take long-term responsibility for ongoing pursuit of their cultural education, supported and enabled by their professions and by the organisations and systems in which they work (Like 2011; Farrelly & Lumby 2009; Borkan, Culhane-Pera & Goldman 2008; Coffin 2007). Cultural education early in a doctor’s career represents an opportunity to embed a ‘life-long’ perspective on cultural competence.

3.3. Survey results

3.3.1. Responses

Tailored surveys for four target cohorts RTPs, CEs/CMs, IHTPs and GPRs/ JDs, were distributed between May and August 2013 (inclusive of a pilot phase). This generated 55 valid responses in total, including seven from RTPs, 10 from CE/CMs, two from IHTPs and 36 from GPR/JDs.
3.3.2. Understanding of cultural education and cultural mentoring including roles of people engaged in its delivery

The definitions offered within the survey appeared to be familiar to most respondents. However, it was evident that there are variations in the understanding of cultural education and cultural mentoring particularly from responses of the GPR/JDs.

A high proportion of GPR/JD respondents reported that they were not familiar with the definitions of cultural education (33 per cent) or mentoring (53 per cent). Given that this survey drew on a non-representative, self-selected sample of people who were interested enough to take the time to complete the survey (and therefore more likely to be informed in the first place), this is of potential concern.

Some GPR/JDs consider the purpose of cultural education and mentoring to be primarily about knowledge or understanding, while others appear to see it from a more reflexive learning perspective. For example, one GPR/JD respondent noted that cultural education provided “knowledge about social behaviour, lifestyles, religious and moral; values of a particular culture”, while another considered that it “...helps create awareness of how the culture of our patient and our own cultures (in all the many aspects) affect our interaction...”.

For RTPs and GPR/JDs, cultural education and cultural mentoring provide a greater understanding of Aboriginal and Torres Strait Islander culture and promote awareness of cultural norms. Respondents consider that education and mentoring deliver different learning experiences, with cultural education providing some preparation for working within Aboriginal and Torres Strait Islander communities, and cultural mentoring supporting the individual as they work within a community.

Several survey respondents described other important facets of cultural education and cultural mentoring. Instilling an appreciation and respect for different cultural knowledge systems and beliefs, particularly in the context of the Western medical model’s engagement with Aboriginal and Torres Strait Islander people, was considered of particular importance. One CE/CM wrote “hopefully [GPR/JDs] will grasp the concept that although they wear a ‘white coat’ [this] does not necessarily mean they possess more ‘knowledge’ than that of the Aboriginal patient”.

Other key themes included:

- the importance of self-awareness and reflexivity in practice, and of understanding the impact of the GPR/JD’s culture;

- the importance of valuing cultural knowledge through acknowledgement that it is the “intellectual property” of communities and individuals;
• the influence of culture on the medical aspects of the doctor-patient relationship, and the implication this has for integration of medical and cultural training; and

• the characterisation of mentoring as a dialogue and an exchange; both mentor and mentee can gain from the process.

3.3.3. Employment of and support for Cultural Educators and Cultural Mentors

All CE/CM respondents agreed that RTPs supported them to participate in cultural networking events, two thirds agreed there were opportunities for professional development and 60 per cent agreed they had a supervisor for support. Responses indicated room for improvement in terms of professional development and supervisory support, indicating that a positive experience of RTP support is not universal. Cultural Educators and CMs were also less positive about the extent to which RTPs looked after their welfare, with only a third agreeing that this was the case (a third disagreed and a third did not know).

Regional Training Provider respondents also offered mixed responses about support offered to CE/CMs compared to CE/CMs themselves. Regional Training Provider responses to questions about improvements to supports for CE/CM roles focused in several cases on adding roles or increasing the (paid) hours allocated.

Fewer than half of the CE/CMs reported employment in a paid role. However, CEs and CMs appear to feel valued in their roles, and nominated a range of reasons for their views including reference to both tangible supports (including funding professional development, remunerated roles, direct support and feedback in training delivery), as well as less tangible factors, including a sense of being listened to and respected.

Cultural Educators and CMs also related their own sense of being valued to the way RTPs responded to Aboriginal and Torres Strait Islander issues more broadly, for example through development of a reconciliation action plan (RAP), adoption of Welcome to Country protocols and visible advocacy of Aboriginal and Torres Strait Islander culture to GPR/JDs. This suggests that while personal recognition and support are clearly factors in feeling valued, organisational respect for Aboriginal and Torres Strait Islander culture and history is also important.

There were a number of themes which emerged from comments provided by CE/CMs on the personal support available to them. These include:

• the importance of role clarity, including understanding of the contribution and purpose of cultural education and mentoring as a complement to medical or clinical training;
• perceived value in access to continuing education/training for CE/CMs;

• interests in both formal and informal networking among CE/CMs but also within the local community; and

• calls for increased number of people doing the work to alleviate or share the burdens associated with the role.

3.3.4. Nature and extent of cultural education and cultural mentoring programs

Regional Training Provider policies

Five of the seven respondent RTPs indicated that there were formal policies in place to guide cultural education and mentoring programs, and these were generally developed in consultation with local communities or ACCHSs. Three of these five RTPs also reported that they had employed an Aboriginal or Torres Strait Islander person to assist in development of their policy framework.

Cultural education and mentoring appeared to be provided by RTPs to all GPRs, but was less consistently available to JDs and other medical professionals involved in GP training. The variation may reflect the different operating contexts of different RTPs, or potentially different views regarding the responsibilities of RTPs for wider professional training. The only RTP that expressly indicated it did not have a policy framework for cultural education and mentoring was also the only RTP not offering cultural education or cultural mentoring to its MEs or GP Supervisors.

Range of programs offered

The range of program activities provided by RTPs varied. All RTPs reported providing Aboriginal and Torres Strait Islander health workshops or short training events, day visits to an ACCHS or other Aboriginal service, and education from a non-Aboriginal health professional such as a ME or GP Supervisor with experience in Aboriginal health. While all RTPs mandated GPR participation in short training and workshops, day visits to an ACCHS were less common.

On the whole, GPRs were able to access a significantly greater range of programs than were JDs, who tended not to have access to cultural mentoring. Cultural education and mentoring programs are offered early in GPR training, with all RTP respondents indicating that the programs commenced in either the first or second year. Four also offered it within the PGPPP.

The GPR/JD responses appear to indicate that cultural education delivered to GPR/JDs is broadly satisfactory but more could be done to improve the relevance of the programs, particularly in relation to assisting GPR
understanding of cultural norms in specific locations. Some GPR/JDs also expressed some frustrations about consistency of access to cultural mentoring, although its value was generally recognised.

A quarter of GPR/JD respondents indicated that, overall, their training program had increased their interest in working in Aboriginal and Torres Strait Islander health, although most of these respondents also indicated a pre-existing interest. However, a half indicated that the training program had made no difference to their level of interest, while the remainder did not know.

High levels of confidence were expressed by CE/CM, RTPs and IHTPs that cultural education and mentoring programs increase GPR/JD interest.

### 3.3.5. Areas for future program improvement

Perspectives on potential future improvements to cultural education and cultural mentoring programs varied, although there were some themes which appear in GPR/JD responses. These included support for mandating participation in cultural education and cultural mentoring, and the corollary implication that there could be increased opportunities for GPR/JDs to participate, through both increased access to programs and placements generally, and also specifically to CMs.

Some GPR/JDs felt that there was room to improve the integration of theory and practice to make cultural education and cultural mentoring more directly relevant to GPR/JDs. Comments focused on the application of cultural education to General Practice. For example, one GPR/JD commented that a GP should work with CE/CMs to assist them to tailor material to ensure it addressed GPR learning needs as well as the CE/CM’s own teaching goals. The value placed on the ‘practical’ was also evident in one GPR/JD’s suggestion that training should include ‘[m]ore specific examples of Indigenous culture focussing specifically on the things we do wrong, in order to avoid that. If advice could come from Indigenous health workers, that would be ideal...”.

Improving access to in-community training or IHTPs was also a consistent theme with several GPR/JD responses, including one respondent who felt it should be mandatory to complete an Aboriginal health placement during medical school.

Cultural Educators and CMs tended to agree with GPR/JDs on some fronts, including boosting the time granted to cultural education and cultural mentoring. One CE/CM suggested better awareness of RACGP/ACRRM curricula could making training more relevant for GPRs. However, CE/CM respondents also provided a broader and more nuanced range of suggestions for future enhancement including:

- developing strategies to address pre-conceived notions held by some GPR/JDs and the need to increase their engagement in cultural education and mentoring, as “many do not recognise the
privileged position they are in and cannot / do not understand the history of Aboriginal disadvantage”. One respondent did not want to have to “spend time trying to convince people that Aboriginal people in fact exist, have a history and should not have to be ‘just like us’...”;

- increasing the amount of time given to cultural education and mentoring activities, and positioning this as an ongoing activity (not a once-off);

- devising opportunities that add ‘depth’ to the experiences of GPR/JDs, including more cultural immersion in place of the “watered down classroom experience”. One CE/CM suggested allowing time to visit significant sites;

- increasing accountability through mandating (and assessing) cultural training, and ensuring GPR/JDs “take the placements seriously... and not just look at them as one more thing to be done...”;

- providing CE/CMs with more training to improve the alignment between what they deliver and the training curricula. One CE/CM indicated that they were “not even sure whether all CEs are even aware [the RACGP/ACRRM standards] exist and this is what GPRs are likely to be examined against...”;

- increasing centralised training provided to AHWs in CE, CM or supporting roles, noting the reciprocal benefits of developing relationships between these workers and GPs; and

- ensuring that cultural education is regionally and locally relevant.

Regional Training Providers provided relatively less information about their views on future program improvements, but did agree with GPR/JDs and CE/CMs in relation to increasing access to cultural education and cultural mentoring. The mechanisms for achieving this suggested by RTPs included engagement of CE/CMs in each IHTP. One RTP noted that the relationship with the CE/CMs in their region was held primarily by the ACCHS at which they were employed, and indicated an interest in developing a direct relationship.

### 3.3.6. Survey limitations

This report is subject to a number of important limitations. In particular, the low response rate to the surveys limits the extent to which strong inferences can be made from results, and particularly the quantitative aspects of the survey. The low response rate also means that the survey is not likely to be representative, and a number of features of the recruitment strategy (including promotion through special interest networks) and the lengthy nature of the survey are likely to have resulted in self-selection by respondents with a specific interest in Aboriginal and Torres Strait Islander health. The low response rate of the GPR/JD survey in particular was probably influenced by the presence of several other surveys in the field at the same time.
A substantial number of incomplete surveys have also been included in the analysis (in particular, eight from GPR/JDs), and this means that the pool of respondents for questions appearing later in the GPR/JD survey may represent a different group (potentially those with higher levels of interest).

Finally, the number of responses associated with each of the RTPs across all surveys were generally low (0 to 4 responses), though two RTPs attracted higher response rates. The two RTPs with higher response rates made up more than half of responses for which an RTP was identified and indicates that the data is not representative across all RTPs. Data (particularly from GPR/JD surveys) is likely to be skewed toward the two RTPs with stronger response rates.

As the limitations are most profound with respect to quantitative data, this report has focused on the significant detail from the qualitative aspects of the survey.

3.2.7. Conclusions

The conclusions that can be drawn from this survey are constrained by the survey’s limitations outlined above, particularly its low response rate and the high likelihood that it draws on an unrepresentative sample. However, a number of interesting observations may be made, particularly where there is a very high level of concordance across survey responses and where qualitative responses provide additional depth and insight.

Respondents other than GPR/JDs reported high levels of concordance between the formal definition and their own understandings of cultural education and cultural mentoring. Respondents who offered additional comments about cultural education and cultural mentoring demonstrated an understanding of the importance it can play in overcoming cultural barriers to effective care.

A majority of CE and CM respondents feel supported and valued by their RTP, although responses were mixed. In particular, only one third agreed that RTPs look after their welfare (a third did not know and one third disagreed). Key factors noted as leading to CE/CMs feeling valued include tangible personal support and organisational practices that are respectful of Aboriginal and Torres Strait Islander culture. Improvements suggested to the support offered to CE/CMs included greater role clarity, provision of training and networking opportunities, increasing resources and CE/CMs being able to share the load with other community members.

Most RTPs have a formal policy in place to support cultural education and mentoring, although how this was implemented varied. The only RTP not to have a policy in place was also the only RTP not to report offering any cultural education or mentoring to its MEs or GP Supervisors.
All RTPs offered cultural education in the form of short training and workshops opportunities for day visits to ACCHSs and longer IHTP placements. Short trips and day visits to Aboriginal and Torres Strait Islander communities were delivered in some IHTPs. Four of the seven responding RTPs offered cultural mentoring. Different combinations of training modules were delivered depending on the intended audience; GPRs were more likely to receive cultural education and cultural mentoring programs than JDs.

When asked to comment on the impact of cultural education and cultural mentoring programs, CE/CMS, RTP and IHTP respondents were very positive about the impacts of cultural education and mentoring on health outcomes, health services access and health service quality for Aboriginal and Torres Strait Islander people. They also felt strongly that such programs would influence GPR/JDs to work in Aboriginal and Torres Strait Islander health. In contrast to this view, one quarter of GPR/JD respondents indicated that their training program had increased their interest in working in Aboriginal and Torres Strait Islander health, while half indicated that it had made no difference.

In response to questions about how the program could be improved, GPR/JDs focused on increasing the availability of training and placements in Aboriginal and Torres Strait Islander health, and on better integration of cultural education and cultural mentoring with medical training. Cultural Educators and CMs offered a broader range of areas for improvement, including tackling pre-conceptions held by some GPR/JDs, adding time and depth to cultural education and cultural mentoring, boosting GPR/JD accountability, supporting regional training to engage more AHWs in cultural education and cultural mentoring, and ensuring training is tailored to the local community context.

### 3.4. Interview results

#### 3.4.1. Responses

Interviews were conducted between May 2013 and January 2014 with RTPs, CE/CMS, MEs, IHTPs, GPRs/JDs and key stakeholders. Interview data was collected from 95 participants representing 13 RTPs, 11 IHTPs and representatives of 18 stakeholder organisations. A further 59 participants attending a GPET CE and CM Network meeting and CE and ME workshop (September 2013) provided input via small group sessions during which they considered key questions related to this project. Additionally a large group consultation with 20 consenting participants was held in one RTP, comprising CEs/CMS, GPRs, JDs, MEs, RTP staff and GP Supervisors. Of this group 14 are additional to the total participant figure.
3.4.2. Understanding of cultural education and cultural mentoring including roles of people engaged in its delivery

Most participants agreed that the current definitions used by GPET to describe cultural education and cultural mentoring were appropriate. There was consensus that CEs and CMs must themselves be Aboriginal and/or Torres Strait Islander people. However, participants identified the difficulties of defining these often overlapping activities and roles. The overlap with the AHW role within IHTPs was particularly noted and some interviewees considered cultural education and mentoring to be part of the AHW role. In some situations, AHWs may receive training in cultural mentoring. However several interviewees observed there was a risk of overburdening these already busy health professionals. It was also noted that mentoring can be undertaken by Aboriginal and Torres Strait Islander GPs and can comprise both professional and cultural support.

Interviewees further noted the impact on cultural education and mentoring of varying contexts and community and organisational expectations and advised on respecting the rights of Aboriginal and Torres Strait Islander people and IHTPs to define the CE/ME roles and responsibilities in a way that feels appropriate to them.

A variety of models of cultural education delivery and content were identified with concepts of cultural respect, humility and competence, and the principle of listening to the Aboriginal and Torres Strait Islander communities and individuals, seen as essential in any cultural education program. Interviewees further recommended that programs include discussion of Aboriginal and Torres Strait Islander culture and history and how these interact with health and health care. Though online and distance learning approaches were sometimes reported to be used, face to face interaction with Aboriginal and Torres Strait Islander people and communities was noted to be a critical element of effective cultural education.

Interviewees agreed that while roles performed by CEs vary according to location, the principal role of the CE engaged in GP training is to provide information that can assist GPRs and JDs in their communication and relationships with Aboriginal and Torres Strait Islander people and communities. Cultural education was seen by all as an important component of Aboriginal and Torres Strait Islander health training for GPs, particularly in view of the need to ensure that GPRs and JDs have at least baseline knowledge when they start their IHTP placements.

Interviewees also described many models of cultural mentoring, depending on the local context and with determination of the model often made by the IHTP. From the interviews, cultural mentoring appears to be less consistently provided to learners than cultural education. While roles of the CM were described as
sometimes including cultural education activities, interviewees highlighted cultural mentoring as needing to be specific to a local context.

In some RTPs, CE/CMs were described as providing advice on organisational direction, culturally appropriate practice, and liaison with communities.

Challenges for cultural education and cultural mentoring described by interviewees include the need to better understand the CE and CM roles and the kinds of support that strengthen those roles; engagement of CEs and CMs; embedding cultural education in organisations and valuing those who deliver the education; re-balancing the medical model of teaching and ensuring cultural education was equally valued compared to medical teaching; adaptation of cultural education to local communities and to individual learner needs; ensuring sufficient time for learner reflection in a safe learning environment; catering for the particular needs of Aboriginal and Torres Strait Islander GPRs; and engagement of CEs and CMs in evaluation of teaching programs and assessment of GPR/JD learning.

### 3.4.3. Employment and support of Cultural Educators and Cultural Mentors

Employment or engagement with CMs appears to be less formal than that described for CEs. As noted above, at times cultural mentoring tasks were described as part of the AHW role within the IHTP, and sometimes Aboriginal and Torres Strait Islander GP Supervisors would take on mentoring tasks.

While CEs mostly appear to be remunerated for their work, the prevalent model of voluntary cultural mentoring is seen as unjust by many interviewees. Many interviewees believe some kind of reimbursement for CEs and CMs is needed, arranged in such a way that is sustainable and appropriate to the individual and the community.

Interviews did not reveal many formal policies relating to support of CEs and CMs, particularly where RTPs enter into *ad hoc* arrangements according to the need for cultural education and cultural mentoring at a particular time. Interviewees indicated that support for CEs and CMs tends to be largely informal and relationship based. Respectful relationships, in particular with MEs, were noted to be critical in the delivery of shared cultural and medical teaching as well as in valuing the CE/CM and the learning they facilitate. Similarly RTP organisational approaches such as RAPs were described as providing evidence of cultural education being valued and RTP advocacy for the roles was strongly recommended.

In addition to support from within training organisations, CE/CMs were noted to draw support from Aboriginal and Torres Strait Islander communities. This support and the importance of connection with communities, was recommended to be reflected in the terms and conditions of their employment.
Regional Training Providers requested guidance on identification, engagement and employment of CEs and particularly CMs.

Interviewees agreed that CEs and CMs must be supported through relevant professional development including skill development, for example in managing confrontation and bias as well as in relevant teaching skills. Whilst identification and support of career pathways for CE/CMs was generally supported, interviewees cautioned about requiring professional development and progression as a prerequisite for employment. Mentoring of new CEs and CMs was observed to be important for the sustainability of the roles.

### 3.4.4. Nature and extent of cultural education and cultural mentoring programs including development and evaluation of programs

Engagement between RTPs and Aboriginal and Torres Strait Islander communities and organisations was noted to be critical to delivery of effective cultural education for GPRs and JDs. The employment of CMs and CEs by RTPs or RTPs in collaboration with other organisations, for example NACCHO Affiliates, was seen as a means of achieving this and of enhancing collaborative organisational planning. Similarly RAPs were noted to enhance RTP engagement with Aboriginal and Torres Strait Islander people and communities.

All RTPs reported formal requirements for GPRs to participate in cultural education, though the nature and extent of the programs provided varied greatly. Mostly, orientation to the IHTP was considered to be the role of the IHTP, formulated with CEs/CMs and individualised to the particular IHTP needs.

In general, there was reported to be less cultural education provided to JDs and to RTP staff and other stakeholders such as GP Supervisors compared with GPRs. Some RTPs reported integration of cultural education into “mainstream” teaching.

Challenges noted for cultural education and mentoring programs included the tailoring of learning to individual learner need and the related vertical integration of learning as part of a life-long learning experience; engagement of learners who believed cultural education was less relevant to them; recruiting and preparing GPR/JDs for IHTP placements; provision of appropriate cultural education and mentoring for Aboriginal and Torres Strait Islander GPRs; evaluation of programs and IHTP placements; and assessment particularly of GPR and JD values and attitudes.

### 3.4.5. The future

Interviewees noted that to build sustainable CE/CM capacity to meet GP training needs required formalised, but flexible and localised policies; respectful engagement with IHTPs; clarification around roles and
responsibilities of CE/CMs and who is appropriate to undertake these roles; individualised support for professional development and consideration but not requirement for career pathways; succession planning; valuing, respecting of and advocating for the CE/CM roles; CE/CM and ME partnerships modelled in learning activities; a move away from medical models of education to strengthen cultural education; extension of cultural education particularly to JDs and other RTP staff and stakeholders; and enhancing life-long learning approaches, mentoring, evaluation and assessment activities.

Improving the capacity for cultural education and mentoring was noted to require increasing the number and range of IHTP placements, including providing outreach experiences in some places. Mentoring was noted to be important in supporting these placements as was preparation prior to undertaking the placement. Integration of cultural education into “mainstream” medical teaching was observed to be one way in which all GPRs and JDs could be exposed to cultural education prior to IHTP placements.

Finally partnerships with Aboriginal and Torres Strait Islander people and communities was observed to be a whole of organisation priority requiring time, patience, commitment and understanding on all sides.

A number of core principles to inform a future framework for cultural competence in the context of GP vocational training were suggested. These are listed in Section 3 of Appendix 3 and included in core principles listed in this report.
4. Discussion

4.1. Introduction

Aboriginal and Torres Strait Islander peoples have unacceptably poor health outcomes (Steering Committee for the Review of Government Service Provision 2011) and key to addressing this is ensuring access to effective primary health care services. Cultural Educators and CMs have been identified as central to best practice development and delivery of GP training in Aboriginal and Torres Strait Islander health (GPET 2008; Alberts and McKenzie 2002). There is a paucity of evidence regarding the current nature and extent of cultural education and cultural mentoring in prevocational and vocational General Practice training.

This research, commissioned by GPET, has engaged in wide ranging consultations in order to achieve an understanding of cultural education and cultural mentoring from the perspectives of all stakeholders, namely, GPRs and JDs, RTPs, IHTPs and CMs and CEs as well as a number of relevant organisations as listed in Table 2.

This discussion focuses on key areas identified by the project including understanding the CE and CM roles, employment and support for CEs and CMs, and cultural education and cultural mentoring programs. Each key area is examined in light of what is happening in Australian vocational training, what gaps exist in the way cultural education and cultural mentoring is currently delivered to GPRs and JDs in Australia and what is recommended to address these gaps. The discussion is informed by a review of the literature together with survey and interview data and other relevant publications and documents which add to current knowledge about cultural competence in prevocational and vocational General Practice training.

Throughout the discussion “case studies” identified through the course of the research are presented with the consent of those involved. These include examples of best practice and innovative approaches to cultural education and mentoring.

Following the discussion the key research findings are reported (as required in the UWS contract with GPET) and recommendations for future practice and research are outlined, including recommended core principles for a new National Framework for Cultural Competence in Prevocational and Vocational GP Training.
4.2. Understanding of cultural education and cultural mentoring

4.2.1. What is known?

The review of the literature identified a range of understandings regarding the definition of cultural competence generally and specifically in relation to Aboriginal and Torres Strait Islander people, and a dearth of evaluative material providing evidence about effective strategies to promote cultural competence in Australian General Practice training settings. Much of the learning about cultural education in this setting resides with those engaged in this work, hence the importance of the survey and interview approaches to adequately reflect these understandings.

**Understanding cultural competence, cultural education and cultural mentoring in the Aboriginal and Torres Strait Islander General Practice training context**

In the GP vocational training context cultural competence can be seen as a standard of General Practice related to awareness of and engagement with Aboriginal and Torres Strait Islander peoples. Cultural competence is assessed from the viewpoint of Aboriginal and Torres Strait Islander consumers. It can be defined at different levels of the health system and of GP training, including at systemic, organisational, professional and individual levels. It is a dynamic, evolving and lifelong process, which requires ongoing self-reflection on the part of health care providers and internal scrutiny and monitoring at the organisational level (Cross et al 1989, NACCHO 2011, AHMAC 2004, Eckerman et al 2010). One relevant definition of cultural competence considers cultural competence to be “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations” (Cross et al 1989).

Drawing on Cross et al.’s model (1989), the National Aboriginal Community Controlled Health Organisation (NACCHO) recommends an Aboriginal and Torres Strait Islander cultural competence continuum highlighting the view that ‘achieving cultural competence is a journey, and that non-Aboriginal health care providers and organisations may move back and forth along the continuum’ (NACCHO 2011:13) (see Appendix 1).

Survey respondents and interviewees supported the debate around the sometimes confusing complexity of the terminology of cultural competence, however interviewees were in agreement with these principles. It was repeatedly emphasised that in GP training, attention needs to be paid to the cultural competence of all those involved in GP training, including MEs, RTP staff and GP Supervisors, as well as that of GPRs and JDS.
Furthermore, the cultural competence of organisations involved in GP training is vital, requiring ongoing consideration and support.

Many interviewees from diverse backgrounds identified that cultural competence is a lifelong journey, requiring ongoing self-reflection, and that cultural education and mentoring programs must be designed and delivered accordingly. There is also concordance between the literature and the views of those consulted, concerning the need for Aboriginal and Torres Strait Islander people to be meaningfully engaged in planning, developing, delivering and evaluating cultural education.

Both the literature review and the survey and interview data highlight the widely varying perceptions and experiences of the scope and practice of cultural education and cultural mentoring in General Practice training. Furthermore, participants identified the difficulties of defining these often overlapping and intertwined activities and roles, noting the impact of varying contexts and varying community and organisational expectations, as well as the need to respect the autonomy of Aboriginal and Torres Strait Islander people and organisations in defining their work and their role in General Practice education.

In this study, interviewees and survey participants were presented with definitions of cultural education and cultural mentoring provided by GPET in order to assess familiarity with these definitions (see survey and interview tools in Appendices 2 and 3). While there was broad agreement with the definitions provided, many felt that the definitions need to reflect more flexible understandings of the roles of CEs and CMs. For example, IHTP staff appeared to have a more holistic interpretation of both terms and were more likely to see the roles of CEs and CMs as intertwined within their organisations. Generally, survey and interview data indicate a commonality in understanding that cultural education in General Practice training provides some preparation for working within Aboriginal and Torres Strait Islander communities and cultural mentoring supports the individual as they work in the community.

However, surveys returned by GPRs and JDs, supported by interview data, indicated a lack of familiarity with the concepts and definitions of cultural education and cultural mentoring. Cultural mentoring seemed to be particularly poorly understood by GPRs and JDs. Given that the survey drew on a non-representative, self-selected sample of people who were interested enough to take the time to complete the survey (and therefore more likely to be informed in the first place) this is of potential concern.

This may suggest a lack of understanding of terminology, however, it is clear this is a far more complex issue than a need for wider education about the definitions of cultural education and mentoring. It appears that despite the general agreement with the GPET definitions of cultural mentoring and cultural education, the challenges in operationalising this have led to contention regarding the terms ‘Cultural Educator’ and ‘Cultural
Mentor’. For many interviewees the terms appear to have become conceptually linked with a requirement to have particular authority within the community to advise on cultural knowledge, and correspondingly CEs and CMs may be expected to be older, born in the community in which they reside and perceived as a person of stature within the community. This appears to have become a problem within some RTPs and IHTPs, where terminology alone may have become a barrier to some suitable and well placed staff feeling confident to take on the role of a CE or CM. This may also have a negative impact on the ability of some staff to access training and support which could benefit them and their organisation. In some settings, organisations and individuals have suggested local decisions to use other terms such as ‘cultural guide’, ‘cultural coordinator’ and ‘cultural advisor’, would be a simple solution to this difficulty.

However, the terminology and associated expectations around cultural education and mentoring is only one part of the difficulties associated with how best to support cultural mentoring for GPRs within some IHTPs. That cultural mentoring tasks often fall to the AHWs within IHTPs is somewhat controversial. Some participants indicated that cultural education and mentoring are natural parts of the AHW role, and in one location AHW training includes a module on cultural mentoring. The role of AHWs as cultural and communication brokers is a recognised part of their work within General Practice (Bird and Henderson, 2005; Abbott 2007). Acknowledging and supporting the cultural mentoring work that is being undertaken by AHWs in some IHTPs may promote understanding and recognition of this work and how it fits within General Practice training.

On the other hand, some interviewees argued that cultural education and cultural mentoring should not be an extra burden placed on the already busy AHW. In some settings it was strongly felt that services already have difficulty recruiting AHWs and other Aboriginal staff to areas of need and that it is difficult to justify the use of their time in providing cultural education rather than direct provision of services to the community. Furthermore, some interviewees argued that the CM should not be a member of the organisation in which cultural mentoring is provided so that cultural mentoring advice and discussion could be seen to be at arm’s length from the employing organisation. Finally it appears that, contrary to much of the literature in this area, in some IHTPs, cultural mentoring is seen as delivered in a whole-of-service approach to all non-Indigenous staff, rather than through one-on-one relationships. This appears to be an important issue requiring clarification in order to better understand and support cultural mentoring in those services and will require sensitivity to the local contexts.

Aboriginal and Torres Strait Islander GPs were seen by some to have an increasingly important role in GP training, particularly in providing professional and cultural support to Aboriginal and Torres Strait Islander
GPRs and JDs. These GPs are also likely to face similar challenges as other Aboriginal and Torres Strait Islander health professionals, including time pressure and working in communities different to their own.

One area of confusion, somewhat surprisingly was the self-nomination of a number of non-Indigenous educators as CEs. This runs counter to the generally accepted GPET definitions and the consensus of people who participated in this research. Though responses from these educators indicated in some instances deep understandings of the issues for CEs and CMs, this confusion in terminology and roles is best resolved in order to better target recruitment, employment and support strategies with Aboriginal and Torres Strait Islander CEs and CMs.

Understandings of the roles of CEs and CMs, and the available support for CEs and CMs, is likely to impact on the quality and quantity of cultural education and cultural mentoring offered to GPRs and JDs. General Practice Registrars and JDs undertaking training with RTPs and IHTPs who employ CEs and CMs, or who have more formalised processes and standards around recommended or minimum levels of cultural education and mentorship, may be offered more cultural education and mentoring than those engaged with RTPs and IHTPs who have more ad hoc arrangements for the provision of cultural education and mentoring.

**Cultural Educator and Cultural Mentor roles: a continuum**

Interview data reinforces the view that cultural education and cultural mentoring are not two separate fields but are complementary approaches to providing cultural training to GPRs and JDs. Similarly, CE and CM roles are best understood according to a continuum and roles do not always easily fit into positions if defined rigidly. Rather, various tasks belonging to both cultural education and cultural mentoring may be taken up by people who are formally recognised as CEs and/or CMs, AHWs, RTP and IHTP staff. Figure 1 is proposed by the research team as a way of depicting this continuum. The assigning of relevant tasks and roles according to the local needs and the characteristics of the staff involved, with role titles adjusted as required, appears to be a potentially useful approach to ensure delivery of cultural education and cultural mentoring across multiple settings.

The overlapping of informal cultural mentoring with the role of the AHW (which appears to create an artificial divide between a CM and an AHW) is a practical example of how establishing CE and CM roles according to formal, discrete positions does not always work in the day-to-day reality of the IHTP.
FIGURE 1 CULTURAL EDUCATOR CULTURAL MENTOR CONTINUUM

CULTURAL EDUCATION

- Small and large group teaching
- May be delivered in partnership with non-Indigenous Educator
- Can occur at systems, organisational, professional and individual level
- Usually formally planned
- Includes generic learning
- May be summatively assessed on completion

CULTURAL MENTORING

- Requires experienced Aboriginal and/or Torres Strait Islander person
- Two-way learning approaches recommended
- Needs strong relationships with or endorsement by Aboriginal and/or Torres Strait Islander communities or organisations
- Can be carried out by people in a variety of roles including AHWs
- Can involve cultural broker/liaison role
- May include formative assessment

Individualised learning
- Unlikely to involve a non-Indigenous Educator
- One on one relationship usually though may also include organisational mentoring
- May occur on ‘as needed’ basis
- Localised to a particular community/organisation or situation
- Assessment may be a risk to relationship

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2 Proposed by research team as a way of depicting the continuum across cultural education and mentoring activities.
Frameworks and organisational strategies

As emphasised in the literature, the institutional setting and culture in which cultural education is delivered has a significant impact on students. As students learn informally through modelling by peers and teachers and through the degree of cultural respect demonstrated implicitly and explicitly within the learning environment (Ewen, Knoche & Mazel 2012), institutions themselves need to adopt a reflexive approach to cultural competence. This requires ongoing critical examination of assumptions and biases that underpin their organisational structures and processes. Common cultural respect frameworks and models can tend to rely on a general approach of raising cultural awareness because of the difficulty in determining how to explicitly promote cultural competence (Downing, Kowal and Paradies 2011).

The Aboriginal Health Cultural Competence Framework developed by the Kaiela Institute (Yorta Yorta National Aboriginal Corporation et al 2011) represents an example of how cultural competence can be addressed at the organisational level through identification of standards to inform good practice at all levels of health service delivery. Similarly, RAPs include practical standards based on the underpinning concepts of organisational cultural competence. Some interviewees identified their employing organisation’s implementation of a RAP, as a helpful tool to guide reflection and action on the cultural competence of their organisations. Some CEs employed in RTPs felt the RAP provided evidence of support for their role within the organisation. It was evident from the research that a number of RTPs would value and benefit from increased and long term support and guidance particularly in terms of practical strategies to promote organisational cultural competence and positive relationships with local Aboriginal and Torres Strait Islander communities.

Organisational support for CEs and CMs working in RTPs was reported by some CEs as strengthened by strong respectful partnerships between CEs and MEs. This aligns with the prominent theme in the interviews that there was the need to promote a “two-way learning approach” in which GP education is informed by Aboriginal and Torres Strait islander culture and knowledge as well as medical and other non-Indigenous learning. ‘Two-way’ learning, also referred to as ‘both ways’ learning, refers to the acceptance of the need to mix Aboriginal and Torres Strait islander knowledge with Western knowledge, with an emphasis on ways in which people of different cultures can learn from each other (Purdie et al 2011). This learning approach is discussed further in a later section of this discussion.

Partnerships and engagement with community, flexibility and local adaptation

Throughout the study the flexibility that is required in the ways that cultural education and cultural mentoring is delivered to GPRs and JDs was evident. In keeping with the recommendations of the literature (NHMRC 2005; Universities Australia 2011a), most cultural education and mentoring described includes some element
of partnership and collaboration with communities and community controlled organisations. For example, RTPs employing a CE and or CM with strong links to the community; RTPs sharing employment of CEs/CMs from the local community with the State or Territory Affiliate; RTPs contracting local community members to provide cultural education / mentoring; Aboriginal and Torres Strait Islander external reference and advisory groups providing advice on organisational direction; community reference or action groups that provide cultural direction to a large centralised RTP; and CEs providing advice to RTP and IHTP management through organisational arrangements.

Interviewees warned however about the risk of tokenism in having one Aboriginal or Torres Strait Islander person employed in the organisation rather than genuinely seeking engagement with communities and or organisations representative of communities.

**Adult learning and two-way learning approaches**

The literature strongly recommends a lifelong adult learning approach to cultural education, including active learning opportunities tailored to the needs of the learner with opportunity to reflect on the impact of culture on interactions and relationships with Aboriginal and Torres Strait Islander people. This was highly supported by interview data collected in this research and is further explored in the discussion of cultural education and mentoring programs.

The importance of the two-way learning approach in GP training was a strong theme within the data, with emphasis from participants of diverse backgrounds that Aboriginal and Torres Strait Islander culture and knowledge needed to be integrated with non-Indigenous medical teaching in delivery of GP training. As Purdie et al (2011) point out, the two-way educational process must be informed by Indigenous culture within which “teaching and learning become part of an equal and genuine cultural exchange”. Gientzotis notes that two-way learning involves “respecting the learning processes and perspectives of another people and recognising that they are learning about another culture and knowledge system, at the same time as sharing their own knowledge... It requires constant learning and questioning of ourselves if we are to be ‘partners in a learning culture’” (2006). This concept resonates particularly with the previously discussed opinion of several CE/CMs that a collegial and visible relationship between CE/CMs and MEs or GP Supervisors is crucial in delivery of cultural education and mentoring. Two-way learning approaches are increasingly recommended to frame teaching within Aboriginal and Torres Strait Islander communities (Government of Western Australia 2012) and in cross cultural training (Farrelly and Lumby 2009) and align well with the principles of General Practice training.
4.2.2. What are the gaps?

There is limited literature exploring cultural education and its impact within prevocational and vocational training in Australia. There is a need for rigorous evaluation beyond short-term student satisfaction and exploring the impact of cultural training on changes in practice at the individual and organisational levels. Similarly the evidence for health impact resulting from cultural education is limited and could be strengthened by research addressing this issue.

Significant differences in understanding of the roles and scope of cultural education and cultural mentoring appear to influence the employment and support for CEs and CMs and the nature and extent of cultural education and mentoring programs. The roles of Aboriginal and Torres Strait Islander educators and mentors require clarification, particularly given the interaction and integration with their roles and responsibilities as community members. It is of concern that survey and interview data indicated GPR/JDs demonstrated relatively high levels of unfamiliarity with the terms cultural education and cultural mentoring, and particularly with the concept of cultural mentoring.

Clear definition of cultural mentoring functions and responsibilities as mentors rather than supervisors may be appropriate, as the latter carries connotations of vicarious responsibility for the practice of the mentee – and has significant implications for the mentor as a community member. In further development of the CM role, it is likely to need some delineation to avoid the potentially unlimited scope of the role, both in terms of time commitment and availability and the expertise expected of the CM. This may contribute to differing expectations by GPRs and JDs, and also contribute to the difficulty in engaging CMs reported by some RTPs.

Cultural competency is not always demonstrated at systemic, organisational, professional and individual levels in the GP training environment, thereby compromising the cultural education provided.

4.2.3. What is recommended?

Locally based collaborative engagement between RTPs and Aboriginal and Torres Strait Islander communities and organisations in developing cultural education and mentoring approaches is likely to promote a better and shared understanding of the roles of CEs and CMs. This understanding of the roles, rather than position descriptions will enable the positions to be filled by a variety of people judged by local communities and organisations to be suitable. Then the role title can be determined locally to suit the particular context if the terms CE and CM appear to be a barrier to utilising staff who are well placed to take on these roles.
Consultation with local Aboriginal and Torres Strait Islander communities and organisations will also assist in clarifying the scope of the CE and CM roles in the local context. The work of CEs and CMs is inherently challenging, and differing expectations of the job can lead to misunderstandings and role stress, as well as making it difficult for some organisations to attract CEs and CMs. A recent document published by the Australian Indigenous Doctors Association (AIDA) describing criteria that a culturally safe Aboriginal and Torres Strait Islander person should demonstrate, may usefully inform the discussion around roles and attributes of CEs and CMs (AIDA 2013).

Promoting cultural competence at systemic, organisational, professional and individual levels must be an ongoing and clear principle within the General Practice training environment. Similarly, there is a need for ongoing focus on promoting cultural education and mentoring at organisational, professional and individual levels in the General Practice vocational training setting. Engagement with local Aboriginal and Torres Strait Islander communities and organisations, with CEs and CMs and the development of RAPs have all been noted to facilitate these organisational and systems approaches. Promoting the cultural competence of all those involved in GP training such as MEs, RTP staff and GP Supervisors must be an ongoing priority which is complementary to the primary focus on GPRs and JDs.

**Icebergs in the Torres Strait: an innovative approach to cultural mentoring**

Maria Tapim, the Cultural Practice Program Coordinator for the Torres Strait- Northern Peninsula Hospital and Health Service and also a CE with Tropical Medical Training, described the approach used in the Torres Strait-Northern Peninsula for recruitment of CMs for Queensland Health employees including GPRs working on remote islands. Maria talked about the iceberg model used in their Cultural Practice Program orientation — “You need to be aware of what’s under the water, the unseen part of culture...or you will hit the iceberg!” (The iceberg model is used because the tragic history of the sinking of Titanic is universally known and everyone can relate to it.)

Maria and Marat Ketchell use approaches to mentoring that are specific to each island community of the Torres Strait, recognising the diversity within each community. Maria described the following key features of their program:

- recruitment of several mentors in each community so that the views of different families are heard and the load doesn’t fall on one individual;
- Mentors from outside the health system – “based in the community”; Maria is liaising with local councils to instigate plans for establishing positions;
- provision of information about the community (Community Profiles, ideally on line) so that the doctor has a realistic understanding of the community before they arrive – not just the “tropical island” view; and
- ensuring GPRs are aware that there is cultural support and mentoring all the time.
Northern Territory General Practice Education (NTGPE) – working with communities to develop a community centred cultural mentoring project

In 2013 NTGPE MEs and CEs worked together with the Aboriginal Medical Services Alliance Northern Territory – NTGPE Liaison Officer, GroundUP (a NT based research group with expertise in community development) and a local group of community Elders to design a new approach to recruitment of CMs in communities related to GPR and JD placements. In 2013 this was piloted in Galiwink’u on Elcho Island. This community was chosen because it has worked with NTGPE for more than 10 years, and also because of some previous work there by the GroundUp team. The pilot involved working with NTGPE CEs and the local group to develop a model specific to that community. In 2014 the local pilot will be implemented and cultural mentoring delivered, whilst the same development work will be undertaken in another two communities.

Key features of the approach have been:

- specific design, led and created within community and then later generalised;
- combination of RTP CEs, NACCHO Affiliate liaison officer and a research based community development group;
- adaptation in consultation with local communities; and
- recruitment, role and support processes negotiated with the local communities.
4.3. Employment and support of Cultural Educators and Cultural Mentors

4.3.1. What is known?

Survey and interview participants commented on the needs for recognition and remuneration, role clarity, support including training and networking opportunities, and career pathways.

**Recognition and remuneration**

Issues common to both CEs and CMs include the need for formal recognition and remuneration for their role, and acknowledgement that it is a role with particular responsibilities, not something which can be expected of anyone. A recommendation of the evaluation of GPET’s previous Aboriginal and Torres Strait Islander Health Training framework was to increase the support provided to both CEs and CMs (Urbis 2008). Because many CEs and CMs balance responsibilities for family and community as well as existing employment commitments (Martin & Reath 2011; Fredericks 2008; Nguyen & Gardiner 2008), appropriate recognition and remuneration of CEs and CMs is essential.

Interviews illustrated the many locally adapted models of CE and CM employment and remuneration. For example, CMs working in IHTPs may be remunerated by the IHTP via funding provided by the RTP; CEs may be employed by RTPs; CE/CMs may be employed by other organisations (for example by IHTPs) and be called upon to provide services to RTPs on an *ad hoc*, unremunerated basis. In some instances, paid community advisors attached to IHTPs provide cultural mentoring outside any funding structure provided by the RTP, for example, one RTP described drawing on the services of a CE/CM who is remunerated by the State/Territory Government. Occasionally, unpaid community advisors provide cultural mentoring to GPRs and JDs, outside their usual employment, and, in one instance, a local community reference group was described as identifying community members appropriate to provide cultural mentoring. At times cultural mentoring tasks fall to the AHW within the IHTP. Often no additional funding is provided to the AHW, although RTPs may provide general funding to the IHTP to support delivery of training.

The time commitment required of a mentor may be considerable, so that the person who agrees to take on the role may be retired or not in the workforce, again highlighting the importance of recognising their contribution with remuneration appropriate to their circumstances (McKenzie & Alberts 2002). Remuneration was discussed by many interviewees, particularly in relation to cultural mentoring which is often not
remunerated. Some interviewees noted that remuneration is about more than monetary recompense - CMs ought to be able to receive benefits that do not impact on existing entitlements. For instance benefits received by some GRPs and JDs (such as payment of a telephone account) were suggested as a potential way of supporting CMs as well.

Several interviewees commented that involvement of more than one CM associated with an RTP or IHTP would have the benefits of allowing the CM to attend to family and community commitments and allowing both CMs to provide peer support to each other.

Additional support, such as through employment models recognising other work commitments (for example with NACCHO State or Territory Affiliates) or in relation to community and family obligations, was also important for CEs.

**Role clarity**

Whilst role definition is discussed in some detail in the previous section of this section, in terms of employment and support of CEs and CMs, it is clear from interview data that it is important for employers to take into account the active participation of CEs and CMS as members of local communities, with all the social responsibilities and potential emotional impact that this may entail.

Given the diverse contexts in which cultural education and mentoring operates, this will require ongoing local consultation with CEs and CMs, to identify which aspects of the roles they most value themselves, and also what additional support or training is required for them to fulfil their roles.

**Support, training and networking activities**

While, the majority of CEs and CMs surveyed felt they were supported in terms of access to professional development and attendance at cultural training network events, only one third agreed that RTPs looked after their welfare while a further third disagreed. This was further explored in the interviews, from which it was clear that relational support within the RTP was vital. In one innovative model in the Northern Territory, Balint groups involving CEs and MEs showed promise in supporting CEs and sharing understandings within the training team.
There was consensus that training for CEs and CMs should be promoted. This could include training in teaching and mentoring, and it was surprising that little specific training for CEs promoting teaching skills was reported in this study. In the RTPs where it had taken place it appeared to have been well received and considered valuable. Training which promoted CE/CM understanding of the cross cultural experiences and perspectives of GPRs and JDs and how these impacted on expectations and behaviours during training was another promising suggestion. Understanding of the context and organisation of GP training was also noted as an important area of awareness for CEs and CMs.

It was recommended that training would need to be adapted to suit local contexts and individual learning needs. For example, some CEs/CMs may be particularly interested in training in the use of technology to improve presentation skills, while for others this may not be a need. Most agreed that it was important that formal qualifications and a career pathway for CEs and CMs was available, though equally this should not be mandatory as there were many CEs /CMs who would not be interested.

The GPET CE and CM network meetings were noted to be well attended and though they appear to address CE and CM requests for networking and sharing amongst CEs and CMs, surprisingly few CEs and CMs mentioned these meetings. When asked, some did not appear to be aware of this network. This may be especially the case for AHWs working as CEs and CMs and for those new to these roles.

### 4.3.2. What are the gaps?

Gaps in employment and support common to both CEs and CMs include formal recognition and remuneration for their role and acknowledgement that cultural education and mentoring are additional roles with particular responsibilities, not something which can be expected of anyone simply by being a staff member or a member of the community. Other gaps noted are the lack of formal policies supporting CE and CM roles in some regions and, in most regions, the absence of career pathways and formal peer mentoring and occasional ad
hoc needs based employment or other contractual arrangements between RTPs and CEs and CMs. Some participants suggest that CEs and CMs may benefit from strengthening their awareness of the RACGP/ACRRM curricula, which could help make cultural education and mentoring more relevant for GPRs and JDs.

4.3.3. What is recommended?

In further development of the CM role, some delineation to avoid the potentially unlimited scope of the role is needed, both in terms of the time commitment and availability and the expertise expected of the CM. Providing some clarity and defining expectations and the scope of the CM role in particular, may also increase satisfaction and wellbeing of all parties concerned, including CMs, GPRs and RTP staff.

Recognition of the contribution that CEs and CMs make to GP training and acknowledgement of the imperative to provide appropriate personal support, remuneration, career pathways and networking opportunities is also a key recommendation of the research.

The study findings recommend support of CE and CMs by modeling collaborative, respectful relationships, for example between CE/CM and MEs, and enhancing the sustainability of these roles through networking opportunities, peer mentoring and development and career pathways.

Professional development for CE/CMs should incorporate teaching skills, such as small group facilitation and principles of mentoring, and familiarisation with RACGP/ACCRM curricula.
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Collaborating across services

The Institute for Urban Indigenous Health is a regional body which was set up in 2009 by the four independent ACCHSs in South East Queensland. The Institute for Urban Indigenous Health has a key focus on workforce and service development.

Clinical Director, Dr Carmel Nelson, describes a collaborative approach to a range of cultural education activities including:

- regular orientation workshops for students and for new staff including GPRs;
- a cultural mentoring program incorporating:
  1. formal training and support for CMs and educators;
  2. establishment of clusters of CMs and non-Indigenous mentees;
  3. immersion workshop over two days for mentors and mentees;
  4. three additional days of formal training over a six month period; and
  5. ongoing supported meetings and discussions with mentor partners and clusters.
- delivery of cultural training for mainstream general practices, pharmacy and allied health providers as part of the Close the Gap program.

This cross service approach of “bringing people together who have shared roles and responsibilities” has great potential for enhancing sustainability of those undertaking cultural education and mentoring roles.

Cultural education and mentoring in a re-settlement Community: an innovative model

A number of RTPs now contract local ACCHSs to provide cultural education for GPRs and JDs, however Bogong have taken this a step further by funding a CE /CM position in one of their IHTPs – Albury Wodonga Aboriginal Health Service.

Being a re-settlement area, Albury Wodonga encounters the same challenges faced by many urban IHTPs in identifying a Cultural Mentor who is acceptable to the wide range of family and community groups now living in the area. Darren Wighton had a previous role as Pastor to the local community and was an ideal choice with great connections across all the community groups. Darren sees his role as extending not only to GPRs and JDs but also to medical students and to other staff of the service. This vertical integration of cultural education would however, require a greater time commitment than Darren’s present two days a week. Darren is currently also teaching regularly at Bogong’s regional cultural education workshops.
4.4. Programs

4.4.1. What is known?

All RTPs have formal requirements for GPRs to participate in some cultural education activities however the amount and the particular activities undertaken may vary considerably from region to region. Survey respondents indicated that, while all RTPs mandate GPR participation in short training and workshops, the range of additional and experiential training varies. Several RTP interviewees commented that increased sharing of information regarding cultural education and mentoring between RTPs would be of great benefit.

The literature and study findings identified that cultural education is provided to GPRs in a range of ways, on a spectrum from didactic classroom teaching to one-on-one mentoring by an acknowledged CM within the community setting. Preparation for GPRs undertaking IHTP placements was also variable. Some regions include residential cultural immersion experiences as part of GPR training while other regions rely on a workshop of several hours – possibly supplemented by written or on-line material - to prepare GPRs for work with an IHTP, and it was seen as the IHTP role to provide subsequent local orientation and cultural education.

Cultural awareness training strategies were common and many participants saw these as an essential first step to increasing cultural competence. However it was clear that participants believed that experiential training, including cultural immersion activities, meetings with Elders and short and long term placements in IHTPs were likely to have a stronger impact on learning and that GP training should include as many opportunities for learning from the community as possible. It was commented that this learning should involve two-way communication to ensure that knowledge is shared. Finally, the literature and the interview data strongly endorse the critical need for cultural training to incorporate reflexivity on the part of learners, examining hidden assumptions and unconscious bias in a non-threatening environment. It appears that cultural education activities incorporating self-reflection on the part of GPRs and JDs, GP Supervisors, MEs and RTP staff are occurring in many RTPs with encouraging results in the opinion of many participants, and that guidance and relational support through CEs and CMs can assist this learning.

The need for Aboriginal and Torres Strait Islander people to be engaged in cultural education and mentoring delivery appears well established, however the literature and research findings suggest that there is substantial room to improve how Aboriginal and Torres Strait Islander people are engaged in planning, developing and evaluating training. Survey and interview participants identified some innovative ways in which collaboration in the planning, design, delivery and evaluation of cultural education and mentoring is occurring.
In some cases shared cultural education planning and development within RTPs occurred through formalised processes of collaboration between RTPs and IHTPs, and this model was highly regarded. Several participants noted however the development of this degree of collaboration can take time and some believed such connections needed to be facilitated in their regions. It was also apparent that informal relationship building activities undertaken in a two-way learning approach within RTPs can lead to increased involvement of CEs and CMs in training planning and development. Examples of activities seen to promote whole of organisation collaboration were shared morning teas incorporating discussion focused on training delivery and organisational cultural competence (including RAPs), and shared cultural immersion and cultural education activities. Employment of RTP staff with a specific remit to promote Aboriginal and Torres Strait Islander health training was reported to have led to beneficial changes within several RTPs, giving regions the opportunity to more proactively develop their cultural education and mentoring delivery.

Survey data indicates that cultural education and cultural mentoring does provide RTP staff and GPRs and JDs with a greater understanding of Aboriginal and Torres Strait Islander culture. Several survey respondents described other important facets of cultural education and cultural mentoring including instilling an appreciation and respect for different cultural knowledge systems and beliefs. As indicated in the literature and interview data, a capacity for self-reflection and reflexive practice is a fundamental skill underpinning cultural competence, a skill which requires an understanding of the complexities of the interaction of cultures and refutation of the simplistic and fallacious notion that cultural competence is needed in order to deal with ‘problems’ causatively attributed to the patient. Training which excludes reflexive content is unlikely to create the insight necessary to challenge pre-existing prejudices and runs the risk of reinforcing racial stereotypes.

While those involved in delivery of cultural education and cultural mentoring were generally positive about its expected impact on GPR/JDs and GPR/JDs expressed high levels of satisfaction with the programs, they were less confident that the programs would prepare them well for practice in Aboriginal and Torres Strait Islander health. This may not indicate lack of confidence in their learning, it is also possible that the learners are demonstrating self-reflection and cultural humility (Borkan et al 2008). A very small number of survey respondents indicated that their interest in working in the area had increased as a result of cultural education. At the same time, some respondents requested increased access to programs and training placements generally, but also specifically to cultural mentoring. Interview data suggests that cultural mentoring has been of great value to many GPRs and JDs in the day-to-day management of their Aboriginal and Torres Strait Islander health practice, including having a better appreciation of community complexities, although most did not frame the support they had received using the term ‘cultural mentoring’.
Some GPR/JDs felt that there was room to improve the integration of theory and practice to make cultural education more directly relevant to GPR/JDs and that this might be achieved by increased reference to the RACGP/ACCRM curriculum or by increased partnership in delivery of cultural education between CEs and GPs. It was also noted by a few participants that in some circumstances GPRs or JDs may benefit from a modular approach to cultural education in which they have access to multiple levels of training as they build their experience.

Evaluation of cultural education and mentor programs was considered to be relatively underdeveloped. Evaluation largely occurs through standard RTP program and training placement evaluation processes. Thus cultural education sessions are likely to be evaluated through participant feedback at the end of activities and through (often informal) ME or CE assessments of how the GPRs and JDs appear to be learning. Similarly cultural mentoring at the IHTP level does not appear to be evaluated beyond giving GPRs and JDs opportunities to express their satisfaction or otherwise with the IHTP placement. The fact that some interviewees believed the value of the IHTP placement for GPRs was undervalued at the RTP level, suggests there is a need for more comprehensive evaluation of GPR learning in IHTPs and exploration of whether this perception is in fact widespread or problematic.

Similarly, assessment and evaluation of GPR and JD cultural competence was perceived by participants to be important yet difficult, and a complex area in which further attention by GPET and RTPs was needed. It was noted that most current formalised assessment processes undertaken by all registrars are summative rather than formative, and occur at the level of the RACGP or ACCRM fellowship exams. Significant formative assessment can occur within IHTPs, where it was reported that CMs, or AHWs in a cultural brokerage role, tended to be called on to assist GPRs and JDs with higher identified learning needs. In keeping with the strong focus within IHTPs on maintaining the cultural safety of their clients, it appears that communication skills and cross-cultural understandings of GPRs and JDs are scrutinised and supported closely during placements, with GP Supervisors and Aboriginal health professionals identifying this as a key part of their role in GP training.

Thus the formative assessment of the cultural training needs of GPRs at IHTPs was integral to the teaching which occurred in the placement, but targeted in particular, GPRs and JDs who were seen as needing more cultural awareness. It is possible that GPRs and JDs whose work was seen as satisfactory or high level were not receiving the same opportunities to enhance their work further through formative assessment processes.

The challenges inherent in assessment of values and attitudes were clear in both the literature and interview data. Some cultural education activities were didactic and evaluations summative. Other assessment and evaluation processes which required significant participant interaction were described, including presentations
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of reflective statements to Elders. The involvement of CEs in ECT visits, thus providing both medical and cultural formative GPR evaluation, was identified as an innovative and effective model, not least because it modelled to GPRs the need for learning in both these dimensions during their training.

4.4.2. What are the gaps?

Participant comments indicate that cultural competence learning for GPR/JDs can be discontinuous and ad hoc. Some GPR/JDs note that they have completed the same basic cultural education program on several occasions and requested a more cumulative, deepened teaching approach. Some GPR/JD participants believed that there was a need for increased targeting of cultural education to increase its relevance to their work context and also to the RACGP/ACCRM curricula. It appears that cultural education may not be explicitly incorporated into GPR training or promoted beyond attendance at required cultural education activities. For example, there was no evidence that cultural competence was considered within GPR learning plans, as would be ideal in a two-way learning approach.

Other data suggests that there are limited cultural education and mentoring opportunities for JDs, or that JDs did not take advantage of such opportunities. The relatively small numbers of GPRs/JDs who participated in this project mean that this data may not be representative of the wider group of GPRs and JDs, however exploration of training offered to JDs with others involved in GP training did suggest this was a potential gap.

Appropriate cultural education and mentoring is required for Aboriginal and Torres Strait Islander GPRs and JDs. This is an area requiring further exploration given the increasing numbers of Aboriginal and Torres Strait Islander JDs and GPRs.

The relatively high levels of unfamiliarity with the terms cultural education and cultural mentoring shown by GPR/JDs indicate a need for greater familiarisation with these terms. It also appeared there was little knowledge amongst many GPRs/JDs involved in this study of the concept of cultural mentoring, which may reflect a lack of personal experience of cultural mentoring, a low self-perceived need for cultural mentoring, or may highlight the wide variation of forms in which cultural mentoring can be delivered. This was particularly the case with JDs.

It appeared in some cases there could be better preparation for GPRs working in an IHTP. This may be possible through improved communication between RTPs and IHTPs regarding the kind of preparation that would be most helpful in the local context. In some regions there was a perception of good and beneficial communication between the RTP and the IHTP as well as integration of cultural education and cultural mentoring. However in other regions the preparation of GPRs and JDs for IHTPs was less apparent.
4.4.3. What is recommended?

Cultural education and mentoring in General Practice training should use adult learning principles incorporating self-reflection, demonstration of relevance and increased opportunities for active and experiential learning. Reflexivity regarding values and attitudes should occur at all levels of GP training, including by educational institutions, RTPs and staff, as well as GPRs and JDs. This is a practice recognised in the literature as crucial to development of cultural competence within institutions and individuals.

General Practice training should be delivered in a two-way learning approach, in which Aboriginal and Torres Strait Islander knowledge and learning is of recognised importance. This includes promoting partnerships between CMs and CEs and non-Indigenous educators and GPs engaged in education delivery. This is likely to demonstrate the value RTPs place on Aboriginal and Torres Strait Islander health training and to increase the perceived relevance of training to GPRs and JDs. This active collaboration is often already in place in the delivery of cultural education, but should also extend to development and evaluation of cultural education programs and to assessment of the cultural competence of GPRs and JDs.

Experiential training for GPRs and JDs in Aboriginal and Torres Strait Islander health is important and opportunities for this should be available to all GPRs and JDs. Ideally this would involve working within IHTPs. It can also incorporate cultural immersion activities and personal engagement with Aboriginal and Torres Strait Islander individuals and communities.

A framework guiding cultural education and cultural mentoring should acknowledge that cultural competence builds cumulatively, over time, and thus must include programs and reflexively-oriented processes that expand and deepen learning across the continuum of cultural competence. A modular approach to cultural education should be considered. Teaching should continue throughout the whole of GP training, including through existing programs such as GP Start and use of GPR learning plans. Vertical integration of cultural education throughout medical training will encourage continuing, cumulative learning. This will require formative assessment processes in order to develop appropriate cultural education for GPRs and JDs whose previous experience will be varied. The particular needs of Aboriginal and Torres Strait Islander JDs and GPRs should be considered in development of cultural education and mentoring programs.

Increased preparation for GPRs and JDs working in IHTPs may be advantageous in some regions. This may occur through increased integration and enhanced cultural education programs at the RTP, and also through support to IHTPs to offer locally adapted cultural education programs and mentorship to GPRs and JDs who commence at the IHTP.
Guidance on the types of cultural education activities that are likely to have the greatest impact may assist RTPs. Similarly, models which are currently used to evaluate programs and GPR/JD learning should be disseminated. This should include promoting collaboration among RTPs to enable better sharing of information about cultural education and mentoring strategies at both the GPR/JD and the organisational levels.

Increasing formative assessment processes of cultural as well as medical learning would complement current summative assessment processes.
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FIGURE 2 ‘GP TRAINING IN THE KIMBERLEY REGION – A COMMUNITY AFFAIR’

Outcomes of a vertically integrated training approach

The Kimberley Aboriginal Medical Services (KAMS) have a through flow to their Aboriginal Medical Services of students, JDs and GPRs. Their “pipeline” extends also to AHWs and Registered Nurses, some of whom have ended up in leadership positions in the KAMS services.

Integrated learning opportunities afforded by this multi-level learning community include a range of joint teaching activities, clinical support by senior trainees for more junior trainees and overnight camps for GPRs and students. The everyday awareness of career opportunities engendered by this integrated learning environment has been a significant factor in building a sustainable workforce in the remote communities of the Kimberleys. General Practice Registrars and JDs now number over 20 compared to just one or two, when the program started 11 years ago, with student numbers increasing from one to 14 over the same time period. If building a culturally competent workforce for Aboriginal and Torres Strait Islander communities is the aim of cultural education, then the Kimberley model has much to teach us!

Cultural Educators on external clinical teaching visits

In the Northern Territory CEs often work with MEs on ECT visits to GPRs. The CE specifically comments on the cultural issues related to the GPR communication and assures the patient that she is not there to listen to their health problems but to watch, listen and see how the GPR was communicating with them, making it a safe environment for all.

This two-way learning approach between ME and CE with the GPR not only facilitates timely, relevant cultural education but it models a partnership approach to learning and clinical practice and highlights the importance of cultural education in the context of GP vocational training. Ada Parry, a CE who has been engaged in this activity, tells us also that this approach values the CE involved and the input they provide. In addition she comments that this learning approach provided her with an understanding of the work load and challenges for GPRs, especially working in an AMS or a remote Aboriginal health setting. This understanding informed later CE workshop teaching.
5. Conclusions

In this section of the report the research outcomes noted in the GPET contract with UWS are presented, followed by the findings in regards to the research questions posed by GPET. Recommendations are made based on the research findings, including regarding conduct of future research. In conclusion recommendations are made for a set of principles to inform a “National Framework for Cultural Competence in Prevocational and Vocational General Practice Training”.

5.1. Research outcomes

In the contract with GPET a number of research outcomes were required in addition to evidence based responses to the research questions posed (see Table 3). The findings in regards to these outcomes have been woven through the research findings reported in section 3 and discussed in section 4 of this report.

A synopsis of the research findings in regards to the GPET research outcomes is provided below.

a) Regional Training Provider assessment of cultural competence against the outcomes specified in the Aboriginal and Torres Strait Islander health curriculum statements of the RACGP and ACRRM

In the consultations it was acknowledged that responsibility for summative assessment of GPR learning in the area of cultural competence rests with the RACGP and ACRRM and is addressed through their various examination processes in alignment with their curriculum statements.

There was little evidence in the research findings that systematic assessment of cultural competence against curricula outcomes is currently taking place in RTPs. Some RTPs undertake formative assessment processes, including reflective activities in which assessment of attitudes were described. Some RTPs described mock objective structured clinical examinations (OSCEs), in which MEs and CEs provide feedback on medical and cultural skills. One RTP had used ECT visits in which a CE and ME assess GPR cultural and clinical competence in an innovative model.

b) Regional Training Provider development and determination of cultural education, in particular:

Reasons for this educational methodology.

There does not appear to be one methodological approach used by RTPs in the development and determination of cultural education. In some RTPs it appeared substantial and systematic planning and development of cultural education occurs, with a focus on knowledge and attitudes and use of adult learning principles and integration of cultural education into whole of RTP teaching. In others cultural education
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appeared less planned and integrated and may simply consist of purchasing externally developed cultural education packages.

Regional Training Providers individually develop and determine their cultural education, usually, working collaboratively with CEs or IHTPs to plan and deliver individual activities. Local adaptation was noted to be a feature of these programs particularly in relation to cultural mentoring. Cultural education was reported to be more consistently attended than cultural mentoring and programs were generally observed to target GPRs to a greater extent than JDs. Approaches to supporting the cultural education and mentoring needs of Aboriginal and Torres Strait Islander registrars at the RTP level appeared to be under-developed.

Workforce used to develop and deliver this training.
Cultural education is almost always delivered by Aboriginal and Torres Strait Islander people, often in partnership with non-Indigenous MEs. The Aboriginal and Torres Strait Islander people who deliver cultural education within GP training were usually referred to as CEs, though the CE/CM role shows significant overlap, and in some settings CE and CM roles and tasks do not always easily fit into positions. Rather, various cultural education tasks may be taken up by people who are formally recognised as CEs and/or CMs, AHWs or RTP and IHTP staff. There is less involvement of CE/CMs or IHTPs in development of cultural education training than in the delivery of training.

How is this training evaluated?
Cultural education activities appeared to be most often evaluated by standard teaching evaluations, for example, through paper-based workshop evaluation forms. Standard feedback mechanisms were reported also for GPR/ JDs undertaking a term in an IHTP, such as through ME or ECT contacts and through GP Supervisor teaching sessions, as well as through mid and end of placement feedback opportunities. These are the same training evaluations which would occur in non-IHTP placements.

c) Identification of how GPRs and JDs are prepared for working in an IHTP

All RTPs reported formal requirements for GPRs to participate in some cultural education activities however the duration and content of the training varies considerably from region to region. Usually GPRs and JDs do not receive any additional preparation from the RTP for working in an IHTP, beyond the standard cultural education activities provided to all GPRs and JDs. Rather, this is seen to be the role of the IHTP and how this occurs is variable and determined by the local context. Some RTPs and IHTPs described formal orientation programs which incorporate information about the local community and health service, including community visits, cultural immersion camps and written resources.
Is cultural mentoring provided?
Cultural mentoring does not usually occur within current GP training structures for GPRs and JDs unless they are undertaking an IHTP placement. Within IHTP placements provision of cultural mentoring is usually not formalised and commonly occurs when GPRs/JDs are seen to need support or cultural guidance, or when consultation or communication issues have occurred with clients of the service and cultural brokerage is required to assist in their management. Thus cultural mentoring is generally responsive rather than planned. Given the strong emphasis within IHTPs on culturally safe and effective health care for their clients, it seems the performance of GPRs and JDs is monitored carefully within their training placements, and GP Supervisors and AHWs are quick to organise cultural mentoring as required. However it was noted by several participants that this model can mean that GPRs and JDs who do not cause concern within their placements may not be getting the cultural mentoring that would be ideal. Cultural mentoring can also occur within IHTPs through systems which support the non-Indigenous workforce as a whole, such as through group cultural education/mentoring meetings at the IHTP and through practice systems which support the joint management of clients by Aboriginal and Torres Strait Islander health professionals.

Although formalised one-to-one cultural mentoring was not a universal experience of GPRs and JDs, when it did happen it was seen as particularly valuable. Many participants, both GPR and JDs and more experienced GPs now working as GP Supervisors and MEs, recalled positive experiences of cultural mentoring, usually involving naturally emerging mentoring relationships.

Is the GPR’s experience assessed and evaluated?
General Practice Registrars who have undertaken IHTP placements are most commonly evaluated via the usual RTP processes for evaluating performance of GPRs undertaking training placements. This includes contacts with MEs and ECT visits. One RTP used an innovative model where ECT visits are undertaken by a CE and a ME in a two-way learning approach. It was clear that formative assessment did take place within IHTPs, facilitated particularly by GP Supervisors and CE/CMs or AHWs within the service, who would identify cultural and communication learning needs and institute cultural mentoring as a response.

d) Identification of core principles which will inform a new National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

The core principles are reported in the front of this report and discussed in the following section.

5.2. Response to the research questions
In this section of the conclusions the research findings in relation to the questions posed in the GPET contract are presented.
5.2.1. Understanding of cultural education and mentoring including roles of people engaged in its delivery

Under this thematic heading the following research questions are addressed:

- What is currently understood to be cultural education?
- What is currently understood to be cultural mentoring?
- When are CEs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of GP training?
- When are CMs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of GP training?

The review of the literature, supported by the survey and interview qualitative research findings, highlighted key understandings of cultural education and mentoring relevant in the Australian General Practice vocational training context. Cultural education in this context can be understood as a life-long learning process which shapes the knowledge, values, attitudes and behaviours of general practitioners (GPs). It occurs through both the formal and informal or hidden teaching which takes place at all levels of training, including from medical school, through hospital-based and then vocational General Practice training and on to continuing medical education.

Cultural education and mentoring are provided by experienced Aboriginal and Torres Strait Islander people in a wide variety of roles. This includes people working in a cultural brokerage role such as AHWs. Strong relationships with or endorsement by Aboriginal and Torres Strait Islander people, communities or organisations is required for cultural education and mentoring.

Both cultural education and mentoring are facilitated by adult learning approaches, including learner centredness, a focus on relevance and active learning. Reflection on the values and attitudes and engagement with Aboriginal and Torres Strait Islander people and communities is vital for both individuals and organisations. Similarly, application of a two-way learning approach in which Aboriginal and Torres Strait Islander knowledge and culture is valued together with medical and non-Indigenous knowledge, culture and teaching within GP training is important.

Cultural education is commonly delivered in small and large group teaching, often in partnership with a non-Indigenous educator and can occur at systems, organisational, professional and individual levels. It is
commonly formally planned and can include generic teaching which is not specifically targeted to the local Aboriginal and Torres Strait Islander community.

Cultural mentoring shares many similarities with cultural education with key differences being that this approach is generally based on a one-on-one relationship with the learner and is highly localised to the local Aboriginal and Torres Strait Islander community. It can however also include organisational mentoring. Cultural mentoring is unlikely to involve a non-Indigenous educator in its delivery and is less likely to be planned than cultural education, often occurring on an ‘as needed’ basis.

In the General Practice training context CEs and CMs are both engaged in delivery of the training, though sometimes less engaged in its development and evaluation. Cultural Educators and CMs are engaged differently in different regions including by RTPs, IHTPs, NACCHO Affiliates and through private contracting arrangements as well as in combined organisational roles. Aboriginal Health Workers are commonly engaged in GPR and JD training though sometimes this role is not well acknowledged and supported. Aboriginal and Torres Strait Islander GP Supervisors and MEs are also engaged in both medical and cultural training in some settings.

5.2.2. Employment and support for Cultural Educators and Cultural Mentors

Under this thematic heading the following research questions are addressed:

- How are CEs and/or CMs remunerated?
- Do RTPs have formal policies in place in relation to supporting CEs and CMs?
- Are CEs and/or CMs provided with the opportunity to participate in professional and cultural support and development?

Depending on the employing organisation CEs and CMs are remunerated through a range of arrangements. Often however contracts are not long term and sometimes those undertaking the CE/CM are not recognised or remunerated specifically for this activity particularly when it is undertaken within another role such as that of an AHW. Cultural Mentors are often not remunerated and there was some discomfort expressed at the injustice of this and some confusion regarding how best to remunerate CMs when the scope of the role was often so poorly defined.

Cultural Educators and CMs themselves expressed a variety of views regarding the best means of remuneration with some requesting salary payments and employee entitlements like any other employee, and others advising that for some engaged in cultural education and mentoring, remuneration needs to be
negotiated so as not to impact on other employment or benefits. There is however general agreement that
financial remuneration is only a part of the remuneration package, with terms and conditions of employment
need to reflect the community responsibilities of the roles, and demonstrated valuing of the roles by the
employing organisation paramount.

The literature recommends organisational structures, policies and processes to support cultural competency.
and a number of RTPs are now developing RAPs. However, there are few formal policies evident in the
research findings in relation to the support of CEs and CMs. Some RTPs described community reference groups
and CEs acting as organisational advisers. These roles appear to relate more to program development and
oversight and in some settings also support of the IHTPs, rather than support of those engaged in the
education.

Cultural Educators and CMs reported support largely based on relationships particularly with MEs. In the
Northern Territory a new approach is being trialled in recruitment and support of CMs in local communities.
Though specific to the local context, this approach may inform future policies and programs in other RTPs.
Relationship building activities within RTPs, both formal and informal, which promote interaction and
understandings between CEs and CMs with MEs and RTP staff, appear to be important in supporting CEs and
CMs.

Whilst many RTPs acknowledged the importance of professional development for CEs and CMs, and some CEs
and CMs reported engaging in professional development activities, this is not routinely formalised. Cultural
development and support were noted by CEs and CMs as best received from their communities, yet the time
spent undertaking community activities is not often recognised as professional development by employing
organisations. Some CE/CMs warned against an assumption that all CEs and CMs would want or need
professional development, given the diversity of Aboriginal and Torres Strait Islander people who take on
these roles.
Under this thematic heading the following research questions are addressed:

- What practices are currently used to establish positive relationships with Aboriginal and Torres Strait Islander peoples and communities? What is needed to engage and establish partnerships?
- Do RTPs run cultural education activities for staff at all levels, including MEs and GP Supervisors?
- Are GPRs and JDs required to prepare for working in Aboriginal and Torres Strait Islander communities?
- Are GPRs and JDs required to undertake formal cultural awareness training at any point during General Practice training?
- How is Aboriginal and Torres Strait Islander health incorporated into current General Practice education and training practices?
- Are there formal processes for feedback on cultural education and/or cultural mentoring activities?
- Are there feedback mechanisms for GPRs and JDs who undertake an IHTP, and vice-versa?

Cultural education and mentoring requires partnership with communities and Aboriginal and Torres Strait Islander community controlled organisations, and this is currently actioned through a variety of approaches. Examples include RTPs employing or contracting CEs/CMs with strong community links or RTPs sharing employment of CEs/CMs with the NACCHO State or Territory Affiliate. Sometimes partnerships are promoted at the organisational level, such as through community advisory groups that provide cultural direction to RTPs. In some settings it appears that collaborations between Aboriginal communities and community controlled organisations are active, and in other settings such collaboration is still developing and some RTPs requested appreciate advice and support in how best to initiate and promote effective and respectful partnerships. For some there is uncertainty as to how to best respect the IHTP lead in the provision of GP training within that organisation, whilst remaining answerable to perceived GPET and GPR/ JD requirements and ensuring best practice Aboriginal and Torres Strait Islander training and appropriate high-level community engagement.

All RTPs have formal requirements that GPRs participate in cultural education though is less commonly required of JDs. Attendance at cultural education is not always be required of MEs, GP Supervisors or RTP
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity  
Section 5: Conclusions

staff, though in many areas this does occur. This appears to be dependent on the proactivity of the RTP in supporting these activities. There is a great variation in the approaches to and the duration and content of the cultural education activities. In some areas extensive teaching including community contact and cultural immersion activities is provided, whilst others provide more didactic programs. In some regions cultural education is delivered in strong partnership with local communities or ACCHOs, and this collaborative model appears to be highly regarded and contributes to positive relationships with Aboriginal and Torres Strait Islander communities. There is some concern that sometimes training can be delivered through commercial training packages which are disconnected from local Aboriginal leadership and communities.

Cultural education provides important preparation to GPRs and JDs to work in Aboriginal and Torres Strait Islander communities, though it is not clear how confident GPRs and JDs are that this prepares them well for practice. This preparation is likely to be enhanced by ensuring cultural education is vertically integrated throughout GPR/JD training, takes place on more than one occasion and in a modular approach which takes into account the GPR/JDs individual needs. It was emphasised that cultural education provides only the early stepping stones for building cultural competence and needs to be supported by local cultural mentoring when GPRs /JDs are in IHTP placements. This cultural mentoring requires additional support.

Currently there is a wide variation in how Aboriginal and Torres Strait Islander health is incorporated into General Practice education and training practices. In some settings there is an integrated approach. In RTPs where there are large numbers of IHTPs this can mean that all GPRs /JDs undertake experiential training in IHTPs and participate in many educational and mentoring activities. In RTPs within regions of lower Aboriginal and Torres Strait Islander populations, and lesser availability of IHTPs, this may be approached through cultural immersion and community activities for all GPRs/JDs as well as incorporating Aboriginal and Torres Strait Islander teaching into all aspects of the curriculum. In some RTPs there appears to be a need for improved integration of Aboriginal and Torres Strait islander health with other learning activities in order to ensure the curricula requirements are met. This will need to include development in most areas, of learning pathways for GPRs and JDs which cater to the differing levels of experience and cultural competence.

Evaluation of cultural education and mentoring activities does occur, both formally and informally, though this is an area which would appear to benefit from further development. Cultural education activities may be evaluated through written or oral feedback provided by participants. Cultural mentoring does not appear to be commonly evaluated either by the IHTP or the RTP, beyond the general feedback collected from GPRs and JDs during their training.

Assessment of GPR and JD cultural competence and the learning they have received from cultural education and mentoring is also a relatively underdeveloped area. Most current summative GPR/JD assessment is seen
to occur at the level of the RACGP/ACCRM fellowship exams. Formative assessment occurs, though usually in an informal way, as CEs and MEs note the learning needs of GPRs/JDs during cultural education activities at the RTP or CMs/CEs and GP Supervisors and other IHTP staff identify learning needs in IHTP placements. There are formal assessment activities taking place in some RTPs, such as through reflective case based teaching in Aboriginal health and in attendance of CEs and MEs at joint ECT visits.

5.2.4. The future

In this section the questions remaining to be addressed are:

- What is needed to build sustainable cultural education and cultural mentoring capacity to meet registrar training needs?
- What is needed to build partnerships with Aboriginal and Torres Strait Islander peoples and communities to sustain registrar training needs?

These issues are addressed throughout the report and in particular, in those sections of the discussion headed “What is recommended?” under each of the thematic headings above. In additional the “core principles” identified in the following section of the report gather key recommendations for future practice in these areas.

5.3. Reflections on the research process

Many aspects of the research approach were best practice. In particular the development of the research and the oversight by CEs and CMs, both those in the GPET CE/CM Reference Group and those employed as cultural consultants to the research team, ensured the research was responsive to and responsible to the CEs and CMs whose roles and activities were the focus of the research.

The great enthusiasm and generosity of those approached to participate in the research meant that the wide ranging consultations covered all RTP areas and included a variety of participants. The snowballing recruitment used to identify other key informants further increased the range of views provided.

The use of a variety of research methods enabled the findings to be triangulated. In particular, the literature informed understandings of best practice in cultural education and mentoring, as well as providing information concerning the history of cultural education and current practice in the General Practice vocational training context. Though the surveys reached a slightly different target audience compared to the interviews (fewer IHTPs and CE/CM respondents) many of the views expressed were congruent across the two approaches thus providing more confidence in the research findings.
The early analysis of the survey findings and progressive analysis and interpretation of the interview data, meant that later interviews were able to be tailored to target areas of discussion and issues where further information was required. In particular the face to face review of the research findings with the cultural consultants enabled deeper understandings and shared interpretations of the results.

There were however, a number of difficulties encountered. The small number of survey respondents, particularly amongst the GPR and JD groups, may have resulted from competing surveys distributed around the same time and perhaps some “survey burnout”. The skewing of survey results to two RTPs may also have limited the generalisability of these results. The time needed to set up interviews was underestimated, hence the interview process was ongoing well after the projected timelines.

As a result of this experience the following recommendations are made concerning future research in this area:

- Focus on face to face interviews and focus groups as a means of gathering research data;
- Allow more time for data collection using this approach; and
- More focussed research in particular areas as highlighted below.

A number of aspects of cultural education would benefit from further research in the General Practice vocational training context. These include:

- roles of the AHW in cultural education and cultural mentoring;
- Cultural mentoring as an organisational responsibility in IHTPs and ACCHSs;
- “opening the black box” – development of program evaluations that focus on more than participant satisfaction;
- evaluation of GPR/JD learning in IHTP placements and also perceptions around these placements;
- cultural education and mentoring needs of Aboriginal and Torres Strait Islander GPRs and JDs;
- assessment of learner values and attitudes; and
- health impacts of cultural education.
5.4. Core principles for a National Framework for Cultural Competence

Based on the research findings the following core principles are recommended to inform a new *National Framework for Cultural Competence in Prevocational and Vocational General Practice Training*. These core principles are summarised in the front of the report.

The recommended principles are numbered below under the thematic headings of the research: understandings of cultural education and mentoring, employment and support of CEs and CMs, and cultural education and mentoring programs. Under each of the highlighted principles is a brief explanation of the principle including how this has been derived.

5.4.1. Understandings of cultural education and cultural mentoring

1. *In the General Practice environment, cultural education and cultural mentoring are best experienced through a two-way learning approach in which GP education is informed by Aboriginal and Torres Strait Islander cultures, experience and knowledge as well as medical learning. In some circumstances this may mean cultural and medical teaching is delivered in partnerships between Aboriginal and Torres Strait Islander people and non-Indigenous health professionals or medical educators.*

The two-way learning approach is recommended in the literature and was also noted by a number of research participants as not only educationally sound but also a means of demonstrating and modelling respectful collaborative professional relationships, increasing GPRs and JDs recognition of the importance of cultural training within General Practice and providing professional and cultural support for CEs and CMs.

2. *Cultural education and cultural mentoring are carried out by Aboriginal or Torres Strait Islander people. They may be engaged in a variety of roles with relevant organisations and/or within local communities.*

Almost all respondents agreed that cultural education and mentoring is delivered by Aboriginal and Torres Strait Islander people. This is also in agreement with the GPET definitions. Some of the confusion about terminology noted in the survey and interview findings is illustrated by some non-Indigenous educators defining themselves as “Cultural Educators”.

Some research participants clearly delivering cultural education or mentoring declined to define themselves as CEs or CMs, in part because this was not their principle role. An inclusive approach is recommended, recognising all who deliver this training no matter what their principle role or their preferred title.
3. **Cultural education and cultural mentoring are recognised as overlapping activities.**

Some activities are clearly described as definitive of either cultural education (for example delivery of workshops) or of cultural mentoring (such as the one on one relationship between the mentor and the learner). Other activities, such as providing guidance and feedback on GPR and JD consultations and communication skills or arranging immersion activities in local communities can be undertaken by either CEs or CMs.

Recognising the overlap in these roles and focusing on the activities, rather than the position title of the person delivering them, may assist in making the roles more attractive and sustainable. This may also ensure the expectations of those taking on these roles are clarified.

4. **Cultural education and cultural mentoring activities may be carried out in a variety of locations, including in the RTP offices, however they should engage ACCHSs or State or Territory Affiliates of NACCHO.**

Both the literature and the research participants highlight the importance of interaction with Aboriginal and Torres Strait Islander people and communities in cultural education and mentoring. The most appropriate organisations providing this context in the primary health care setting are ACCHSs and NACCHO State and Territory Affiliates.

5. **Cultural education and cultural mentoring are delivered enacted in different ways according to the local Aboriginal and/or Torres Strait Islander context.**

The critical importance of local adaptation of cultural education and mentoring is well established in the literature and was reinforced by the research participants.

6. **Cultural education and cultural mentoring are supported by systems and organisational approaches as well as professional standards that value cultural competence. This includes a reflexive approach on the part of the organisation.**

The literature describes the importance of organisational and structural approaches to supporting cultural competency of individuals. This was noted by respondents to apply to RTPs employing CEs and CMs as well as to IHTPs and also to the professional colleges whose curricula underpin vocational and pre-vocational training in General Practice. A reflexive approach similar to that advocated for individuals is noted to also apply to organisations. Such reflection on operations, policies and activities and their impact on the cultural safety of the organisation is suggested as an important enabler of effective cultural education. Reconciliation action plans are well supported as a means of facilitating this organisational self-reflection.
5.4.2. Employment and support of Cultural Educators and Cultural Mentors

1. **Cultural Educators and CMs are recognised and supported by Aboriginal and Torres Strait Islander communities and/or organisations.**

Whilst the principle of community endorsement of CEs and CMs was espoused by some research participants, for others this was problematic, for example when the CE or the CM was working away from their community of origin. In these situations the CE or CM generally had been endorsed and was supported by the ACCHS or the NACCHO state or territory affiliate with whom they worked closely.

The support of CEs and CMs by Aboriginal and/or Torres Strait Islander communities and organisations, whether those in which they currently work or those from which they originate, is an important means of sustaining those taking these roles.

2. **Those engaged in cultural education and cultural mentoring are encouraged but not required to nominate themselves as CEs and CMs. The roles and activities rather than the position titles of CE or CM can be used to describe the personnel engaged in cultural education and mentoring activities.**

As noted above some research respondents were reluctant to describe themselves as CEs or CMs though they were clearly engaged in roles and tasks which involved cultural education and/or mentoring. This was particularly the case for AHWs employed in IHTPs. Whilst those taking on the roles can be encouraged to assume the titles of CE and CM, in some situations this may not be preferred. Acknowledging the roles and responsibilities/ tasks may be preferable for those people.

3. **Cultural Educators and CMs are remunerated through negotiated arrangements according to individual circumstances.**

Remuneration for cultural education and cultural mentoring was seen as vital to the recognition and sustainability of CEs and CMs in their diverse contexts. Some CEs and CMs receive employment and other benefits which may be affected by some methods of payment. Payment needs to be negotiated with each individual to ensure they are not disadvantaged either through not being paid, or by a negative impact on their other benefits.

4. **Employment terms and conditions include recognition of the importance of time spent with communities engaging in culturally significant activities.**

Many CEs and CMs referred to the importance of maintaining links with their communities in order to fulfil their CE and CM roles. Some commented on the need for the time required in the community to be valued, respected and remunerated as part of their CE/CM responsibilities.
5. **Professional needs of CEs and CMs are addressed through support for professional development activities including peer support and networking activities.**

Key peer support valued by CEs and CMs included mentoring of younger community members into CE/CM roles. This, in addition to opportunities to share ideas with other CEs and CMs (such as provided by the GPET CE and CM Network), was described as increasing the sustainability of cultural education and cultural mentoring.

6. **Cultural Educator and CM professional development activities are negotiated according to individual, community and organisational needs including, potentially, development of teaching and mentoring skills; understandings of cross cultural stress and impacts of cross cultural stress on non-Indigenous health professionals as well as on CEs and CMs; and awareness of the Australian General Practice training program context including colleges’ curriculum requirements.**

A range of professional development activities for CEs and CMs was suggested including development of a variety of teaching skills as well as understandings of cross cultural stress and its impact on both non-Indigenous health professionals and CEs and CMs. Whilst the teaching skills were noted to vary according to the context of teaching, recognition of cross cultural stress was perceived to be applicable in all cultural education contexts. Interviewees and survey respondents noted a need for CE/CM awareness of the RACGP and ACRRM curricula.

The particular training required and the provider of the training (either the RTP or external provider) is best negotiated with the individual CE or CM. Having an opportunity to de-brief following cultural education activities was noted by some interviewees as a particularly useful means of professional development as well as a valued support mechanism.

7. **Cultural Educators and CMs are supported to plan individualised career pathways including the achievement of additional qualifications. Additional study or achievement of qualifications is not however, a requirement for the roles.**

Whilst some respondents reinforced that CEs and CMs should have the opportunity for career pathway development to enhance the attractiveness and sustainability of the roles, others advised that for some CEs and CMs, knowledge of cultural issues is part of their lives and experience and requires no additional training or qualifications.
5.4.3. Cultural education and cultural mentoring programs including development, evaluation and assessment:

1. **Local communities and/or IHTPs are actively engaged in the development and oversight of cultural education and cultural mentoring programs so that these are reflective of local community experience, knowledge, values, and needs.**

   The local adaptation of cultural education and mentoring was observed to be facilitated by strong engagement of local communities and the IHTPs. In some sites this included consultation with local Elders or Traditional Owners.

2. **Cultural Educators and CMs work in respectful partnerships with MEs in implementing two-way learning approaches that value both cultural and medical learning.**

   The engagement of GP and medical educators, including non-Indigenous educators, in learning approaches that value both the cultural and medical learning, was observed to encourage GPRs and JDs to value both aspects of their learning as well as the CEs and CMs engaged in their teaching. Examples of these two-way learning approaches include shared workshop facilitation as well as shared consultation skills training such as through external clinical teaching visits.

3. **Cultural education programs are based on adult learning principles with a particular focus on active learning through engagement with Aboriginal and/or Torres Strait Islander people.**

   Many respondents concurred with the findings of the literature review related to the need for active, face to face engagement with Aboriginal and Torres Strait Islander people to optimise cultural education. Experiential training opportunities, such as cultural immersion experiences and IHTP experience, were suggested as a potent means of facilitating this engagement.

4. **Increased GPR and JD access to well supported IHTPs provides the most effective and appropriate learning engagement with Aboriginal and/or Torres Strait Islander people.**

   Experiential learning is recognised as an effective learning approach and many who responded to the surveys and interviews noted the value of cultural immersion and experience in an IHTP. Support of the IHTPs and preparation of GPRs and JDs for the experience is vital to ensuring the success and sustainability of these placements.
5. Programs present cultural education as life-long learning and as a result of this, formative assessment is used to gauge knowledge, skills, attitudes and behaviours, in order to tailor learning to individual GPR and JD needs. As a life-long learning activity, cultural education also needs to be vertically integrated across university, vocational training and ongoing General Practice learning environments.

The literature highlights the need for life-long cultural learning and many participants also warned of the risk of a “tick the box” or “one stop shop” approach to cultural education. Some respondents similarly noted the variety of experience and skills with which GPRs and JDs come to cultural education and the need to adapt the cultural education accordingly.

Some form of “in training” cultural education needs assessment was recommended as a means of both providing a learner centred approach and of building on previous learning using a “life-long learning” approach. Such cultural learning needs assessments could be facilitated by GPR/JD development of individual cultural learning plans in consultation with CEs/CMs. Assessment of attitudes and behaviours was noted as particularly problematic. Face to face interaction with CEs and CMs was suggested as one means of providing such formative assessment.

6. The RACGP and ACRRM Aboriginal and Torres Strait Islander health curriculum statements define the learning outcomes required of GPRs. These along with the related assessment processes set the standard for cultural education and mentoring activities provided by RTPs.

Whilst this point was not widely raised in surveys and interviews, the RACGP and ACRRM curriculum statements clearly make this point.

7. Cultural education is extended to all stakeholders within the organisation including RTP staff and GP Supervisors as well as GPRs and JDs.

A number of respondents noted the importance of consistency of messages around cultural education. To this end cultural education for all RTP staff as well as GP Supervisors not employed in IHTPs was recommended as a means of strengthening cultural education for GPRs and JDs.

8. Effective cultural education and cultural mentoring programs require opportunities for learners and organisations to reflect on their own cultures and their impact on interactions and relationships with Aboriginal and Torres Strait Islander people. This is best facilitated through open and respectful communication in a culturally safe environment.

The literature strongly supports cultural education and cultural mentoring approaches that enable the learner to reflect on their own culture, attitudes to other cultures and world view in order to create the insight necessary to challenge pre-existing prejudices. Interviewees commented on the need for a mutually safe space within which CEs/CMs and GPRs/JDs can express ideas and thoughts and ask questions and noted the importance of feeling comfortable to share.
6. Appendices

Appendix 1 Literature Review

Appendix 2 Survey Report

Appendix 3 Interview Report

7. References
Urbis staff responsible for this report

Director        Linda Kurti
Associate Director Julian Thomas
Senior Consultant Ronald Woods
Job Code         SPP 14312

Note on language: In this report, the word *Indigenous* is used primarily in the international context to denote the first peoples of a land. Within Australia, the phrase *Aboriginal and Torres Strait Islander people* is used wherever possible to refer to the original inhabitants and their descendants; however, in places the terms *Indigenous* or *Aboriginal and Islander* are used where this allows the text to flow more easily, for instance, when referring to Indigenous and non-Indigenous Australians, or when used in a quoted text. The term “Indigenous” is used with reference to and respect of both Aboriginal and Torres Strait Islander peoples.

This literature review was prepared by Urbis primarily for the use of the project team brought together by the University of Western Sydney in the course of a commissioned research project for General Practice Education and Training Pty Ltd. Urbis wishes to thank all those who have assisted with the preparation of the literature review, or provided insight and perspectives as well as guidance on published and unpublished literature. We thank the staff at the University of Western Sydney (particularly Jennifer Reath and Penelope Abbott) who have provided detailed comments and helpful advice throughout the development of this document.
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Executive Summary

General Practice Education and Training commissioned the University of Western Sydney, who subcontracted with Urbis, to conduct research aimed at developing the evidence base to support training in cultural competence for doctors working with Aboriginal and Torres Strait Islander people. This research will inform a proposed *National Framework for Cultural Competence in Prevocational and Vocational General Practice Training*. This literature review comprises the first part of the project, and seeks to answer three key questions:

- What is currently understood to be cultural education?
- What is currently understood to be cultural mentoring?
- What constitutes best practice in cultural education and mentoring in prevocational and vocational General Practice training?

Section 1 sets out the purpose, approach and structure of this review. The methodological approach has focused on Australian sources where possible, but also draws significantly on literature from the United States (USA), Canada and New Zealand on the basis that there has been a health-system focus on Indigenous or First Nations peoples in these countries.

There is no single definition of cultural competence generally or in relation to Aboriginal and Torres Strait Islander people, although a number of models have been proposed. As a starting point, section 2 of this review examines definitions of cultural competence, exploring the meanings and relationships between concepts of ‘cultural awareness’, ‘cultural safety’, and ‘cultural respect’. The review identifies five key aspects of cultural competence which assist in understanding its nature. These features are that cultural competence:

- is a subjective standard of competence assessed from the viewpoint of Aboriginal and Torres Strait Islander consumers;
- is a process of both awareness of and engagement with another culture;
- can be defined at different (but interdependent) levels of the health system – the systemic, organisational, professional and individual – and ideally requires integrated action at all levels to create an environment which is culturally secure;
- is a dynamic and evolving process rather than a static concept, both in relation to the cultural context within which ‘competence’ is framed and the subjective attributes and capabilities of individuals, professions, organisations and systems demonstrating cultural competence; and
• requires ongoing self-reflection and insight on the part of clinicians, and similarly, for organisations to internally scrutinise and monitor their organisational performance.

In general, while there is a range of literature exploring and defining cultural competence and a number of guiding frameworks developed, there is less evaluative material available which provides a robust evidence base about effective strategies to create cultural competence.

Section 3 considers the role of cultural education in medical education, particularly in the context of undergraduate training, drawing on Australian and international examples. It sets out a number of different approaches to delivering cultural education and examines the available evidence to support effective practice, noting that there is very little in the evaluative literature about the impact of cultural education on patient outcomes. The focus of most evaluative activities appears to have been on assessment of the impact of training on participants, and these studies appear to indicate good evidence for positive impacts on knowledge, attitudes and skills.

It appears clear that the institutional setting and culture in which cultural education is delivered has a significant impact on students, who learn informally through behaviours of their peers, modelling by teachers, and the degree of cultural respect demonstrated implicitly and explicitly within the learning environment. This suggests that institutions themselves need to adopt a reflexive approach to cultural competence and to acknowledge the limitations of their epistemological frameworks. The literature which is available also suggests that cultural education should be delivered in a manner consistent with good practice in adult education (i.e. learner centeredness, encouraging self-direction and providing opportunity to apply knowledge and skills in practice). Educational modalities which include direct engagement with community and facilitate the application of skills in practice also find particular support in the literature.

Development of self-awareness and an appreciation of the influence of clinicians’ own cultural standpoints on their engagement with other cultures are important. Such insights can help to address risks associated with inadvertent reinforcement of pre-existing prejudice, propagation of stereotypes and perceptions of cross-cultural issues being a ‘problem’ located within the Aboriginal and Torres Strait Islander patient. Cultural mentoring arrangements may be particularly supportive of reflexive practice, as they provide a more tailored, one-to-one form of direct engagement and teaching.

Section 4 focuses specifically on cultural education and mentoring within vocational General Practice training, exploring the current structures through which this occurs as part of core curricula and optional Aboriginal and Torres Strait Islander health clinical placements or training posts. In general, findings are limited by a lack of evaluative literature examining cultural education in Australian General Practice training settings, but what is
available indicates the importance of ensuring that Aboriginal and Torres Strait Islander people are meaningfully engaged in planning, developing, delivering and evaluating cultural education.

Cultural Educators and Mentors are reasonably well established in vocational training, but their specific roles could be further clarified, particularly given the interconnectedness of their roles and responsibilities as both community members and educators. This complexity also points to the need to ensure that appropriate recognition, personal and professional support is available to Cultural Educators and Mentors, including remuneration.

Section 5 returns to the three key research questions, drawing together and synthesising the analysis presented in the preceding three sections. It sets out emergent themes and summary findings that will provide a basis for the next stage of the project.

In addressing what is currently understood to be cultural education, section 5 concludes that cultural education includes the transmission of history and knowledge of Aboriginal and Torres Strait Islander cultures, through a range of pedagogical approaches, in order to build the knowledge, attitudes, skills and behaviours of students and professionals. Cultural education can be perceived to take place at the system, organisational, professional and individual levels.

Cultural mentoring occurs in a more individually focused way, with the Cultural Mentor providing guidance and advice on negotiation across cultures, and acting as a confidential and knowledgeable ‘sounding board’ for the mentee to reflect on his/her experiences in working with Aboriginal and Torres Strait Islander people.

Finally, section 5 summarises what is understood to be cultural education and cultural mentoring, and provides guidance on the probable features of best practice in prevocational and vocational General Practice training. These include adopting a reflexive, multi-level approach to developing competencies (systemic, organisational, professional and individual), valuing, respecting and engaging with holders of cultural knowledge. Specific pedagogical strategies for developing cultural competence should emphasise opportunities to engage with Aboriginal and Torres Strait Islander people and communities over a period of time, should reflect adult learning principles and should foster reflexive practice and a personal commitment to long term development of cultural competence.
1. Introduction

The organisation responsible for the contracting of vocational General Practice training, General Practice Education and Training Pty Ltd (GPET), commissioned the University of Western Sydney (UWS), in partnership with Urbis, to undertake research to develop an evidence base that improves knowledge and understanding of what constitutes cultural education and cultural mentoring for doctors in training to become General Practitioners (GPs). The focus of the project is on supporting doctors to work effectively with Aboriginal and Torres Strait Islander people. In particular this project identifies an accepted set of core principles which will inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

1.1. Aim of literature review

A literature review was undertaken at the start of this project to determine what is already known about cultural education and Cultural Mentoring within the context of prevocational and vocational training in General Practice.

The questions the review sought to answer are:

- What is currently understood to be cultural education?
- What is currently understood to be cultural mentoring?
- What constitutes best practice in cultural education and mentoring in prevocational and vocational General Practice training?

The review informed the survey and consultation components of the project, and contributed to the evidence base and the development of an accepted set of principles to support the proposed national framework. The other components of this research are reported in Appendices 2 and 3 of this report.

1.2. Methodology

In the search for relevant literature, the primary emphasis was on material produced within the last ten years in Australia. Evidence was also included from other English-speaking countries where Indigenous or First Nations peoples have been a prominent focus of the health system, primarily from the United States (USA), Canada and New Zealand. While the search was generally confined to publications since 2000, several seminal papers or reports prior to 2000 were included because of their importance in the development of
understandings of cultural competence, and the development of medical pedagogy concerning cultural competence in the clinical environment.

The databases used in the literature search were primarily the following:

- APAIS (Australian Public Affairs Information Service) Social Issues
- APAIS Education
- Australian Family & Society Abstracts, produced by the Australian Institute of Family Studies
- Academic Search Complete
- Social Sciences Citation Index (SocINDEX)
- Australian/New Zealand Reference Centre
- Education Resources Information Center (ERIC)
- Medline

Since the above databases do not capture all literature, an internet search was carried out of relevant websites and search engines, including Google Scholar, the Australian Department of Health and Ageing, government departments of health in New Zealand, Canada and the USA, and open source journals. The websites of key organisations, search engines and clearinghouses were also considered. These included:

- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine (ACRRM)
- Council of Australian Governments (COAG)
- Australian Indigenous HealthInfoNet

A variety of keyword combinations were used for the searches and included General Practice, family practice, Aboriginal and Torres Strait Islander, cultural education, cultural mentoring, Indigenous health, medical training, cultural competence, cultural mentoring for medical students.

In addition, a number of unpublished reports and documents were provided to Urbis by Professor Jennifer Reath of the UWS, and by the staff of GPET. Informal conversations with GPET staff and others also highlighted additional ideas and perspectives which were explored through a further search of the literature and the internet.
Table 1 shows the criteria used for identifying documentation to be included in the literature review.

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<thead>
<tr>
<th>CRITERIA</th>
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<td>Topic</td>
<td>cultural competence in health service delivery</td>
<td>cultural competence in other policy domains</td>
</tr>
<tr>
<td></td>
<td>cultural education/mentoring/training for medical practitioners</td>
<td>cultural education/mentoring/training in other professions (with rare exception)</td>
</tr>
<tr>
<td></td>
<td>cultural education and mentoring in undergraduate, prevocational and vocational General Practice training</td>
<td></td>
</tr>
<tr>
<td>Type of publication</td>
<td>peer reviewed journal articles</td>
<td>newspaper articles</td>
</tr>
<tr>
<td></td>
<td>conference presentations</td>
<td>magazine articles</td>
</tr>
<tr>
<td></td>
<td>organisational and project reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>theoretical or conceptual papers</td>
<td></td>
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<tr>
<td></td>
<td>training documentation and curricula</td>
<td></td>
</tr>
<tr>
<td>Rigour of research</td>
<td>systematic reviews</td>
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<tr>
<td></td>
<td>randomised controlled studies</td>
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<td></td>
<td>surveys</td>
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<td></td>
<td>content analysis</td>
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<tr>
<td></td>
<td>pre and post evaluations</td>
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<td></td>
<td>qualitative research</td>
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<td></td>
<td>process evaluations</td>
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<tr>
<td></td>
<td>theoretical and conceptual analyses</td>
<td></td>
</tr>
<tr>
<td>Findings</td>
<td>the findings are applicable to cultural competency in medical education</td>
<td>no description of findings or relevance to cultural competency in medical education</td>
</tr>
</tbody>
</table>
One hundred and eleven documents formed the basis of the exploration of the concept of cultural competence, and the subsequent development of cultural education and cultural mentoring as means for training medical practitioners to provide culturally-appropriate care. A few exceptions to the criteria were made when a seminal article was published before 2000, and/or where an important influence to medical education was provided from the nursing literature. As indicated in the table above, while the search for evidence of best practice began by identifying evaluative and empirical studies, it was expanded to include a wide range of literature including:

- documents produced as part of medical education programs, such as published curricula, descriptions of training programs, and reports from training providers;
- theoretical and conceptual literature which seeks to define and/or propose measures for assessing cultural competence and related concepts such as cultural safety, cultural security and cultural respect;
- program documentation defining cultural education and cultural mentoring, and seeking to describe these and their impacts; and
- published reports of pilot programs and training initiatives seeking to deliver training in cultural competence.

While key themes or principles from the international literature which are applicable to Australia have been extracted, the review also sought to focus on what is already known within the Australian context, and particularly within the context of prevocational and vocational training. For that reason, although undergraduate medical education is broadly discussed, to the extent that it prepares doctors for their prevocational and vocational experiences, postgraduate or continuing medical education has been largely excluded from the discussion.

There is a significant theoretical and practical literature exploring, and seeking to assess, cultural competence. There is a smaller body of literature discussing exactly what cultural education is, how it is organised and how it is delivered, and a smaller body still of literature specifically defining or articulating cultural mentoring. Cultural education and cultural mentoring are understood to be responses to the need to equip doctors-in-training with the skills, knowledge and insight to be able to work effectively in partnership with Aboriginal and Torres Strait Islander patients and health practitioners, and the research has explored these two responses as part of a spectrum of training opportunities rather than looking at them in isolation.

It should be noted that a substantial portion of the identified relevant literature originates in the North American context, both because of the limitation of the search to English language publications, and because
of the size of the USA health and educational systems. It is fair to say that the growing diversity of the US population and the fragmentation of the USA health system have led to significant efforts by many health providers to understand how to provide health care to an ethnically diverse population without the benefits of a single, unifying national approach. Although the USA health system is very different from the Australian system, there is still much which can be learned from the intellectual, theoretical and practical work which has been undertaken to ensure that people from underserved populations are able to access health care. Some of these lessons will be adaptable to the distinct Australian context in which the first peoples of the land, Aboriginal and Torres Strait Islander peoples, continue to experience the health system environment as one which is often alienating and disempowering.

1.3. This document

The literature review first explores the definition of cultural competence. The reason for this is that the basis of cultural education is to prepare health practitioners to become culturally competent, yet the definition and understanding of cultural competence itself is contested. A number of terms are used synonymously by some, and considered to align on a spectrum by others, terms such as ‘cultural awareness’, ‘cultural safety’, and ‘cultural respect’. Frameworks for understanding cultural competence developed in Australia are also explored and guiding principles for culturally competent organisations, to form an understanding of what cultural education is seeking to achieve.

In section 3, the evidence for cultural education and mentoring in medical education, nationally and internationally is considered. While the majority of articles focus on cultural education in medical school, cultural education provided at postgraduate level and as part of continuing professional development is briefly considered. While there is also a considerable amount of literature from other health disciplines, particularly nursing, this has largely been excluded from the discussion (with a few exceptions) in order to focus on what the literature suggests regarding medical training.

Section 4 examines what is known about cultural education and mentoring specifically in regard to prevocational and vocational training in General Practice in Australia. There is a small body of literature here, and the discussion relies heavily on organisational and program documentation developed by the RACGP, the ACRRM, and GPET. This section describes what is known about what Cultural Educators (CEs) and Cultural Mentors (CMs) actually do, and what evidence there is of the impact of cultural education and mentoring on individual medical practitioners, organisations and communities.

Finally section 5 draws together some emerging themes, which will form the basis for further research to be conducted later in the year through survey and interview consultation with a range of stakeholders including
CEs, CMs, General Practice Registrars (GPRs), Junior Doctors (JDs), Regional Training Providers (RTPs), Aboriginal and Torres Strait Islander Health Training Posts (IHTPs) and peak bodies.
2. Cultural competence – a continuum

2.1. Introduction

The existence of health disparities between population groups provides a strong rationale for cultural competence to be included in medical education and for training clinicians to provide culturally competent care (Like 2011). There is some evidence that cultural differences between patients and physicians may contribute to differentials in health status between ethnic or cultural groups (Gates & Bradley 2009).

It has also been argued by many that developing a culturally competent health workforce can assist to address disparities in access to services which continue to have a negative impact on the health and general wellbeing of minority groups (Like 2011; Betancourt et al. 2003; Purnell 2000), and specifically the health outcomes for Aboriginal and Torres Strait Islander peoples (Paul, Hill & Ewen 2012; Grote 2008; AHMAC 2004). Cultural conceptions of health and wellbeing influence which management options are preferred (Saethre, 2007); and health practitioners providing services that make sense within a patient’s cultural frame may be more likely to negotiate engagement in and adherence to treatment (Nam et al. 2011).

2.2. What is cultural competence

2.2.1. Definitions

The literature suggests that the terminology of cultural competence itself is contested (see, for instance, the Australian Human Rights Commission (AHRC) 2011; Walker et al. 2009; Farrelly & Lumby 2009; Grote 2008). The American-based National Center for Cultural Competence (NCCC)\(^1\) states that ‘there is no one definition of cultural competence’, before providing 16 separate descriptions of cultural competence (NCCC n.d.). These appear to differ in the emphasis placed on the individual health provider or the health system; on behaviour, knowledge or skills of the care provider; and on the clinical interaction itself or the wider environment of health care.

A definition of ‘cultural competence’ which has come to be commonly used is ‘a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations’ (Cross et al. 1989 cited in Royal Australian College of Physicians (RACP) 2004:1).

The term ‘cultural competence’ is defined in some instances as the end point, in others as the beginning of the path to cultural security, and in still others as an umbrella term encompassing other concepts such as cultural awareness or cultural safety.

\(^1\) See http://nccc.georgetown.edu/
‘Cultural safety’ was first defined in the 1990s by a Maori nurse and educator in New Zealand, Irhapeti Ramsden, and her seminal work has informed the development of cultural education around the world (Koptie 2009; Papps & Ramsden 1996). Cultural safety has been defined as: ‘an environment that is safe for people, where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening’ (Williams 1999, cited in AHRC 2011:123).

The essential component of cultural safety is that it is determined by the perception of the service user rather than the service provider. That is, whether or not a health service is considered to be culturally safe is a judgement made not by the service but by the client. This is illustrated by Eckermann et al. (2010:188), who have observed that each interaction between health professionals and health consumers represents the “…convergence of two cultures – the professional culture of the practitioner and the culture of the consumer”. They suggest that the power imbalance can create an unsafe environment where consumers feel disempowered and intimidated, yet the consumer’s response is often not understood in this context and may be labelled “non-compliance” by the health system.

Another term which is used often in Australia is ‘cultural respect’, which has been defined as ‘the recognition, protection, and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples’ (Australian Health Ministers’ Advisory Council (AHMAC) 2004:7).

The RACP also provides a more outcomes focussed definition of cultural competence, suggesting that ‘cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context’ (RACP 2004:1). However, Betancourt et al. (2003) suggest that cultural competence is required not just at the clinical interface but at three levels: organisational, structural, and clinical, arguing the need for the health system to be reflective of the diverse population which it serves, including visibility of diversity at leadership and management levels and through policies which facilitate cross-cultural communication and access. Purnell (2000:193) expands this further and offers a theoretical model of cultural competence, with 12 domains from social, historic and family aspects of culture to rituals related to health (such as rituals for birth and death, or traditional healing practices), suggesting that cultural competence is ‘the adaptation of care in a manner that is congruent with the culture of the client’.

The RACP in its definition explicitly positions cultural competence in relation to ‘cultural awareness’, arguing that ‘recognition of culture is not by itself sufficient rationale for requiring cultural competence; instead the point of the exercise is to maximise gains from a health intervention where the parties are from different cultures’ (RACP 2004:1). Jenks (2011), taking a medical anthropology approach, points out that cultural competence is similar to ‘open-mindedness’, but warns against taking either a view of culture as static and
unchanging for all members of a group, or a view that culture is so subjective for each individual that larger political or historical influences are missed. This view is supported by others (Simon, Chang & Dong 2010; Wear 2008) who note that cultural competence is ultimately about open and honest human engagement between health providers and service users which recognises cultural factors as some of the many influences on an individual’s experience of health and illness. A key component of cultural competence, sometimes more or less explicit in the literature, is the requirement for the clinician him/herself to gain insight into their own cultural assumptions and biases (Jenks 2011; Simon, Chang & Dong 2010; Charboneau et al. 2009; Borkan, Culhane-Pera & Goldman 2008; Wear 2008; Purnell 2000; Tervalon & Murray-Garcia 1998).

2.2.2. The clinical context

The basis of the argument for cultural education for General Practitioners (GPs) is that the cultural attitude of the GP him/herself has an impact on the health outcomes of a patient, and that seeing a patient as ‘other’ or different can create a barrier to open and effective communication (Paul, Hill & Ewen 2012; Dharamsi 2011). While not a phenomenon solely of white doctors relating to non-white patients, the literature does tend to position the patient/clinician encounter in this way. Dharamsi (2011) points out that all people, from whatever cultural background, will bring to the encounter the teachings and experiences of their own upbringing, and that ‘we [all] have developed deeply rooted conceptions of how society works or should work, accepting unreflectively that who we are and what we do is natural and true. It is very difficult – indeed impossible – to undo all of these biases’ (Dharamsi 2011:764).

Eckerman et al. (2010:189) have described the “professional baggage” carried by health professionals who are a product of the dominant professional health culture. They argue that it is essential that health practitioners reflect on their professional culture and “comb through [their] values and assumptions in the light of cultural safety”. A number of authors have argued that training in cultural competence needs to focus the lens not solely on the cultural background of the patient, but on the practitioner him/herself, to uncover one’s own hidden biases and develop awareness of the impact of one’s own culture, attitudes and judgements on the clinical encounter (Thackrah & Thompson 2013; Paul, Hill & Ewen 2012; Dharamsi 2011; Borkan, Culhane-Pera & Goldman 2008; Tervalon & Murray-Garcia 1998).

Hasnain-Wynia (2006) follow this argument by placing cultural competence within the general move over recent decades towards patient-centred medicine, noting the tension between evidence-based medicine which relies on population-level standardisation of care, and cultural competence which aims to personalise the intervention to the individual patient’s particular circumstances. Eckermann et al. (2010:163) refer to
people-centred care as a key component of effective primary health care (PHC), but also observe that this (and other aspects of PHC) represents a fundamental shift in the traditional structure, philosophy and culture of health systems.

Cultural competence in health care can be seen to combine ‘the tenets of patient/family-centred care with an understanding of the social and cultural influences that affect the quality of medical services and treatment’ (Association of American Medical Colleges 2005:1). According to Ewen (2011:17), the main impetus to the development of cultural competence initiatives in medical education has been ‘the coming together over the past three decades of patient-centred medicine, the biopsychosocial model and an acute awareness (if not complete understanding and acknowledgement of) cultural and ethnic disparities in health care outcomes’.

A culturally-competent health approach can be seen to be aligned with a patient-centred approach, by integrating the cultural aspect of the individual or community, along with other social and emotional components, into the traditional biomedical model. Linking cultural competence to competencies in professionalism and patient-centred care, Like (2011:202) reports on the place of cultural education at all points of the US medical education spectrum, from undergraduate training through to continuing medical education tied to accreditation, with cultural competence understood as ‘a life-long journey and not a final destination’.

The term ‘cross-cultural’ education or training is most often used in the North American literature, implying the transactional nature of the interaction between clinician and patient, and that each party brings their own culture to the engagement. In Australia, the term most often used is ‘cultural competence’ training although other terms such as ‘cultural awareness’, ‘cultural safety’, ‘cultural security’, and ‘cultural respect’ training are also used. Sometimes these terms appear to be used interchangeably, although many authors (Downing, Kowal & Paradies 2011; NACCHO 2011; Coffin 2007) articulate the distinctions between the concepts, discussed further in section 2.3 below. Downing, Kowal & Paradies (2011) note that, currently, the training that is most often provided is training in cultural awareness, focussed on raising the level of knowledge within the individual. In contrast, on a spectrum moving from the individual to the health system, cultural safety, cultural security and cultural respect are training models which seek to influence change at the system level.

Another term, which is frequently discussed in the USA, is that of ‘cultural humility’ (Borkan, Culhane-Pera & Goldman. 2008; Tervalon &Murray-Garcia 1998). ‘Cultural humility’ was introduced in the 1990s in the US in a

\[\text{Primary health care in this context was defined by the World Health Organisation’s Alma Ata Declaration in 1978:
“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO 1978).}\]
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 1: Literature Review

A seminal article by Tervalon & Murray-Garcia (1998) and has since been adopted by many within the American health system. The term is used to highlight the importance of the stance taken by the individual within the dominant culture when meeting with a person from a minority group. This term does not appear to be used in Australia although it is probably closest to the notion of ‘cultural respect’. Both of these terms are reflexive, pointing back to the stance of the health provider rather than to the culture of the health service user. Discussions of cultural humility acknowledge and articulate the difficulty of judging when one is truly culturally competent, and rely on an actively alert and reflexive stance of the practitioner (Cruess et al. 2010; Borkan, Culhane-Pera & Goldman 2008; Wear 2008; Tervalon & Murray-Garcia 1998). Borkan, Culhane-Pera and Goldman (2008) have described the activities of cultural humility with their HUMBLE model, shown below.

**FIGURE 1 – CULTURAL HUMILITY (HUMBLE) MODEL**

| H | Be Humble about the assumptions you make about knowing the world from your patients’ shoes |
| U | Understand how your own background and culture can impact your care of patients |
| M | Motivate yourself to learn more about the patient’s background, culture, health beliefs and practices, as well as the unique points of view of their families and communities |
| B | Begin to incorporate this knowledge into your care |
| L | Life-long learning |
| E | Emphasise respect and negotiate treatment plans |

*Source: Borkan, Culhane-Pera and Goldman 2008 (used with permission)*

2.2.3. Issues of contention

As suggested by the discussion above, there is a lack of clarity and coherence regarding the concept of cultural competence, which some have challenged on the basis that reducing culture to a ‘competency’ risks creating a static and unreflective notion of culture (Paul, Hill & Ewen 2012; Jenks 2011; Kleinman & Benson 2006). Culture may then be interpreted as monolithic, negating the distinct differences within cultural groups influenced by gender, age, religious affiliation, and other personal characteristics (Thackrah & Thompson 2013;)

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3 Consider, for instance, the Cultural Humility Task Force, at San Francisco General Hospital: [http://psych.ucsf.edu/sfgh/chtf/](http://psych.ucsf.edu/sfgh/chtf/)
Kleinman & Benson 2006). In a sense, the argument for cultural competence can be seen to elevate the realm of culture to such an extent that other influences within the patient/clinician encounter are not recognised, such as the physical illness itself, differing social determinants or personality attributes, or the instinctive response of a patient or clinician to each other (Lo & Stacey 2008; Kleinman & Benson 2006).

While there may be agreement on goals for improved health care, there is a lack of a rigorous theory of the role of culture in medicine (Lo & Stacey 2008). Cultural competence may be perceived as ‘unscientific’ within medical education (Chun 2010; Wachtler & Troein 2003) and, in one view, may actually heighten power differences between patient and clinician by further entrenching the clinician’s own culture as dominant, thereby further ‘othering’ the patient (Paul, Hill & Ewen 2012:319, based on Pon 2009) or in Jenks’ term, ‘decontextualising difference’ (Jenks 2011:212).

Several authors (Durey, 2010; Shim 2010; Lo & Stacey 2008) have used the work of Pierre Bourdieu (Bourdieu and Wacquant, 1992; Bourdieu, 1990; Bourdieu, 1977) to challenge the positioning of cultures as dominant or subordinate with relation to the clinician-patient interaction. Shim (2010) provides a theoretical framework that could be regarded as a means to address this challenge. Based on the work of Pierre Bourdieu on ‘cultural capital’, Shim (2010:3) extends the concept to suggest that ‘cultural health capital’ is one aspect of cultural capital that can be used by patients in their interactions with health providers. What is unusual about Shim’s approach is that it appears to put the responsibility on to patients, rather than clinicians, to address the cultural barriers which may exist between the patient and clinician. This may have the effect of empowering the patient to take control of the encounter, placing their own cultural paradigm as the primary viewpoint.

Lo & Stacey (2008) use Bourdieu’s concept of ‘habitus’ to argue that doctors can understand a patient through recognising that the patient’s culture is both internally bound (through learned habits of culture and society) and externally influenced (by unpredictable and unknown events and responses), and offers this as a construct for recognising the complex interplay of structural and individual influences which impact upon the clinical encounter. Durey (2010) moves further along the structuralist spectrum to take a systems focus, adopting Bourdieu’s term ‘symbolic violence’ to argue for an explicit anti-racism framework to address systemic factors which reinforce inequity, including the lack of involvement of Aboriginal Australians in decision-making and collaboration to improve health services. Each of these theoretical approaches seeks to change the positioning of the health consumer from ‘patient’ (with the clinician as dominant actor), to ‘actor’ (with the clinician as co-creator in the interaction).

Following these suggestions that cultural competence in health care requires not just awareness on the part of the clinician, but also a willingness to change the locus of power in the clinical encounter, it is possible that the cultural competence within the health system will most improve when health service users and the general
public begin to demand change, reinforcing the ultimate power of the consumer to drive improvements within the health system. Some recent initiatives through the Closing the Gap campaign and subsequent government policy developments suggest that structural and system changes can be responses to public demand, and will themselves become drivers of behavioural and organisational change.  

As an example, the Government of Victoria has developed a Statement of Intent which has been signed by the Premier of Victoria, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), and heads of health services across the state, publicly committing the Victorian Government, and government-funded health services, to improve the access to, and quality of, health services for Aboriginal people in Victoria. The commitment to close the gap, as publicly symbolised through the Statement of Intent, is driving actions for change at all levels of the Victorian health system (Powell 2012).

Thus, while the clinical engagement can be positioned as the most visible aspect of cultural competence, a number of factors contribute to a culturally competent approach, from the stance and education of the health practitioner to the level of empowerment of the patient, and the organisational and system elements which make health services more or less available to individuals. As Betancourt et al. (2003) have argued,

> A culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations. Furthermore, the field of cultural competence has recognized the inherent challenges in attempting to disentangle “social” factors (e.g., socioeconomic status, supports/stressors, environmental hazards) from “cultural” factors vis-à-vis their influence on the individual patient. As a result, understanding and addressing the “social context” has emerged as a critical component of cultural competence.

(Betancourt et al. 2003:294)

The importance of a culturally-appropriate approach to Aboriginal and Torres Strait Islander health has been recognised in Australia since the formation of the first Aboriginal Community Controlled Health Service (ACCHS) in the 1970s (NACCHO 2011:1), and over the years a number of frameworks and approaches have been developed to provide a theoretical basis for the place of culture within health service delivery. Some of these frameworks are discussed in section 2.3 below.

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4 The Close the Gap campaign was launched in 2007 by a coalition of non-government and non-profit organisations, both Aboriginal and Torres Strait Islander-specific organisations and others with a focus on social justice and equality (see [http://www.humanrights.gov.au/social_justice/health/index.html](http://www.humanrights.gov.au/social_justice/health/index.html)). The purpose of the campaign is to close the gap in inequality between Indigenous and non-Indigenous Australians. Subsequently, in 2008 the Council of Australian Governments (COAG) endorsed a National Indigenous Reform Agreement (NIRA) to close the gap in a number of domains including health, education, housing, employment, and access to services (see [http://www.coag.gov.au/closing_the_gap_in_Indigenous_disadvantage](http://www.coag.gov.au/closing_the_gap_in_Indigenous_disadvantage)). Work continues at Commonwealth, state/territory and local levels on a wide range of National Partnership Agreements which sit under the NIRA.

2.3. Australian frameworks for cultural competence

Ramsden’s initial work on cultural safety was based on a three-stage movement from cultural awareness, through cultural sensitivity to cultural safety (Koptie 2009:31). Since then, a number of frameworks have positioned cultural safety as itself part of the journey towards cultural security, or cultural respect. The Australian Human Rights Commission (AHRC) (2011:123-137) notes that there is a continuum through which organisations that work with Aboriginal and Torres Strait Islander people move from cultural awareness, through cultural safety to cultural security.

Ranzjin, McConnochie and Nolan (2008) proposed a developmental model applicable across a range of disciplines, through which general expectations are established and specific content or pedagogical strategies can be devised (Figure 2). The matrix suggests a pathway to cultural proficiency through development of knowledge, understandings, skills and attributes that are necessary for culturally competent engagement in the professional context.

FIGURE 2 – DEVELOPMENTAL MODEL OF CULTURAL COMPETENCE

<table>
<thead>
<tr>
<th>Professionally specific skills</th>
<th>Cross-cultural skills</th>
<th>Critically examining the profession</th>
<th>Reflexivity of values and attitudes</th>
<th>Understanding Indigenous cultures and histories</th>
<th>Generic understanding of culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally incompetent</td>
<td>Cultural knowledge</td>
<td>Cultural awareness</td>
<td>Cultural sensitivity</td>
<td>Cultural competence</td>
<td>Cultural proficiency</td>
</tr>
</tbody>
</table>

Source: Adapted with permission from Ranzijn, McConnochie and Nolan (2008)

The work of Ranzjin, McConnochie and Nolan builds on an early and influential model of cultural competence developed by Cross et al. (1989, cited in Universities Australia 2011a:49). The model, which is not specific to Indigenous cultures, proposes that individuals and organisations can progress from ‘cultural destructiveness’ toward ‘cultural proficiency’ through a process of professional development, commitment and systemic
organisational change. Drawing on Cross et al.’s model, NACCHO (NACCHO 2011:13-14) has put forward an Aboriginal cultural competence continuum (see Figure 3) which highlights the view that ‘achieving cultural competence is a journey, and that non-Aboriginal health care providers and organisations may move back and forth along the continuum’ (NACCHO 2011:13).

FIGURE 3 – CULTURAL COMPETENCE CONTINUUM

Source: NACCHO 2011 (used with permission); Cross et al. 1989

Coffin (2007) proposes a slightly different trajectory (Figure 4) underlining the importance of brokerage and protocols in the development of sustainable cultural security. Based on Maslow’s hierarchy of needs, Coffin implies that the movement to cultural safety is a journey of movement towards increasing sophistication of
understanding of Aboriginal culture: when starting out, it may be enough for someone to be aware of cultural needs, but as basic needs are met, greater depth of engagement is required, leading someone to move from holding cultural awareness through providing cultural safety to ensuring cultural security.

Building on this concept, Coffin’s cultural continuum contains only three of the stages included in the NACCHO framework in figure 1 above, but adds ‘brokerages’ and ‘protocols’ – actions necessary to move from one stage to the other, and ends with ‘sustainability’, suggesting the dynamic nature of the cultural environment.

A commonly used framework for defining cultural competence at different levels of the health system (NACCHO 2011; Nguyen 2008; National Health and Medical Research Council 2005), based on work by Betancourt et al. (2003), suggests that cultural competence focuses on four interrelated levels – systemic, organisational, professional and individual – summarised in Figure 6 following.
Within this model, developed initially to inform culturally appropriate health practice with people from culturally and linguistically diverse backgrounds, there is an interplay among the dimensions of cultural competency, recognising the interdependency of the system, the organisation, and the individuals who work or attend there (Jenks 2011; National Health and Medical Research Council 2005; Betancourt et al. 2003).

Downing, Kowal and Paradies (2011:248) note that most approaches described in the literature have been shaped by the cultural awareness framework, with the belief that raising awareness among health service providers will influence the experience of patients. However the authors observe that such an approach may not bridge the divide between health services and Aboriginal and Torres Strait Islander people, as it is focussed on increasing the knowledge of individual practitioners rather than influencing the service system itself.

Further, by generating a false sense of ‘cultural knowledge’, cultural awareness training may create an unjustified confidence in an understanding which might not be sensitive to the nuances of the individuals and communities with whom the clinician engages (Downing, Kowal & Paradies 2011). It may also lead to conflation of the cultures of Aboriginal and Torres Strait Islander people with “the culture of poverty into which Indigenous people have been driven” (Ramsden 1993, cited in Downing, Kowal & Paradies 2011:10).

The limitations of Aboriginal cultural awareness training are also addressed by Fredericks (2008:86), who argues that, while it may be influential in changing long held beliefs and attitudes and assist in better communication with Aboriginal and Torres Strait Islander peoples, it ‘does not challenge the societal inequities

<table>
<thead>
<tr>
<th>Systemic</th>
<th>Organisational</th>
<th>Professional</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective policies and procedures, mechanisms for monitoring, and sufficient resources are needed to foster culturally competent behaviour and practice. Policies would support the active involvement of culturally diverse communities in matters concerning their health and environment.</td>
<td>An organisational culture is created where cultural competency is valued as integral to core business, and it is supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels. Culturally competent organisations recognise that cultural competence requires organisational change. They draw upon and contribute to an evidence base drawn from cultural competency research.</td>
<td>A culturally competent profession builds cultural competency into generic and specialist training, and into professional development. It develops cultural competency standards to guide the work of health professionals and disseminates information about diverse groups to help health professionals become more confident in working with them. It encourages and supports integration of cultural competencies into health professional practice.</td>
<td>Individual health professionals feel supported to work with diverse communities to develop relevant, appropriate and sustainable health promotion programs. 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.</td>
</tr>
</tbody>
</table>

Sources: NACCHO (2011:13); National Health and Medical Research Council (2005:30)
or structural constraints that maintain Indigenous disadvantage’. Likewise, Edwards and Taylor (2008) consider that cultural awareness is not enough, and that cultural safety requires a conscious de-colonising of the entire health system, including the recognition of the dominant cultural position of most health care providers. Downing and Kowal (2011) suggest that the adoption of a cultural safety approach is itself an explicitly de-colonising approach which places the client’s perception of safety at the heart of the interaction, and is concerned with both systemic and individual change, with the latter incorporating enhanced awareness of the health practitioners’ own identity.

As systems move towards cultural safety, the outcome should be that cultural needs are met for individuals and that appropriate processes are in place from the time when Aboriginal and Torres Strait Islander people first seek health care. This supports the position of Farrelly and Lumby (2009:14) who write that ‘cultural security is built from the acknowledgment that theoretical ‘awareness’ of culturally appropriate service provision is not enough. It shifts the emphasis from attitudes to behaviour, focusing directly on practice, skills and efficacy’.

Cultural respect, one of the models identified by Downing, Kowal and Paradies (2011), seeks to influence change at the systemic level, and an initial attempt to articulate this approach in Australia was made by the AHMAC (2004) in its Cultural Respect Framework 2004-2009. The Framework seeks to create a mechanism by which organisations and services can embed core principles of good practice at all levels of health service delivery. However, as Downing, Kowal and Paradies (2011) note, the Framework, as with other cultural models, is not explicit in exactly how this should be accomplished and for that reason tends to fall back on a general approach of raising awareness.

2.4. Principles for culturally competent organisations

A number of statements on key principles relevant to organisational cultural competence in the health workforce sector have been developed within Australia. These include Universities Australia’s National Best Practice Framework for Indigenous Cultural Competency (Universities Australia 2011a; Universities Australia 2011b), the National Health and Medical Research Council’s Cultural competency in health: A guide for policy, partnerships and participation (NHMRC 2005) and AHMAC’s Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (AHMAC 2004).

The Universities Australia’s National Best Practice Framework for Indigenous Cultural Competency aims to provide the university sector with practical guidance on building cultural competency within the university environment. Guiding principles are articulated under five domains, reflecting the organisational focus of the tertiary sector: university governance, teaching and learning, Indigenous research, human resources, and
community engagement. The principles themselves are expressed as a set of key aspirational statements relevant to each of the domains (Universities Australia 2011a):

- Indigenous people should be actively involved in university governance and management;
- all graduates of Australian universities should be culturally competent;
- university research should be conducted in a culturally competent way that empowers Indigenous participants and encourages collaboration with Indigenous communities;
- Indigenous staffing should be increased at all appointment levels and, for academic staff, should cover a wider variety of academic fields; and
- universities should operate in partnership with local Indigenous communities and should help disseminate culturally competent practices to the wider community.

The NHMRC’s *Cultural competency in health: A guide for policy, partnerships and participation* (NHMRC 2005) is a general guide. It expressly notes that while much of its content is relevant to developing cultural competency in working with Aboriginal and Torres Strait Islander people, the scope of the guidelines ‘ran the risk of diluting the complexities’ of working with these populations, recommending the development of additional, Indigenous-specific resources (NHMRC 2005:10). With this caveat in mind, the NHMRC’s four underpinning principles to guide development of a culturally competent health sector include engaging consumers and communities and sustaining reciprocal relationships; using leadership and accountability for sustained change; building on strengths - know the community, know what works; and a shared responsibility - creating partnerships and sustainability (NHMRC 2005:27).

These four principles are framed within a rights-based perspective, in which a universal right of access to health care gives rise to a social responsibility to ensure that these rights are satisfied.

The AHMAC *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009* is intended as an overarching document and seeks to provide guidance on a system-wide approach to improving the cultural competency of health services. In promoting a multi-dimensional approach and ‘systemic action’, AHMAC propose a framework comprising knowledge and awareness, skilled practice and behaviour, strong relationships and equity of outcomes (AHMAC 2004:9-10).

The ‘strong relationships’ dimension is identified as the key organisational dimension, incorporating both individual and community relationships. Included within this dimension are organisational practices that uphold and secure cultural rights, including workforce and workplace management. The necessity for
organisational leadership in the remaining dimensions is also directly implied. This includes recognition of the legitimacy of traditional health practices and developing practice protocols that are culturally appropriate to support the ‘skilled practice and behaviour’ dimension, and data collection, benchmarking and monitoring of key performance indicators relating to the ‘equity of outcomes’ dimension (AHMAC 2004:11).

The Cultural Respect Framework also expressly recognised nine core principles, reflected in the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989) and the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (AHMAC, 2002).

An expanded suite of 12 principles appear in the updated National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011–2015 (AHMAC 2011:5-6), and provide specific guidance on principles to underpin health workforce planning and development (see Figure 7). While these principles have broader application than organisational cultural competence, a number of these principles are especially relevant.

The principle of cultural respect seeks to ensure that ‘cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services’.

AHMAC indicate that a holistic approach requires recognition that improving health outcomes for Aboriginal and Torres Strait Islander people requires ‘attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance’.

The principle of health sector responsibility positions the improvement of Aboriginal and Torres Strait Islander health (at individual and community level) as a fundamental responsibility for the health sector and health sector organisations. It also highlights that responsiveness to the needs of Aboriginal and Torres Strait Islander people on the part of all health services increases overall choice for Indigenous people.

The principles of reciprocal capacity building, and of partnership and coordination are also relevant to the development of cultural competence at the organisational level.
In summary, there appear to be a number of consistent themes in the three sources reviewed which provide an indication of some of the key principles supporting culturally competent organisations. These include an acceptance of organisational responsibility for providing and advocating culturally appropriate services and for providing a culturally respectful workplace environment that is supportive and enabling of culturally appropriate practices. They also include a focus on engaging with and drawing on the expertise of the Aboriginal and Torres Strait Islander community in the service planning and governance, including through direct involvement of Aboriginal and Torres Strait Islander people within organisations and in the development of partnerships between organisations and community.

2.5. Key points

There is a range of definitions of cultural competence, reflecting in part the challenge of defining what exactly ‘culture’ means, how it relates to medical care, and what the goals of increasing attention to culture in medical care should be. Overall, the body of literature discussed above suggests that cultural competence in relation to health care with Aboriginal and Torres Strait Islander peoples:

- is a subjective standard assessed from the viewpoint of Aboriginal and Torres Strait Islander consumers;
- is a process of both awareness of and engagement with another culture;
- can be defined at different (but interdependent) levels of the health system – the systemic, organisational, professional and individual – and ideally requires integrated action at all levels to create an environment which is culturally secure;
- is a dynamic and evolving process rather than a static concept, both in relation to the cultural context within which ‘competence’ is framed and the subjective attributes and capabilities of individuals, professions, organisations and systems demonstrating cultural competence; and
- requires ongoing self-reflection and insight on the part of clinicians, and similarly, for organisations to internally scrutinise and monitor their organisational performance.

It is generally considered that cultural awareness in itself is not enough (as will be explored further in section 3), and that cultural competence requires understanding one’s own cultural stance as well as that of another. It is also acknowledged that cultural competence does not just apply to the individual health provider, but requires understanding and change at the organisational and system levels.

Ultimately, what is required is a system which provides a culturally secure environment in which health providers are supported and enabled to provide culturally appropriate care for service users. While this will require more than cultural awareness training for individual practitioners, this appears to be where most
efforts are concentrated, with the implied assumption that informed individuals will be better prepared to provide culturally sensitive care and influence the organisations and systems within which they work.

The model initially proposed by Cross et al. (1989, cited in Universities Australia 2011a:49) and further developed by NACCHO (see Figure 3) proposes a ‘cultural competence continuum’, with the suggestion that individuals and organisations can progress from ‘cultural destructiveness’ toward ‘cultural proficiency’ through a process of professional development, commitment and systemic organisational change. This model implies the fluid nature of cultural competence and the possibility that individuals, organisations and systems may move both forward and back on a spectrum of awareness and action in response to a recognition of the importance of culture in health services.

In the Australian context, while a number of frameworks have been developed and described, there is not (nor, perhaps need there be) one single agreed understanding of how cultural competence is best achieved. While cultural education is generally agreed to be essential, there is a paucity of literature or recommendations based on well-evaluated studies that could provide guidance as to exactly what one does to create cultural competence and how best it might be evaluated. These concepts will be explored further in the following sections, looking at cultural education within medical education in Australia and internationally (section 3), and in particular, exploring cultural education in Australian vocational General Practice training (section 4).
3. Cultural education in medical education

3.1. Introduction

The previous section explored the definitions, frameworks and principles for conceptualising cultural competence. As noted above, there are a range of definitions of cultural competence and, accordingly, there are also a range of approaches to the provision of cultural training for health professionals. In this section, the evidence regarding cultural education in Australia and internationally is considered, with a particular focus on cultural education and mentoring provided along the spectrum of medical education, from medical school through continuing professional education. While the focus has been on the literature related to the teaching of Indigenous culture(s) in countries with a colonising history, articles on more general cross-cultural training have been included where the findings seemed relevant to the current project. Section 4 explores evidence and information regarding cultural education and mentoring in the specific context of prevocational and vocational General Practice training in Australia.

In the USA, cross-cultural competencies have been a requirement for residency programs since 1999, and a required outcome for medical students since 2000 (Gates & Bradley 2009). This is similar to Australia where cultural competence was first required for fellowship of the RACGP in 1997 (Martin & Reath 2011), and mandated for all medical schools by the Australian Medical Council (AMC) from 2006 (Ewen, Paul & Bloom 2012; CDAMS 2004). As noted in section 2, cultural education has been introduced into the curricula of medical schools and vocational training programs as one response to the existence of health disparities among different groups within the population, although the definition and understanding of ‘cross-cultural training’ continue to evolve (Gates & Bradley 2009).

In an overview of undergraduate training in cultural competence, Lyons and Laugharne (2011:58) suggest that ‘it is likely that almost all medical schools in the developed world incorporate some level of cultural competency training into their medical curricula’, although a prior study showed that 6% of US medical schools had no cultural education in their curricula, and only 9% included cultural education as a separate course (cited in Bussey-Jones et al. 2005). On the basis of a systematic literature review, Gates and Bradley (2009) found that although cross-cultural education was seen as important and relevant, and led to increased knowledge and improved attitudes, practitioners still often felt unprepared to treat diverse patients in a manner that was culturally appropriate, suggesting ‘medical schools had not made cross-cultural education an important part of the curriculum’ (Gates & Bradley 2009:12). Consistent with much of the available literature, none of the studies included in Gates and Bradley’s (2009) review assessed what clinicians knew or practiced, making it difficult to measure the effectiveness of training programs.
The discussion following is structured to explore cultural education within the medical education system and institutions, and then with regard to the professional and individual levels, before considering the evidence for the impact of cultural education on medical professionals and their patients. This approach is broadly consistent with the framework developed by Betancourt et al. (2003) and used by the NHMRC (2005) and NACCHO (2011) for cultural competence to be embedded at the system, organisational, professional and individual levels (see Figure 6).

3.2. Cultural education within the medical education system

When considering the question of what is understood to be cultural education in medicine, it is important to recognise that medical schools themselves are both products of culture, and enforcers of a particular medical and scientific culture (Paul, Hill & Ewen 2012; Jenks 2011; Rodgers 2005; Health Resources and Services Administration 2004). Medical schools thus have a powerful influence on students in transmitting values and attitudes, and shaping behaviours. Ewen, Mazel & Knoche (2012) argue that this influence is evident not only in the formal curriculum but in the informal and hidden ‘curricula’, that is, the norms and modelling which take place through conversations in the corridor, and through systemic reinforcement of normative behaviour.

Consequently, even when the formal curriculum may include cultural education, the extent to which culturally respectful behaviour is modelled within the medical school and health setting may be of a greater influence in shaping individuals’ behaviour. The question then becomes whether what is understood to be cultural education within the formal curriculum aligns with what it ‘taught’ through the informal or hidden curricula (Ewen, Mazel & Knoche 2012). Competency-based education itself influences values, skills and behaviour, in that those competencies which are valorised by the institution and its educators are those which come to be valued by students (Rodgers 2005).

The influence of the learning environment and the teaching institution on the ways in which learning is imparted have additional significance in the context of Nakata’s conceptualisation of the Indigenous standpoint (Nakata 2007). A key implication is the premise that Indigenous processes for knowledge transmission may be more fundamental to development of an understanding of Indigenous perspectives than Indigenous content (Universities Australia 2011a: 61).

The final report on the UWS implementation of an Indigenous Graduate Attribute as an outcome to all courses (including the medical program) indicates that institutional change requires considerable effort, investment and persistence (Badanami Centre for Indigenous Education 2012). In describing a project seeking to embed Indigenous perspectives in humanities and human services curricula at Queensland University of Technology, Williamson and Dalal (2007) reflect on the challenges associated with integration and assessment of
Indigenous knowledge within a Western pedagogy and observe the importance of institutional reflexivity and recognition of the limits of existing epistemological frames. Hart’s (2003) observation that the limits of an institution’s cultural knowledge constrains its ability to appropriately ‘recognise and reward’ it in others may also have important implications for both the selection and support of CEs and CMs and for the positioning and assessment of cultural competence within a curriculum.

While a number of organisations have developed various principles or standards for cultural competence (see discussion in section 2.4), Grote (2008) notes that these are often focussed on health services and providers, rather than providing foundational principles for the teaching of cultural education. Adult learning principles, including such concepts as learner-focussed teaching, autonomy and self-direction of the student, collaborative learning and sharing of ideas (Collins 2004; RACGP 2004) are particularly appropriate for cultural education in their emphasis on the development of student insight. The RACGP, in its audit of cultural safety training programs within health services and government departments, noted that:

*If the session is too didactic then participants do not have the chance to reflect with colleagues and fellow participants on the cultural safety and sensitivity of their individual practices and clinics.*

*If too much information is provided without sufficient chances to absorb and reflect on how the information can be implemented in practice, then adult learners will lose interest in the training.*

(RACGP 2010:2-3).

The RACGP study focussed on the provision of cultural safety training with health services, rather than the medical school. However, the findings of the study are relevant to cultural education more broadly as medical schools begin to practice ‘socially accountable medical education’ (Murray et al. 2012), and to take learning outside of the classroom into health services and community settings. The global Training for Health Equity Network, for instance, calls for a whole of school approach; community-based, practically-focussed teaching, and curriculum design which integrates science with population health and early clinical contact, based on the need of local communities (Murray et al. 2012).

Particularly with regard to Aboriginal and Torres Strait Islander health, this approach provides an opportunity for students to gain exposure to Indigenous health issues throughout their training. It also requires that educators work in partnership with Aboriginal community-controlled and other health services to create cultural education opportunities across the spectrum of medical education, from medical school through vocational training (Murray et al. 2012). Where engagement with community in development of training opportunities is effective, there is significant potential for reciprocal benefit and knowledge transfer (Duffy et al. 2013, Woolley et al. 2013).
Taking a systems approach, Ewen (2011) suggests that medical schools should develop a ‘cultural competency community of practice’ as a means of furthering cultural competence within the curriculum. An active community of practice would strive to develop a shared understanding of cultural competence and would not be dependent on a particular definition of cultural competence or based on whatever the school decides are the priorities for cultural competence. A ‘cultural competence community of practice’ could also assist in the development of a coordinated and strategic approach, building on existing strengths within the organisation, and having influence at multiple levels of the medical school. As noted by the researcher, ‘the development of a cultural competence community of practice provides an approach to ensure alignment of the actions, and consideration of the governing values and variables, to guide future efforts’ (Ewen 2011:145-146).

At a very practical level, engaging in organisational assessment of the place of cultural education within the institution, through reflective analysis of both curriculum and practice, can assist institutions to become more aware of how norms of culture are transmitted and reinforced (Ewen, Mazel & Knoche 2012). A critical reflection tool (CRT), developed and piloted by Ewen, Mazel and Knoche (2012), was provided to all medical schools in Australia and New Zealand in 2007 and again in 2011 with a request for participation and feedback through a survey. The responses from those schools which used the CRT suggested that the tool provided a resource to encourage staff dialogue and discussion about the place of culture, and particularly Indigenous culture, in medical school. Ewen, Mazel and Knoche (2012) point out that evaluation, or even a level of critical reflection, is itself an indication of what organisations see as important, and the investment of time in critical reflection or organisational review sends a message throughout the organisation that cultural education is valued. The authors write:

_In aiming for excellence in teaching and learning regarding Indigenous health, the challenge for medical schools is to reconfigure their operations, policies, and activities in a way which is consistent with planned teaching and learning outcomes._

(Ewen, Mazel & Knoche 2012:204)

Another approach to strengthening organisational competence by teachers involved providing opportunities for academics with teaching responsibilities to engage in an experiential program in the Mount Magnet community, grounded in situated learning theory (Durey, Lin, & Thompson 2013). Durey, Lin and Thompson noted that more than half of the academics attending changed their teaching practice as a result, and contend that “targeting academics can sensitise hundreds of health science students annually to the realities of rural and Indigenous health and better prepare them for practice in these contexts...” (Durey, Lin, & Thompson 2013).
The embedding of cultural competence within the entire curriculum of medical training, rather than relegating it to a separate study, is encouraged by a number of authors (Murray et al. 2012; Paul, Hill & Ewen 2012; Kripalani et al. 2006). In this way, cultural insight could be encouraged through opportunities such as interactive practical skills teaching, including discussions of culture in clinical and other patient-focussed discussions, as well as through institutional modelling through visible endorsement from senior clinicians and organisational leaders (Kripalani et al. 2006). In many ways this ‘prescription’ for cultural competence, as Kripalani et al. call it, is similar to Ewen’s (2011) call for a ‘cultural community of practice’, with the emphasis on embedding awareness of the presence of culture into all aspects of educational community life, and Murray et al.’s (2012) discussion of a community of practice based on social accountability.

This focus on social accountability and cultural competence at the institutional level includes the need to encourage cultural diversity within both teachers and students (Murray et al. 2012; Kripalani et al. 2006). In Australia in 2010, reportedly 1.3% of Australian medical students were Indigenous (Ewen, Mazel & Knoche 2012), and in 2011 there were reportedly 153 Indigenous doctors and 218 Indigenous medical students in Australia (Australian Indigenous Doctors Association (AIDA) 2011, cited in Murray et al. 2012). One essential way of changing the culture of the medical education system will be to ensure that the ‘face’ of medicine reflects the demographics of society (Kripalani et al. 2006). Encouragingly, the most recent figures publicly available indicate that Indigenous students made up 2.5% of first year medical enrolments in 2012 (AIDA & Medical Deans of Australia and New Zealand, 21 August 2012), equivalent to the proportion of Aboriginal and Torres Strait Islander people within the Australian population.

Cultural education can, therefore, be understood as one aspect of the overall shaping of values, ideas and worldview (Ewen 2011; Jenks 2011; Grote 2008; Kripalani et al. 2006), which occurs through both the formal and informal or hidden teaching at medical school, through clinical placements, and into later specialist training and continuing medical education. At the system or organisational level, this takes place not only in the identified curriculum, but in the very attitudes and behaviours that are modelled by faculty and staff. Providing cultural education to create culturally competent clinicians requires the type of critical reflection promoted by Ewen, Mazel and Knoche (2012) to create a system in which patients’ own cultural norms are respected and valued, becoming collaborators in the care process (Fredericks & Thompson 2010). Such a system will both require and encourage the development of cultural insight at the professional and individual levels.
3.3. Cultural education at the professional and individual levels

One of the aims of cultural education is to heighten the visibility of Aboriginal and Torres Strait Islander health within the medical curriculum, and to raise awareness among students of both their own cultural stance and that of people within the communities they will serve. Developing cultural education which includes local Aboriginal communities as well as partnership between Aboriginal and non-Aboriginal educators is critical to ensuring that health promotion and other health service activities are delivered in a culturally appropriate way (Main et al. 1998).

While much of the literature is focussed on cross-cultural education, it is also important to note that Indigenous health professionals may also benefit from cultural mentoring. When Indigenous doctors are practicing outside their own country and culture, they may benefit from local knowledge and may also find additional support and advice in relation to drawing on cultural strengths and addressing their own cultural needs (AIDA 2012).

A rare opportunity to hear the medical students’ voice has recently been provided by Klopp and Nakanishi (2012) who write of their experience in a cultural immersion experience in northern Canada. One of the key lessons for the two students is the way in which perceptions of time and schedules differ in the community they entered, when compared to the students’ own highly regimented normal routine in medical school. By spending time within a community, the two authors become aware of how their own perceptions are not necessarily normative, and that the world may look different to different people. Informal daily activities such as sharing food became opportunities to listen to and learn from others. Reflective writing helped the students to challenge their own worldviews. One of the lessons which emerged for the students is that it is not ‘culturally safe’ to assume that all people within a particular community will share the same perceptions or experiences of the world. This immersion experience, while challenging their ways of thinking, provided the writers with insight for their future medical practice:

Engaging with patients in order to recognize how they perceive their own cultural identity, reflexively acknowledging how one’s own culture is influencing interactions, and routinely empowering patients to evaluate what matters most to them in the experience of illness and treatment is paramount and culturally safe health care.

(Klopp & Nakanishi 2012:129)

It appears from what has been reported by Klopp and Makanishi (2012) and others (Murray et al. 2012; Fredericks and Thompson 2010), that learning which occurs through direct engagement with those from a different culture is the most effective and sustainable. Mentoring is another such opportunity, where a
student meets with another person for the purpose of learning directly from someone whose experiences are different from one’s own.

Mentoring across cultural boundaries is described by Johnson-Bailey and Cervero (2002:15) as ‘an especially delicate dance that juxtaposes group norms and societal pressures and expectations with individual personality traits’. The cultural mentoring relationship is potentially an intimate one, with the mentor assisting the mentee to negotiate an unfamiliar cultural milieu and the mentee requiring openness to reflective engagement with another person. In addition, both sides need to develop a sense of trust. Johnson-Bailey and Cervero (2002) discuss their relationship in the American context of race relations and their frank discussion of the building of a relationship between a white male mentor and a black female mentee articulates lessons which may arise within any cross-cultural mentoring relationship:

- understanding privilege and its impact;
- understanding disenfranchisement and its impact;
- developing genuine and warm respect for each other;
- constructing the mentoring relationship in the wider context of historic colonialism and its legacy; and
- building trust while recognising one’s own inherent (and often justified) reasons not to trust.

What is interesting when comparing the experience of Johnson-Bailey and Cervero is that in cultural mentoring for Australian GP Registrars (GPRs), it is (most often) the Aboriginal or Torres Strait Islander mentor who has historic reasons not to trust, and the (most often) white registrar who finds him/herself having to set aside positional power in order to occupy the role of mentee. Understanding and being open about the relationship between mentor and mentee, including issues such as positional power, cultural influence, and the wider historical and social context may assist in making the mentoring relationship one which enhances the health professional’s understanding and practice (Johnson-Bailey & Cervero 2002).

3.4. Assessing the impact of cultural education

There are a range of formal and informal approaches to teaching and learning to enhance cultural competence, offering varying degrees of integration with ‘mainstream’ curricula (Lyons & Laugharne 2011; Mak, Watson & Hadden 2011; Farrelly & Lumby 2009; Shapiro et al. 2006). Some of these approaches include:

- incorporation of cultural issues into a few lectures;
• web-based programs focused on cultural issues;
• standardised patient modules containing a cultural component;
• units or modules that focus specifically on cultural competence;
• extensive programs, often including language acquisition, designed to promote a career preference to work with multicultural or Indigenous populations;
• cultural immersion;
• informal learning opportunities, including learning from physicians and patients during clinical contact time, as well as from the diversity of fellow students; and
• formal mentoring relationships.

The extent to which different modalities of teaching and learning result in acquisition of knowledge, skills, attitudes and behaviours that are consistent with cultural competence also varies. Didactic techniques, for example, can be effective at building knowledge but may be less effective in changing behaviours. Conversely, experientially orientated approaches including cultural immersion, clinical placements or mentoring arrangements potentially encourage a more ‘reflective’ practice and support translation of knowledge and skills into attitudes and behaviours (Klopp & Nakanishi 2012, Johnson-Bailey & Cervero 2002, Main et al. 1998).

3.4.1. A dearth of evidence

Thackrah and Thompson (2013) have observed that the value of cultural competence training in health settings is ultimately validated by ‘enhancing access to and achieving equity of health services and better health outcomes for culturally diverse groups’. Yet assessing the effectiveness of cultural education is difficult, and the literature on impact is limited (Thackrah & Thompson 2013; Paul, Hill & Ewen 2012; Downing et al. 2011; Blue et al. 2005). In their review of 36 studies of Indigenous cultural education for health professionals, Ewen, Paul & Bloom (2012) note that while 31 articles described evaluating the knowledge, skills or attitudes of students, none described any evaluation of the impact of training on patient outcomes.

Another recent review further suggests that studies examining the effect of cultural competence on patient outcomes are rare. Lie et al. (2011) found only seven studies which examined the evidence for a direct link between cultural competence training and patient outcomes. Of these, three studies reported positive or beneficial effects, while none demonstrated a harmful effect. The authors found that the quality of the studies
was low to moderate, and that most did not provide sufficient information on the curricula, health providers, learners or patients to allow replication.

Although acknowledging the challenges of attributing patient outcomes to health professionals’ cultural education training, Ewen, Paul & Bloom (2012) call for a great focus on evaluation of Indigenous health curricula, first seeking to assess the impact on the learner and, ultimately, seeking to measure the impact of cultural education on patient health. Paul, Hill & Ewen (2012) argue that cultural skills should be amenable to assessment just as clinical and communication skills are currently assessed during medical training.

In short, while developing the cultural skills and knowledge of the health professional is a means to the end of improving the quality of health care for Aboriginal and Torres Strait Islander people, there is currently little evidence to demonstrate that improving the cultural skills of health professionals has had an impact on the health outcomes of Aboriginal and Torres Strait Islander people (or other minority groups, in the case of the international literature) (Paul, Hill & Ewen 2012; Dharamsi 2011; Downing, Kowal & Paradies 2011). Nor, it must be said, is there evidence that cultural education is not making an impact.

### 3.4.2. Assessment and evaluation approaches

While studies linking cultural education to patient outcomes are few, there have been attempts to assess the impact of cultural training on students. Blue et al. (2005) applied a theoretical model to the assessment of a medical students’ reflective project. The model, adapted from the work of Crandall et al. (2003, cited in Blue et al. 2005) consisted of five hierarchical levels of understanding of the influence of culture on medical care, from the first level ‘no understanding’ to the fifth level ‘attention to culture integrated into all aspects of professional life’. The authors discovered that 66% of the 131 students demonstrated a mid-level ‘acceptance’ understanding of cultural difference, with 34% at ‘no’ or ‘minimal’ levels of understanding. However, there was no baseline measurement so it was not possible to say whether the students’ scores were an improvement as a result of the project, or whether the students’ scores could be attributed to the impact of the project or to some other input into their thinking. Nevertheless, the authors argue that such a theoretical model can be applied to assessing students’ competence at various points during their training, allowing the measurement of changes in knowledge and attitudes over time (Blue et al. 2005).

Although not focused on the Indigenous context, Kumaş-Tan et al.’s (2007) review of quantitative instruments used to assess cultural competence of health professionals provides useful insights into potential shortcomings of common assessment practices. Among six principles or assumptions evident from the construct of the instruments examined, they identified consistent patterns of assuming that ‘individual knowledge and self-
confidence are sufficient for change’ and that the ‘problem’ is situated in the ‘other’. They recommended that assessment increase focus on cultural humility and a preference for practice-based assessment.

Mooney et al. (2005) conducted an evaluation of a once-off, half-day cultural training program for health professionals, and found limited impact on shifting beliefs and attitudes of health professionals and the perceptions they might have of Aboriginal and/or Torres Strait Islander people. The authors suggested that the short duration may have been a factor, but also theorised that a program that integrated content relating to knowledge development and attitude alteration with work practices might be more likely to have better results.

Describing a university cultural education program first offered to undergraduate public health students in Victoria, Main et al. (1998) emphasise the highly interactive and experiential course which was considered by students to heighten their awareness of Koori history, culture, and health paradigm. The aim of the program was that these positive experiences of engaging with, and learning from, Aboriginal community members and educators would improve health workers’ capacity to provide culturally appropriate services in the future. Evaluation of the pilot suggested that the model provided positive results for students, as well as resulting in the development of sustainable collaborative relationships to improve Aboriginal health, and endorsement of the model by the university (Main et al. 1998).

Recognising a need for ongoing professional education for qualified practitioners, the Aboriginal Health Council of Western Australia (AHCWA) developed and piloted a training program in Indigenous health for General Practitioners, which included both a train-the-trainer component, and a set of training modules (AHCWA 2005). The model included training delivery by both a cultural facilitator and a medical facilitator experienced in working in Aboriginal health, and this joint delivery model was considered to be effective in providing both cultural and clinical perspectives. Pilot results of the training for GPs were considered positive, although the extent of the shift in knowledge varied, and there is no assessment of the impact of the training on the quality of care for Aboriginal and Torres Strait Islander patients.

Beach et al. (2005) carried out a systematic literature review and analysis of studies evaluating interventions to improve the cultural competence of health professionals. Key findings from the study include:

- there is strong evidence that cultural competence training improves the knowledge of health professionals, including knowledge about general cultural concepts, disease burdens across particular populations, and traditional cultural practices;
there is good evidence that the training improves the attitudes and skills, including communication skills, of health professionals. However, there was also evidence that cultural education can solidify racial stereotypes and perceptions of uniformity about ethnic groups;

there is good evidence that cultural competence training has an impact on patient satisfaction;

there is poor evidence to determine the costs of cultural competence training; and

there is poor evidence that training has an impact on patient adherence to follow-up. No studies were found that had evaluated patient health status outcomes.

While there is some evidence of assessment of cultural education, measurement of cultural competence and of the impact of cultural competence training on clinical practice, is more challenging. There remains a clear need for studies that systematically examine the relationship between cultural competency inputs and patient outcomes (Paul, Hill & Ewen 2012; Downing, Kowal & Paradies 2011; Lie et al. 2011; Beach et al. 2005).

3.4.3. Reflexivity and Aboriginal and Torres Strait Islander educators

In an attempt to consider how cultural education impacts on Aboriginal and Torres Strait Islander people, Fredericks (2008) explored the notion of cross-cultural training with a number of Aboriginal and Torres Strait Islander women in Queensland. While her study considered cultural training generally and was not exclusive to medical education, Fredericks’ findings are pertinent for cultural education provided to medical trainees and professionals.

Fredericks (2008) joins with the many authors (eg Downing, Kowal & Paradies 2011; Jenks 2011, NACCHO 2011; Eckermann et al. 2010) who point to the danger of seeing Aboriginal and Torres Strait Islander people as ‘the problem’, and cultural awareness training as the means for professionals to treat ‘them’. Rather, she calls for a platform of respect and for Aboriginal and Islander involvement at all levels of teaching of Indigenous health. She, and the women whose voices she reports, locate the ‘problem’ of cultural competence within the non-Indigenous population, arguing that cross-cultural training in itself won’t create structural change in health or other services. Recognising that awareness is only a beginning, she calls for reflexivity and self-awareness on the part of those within the dominant culture and, particularly, for anti-racism training for all service providers, in order to create services which benefit Indigenous women (Fredericks, 2008).

Frederick’s perspective is consistent with the discussion in section 2, which highlighted the importance of clinician insight and reflection as part of the cultural competence model. Her views also find support in Farrelly and Lumby’s (2009:17) recommendation that best practice cultural competency training include self-reflection of participants as a core learning objective.
Wain et al.’s (2013) review of the literature on unconscious bias suggests that useful teaching approaches in this context may include exploration of unconscious bias in a non-threatening environment, placing emphasis on perspective taking and empathy, and incorporating the voice of the patient on cultural difference and their experience of care.

### 3.4.4. Other responses and recommendations in the literature

Farrelly and Lumby (2009) provide recommendations for best practice in cultural competence training in the workplace, based on their review of the literature. These include having an articulated policy framework, clearly stated goals and objectives, a commitment to cultural competence within the organisation, and the use of a variety of learner-centred teaching methods. The authors also stress that cultural competence training should be ‘frequent, long-term, and ongoing’, so that skills can be learned and culturally appropriate work practices can be embedded within the organisation (Farrelly & Lumby 2009:18).

The conclusion that cultural education needs to be part of continuing education is supported by a survey undertaken by Western Australian General Practice Education and Training (WAGPET) in 2009 in which a number of respondents considered that short, one-off training workshops were unlikely to produce changes to attitudes and behaviours (WAGPET 2009).

### 3.5. Key points

There are a range of different approaches to providing cultural education within medical training, from didactic lectures through to culturally immersive programs with a high level of contact with communities. Formal teaching and learning are noted to be mediated by the informal, but powerful, social and cultural norms perpetuated or reinforced by the institutional culture of the teaching organisation.

The significance of informal learning led a number of authors to argue that institutions need to adopt a reflexive approach to their operations, policies and activities that would be consistent with and enabling of the desired learning outcomes in their students. At the organisational level, it may mean attention to the attitudes and behaviours modelled by faculty and staff. Within the context of the teaching approach, this might include moving from a view of cultural competency as a discrete and separate unit of study to a focus on embedding cultural competency within the curriculum as a whole.

A fundamental mechanism for strengthening organisational capabilities in providing cultural education is through partnership with Aboriginal and Torres Strait Islander people. The core rationale is that educational...
institutions themselves are constrained by their own institutional cultures and epistemological traditions in terms of how they teach and assess knowledge and skills.

What is evident from the evaluative literature is that cultural education, while on the whole not rigorously evaluated, has demonstrated capacity to improve individual clinician attitudes and skills. There is very little available on the impact that cultural education for clinicians has on actual outcomes for patients, although there is some suggestion that it may improve perceived satisfaction.

Cultural education should be delivered consistently with accepted adult learning principles, including being learner-centred, encouraging self-direction and autonomy, and with a focus on applied knowledge. It appears that cultural educational activities may also be more effective when they are of extended duration (over the course of days, weeks or months rather than brief or intensive workshops) and when they are experiential and interactive. Approaches to education which include some form of direct engagement with community and which have an orientation toward facilitating the practical application of skills associated with cultural competency appear to be preferred in the literature.

A number of authors argue that self-reflection and the development of an understanding of students’ own cultural biases and perceptions, and how these colour their interactions with others is a critical component of cultural education. In particular, cultural education needs to avoid locating the ‘problem’ of complex inter-cultural dynamics within Aboriginal and Torres Strait Islander people and framing cultural competence as a tool or technique for ‘treating’ those problems. Effective cultural mentoring, in which trust is established and cross-cultural dynamics are explored, can encourage more reflexive practice.
4. Cultural education and cultural mentoring in vocational General Practice training

4.1. Introduction

This section explores cultural education in the context of prevocational and vocational training in Australia. There is limited published evaluative literature about the impact of cultural education at the prevocational and vocational levels in Australia, what it entails, how it is delivered, how it is received by students, and how it influences the care provided to Aboriginal and Torres Strait Islander individuals and communities. This discussion will consider both the program publications which describe cultural education and mentoring, as well as a small number of articles and reports which specifically examine training provided at the prevocational or vocational levels. Given the focus of this report on cultural competence for addressing the health needs of Aboriginal and Torres Strait Islander Australians, literature concerning cultural diversity training which is not Indigenous-specific has been excluded from this discussion.

It is clear in documentation from training providers that Aboriginal and Torres Strait Islander cultural education is provided to GPRs in a range of ways, on a spectrum from didactic classroom teaching to one-on-one mentoring by an acknowledged CM within the community setting (GPET 2011a). Cultural mentoring and cultural education are positioned as two separate but related aspects of building cultural capacity and competence among health practitioners.

Cultural education occurs in all Australian medical schools as required by the AMC (Martin & Reath 2011; Committee of the Deans of Australian Medical Schools 2004). However, ‘for many GPs their first substantial experience in this area occurs during vocational training. It is critical that this experience occurs in a well-supported learning environment, facilitating development of skills and attitudes that promote effective work within these communities’ (Martin & Reath 2011). There have been significant developments in the provision of cultural education within vocational General Practice since the mid-1990s. The following sections briefly outline this history, and then explore what is known about cultural education and mentoring as it is implemented in vocational General Practice training in Australia.

4.2. Prevocational and vocational General Practice training in Australia

As noted in section 3, training in Aboriginal and Torres Strait Islander health is required for fellowship of both the RACGP and ACRRM (Martin & Reath 2011). Each College has its own curriculum for Aboriginal and Torres
Strait Islander health education (RACGP 2011b; ACRRM 2011), outlining the competencies expected of GPRs. Each College has identified domains of competence within their Aboriginal and Torres Strait Islander curriculum, as outlined below:

**TABLE 2 – COMPETENCE DOMAINS FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH**

<table>
<thead>
<tr>
<th>RACGP Competence domains (RACGP 2011b:54-55)</th>
<th>ACRRM Competence domains (ACRRM 2011:8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication skills and the patient-doctor relationship</td>
<td>Core clinical knowledge and skills</td>
</tr>
<tr>
<td>Applied professional knowledge and skills</td>
<td>Extended clinical practice</td>
</tr>
<tr>
<td>Population health and the context of General Practice</td>
<td>Population health</td>
</tr>
<tr>
<td>Professional and ethical role</td>
<td>Professional, legal and ethical practice</td>
</tr>
<tr>
<td>Organisational and legal dimensions</td>
<td>Aboriginal and Torres Strait Islander health</td>
</tr>
<tr>
<td></td>
<td>Emergency care</td>
</tr>
<tr>
<td></td>
<td>Rural and remote context</td>
</tr>
</tbody>
</table>

Prior to 2001, the oversight of vocational placements had been the responsibility of the RACGP (Martin & Reath 2011). Since 2001, GPET has been the agency responsible, on behalf of the Commonwealth Government, for ensuring the provision of vocational General Practice training across Australia. General Practice Education and Training contractually engages a number of RTPs throughout Australia to provide vocational training in accordance with the national curricula of both the RACGP and the ACRRM (GPET 2011a). General Practice Education and Training also carries the responsibility, on behalf of the Commonwealth Government, of managing the Prevocational General Practice Placements Program (PGPPP), which provides General Practice-specific placements of up to 13 weeks for JDs. The PGPPP will provide up to 961 placements in 2013.

The development of Aboriginal and Torres Strait Islander-specific curricula by both General Practice Colleges was a response to the recommendation within the National Aboriginal Health Strategy calling for Aboriginal cultural training to be provided to students training to become health professionals (Martin & Reath 2011). GPET’s own *Framework for General Practice Training in Aboriginal and Torres Strait Islander Health* (GPET 2004b) was published in 2004, subsequently evaluated (Urbis 2008), and revised in 2011 as the *Guide to General Practice Training in Aboriginal and Torres Strait Islander Health* (GPET 2011a).

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4.3. Aboriginal and Torres Strait Islander cultural education

The Guide to General Practice Training in Aboriginal and Torres Strait Islander Health identifies two types of Aboriginal and Torres Strait Islander health training activities for GPRs: mandated educational activities delivered through an RTP, and optional experiential training, provided within an Aboriginal and Torres Strait Islander Health Training Post (GPET 2011a:7).

The core cultural education component has been described by GPET as comprising:

…centralised training workshops and sessions arranged by RTPs for the benefit of all registrars…Cultural education is provided through RTPs and delivered by, or with a Cultural Educator and can include: cultural education and training; contextualising culture to clinical settings; orientation and block release activities.

(GPET 2011a:11)

A recent GPET study of a randomised sample of GPRs and JDs showed that the majority of Australian GPRs (90%) and JDs (84%) had received some Indigenous cultural education (GPET 2010a:24). A majority of both GPRs and JDs had gained professional exposure to Indigenous health during medical school, but other sources included information sessions led by Indigenous people, literature, media and other training workshops or courses (GPET 2010a:23-27).

More extensive and experiential General Practice training in Aboriginal and Torres Strait Islander health is primarily gained through working at an ACCHS or another Aboriginal and Torres Strait Islander Health Training Post (including through the PGPPP program for JDs) (GPET 2011a). GPET (2012a) identified that there is currently considerable scope to increase the cultural education experiences available through placements with ACCHSs, with a recent scoping assessment identifying that 44% of accredited ACCHSs were not currently providing a training placement. The reasons for this included the lack of a GP or General Practice Supervisor (GP Supervisor), and lack of information regarding the Australian General Practice Training (AGPT) program. Many of the services that were not accredited indicated a willingness to gain accreditation but also appeared to have limited understanding about the AGPT program (GPET 2012a), suggesting that training capacity within the ACCHS sector could be increased.

Focus group sessions conducted on behalf of GPET to explore attitudes toward Aboriginal and Torres Strait Islander Health Training Posts suggested that both JDs and GPRs had varied experiences and perspectives. Factors which influenced participant’s views included whether participants had prior rural experience and the quality of Aboriginal and Torres Strait Islander health training previously received. The remoteness of many training locations was a key factor, with location, family and lifestyle factors influential, including the potential
need to find boarding schools for children, or the perceived lack of anonymity of practicing in a small town (GPET 2010b:6). It is well documented that those who have grown up or lived in rural areas are generally more willing to consider rural or remote locations (Murray et al. 2012).

While little evidence is available which specifically considers the cultural education or mentoring provided to doctors participating in PGPPP, the GPET (2010a, 2010b) study suggested that JDs did not have good information about Aboriginal and Torres Strait Islander health training, and that they have some misconceptions about practicing in Indigenous health, with a number of focus group participants perceiving that Indigenous health only takes place in remote locations (GPET 2010b:25-26). Participant responses suggest that early exposure to Aboriginal and Torres Strait Islander health issues, such as in medical school, followed up with informative and positive promotion of training opportunities, may help people choose to undertake an Indigenous health placement (GPET 2010b).

Regardless of whether a JD or GPR chooses an Indigenous health placement, the mandated curriculum will still provide the student with some form of cultural education. Mandated activities may include cultural awareness training and cultural education provided by the RTP. Cultural education is provided through RTPs and delivered by, or with, a CE and may focus on cultural education and training, contextualising culture to clinical settings, orientation and block release activities (GPET 2011a: 11).

While core learning outcomes are set out within the RACGP and ACRRM curriculum statements (RACGP 2011b; ACRRM 2011), the importance of adapting teaching to reflect cultural differences and experiences of colonisation unique to the region in which the registrar is training is also generally recognised (GPET 2011a: 6).

Should a registrar choose to undertake an Indigenous health placement, she/he will be provided with a GP Supervisor, and also a CM who will be available as a support person to assist the registrar to learn how best to work within the local community. Orientation and other resources are provided, and in addition the registrar will continue to have access to other cultural education activities provided by their RTP (GPET 2004a).

4.3.1. Aboriginal and Torres Strait Islander Cultural Educators

**Role in training**

All the major organisations involved in General Practice vocational and prevocational training emphasise the importance of having leadership from Aboriginal and Torres Strait Islander people in the design, development, implementation and evaluation of cultural education (RACGP 2011a; ACRRM 2011; GPET 2011a). A RACGP report found that of 14 cultural training programs included in a literature review and survey, all involved Indigenous people in the implementation, but only around half of the programs surveyed involved Aboriginal
and Torres Strait Islander people in the evaluation of training programs (RACGP 2004). While the scope of the survey included programs outside the vocational training sphere, the results highlight a common shortcoming with program evaluation.

Cultural Educators have reported working in a range of ways (VACCHO 2001), including:

- giving one-off workshops and presentations within a work environment, such as a hospital or health service;
- telling stories and having informal discussions;
- providing case studies and undertaking role plays; and
- providing teaching on history and local context.

A draft job description for CEs was developed through the GPET Cultural Educators and Cultural Mentors Network (GPET 2008), which identified a number of essential criteria for a cultural educator:

- Aboriginal or Torres Strait Islander;
- sound knowledge of Aboriginal and Torres Strait Islander history;
- demonstrated experience in the design and delivery of cultural awareness training;
- demonstrated skills and experience in cross cultural facilitation;
- possess skills in facilitation and presentation, interpersonal communication and brokerage (as required and defined by the ACCHS);
- demonstrated understanding of Aboriginal community controlled health sector and the environment where registrars works;
- strong written and oral communication skills; and
- well-developed sense of personal responsibility, and grounded cultural identity.

**Motivations for teaching**

A number of authors have highlighted the willingness of Aboriginal and Torres Strait Islander people to contribute to cultural education, with the belief that helping non-Indigenous people to learn about local cultures and to examine their own attitudes could improve service delivery for Aboriginal and Islander people (Martin & Reath 2011; Nguyen & Gardiner 2008; Fredericks 2008).
Seeking to include the voices of CEs in the literature on cultural training in Australia, Nguyen and Gardiner (2008) conducted a study amongst members of an Aboriginal community in Melbourne in order to gain a better understanding of their feelings toward their role as teachers in health education programs. The study, conducted in the Dandenong district on the outskirts of Melbourne, reported results from two focus groups and one interview held with eight community members who were involved with the education and training of medical students and General Practice registrars. The authors noted that participants were motivated by a desire to improve the service environment for Aboriginal people.

**Facilitating the teaching role**

Factors which enhanced the CEs’ experience as educators were keeping groups small, using informal, narrative teaching approaches, and using multiple presenters so the burden of teaching was shared. The best outcomes were achieved when Aboriginal people’s contribution was recognised and respected (Nguyen & Gardiner 2008).

Because many educators balance responsibilities for family and community as well as existing employment commitments (Martin & Reath 2011; Fredericks 2008; Nguyen & Gardiner 2008), the appropriate recognition and remuneration of Cultural Educators is essential. Cultural Educators need also to receive the same opportunities for professional development and training that other staff might receive, as well as additional personal support as required to assist them to function strongly as an educator and carrier of culture within the medical training environment. As was noted at a VACCHO workshop in 2001, Aboriginal people providing cultural education need to be acknowledged and valued for the contribution which they make:

> Teaching has to be good for the Community. If it is not good for the Community then it won’t happen. People will do it once and the next time you ask them, they won’t want to come. So it has to be good for the community…Teaching also has to be about collaboration because we all work on these issues and they do take a lot of work and preparation and chasing resources and the anxiety of worrying about it. I am sure that if we can share some of those resources then it will be a lot easier for all of us.

(Ian Anderson, quoted in VACCHO 2001:17)

More generally, it is considered important that CEs are able to provide a sense of the real lives and stories of Aboriginal and Torres Strait Islander people, so that non-Indigenous people are able to understand better the priorities and needs of Indigenous people (Fredericks 2008; Nguyen & Gardiner 2008; VACCHO 2001). For that reason, the mode of learning – whether formal or informal, classroom or in field – is less important than that the process valorises Aboriginal and Torres Strait Islander culture. This reinforces the notion that cultural
education does need to be embedded at all levels of the system, rather than being an ‘afterthought’ (Fredericks 2008).

### 4.3.2. Aboriginal and Torres Strait Islander Mentors

In the general literature, mentoring has been defined as ‘the process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development. The mentor who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee’ (Oxley et al. 2003, cited in Maloof 2012:4).

In terms of prevocational and vocational General Practice training in Australia, cultural mentoring refers to

> ...a developmental relationship between an Aboriginal and Torres Strait Islander community member and a registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe General Practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

(GPET 2011a:10)

A workshop held in 2001 to discuss cultural mentoring agreed that a CM is ‘a teacher, counsellor, parent, historian, politician, anthropologist and psychologist’ (McKenzie & Alberts 2002:3). The essential criteria for a CM are that the mentor should be an Aboriginal or Torres Strait Islander person and should have knowledge of, and standing within, the local community (GPET 2008; McKenzie & Alberts 2002). In addition, it is important that gender and age are considered, as it may be appropriate to have more than one mentor to ensure that different roles and relationships within the community can be adequately represented. The mentor should also have the capability to work across cultures (McKenzie & Alberts 2002).

Cultural Mentors support GPRs undertaking placements within an Aboriginal or Islander context. Very often the mentors are Aboriginal Health Workers (AHWs) who take on this role in addition to other duties (WAGPET 2009), although it has been suggested that it may be advisable for the mentor not to be employed in the health service where the registrar is based, so that they are able to remain independent of the health service (McKenzie & Alberts 2002).

The time commitment required of a mentor may be considerable, so that the person who agrees to take on the role may be retired or not in the workforce, again highlighting the importance of recognising their contribution with appropriate remuneration (McKenzie & Alberts 2002). In particular, it is appropriate to
consult with the local community to identify who may be the best person to take on the role of CM, since in that role they are acting as a representative of the local community (WAGPET 2009; McKenzie & Alberts 2002).

The role of the mentor will include face-to-face meetings with the registrar, and possibly telephone contact as agreed between the two. The mentor can reflect with the registrar on questions of culture and understanding, recognising that maintaining patient confidentiality will be essential in a community where someone may be easily identified (McKenzie & Alberts 2002). The mentor can also provide liaison to other members of the community and facilitate other learning opportunities as appropriate for the registrar. The Cultural Mentor role offers personal support to the registrar as the registrar gains insight through his/her experience, but is not in a supervisory role and should not be expected to resolve problems which might arise (McKenzie & Alberts 2002).

While some small studies suggest that registrars feel positively about cultural value (Doolan 2012, Parry 2007), Doolan’s 2012 survey of registrars found relatively low levels of awareness and understanding of Cultural Mentoring. Parry (2007) reported that Cultural Mentors engaged by Northern Territory General Practice Education provided community-specific cultural education and one-to-one support for medical students. The education is provided on traditional lands and students are invited to take part in cultural activities on the land, giving them an opportunity to experience life in a community. Debriefings with students following their placements suggest an ‘overwhelmingly positive’ experience. Students reported increased understanding of Aboriginal culture and about determinants of health in remote communities, and increased awareness of effective communication with Aboriginal people.

**Issues common to Cultural Educators and Cultural Mentors**

Issues common to both Cultural Educators and Cultural Mentors include formal recognition and remuneration for their role, and acknowledgement that it is an additional role with particular responsibilities, not something which can be expected of anyone. One of the recommendations of the evaluation of GPET’s Aboriginal and Torres Strait Islander Health Training framework was to increase the support provided to both Cultural Educators and Cultural Mentors (Urbis 2008). Similar sentiments have been expressed in other forums, where the pressures associated with holding dual roles as both members of their community and teachers can create significant personal strain, and indicate the importance of professional and cultural support (AGPT 2011).

As one way of supporting both Cultural Educators and Cultural Mentors, GPET facilitates a network for Cultural Educators and Cultural Mentors, with a current membership of 20, although there are reportedly approximately 60 in the larger network who attended the annual workshop in 2012 (personal communication, Nicole Pollock, GPET). This network has discussed definitions and descriptions of the two roles, as well as ways of improving support for people in the roles, and promotion of the roles to a wider audience.
4.4. Key points

Cultural education is provided as a part of core curricula at both pre-vocational and vocational level, through a variety of educational modalities. Completion is mandatory to meet the requirements for fellowship of the RACGP and ACRRM. Optional placements or training posts in Aboriginal and Torres Strait Islander health settings provide opportunity for more in-depth experiential learning. A range of factors influence the likelihood that JDs or GPRs will opt to undertake a placement in Aboriginal and Torres Strait Islander health, including their past experience with cultural education and their receptiveness to undertaking a rural placement (many posts are in rural and remote areas).

There is limited literature exploring cultural education and its impact within prevocational and vocational training in Australia, and there is a need for rigorous evaluation which rises above short-term student satisfaction and explores the impact of cultural training on changes in practice at the individual and organisational levels. However, the literature does strongly support the active involvement of Aboriginal and Torres Strait Islander people in cultural training, preferably through a partnership model. While this is occurring in most vocational training, at least to some extent, the literature suggests there is still room to improve how Aboriginal and Torres Strait Islander people are engaged in planning, developing and evaluating training.

Cultural education and cultural mentoring are not two separate fields but are complementary approaches to providing cultural training to GPRs. The roles have been acknowledged by many authors as critical to heightening awareness and understanding among health practitioners, in order to provide culturally secure health service environments for Aboriginal and Torres Strait Islander people. While the roles have been supported for many years through GPET and the RTPs, it appears from the small amount of literature available that the roles are still developing. In particular, there appear to be questions regarding how best to support individuals in these roles, not only through appropriate remuneration and recognition, but also in personal support and ongoing professional and personal development.

There is a need to clarify the roles of CEs and CMs, taking into account people’s participation in these roles as representatives of local communities with all the social responsibilities and potential emotional impact that this may entail. This will require ongoing consultation with CEs and CMs, particularly to identify which aspects of the roles are most valued by CEs and CMs themselves, and also what additional support or training is required to fulfil their roles. There is also a need to recognise the contribution that CEs and CMs make to vocational medical training and an imperative to provide appropriate personal support and remuneration.
There is a need for evaluation of both cultural education and cultural mentoring which assesses both the increase in learning of students’ and the impact of cultural training on clinical practice. Research which explores the activities of CEs and CMs, and evaluative research to identify the impact of cultural education and mentoring on doctors-in-training, would make a useful contribution to the evidence base.
5. Summary of findings of the literature review

In the sections below emerging themes from the literature review with regard to the three research questions are summarised. These emerging themes have been explored further through survey and consultation research and served as a basis for the development of core principles to inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

5.1. What is currently understood to be cultural education?

Cultural education is the transmission of history and knowledge of Aboriginal and Torres Strait Islander cultures, through a range of pedagogical approaches, in order to enhance the knowledge, attitudes, skills and behaviours of students and professionals. Cultural education can be perceived to take place at the system, organisational, professional and individual levels.

The design, delivery, evaluation and assessment of cultural education need to occur in partnership with, and be led by, Aboriginal and Torres Strait Islander people. Cultural education may take place in a range of ways, from didactic teaching through to informal discussions and field trips. In all cases it should be delivered by, or with, a CE who is both grounded in their own cultural identity and able to communicate across cultures, with good communication and teaching skills.

The content of cultural education is mediated by the teaching environment and the norms, values, language and attitudes which are modelled by the organisation and which valorise the place of Aboriginal and Torres Strait Islander culture within the medical and vocational curriculum. Medical students and doctors-in-training absorb both the explicit and implicit teaching of culture as it is presented through both the formal and informal or hidden curricula.

For this reason, educational institutions need to continuously engage in a process of critical reflection and analysis of the degree to which the organisation is culturally competent. Cultural education should be embedded in all aspects of the medical curriculum, and not considered as an adjunct or optional course. In keeping with this, medical schools and RTPs themselves need to reflect the cultural diversity of the community and should be modelling, at an institutional level, the kinds of culturally appropriate behaviour they wish to inculcate in their students and registrars. Medical schools and training institutions wield a great deal of power in shaping their students’ values, attitudes, and cultural priorities. Increasingly, academics working in this area are calling on educational institutions to acknowledge the importance of providing ‘socially accountable’
education, including the recognition of the medical schools’ own role in transmitting norms of privilege and power.

At present, it appears that much cultural education at the pre-vocational level falls back on developing cultural awareness as this is something which can be readily assessed, for instance through surveys and questionnaires. At the vocational training level, in addition to the cultural education provided in workshops, seminars and block release activities, there are further opportunities for experiential or immersive training, particularly through Aboriginal and Torres Strait Islander Health Training Posts or placements in ACCHSs, although these are optional.

Cultural competence requires assessment in practical, applied environments just as any other required competence, and there have been some attempts to measure the impact of cultural education on students. Assessing culture as a ‘competence’ also presents a challenge in deciding how and what is assessed, and there is some evidence in the literature that in presenting culture as a competence, cultural education faces a danger of presenting culture as static and monolithic, rather than evolving and dynamic. Correspondingly, it is important to acknowledge that cultural competence is assessed not by the individual service provider but by the Aboriginal and Torres Strait Islander patient, and although not explicitly discussed in the literature, who can assess cultural competence is another important issue to be considered.

A fundamental skill which underpins cultural competence is the capacity for self-reflection and reflexive practice on the part of clinicians. At its core, this requires an understanding of the complexities of the interaction of cultures and refutation of the simplistic and fallacious notion that cultural competence is needed in order to deal with ‘problems’ causatively attributed to the patient. Training which does not incorporate reflexive content is unlikely to create the insight necessary to challenge pre-existing prejudices and runs the risk of reinforcing racial stereotypes. It follows that cultural education needs to focus on supporting doctors to develop an awareness of the cultural content they bring to their practice and skills in reflexively moderating how they engage with Aboriginal and Torres Strait Islander people.

5.2. What is currently understood to be cultural mentoring?

Cultural mentoring is a more focussed and personal process than cultural education. A CM has been described as ‘a teacher, counsellor, parent, historian, politician, anthropologist and psychologist’ (McKenzie & Alberts 2002:3). Unlike cultural education, which can be provided in groups or for individuals, and in a range of settings, cultural mentoring takes place between two people within the mentee’s professional environment. This places a large responsibility on the CM to assist the mentee to negotiate across cultures, and to provide a
confidential and knowledgeable ‘sounding board’ for the mentee to reflect on his/her experiences in working with Aboriginal and Torres Strait Islander people.

Mentors (and educators) may come from a variety of backgrounds including in some cases employment as an AHW. As Aboriginal and/or Torres Strait Islander people who are representing their community, they need to have a specific knowledge and skillset including connection to local community and an understanding of its local issues and politics, communication skills, and an understanding of ACCHS and other IHTPs and the context in which registrars are working.

Where the mentoring role is seen to deliver benefits to community, Aboriginal and Torres Strait Islander people are willing to provide their expertise. However, the cumulative and at times conflicting pressures associated with mentors’ roles as teachers and as community members mean that the vocational training organisations need to ensure that they feel valued (including in the tangible, remunerative sense), and personally and professionally supported.

As with any mentoring relationship, there may be challenges with two people learning to work together when they come from different backgrounds and experiences, and the mentor will require organisational support and backing, to assist them to facilitate the mentee’s reflection and learning. Adequate professional and personal support is required to enable a CM to be effective in a role which may require the discussion of challenging emotional and social issues.

The role of CMs, as defined and delivered within the AGPT, appears to be unique, as there is little mention in the literature of other explicit Indigenous mentoring programs. At the same time, little appears in the literature about the Australian Aboriginal and Torres Strait Islander cultural education model as well, so it may be that people in this and other countries are undertaking similar processes but not writing about them. If this is the case, then sharing the experiences of the CMs working in Australia will be an important contribution to the literature.

Notwithstanding the relative development of cultural mentoring within vocational training, there remains a need to clarify the roles of Aboriginal and Torres Strait Islander mentors (and educators), particularly given the interaction and integration with their roles and responsibilities as senior community members. Clear definition of their functions and responsibilities as mentors rather than supervisors may be appropriate, as the latter carries connotations of vicarious responsibility for the practice of the mentee – and has significant implications for the mentor as a community member.
5.3. What is known about best practice in cultural education and cultural mentoring?

Cultural competency is demonstrated at systemic, organisational, professional and individual levels. These layers are inter-dependent and each influences how the others are able to implement culturally competent practices. While each layer may have a different degree of impact on an individual patient’s experience, ultimately, it is the combination of the systemic, organisational, professional and individual competency that will determine the experience of cultural competency and culturally safety.

The importance of cultural education and mentoring for individuals should be supported by professional standards and cultures which value attainment of cultural competence. It will be reinforced in practice through enabling policies and practices which facilitate and enact cultural respect at the systemic and organisational levels.

This means that educational institutions which are delivering or coordinating cultural education (and who are propagators of professional values and culture) must engage meaningfully with Aboriginal and Torres Strait Islander people at the institutional level, particularly in the design and delivery of curricula, and valuing and respecting the contributions of CEs and CMs.

There is also a need for a theoretical framework to guide the development, implementation and assessment of cultural education, including both formal training and mentoring. Some frameworks do already exist, both from the USA and here in Australia, and these could form the basis for designing a framework for curriculum development, which could include identified competencies at each stage of a developmental continuum. This could inform both course planning and ongoing student assessment.

Specific cultural education activities should adhere to the accepted principles of adult education and should emphasise opportunities to engage students in interactive learning with Aboriginal and Torres Strait Islander communities. They should preferably be offered regularly over a longer period of time to allow for consolidation and implementation of learning, rather than as brief, one-off events.

The literature, both in Australia and internationally, is particularly clear regarding the critical need for reflexivity by students, to better understand their own cultural stance and the ways in which their own culture (which may not be visible to them) may be perceived by others. Cultural education and mentoring for JDs and GPRs need to incorporate such learning methods as self-reflection, journaling, and mentoring to assist students to develop self-insight.

Finally, the nature of cultural competence as a dynamic process of growth and change over time suggests that individual clinicians need to take long-term responsibility for ongoing pursuit of their cultural education,
supported and enabled by their professions and by the organisations and systems in which they work. Cultural education early in a doctor’s career represents an opportunity to embed a ‘life-long’ perspective on cultural competence.
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity

APPENDIX 2: SURVEY REPORT
Urbis staff responsible for this report

Director            Linda Kurti
Associate Director   Julian Thomas
Senior Consultant    Col Mackin
Job Code             SPP14312
Report Number        Final
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Executive Summary

This report provides analysis of survey data collected as part of research commissioned by General Practice Education and Training aimed at developing the evidence base to support training in cultural competence for doctors working with Aboriginal and Torres Strait Islander people. This research will inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

Tailored surveys for four target cohorts (Regional Training Providers, Cultural Educators and Mentors, Aboriginal and Torres Strait Islander Health Training Posts and General Practice Registrars and Junior Doctors) were distributed between May and August 2013 (inclusive of a pilot phase). This generated 55 valid responses in total, including seven from Regional Training Providers, 10 from Cultural Educators and Mentors, two from Aboriginal and Torres Strait Islander Health Training Posts and 36 from General Practice Registrars and Junior Doctors.

Key findings included that while Regional Training Providers, Cultural Educators and Mentors and Aboriginal and Torres Strait Islander Health Training Posts were familiar with the General Practice Education and Training definitions of cultural education and mentoring, General Practice Registrars and Junior Doctors demonstrated relatively high levels of unfamiliarity, particularly with cultural mentoring. There were differences in the degree of sophistication in understanding between respondents, particularly General Practice Registrars and Junior Doctors.

On the whole, all or at least the significant majority of Cultural Educators and Mentors tend to feel well supported in their roles in terms of access to professional development and support to attend cultural training network events and report being involved by their Regional Training Provider in planning, delivering and evaluating programs. However, only a third agreed that Regional Training Providers looked after their welfare, while the remainder disagreed or did not know. In terms of areas for improved support, responses focused on role clarity, training and networking opportunities, resources and being able to share the load with other community members.

Most Regional Training Providers reported having a formal policy to support cultural education and mentoring in place. All Regional Training Providers reported providing cultural awareness training, and most offered day visits to an Aboriginal Community Controlled Health Services, advice from a non-Aboriginal health professional and longer term placements with Aboriginal and Torres Strait Islander Health Training Posts. Programs were offered from early in the General Practice training program (year 1 or 2), however, were much less available to Junior Doctors.
Those involved in delivery of cultural education and mentoring were generally positive about its expected impact on General Practice Registrars and Junior Doctors, in terms of preparing and encouraging them to work in Aboriginal and Torres Strait Islander health. General Practice Registrars and Junior Doctors expressed high levels of satisfaction with the programs, but were less confident that the programs would prepare them well for practice in Aboriginal and Torres Strait Islander health. A very small number indicated that their interest in working in the area had increased as a result of cultural education.

When asked to identify areas for improvement, General Practice Registrars and Junior Doctors, Regional Training Providers and Aboriginal and Torres Strait Islander Health Training Posts focused on increasing the opportunities to participate in cultural education and mentoring including in some cases, mandating training. Some General Practice Registrars and Junior Doctors also indicated that cultural education/mentoring could be better integrated with clinical training and include a focus on practical aspects of providing culturally competent care. Cultural Educators and Mentors shared some of these views, but also put forward a broader range of opportunities for improvement including in relation to addressing problematic pre-existing conceptions about Aboriginal and Torres Strait Islander people and the value assigned by some General Practice Registrars and Junior Doctors to cultural education and mentoring, deepening the training (e.g. through immersion programs), increasing General Practice Registrars and Junior Doctors accountability to learning, ensuring cultural education was locally relevant and engaging more Aboriginal Health Workers in peer training to boost the Cultural Educator and Cultural Mentor workforce.

These findings are subject to a number of key limitations of the survey process, including the relatively low response rate with consequent risk of non-representative sampling of stakeholders.

This report provides a description of the methodology employed to develop and conduct the survey in section 3 and presents the results from the collation of returned surveys in section 4. Discussion and analysis of the implications of the results are presented in section 5, while section 6 provides concluding remarks on the implications of the survey for the project as a whole.
1. Introduction

1.1. Research context

General Practice Education and Training (GPET) commissioned the University of Western Sydney (UWS), who subcontracted with Urbis, to conduct research aimed at developing the evidence base to support training in cultural competence for doctors working with Aboriginal and Torres Strait Islander people. This research will inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

This report presents the findings from a series of surveys focused on cultural education and cultural mentoring provided to General Practice Registrars (GPRs) and Junior Doctors (JDs). The surveys were conducted between May and August 2013 (including a piloting phase), and sought responses from Regional Training Providers (RTPs), Cultural Educators (CEs) and Cultural Mentors (CMs), and GPR/JDs.

The information collected through these surveys is a key component of a mixed-method approach which also included a range of other primary data collection activities. These included conduct of focus groups, face-to-face interviews, and site-based visits to consult with a wide range of stakeholders including GPET, the Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine (ACRRM), RTPs, Aboriginal and Torres Strait Islander Health Training Posts (IHTPs), GPR/JDs, and the GPET CE/CM Network.

A comprehensive literature review also formed a part of the overall research methodology. The review provides a synthesis of what is known about cultural education and cultural mentoring, what works, and what gaps have been identified to date within the published literature.

The other components of this research are reported in Appendices 1 and 3 of this report.

1.2. The research team and oversight of research

The UWS-led research team included an experienced Aboriginal researcher and was advised in all aspects of the research by a consultant team of highly experienced CEs. Urbis contributed expertise in the development and analysis of surveys, and in the completion of the literature review. The CE consultant team also provided expert assistance in the development of survey materials and in review of the results and analysis.
The research was further supported by a GPET CE/CM Reference Group, which provided oversight of the research project overall and endorsed the survey instruments used to gather data for this report.

1.3. Ethics approval

This research has received ethics approval from a number of Human Research Ethics Committees (HRECs):

- HREC of the University of Western Sydney
- Aboriginal Health & Medical Research Council Ethics Committee
- Central Australia HREC
- Aboriginal HREC of the Aboriginal Health Council of South Australia
- Western Australian Aboriginal Health Ethics Committee
- HREC of the Northern Territory Department of Health and the Menzies School of Health Research

1.4. References to data sources

Throughout this report, the origin of data is indicated by reference to the type of survey (CE/CM, GPR/JD, RTP or IHTP) and also the question from which data is drawn (e.g. A1, D4, G1). The full surveys are provided as appendices to this report.
2. Methods

2.1. Aim

The purpose of the survey was to gather quantitative and qualitative data that would provide insights on aspects of the 16 key research questions identified through the GPET tender brief.

As the survey is one component of a research approach, it does not address all questions in the same depth. The findings of the literature review, interviews and other research elements are synthesised within the project’s final report to provide a complete response to the suite of research questions.

2.2. Development of surveys

The respondents for the surveys were RTPs, IHTPs, CE/CMs and GPR/Js.

In recognition of the differing roles, experiences and perspectives of each of these groups, tailored surveys were designed for each type of respondent. The surveys did not each address all of the research questions, with questions directed toward the expected areas of knowledge and experiences of each respondent group.

Surveys focused on the experience of delivering, receiving or supporting cultural education/mentoring programs, and did not explore the specific content of programs in different locations.

Surveys were iteratively developed with input from all members of the research team, including the consultant team of experienced CE/CMs. The GPET Reference Group provided endorsement of the surveys in their final form prior to piloting.

2.3. Survey distribution

Survey distribution occurred over two phases; a pilot phase and a full distribution phase. The purpose of the pilot phase was to test both the form and distribution method of the surveys, with a view to ultimately improving response rates and data quality during full distribution.

2.3.1 Pilot phase distribution

The pilot phase for the surveys occurred in April and May 2013, and focused on two of the 17 RTPs nationally. A number of different strategies were employed to disseminate the surveys and recruit respondents.
The approaches selected in each case were those identified by the research team as most likely to secure a good response rate:

- The RTP survey was sent directly to the Chief Executive Officers (CEOs) of the two selected RTPs with a request for a representative of the RTP to complete and return the survey;

- the CE/CM survey was emailed directly to CE/CMs in the CE/CM Network by GPET, and also to the two pilot RTPs with a request to also disseminate this survey to their CE/CMs;

- the IHTP survey was sent to the two pilot RTPs with a request to disseminate to their local IHTPs;

- the GPR/JD survey was made available through an online web link, and this web link was provided to the two designated pilot RTPs for dissemination to their GPRs and JDs; and

The research team made minor (but non-substantive) modifications to the content of the surveys following the pilot phase, and also identified improvements to the dissemination process.

2.3.2. Full distribution

Between June and August 2013, surveys were again distributed through a variety of channels selected to maximise the response rate for each respondent group. The distribution reach on this occasion was extended to include all RTPs and associated CE/CMs, IHTPs and GPR/JDs.

Surveys were disseminated through similar mechanisms to those utilised during the pilot phase. Direct email distribution was employed to reach RTPs, IHTPs and CE/CMs.

Distribution to GPR/JDs was again via a direct weblink to the survey; however the link was circulated to all registrars by General Practice Registrars Australia (GPRA) rather than by RTPs. Due to a GPET survey scheduled for release to registrars during the same timeframe, release of the GPR/JD survey was slightly delayed, but was still in the field for more than a month.
A number of modifications to survey distribution and related processes were designed to increase response rates. These included:

- telephone contact with organisations (RTPs and IHTPs) targeted by the survey to prime them for receipt of the emailed survey in advance of distribution;
- direct follow up with RTPs and IHTPs (in some cases) after distribution;
- direct engagement by members of the research team with their networks to encourage survey completion; and
- surveys were also held open for two weeks longer than initially planned.

The results from the survey are reported in the following section.
3. Results

3.1. Respondent profile

The pilot surveys were live with two RTPs for approximately one month, and generated 14 responses. Full distribution of the surveys to respondents associated with the remaining RTPs generated a further 45 valid responses. As there were no adverse methodological issues identified through the pilot, nor changes to the data items that would affect validity of aggregated analysis, responses from the pilot phases of the surveys are included in the final dataset under analysis in this report.

The analysis in this report thus draws on both pilot and final data received from all four surveys to 19 August 2013. A total of 55 valid surveys were received across the pilot and main survey period (see Table 1.)

TABLE 1: SURVEY RESPONDENTS

<table>
<thead>
<tr>
<th>Group</th>
<th>Pilot Phase</th>
<th>Full Distribution</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTPs</td>
<td>1</td>
<td>6</td>
<td>7*</td>
</tr>
<tr>
<td>IHTPs</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CEs /CMs</td>
<td>1</td>
<td>9</td>
<td>10**</td>
</tr>
<tr>
<td>GPRs /JDs</td>
<td>12</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>All</td>
<td>14</td>
<td>45</td>
<td>55*</td>
</tr>
</tbody>
</table>

* One RTP provided two near identical responses which were aggregated into one response for the purposes of analysis.

** Four CE/CM survey responses were received from non-Aboriginal and Torres Strait Islander respondents. These have been excluded from the sample (CE/CM 2, 3, 8 & 12).

Four CE/CM survey responses received from non-Aboriginal and Torres Strait Islander respondents have been excluded from the sample. However, in select cases where the research team considered that qualitative comments provided within these responses provided particular insights, they have been included in Tables 19 and 20.

One RTP provided two responses, one from a member of the senior management team and a second from an Aboriginal project officer within the RTP who fulfils many of the duties performed by a CE/CM. As the surveys recorded identical responses, one was discarded as a duplicate.
One CE/CM survey (CE/CM 7) was incomplete however the completed survey data has been incorporated into the analysis. There were a number of GPR/JD surveys (8) which were only partially completed, meaning that demographic information captured toward the end of the survey was incomplete.

Table 2 summarises the respondent profile. The gender balance of CE/CM and GPR/JD respondents was 2 to 1 in favour of female respondents, while RTP and IHTP respondents were relatively even. A mix of ages was recorded, with GPR/JDs respondents tending to be younger when compared to CE/CMs and RTP respondents.

No GPR/JDs identified as Aboriginal or Torres Strait Islander, while one RTP respondent and one IHTP respondent identified as Aboriginal. Eight CE/CMs identified as Aboriginal, while two did not wish to say. Four CE/CM surveys were received from respondents who indicated that they were non-Indigenous; these have been excluded from the analysis as it was considered the respondents were not employed as CEs as such, but were substantively employed in other roles (e.g. as a Medical Educator).
### TABLE 2: RESPONDENT PROFILE

<table>
<thead>
<tr>
<th></th>
<th>CE/CM (n=10)</th>
<th>GPR/JDs (n=36)</th>
<th>RTP (n=7)</th>
<th>IHTP (n=2)</th>
<th>ALL (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>60% (6)</td>
<td>53% (19)</td>
<td>57% (4)</td>
<td>50% (1)</td>
<td>55% (30)</td>
</tr>
<tr>
<td>Male</td>
<td>20% (2)</td>
<td>25% (9)</td>
<td>43% (3)</td>
<td>50% (1)</td>
<td>27% (15)</td>
</tr>
<tr>
<td>Prefer not to say/not stated</td>
<td>20% (2)</td>
<td>22% (8)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>18% (10)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24 years</td>
<td>0% (0)</td>
<td>3% (1)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>2% (1)</td>
</tr>
<tr>
<td>25-34 years</td>
<td>20% (2)</td>
<td>47% (17)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>35% (19)</td>
</tr>
<tr>
<td>35-44 years</td>
<td>0% (0)</td>
<td>19% (7)</td>
<td>43% (3)</td>
<td>50% (1)</td>
<td>20% (11)</td>
</tr>
<tr>
<td>45-54 years</td>
<td>0% (0)</td>
<td>8% (3)</td>
<td>14% (1)</td>
<td>50% (1)</td>
<td>9% (5)</td>
</tr>
<tr>
<td>55+ years</td>
<td>50% (5)</td>
<td>0% (0)</td>
<td>43% (3)</td>
<td>0% (0)</td>
<td>15% (8)</td>
</tr>
<tr>
<td>Prefer not to say/not stated</td>
<td>30% (3)</td>
<td>22% (8)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>20% (11)</td>
</tr>
<tr>
<td><strong>Aboriginal and/or Torres Strait Islander Identification</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>80% (8)</td>
<td>0% (0)</td>
<td>14% (1)</td>
<td>50% (1)</td>
<td>18% (10)</td>
</tr>
<tr>
<td>Torres Strait Islander</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Both</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Neither</td>
<td>N/A*</td>
<td>78% (28)</td>
<td>86% (6)</td>
<td>50% (1)</td>
<td>64% (35)</td>
</tr>
<tr>
<td>Prefer not to say/not stated</td>
<td>20% (2)</td>
<td>22% (8)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>18% (10)</td>
</tr>
</tbody>
</table>

Four CE/CM surveys were completed by non-Aboriginal and Torres Strait Islander people. These responses have been excluded.

### 3.1.1. Representation of Regional Training Providers

Forty-seven respondents indicated an affiliation with a particular RTP, and 14 different RTPs are represented in the responses across all four surveys. In this analysis, individual RTPs have been de-identified. Where
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 2: Survey Report

reference is made to individual RTPs they have been referred to by a code from RTP A to RTP Q. There were no respondents affiliated with three RTPs (D, F and P). A further two RTPs (A and G) accounted for more than half of all respondents.

Table 3 shows the RTP affiliations reported. Twelve respondents did not indicate their RTP.

TABLE 3: REGIONAL TRAINING POSTS AFFILIATION AMONG SURVEY RESPONDENTS (CE/CM I1; GPR/JD G1; RTP H6; IHTP F3)

<table>
<thead>
<tr>
<th>Regional Training Provider</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>O</th>
<th>P</th>
<th>Q</th>
<th>Not stated</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE/CM</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>GPR/JD</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>-</td>
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<td>2</td>
<td>1</td>
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<td>-</td>
<td>1</td>
<td>8</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTP</td>
<td>1</td>
<td>1</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>IHTP</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>2</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>4</td>
<td>12</td>
<td>55</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.1.2. Educational attainment

Educational attainment questions were asked of CE/CMs (CE/CM I6). Forty per cent of respondents reported that they had completed a university undergraduate degree or higher (see Table 4).

TABLE 4 CULTURAL EDUCATORS/CULTURAL MENTORS EDUCATIONAL ATTAINMENT (CE/CM I6)

<table>
<thead>
<tr>
<th>Highest education attained</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed postgraduate university diploma/degree or equivalent</td>
<td>30% (3)</td>
</tr>
<tr>
<td>Completed undergraduate university diploma/degree or equivalent</td>
<td>10% (1)</td>
</tr>
<tr>
<td>Completed trade or technical qualification</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Completed secondary school</td>
<td>20% (2)</td>
</tr>
<tr>
<td>Completed some secondary school</td>
<td>10% (1)</td>
</tr>
<tr>
<td>Not stated</td>
<td>30% (3)</td>
</tr>
</tbody>
</table>

Respondents from RTPs were also asked a similar question (RTP H4); six reported having completed an undergraduate or post-graduate qualification and one had completed a trade or technical qualification.
3.1.3. Current occupation

All respondents to the CE/CM survey identified themselves as CEs (CE/CM A1). Four stated that they were also CMs and two reported additional functions as community workers and staff trainers.

Three RTP respondents described themselves as Medical Educators (MEs), while others worked in different occupations across a broad range of functions, including Director of Training (1), business or administration manager or officer (1), Aboriginal health program coordinator (1), and Aboriginal or Torres Strait Islander health training program manager (1) (RTP H5).

3.2. Thematic results

Survey data has been grouped under five key themes, reflecting the key research questions identified in Section 2 above and consistent with the approach used for analysis of data from other sources within the broader research project. These themes (and their relation to the research questions) are set out in Table 5 below. It is important to note that the data from the survey does not necessarily provide an answer to all of the questions below, as these questions are overarching ones for the entire project and some are more extensively explored through the qualitative research or the literature review.

Throughout this section, where respondent comments are reported, minor spelling and typographical errors in responses have been amended for ease of reading where this did not affect the substance of the response.
## TABLE 5 THEMES USED TO GROUP RESULTS AND INFORM ANALYSIS

<table>
<thead>
<tr>
<th>Themes</th>
<th>Related key research questions</th>
</tr>
</thead>
</table>
| Understanding of cultural education and mentoring, including the roles of people engaged in its delivery | 1. What is currently understood to be cultural education?  
2. What is currently understood to be cultural mentoring?  
4. When are CEs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training?  
5. When are CMs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training? |
| Employment and support of CEs and CMs | 6 How are CEs and/or CMs remunerated?  
7. Do RTPs have formal policies in place in relation to supporting CEs and CMs?  
8. Are CEs and/or CMs provided with the opportunity to participate in professional and cultural support and development? |
| Nature and extent of cultural education and mentoring programs | 9. What practices are currently used to establish positive relationships with Aboriginal and Torres Strait Islander peoples and communities? What is needed to engage and establish partnerships?  
10. Do RTPs run cultural education activities for staff at all levels, including MEs and supervisors?  
11. Are GPRs and JDs required to prepare for working in Aboriginal and Torres Strait Islander communities?  
12. Are GPRs and JDs required to undertake formal cultural awareness training at any point during General Practice training?  
13. How is Aboriginal and Torres Strait Islander health incorporated into current General Practice education and training practices? |
| Development and evaluation of cultural training and cultural competence assessment | 14. Are there formal processes for feedback on cultural education and/or cultural mentoring activities?  
15. Are there feedback mechanisms for GPRs and JDs who undertake an IHTP, and vice-versa?  
**Additional question:** How do RTPs currently assess cultural competence against the outcomes specified in RACGP and ACRRM Aboriginal and Torres Strait Islander health curriculum statements? |
| The future | 16. What is needed to build sustainable cultural education and cultural mentoring capacity to meet GPR training needs?  
17. What is needed to build partnerships with Aboriginal and Torres Strait Islander peoples and communities to sustain registrar training needs?  
**Additional question:** What are the core principles that should underpin a new National Framework for Cultural Competence in Prevocational and vocational General Practice training? |

### 3.2.1. Understanding of cultural education and cultural mentoring

This section considers respondents’ perspectives of the definitions of cultural education and mentoring and summarises the understanding of the terms from the different survey participant groups.
The definitions were:

**Cultural education** addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health.

And

**Cultural mentoring** refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe General Practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

General Practice Registrars and JDs were also asked about their level of familiarity with the formal definitions provided (GPR/JD B2, C2); 57 per cent indicated that they were *not at all familiar* or *not very familiar* with the definition of cultural mentoring, and 33 per cent were similarly unfamiliar with the definition of cultural education.

All survey respondents were asked *how similar* they felt these definitions were to their own understanding of the terms. All, other than GPR/JDs, reported both definitions were either *very similar* or *fairly similar* to their own understanding of the terms (see Figure 1 and Figure 2). GPR/JDs appeared to have less confidence in the similarity of definitions, and a small number reported that the definitions were *not very similar*.

FIGURE 1: SIMILARITY OF THE DEFINITION OF CULTURAL EDUCATION AND RESPONDENTS’ OWN UNDERSTANDING (N=51) (CE/CM, RTP B2; GPR/JD B3; IHTP C2)
Alternative perspectives on definitions of cultural education and cultural mentoring

Fifteen respondents offered alternative perspectives on the GPET definitions of cultural education or cultural mentoring, set out in Table 6. General Practice Registrar/JD and RTPs’ perspectives tended (though not exclusively) to focus on knowledge transfer and practical aspects of training, while some CE/CMs saw cultural education and mentoring as geared toward fostering reflexive practices and respect for Aboriginal and Torres Strait Islander knowledge and culture.

TABLE 6: ALTERNATIVE PERSPECTIVES OFFERED FOR CULTURAL EDUCATION AND MENTORING (CE/CM B3; CE/CM C3)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE/CM 4</td>
<td>I agree that the description is basically close to my own but, I guess it is too cold, too clinical and I really don’t know how we would be able to implement it. To me as a [de-identified country 1] WOMAN [sic] I think that there should be a sacred sense of mystery about a person’s culture, but how in the world would you pass that on? I feel that cultural mentoring should not be a major essential of working in an ATSI [sic] Training Post. To me the cultural experience can only be provided through working in an AMS which is controlled by an elected ATSI [sic] Board with an extensive knowledge and living experience of the needs, how government policies impact on services etc.</td>
</tr>
<tr>
<td>CE/CM 6</td>
<td>In relation to both the Cultural Educator and Cultural Mentor it is important to understand that the intellectual property belongs to the community or the individual and should not be exploited or exported as a right without consent or acknowledgement. Cultural Educators and Cultural Mentors need to be valued for their expertise and not seen as a ‘one off’ tick the box session that registrars know… is not assessed.</td>
</tr>
<tr>
<td>CE/CM 11</td>
<td>Also assists medical professionals to get to know the patient as an individual and as part of the wider family member. Opens up communication between doctor and patient as a 2 way approach rather than top down model. Doctors hopefully will learn from the patient that they too are a cultural educator. Hopefully they will grasp the concept that although they wear a “white coat” does not necessarily mean they possess more “knowledge” than that of the Aboriginal patient and to “make better” a patient, does not only involve medicines.</td>
</tr>
<tr>
<td>Respondent</td>
<td>Response</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>CE/CM 13</td>
<td>Cultural education is also about helping non-Indigenous people to acknowledge and appreciate the fact that [de-identified country] people also have their own beliefs and processes that may conflict with Western medicines/practices. It is so important that both [de-identified country 2] and [de-identified country 3] work together on such issues to ensure there are no misunderstandings from either party.</td>
</tr>
<tr>
<td>CE/CM 14</td>
<td>Cultural education provides awareness of the differences in social, communication and knowledge in Indigenous communities throughout Australia. Cultural mentoring is a two-way communication to ensure that knowledge is shared. It should be embedded in relationships. You receive cultural mentoring and you give it to, whether [de-identified country 2] to [de-identified country 2], or between [de-identified country 2] and [de-identified country 3]. It is a way of ensuring effective support.</td>
</tr>
<tr>
<td>GPR/JD 7</td>
<td>[Cultural education] provides a background and context to better understand Aboriginal and Torres Strait Islander people’s histories, culture and way of life. [Cultural mentoring] also provides a contact to whom one can direct cultural questions without fear of being culturally insensitive.</td>
</tr>
<tr>
<td>GPR/JD 8</td>
<td>[Cultural education is] a more organic process achieved through interaction with various different cultures.</td>
</tr>
<tr>
<td>GPR/JD 9</td>
<td>Cultural education helps create awareness of how the culture of our patient and our own cultures (in all the many aspects) affect our interaction and how the interaction can be optimised in this setting.</td>
</tr>
<tr>
<td>GPR/JD 23</td>
<td>Cultural mentoring is more about guidance and helping to shape the mentee’s ability to understand and treat Aboriginal patients, but also about helping to interpret the culture of the patients to the doctor.</td>
</tr>
<tr>
<td>GPR/JD 25</td>
<td>[Cultural mentoring involves learning] from both people representative from different cultures, but also from peers who have served these communities and have a great deal of experience with them.</td>
</tr>
<tr>
<td>GPR/JD 34</td>
<td>[Cultural education includes] knowledge about social behaviour, lifestyles, religious and moral; values of a particular culture.</td>
</tr>
<tr>
<td>GPR/JD 35</td>
<td>[Cultural education incorporates] different way of presentation of issues [through] stories, visual aids.</td>
</tr>
<tr>
<td>RTP B</td>
<td>We would apply a very similar definition [of cultural education] to that in the GPET guide. We emphasise the cultural and historical context of health and illness. This includes the influence of Aboriginal and Torres Strait Islander culture on the consultation, along with the impact of colonisation contributing to the complex range of health issues. Our interpretation of cultural mentoring is similar to that above. However, we feel that cultural mentoring can be delivered by an individual or group of individuals. Similarly, we believe that cultural mentoring is not exclusive to registrars working in IHTPs, though this is the most likely setting.</td>
</tr>
<tr>
<td>RTP C</td>
<td>[In relation to cultural education] I would only add specifically that quality patient care includes cultural safety as judged by the Aboriginal or Torres Strait Islander patient. [In relation to cultural mentoring] I agree but would add that the purpose of the relationship with the Cultural Mentor is for the registrar to learn and debrief about cultural issues that may arise during consultations and other interactions with the Aboriginal community. It may also provide the Cultural Mentor with a perspective of the registrar’s experience and world view that may also assist the community to understand some of the registrar’s attitudes and behaviours.</td>
</tr>
<tr>
<td>RTP G</td>
<td>[de-identified RTP] also integrates the cultural education with clinical education i.e. cultural aspects which can impact on the consultation. Cultural mentoring develops a relationship between the registrar and the Aboriginal and Torres Strait Islander community but also helps develop a stronger relationship with the ACCHS as well.</td>
</tr>
</tbody>
</table>
3.2.2. Management and support for Cultural Educators and Cultural Mentors

Both RTPs and CE/CMs were asked a series of specific questions designed to understand the level of support and management structures available to CE/CMs. The questions explore a range of areas including informal linkups with other educators and mentors and more formal training and support processes.

Structure of employment

Questions in the RTP survey explored the structure of employment of CE/CMs within RTPs. The majority of the seven respondent RTPs retain CE/CMs in paid positions (71 per cent) (RTP F1). One RTP retains a mix of paid part-time and voluntary positions and another uses an existing resource from a different program of work to deliver cultural education/mentoring programs. Two RTPs reported offering ongoing contracted positions, while one offered time-limited contracts and another offered a casual role (three RTPs did not answer or did not know the answer to this question) (RTP F4). The time limited contract had been in place for more than two years and operates much like an ongoing contract (RTP F5).

When asked how many CE/CMs were employed (RTP D4), RTPs reported at least one or two CE/CMs delivered program activities (71 per cent), with two RTPs employing three to five CE/CMs. Four RTPs reported that CE/CM roles were delivered mostly or entirely by different people. Two RTPs indicated that it was mostly the same person performing both roles, while one respondent did not know (RTP D6).

Payment structures range from a fixed salary (2) and an hourly rate (4), which can be agreed depending on the amount of time and the types of services delivered (workshops or support) (RTP F6).

Only four of nine CE/CMs reported they were in paid positions as CE/CMs (CE/CM G1), and one further respondent indicated that they were paid at a later question (CE/CM G6), although whether that remuneration was in recognizance of CE and CM functions was not clear.

Four CE/CMs indicated their level of satisfaction with their remuneration (CE/CM G7), and all but one were fairly satisfied, while one reported being very unsatisfied. However, the question of satisfaction with remuneration was not asked of CE/CMs who did not work for an RTP; it is not clear whether respondents paid by other organisation (e.g. Aboriginal Community Controlled Health Service) or in unpaid voluntary roles considered their remuneration satisfactory.
Training and qualifications

Respondent CE/CMs reported a range of training experiences to support their work (CE/CM F1), from informal on the job training (38 per cent), own culture/Aboriginality (38 per cent), formal Aboriginal and Torres Strait Islander education and mentoring courses (25 per cent).

Table 7 shows how CE/CMs reported continuing to develop skills to deliver cultural education/mentoring programs. All CE/CMs continue to develop through informal on the job experience, with others reporting contact with community (89 per cent) and elders (56 per cent) or attendance at cultural training networks (44 per cent) and events (44 per cent). Fifty-six per cent reported attending formal cultural training.

TABLE 7: MAINTENANCE OF LEARNING ABOUT ABORIGINAL AND TORRES STRAIT ISLANDER CULTURAL EDUCATION/MENTORING (N=9) (CE/CM F2)

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Respondents (N=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I learn myself through experience</td>
<td>100% (9)</td>
</tr>
<tr>
<td>I learn through my connections with community</td>
<td>89% (8)</td>
</tr>
<tr>
<td>I learn from my Elders</td>
<td>56% (5)</td>
</tr>
<tr>
<td>I attend cultural training network events</td>
<td>44% (4)</td>
</tr>
<tr>
<td>I attend formal cultural training courses (e.g. Binan Goonj)</td>
<td>56% (5)</td>
</tr>
<tr>
<td>I attend local cultural training events</td>
<td>44% (4)</td>
</tr>
<tr>
<td>I attend courses through university or college</td>
<td>33% (3)</td>
</tr>
<tr>
<td>I am an Elder</td>
<td>11% (1)</td>
</tr>
<tr>
<td>I learn from the patients</td>
<td>11% (1)</td>
</tr>
<tr>
<td>I learn from the youth</td>
<td>11% (1)</td>
</tr>
</tbody>
</table>

Formal supports

When asked about the range of professional development, training and support provided by individual RTPs, CE/CMs were asked to describe to what extent they agreed with a number of positively framed statements (see Figure 3). Responses from six CE/CMs indicated mixed levels of agreement with the statements.

Respondents agreed or strongly agreed that they were involved in planning and delivery of the cultural education and/or mentoring program, and were supported to attend cultural training events. The majority
agreed that they were provided with a supervisor for support and had access to professional development, but only a third of respondents were able to affirm that their RTP looked after their welfare. A third of respondents also felt that they were not involved in evaluating cultural education and/or mentoring programs.

FIGURE 3: CULTURAL EDUCATORS/CULTURAL MENTORS PERCEPTIONS OF SUPPORT “MY RTP…” (N=6) (CE/CM D5)

When RTPs were asked the same questions about levels of support made available to CE/CMs there was some divergence in response (RTP F2). There were high levels of agreement in relation to engagement of CE/CMs in relation to planning (86 per cent in agreement), delivery (100 per cent in agreement) and evaluation of programs (86 per cent), as well as in the provision of support to attend cultural events (86 per cent). Responses to questions about supervision (57 per cent in agreement), professional development (43 per cent) and general welfare (43 per cent) were more mixed, although these also attracted some ‘don’t know’ responses.

**Informal supports**

Informal linkages were reported to be strong, and only one CE/CM reported no engagement with CE/CM peers. Cultural Educators and CMs maintain contact with each other using a range of activities and mediums (CE/CM A5). These included:

- membership of CE/CM networks (reported by 60 per cent CE/CMs);
- regular email and phone contact with other CE/CMs (60 per cent);
• regular meetings with other CE/CMs (20 per cent); and
• information sharing with other CE/CMs and important stakeholders (10 per cent).

One CE/CM kept in regular contact with the local Aboriginal and Torres Strait Islander community Elders, another attended GPET conferences and meetings, and a third indicated that they shared resources across a network.

**Experience of being valued**

When asked if they feel valued in their roles (CE/CM D3), all six CE/CMs who responded to this question agreed to feeling either *fairly* (50 per cent) or *fully* (50 per cent) valued by their RTP. When asked to elaborate on why they felt valued (or otherwise) in their roles, CE/CMs provided a range of responses set out in Table 8. These included feeling personally respected, demonstrated organisational respect for Aboriginal and Torres Strait Islander culture and promotion of cultural education and mentoring to GPRs/JDs, and RTPs making specific resource commitments in support of cultural education and mentoring (remuneration of CE/CMs or training support).
TABLE 8: CULTURAL EDUCATORS/CULTURAL MENTORS RESPONSES TO WHY THEY FELT (OR DID NOT FEEL) VALUED (CE/CM D4)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE/CM 1 (Fully Valued)</td>
<td>I know that I am listened to and respected and always welcomed at my RTP.</td>
</tr>
<tr>
<td>CE/CM 4 (Fairly Valued)</td>
<td>Even though Aboriginal cultural awareness is supposed to be an essential part of the training, it is fairly limited mainly because things such as visits to the practices to see the registrars on a three monthly basis, having some of the meetings at the local AMS etc. are not considered to be an effective method of using the available funding.</td>
</tr>
<tr>
<td>CE/CM 6 (Fully Valued)</td>
<td>There has been a concerted effort to include CE/CM in all registrar and Junior Doctor activities. Pay CE/CM on a salary basis. Their willingness to embrace Welcome to Country and development of a RAP. Developed cultural immersion program that is locally based before any out of area programs are undertaken.</td>
</tr>
<tr>
<td>CE/CM 9 (Fully Valued)</td>
<td>The organisation supports and encourages participation by all GPRs, and is flexible in providing their training.</td>
</tr>
<tr>
<td>CE/CM 10 (Fairly Valued)</td>
<td>The RTP provides additional funding for a 2nd Cultural Educator to attend GPET CE/CM workshops.</td>
</tr>
<tr>
<td>CE/CM 11 (Fairly Valued)</td>
<td>My position is only very new. Time will tell. From what I have witnessed thus far, I am sure that Cultural Mentor / education will become more meaningful. I believe this will also depend upon how I shape this role.</td>
</tr>
</tbody>
</table>

3.2.3. Nature and extent of cultural education and mentoring programs

Regional Training Providers policy frameworks

Five of the seven RTPs that responded to this survey indicated that they had formal policies in place to deliver cultural education and mentoring programs (RTP D3). Regional Training Provider A was unable to respond directly to this question (the respondent worked in the business or administration unit of the RTP). Regional Training Provider J did not have a formal policy in place.

Table 9 indicates that while there were differences in the methods used, those RTPs with formal policies indicated they had consulted with the local Indigenous community or Aboriginal Community Controlled Health Service (ACCHS), and either worked with the local community or employed an Aboriginal and Torres Strait Islander person to further develop the program. Regional Training Provider B and RTP G also adopted existing policies from other organisations.
TABLE 9: REGIONAL TRAINING PROVIDERS WITH FORMAL POLICIES IN PLACE AND POLICY DEVELOPMENT ACTIVITIES FOR CULTURAL EDUCATION / MENTORING PROGRAMS (RTP D3)

<table>
<thead>
<tr>
<th>RTP</th>
<th>Formal policies?</th>
<th>How have these policies been developed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Adopted from other organisation</td>
</tr>
<tr>
<td>RTP A</td>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>RTP B</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>RTP C</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>RTP G</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>RTP I</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>RTP J</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>RTP Q</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Range of programs and activities provided by Regional Training Providers

All seven respondent RTPs reported delivery of cultural education to General Practice Supervisors (GP Supervisors), while four reported offering cultural mentoring (see Table 10).
TABLE 10: PROPORTION OF REGIONAL TRAINING PROVIDERS’ RESPONDENTS PROVIDING AND/OR MANDATING PROGRAM ACTIVITIES (N=7) (RTP D2)

<table>
<thead>
<tr>
<th>Program activity</th>
<th>Program provided</th>
<th>Program mandated</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training</td>
<td>100% (7)</td>
<td>85% (6)</td>
</tr>
<tr>
<td>Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (e.g. GP Supervisor, ME) with experience in this field</td>
<td>100% (7)</td>
<td>57% (4)</td>
</tr>
<tr>
<td>Day visits to an ACCHS and other facilities (e.g. Aboriginal community child care)</td>
<td>100% (7)</td>
<td>14% (1)</td>
</tr>
<tr>
<td>Mentoring from an Aboriginal and Torres Strait Islander CM</td>
<td>57% (4)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Extended (6 months or more) experience in a training post(s) at an ACCHS or another Indigenous Health Service</td>
<td>100% (7)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Other Aboriginal and Torres Strait Islander health training opportunities</td>
<td>87% (6)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>57% (4)</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

Six RTPs reported providing ‘other’ forms of cultural education, and described these as including:

- workshops/short training sessions;
- cultural immersion camp/activities;
- presentations at supervisor workshops;
- presentations by Aboriginal academics, Aboriginal Health Workers (AHWs) and by GPRs; and
- clinical attachments.

One RTP also reported encouraging registrars to undertake self-directed activities through crediting these activities, provided they were assessed to have an additive learning value to the RTP provided program.

Programs available to JDs were more limited (RTP D8). All RTPs, except RTP I, provided program activities but these were limited to general information and/or advice from a non-Aboriginal and Torres Strait Islander health professional. Day visits to Indigenous communities were offered by RTP Q and only one RTP (RTP P) reported a mandatory course for JDs, which was limited to the provision of general information.
Targeting of cultural education and cultural mentoring

When asked which medical professionals received cultural education/mentoring programs, all respondent RTPs reported delivery to GPRs, and some reported wider delivery (see Table 11). Only one RTP (RTP G) reported provision of cultural education and/or mentoring to all medical professionals engaged in GP training.

<table>
<thead>
<tr>
<th>RTP</th>
<th>GP Registrars</th>
<th>Junior Doctors</th>
<th>Medical Educators</th>
<th>Medical Supervisors</th>
<th>GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTP A</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RTP B</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RTP C</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RTP G</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RTP I</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RTP J</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>RTP Q</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Timing of program delivery

The majority of RTPs (5) delivered cultural education and mentoring programs to GPR/JDs from the first year of General Practice training. However, RTP B and RTP G opted for year two of General Practice training. Four RTPs also offered programs during the Prevocational General Practice Placement Program (PGPPP).

<table>
<thead>
<tr>
<th>RTP</th>
<th>Within PGPPP</th>
<th>GPT Yr 1</th>
<th>GPT Yr 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTP A</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>RTP B</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>RTP C</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTP G</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>RTP I</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTP J</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>RTP Q</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Types of programs Cultural Educators and Cultural Mentors report that they deliver

As part of the CE/CMs survey, participants were asked to identify the range of programs that they delivered to GPRs and JDs. Table 13 indicates that workshops, cultural training and ongoing cultural mentoring are the primary activities reportedly delivered by CE/CMs. Cultural Educators and CMs were less frequently involved in providing short trips and day visits to Indigenous communities.

<table>
<thead>
<tr>
<th>Program type</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural training events / workshops at an ACCHS</td>
<td>88% (7)</td>
</tr>
<tr>
<td>Education about Aboriginal and Torres Strait Islander health as part of a workshop outside an ACCHS (e.g. with a university, RTP or Medicare Local)</td>
<td>75% (6)</td>
</tr>
<tr>
<td>Cultural mentoring support during placements in an IHTP</td>
<td>63% (5)</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>50% (4)</td>
</tr>
<tr>
<td>Other cultural/mentoring services to GPRs</td>
<td>38% (3)</td>
</tr>
<tr>
<td>Day visits to ACCHS and other facilities (e.g. Aboriginal community child care)</td>
<td>25% (2)</td>
</tr>
</tbody>
</table>

Three CE/CMs reported providing ‘other services’, and described these as including:

- attendance at National Aborigines and Islanders Day Observance Committee (NAIDOC) programs;
- reconciliation workshops;
- flag raising at the local hospitals;
- providing appropriate resources and ensuring reading material includes an Aboriginal perspective; and
- occasional visits to rural practice GPRs.

Types of programs engaged in by General Practice Registrars and Junior Doctors

General Practice Registrars and JDs were asked to report on the type of program activities they had participated in, or expected to participate in at a later point in their training. The activities most frequently reported by the 26 GPR/JDs who provided a response to this question included current or expected receipt of general information and advice and day visits. Half of respondents indicated they were undertaking or
expected to undertake a long placement (six months) in an IHTP, while 62 per cent were engaged in or expected to engage in a cultural mentor-mentee relationship.

**TABLE 14: GENERAL PRACTICE REGISTRARS/JUNIOR DOCTORS REPORTED INVOLVEMENT IN CULTURAL EDUCATION OR MENTORING ACTIVITIES (N=26) (GPR/JD D4)**

<table>
<thead>
<tr>
<th>Program type</th>
<th>Current</th>
<th>Future</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training</td>
<td>73% (19)</td>
<td>27% (7)</td>
<td>100% (26)</td>
</tr>
<tr>
<td>Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (e.g. GP Supervisor, ME) with experience in this field</td>
<td>65% (17)</td>
<td>19% (5)</td>
<td>85% (22)</td>
</tr>
<tr>
<td>Day visits to an ACCHS and other facilities (e.g. Aboriginal community child care)</td>
<td>65% (17)</td>
<td>15% (4)</td>
<td>81% (21)</td>
</tr>
<tr>
<td>Mentoring from an Aboriginal and Torres Strait Islander CM</td>
<td>31% (8)</td>
<td>31% (8)</td>
<td>62% (16)</td>
</tr>
<tr>
<td>Extended (6 months or more) experience in a training post(s) at an ACCHS or another Indigenous Health Service</td>
<td>27% (7)</td>
<td>23% (6)</td>
<td>50% (13)</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>19% (5)</td>
<td>15% (4)</td>
<td>35% (9)</td>
</tr>
<tr>
<td>Other Aboriginal and Torres Strait Islander health training opportunities</td>
<td>19% (5)</td>
<td>19% (5)</td>
<td>38% (10)</td>
</tr>
</tbody>
</table>

General Practice Registrars and JDs were asked some specific questions about the cultural mentoring program they received. Mentoring was reportedly provided to GPR/JDs at only four RTPs and received by eight GPR/JD respondents (a further eight GPR/JDs indicated that they expected to work with a mentor in the future) (GPR/JD D4). Of those who had worked with a mentor, four had worked with one person, while four had worked with more than one (GPR/JD D5).

Table 15 indicates the characterisation of the supports reported to be received by the eight GPR/JD respondents who had indicated that they had received cultural mentoring.
TABLE 15: GENERAL PRACTICE REGISTRAR/JUNIOR DOCTOR SUPPORTS RECEIVED FROM CULTURAL MENTORS (GPR/JD D7)

<table>
<thead>
<tr>
<th>Support provided</th>
<th>Respondents (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is/was available for advice</td>
<td>63% (5)</td>
</tr>
<tr>
<td>Provides/provided me with personal support</td>
<td>38% (3)</td>
</tr>
<tr>
<td>Provides/provided me with supervision about cultural matters that impact on patient care</td>
<td>38% (3)</td>
</tr>
<tr>
<td>Assists/assisted me in the communication with the community</td>
<td>25% (2)</td>
</tr>
<tr>
<td>Assists/assisted me during my consultations with patients</td>
<td>38% (3)</td>
</tr>
<tr>
<td>Other</td>
<td>25% (2)</td>
</tr>
<tr>
<td>Don’t know/not sure</td>
<td>13% (1)</td>
</tr>
</tbody>
</table>

Respondents who selected ‘other’ support indicated that this took the form of a workshop in one case, and invitations and inclusion in cultural events in the other.

**General Practice Registrar and Junior Doctor satisfaction with programs**

Of the 17 GPR/JDs who responded to questions about their satisfaction with cultural education and mentoring (GPR/JD D7), the great majority were either *fairly* or *very satisfied* (88 per cent) with the program they received. Some offered comments on their general experience of cultural education and mentoring, set out in Table 16. Observations included a preference for locally relevant education and meetings with workers in place of generalised cultural training provided as part of training days, preference for training to be integrated into broader workshops (rather than being solely a standalone workshop), and some difficulties accessing CMs and IHTPs.
### TABLE 16: GENERAL PRACTICE REGISTRARS/JUNIOR DOCTORS COMMENTS ON OVERALL EXPERIENCE OF CULTURAL EDUCATION OR MENTORING PROGRAMS (GPR/JD D8)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPR/JD 2</td>
<td>Cultural education provided for everyone at training days hasn’t been as useful as the small-group advice given by the Cultural Mentor to those of us starting an AMS term.</td>
</tr>
<tr>
<td>GPR/JD 4</td>
<td>I feel that, in general, cultural education was done well but did not know much about cultural mentoring. I also feel more emphasis should be made in orientation to a practice that works, for example, with Indigenous people, to include LOCAL education and meetings with health workers to enhance understanding of the specific local culture in which you work (rather than the broad, sweeping generalisations that we are taught).</td>
</tr>
<tr>
<td>GPR/JD 9</td>
<td>There is only limited opportunities within the [de-identified RTP] program to work at an Aboriginal and Torres Strait Islander Health Training Post so they are in high demand.</td>
</tr>
<tr>
<td>GPR/JD 23</td>
<td>It is difficult to know how to get in touch with the mentor as there aren’t regular sessions and the medical service is busy most of the time - sometimes the mentor seemed too busy to easily approach. The workshop was very helpful but frustrating that it is a standalone workshop and not integrated into other workshops, so that you don’t forget what was learned.</td>
</tr>
<tr>
<td>GPR/JD 28</td>
<td>Cultural education should be more open ended and allow a general understanding and appreciation of ALL cultures, not just Indigenous. Indeed some minority populations in Australia represent a larger percentage of the population than the Indigenous population and this should be reflected in training pathways especially for registrars working in urban areas with high concentrations of immigrant populations.</td>
</tr>
<tr>
<td>GPR/JD 30</td>
<td>Good experience. A day at the AMS was very valuable.</td>
</tr>
</tbody>
</table>

### Integration of cultural education and cultural mentoring into General Practice training

All respondents except IHTPs were asked to indicate if they felt cultural education and mentoring programs were integrated into all aspects of training or delivered as a discrete training segment. Table 17 shows responses from each survey cohort by response type, and indicates that across all cohorts, delivery of cultural education and mentoring programs was often thought to be at least partly integrated into training. Cultural Educators and CMs and RTPs appeared to consider cultural education and mentoring was integrated, with only one CE/CM and one RTP respondent indicating it was solely delivered as a separate activity.

---

### TABLE 17: LEVEL OF INTEGRATION OF CULTURAL EDUCATION/MENTORING INTO TRAINING (CE/CM D2; GPR/JD D4; RTP D11)

<table>
<thead>
<tr>
<th>Response</th>
<th>CE/CM (n=6)</th>
<th>RTP (n=7)</th>
<th>GPR/JD (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated as part of all training</td>
<td>67% (4)</td>
<td>14% (1)</td>
<td>38% (10)</td>
</tr>
<tr>
<td>Delivered as separate/stand-alone training</td>
<td>17% (1)</td>
<td>14% (1)</td>
<td>19% (5)</td>
</tr>
<tr>
<td>Both</td>
<td>*</td>
<td>71% (5)</td>
<td>23% (6)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>17% (1)</td>
<td>0% (0)</td>
<td>19% (5)</td>
</tr>
</tbody>
</table>

*This response was not an option for CE/CM.*
3.2.4. Development and evaluation of programs

The impact of cultural education and mentoring programs on GPR/JDs and their capacity to deliver improved health services to Indigenous communities was explored in the survey. These questions evaluate the effectiveness of the programs from different participant perspectives.

**General Practice Registrar and Junior Doctor perspectives on the impact of cultural education and cultural mentoring programs**

General Practice Registrars and JDs were asked a series of questions about the impact of cultural education/mentoring programs. These included questions about their desire to undertake Aboriginal and Torres Strait Islander specific training, the impact of training on interests in Aboriginal and Torres Strait Islander health and the extent to which cultural education/mentoring programs prepare GPR/JDs for working in Indigenous communities.

Overall, GPR/JDs provided a range of responses when asked how interested they were in working in Aboriginal and Torres Strait Islander health or pursuing Aboriginal and Torres Strait Islander training opportunities (see Figure 4). Respondents were divided when asked about their interest in Aboriginal and Torres Strait Islander health, with 47 per cent stating they were interested in working in this area and 40 per cent who were not. Similarly, there were slightly more respondents who were interested (54 per cent) in pursuing Aboriginal and Torres Strait Islander training than those who were not (40 per cent).

Those who were generally interested in working in Aboriginal and Torres Strait Islander health were also interested in pursuing training opportunities in this area, with the exception of two participants who indicated that they were fairly interested in working in Aboriginal and Torres Strait Islander health but not very interested in pursuing Aboriginal and Torres Strait health Islander training opportunities.

Seven (25 per cent) GPR/JD participants indicated that overall, their training program had increased their interest in working in Aboriginal and Torres Strait Islander health, while 14 (50 per cent) felt it had made no difference and the remainder did not know (GPR/JD E2).

Two of the respondents who indicated increased interest were among 11 who indicated in a preceding question that they had not been very interested in working in this area when they started their General Practice training (GPR/JD E1: Figure 4). No participants indicated that their interest had decreased as a result of their training.
When asked how prepared they felt for work in Indigenous communities after the cultural education/ cultural mentoring program they received from their RTP (GPR/JD E3), 46 per cent of GPR/JDs responding to this question indicated they were *fairly or very well*, while 14 per cent indicating the program had left them feeling *not very well* prepared. There were a considerable number of GPR/JDs who were not sure or did not know (39 per cent).

**FIGURE 4: AT COMMENCEMENT OF THE TRAINING PROGRAM, HOW INTERESTED WERE YOU IN... (N=28) (GPR/JD E1)**

Only a small number of GPR/JDs responded to questions in relation to the quality of support received during General Practice training (n=8), but three quarters *agreed or strongly agreed* that CMs improved their understanding of Aboriginal and Torres Strait Islander health and improved the ability of GPR/JDs to work in an Aboriginal and Torres Strait Islander health setting (Figure 5).
Regional Training Provider, Aboriginal and Torres Strait Islander Health Training Post and Cultural Educator and Cultural Mentor perspectives on the impact of cultural education and cultural mentoring programs

Regional Training Providers, IHTPs and CE/CMs were all asked the same two questions to measure the impact of cultural education/mentoring programs. The responses are shown in aggregate in Figure 6. Overall, respondents tended to either agree or strongly agree with the proposition that cultural education and mentoring:

- improve health outcomes for Aboriginal and Torres Strait Islander people;
- improve the access to health services available to Aboriginal and Torres Strait Islander people;
- improve the quality of health services provided to Aboriginal and Torres Strait Islander people; and
- increase the interest of GPR/JDs in Aboriginal and Torres Strait Islander health.

Respondents were much more likely to agree with the statements in the survey than disagree. However, there was less certainty about the program’s ability to support improved outcomes for Aboriginal and Torres Strait Islander health and to improving access to health services.
When asked to evaluate their own cultural education/mentoring program RTPs, IHTPs and CE/CMs generally agreed that programs prepared GPR/JDs for work with Aboriginal and Torres Strait Islander communities either very well or fairly well. Only two survey respondents offered alternative views. One indicated their program prepared program participants not very well (RTP), and another went further, suggesting their program prepared participants not very well at all (CE/CM).
3.2.5. The future

General Practice Registrar and Junior Doctor views on improving cultural education and cultural mentoring

When offered the opportunity to identify a key change to cultural education and mentoring, 12 GPR/JDs offered a response (see Table 18). Themes which appear in some responses include increasing access to cultural education and mentoring programs (and mandatory participation in some cases), improved integration of cultural education within clinical training and a focus on making cultural education and training more ‘learner directed’ and orientated toward examples to aid practice.
### TABLE 18: GENERAL PRACTICE REGISTRARS/JUNIOR DOCTORS IDENTIFICATION OF CHANGES THAT WOULD IMPROVE CULTURAL EDUCATION AND MENTORING (GPR/JD E4)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GPR/JD 2</strong></td>
<td>A GP (preferably even an Registrar Medical Educator) should work with the Cultural Educator or Mentor in preparing talks for Registrars, to give them a list of knowledge areas registrars want to know about, or a list of questions Registrars want to have answered - so that, along with their own information they feel is important and wish to pass on, they can also address the audience’s major questions / learning needs too.</td>
</tr>
<tr>
<td><strong>GPR/JD 4</strong></td>
<td>It is so difficult as there is NO specific right or wrong answer. More specific examples of Indigenous culture focussing specifically on the things we do wrong, in order to avoid that. If advice could come from Indigenous health workers, that would be ideal.</td>
</tr>
<tr>
<td><strong>GPR/JD 7</strong></td>
<td>I think it should be compulsory for everyone.</td>
</tr>
<tr>
<td><strong>GPR/JD 8</strong></td>
<td>Make it compulsory, but also non-judgemental for junior Registrars- compulsory to attend and participate, not to reach certain targets (e.g. 5 ATSI checks [sic] - difficult and not useful!)</td>
</tr>
<tr>
<td><strong>GPR/JD 9</strong></td>
<td>To allow all JDs/Registrars the opportunity to work in an Aboriginal Health Post if they wished</td>
</tr>
<tr>
<td><strong>GPR/JD 12</strong></td>
<td>Have more available in medical school. At [de-identified medical school] - we are lucky to have a bit considering there is a regional rural focus. Mandatory Aboriginal health placement should be executed across all medical programs in Australia regardless of whether anyone has intention to work in Indigenous communities</td>
</tr>
<tr>
<td><strong>GPR/JD 23</strong></td>
<td>Integrate it throughout the other clinical training to reinforce the training and also make it more practical for those not doing Aboriginal health posts, and make Mentors more easily accessible (e.g. scheduled sessions etc.) for the Registrars so there is frequent contact (and not just lip service to the role)</td>
</tr>
<tr>
<td><strong>GPR/JD 25</strong></td>
<td>Better integration between theory and practice - rather than separated.</td>
</tr>
<tr>
<td><strong>GPR/JD 26</strong></td>
<td>I think ideally time spent in Aboriginal health centres or communities is the most valuable thing and it needs to be more than a day to get the most out of it</td>
</tr>
<tr>
<td><strong>GPR/JD 28</strong></td>
<td>See previous comment about making it relevant to ALL cultures thereby making it more inclusive. Australia is not just a White and Indigenous society - we are multicultural and this should be reflected in the training program of cultural awareness.</td>
</tr>
<tr>
<td><strong>GPR/JD 34</strong></td>
<td>Need more cultural training during training- especially on practical GP issues.</td>
</tr>
<tr>
<td><strong>GPR/JD 35</strong></td>
<td>Mandatory training period for at least 4 weeks</td>
</tr>
</tbody>
</table>

### Cultural Educator and Cultural Mentor views on improving cultural education and cultural mentoring

Cultural Educators and CMs were asked to identify improvements to the support that they were provided and also for any general improvements to cultural education and mentoring programs. In terms of areas for improved support, responses focused on role clarity, training and networking opportunities, resources and being able to share the load with other community members (see Table 19). Improvements identified to cultural education and mentoring generally included addressing preconceived prejudice among GPR/JDs,
ensuring cultural education is taken seriously, increasing time allocated to it and opportunities for greater depth in training (e.g. through immersive experiences), region-specific education prior to GPR/JD arrival and strengthening the capabilities of the local AHWs to teach GPR/JDs (and reap reciprocal benefit learning about ‘mainstream processes’) (see Table 19).

TABLE 19: CULTURAL EDUCATORS/CULTURAL MENTORS IDENTIFICATION OF AREAS FOR INCREASED SUPPORT TO CE/CM ROLES (CE/CM H1)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE/CM 2*</td>
<td>It would be good to have more people doing this. It is exhausting – it really takes a lot of energy. I do understand that it must be very hard for an Aboriginal person to do this on an ongoing basis. I have witnessed staff have their personal story questioned and vilified. The ones I see give it their all just a little every time they run a session, till they say they can do it no more. I could not do this for very long. I see myself fading fast.</td>
</tr>
<tr>
<td>CE/CM 4</td>
<td>I guess if knew for certain exactly what I was supposed to do and did not have other people telling me that that is their job.</td>
</tr>
<tr>
<td>CE/CM 5</td>
<td>The timing of some of the visits and the length of time that they request for training. Sometimes too much emphasis is placed upon the medical model of ailments and diseases. As I don’t have a health background I am uncomfortable talking about health issues when this should be the job of the training provider away from the cultural awareness programs. We are not Medical Educators and this seems to be overriding the cultural model of training delivery.</td>
</tr>
<tr>
<td>CE/CM 6</td>
<td>We have two part time CE/CMs in our RTP and we need to be able to spend time developing a consistent program to deliver across our footprint. Purchasing of resources (books etc)</td>
</tr>
<tr>
<td>CE/CM 9</td>
<td>The organisation provides opportunities to extend my contact with other CEs and CMs. It has established an ongoing and supportive partnership between a GP Clinical/Cultural Educator and myself.</td>
</tr>
<tr>
<td>CE/CM 10</td>
<td>I would like to see all CEs having access to the opportunity to undertake a recognised course in Training and Assessment. Many have the cultural knowledge but lack the presentation and assessment skills which could enhance their role. I would include myself among these.</td>
</tr>
<tr>
<td>CE/CM 11</td>
<td>As my role / position is new, this will become more defined during the next few months. I hope that I am utilised by the GPRs re cultural aspects of their work.</td>
</tr>
<tr>
<td>CE/CM 12*</td>
<td>I am curious about the [Leaders in Indigenous Medical Education] network and how much relevance it has to the work I do and whether I should be more involved. I would like to attend one of their conferences but not sure how much I would get out of it. It seems that it should be very relevant. I think that having a living network of CEs would be ideal but the recurrent issues of being time poor and having too many responsibilities get in the way. I think we need to be present for one another on a more personal basis when we live in an area or region too.</td>
</tr>
<tr>
<td>CE/CM 13</td>
<td>Increased support from other [de-identified country] community workers/members to prevent being overloaded with demands from agencies and co-workers.</td>
</tr>
</tbody>
</table>

* Non-Indigenous respondent to the CE/CM survey.
TABLE 20: CULTURAL EDUCATORS/CULTURAL MENTORS IDENTIFICATION OF CHANGES THAT WOULD IMPROVE CULTURAL EDUCATION AND MENTORING (CE/CM H2)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE/CM 2*</td>
<td>I would like a filter to get rid of the people who do not want to be there. So I would rather only work with people who want to do a better job and improve them myself. Not spend time trying to convince people that Aboriginal people in fact exist, have a history and should not have to be “just like us”</td>
</tr>
<tr>
<td>CE/CM 4</td>
<td>I would want them to take the placements seriously, fill in the reports with a lot more detail than they do at the present moment and not just look at them as one more thing to be done and…..whose going to care anyway.</td>
</tr>
<tr>
<td>CE/CM 5</td>
<td>Allow them more time to spend in community visiting people, visiting significant sites and having hands on approach. Having a real cultural immersion experience instead of a watered down classroom experience.</td>
</tr>
<tr>
<td>CE/CM 6</td>
<td>The preconceived attitudes some Registrars have towards Aboriginal and Torres Strait Islander people and ultimately patients – many do not recognise the privileged position they are in and cannot / do not understand the history of Aboriginal disadvantage. My experience has been that many Registrars see Aboriginal health as something they will not have to work with but in their chosen profession as a GP this is something that will occur. Compulsory (assessed) training will help overcome this attitude.</td>
</tr>
<tr>
<td>CE/CM 8*</td>
<td>More time! I am always thinking of ways to improve the workshops e.g. looking at a visit to a culturally important site.</td>
</tr>
<tr>
<td>CE/CM 9</td>
<td>More time and greater depth</td>
</tr>
<tr>
<td>CE/CM 10</td>
<td>I think CEs should be provided with training to ensure they have knowledge of the RACGP and ACRRM curricula and that the cultural education they are providing meets these standards. I am not sure whether all CEs are even aware these exist and this is what GPRs are likely to be examined against. I also think that anyone who is providing cultural mentoring to a GPR should be aware of the wider General Practice training program and how their role as a Cultural Mentor fits within the program.</td>
</tr>
<tr>
<td>CE/CM 11</td>
<td>That they receive this training during their orientation at the AMSs That they receive ongoing cultural training not only a one off.</td>
</tr>
<tr>
<td>CE/CM 12*</td>
<td>I have just had a conversation with a registrar working now full time in an AMS, who was completely unprepared for the psycho-social burden of illness in the community in which she is working. She had worked in a remote community up north in the past and perhaps had assumed that all communities are the same. They are definitely NOT the same and the importance of this is manifest in the absolute numbers of Indigenous people and where they live. Most Indigenous people do not live in remote communities and their health needs are in many instances very different from those who do. This needs to be clear to registrars and to those people supporting the many and varied ways in which we deliver cultural education and registrar support</td>
</tr>
<tr>
<td>CE/CM 13</td>
<td>There would be more training provided locally for Aboriginal Health Workers from this region, so that they can provide mentoring/education on cultural issues within the clinics and at the same time be learning mainstream processes from the GPs. It makes sense that we all work together, rather than educating one another and then going our separate ways to do our work.</td>
</tr>
<tr>
<td>CE/CM 14</td>
<td>I would like the [de-identified RTP] to provide region specific cultural education before GPRs come to work here and as a mentor I am happy to assist with this.</td>
</tr>
</tbody>
</table>

* Non-Indigenous respondent to the CE/CM survey.
Regional Training Provider/Aboriginal and Torres Strait Islander Health Training Post views on improving cultural education and cultural mentoring

Regional Training Provider and IHTP respondents were asked what they would change for CEs and CMs, and also what they would change about the cultural education and mentoring overall. All RTPs and one IHTP provided responses, set out in Table 21.

The most consistent response from RTPs when asked about improving support to CE/CMs related to the need to expand capacity of these roles, including increasing emphasis on providing more paid roles. Program enhancements identified were generally limited to increasing GPR access to cultural education and mentoring by boosting availability.

One RTP noted they would welcome a more direct relationship between local CMs and the RTP, as opposed to the current relationship where the CMs had a working relationship with the IHTP where they were employed as AHWs.

TABLE 21: REGIONAL TRAINING POST/ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH TRAINING PROGRAM CHANGES THAT WOULD SUPPORT CE/CMS AND IMPROVE CULTURAL EDUCATION AND MENTORING PROGRAMS (RTP, IHTP G1, G2)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Improvements for CE/CMs (G1)</th>
<th>Improvements to program (G2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTP A</td>
<td>Increased availability (time fraction) so they can be more involved/provide greater input</td>
<td>Increased availability (time fraction) so they can be more involved/provide greater input</td>
</tr>
<tr>
<td>RTP B</td>
<td>Provision of more paid hours to undertake the job – more incentive to engage in a meaningful way with registrars.</td>
<td>Recruitment of a CE/CM in each AMS</td>
</tr>
<tr>
<td>RTP C</td>
<td>Greater recognition of the roles</td>
<td>The opportunity to expand what is currently offered to GPRs that seek further support, knowledge and experience in Aboriginal health. The inclusion of live case studies into our training program.</td>
</tr>
<tr>
<td>RTP G</td>
<td>Employ an Aboriginal Cultural Mentor at the RTP in a permanent capacity</td>
<td>Formalise their access to cultural mentorship opportunities</td>
</tr>
<tr>
<td>RTP I</td>
<td>We have very limited experience with CEs, our educator being a recent addition to the educator group. It is a little early to comment. Our RTP does not employ a Cultural Mentor at present.</td>
<td>Our RTP would like to see a relationship between the RTP and CMs but at present the CMs have a working relationship with the ACCHS where our registrars work but not with the RTP. They tend to be Aboriginal Health Workers in the ACCHS.</td>
</tr>
<tr>
<td>RTP J</td>
<td>Increased numbers and establish a network for improved support and sustainability of this program</td>
<td>Implementation of a Cultural Mentor position in all our Aboriginal training posts</td>
</tr>
<tr>
<td>RTP Q</td>
<td>Develop cultural mentor positions</td>
<td>Increase the amount of education/mentoring</td>
</tr>
<tr>
<td>IHTP 2</td>
<td></td>
<td>That they get a personal experience and connection with Aboriginal people and an Aboriginal community.</td>
</tr>
</tbody>
</table>
4. Discussion

4.1. Understanding of cultural education and cultural mentoring, including roles of people engaged in its delivery

The definitions offered within the survey appeared to be familiar to most respondents. However, it was evident that there are variations in the understanding of cultural education and mentoring from GPR/JDs.

A high proportion of GPR/JD respondents reported that they were not familiar with the definitions of cultural education (33 per cent) or mentoring (53 per cent). Given that this survey drew on a non-representative, self-selected sample of people who were interested enough to take the time to complete the survey (and therefore more likely to be informed in the first place), this is of potential concern.

Some GPR/JDs considered the purpose of cultural education and mentoring to be primarily about knowledge or understanding, while others appear to see it from a more reflexive learning perspective. For example, GPR/JD 34 felt that cultural education provided “knowledge about social behaviour, lifestyles, religious and moral; values of a particular culture”, while GPR/JD 9 considered that it “…helps create awareness of how the culture of our patient and our own cultures (in all the many aspects) affect our interaction…“.

For RTPs and GPR/JDs cultural education and mentoring provide a greater understanding of Aboriginal and Torres Strait Islander culture and promote awareness of cultural norms. Respondents considered that education and mentoring deliver different learning experiences, with cultural education providing some preparation for working within Aboriginal and Torres Strait Islander communities, and cultural mentoring supporting the individual as they work within a community.

Several survey respondents described other important facets of CE/CM that should be understood. Instilling an appreciation and respect for different cultural knowledge systems and beliefs, particularly in the context of the Western medical model’s engagement with Aboriginal and Torres Strait Islander people, was considered of particular importance. One CE/CM wrote “hopefully [GPR/JDs] will grasp the concept that although they wear a ‘white coat’ [this] does not necessarily mean they possess more ‘knowledge’ than that of the Aboriginal patient” (CE/CM 11).
Other key themes included:

- the importance of self-awareness and reflexivity in practice, and of understanding the impact of the GPR/JD’s culture;
- the importance of valuing cultural knowledge through acknowledgement that it is the “intellectual property” of communities and individuals;
- the influence of culture on the clinical aspects of the doctor-patient relationship, and the implication this has for integration of clinical and cultural training; and
- the characterisation of mentoring as a dialogue and a two-way exchange; both mentor and mentee can gain from the process.

4.2. Employment of and support for Cultural Educators and Cultural Mentors

All CE/CM respondents agreed that RTPs supported them to participate in cultural networking events, two thirds agreed there were opportunities for professional development and 60 per cent agreed they had a supervisor for support (Figure 3). Responses indicated room for improvement in terms of professional development and supervisory support, indicating that a positive experience of RTP support is not universal. Cultural Educators and CMs were also less positive about the extent to which RTPs looked after their welfare, with only a third agreeing that this was the case (a third disagreed and a third did not know).

Regional Training Provider respondents also offered mixed responses about support offered to CE/CMs compared to CE/CMs themselves. Regional Training Provider responses to questions about improvements to supports for CE/CM roles focused in several cases on adding roles or increasing the (paid) hours allocated (Table 21).

Fewer than half of the Aboriginal or Torres Strait Islander CE/CMs reported employment in a paid role (see section 3.2.2). However, CEs and CMs appear to feel valued in their roles, and nominated a range of reasons for their views (see section 3.2.2). Comments included reference to both tangible supports (including funding professional development, remunerated roles, direct support and feedback in training delivery), as well as less tangible factors, including a sense of being listened to and respected.

Cultural Educators and Mentors also related their own sense of being valued to the way RTPs responded to Aboriginal and Torres Strait Islander issues more broadly (for example, through development of a Reconciliation Action Plan, adoption of Welcome to Country protocols and visible advocacy of Aboriginal and Torres Strait Islander culture to GPR/JDs). This suggests that while personal recognition and support are clearly
factors in feeling valued, organisational respect for Aboriginal and Torres Strait Islander culture and history is also important.

There were a number of themes which emerged from comments provided by CE/CMS on the personal support available to them (Table 19). These include:

- the importance of role clarity, including understanding of the contribution and purpose of cultural; education and mentoring as a complement to medical or clinical training;
- perceived value in access to continuing education/training for CE/CMs;
- interests in both formal and informal networking among CE/CMs but also within the local community; and
- calls for increased number of people doing the work to alleviate or share the burdens associated with the role with other community members.

4.3. Regional Training Provider policies

Five of the seven respondent RTPs indicated that there were formal policies in place to guide cultural education and mentoring programs, and these were generally developed in consultation with local communities or ACCHS. Three of these RTPs also reported that they had employed an Aboriginal or Torres Strait Islander person to assist in development of their policy framework (Table 9).

Cultural education and mentoring appears to be provided by RTPs to all GPRs, but is less consistently available to JDs and medical professionals involved in GP training. The variation may reflect the different operating contexts of different RTPs, or potentially different views regarding the responsibilities of RTPs for wider professional training.

The only RTP which expressly indicated that it did not have a policy framework for cultural education and mentoring was also the only RTP which did not offer cultural education or mentoring to its MEs or GP Supervisors.

4.4. Range of programs offered

The range of program activities provided by RTPs varied. All RTPs reported providing Aboriginal and Torres Strait Islander health workshops or short training events, day visits to an ACCHS or other Aboriginal service and education, from a non-Aboriginal health professional such as a ME or GP Supervisor with experience in
Aboriginal health. While most RTPs mandated GPR participation in short training and workshops, only one RTP mandated participation in a day visit to an ACCHS (Table 10).

On the whole, GPRs were able to access a significantly greater range of programs than were JDs, who tended not to have access to mentoring. Cultural education and mentoring programs are offered early in GPR training, with all RTP respondents indicating that they commenced in either the first or second year. Four also offered it within the PGPPP (Table 12).

The GPR/JD responses appear to indicate that cultural education delivered to GPR/JDs is broadly satisfactory but more could be done to improve the relevance of the programs, particularly in relation to assisting GPRs’ understanding of cultural norms in specific locations. Some GPR/JDs also expressed some frustrations about consistency of access to cultural mentoring, although its value was generally recognised (Table 16).

A quarter of GPR/JD respondents indicated that, overall, their training program had increased their interest in working in Aboriginal and Torres Strait Islander health, although most of these respondents also indicated a pre-existing interest (see 3.2.4). However, twice as many indicated that the training program had made no difference to their level of interest, while the remainder did not know.

High levels of confidence were expressed by CE/CM, RTPs and IHTPs that cultural education and mentoring programs increase GPR/JD interest (see 3.2.4).

4.5. Areas for future program improvement

Perspectives on potential future improvements to cultural education and mentoring programs varied, although there were some themes which appear in GPR/JD responses (see Table 16 and Table 18). These include support for mandating participation in cultural education and mentoring (“it should be compulsory for everyone...” – GPR/JD7), and the corollary implication that there could be increased opportunities for GPR/JDs to participate. This included both increased access to programs and placement generally, but also specifically to CMs (GPR/JD 23).

Some GPR/JDs felt that there was room to improve the integration of theory and practice to make cultural education and mentoring more directly relevant to GPR/JDs. Comments focused on the application of cultural education to General Practice; for example, one GPR/JD commented that a GP should work with CE/CMs to assist them to tailor material to ensure it addressed GPRs’ learning needs as well as the CE/CM’s own teaching goals (GPR/JD 2). The value placed on the ‘practical’ was also evident in GPR/JD 4’s suggestion that training
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 2: Survey Report

should include ‘[m]ore specific examples of Indigenous culture focussing specifically on the things we do wrong, in order to avoid that. If advice could come from Indigenous health workers, that would be ideal...’.

Improving access to in-community training or IHTPs was also a consistent theme with several GPR/JD responses, including one respondent who felt it should be mandatory to complete an Aboriginal health placement during medical school.

Cultural Educators and CMs tended to agree with GPR/JDs on some fronts, including boosting the time granted to cultural education and mentoring; one CE/CM suggested better awareness of RACGP/ACRRM curricula could making training more relevant for GPRs (CE/CM 10). However, CE/CM respondents also provided a broader and more nuanced range of suggestions for future enhancement (see Table 23), including:

- developing strategies to address pre-conceived notions held by some GPR/JDs and the need to increase their engagement in cultural education and mentoring, as “many do not recognise the privileged position they are in and cannot / do not understand the history of Aboriginal disadvantage” (CE/ME 6). One respondent did not want to have to “spend time trying to convince people that Aboriginal people in fact exist, have a history and should not have to be ‘just like us’…” (CE/ME 1);

- increasing the amount of time given to cultural education and mentoring activities, and position this as an ongoing activity (not a once-off);

- devising opportunities that will add ‘depth’ to the experiences of GPR/JDs, including more cultural immersion in place of the “watered down classroom experience” (CE/CM 6). One CE/CMs suggested allowing time to visit significant sites (CE/CM 5);

- increasing accountability through mandating (and assessing) cultural training, and ensuring GPR/JDs “take the placements seriously... and not just look at them as one more thing to be done...” (CE/ME 4);

- providing CE/CMs with more training to improve the alignment between what they deliver and the training curricula. One CE/CM indicated that they were “not even sure whether all CEs are even aware [the RACGP/ACRRM standards] exist and this is what GPRs are likely to be examined against...” (CE/CM 10);

- increasing centralised training provided to AHWs in cultural education, mentoring or supporting roles, noting the reciprocal benefits of developing relationships between these workers and GP Supervisor; and
• ensuring that cultural education is regionally and locally relevant.

Regional Training Providers provided relatively less information about their views on future program improvements, but did agree with GPR/JDs and CE/CMs in relation to increasing access to cultural education and mentoring. The mechanisms for achieving this suggested by RTPs included engagement of CE/CM(s) in each IHTP. One RTP noted that the relationship with the CE/CMs in their region was held primarily by the ACCHS at which they were employed, and indicated an interest in developing a direct relationship.

4.6. Survey limitations

This report is subject to a number of important limitations. In particular, the low response rate to the surveys limits the extent to which strong inferences can be made from results, and particularly the quantitative aspects of the survey. The low response rate also means that the survey is not likely to be representative, and a number of features of the recruitment strategy (including promotion through special interest networks) and the lengthy nature of the survey are likely to have resulted in self-selection by respondents with a specific interest in Aboriginal and Torres Strait Islander health. The low response rate of the GPR/JD survey in particular was probably influenced by the presence of several other surveys in the field at the same time.

A substantial number of incomplete surveys have also been included in the analysis (in particular, eight from GPR/JDs), and this means that the pool of respondents for questions appearing later in the GPR/JD survey may represent a different group (potentially those with higher levels of interest).

Finally, the number of responses associated with each of the RTPs across all surveys were generally low (0 to 4 responses), while two RTPs attracted higher response rates (16 and 7). The two RTPs with higher response rates made up more than half of responses for which an RTP was identified and indicates that the data is not representative across RTPs. Data (particularly from GPR/JD surveys) is likely to be skewed toward the two RTPs with stronger response rates.

The limitations are most profound with respect to quantitative data. This report has focused on reporting significant detail from the qualitative aspects of the survey.
5. Conclusions

The conclusions that can be drawn from this survey are constrained by the survey’s significant limitations outlined in section 4.6, particularly its low response rate and the high likelihood that it draws on an unrepresentative sample. However, there are a number of interesting observations which may be made, particularly where there is a very high level of concordance across survey responses and where qualitative responses provide additional depth and insight.

Respondents other than GPR/Js report high levels of concordance between the formal definition and their own understandings of cultural education and mentoring. Respondents offering additional comments about cultural education and mentoring demonstrate an understanding of the importance it can play in overcoming cultural barriers to effective care.

A majority of CEs and CMs respondents feel supported and valued by their RTP, although responses were mixed. In particular, only one agreed that RTPs looked after their welfare (a third did not know and one third disagreed). Key factors which lead to CE/CMs feeling valued include tangible personal support and organisational practices that are respectful of Aboriginal and Torres Strait Islander culture. Improvements suggested to the support offered to CE/CMs included greater role clarity, provision of training and networking opportunities, increasing resources and CE/CMs being able to share the load with other community members.

Most RTPs had a formal policy in place to support cultural education and mentoring, although how this was implemented varied. The only RTP not to have a policy in place was also the only RTP not to report offering any cultural education or mentoring to its ME or GP Supervisors.

All RTPs offered cultural education in the form of short training and workshop opportunities for day visits to ACCHSs and longer IHTP placements. Short trips and day visits to Indigenous communities were delivered in some IHTPs. Fifty-seven per cent offered cultural mentoring. Different combinations of training modules were delivered depending on the intended audience, with GPRs more likely to receive cultural education/mentoring programs than JDs.

When asked to comment on the impact of cultural education and mentoring programs, CE/CM, RTP and IHTP respondents were very positive about the impacts of cultural education and mentoring on health outcomes, health service access and health service quality for Aboriginal and Torres Strait Islander people. They also felt strongly that such programs would influence GPR/Js to work in Aboriginal and Torres Strait Islander health.
One quarter of GPR/JD respondents indicated that their training program had increased their interest in working in Aboriginal and Torres Strait Islander health, while half indicated that it had made no difference.

When asked how the program could be improved, GPR/JDs focused on increasing the availability of training and placements in Aboriginal and Torres Strait Islander health, and better integrating cultural education and mentoring with clinical training. Cultural Educators and CMs offered a broader range of areas for improvement, including tackling pre-conceptions held by some GPR/JDs, adding time and depth to cultural education and mentoring, boosting GPR/JD accountability, supporting regional training to engage more AHWs in cultural education and mentoring and ensuring training was tailored to the local community context.
6. Appendix A: Cultural Educator/Cultural Mentor Survey

INVITATION: RESEARCH INTO CULTURAL EDUCATION AND CULTURAL MENTORING

Dear Cultural Educator or Mentor,

General Practice Education and Training Limited (GPET) has commissioned the University of Western Sydney to conduct research into cultural education and cultural mentoring. This study aims to gain a better understanding of Aboriginal and Torres Strait Islander cultural education and mentoring.

A key component of this study involves a survey for CEs and CMs throughout the country. It also involves consultations with other stakeholders and clients, such as GPRs, Regional Training Providers (RTPs), the National Aboriginal Community Controlled Health Organisation (NACCHO), the Royal Australian College of General Practitioners (RACGP), and the Australian College of Rural and Remote Medicine (ACRRM).

We are very interested in your experiences as a cultural educator and/or mentor. We recognise that the work that you do may not exactly fit some of the questions in this form, so please feel free to use the open-text boxes to add any comments or thoughts you may have, even if they don’t directly fit the question. Your views will be very helpful.

Your feedback is greatly appreciated, and will allow the researchers to provide recommendations to GPET on how cultural education and cultural mentoring might be strengthened. Our report will also suggest principles to inform a framework for cultural education and cultural mentoring for GP training.

When can I participate?

You can fill in the survey from the time of receiving this invitation up till 5th August 2013. After this date, the survey will be closed. The survey will take no longer than 10 minutes of your time.

If you would prefer to have a conversation with a researcher rather than fill in this form, please contact Dr Ruth Morgan on 02 4620 3933.

We will be conducting a limited interview consultation later in the year. If you would like to be interviewed by the evaluation team, you can provide your details at the end of the survey.

Your consent

By completing this survey, you are giving your consent that your information can be used for this study. Your participation is completely confidential. While we are interested in knowing a little about you and the RTP you work with, we will not share any of that information publically in a way that identifies you. We will receive and analyse your response but will not report any data that identifies you or your RTP.
How to complete and return this survey

There are three ways you can complete this survey. These options are explained below.

To complete this survey in Microsoft Word:

- Once you open the attached document, save it to your desktop (or somewhere else easy to find)
- You can ‘tick’ the boxes by clicking in them, and type your comments in the boxes provided.
- After completing the survey, please email the document back to: J.Reath@uws.edu.au

To complete this survey on paper:
If you prefer to complete the survey on paper, please post it to Professor Jenny Reath, Peter Brennan Chair of General Practice, University of Western Sydney, Locked Bag 1797, Penrith NSW 2751.

To complete this survey by phone:
If you prefer to complete this survey by phone, please contact Dr Ruth Morgan on 02 4620 3933.

Who to contact for questions

This study has been approved by the following Human Research Ethics Committees:

<table>
<thead>
<tr>
<th>Human Research Ethics Committee of the University of Western Sydney</th>
<th>UWS Ethics Officer: Tel- 02 4736 0229</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health &amp; Medical Research Council Ethics Committee</td>
<td>The Secretariat: Tel- 02 9212 4777</td>
</tr>
<tr>
<td>Central Australia Human Research Ethics Committee</td>
<td>The Secretariat: Tel- 08 8951 4700</td>
</tr>
<tr>
<td>Aboriginal Health Research Ethics Committee</td>
<td>Senior Research &amp; Ethics Officer: Tel- 08 8273 7200</td>
</tr>
<tr>
<td>Western Australian Aboriginal Health Ethics Committee</td>
<td>Email: <a href="mailto:ethics@ahcwa.org">ethics@ahcwa.org</a></td>
</tr>
<tr>
<td>Human Research Ethics Committee of the NT Department of Health and the Menzies School of Health Research</td>
<td>Ethics Administration Officer: Tel- 08 8922 7922</td>
</tr>
</tbody>
</table>

If you have any concerns or complaints regarding the way this research has been conducted, you can reach the relevant Ethics Committee using the above contact details.

If you would like further information, please contact Dr Ruth Morgan on 02 4620 3933 or Professor Jenny Reath on 02 4620 3725.

Thank you very much!
YOUR CONSENT

I have read the information provided to me and I hereby give my consent to participate in this survey:

☐ 1: Yes

☐ 2: No

A: CONTEXT OF THE CULTURAL EDUCATOR AND CULTURAL MENTOR

A1 Please tell us a little bit about yourself. Are you a: (please select one)

☐ 1: Cultural educator

☐ 2: Cultural mentor

☐ 3: Both

☐ 4: Other role in cultural education, please describe:

☐ 5: None of the above \text{\textbf{\textit{If this is the case, there is no need for you to complete this survey}}}

A2 How long have you been working in this role? (please select one)

☐ 1: 0-1 year

☐ 2: 1-5 years

☐ 3: 6-10 years

☐ 4: Longer than 10 years

A3 How would you describe your current role? (For instance, please tell us a little about what you do, what you hope to achieve and/or how you organise your work)
A4  For which audience(s) do you provide cultural education and/or cultural mentoring? *(Please tick as many as apply)*

- [ ] 1 GP Registrars
- [ ] 2 JDs (hospital doctors in training in General Practice surgeries or ACCHSs)
- [ ] 3 Medical educators
- [ ] 4 Medical supervisors
- [ ] 5 GP Supervisor
- [ ] 6 Other, please specify:

A5  In what ways do you work or link up with other Cultural Educators and/or Cultural Mentors? *(Please tick as many as apply)*

- [ ] 1 I am a member of a network for Cultural Educators and/or mentors *(please go to B1)*
- [ ] 2 I meet regularly with other Cultural Educators and/or mentors in my local area *(please go to B1)*
- [ ] 3 I keep in touch with other Cultural Educators and/or mentors by phone or email or via other communication sources *(please go to B1)*
- [ ] 4 Other, please specify: *(please go to B1)*
- [ ] 5 I do not work or link up with other Cultural Educators and/or Cultural Mentors *(please go to A6)*

A6  You answered you do not work or link up with other Cultural Educators/mentors. What is the main reason for this? *(please select one)*

- [ ] 1 I do not know how to do this
- [ ] 2 I do not have time to do this
- [ ] 3 My work makes it difficult for me to organise this (e.g. absence of computer, remoteness of location, too busy)
- [ ] 4 I have never thought of the possibility of linking up with other Cultural Educators/mentors
- [ ] 5 I don’t need/wish to link up with other Cultural Educators/mentors
- [ ] 6 Something else, please specify:
B: CULTURAL EDUCATION

B1 The following questions are about cultural education. Please read the description of cultural education as provided by the Australian General Practice Training (AGPT) Program in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health:

| Cultural education | addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health. |

B2 To what extent is the description similar to your own thoughts about cultural education? (please select one)

Please note cultural mentoring is discussed separately in section C

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Very similar</td>
</tr>
<tr>
<td>2</td>
<td>Fairly similar</td>
</tr>
<tr>
<td>3</td>
<td>Not very similar</td>
</tr>
<tr>
<td>4</td>
<td>Not at all similar</td>
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</tbody>
</table>

B3 If your ideas about cultural education are different, can you describe your own view? (Please feel free to add your own descriptions or key words here)

C: CULTURAL MENTORING

C1 The following questions are about cultural mentoring. Please read the description of cultural mentoring as provided by the AGPT in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health:

| Cultural mentoring | refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres |

50
Strait Islander community’s need for culturally safe General Practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

C2 To what extent is the description similar to your own description of cultural mentoring? *(please select one)*

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<tbody>
<tr>
<td>1</td>
<td>Very similar</td>
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<td>2</td>
<td>Fairly similar</td>
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<tr>
<td>3</td>
<td>Not very similar</td>
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<tr>
<td>4</td>
<td>Not at all similar</td>
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</table>

C3 If your ideas about cultural mentoring differ from the description, how would you describe it? *(Please feel free to add your own descriptions or key words here)*

D: CULTURAL EDUCATION AND MENTORING PROGRAM

The following questions are about cultural education and mentoring programs that Cultural Educators and mentors can provide to GP Registrars and JDs.

D1 The list below shows different programs of cultural education and mentoring. Please select all programs you provide to GP Registrars and JDs. *(Please tick as many as apply)*

<table>
<thead>
<tr>
<th>Services I provide to GP Registrars</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Education about Aboriginal and Torres Strait Islander health as part of a workshop outside an ACCHS (eg with a university, RTP or Medicare Local)</td>
<td>□1</td>
</tr>
<tr>
<td>Cultural training events / workshops at an ACCHS</td>
<td>□2</td>
</tr>
<tr>
<td>Cultural mentoring support during placements in an Aboriginal training post</td>
<td>□3</td>
</tr>
</tbody>
</table>
Day visits to Aboriginal Community Controlled Health Service (ACCHS) and other facilities (e.g. Aboriginal community child care) □ 4
Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there □ 5
Other cultural/mentoring services to GP Registrars, please specify: □ 6

D2 Which of the statements best describes how your main RTP delivers cultural education and mentoring? *(Note: if you don’t work for an RTP please go to question E1)*

*I feel that the RTP I work for...*(please select one):

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</thead>
<tbody>
<tr>
<td>□ 1</td>
<td>Includes cultural education and mentoring programs into all its training</td>
</tr>
<tr>
<td>□ 2</td>
<td>Treats cultural education and mentoring programs as separate/stand-alone training</td>
</tr>
<tr>
<td>□ 3</td>
<td>Don’t know/not sure</td>
</tr>
</tbody>
</table>

D3 To what extent does your RTP value the role of the cultural educator and mentor?

*I feel that in my RTP the role of the cultural educator and mentor is ...:* *(please select one)*

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>□ 1</td>
<td>Fully valued</td>
</tr>
<tr>
<td>□ 2</td>
<td>Fairly valued</td>
</tr>
<tr>
<td>□ 3</td>
<td>Not very valued</td>
</tr>
<tr>
<td>□ 4</td>
<td>Not valued at all</td>
</tr>
<tr>
<td>□ 5</td>
<td>Don’t know/not sure</td>
</tr>
</tbody>
</table>

D4 What makes you feel this way? Please provide any comments you would like to add in the box below.
D5  How much do you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t know/not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My RTP provides me with professional development opportunities</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. My RTP looks after my welfare</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. My RTP provides me with a supervisor to support/guide me in my work</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. My RTP supports me to attend cultural training network events</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. My RTP involves me in the planning of the cultural education program</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. My RTP involves me in the delivery of the cultural education program</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. My RTP involves me in evaluating the cultural education program</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

E: IMPACT OF CULTURAL EDUCATION AND MENTORING

The following questions are about the impact of cultural education and mentoring.

E1  How much do you agree or disagree with the following statements about cultural education and mentoring?

*Cultural education and mentoring...*:

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t know/not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. increase the interest of GP Registrars in Aboriginal and Torres Strait Islander health</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. improve the quality of health services provided to Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. improve the access to health services available to Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
4. Improve health outcomes of Aboriginal and Torres Strait Islander people in your part of Australia

E2 Overall, how well does your main RTP prepare GP Registrars for working with Aboriginal and Torres Strait Islander people? *(please select one)*

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very well</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Fairly well</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not very well</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Not very well at all</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Not sure, can’t say</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I don’t work for an RTP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F: TRAINING AND QUALIFICATIONS

The following questions are about your training and qualifications in cultural education and mentoring.

F1 Which of the following statements describes you best?

*To become a cultural educator or mentor, I...*(please select one):

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Undertook formal education/training in Aboriginal and Torres Strait Islander cultural education and mentoring (e.g. a formal training course with a certificate)</td>
</tr>
<tr>
<td>2</td>
<td>Have learnt on the job, without formal training or education</td>
</tr>
<tr>
<td>3</td>
<td>Other, please specify:</td>
</tr>
</tbody>
</table>

F2 How do you keep learning about Aboriginal and Torres Strait Islander cultural education and mentoring? *(Please tick as many as apply).*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I attend cultural training network events</td>
</tr>
<tr>
<td>2</td>
<td>I attend local cultural training events</td>
</tr>
<tr>
<td>3</td>
<td>I attend formal cultural training courses (e.g. Binan Goonj)</td>
</tr>
<tr>
<td>4</td>
<td>I attend courses through university or college</td>
</tr>
<tr>
<td>5</td>
<td>I learn myself through experience</td>
</tr>
<tr>
<td>6</td>
<td>I learn through my connections with community</td>
</tr>
<tr>
<td>7</td>
<td>I learn from my elders</td>
</tr>
<tr>
<td>8</td>
<td>Other, please specify:</td>
</tr>
<tr>
<td>9</td>
<td>None of the above</td>
</tr>
</tbody>
</table>
G: EMPLOYMENT (ONLY FOR THOSE WHO WORK FOR AN RTP)

If you don’t work for an RTP, please go to section H.

The following questions are about how Cultural Educators and mentors are employed by RTPs. If you work for more than one RTP, please think of the RTP you work for most often, when answering the questions.

G1 Which of the following statements describes you best? *(please select one)*

- ☐ 1 I am in an **unpaid** position as a cultural educator and/or mentor (voluntarily)
- ☐ 2 I am in a **paid** position as a cultural educator and/or mentor

G2 Do you have a: *(please select one)*

- ☐ 1 Full time position *(please go to G4)*
- ☐ 2 Part time position

G3 If you work part time, please indicate how many days a week you work as a cultural educator/mentor. *(please select one)*

- ☐ 1 0-1 day a week
- ☐ 2 2-3 days a week
- ☐ 3 4-5 days a week

G4 Which of the following statements applies to your employment contract as a cultural educator and/or mentor? *(please select one)*

- ☐ 1 My employment status is based on an open contract (ongoing status) *(please go to G6)*
- ☐ 2 My employment status is based on a time limited contract *(please go to G5)*
- ☐ 3 Other, please specify: *(please go to G6)*
- ☐ 4 I don’t know/not sure *(please go to G6)*

G5 If you answered that your contract has a time limit, please indicate the time limit of your **current** contract. If you are not working at the moment, please indicate the time limit of your last received contract.

*My contract is limited to: *(please select one)*
G6 If you are employed as a cultural educator or cultural mentor, which of the following statements applies to the wage you receive? *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My wage is based on a fixed salary</td>
</tr>
<tr>
<td>2</td>
<td>My wage is based on an hourly rate, depending on the amount of hours I work within a specific time frame</td>
</tr>
<tr>
<td>3</td>
<td>Something else, <em>please specify:</em></td>
</tr>
<tr>
<td>4</td>
<td>I don’t know/not sure</td>
</tr>
</tbody>
</table>

G7 How satisfied or unsatisfied are you about your current wage as an educator and/or mentor? If you are not working at the moment, please indicate how satisfied or unsatisfied you were about your last received wage as a cultural educator and/or mentor. *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very satisfied</td>
</tr>
<tr>
<td>2</td>
<td>Fairly satisfied</td>
</tr>
<tr>
<td>3</td>
<td>Fairly unsatisfied</td>
</tr>
<tr>
<td>4</td>
<td>Very unsatisfied</td>
</tr>
</tbody>
</table>

H: THE FUTURE

The following questions are about changes or improvements you wish to see in cultural education and mentoring.

H1 Overall, what kind of support could improve your role as a cultural educator and/or mentor? Why? Who can give you that support?
H2 Overall, if you could change one thing about providing cultural education and/or mentoring for GP Registrars, what would that be? Why?
I: A LITTLE MORE ABOUT YOU

This last section contains a few last questions about the RTP(s) you work for and about yourself.

I1 For which RTPs do you work at the moment? *(please tick as many as apply to you)*

- [ ] 1. Adelaide to Outback GP Training Program
- [ ] 2. Bogong Regional Training Network
- [ ] 3. Beyond Medical Education
- [ ] 4. Central and Southern Queensland Training Consortium
- [ ] 5. CoastCityCountry General Practice Training
- [ ] 6. General Practice (GP) Synergy
- [ ] 7. General Practice (GP) Training Tasmania
- [ ] 8. General Practice (GP) Training Valley to Coast
- [ ] 9. North Coast General Practice (GP) Training
- [ ] 10. Northern Territory General Practice (GP) Education
- [ ] 11. Southern General Practice (GP) Training
- [ ] 12. Sturt Fleurieu
- [ ] 13. Tropical Medical Training
- [ ] 14. Queensland Rural Medical Education
- [ ] 15. Victorian Metropolitan Alliance (VMA) GP Training
- [ ] 16. Western Australia General Practice Education and Training (WAGPET)
- [ ] 17. WentWest

I2 If you work for more than one RTP, which RTP do you consider as your main RTP? *(please select one)*

- [ ] 1. Adelaide to Outback GP Training Program
- [ ] 2. Bogong Regional Training Network
- [ ] 3. Beyond Medical Education
- [ ] 4. Central and Southern Queensland Training Consortium
- [ ] 5. CoastCityCountry General Practice Training
- [ ] 6. General Practice (GP) Synergy
- [ ] 7. General Practice (GP) Training Tasmania
- [ ] 8. General Practice (GP) Training Valley to Coast
- [ ] 9. North Coast General Practice (GP) Training
- [ ] 10. Northern Territory General Practice (GP) Education
- [ ] 11. Southern General Practice (GP) Training
- [ ] 12. Sturt Fleurieu
- [ ] 13. Tropical Medical Training
- [ ] 14. Queensland Rural Medical Education
- [ ] 15. Victorian Metropolitan Alliance (VMA) GP Training
13 Are you... (please select one)

- [ ] 1 Male
- [ ] 2 Female

14 Are you... (please select one)

- [ ] 1 18-24 years
- [ ] 2 25-34 years
- [ ] 3 35-44 years
- [ ] 4 45-54 years
- [ ] 5 55+ years
- [ ] 6 Prefer not to say

15 Are you... (please select one)

- [ ] 1 Aboriginal
- [ ] 2 Torres Strait Islander
- [ ] 3 Both
- [ ] 4 Neither

16 What is the highest level of education you have completed? (please select one)

- [ ] 1 No formal schooling
- [ ] 2 Primary school
- [ ] 3 Some secondary school
- [ ] 4 Completed secondary school (HSC, Leaving Certificate, etc.)
- [ ] 5 Trade or technical qualification (e.g. TAFE)
- [ ] 6 Undergraduate university diploma/degree or equivalent
- [ ] 7 Postgraduate university diploma/degree or equivalent
J: FOLLOW-UP INTERVIEW

Thank you very much for completing this questionnaire. We really appreciate your feedback.

We will be talking with people later in the year to explore these questions further. If you would be interested in taking part in an interview, please fill in your contact details below, and we may contact you before September 2013 to speak with you about your experiences.

1  ☐ Yes (please provide details below)

2  ☐ No

Name/s: ______

Daytime phone number/s: ______

Email: ______

Preferred day/s, time/s etc: ______
EMAIL INVITATION

Subject: Cultural Education and Mentoring for AGPT GP Registrars and PGPPP Junior Doctors—10 minutes max

Body:

Please click here to do a short online survey about Cultural Education and Mentoring for Australian General Practice Training (AGPT) Registrars.

The survey is for:
* all current Registrars (GPT Year 1 and above)
* former Registrars who finished the AGPT program after January 2010
* all current Junior Doctors.

General Practice Education and Training Limited (GPET) has commissioned the University of Western Sydney to conduct research into cultural education and cultural mentoring. This study aims to gain a better understanding of Aboriginal and Torres Strait Islander cultural education and mentoring.

A key component of this study involves a survey for all GP Registrars and Junior Doctors throughout the country. It also involves consultations with other stakeholders and clients, such as Cultural Educators and Cultural Mentors, and Regional Training Providers (RTPs).

Your feedback is greatly appreciated, and will allow the researchers to provide informed recommendations to GPET on principles to inform future development of cultural education and cultural mentoring.

Click here for more information about GPET.

When can I participate?

You can fill in the survey from the time of receiving this invitation up till 5th August 2013. After this date, the survey will be closed. The survey will take no longer than 10 minutes of your time.

We will be conducting a limited interview consultation later in the year. If you would like to be interviewed by the evaluation team, you can provide your details at the end of the survey.

Your consent

By completing this survey, you are giving your consent that your information can be used for this study. Your participation is completely confidential; your response will be received and analysed by the University of Western Sydney. You will not be identified in the report, only aggregated results will be published.
Who to contact for questions

This study has been approved by the following Human Research Ethics Committees:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Research Ethics Committee of the University of Western Sydney</td>
<td>UWS Ethics Officer:</td>
</tr>
<tr>
<td></td>
<td>Tel: 61 2 4736 0229</td>
</tr>
<tr>
<td>Aboriginal Health &amp; Medical Research Council Ethics Committee</td>
<td>The Secretariat:</td>
</tr>
<tr>
<td></td>
<td>Tel: 61 2 9212 4777</td>
</tr>
<tr>
<td>Central Australia Human Research Ethics Committee</td>
<td>The Secretariat:</td>
</tr>
<tr>
<td></td>
<td>Tel: 61 8 8951 4700</td>
</tr>
<tr>
<td>Aboriginal Health Research Ethics Committee</td>
<td>Senior Research &amp; Ethics Officer:</td>
</tr>
<tr>
<td></td>
<td>Tel: 61 8 8273 7200</td>
</tr>
<tr>
<td>Western Australian Aboriginal Health Ethics Committee</td>
<td>Email: <a href="mailto:ethics@ahcwa.org">ethics@ahcwa.org</a></td>
</tr>
<tr>
<td>Human Research Ethics Committee of the NT Department of Health and the</td>
<td>Ethics Administration Officer:</td>
</tr>
<tr>
<td>Menzies School of Health Research</td>
<td>Tel: 61 8 8922 7922</td>
</tr>
</tbody>
</table>

If you have any concerns or complaints regarding the way this research has been conducted, you can reach the relevant Ethics Committee using the above contact details.

If you would like further information, please contact Dr Ruth Morgan on 02 4620 3933 or Professor Jenny Reath on 02 4620 3725.

Thank you very much!

BACKGROUND INFORMATION ABOUT GPET (showed on separate webpage):

About General Practice Education and Training (GPET)

GPET looks after the training programs health professionals and students receive to meet the primary health care of all Australians. Education in Aboriginal and Torres Strait Islander health is a key aspect of the training program. GPET has established some guidelines to how people are trained in Aboriginal and Torres Strait Islander health.

In 2004, GPET’s Framework for General Practice Training in Aboriginal and Torres Strait Islander Health was developed. This Framework has resulted in the development of the GPET’s Guide to General Practice Training in Aboriginal and Torres Strait Islander Health. The Guide represents GPET’s regional contribution to the Council of Australian Government’s (COAG’s) initiative to close the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and other Australians.

The Guide has been developed for RTPs, the Aboriginal Community Controlled Health Services (ACCHSs) sector and other Aboriginal and Torres Strait Islander Health Training Posts. Its purpose is to provide these key stakeholders with consistent principles as a national framework for the regional delivery of culturally-safe General Practice training in Aboriginal and Torres Strait Islander health.
YOUR CONSENT

I have read the information provided to me and I give hereby my consent to participate in this survey:

☐ 1  Yes
☐ 2  No

A: PRELIMINARY QUESTIONS

A1  Which of the following statements describes you best? (Select one)

☐ 1  I am currently enrolled in the Prevocational General Practice Placements Program (PGPPP) → Q4
☐ 2  I am currently undertaking the AGPT program → Q3
☐ 3  I finished the AGPT program between 2010-2012 → Q4
☐ 4  None of the above → A2: exit survey

If A1, code 4:

A2  This survey is only for people who are currently enrolled in the Prevocational General Practice Placements Program (PGPPP) or the AGPT program, or who completed the AGPT program between 2010-2012. → EXIT SURVEY

If A1, code 2:

A3  What stage of your training are you currently in? (select one)

☐ 1  GPT Year 1
☐ 2  GPT Year 2
☐ 3  GPT Year 3
☐ 4  GPT Year 4

If A1, code 1-3:

A4  Which pathway of training did you undertake / are you currently undertaking? (select one)

☐ 1  General training pathway
☐ 2  Rural training pathway
☐ 3  I haven’t decided yet which pathway to undertake
B: CULTURAL EDUCATION

B1  The following questions are about cultural education. Cultural mentoring is considered in the next question. Please read the description of cultural education as provided by the AGPT in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health:

**Cultural education** addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health.

B2  How familiar or unfamiliar are you with the description of cultural education? *(select one)*

- □1 Very familiar
- □2 Fairly familiar
- □3 Not very familiar
- □4 Not at all familiar

B3  To what extent is the description similar to your own description of cultural education? *(select one)*

- □1 Very similar
- □2 Fairly similar
- □3 Not very similar
- □4 Not at all similar

B4  If your ideas about cultural education differ from the description, how would you describe it?

B5  How relevant or irrelevant do you consider cultural education for your training as a registrar or Junior doctor? *(select one)*
C: CULTURAL MENTORING

C1 The following questions are about cultural mentoring. Please read the description of cultural mentoring as provided by the AGPT in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health:

**Cultural mentoring** refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe General Practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

C2 How familiar or unfamiliar are you with the description of cultural mentoring? *(select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very familiar</td>
</tr>
<tr>
<td>2</td>
<td>Fairly familiar</td>
</tr>
<tr>
<td>3</td>
<td>Not very familiar</td>
</tr>
<tr>
<td>4</td>
<td>Not at all familiar</td>
</tr>
</tbody>
</table>

C3 To what extent is the description similar to how you would describe cultural mentoring? *(select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very similar</td>
</tr>
<tr>
<td>2</td>
<td>Fairly similar</td>
</tr>
<tr>
<td>3</td>
<td>Not very similar</td>
</tr>
<tr>
<td>4</td>
<td>Not at all similar</td>
</tr>
</tbody>
</table>

C4 If your ideas about cultural mentoring differ from the description, how would you describe it?
C5 How relevant or irrelevant do you consider cultural mentoring for your training as a registrar or Junior doctor? (select one)

- [ ] 1. Very relevant
- [ ] 2. Fairly relevant
- [ ] 3. Not very relevant
- [ ] 4. Irrelevant

D: CULTURAL EDUCATION AND MENTORING PROGRAMS

The following questions are about cultural education and mentoring programs that can be provided to registrars and Junior Doctors during their training.

If A1, code 3 and 4 (only registrars):

D1 From which year during your training is/was participation in cultural education and mentoring programs possible? (multiple)

- [ ] 1. From GPT Year 1
- [ ] 2. From GPT Year 2
- [ ] 3. From GPT Year 3
- [ ] 4. From GPT Year 4
- [ ] - Don’t know/not sure

TO ALL

D2 The list below shows different cultural education and mentoring programs. Please select all programs you are currently receiving (or received) or you will receive over the next period. (multiple)

<table>
<thead>
<tr>
<th>General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training</th>
<th>I’m receiving (or have received) the following programs</th>
<th>I expect to receive the following programs in the future</th>
</tr>
</thead>
<tbody>
<tr>
<td>□1</td>
<td>□8</td>
<td></td>
</tr>
</tbody>
</table>
# Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity

## Appendix 2: Survey Report

### I’m receiving (or have received) the following programs

<table>
<thead>
<tr>
<th>Program</th>
<th>I’m receiving (or have received)</th>
<th>I expect to receive the following programs in the future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (e.g. GP supervisor, Medical Educator) with experience in this field</td>
<td>□2</td>
<td>□9</td>
</tr>
<tr>
<td>Mentoring from an Aboriginal and Torres Strait Islander cultural mentor</td>
<td>□3</td>
<td>□10</td>
</tr>
<tr>
<td>Day visits to an Aboriginal Community Controlled Health Service (ACCHS) and other facilities (e.g. Aboriginal community child care)</td>
<td>□4</td>
<td>□11</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>□5</td>
<td>□12</td>
</tr>
<tr>
<td>Extended (6 months or more) experience in a Training post(s) at an Aboriginal Community Controlled Health Service (ACCHS) or another Indigenous Health Service</td>
<td>□6</td>
<td>□13</td>
</tr>
<tr>
<td>Other Aboriginal and Torres Strait Islander health training opportunities</td>
<td>□7</td>
<td>□14</td>
</tr>
</tbody>
</table>

*Please specify:* □7  

None of the above □15 → continue with D3  

Don’t know /not sure □16 → continue with D3

---

**If D2, code 15:**

**D3** You indicated you did/will not participate in any of the cultural education and mentoring programs. Which of the following answers applies to you? *(select one)*

- [ ] □1 The programs are/were not relevant for my training
- [ ] □2 I have/had the intention to participate in a cultural program but I am/was unable to arrange this
- [ ] □3 I am/was not aware of the availability of participating in cultural programs
- [ ] □4 Other reasons, *Please specify:*

---

**If code D2, code 1-14 (show only given answers of question D2):**

**D3** You indicated you are receiving (or received) the cultural education and/or mentoring programs as listed below. Please select each program that is/was mandatory to participate in as part of your training.

<table>
<thead>
<tr>
<th>Program</th>
<th>My participation is/was mandatory</th>
</tr>
</thead>
</table>

---

67
My participation is/was mandatory

| General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training | □1 |
| Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (eg GP supervisor, Medical Educator) with experience in this field | □2 |
| Mentoring from an Aboriginal and Torres Strait Islander cultural mentor | □3 |
| Day visits to Aboriginal Community Controlled Health Service (ACCHS) and other facilities (e.g. Aboriginal community child care) | □4 |
| Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there | □5 |
| Extended (6 months or more) experience in a training post(s) at an Aboriginal Community Controlled Health Service (ACCHS) or another Indigenous Health Service | □6 |
| Extended (6 months or more) experience in another training post(s) with an Aboriginal and Torres Strait Islander focus | □7 |
| Other Aboriginal and Torres Strait Islander health training opportunities | □8 |

**TO ALL:**

**D4**  Which of the statements best describes how your Regional Training Provider delivers/delivered cultural education and mentoring? *(select one)*

*I feel that my Regional Training Provider...:*

| □1 | Integrates/integrated cultural education and mentoring programs into general workshops and practice experiences |
| □2 | Treats/treated cultural education and mentoring programs as a discrete/stand-alone unit of work |
| □3 | Both |
| □4 | Not applicable, I do/did not receive cultural education and mentoring |
| □5 | Don’t know/not sure |

**D5**  The following questions are about cultural mentoring support. If you are/were receiving cultural mentoring support, with how many Cultural Mentors do/did you work during your training?

| □1 | 1 |
| □2 | 2 |
| □3 | 3 |
| □4 | More than 3, please specify: |
| □5 | I will work with a cultural mentor over the next period |
| □6 | I do not /did not work with a cultural mentor |
If code D5, code 1-4:

D6 Which of the following statements describe the type of contact you have or had with your cultural mentor(s)? You can choose more than one answer.

**My cultural mentor...: (multiple)**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>is/was available for advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>provides/provided me with personal support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>provides/provided me with supervision about cultural matters that impact on patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>assists/assisted me in the communication with the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>assists/assisted me during my consultations with patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Something else, please specify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Don’t know/not sure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I do not /did not work with a cultural mentor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If code D5, code 1-4:

D7 To which extent do you agree or disagree with the following statements about your cultural mentor(s)? **(single)**

**My cultural mentor...:**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
<td>Don’t know/not sure</td>
</tr>
<tr>
<td>1. gives/gave me the support I need</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. improves/improved my understanding of Aboriginal and Torres Strait Islander health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. improves/improved my ability to work as a GP in an Aboriginal and Torres Strait Islander health setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If code D2, code 1-7 (=those who are currently receiving or received support in the past):

D8 When you think about the cultural education and/or mentoring programs you received so far, to what extent can you give feedback to the provider about the program?

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am/was required to give feedback to the provider about the cultural program</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### If code D2, code 1-7 (=those who are currently receiving or received support in the past):

**D7** Overall, how satisfied or unsatisfied are you about the cultural education/mentoring programs you received so far?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very satisfied</td>
</tr>
<tr>
<td>2</td>
<td>Fairly satisfied</td>
</tr>
<tr>
<td>3</td>
<td>Fairly unsatisfied</td>
</tr>
<tr>
<td>4</td>
<td>Very unsatisfied</td>
</tr>
<tr>
<td>5</td>
<td>Do not know/not sure</td>
</tr>
</tbody>
</table>

### TO ALL

**D8** Please feel free to add any comments about your experiences with cultural education and mentoring programs.
E: IMPACT OF CULTURAL EDUCATION AND MENTORING

E1 The following questions are about the impact of cultural education and mentoring.

When you started your training program, how interested were you in... *(select one)*

<table>
<thead>
<tr>
<th></th>
<th>Not at all interested</th>
<th>Not very interested</th>
<th>Fairly interested</th>
<th>Very interested</th>
<th>Don't know/ not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. pursuing Aboriginal and Torres Strait Islander training opportunities</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>2. working in Aboriginal and Torres Strait Islander health</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

E2 Overall, did your training program make you... *(select one)*

<table>
<thead>
<tr>
<th></th>
<th>more interested in working in Aboriginal and Torres Strait Islander health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>□ 1</td>
</tr>
<tr>
<td>2</td>
<td>□ 2</td>
</tr>
<tr>
<td>3</td>
<td>□ 3</td>
</tr>
<tr>
<td>4</td>
<td>□ 4</td>
</tr>
</tbody>
</table>

E3 Overall, how well prepared do/did you feel after the cultural education/mentoring you received from your training provider to work with Aboriginal and Torres Strait Islander people?

<table>
<thead>
<tr>
<th></th>
<th>Very well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>□ 1</td>
</tr>
<tr>
<td>2</td>
<td>□ 2</td>
</tr>
<tr>
<td>3</td>
<td>□ 3</td>
</tr>
<tr>
<td>4</td>
<td>□ 4</td>
</tr>
<tr>
<td>5</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

E4 Overall, if you could change one thing about cultural education/mentoring for Junior Doctors or registrars, what would that be? Why?
G1 This last section contains a few last questions about the training provider you are/were enrolled in and about yourself.

Which training provider are/were you enrolled in? If you are/were enrolled in more than one training provider, please select the training provider where you have/had your most substantial experience of Aboriginal and Torres Strait Islander training. *(select one)*

<table>
<thead>
<tr>
<th></th>
<th>Training Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adelaide to Outback GP Training Program</td>
</tr>
<tr>
<td>2</td>
<td>Bogong Regional Training Network</td>
</tr>
<tr>
<td>3</td>
<td>Beyond Medical Education</td>
</tr>
<tr>
<td>4</td>
<td>Central and Southern Queensland Training Consortium</td>
</tr>
<tr>
<td>5</td>
<td>CoastCityCountry General Practice Training</td>
</tr>
<tr>
<td>6</td>
<td>General Practice (GP) Synergy</td>
</tr>
<tr>
<td>7</td>
<td>General Practice (GP) Training Tasmania</td>
</tr>
<tr>
<td>8</td>
<td>General Practice (GP) Training Valley to Coast</td>
</tr>
<tr>
<td>9</td>
<td>North Coast General Practice (GP) Training</td>
</tr>
<tr>
<td>10</td>
<td>Northern Territory General Practice (GP) Education</td>
</tr>
<tr>
<td>11</td>
<td>Southern General Practice (GP) Training</td>
</tr>
<tr>
<td>12</td>
<td>Sturt Fleurieu</td>
</tr>
<tr>
<td>13</td>
<td>Tropical Medical Training</td>
</tr>
<tr>
<td>14</td>
<td>Queensland Rural Medical Education</td>
</tr>
<tr>
<td>15</td>
<td>Victorian Metropolitan Alliance (VMA) GP Training</td>
</tr>
<tr>
<td>16</td>
<td>Western Australia General Practice Education and Training (WAGPET)</td>
</tr>
<tr>
<td>17</td>
<td>WentWest</td>
</tr>
</tbody>
</table>

G2 Is your primary medical qualification from ... *(select one)*

<table>
<thead>
<tr>
<th></th>
<th>Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>An Australian university</td>
</tr>
<tr>
<td>2</td>
<td>An overseas university</td>
</tr>
</tbody>
</table>

G3 At what age did you start with the AGPT program? *(select one)*

<table>
<thead>
<tr>
<th></th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18-24 years</td>
</tr>
<tr>
<td>2</td>
<td>25-34 years</td>
</tr>
<tr>
<td>3</td>
<td>35-44 years</td>
</tr>
<tr>
<td>4</td>
<td>45-54 years</td>
</tr>
<tr>
<td>5</td>
<td>55+ years</td>
</tr>
<tr>
<td>6</td>
<td>Prefer not to say</td>
</tr>
</tbody>
</table>
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 2: Survey Report

G4 Are you… *(select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18-24 years</td>
</tr>
<tr>
<td>2</td>
<td>25-34 years</td>
</tr>
<tr>
<td>3</td>
<td>35-44 years</td>
</tr>
<tr>
<td>4</td>
<td>45-54 years</td>
</tr>
<tr>
<td>5</td>
<td>55+ years</td>
</tr>
<tr>
<td>6</td>
<td>Prefer not to say</td>
</tr>
</tbody>
</table>

G5 Are you… *(select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
</tbody>
</table>

G6 Are you… *(select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aboriginal</td>
</tr>
<tr>
<td>2</td>
<td>Torres Strait Islander</td>
</tr>
<tr>
<td>3</td>
<td>Both</td>
</tr>
<tr>
<td>4</td>
<td>Neither</td>
</tr>
</tbody>
</table>

**H: FOLLOW-UP INTERVIEW**

Thank you very much for completing this questionnaire. We really appreciate your feedback.

We will be talking with people later in the year to explore these questions further. If you would be interested in taking part in an interview, please fill in your contact details below, and we may contact you before September 2013 to speak with you about your experiences.

**H1** If you would like to participate, please enter your details below:

Name/s: ____

Daytime phone number/s: ____

Email: ____

Preferred day/s, time/s etc: ____
8. Appendix C: Regional Training Provider Survey

RESEARCH STUDY ON CULTURAL EDUCATION AND MENTORING FOR GP REGISTRARS

General Practice Education and Training Limited (GPET) has commissioned the University of Western Sydney to conduct research into cultural education and cultural mentoring. This study aims to gain a better understanding of Aboriginal and Torres Strait Islander cultural education and mentoring.

A key component of this study involves a survey for all Regional Training Providers (RTPs) throughout the country. It also involves consultations with other stakeholders and clients, such as GP Registrars, Cultural Educators and Cultural Mentors and other interested organisations.

Your feedback is greatly appreciated, and will allow the researchers to provide informed recommendations to GPET on principles to inform future development of cultural education and cultural mentoring. We are very interested in your experiences in providing cultural education and mentoring, and we recognise that the work that you do may not exactly fit some of the questions in this form. Please feel free to use the open-text boxes to add any comments or thoughts you may have, even if they don’t directly fit the question. Your views will be very helpful.

When can I participate?

You can fill in the survey from the time of receiving this invitation up till 5th August 2013. After this date, the survey will be closed. The survey will take no longer than 10 minutes of your time.

We will be conducting a limited interview consultation later in the year. If you would like to be interviewed by the evaluation team, you can provide your details at the end of the survey.

Your consent

By completing this survey, you are giving your consent that your information can be used for this study. Your participation is completely confidential; your response will be received and analysed by by the University of Western Sydney but your remarks will not be attributed to you or your organisation. Neither you nor your RTP will be identified in the report, and only aggregated results will be published.

How to complete and return this survey

There are two ways you can complete this survey. You can either complete this survey electronically in Microsoft Word or you can fill it in on paper. Both options are explained below.
To complete this survey in Microsoft Word:

- Once you open the attached document, save it to your desktop (or somewhere else easy to find)
- You can ‘tick’ the boxes by clicking in them, and type your comments in the boxes provided.
- After completing the survey, please email the document back to: J.Reath@uws.edu.au.

To complete this survey on paper:

- If you prefer to complete the survey on paper, please post it to Professor Jenny Reath, Peter Brennan Chair of General Practice, Locked Bag 1797, Penrith NSW 2751

Who to contact for questions

This study has been approved by the following Human Research Ethics Committees:

<table>
<thead>
<tr>
<th>Human Research Ethics Committee of the University of Western Sydney</th>
<th>UWS Ethics Officer: Tel- 02 4736 0229</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health &amp; Medical Research Council Ethics Committee</td>
<td>The Secretariat: Tel- 02 9212 4777</td>
</tr>
<tr>
<td>Central Australia Human Research Ethics Committee</td>
<td>The Secretariat: Tel- 08 8951 4700</td>
</tr>
<tr>
<td>Aboriginal Health Research Ethics Committee</td>
<td>Senior Research &amp; Ethics Officer: Tel- 08 8273 7200</td>
</tr>
<tr>
<td>Western Australian Aboriginal Health Ethics Committee</td>
<td>Email: <a href="mailto:ethics@ahcwa.org">ethics@ahcwa.org</a></td>
</tr>
<tr>
<td>Human Research Ethics Committee of the NT Department of Health and the Menzies School of Health Research</td>
<td>Ethics Administration Officer: Tel- 08 8922 7922</td>
</tr>
</tbody>
</table>

If you have any concerns or complaints regarding the way this research has been conducted, you can reach the relevant Ethics Committee using the above contact details.

If you would like further information, please contact Dr Ruth Morgan on 02 4620 3933 or Professor Jenny Reath on 02 4620 3725.

Thank you very much!
A: YOUR CONSENT

I have read the information provided to me and I give hereby my consent to participate in this survey:

1 Yes
2 No

B: CULTURAL EDUCATION

B1 The following questions are about cultural education. Cultural mentoring will be addressed in the next question. Please read the description of cultural education as provided by the AGPT in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health.

Cultural education addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health.

B2 To what extent is the description similar to your RTP’s understanding of cultural education? (please select one)

1 Very similar
2 Fairly similar
3 Not very similar
4 Not at all similar

B3 If your RTP’s ideas about cultural education differ from the description, how would you describe it? (Please feel free to add your own descriptions or key words here)

C: CULTURAL MENTORING

C1 The following questions are about cultural mentoring. Please read the description of cultural mentoring as provided by the AGPT in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health.
Cultural mentoring refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe General Practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

C2 To what extent is the description similar to your RTP’s description of cultural mentoring? *(please select one)*

- [ ] □ 1 Very similar
- [ ] □ 2 Fairly similar
- [ ] □ 3 Not very similar
- [ ] □ 4 Not at all similar

C3 If your RTP’s ideas about cultural mentoring differ from the description, how would you describe it?

D: CULTURAL EDUCATION AND MENTORING PROGRAMS

The following questions are about Aboriginal and Torres Strait Islander cultural education and mentoring programs that RTPs provide to health professionals and students.

D1 For which audience(s) does your RTP provide cultural education and/or cultural mentoring? *(please tick as many as apply)*

- [ ] □ 1 GP Registrars
- [ ] □ 2 Junior Doctors
- [ ] □ 3 Medical educators
- [ ] □ 4 Medical supervisors
- [ ] □ 5 GP Supervisor
- [ ] □ 6 Other (please specify):
## D2 Does your RTP have formal policies in place for providing cultural education and mentoring programs? *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No <em>(please go to D4)</em></td>
</tr>
<tr>
<td>3</td>
<td>Don’t know/not sure <em>(please go to D4)</em></td>
</tr>
</tbody>
</table>

## D3 How has your RTP developed its policies regarding Aboriginal and Torres Strait Islander cultural education and mentoring? *(please select as many as apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>We have adopted or adapted policies produced by another organisation <em>(please specify)</em>:</td>
</tr>
<tr>
<td>2</td>
<td>We worked together with local Aboriginal and/or Torres Strait Islander community representatives to develop the policies</td>
</tr>
<tr>
<td>3</td>
<td>We employed an Aboriginal and/or Torres Strait Islander person to assist us in the process</td>
</tr>
<tr>
<td>4</td>
<td>We consulted with local community members in developing our policies</td>
</tr>
<tr>
<td>5</td>
<td>We consulted with our local Aboriginal community controlled health organisation</td>
</tr>
<tr>
<td>6</td>
<td>Don’t know/not sure</td>
</tr>
</tbody>
</table>

## D4 How many Cultural Educators have been working for your RTP over the last 12 months? Note: please include all Cultural Educators who work full time, part time, temporarily or as a volunteer. *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-2</td>
</tr>
<tr>
<td>2</td>
<td>3-5</td>
</tr>
<tr>
<td>3</td>
<td>6 or more</td>
</tr>
<tr>
<td>4</td>
<td>Don’t know/not sure</td>
</tr>
<tr>
<td>5</td>
<td>None</td>
</tr>
</tbody>
</table>

## D5 Which persons work as a cultural educator for your RTP? Note: please include all Cultural Educators who work full time, part time, temporarily or as a volunteer. *(please tick as many as apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Local Aboriginal and Torres Strait Islander community members who work with our RTP as Cultural Educators</td>
</tr>
<tr>
<td>2</td>
<td>Aboriginal and Torres Strait Islander people who are employed by our RTP as Cultural Educators</td>
</tr>
<tr>
<td>3</td>
<td>Aboriginal and Torres Strait Islander staff members who provide cultural education at our RTP on a voluntary basis in addition to other duties</td>
</tr>
<tr>
<td>4</td>
<td>Non-Aboriginal and Torres Strait Islander cultural educator(s)</td>
</tr>
<tr>
<td>5</td>
<td>Other <em>(please specify)</em>:</td>
</tr>
</tbody>
</table>
D6 Are the Cultural Educators and mentors (please select one):

- [ ] □ 1. Exactly the same people acting in both roles
- [ ] □ 2. Mostly the same people acting in both roles
- [ ] □ 3. Mostly different people, some (or one) acting as a cultural educator(s), and some (or one) acting as a cultural mentor(s)
- [ ] □ 4. Entirely different people in each role
- [ ] □ 5. Don’t know/not sure

D7 The list below shows different cultural education and mentoring programs that RTPs can provide to GP Registrars. Please select all programs that your RTP provides to GP Registrars and which of these programs are mandatory for GP Registrars to receive. (please tick as many as apply)

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Programs my RTP provides to GP Registrars</th>
<th>Mandatory programs GP Registrars are required to receive</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about Aboriginal and Torres Strait Islander health as part of a</td>
<td>□ 1</td>
<td>□ 8</td>
</tr>
<tr>
<td>workshop or a short training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal</td>
<td>□ 2</td>
<td>□ 9</td>
</tr>
<tr>
<td>health professional (eg GP supervisor, Medical Educator) with experience in this</td>
<td></td>
<td></td>
</tr>
<tr>
<td>field.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentoring from an Aboriginal and Torres Strait Islander cultural mentor</td>
<td>□ 3</td>
<td>□ 10</td>
</tr>
<tr>
<td>Day visits to an Aboriginal Community Controlled Health Service (ACCHS) and other</td>
<td>□ 4</td>
<td>□ 11</td>
</tr>
<tr>
<td>facilities (e.g. Aboriginal community child care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander</td>
<td>□ 5</td>
<td>□ 12</td>
</tr>
<tr>
<td>communities, including experiences with local Aboriginal and Torres Strait Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>people there</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended (6 months or more) experience in a training post(s) at an Aboriginal</td>
<td>□ 6</td>
<td>□ 13</td>
</tr>
<tr>
<td>Community Controlled Health Service (ACCHS) or another Indigenous Health Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Aboriginal and Torres Strait Islander health training opportunities</td>
<td>□ 7</td>
<td>□ 14</td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know/not sure</td>
<td></td>
<td>□ 15</td>
</tr>
</tbody>
</table>
The list below shows different cultural education and mentoring programs that RTPs can provide to Junior Doctors. Please select all programs that your RTP provides to Junior Doctors and which of these programs are mandatory for Junior Doctors to receive. *(please tick as many as apply)*

<table>
<thead>
<tr>
<th>Programs my RTP provides to Junior Doctors</th>
<th>Mandatory programs Junior Doctors are required to receive</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training</td>
<td>☐ 1</td>
</tr>
<tr>
<td>Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (eg GP supervisor, Medical Educator) with experience in this field</td>
<td>☐ 2</td>
</tr>
<tr>
<td>Mentoring from an Aboriginal and Torres Strait Islander cultural mentor</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Day visits to an Aboriginal Community Controlled Health Service (ACCHS) and other facilities (e.g. Aboriginal community child care)</td>
<td>☐ 4</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>☐ 5</td>
</tr>
<tr>
<td>Extended (6 months or more) experience in a training post(s) at an Aboriginal Community Controlled Health Service (ACCHS) or another Indigenous Health Service</td>
<td>☐ 6</td>
</tr>
<tr>
<td>Other Aboriginal and Torres Strait Islander health training opportunities</td>
<td>☐ 7</td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
</tr>
<tr>
<td>Don’t know /not sure</td>
<td>☐ 16</td>
</tr>
</tbody>
</table>
D9 RTPs can also provide cultural education and mentoring programs to GP Supervisors, medical educators and other staff. Please select all programs below your RTP provides to GP Supervisors, medical educators and other staff. (please tick all that apply)

<table>
<thead>
<tr>
<th>Programs my RTP provides to:</th>
<th>GP Supervisors</th>
<th>Medical educators</th>
<th>Other staff (please specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training</td>
<td>□ 1</td>
<td>□ 1</td>
<td>□ 1</td>
</tr>
<tr>
<td>Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (e.g. GP supervisor, Medical Educator) with experience in this field</td>
<td>□ 2</td>
<td>□ 2</td>
<td>□ 2</td>
</tr>
<tr>
<td>Mentoring from an Aboriginal and Torres Strait Islander cultural mentor</td>
<td>□ 3</td>
<td>□ 3</td>
<td>□ 3</td>
</tr>
<tr>
<td>Day visits to an Aboriginal Community Controlled Health Service (ACCHS) and other facilities (e.g. Aboriginal community child care)</td>
<td>□ 4</td>
<td>□ 4</td>
<td>□ 4</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>□ 5</td>
<td>□ 5</td>
<td>□ 5</td>
</tr>
<tr>
<td>Extended (6 months or more) experience in a training post(s) at an Aboriginal Community Controlled Health Service (ACCHS) or another Indigenous Health Service</td>
<td>□ 6</td>
<td>□ 6</td>
<td>□ 6</td>
</tr>
<tr>
<td>Other Aboriginal and Torres Strait Islander health training opportunities Please specify:</td>
<td>□ 7</td>
<td>□ 7</td>
<td>□ 7</td>
</tr>
<tr>
<td>Don't know /not sure</td>
<td>□ 8</td>
<td>□ 8</td>
<td>□ 8</td>
</tr>
</tbody>
</table>

D10 From which year does your RTP give GP Registrars and Junior Doctors the opportunity to participate in cultural education and/or mentoring programs? (please tick as many as apply)

- □ 1 From GPT Year 1
- □ 2 From GPT Year 2
- □ 3 From GPT Year 3
- □ 4 From GPT Year 4
- □ 5 During the Prevocational General Practice Placement Program (PGPPP)
- □ 6 Don’t know/not sure
- □ 7 None

D11 Which of the statements best describes how your RTP delivers cultural education and mentoring?

I feel that the RTP I work for.....:(please select one)

- □ 1 Integrates cultural education and mentoring programs into general workshops

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### E: IMPACT OF CULTURAL EDUCATION AND MENTORING

The following questions are about the impact of cultural education and mentoring.

**E1**  How much do you agree or disagree with the following statements about the impacts of cultural education and mentoring?

* **Cultural education and mentoring...:**

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t know/not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. increase the interest of GP Registrars in Aboriginal and Torres Strait Islander health</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>9. improve the quality of health services provided to Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>10. improve the access to health services available to Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
<tr>
<td>11. improve health outcomes of Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>□ 1</td>
<td>□ 2</td>
<td>□ 3</td>
<td>□ 4</td>
<td>□ 5</td>
</tr>
</tbody>
</table>

**E2**  Overall, in your view how well does your current cultural education or mentoring program prepare GP Registrars for working with Aboriginal and Torres Strait Islander people?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1</td>
<td>Very well</td>
</tr>
<tr>
<td>□ 2</td>
<td>Fairly well</td>
</tr>
<tr>
<td>□ 3</td>
<td>Not very well</td>
</tr>
<tr>
<td>□ 4</td>
<td>Not very well at all</td>
</tr>
<tr>
<td>□ 5</td>
<td>Not sure, can’t say</td>
</tr>
</tbody>
</table>
F: EMPLOYMENT (ONLY FOR RTPS WHO WORK WITH CE AND/OR CM)

The following questions are about how RTPs employ Cultural Educators and mentors. **If your RTP does not work with Cultural Educators and mentors, please continue with section G.**

### F1 Which of the following statements applies to your RTP? *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1</td>
<td>All of our Cultural Educators/mentors are in a <strong>paid</strong> position</td>
</tr>
<tr>
<td>☐ 2</td>
<td>Most of our Cultural Educators/mentors are in a <strong>paid</strong> position and some are in an <strong>unpaid</strong> position (voluntarily)</td>
</tr>
<tr>
<td>☐ 3</td>
<td>Most of our Cultural Educators/mentors are in an <strong>unpaid</strong> position (voluntarily) and some fulfil a <strong>paid</strong> position</td>
</tr>
<tr>
<td>☐ 4</td>
<td>All of our Cultural Educators/mentors are in an <strong>unpaid</strong> position (voluntarily)</td>
</tr>
<tr>
<td>☐ 5</td>
<td>We provide payment to our local Aboriginal training post to provide cultural education and cultural mentoring on our behalf</td>
</tr>
<tr>
<td>☐ 6</td>
<td>Other, please specify:</td>
</tr>
<tr>
<td>☐ 7</td>
<td>Don’t know/not sure</td>
</tr>
</tbody>
</table>

### F2 How much do you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Don’t know/not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My RTP provides Cultural Educators/mentors with professional development opportunities</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>2. My RTP looks after the welfare of Cultural Educators/mentors</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>3. My RTP provides Cultural Educators/mentors with a supervisor to support/guide them in their work</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>4. My RTP supports Cultural Educators/mentors to attend cultural training network events</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>5. My RTP involves Cultural Educators/mentors in the planning of the cultural education program</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>6. My RTP involves Cultural Educators/mentors in the delivery of the cultural education program</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>7. My RTP involves Cultural Educators/mentors in evaluating the cultural education program</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

### F3 Most of our Cultural Educators/mentors have a *(please select one):*
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 2: Survey Report

F4 What type of contract does your RTP offer mostly to Cultural Educators and mentors with a paid position? *(please select one)*

- [ ] 1. Full time position
- [ ] 2. Part time position

F5 You indicated that your RTP offers mostly a time limited contract to Cultural Educators and mentors. Please specify what the average time limit is of these contracts.

*A contract is mostly limited up to: *(please select one)*

- [ ] 1. 1-3 months
- [ ] 2. 4-6 months
- [ ] 3. 7-12 months
- [ ] 4. 1-2 years
- [ ] 5. Longer than 2 years
- [ ] 6. Other (please specify):
- [ ] 7. I don’t know/not sure *(please go to F6)*

F6 Which of the following applies to your RTP’s wage regulations for Cultural Educators and mentors? *(please select one)*

- [ ] 1. Their wage is based on a fixed salary
- [ ] 2. Their wage is based on an hourly rate, depending on the amount of hours they work within a specific time frame
- [ ] 3. Other (please specify):
- [ ] 4. I don’t know/not sure *(please go to F6)*

G: THE FUTURE
The following questions are about changes or improvements you wish to see in cultural education and mentoring. *If your RTP does not work with Cultural Educators and mentors, please continue with question G2.*
G1 Overall, if you could change one thing for Cultural Educators and/or mentors, what would that be? Why?

G2 Overall, if you could change one thing about providing cultural education and mentoring for GP Registrars and Junior Doctors, what would that be? Why?

H: FINAL QUESTIONS

H1 Are you… (please select one)

- 1 Male
- 2 Female

H2 Are you… (please select one)

- 1 18-24 years
- 2 25-34 years
- 3 35-44 years
- 4 45-54 years
- 5 55+ years
- 6 Prefer not to say

H3 Are you… (please select one)

- 1 Aboriginal
- 2 Torres Strait Islander
- 3 Both
- 4 Neither
### H4 What is the highest level of education you have completed? *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No formal schooling</td>
</tr>
<tr>
<td>2</td>
<td>Primary school</td>
</tr>
<tr>
<td>3</td>
<td>Some secondary school</td>
</tr>
<tr>
<td>4</td>
<td>Completed secondary school (HSC, Leaving Certificate, etc.)</td>
</tr>
<tr>
<td>5</td>
<td>Trade or technical qualification (e.g. TAFE)</td>
</tr>
<tr>
<td>6</td>
<td>Undergraduate university diploma/degree or equivalent</td>
</tr>
<tr>
<td>7</td>
<td>Postgraduate university diploma/degree or equivalent</td>
</tr>
</tbody>
</table>

### H5 What is your role in your organisation?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>2</td>
<td>Director of Training</td>
</tr>
<tr>
<td>3</td>
<td>Aboriginal or Torres Strait Islander Cultural Educator or Mentor</td>
</tr>
<tr>
<td>4</td>
<td>Business or Administration Manager or Officer</td>
</tr>
<tr>
<td>5</td>
<td>GP Supervisor</td>
</tr>
<tr>
<td>6</td>
<td>Medical Educator</td>
</tr>
<tr>
<td>7</td>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>

### H6 What is the name of your RTP? Please note that the name and location of your RTP will not be identified in the report. *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adelaide to Outback GP Training Program</td>
</tr>
<tr>
<td>2</td>
<td>Bogong Regional Training Network</td>
</tr>
<tr>
<td>3</td>
<td>Beyond Medical Education</td>
</tr>
<tr>
<td>4</td>
<td>Central and Southern Queensland Training Consortium</td>
</tr>
<tr>
<td>5</td>
<td>CoastCityCountry General Practice Training</td>
</tr>
<tr>
<td>6</td>
<td>General Practice (GP) Synergy</td>
</tr>
<tr>
<td>7</td>
<td>General Practice (GP) Training Tasmania</td>
</tr>
<tr>
<td>8</td>
<td>General Practice (GP) Training Valley to Coast</td>
</tr>
<tr>
<td>9</td>
<td>North Coast General Practice (GP) Training</td>
</tr>
<tr>
<td>10</td>
<td>Northern Territory General Practice (GP) Education</td>
</tr>
<tr>
<td>11</td>
<td>Southern General Practice (GP) Training</td>
</tr>
<tr>
<td>12</td>
<td>Sturt Fleurieu</td>
</tr>
<tr>
<td>13</td>
<td>Tropical Medical Training</td>
</tr>
<tr>
<td>14</td>
<td>Queensland Rural Medical Education</td>
</tr>
<tr>
<td>15</td>
<td>Victorian Metropolitan Alliance (VMA) GP Training</td>
</tr>
<tr>
<td>16</td>
<td>Western Australia General Practice Education and Training (WAGPET)</td>
</tr>
<tr>
<td>17</td>
<td>WentWest</td>
</tr>
</tbody>
</table>
I: FOLLOW-UP INTERVIEW

I1 Thank you very much for completing this questionnaire. We really appreciate your feedback.

We will be talking with people later in the year to explore these questions further. If you would be interested in taking part in an interview, please fill in your contact details below, and we may contact you before September 2013 to speak with you about your experiences.

1 ☐ Yes (please provide details below)
2 ☐ No

Name/s: _____
Daytime phone number/s: _____
Email: _____
Preferred day/s, time/s etc: _____
9. Appendix D: Aboriginal and Torres Strait Islander Health Training Post Survey

RESEARCH SURVEY ON CULTURAL EDUCATION AND MENTORING FOR GP REGISTRARS

General Practice Education and Training Limited (GPET) has commissioned the University of Western Sydney to conduct research into cultural education and cultural mentoring. This study aims to gain a better understanding of Aboriginal and Torres Strait Islander cultural education and mentoring.

A key component of this study involves a survey for Aboriginal community-controlled health services (ACCHSs) and Aboriginal and Torres Strait Islander Health Training Posts (IHTPs) throughout the country. It also involves consultations with other stakeholders and clients, such as Regional Training Providers, GP Registrars, Cultural Educators and Cultural Mentors and other interested organisations.

We value your feedback on how to improve cultural education and cultural mentoring. Your feedback will allow the researchers to provide informed recommendations to GPET on principles to inform future development of cultural education and cultural mentoring.

We recognise that the way in which your organisation is involved with cultural education or mentoring may not exactly fit some of the questions in this form, so please feel free to use the open-text boxes to add any comments or thoughts you may have, even if they don’t directly fit the question. Your views will be very helpful.

When can I participate?

You can fill in the survey from the time of receiving this invitation up till 5th August 2013. After this date, the survey will be closed. The survey will take no longer than 10 minutes of your time.

We will be conducting a limited interview consultation later in the year. If you would like to be interviewed by the evaluation team, you can provide your details at the end of the survey.

Your consent

By completing this survey, you are giving your consent that your information can be used for this study. Your participation is completely confidential; your response will be received and analysed by the University of Western Sydney but your remarks will not be attributed to you or your organisation. Neither you nor your health service will be identified in the report, and only aggregated results will be published.

How to complete and return this survey

There are two ways you can complete this survey. You can either complete this survey electronically in Microsoft Word or you can fill it in on paper. Both options are explained below.
To complete this survey in Microsoft Word:

- Once you open the attached document, save it to your desktop (or somewhere else easy to find)
- You can ‘tick’ the boxes by clicking in them, and type your comments in the boxes provided.

After completing the survey, please email the document back to: J.Reath@uws.edu.au.

To complete this survey on paper:

- If you prefer to complete the survey on paper, please post it to Professor Jenny Reath, Peter Brennan Chair of General Practice, Locked Bag 1797, Penrith NSW 2751

Who to contact for questions

This study has been approved by the following Human Research Ethics Committees:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Research Ethics Committee of the University of Western Sydney</td>
<td>UWS Ethics Officer: Tel- 02 4736 0229</td>
</tr>
<tr>
<td>Aboriginal Health &amp; Medical Research Council Ethics Committee</td>
<td>The Secretariat: Tel- 02 9212 4777</td>
</tr>
<tr>
<td>Central Australia Human Research Ethics Committee</td>
<td>The Secretariat: Tel- 08 8951 4700</td>
</tr>
<tr>
<td>Aboriginal Health Research Ethics Committee</td>
<td>Senior Research &amp; Ethics Officer: Tel- 08 8273 7200</td>
</tr>
<tr>
<td>Western Australian Aboriginal Health Ethics Committee</td>
<td>Email: <a href="mailto:ethics@ahcwa.org">ethics@ahcwa.org</a></td>
</tr>
<tr>
<td>Human Research Ethics Committee of the NT Department of Health and the Menzies School of Health Research</td>
<td>Ethics Administration Officer: Tel- 08 8922 7922</td>
</tr>
</tbody>
</table>

If you have any concerns or complaints regarding the way this research has been conducted, you can reach the relevant Ethics Committee using the above contact details.

If you would like further information, please contact Dr Ruth Morgan on 02 4620 3933 or Professor Jenny Reath on 02 4620 3725.

Thank you very much!
### A: YOUR CONSENT

I have read the information provided to me and I give hereby my consent to participate in this survey:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

### B: DEMOGRAPHIC PROFILE

**B1** Are you... *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
</tbody>
</table>

**B2** Are you... *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18-24 years</td>
</tr>
<tr>
<td>2</td>
<td>25-34 years</td>
</tr>
<tr>
<td>3</td>
<td>35-44 years</td>
</tr>
<tr>
<td>4</td>
<td>45-54 years</td>
</tr>
<tr>
<td>5</td>
<td>55+ years</td>
</tr>
<tr>
<td>6</td>
<td>Prefer not to say</td>
</tr>
</tbody>
</table>

**B3** Are you... *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aboriginal</td>
</tr>
<tr>
<td>2</td>
<td>Torres Strait Islander</td>
</tr>
<tr>
<td>3</td>
<td>Both</td>
</tr>
<tr>
<td>4</td>
<td>Neither</td>
</tr>
</tbody>
</table>

**B4** What is your role in your organisation?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>2</td>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>

**B5** In which state or territory is your health service located? *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>New South Wales</td>
</tr>
<tr>
<td>2</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>3</td>
<td>Victoria</td>
</tr>
<tr>
<td>4</td>
<td>South Australia</td>
</tr>
</tbody>
</table>
Western Australia
Northern Territory
Queensland
Tasmania

And is your health service located in...?

1. A capital city
2. A regional location
3. A remote location

C: CULTURAL EDUCATION

The following questions are about cultural education. Please read the description of cultural education as provided by the Australian General Practice Training (AGPT) Program in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health:

Cultural education addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health.

To what extent is the description similar to your health service’s understanding of cultural education? Please note cultural mentoring is discussed in the next question (please select one)

1. Very similar
2. Fairly similar
3. Not very similar
4. Not at all similar

If your ideas about cultural education are different, can you describe your own view? (Please feel free to add your own descriptions or key words here)
C4 When you think about the description of cultural education, does your health service provide Aboriginal and Torres Strait Islander cultural education to health professionals and students?

| Yes | No | Don’t know/not sure | Other (please specify): |

D: CULTURAL MENTORING

D1 The following questions are about cultural mentoring. Please read the description of cultural mentoring as provided by the AGPT in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health:

**Cultural mentoring** refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe General Practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

D2 To what extent is the description similar to your health service’s understanding of cultural mentoring? *(please select one)*

| Very similar | Fairly similar | Not very similar | Not at all similar |

D3 If your ideas about cultural mentoring differ from the description, how would you describe it? *(Please feel free to add your own descriptions or key words here)*
D4  When you think about the description of cultural mentoring, does your health service provide Aboriginal and Torres Strait Islander cultural mentoring to health professionals and students?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Don’t know/not sure</td>
</tr>
<tr>
<td>4</td>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>

E: CULTURAL EDUCATION AND MENTORING PROGRAMS

*If your health service does not provide cultural education and cultural mentoring, please continue with section F.*

E1  The following questions are about cultural education and mentoring programs that health services can provide to health professionals and students (e.g. GP Registrars and Junior Doctors).

How many Cultural Educators have been working for your health service over the last 12 months?

Note: please include all Cultural Educators who work full time, part time, temporarily or as a volunteer. *(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>1-2</td>
</tr>
<tr>
<td>2</td>
<td>3-5</td>
</tr>
<tr>
<td>3</td>
<td>6 or more</td>
</tr>
<tr>
<td>4</td>
<td>Don’t know/not sure</td>
</tr>
<tr>
<td>5</td>
<td>None</td>
</tr>
</tbody>
</table>

E2  Which educators provide cultural education for your health service? Note: please include all Cultural Educators who work full time, part time, temporarily or volunteer. *(please tick as many as apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Local Aboriginal and Torres Strait Islander community members who work with our service as Cultural Educators</td>
</tr>
<tr>
<td>2</td>
<td>Aboriginal and Torres Strait Islander people who are employed by our Health Service as Cultural Educators</td>
</tr>
<tr>
<td>3</td>
<td>Aboriginal and Torres Strait Islander staff members who provide cultural education on a voluntary basis in addition to other duties</td>
</tr>
<tr>
<td>4</td>
<td>Non-Aboriginal and Torres Strait Islander cultural educator(s)</td>
</tr>
<tr>
<td>5</td>
<td>Other (please specify):</td>
</tr>
<tr>
<td>6</td>
<td>Don’t know/not sure</td>
</tr>
</tbody>
</table>
E3 How many Cultural Mentors have been working for your health service over the last 12 months?

Note: please include all Cultural Mentors who work full time, part time, temporarily or volunteer.

*(please select one)*

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>□ 1</td>
<td>1-2</td>
</tr>
<tr>
<td>□ 2</td>
<td>3-5</td>
</tr>
<tr>
<td>□ 3</td>
<td>6 or more</td>
</tr>
<tr>
<td>□ 4</td>
<td>Don’t know/not sure</td>
</tr>
<tr>
<td>□ 5</td>
<td>None</td>
</tr>
</tbody>
</table>

E4 Which mentors provide cultural mentoring for your health service? Note: please include all Cultural Mentors who work full time, part time, temporarily or volunteer.

*(please tick as many as apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1</td>
<td>Local Aboriginal and Torres Strait Islander community members who work with our service as Cultural Mentors</td>
</tr>
<tr>
<td>□ 2</td>
<td>Aboriginal and Torres Strait Islander people who are employed by our health service as Cultural Mentors</td>
</tr>
<tr>
<td>□ 3</td>
<td>Aboriginal and Torres Strait Islander staff members who provide Cultural Mentorship on a voluntary basis in addition to other duties</td>
</tr>
<tr>
<td>□ 4</td>
<td>Non-Aboriginal and Torres Strait Islander cultural mentor(s)</td>
</tr>
<tr>
<td>□ 5</td>
<td>Other, please specify:</td>
</tr>
<tr>
<td>□ 6</td>
<td>Don’t know/not sure</td>
</tr>
</tbody>
</table>

E5 To which audience(s) does your health service provide cultural education and/or mentoring? *(Please tick as many as apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1</td>
<td>GP Registrars</td>
</tr>
<tr>
<td>□ 2</td>
<td>Junior Doctors (hospital doctors in training in ACCHSs or IHTPs)</td>
</tr>
<tr>
<td>□ 3</td>
<td>Medical educators</td>
</tr>
<tr>
<td>□ 4</td>
<td>GP Supervisors</td>
</tr>
<tr>
<td>□ 5</td>
<td>GP Supervisor</td>
</tr>
<tr>
<td>□ 6</td>
<td>Other, please specify:</td>
</tr>
</tbody>
</table>

E6 The list below shows different programs of cultural education and mentoring. Please select all programs you provide to GP Registrars or Junior Doctors. *(Please tick as many as apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>My health service provides the following programs to GP Registrars or Junior</td>
<td></td>
</tr>
</tbody>
</table>
### Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
#### Appendix 2: Survey Report

<table>
<thead>
<tr>
<th>Activity</th>
<th>Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education about Aboriginal and Torres Strait Islander health as part of a workshop outside your health service (e.g. with a university, RTP or Medicare Local)</td>
<td>1</td>
</tr>
<tr>
<td>Cultural training events / workshops at your health service</td>
<td>2</td>
</tr>
<tr>
<td>Cultural mentoring support during Junior doctor or GP Registrar placements in your service</td>
<td>3</td>
</tr>
<tr>
<td>Day visits to other facilities (e.g. Aboriginal community child care)</td>
<td>4</td>
</tr>
<tr>
<td>Short trips (e.g. spanning a few days) to Aboriginal and Torres Strait Islander communities, including experiences with local Aboriginal and Torres Strait Islander people there</td>
<td>5</td>
</tr>
<tr>
<td>Other cultural/mentoring services to GP Registrars, please specify:</td>
<td>6</td>
</tr>
<tr>
<td>We do not provide any cultural education and mentoring programs to GP Registrars or Junior Doctors</td>
<td>7</td>
</tr>
</tbody>
</table>

---

### F: IMPACT OF CULTURAL EDUCATION AND MENTORING

**F1** The following questions are about the impact of cultural education and mentoring.

How much do you agree or disagree with the following statements about cultural education and mentoring?

*Cultural education and mentoring...:*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don’t know/ not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Increase the interest of GP Registrars and Junior Doctors in Aboriginal and Torres Strait Islander health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Improve the quality of health services provided to Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Improve the access to health services available to Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Improve health outcomes of Aboriginal and Torres Strait Islander people in your part of Australia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 2: Survey Report

F2 Your local Regional Training Provider (RTP) is responsible for training GP Registrars and Junior Doctors (hospital doctors) for General Practice. From your perspective, how well does your local RTP prepare GP Registrars and Junior Doctors for working with Aboriginal and Torres Strait Islander people? (please select one)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very well</td>
</tr>
<tr>
<td>2</td>
<td>Fairly well</td>
</tr>
<tr>
<td>3</td>
<td>Not very well</td>
</tr>
<tr>
<td>4</td>
<td>Not very well at all</td>
</tr>
<tr>
<td>5</td>
<td>Not sure, can’t say</td>
</tr>
</tbody>
</table>

F3 What is the name of your RTP? Please note that the name and location of your RTP will not be identified in the report. (please select one)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adelaide to Outback GP Training Program</td>
</tr>
<tr>
<td>2</td>
<td>Bogong Regional Training Network</td>
</tr>
<tr>
<td>3</td>
<td>Beyond Medical Education</td>
</tr>
<tr>
<td>4</td>
<td>Central and Southern Queensland Training Consortium</td>
</tr>
<tr>
<td>5</td>
<td>CoastCityCountry General Practice Training</td>
</tr>
<tr>
<td>6</td>
<td>General Practice (GP) Synergy</td>
</tr>
<tr>
<td>7</td>
<td>General Practice (GP) Training Tasmania</td>
</tr>
<tr>
<td>8</td>
<td>General Practice (GP) Training Valley to Coast</td>
</tr>
<tr>
<td>9</td>
<td>North Coast General Practice (GP) Training</td>
</tr>
<tr>
<td>10</td>
<td>Northern Territory General Practice (GP) Education</td>
</tr>
<tr>
<td>11</td>
<td>Southern General Practice (GP) Training</td>
</tr>
<tr>
<td>12</td>
<td>Sturt Fleurieu</td>
</tr>
<tr>
<td>13</td>
<td>Tropical Medical Training</td>
</tr>
<tr>
<td>14</td>
<td>Queensland Rural Medical Education</td>
</tr>
<tr>
<td>15</td>
<td>Victorian Metropolitan Alliance (VMA) GP Training</td>
</tr>
<tr>
<td>16</td>
<td>Western Australia General Practice Education and Training (WAGPET)</td>
</tr>
<tr>
<td>17</td>
<td>WentWest</td>
</tr>
</tbody>
</table>

G: THE FUTURE

The following questions are about changes or improvements you wish to see in cultural education and mentoring. If your health service does not work with Cultural Educators and mentors, please continue with question G2.

G1 Overall, if you could change one thing for Cultural Educators and/or mentors, what would that be? Why?
G2 Overall, if you could change one thing about providing cultural education and mentoring for GP Registrars and Junior Doctors, what would that be? Why?

H: FOLLOW-UP INTERVIEW

H1 Thank you very much for completing this questionnaire. We really appreciate your feedback.

We will be talking with people later in the year to explore these questions further. If you would be interested in taking part in an interview, please fill in your contact details below, and we may contact you before September 2013 to speak with you about your experiences.

1  Yes (please provide details below)

2  No

Name/s: _____

Daytime phone number/s: _____

Email: _____

Preferred day/s, time/s etc: _____
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity

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Executive Summary

This report provides analysis of interview data collected as part of research commissioned by General Practice Education and Training aimed at developing the evidence base to support training in cultural competence for doctors working with Aboriginal and Torres Strait Islander people. This research will inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

Interviews were conducted between May 2013 and January 2014 with Regional Training Providers, Cultural Educators and Mentors, Medical Educators, Aboriginal and Torres Strait Islander Health Training Posts, General Practice Registrars and Junior Doctors and stakeholder organisations. Interview data was collected from 95 participants representing 13 Regional Training Providers, 11 Aboriginal and Torres Strait Islander Health Training Posts and 18 stakeholder representatives. A further 59 participants attending a Cultural Educator/Cultural Mentor and Medical Educator workshop during the 2013 General Practice Education and Training Convention provided input via small group sessions during which they considered key questions related to this project. Additionally a large group consultation with 20 participants was held in one Regional Training Provider, comprising Cultural Educators/Cultural Mentors, General Practice Registrars, Junior Doctors, Medical Educators, Regional Training Provider staff and General Practice Supervisors. Of this group 14 are additional to the total participant figure.

The results of the qualitative data analysis are presented in section 3 of this report. Understandings of cultural education and mentoring are described, including definitions, models and content of cultural education and mentoring as well as the roles of the Cultural Educators and the Cultural Mentors.

Most participants agreed that the current definitions used by General Practice Education and Training to describe cultural education and cultural mentoring were appropriate. However, participants identified the difficulties of defining these often overlapping activities and roles. There was consensus that Cultural Educators and Cultural Mentors must themselves be Aboriginal or Torres Strait Islander people. Overlap with the Aboriginal Health Worker role within Aboriginal and Torres Strait Islander Health Training Posts was also noted. Some interviewees considered that cultural education and mentoring are part of the Aboriginal Health Worker role and, in some situations, Aboriginal Health Workers receive training in cultural mentoring. However there was a risk of overburdening these already busy health professionals. It was also noted that cultural mentoring can be undertaken by Aboriginal and Torres Strait Islander general practitioners.
Interviewees highlighted the impact on cultural education and mentoring of varying contexts and community
and organisational expectations and advised on respecting the rights of Aboriginal and Torres Strait Islander
people and Aboriginal and Torres Strait Islander Health Training Posts to define the Cultural Educator/Cultural
Mentor roles and responsibilities in a way that is appropriate for them.

A variety of models of cultural education delivery and content were identified, with concepts of cultural
respect, humility and competence, and the principle of listening to the Aboriginal and Torres Strait Islander
community and individuals, seen to be essential in any cultural education program. Interviewees further noted
that programs should include discussion of Aboriginal and Torres Strait Islander culture and history and how
these interact with health and health care. Though online and distance learning approaches were sometimes
reported to be used, face to face interaction with Aboriginal and Torres Strait Islander people and
communities was noted to be a critical element of effective cultural education.

Interviewees agreed that while roles performed by Cultural Educators vary according to location, the principal
role of the Cultural Educator engaged in General Practice training is to provide information that can assist
General Practice Registrars and Junior Doctors in their communication and relationships with Aboriginal and
Torres Strait Islander people and communities. Cultural education was seen by all as an important component
of Aboriginal and Torres Strait Islander health training for general practitioners, particularly in view of the need
to ensure that General Practice Registrars and Junior Doctors have at least some introductory knowledge
when they start their Aboriginal and Torres Strait Islander Health Training Post Health Training Post
placements.

Interviewees also described many models of cultural mentoring, depending on the local context and with
determination of the model often made by the Aboriginal and Torres Strait Islander Health Training Post. From
the interviews, cultural mentoring appears to be less consistently provided to General Practice Registrars and
Junior Doctors than cultural education. While roles of the Cultural Mentor were described as sometimes
including cultural education activities, interviewees highlighted cultural mentoring as needing to be specific to
a local context.

In some Regional Training Providers, Cultural Educators and Mentors were described as providing advice on
organisational direction, culturally appropriate practice and liaison with communities.

Challenges for cultural education and cultural mentoring described by interviewees include the need to better
understand the Cultural Educator and Cultural Mentor roles and the kinds of support that strengthen those
roles; engagement of Cultural Educators and Cultural Mentors; embedding cultural education in organisations.
and valuing those who deliver the education; re-balancing the medical model of teaching and ensuring cultural education was equally valued compared to clinical teaching; adaptation of cultural education to local communities and to individual learner needs; ensuring sufficient time for learner reflection in a safe learning environment; catering for the particular needs of Aboriginal and Torres Strait Islander General Practice Registrars; and engagement of Cultural Educators and Cultural Mentors in evaluation of teaching programs and assessment of General Practice Registrar and Junior Doctor learning.

A range of employment models and supports for Cultural Educators and Cultural Mentors is described in section 3.2.2 of this report. Employment or engagement with Cultural Mentors appears to be less formal than that described for Cultural Educators. As noted above, at times Cultural Mentor tasks were described to fall to the Aboriginal Health Worker within the Aboriginal and Torres Strait Islander Health Training Post. The role of Aboriginal and Torres Strait Islander general practitioners in providing mentorship for General Practice Registrars, potentially within Aboriginal and Torres Strait Islander Health Training Posts or through arrangements with Regional Training Providers, was also seen as becoming increasingly important by several participants.

While Cultural Educators mostly appear to be remunerated for their work, the prevalent model of voluntary cultural mentoring was seen as unjust by many interviewees. Many interviewees believed some kind of reimbursement for Cultural Mentors is needed, arranged in such a way that is sustainable and appropriate to the individual and the community.

Interviews did not reveal many formal policies relating to support of Cultural Educators and Cultural Mentors, particularly where Regional Training Providers enter into ad hoc arrangements according to the need for cultural education and cultural mentoring at a particular time. Interviewees indicated that support for Cultural Educators and Cultural Mentors tends to be largely informal and relationship based. Respectful relationships, in particular with Medical Educators, were noted to be critical in the delivery of shared cultural and clinical teaching as well as in valuing the Cultural Educator/Cultural Mentor and the learning they facilitate. Similarly Regional Training Provider organisational approaches such as reconciliation action plans were described as providing evidence of cultural education being valued and Regional Training Provider advocacy for the roles was strongly recommended.

In addition to support from within training organisations, Cultural Educators and Cultural Mentors were noted to draw support from Aboriginal and Torres Strait Islander communities. This support and the importance of connection with communities, was recommended to be reflected in the terms and conditions of their employment.
Regional Training Providers requested guidance on identification, engagement and employment of Cultural Educators and particularly Cultural Mentors.

Interviewees agreed that Cultural Educators and Cultural Mentors must be supported through relevant professional development including skill development, for example in managing confrontation and bias as well as in relevant teaching skills. Whilst identification and support of career pathways for Cultural Educators and Cultural Mentors was generally supported, interviewees cautioned about requiring professional development and progression as a prerequisite for employment. Mentoring of new Cultural Educators and Cultural Mentors was observed to be important for the sustainability of the roles.

In section 3.2.3 of the report, cultural education and mentoring programs reported by the interviewees are discussed, starting with a consideration of engagement with Aboriginal and Torres Strait Islander communities and organisations.

Engagement between Regional Training Providers and Aboriginal and Torres Strait Islander communities and organisations was noted to be critical to delivery of effective cultural education for General Practice Registrars and Junior Doctors. The employment of Cultural Educators and Cultural Mentors by Regional Training Providers or Regional Training Providers in collaboration with other organisations, for example National Aboriginal Community Controlled Health Organisation Affiliates, was seen as a means of achieving this and of enhancing collaborative organisational planning. Similarly, reconciliation action plans were noted to enhance Regional Training Provider engagement with Aboriginal and Torres Strait Islander people and communities.

All Regional Training Providers reported formal requirements for General Practice Registrars to participate in cultural education, though the nature and extent of the programs provided varied greatly. Mostly, orientation to the Aboriginal and Torres Strait Islander Health Training Post was considered to be the role of the Aboriginal and Torres Strait Islander Health Training Post, formulated with Cultural Educators and Cultural Mentors and individualised to the particular Aboriginal and Torres Strait Islander Health Training Post needs.

In general, there was reported to be less cultural education provided to Junior Doctors and to Regional Training Provider staff and other stakeholders such as General Practice Supervisors compared with General Practice Registrars. Some Regional Training Providers reported integration of cultural education into “mainstream” teaching.

Challenges noted for cultural education and mentoring programs included the tailoring of learning to individual learner need and the related vertical integration of learning as part of a life-long learning experience; engagement of learners who believed cultural education was less relevant to them; recruiting and
preparing General Practice Registrars and Junior Doctors for Aboriginal and Torres Strait Islander Health Training Post placements; evaluation of programs and Aboriginal and Torres Strait Islander Health Training Post placements; provision of cultural education and mentoring for Aboriginal and Torres Strait Islander General Practice Registrars; and assessment particularly of General Practice Registrar and Junior Doctor values and attitudes.

The report concludes with recommendations for the future. Interviewees noted that building sustainable Cultural Educator and Cultural Mentor capacity to meet General Practice training needs required formalised, but flexible and localised, policies; respectful engagement with Aboriginal and Torres Strait Islander Health Training Posts; clarification around roles and responsibilities of Cultural Educators and Cultural Mentors and who is appropriate to undertake these roles; individualised support for professional development and consideration, but not requirement for career pathways; succession planning; valuing, respecting of and advocating for the Cultural Educator and Mentor roles; Cultural Educator/ Mentor and Medical Educator partnerships modelled in learning activities; a move away from medical models of education to strengthen cultural education; extension of cultural education particularly to Junior Doctors and other Regional Training Provider staff and stakeholders; and enhancement of life-long learning approaches, mentoring, evaluation and assessment activities.

The bottom line to improving the capacity for cultural education and mentoring was noted to be increasing the number and range of Aboriginal and Torres Strait Islander Health Training Post placements including in some places providing outreach experiences. Mentoring was noted to be important in supporting these placements as was preparation prior to undertaking the placement. Integration of cultural education into “mainstream” teaching was observed to be one way in which all General Practice Registrars and Junior Doctors could be exposed to cultural education prior to Aboriginal and Torres Strait Islander Health Training Post placements.

Finally, partnerships with Aboriginal and Torres Strait Islander people and communities were observed to be a whole-of-organisation priority requiring time, patience, commitment and understanding on all sides.

A number of core principles to inform a future framework for cultural competence in the context of General Practice vocational training were suggested. These are listed at the end of section 3.2.5. of this document.
1. Introduction

1.1. Research context

General Practice Education and Training (GPET) commissioned the University of Western Sydney (UWS), who sub-contracted with Urbis, to conduct research aimed at developing the evidence base to support training in cultural competence for doctors working with Aboriginal and Torres Strait Islander people. This research will inform a proposed National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.

In this report the findings from interviews and focus groups are described. These were conducted across Australia between May 2013 and January 2014 (including a piloting phase) with Regional Training Providers (RTPs), Cultural Educators (CEs)/Cultural Mentors (CMs), Medical Educators (MEs), Aboriginal and Torres Strait Islander Health Training Posts (IHTPs) including General Practice Supervisors (GP Supervisors) as well as General Practice Registrars (GPRs), Junior Doctors (JDs) and representatives of stakeholder organisations.

The information collected through these interviews and focus groups is a key component of a mixed-method approach which also included survey of a similar range of people involved in cultural education and cultural mentoring of GPRs and JDs and review of the literature. The other components of this research are reported in Appendices 1 and 2 of this report. In the body of the report all findings of the research are integrated and reported according to the requirements of the contract with GPET.

This report provides an overarching summary analysis of the data and focuses on the key themes identified.

1.1. The research team and oversight of research

The UWS-led research team included an experienced Aboriginal researcher and was advised in all aspects of the research by a consultant team of three highly experienced CEs. The cultural consultant team provided expert assistance in the planning, implementation and data analysis of the interview arm of the project. Urbis contributed expertise in all arms of the research as well as taking the lead on the development and analysis of surveys, and in the completion of the literature review.

The research was further supported by a GPET CE/CM Reference Group, which provided oversight of the research project overall and endorsed the methodology and interview instruments used.
1.2. Ethics approval

Ethics approval was received from a number of Human Research Ethics Committees (HRECs):

- HREC of the University of Western Sydney
- Aboriginal Health & Medical Research Council Ethics Committee
- Central Australia HREC
- Aboriginal HREC of the Aboriginal Health Council of South Australia
- Western Australian Aboriginal Health Ethics Committee
- HREC of the Northern Territory Department of Health and the Menzies School of Health Research.

1.3. References to data sources

Throughout this report interviewee quotes are identified according to the interviewee’s role and organisation type.
2. Method

2.1. Aim

The purpose of the interviews and focus groups was to gather qualitative data that would provide insights on aspects of the 16 key research questions identified through the GPET tender brief (see Figure 1). In the project’s final report the findings of the literature review, surveys, interviews and other research elements are synthesised, in order to provide a complete response to the suite of research questions.

2.2. Development of interview instruments

Interview instruments were designed to elicit data according to the 16 research questions. Interviews were conducted using a semi-structured interview guide. Originally, a suite of interview guides were developed, tailored for each respondent group (RTP staff, IHTP staff, CE/CMs, GPR/JDs and stakeholders). However, after two pilot site visits, these were revised to provide two aggregated interview guides, one for CE/CMs, stakeholders and RTP/IHT staff and another for GPR/JDs. The final interview guides are attached in the appendices of this document.

FIGURE 1: SIXTEEN KEY RESEARCH QUESTIONS IDENTIFIED THROUGH THE GPET TENDER BRIEF.

1. What is currently understood to be cultural education?
2. What is currently understood to be cultural mentoring?
3. What practices are currently used to establish positive relationships with Aboriginal and Torres Strait Islander peoples and communities? What is needed to engage and establish partnerships?
4. When are CEs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training?
5. When are CMs ‘employed’ and/or engaged in the development and/or delivery and/or evaluation of General Practice training?
6. How are CEs and/or CMs remunerated?
7. Do RTPs have formal policies in place in relation to supporting CEs and CMs?
8. Are CEs and/or CMs provided with the opportunity to participate in professional and cultural support and development?
9. Do RTPs run cultural education activities for staff at all levels, including MEs and GP Supervisors?
10. Are GPRs and JDs required to prepare for working in Aboriginal and Torres Strait Islander communities?
11. Are GPRs and JDs required to undertake formal cultural awareness training at any point during General Practice training?
12. How is Aboriginal and Torres Strait Islander health incorporated into current General Practice education and training practices?
13. Are there formal processes for feedback on cultural education and/or cultural mentoring activities?
14. Are there feedback mechanisms for GPRs and JDs who undertake an IHTP, and vice-versa?
15. What is needed to build sustainable cultural education and cultural mentoring capacity to meet GPR training needs?
16. What is needed to build partnerships with Aboriginal and Torres Strait Islander peoples and communities to sustain GPR training needs?
2.3. Interview participant selection and recruitment

2.3.1 Site visits

In consultation with the GPET CE and CM Reference Group six of the 17 RTPs were chosen for site visits. The sites were chosen to provide a mix of sites across jurisdictions, including regional, rural and metropolitan locations. Two or three members of the research team visited each site, usually including one of the Aboriginal cultural consultants to the team and two non-Aboriginal researcher(s).

The selected RTPs were:

- Sturt Fleurieu;
- WentWest;
- Northern Territory General Practice Education;
- General Practice Training Tasmania;
- Bogong Regional Training Network; and
- Tropical Medical Training.

A member of the research team initially contacted each site to arrange one or two days of interviews with RTP staff, IHTPs, CEs and CMs and GPRs and JDs.

The initial two site visits were considered as pilot sites, selected to provide feedback on the research tools and process from both rural and urban participants. Following the initial site visits, in addition to aggregating the interview guides, the recruitment process was altered to include direct contact with IHTPs rather than contact via RTPs so that interviews could be arranged directly with interviewees.

2.3.2 Engagement with stakeholders and other participants

The research team conducted further interviews with representatives of seven other RTPs, as well as with IHTPs, GPRs and JDs, CEs and CMs, and with nominated representatives of other stakeholders. Stakeholders had been identified in the original research plan in consultation with GPET, and included organisations with important roles and perspectives on Aboriginal and Torres Strait Islander General Practice training. These
stakeholders are noted in Table 1 of this report. Approaches to recruitment of interviewees included the following:

- email requests to RTPs for interview with organisational representative and request to circulate to CEs, CMs, MEs, GP Supervisors, GPRs/JDs and IHTPs working with them;
- email requests for interview of organisational representatives to all the stakeholder organisations;
- recruitment via the surveys – a request was made at the end of each survey form for those willing to undertake an interview to provide their contact details. These were followed up in all cases and most were interviewed;
- recruitment at two GPET CE/CM Meetings which took place during the data collection period; and
- snowballing recruitment whereby people noted to be working in related areas or with knowledge that may be useful in the research were contacted for interview.

Interviews were generally with a single participant though in some cases where the preference of the interviewee was for a group interview, this approach was taken. In one RTP a large group consultation session was undertaken with 20 participants who had a mix of roles within the RTP. Of these a proportion also participated in individual or group interviews. An additional opportunity towards the end of the interview period enabled consultation with 59 CE/CM/MEs attending GPET workshops (September 2013). To facilitate the discussions in this workshop, a discussion guide addressed particular questions where limited data had been gathered up to that point in time. Small group discussions were reported back to the wider group and the researchers took notes of the presentations and the discussions in the wider group.

2.3.3 Analysis

The analytical process began at the earliest stage of the project, with assessment of the literature and its key themes. These themes were further tested in the development of the surveys and interview guides, with questions designed to explore any gaps in knowledge and understanding. An iterative process throughout the fieldwork of identifying themes and knowledge gaps, and testing these further in dialogue with the literature, research data, and team members, continued throughout the project.

With participant consent, all interviews were recorded and notes were taken during the course of the interview, except for one interviewee who declined audiotaping, for whom notes only were taken. Most of the interviews were transcribed verbatim. The data from a smaller number of interviews were handled through
direct analysis of the audiotape recording with identification and transcription of key points only. In one case
data was collected via email response to interview questions posed.

These data, together with notes taken during the interviews and at the workshop, were reviewed and themes
corresponding to the research questions identified by two members of the research team in a framework
approach (Pope et al 2000). At two face to face research team workshops, attended also by the cultural
consultants, the research team reviewed the themes identified, looking for common views and areas of
experience, considering the numbers responding and similarities and differences between respondent groups,
as well as seeking divergent views and innovative approaches that may contribute to core principles informing
a new National Framework for Cultural Competence in Prevocational and Vocational General Practice Training.
3. Results

3.1. Participant profile

Interview data was collected from 95 participants, of whom 53 participated via face to face individual or group interviews, 41 via telephone interviews and one via an email response to interview questions.

Further to this, data was collected in two other workshops throughout the study period. Of the 20 participants who took part in a large group consultation within one RTP, 14 participants have not been included in this interview tally above as their roles within the organisation were not all individually clarified, however they were known to be a mix of RTP staff, including MEs and CEs, and GP Supervisors. In addition, a workshop held as a part of the annual CE, CM and ME GPET Convention Satellite workshops (September 2013) was attended by 59 participants, who provided input via small group sessions during which they considered key questions related to this project.

Participants had different roles within Aboriginal and Torres Strait Islander General Practice training. In response to letters of invitation, CEOs (or their delegates) from 13 discrete RTPs (including the initial six RTPs) were interviewed face-to-face or by telephone. Interviews were conducted with other RTP staff, CEs and CMs and MEs, particularly as follow-up to surveys where participants indicated a willingness to be contacted. Interviews were also held with 26 participants from a total of 11 IHTPs. Of the IHTP group four were CEOs, three were management delegates, 14 were CE/CMs or Aboriginal Health Workers (AHWs) and five were Senior Medical Officers or GP Supervisors. Nine GPRs and five JDs were interviewed in total. Including the National Aboriginal Community Controlled Health Organisation (NACCHO) and its State and Territory Affiliates, representatives from 18 stakeholder organisations were interviewed (see Table 1).
### TABLE 1: INTERVIEW AND SURVEY PARTICIPANTS

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Number Face to Face</th>
<th>Number by Phone</th>
<th>Number of RTPs from which participants were drawn</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTP Delegate</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>CE/CMs (including AHWs in these roles)</td>
<td>20</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>MEs</td>
<td>7</td>
<td>3 (plus one via email)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plus 59 CE/CM/ME Workshop attendees</td>
</tr>
<tr>
<td>GPRs/ JDs</td>
<td>4/2</td>
<td>5/3</td>
<td>4+(^1)</td>
</tr>
<tr>
<td>GP Supervisors/ Medical Directors IHTPs</td>
<td>6</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>IHTP CEO or delegate</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>NACCHO and all State and Territory Affiliates</td>
<td>7</td>
<td>2</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Organisations - 9 phone interviews with representatives of:
- Australian Indigenous Doctors Association
- GP Registrars Australia
- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine (ACRRM)
- Indigenous General Practice Registrar Network (IGPRN)
- Aboriginal Health College
- National Aboriginal and Torres Strait Islander Health Worker Association
- Institute for Urban Indigenous Health
- Kaela Institute

All interviewees including the workshop participants were provided with the ethics approved participant information statement and completed a participant consent form.

\(^1\) Four GPRs/ JDs did not specify their RTP. Four distinct RTPs were identified by those GPR/JDs who did specify.
3.2. Thematic results

3.2.1. Understanding of cultural education and cultural mentoring

Definitions

Most participants agreed that the current definitions used by GPET to describe cultural education and cultural mentoring (see Appendix 2) were appropriate. However, participants commented on the difficulties of defining these often overlapping activities and roles, noting the impact of their varying contexts. These comments provided evidence of the varying community and organisational expectations and the importance of respecting the wishes of Aboriginal and Torres Strait Islander people and the IHTPs working in this area to be able to define their work and their role in General Practice education in a way that feels comfortable to them.

Most participants shared the same broad understandings of cultural education and cultural mentoring, but how these were operationalized in local contexts was diverse. Correspondingly, the roles of CEs and CMs were seen as overlapping and varied. Some interviewees commented that definitions may be limiting, as CE and CM roles and job titles can be ambiguous and hence conversations about cultural education and cultural mentoring can be potentially misleading.

I think there’s the potential for people to have their own understandings about what those [cultural education/cultural mentoring] terms mean, and that it’s probably not uniform, even despite these [GPET] definitions. What cultural awareness does and cultural safety does, is give the broader perspective of a completely different outlook that allows us to see that we’re two people in a room, in a consulting room, and your experience may well be hugely different to mine. (Stakeholder).

Aboriginal and Torres Strait Islander Health Training Post staff in particular tended to have a more holistic interpretation of the terms cultural education and cultural mentoring and were more likely to see the roles of CEs and CMs as intertwined within their organisations and affiliated with the work done by AHWs and other Aboriginal health practitioners within the organisations.

Despite the overlap between cultural education and cultural mentoring, most participants agreed it was useful to define them as different activities. Hence, when considering the interview data resulting from this research, these were considered separately while keeping in mind the intersections between both activities. Furthermore it should be noted that participants repeatedly emphasised that local Aboriginal and Torres
Strait Islander communities varied in their models of cultural mentoring in particular, and that dramatic differences can exist within and between regions.

The aims of cultural education and cultural mentoring were seen as similar in that they both aim to train JDs and GPRs so they are able to provide culturally competent and effective care for the benefit of the Aboriginal and Torres Strait Islander people and communities.

According to interviewees, a core principle needing to be taught as part of cultural education is the importance of listening to the community and individuals, and allowing the learning achieved through this approach to facilitate change in understandings and practice. Cultural education was considered to be a lifelong process for the individual however, more likely to be of short term duration in terms of cultural education activities delivered within General Practice training. Cultural education was stated to be required in order to make GPRs and JDs aware of Aboriginal and Torres Strait Islander history, culture and health, and to promote the importance of cultural respect in their work with Aboriginal and Torres Strait Islander peoples. There was consensus that cultural education needs to be endorsed by the local community and delivered in the recognition that local differences are key. However, many felt that cultural education may not require as great a local focus as was characteristic of cultural mentoring.

Cultural mentoring was seen as a one-to-one advisory relationship between an Aboriginal person and a GPR or JD which can be time-limited according to need and is in almost all cases provided in a local context. It was noted cultural mentoring can be wider than General Practice training, with cultural mentoring importantly also identified as being provided to RTPs, IHTP management, non-Indigenous staff and to Aboriginal and Torres Strait Islander staff who may be new to the service area or early in their career. Cultural Mentors were described as trusted, well regarded people in the community who needed to possess both the skills and local knowledge to fulfil the role.

Interviewees commented on the importance of flexibility with terminology referring to cultural mentoring. At present, the term seems to be largely associated with a person of stature who is from the local community. Some people who work within services in this role could be considered ‘cultural coordinators’ because they link GPRs and JDs to others but may decline the title CM because they may be young, or from a different region. Some interviewees suggested that communities might decide on nomenclature and that there isn’t a compelling argument to refer to CEs or CMs if the local community doesn’t find these titles helpful. Others suggested decreasing focus on terminology and increasing focus on the role of the CM.
That’s the issue that I have...I don’t want to be a formal Cultural Mentor or Educator because...I don’t feel like it is my right to do that when I’m not from here. Might be different if I’m back home but not here...Maybe it’s about the title (AHW at IHTP).

**Models of cultural education delivery**

A variety of models of delivery of cultural education were identified during interviews. In some RTPs, cultural education is delivered by RTP staff, in others by the local IHTP on behalf of the RTP or in collaboration with the RTP. In some states or territories, cultural education is delivered by the NACCHO Affiliate, or collaboratively by the NACCHO Affiliate and the RTP. Occasionally, cultural education is provided by the Affiliate for organisations such as hospitals and not necessarily specifically for GPRs. In a minority of locations, cultural education is delivered by the RTP drawing on resources belonging to commercial cultural competence training packages and/or external resource people.

Not all models of cultural education were equally valued by interviewees. Some interviewees viewed commercial packages as an inadequate check-box option for RTPs which did not ensure quality or local endorsement of the training.

*It becomes an issue because there is an industry that’s created across the country which is essentially a cultural education industry, but ...there is no checks and balances to make sure that what [an RTP is] actually purchasing from the person fits against the current GPET framework in terms of the knowledge and skills that it wants to impart upon registrars coming through* (Stakeholder).

Interviewees noted the importance of the orientation of cultural education programs to the local community, and commented that programs ought to be delivered locally when possible. There was agreement that face-to-face program delivery is preferable because of the opportunity for interactive discussion and it was noted that a core component of cultural education is answering the learners’ questions. The face-to-face mode was noted to be usefully supplemented by on-line and written material but interviewees warned that this should not be the sole cultural education opportunity.

**Content of cultural education programs**

Interviewees identified cultural respect, humility and cultural competence as essential elements in any cultural education program. Interviewees believed that cultural education must reference historical events and the way these events continue to impact Aboriginal and Torres Strait Islander health. Other content recommended included explanation of Aboriginal and Torres Strait Islander culture and the way culture interacts with health...
and health care. Including content which allows reflection on attitudes and racism was considered important. Family and community life were seen by interviewees as central to health care concerns and perhaps for this reason emphasis was placed on the need for cultural education programs to be endorsed and delivered locally. On-the-job guidance was also noted as a role of CEs, for example, through accompanying MEs on external clinical teaching (ECT) visits.

**Roles of the Cultural Educator**

Interviewees reported that CE roles vary according to location however there was substantial agreement that the CE’s principal role is to provide information that can assist new GPRs and JDs in their orientation to and work in the health service and community. Cultural Educators can be responsible for facilitating cultural immersion programs, workshop release days and inter and intra organisational staff development programs.

**Cultural Educator engagement in program development, delivery and evaluation**

Interviews indicated that while CE engagement in program development is not a regular feature of cultural education, in some locations CEs design and deliver programs and are fully engaged in ongoing cultural education program development. This appeared to be particularly the case where they are integrated into the RTP either through direct employment or secondment from the NACCHO State Affiliate. Some IHTP staff also reported involvement in multiple aspects of cultural education program delivery, particularly where this is subcontracted to the IHTP.

Interviews revealed that CEs are not frequently or systematically involved in program evaluation or GPR/JD assessment activities. Some interviewees however reported CE roles in formative assessment such as ECT visits and during tutorials, case based discussions, teleconferences, and in review of reflective statements written by GPRs and JDs.

In general it appears that CE involvement in program development, delivery and evaluation is less common within RTPs that do not have a formal relationship with a CE whose time and expertise can be drawn upon in this way. Some RTPs reported this lack as problematic and, as later noted, were keen to receive direction to facilitate a solution to this situation (see The Future, Section 3.2.5).

**Models of cultural mentoring**

Interviews provided ample evidence of the many models and processes belonging to the CM role. Whether or not an RTP employs a CM appeared to vary according to location and organisational structures of the RTP. Furthermore, cultural mentoring was evidenced to be highly variable in its delivery. The model used often depends on the local context and sometimes on decisions of the IHTP.
One example of cultural mentoring described by interviewees is for identified persons, appropriately skilled, to be appointed by the IHTP and to act as the ‘go-to’ persons for the GPR. Another example is a formalised process where GPRs and JDs are linked to a matched community CM or a group of CMs in the community. Other models within some IHTPs include a whole-of-service cultural advice and support process for all non-Indigenous staff and a less formalised CM role such as the cultural brokerage role undertaken by AHWs and other Aboriginal and Torres Strait Islander health practitioners as part of their normal duties within the health service.

Uncommonly, cultural mentoring was described as formalised. It was more usually noted to occur opportunistically and informally, in response to identified needs. Interviewees described a tendency for cultural mentoring to therefore be responsive rather than proactive, in contrast with cultural education which was noted as more likely to be a planned activity. GPRs often were said to be identified as needing mentoring through their own questioning, through referral from the GP Supervisor who had identified cultural learning needs, after complaints from patients or on referral from IHTP staff who were concerned about some element of health care provided by the GPR/JD. It was noted that this could mean some GPRs who did not request support and who were not the target of complaints may not receive the degree of cultural mentoring which may benefit them.

A majority of interviewees supported the model of cultural mentoring delivered in the face-to-face context and with a trusted, well-regarded member of the local community. Cultural mentoring also seemed to include a component of ongoing relationship during the placement.

*But the ongoing relationship, I think that’s what changes people’s behaviours more than one-off teaching, and I think that’s the problem with the way we think about medical education (Stakeholder).*

However, it was also suggested by one participant that mentoring could be provided remotely via video-link in some circumstances.

**Roles of the Cultural Mentor**

Interviewees report that the role of the CM can include cultural education activities, such as facilitation of cultural education workshops and opportunistic on-the-job teaching.

However, interviewees also pointed to the distinction that the content belonging to cultural mentoring is more specific to the local context. For example, the CM may offer guidance on how to apply broad messages that have been communicated within cultural education sessions to the local context. One CE interviewee
described the CM as the ‘extended arm (into the community) of the CE’. Interviewees commented that the CM needs to be the ‘right’ person; that cultural mentoring requires particular personal characteristics or qualities, some of which can’t be learned. These characteristics will assist in forming the cultural mentoring relationship and also provide the CM with the role authority to do his or her job.

An important role of the CM was seen to be as a communication broker between the GPR/JDs and their patients and the local community. In the IHTP setting, this could include providing translation and cultural guidance to assist communication during consultations, both at the IHTP and on outreach visits. Another brokerage role was facilitating connections, including with other IHTP staff or with members of the community, to help meet the cultural awareness needs of GPRs. The CM has been described as the ‘go-to’ person who forges and nurtures links between GPRs and community members, this function may also include advocacy on behalf of community members and also on behalf of GPRs and JDs.

The overlap between the AHW role and the CM role was evident in many IHTPs. Some interviewees commented that informal cultural mentoring models may overlap with the role of the AHW and that the divide between a CM and an AHW is artificial. An example of this naturally intersecting role was described as occurring in an IHTP where an AHW speaks with all patients prior to the consultation with the GPR or JD and then provides advice on cultural or community issues likely to impact on patient management.

A number of AHWs described cultural mentoring as an important facet of their AHW role and argued that this aspect of their work needs to be supported in ways that are decided by the IHTP. Interviewees noted that this support does not necessarily mean payment, rather a designated role within the IHTP. This role would need to take into account the fact that often AHWs may not be from that community.

This view was contested by those who consider cultural mentoring to be a separate role to that of the AHW, primarily because the cultural mentoring task can place a burden upon the AHW and on health service provision that becomes untenable. The AHW can sometimes no longer perform the Health Worker role because of competing cultural mentoring expectations. Some interviewees suggested that the CM should be a person who is outside the organisation of the health service. Similarly health services were also noted to come under pressure if their health care staff are called on to provide cultural education and mentoring to visiting non-Indigenous health providers.

Interviews indicated that Aboriginal and Torres Strait Islander people affiliated with RTPs or IHTPs as ‘community advisors’ fulfil a role similar to that of a CM at the organisational and management level. These ‘community advisors’ appear to exert some level of influence on organisations, though not necessarily with specific engagement in General Practice training.
Some interviewees suggested that cultural mentoring can be more manageable when CMs support specific initiatives rather than all-encompassing mentorship throughout placements, for example, provide mentorship to GPRs and JDs in weekly meetings with set objectives and in cultural awareness workshops.

Interviewees acknowledged the crucial role of the CM in supporting and training younger Aboriginal and Torres Strait Islander people employed within Aboriginal and Torres Strait Islander health services, who may be potential CMs themselves.

**Cultural Mentor engagement in program development, delivery and evaluation**

Interviews revealed minimal evidence of CMs engaging in the development, delivery and evaluation of General Practice training unless the CM holds a dual role as CE. It appeared from some interviews in IHTPs that CMs and AHWs do undertake significant formative assessment of GPRs and JDs during IHTP placements. Though this informs the teaching, it is not formally collected beyond liaison with GP Supervisors.

**Impact of cultural education and cultural mentoring**

Cultural education was seen by most people as an important component of Aboriginal and Torres Strait Islander health training for GPs, particularly in view of the need to ensure that GPRs and JDs have at least some introductory level of knowledge when they start their IHTP placements. Orientation to Aboriginal and Torres Strait Islander history, culture and health through cultural education were seen by CEs and CMs, MEs and GP Supervisors to be key components of cultural education. Furthermore, it was seen as an important and desirable impact of cultural education to create enthusiasm and motivation for GPRs and JDs to seek further learning and experience in Aboriginal and Torres Strait Islander health.

Though most interviewees considered that some cultural education was inevitably relatively didactic and knowledge based, many noted cultural education had more impact when it was more interactive, locally focussed and experiential. There was also broad recognition that the benefits and impact of cultural education would be increased by enabling more GPRs/ JDs to undertake experiential placements. This was a strong theme in the GPR/JD interviews, where the highest perceived impact was from cultural immersion activities and personal relationships and experiences in Aboriginal and Torres Strait Islander health.

Interviewees highlighted the importance of cultural education to IHTPs, given their responsibility to their community to ensure community members receive good health care facilitated by effective communication and health management across cultural barriers. It was stated that without cultural awareness and effective communication, health care provided by GPRs/ JDs may be confusing and unhelpful to patients. Some interviewees from IHTPs also believed that cultural education helps communities attract and retain doctors.
Although formalised, one-to-one cultural mentoring was not a universal experience for GPRs/JDs working in Aboriginal and Torres Strait Islander health, when it did happen it was seen as particularly valuable. Many interviewees, both GPRs and JDs and more experienced GPs now working as GP Supervisors and MEs, recalled positive experiences of cultural mentorship, usually involving mentoring relationships that had emerged naturally. For example, a member of the local community or a staff member within the IHTP would “stand alongside” the GPR/JD and provide both practical and often relational support. One GPR believed that cultural mentoring from a number of community members had enabled him to become involved in the community in a deep and highly supported way.

Cultural Educators working in centralised RTP roles believed CMs within IHTPs and communities were very important and had a very positive impact on General Practice training. They also believed that without their partnership with community CMs it was much more difficult to provide effective cultural education and support to GPRs/JDs. GP Supervisors also emphasised the important role played by CMs, in terms of the teaching a CM could provide to GPRs/JDs and the complementary roles played by GP Supervisors and CMs in ensuring culturally safe and effective care to patients at the IHTP.

Challenges of cultural education and cultural mentoring

A range of challenges in cultural education and cultural mentoring were described by interviewees as discussed below.

Providing cultural education and cultural mentoring that is applicable to the local context

Interview data strongly endorses the view that one model of cultural education and cultural mentoring does not suit every context. Thus, one significant challenge is to both impart particular cultural knowledge while recognising that the imparted knowledge will often need to be adapted to the local contexts. This can be particularly challenging when a centralised RTP has multiple IHTPs from diverse communities.

Why would tropical North Australia have similar cultures, food gathering, experiences and ceremonies, as central desert Australia, as South East coastal Australia, as South West Australia, let alone Melanesian Torres Strait Islanders from different Islands? So we have this word “Aboriginal” that’s actually a coloniser’s word...that puts one thing onto this hugely disparate group of cultures, and then attached to that, we have cultural education and cultural mentoring as if we can teach this one thing, and we can’t (Stakeholder).

Some argued this means that the most effective cultural education in these settings promotes cultural respect and humility, and that it is potentially impossible to provide suitable ‘generic’ cultural education. However,
others argued that at least some orientation is essential before arriving in the community and that clear messages to learners about the need for local adaptation and advice from employing IHTPs mitigate against the risk of locally incorrect messages being given.

Recognising and meeting the needs of Aboriginal and Torres Strait Islander General Practice Registrars

General Practice training was seen by some as not yet adequately catering for the cultural education and mentoring needs of Aboriginal and Torres Strait Islander GPRs. They are likely to come from diverse backgrounds and have received variable cultural education themselves, and face particular challenges throughout their General Practice training. The usual cultural education and mentorship provided within their RTP may need to be adapted in some circumstances.

Delivering cultural education and cultural mentoring programs

Some interviewees questioned what cultural education is teaching GPRs and JDs, and the pedagogy through which cultural education is ‘taught’. For example, are there appropriate reflexive processes providing effective means for GPRs and JDs to improve their practice as opposed to rote learning of static facts which gives the GPR and JD a false impression of their own cultural competency?

Interviewees warned of the temptation to deliver cultural education programs in relatively short time frames or online. The challenge is to allow reasonable time for participants to experience, reflect on and act as a consequence of the cultural education programs they have attended.

Interviewees suggested that some potential exists for the medical model of education to dominate educative processes for GPRs and JDs and that this medical model may not be the most effective instrument for helping GPRs and JDs learn culturally positive ways of working in an Aboriginal and Torres Strait Islander health context. Increased recognition of the importance of combining both cultural and medical education was recommended. A related challenge was observed to be the engagement of potential participants in these cultural awareness activities. The focus on the medical model of health in General Practice training, including in GPR assessment, and the views of some learners that Aboriginal and Torres Strait Islander health was not relevant to them, created significant challenges which were recognised by interviewees from all work roles.

The delivery of cultural education was recommended to be flexible, drawing on formal and informal processes which impart relevant knowledge whilst safeguarding the cultural safety of all participants. Interviewees commented on the need for a mutually safe space within which CEs/CMs and GPRs/JDs can express ideas and thoughts and ask questions, and noted the importance of feeling comfortable to share cultural knowledge and experience. It was further commented that for this to happen, CE/CMs need to possess a very good sense of
self and self-assurance and know how to respond and react to the opinions of others that may well be in conflict with their own cultural mores.

Mention was made of the need to recognise the power differential which exists between the CE or CM and the GPR/JD. Whilst this differential can provide opportunity for reflection by the GPR or JD, it can also create discomfort for the CE/CM. On a related topic, while mandatory cultural education was reported to be desirable, some GPRs were said to hold views and attitudes that are not conducive to a positive experience for other participants attending mandatory cultural education programs and activities.

An interviewee commented on the risk of CEs and CMs developing ‘hard shells’ so that they can keep performing CE and CM roles in sometimes challenging circumstances. It was observed that this protective response can lead to CEs and CMs working less effectively in managing relationships with GPRs.

Some interviewees commented on the need for vertical integration of teaching so that cultural awareness and experiential learning can be built on and deepened for GPR/JDs at different stages of learning. The challenge is to develop a cultural education process that invites GPRs to advance through different levels of expertise and cultural understanding.

The title of Cultural Educator or Cultural Mentor as a barrier
A number of interviewees commented that Aboriginal and Torres Strait Islander people don’t always feel comfortable being considered a CM or CE. Several Aboriginal and Torres Strait Islander interviewees believed that it is unacceptable for them to assume these titles which are seen as implying community recognition of stature and authority to speak about local cultural matters. Though they may have the skills and a compatible position (e.g. as an AHW, clinic coordinator in an IHTP, Aboriginal person working in an RTP or Affiliate, Aboriginal and Torres Strait Islander GP), and often are fulfilling what many would define as the role of a CE or CM, they were reluctant to identify formally as such. Most commonly this was because they were not born in the local community, though in some cases they had lived in the community for many years. In other cases they were young and believed they could not assume a role involving the giving cultural advice. For some interviewees, assuming such titles would be as self-promotion, a ‘shame’ matter.

Sometimes it’s just around clarifying the role though, I mean demystifying it a bit because when we originally were thinking about this it was never meant to be like the cultural – the person who was the owner of all the cultural knowledge stuff. It was just somebody who was Aboriginal and was local, that knew a bit about their local culture that could actually help people out a bit, or even just point them in the right direction for something
'cause they were never intended to be the answer to all of the cultural needs of the person
or knowledge (CE/CM at IHTP).

**Engagement of Cultural Mentors**

Some interviewees expressed uncertainty about how to identify potential CMs and how to approach a community member to ask if they would be willing to be a CM. This was noted to be a difficulty particularly for RTPs. At times this was seen to depend on whether there were key people within the community who were willing to be CMs, given the high expectations of what was in many cases a voluntary role. Several interviewees from RTPs indicated a desire for guidance in this area.

*Cultural mentoring probably does need a position description... Regarding how to appoint a Cultural Mentor... well, I think that it’s a bit tricky. I’ve never been to the community. I’ve been to AMSs [Aboriginal Medical Services] and asked them, but not to the community as a whole and I’ve assumed that the AMS represents the community, but sometimes that’s not always the case and it does have to be somebody who’s just generally recognised as being someone who’s able to take on that title... All the time one should be thinking about successors and potential additional people to the pool so that if someone appears to be maybe a good person for the role, but they should be approached and asked if they want to be involved and maybe mentored by the cultural mentor (RTP CE).*

A challenge identified by some interviewees was the potential conflict between the need for RTPs to respect the IHTP lead in provision of access to CMs within its organisation, while remaining answerable to GPET and its GPR/JDs regarding the provision of best practice Aboriginal and Torres Strait Islander training. It was suggested that IHTPs may need more support to enable cultural mentoring of GPR/JDs during their placements.

**Provision of cultural mentoring**

Understanding of the CM role and how it should be operationalised is a significant challenge identified by several interviewees. Comment was made that the job description endorsed at the September 2013 Perth GPET conference is a positive step in clarifying the role of the CM but it was noted that this job description does not clarify who employs the CM and who funds the CM position.

Provision of cultural mentoring within IHTPs was seen as a challenge by a wide range of participants, including those who worked in RTPs and in IHTPs. It was felt that as cultural mentoring is mainly provided to proactive GPRs and JDs or those who were seen to have cultural support needs, there is a danger that some GPRs and JDs may miss out on valuable cultural mentoring due to personality factors or due to relatively higher cultural
competence. Several interviewees indicated that introducing a process of assigning CMs may be an effective approach to GPR and JD training.

Some IHTP interviewees noted the demands of providing CMs to large numbers of learners coming through communities and IHTPs thus potentially creating a risk that Aboriginal and Torres Strait Islander health practitioners have less capacity to provide the health care that is needed and for which they are employed.

“They have to be left to their job... We’re hearing it from them...They’re being seen as tour guides (CE)”

The pressure placed on the relatively small Aboriginal and Torres Strait Islander workforce by General Practice training placements was recognised also by RTPs.

“Something I think is coming out quite strongly in our RTP and others I heard at the convention, is that sometimes this just falls back on other workers who are there, which is rather than identify someone in the community who you know. Sometimes that does happen, or for part of the cultural education and mentoring an Elder is approached and asked if they would do something. But most of the time it falls back on Aboriginal Health Workers and nurses and other people who are working at the AMSs, and they are already overloaded and we haven’t really worked out a very good way to sort of, I suppose, quarantine some of their time, pay them appropriately, find out even if they really want to do this, it’s just kind of happening a bit by default (RTP).”

**Challenges encountered in cultural mentoring**

Interviewees commented that when the CM is a member of the local community he or she may be required to be constantly accessible to the community and that frictions within the community may further exacerbate the already demanding CM role. There was said to be a real risk that these contextual issues may lead to burnout of experienced CMs.

Interviewees observed a further challenge to the CM role in the area of relationships with GPRs and JDs. In some communities “adoption” of a GPR implies mutual responsibilities and expectations which can occasionally lead to misunderstandings and conflict. Conversely, adoption into communities was seen by others as a community-generated way of formalising the CM role. Finding ways of clarifying these reciprocal relationships so that expectations are understood and acknowledged was noted to be important.

Cultural mentoring was seen as an inherently challenging role, and expectations of CMs could be unrealistic if not clearly delineated to all parties concerned including RTPs and GPRs/ JDs.
It’s just that in that relationship it would be up to GPET or whoever is organising the stuff to, say, get some feedback on what people think is in scope and out of scope, or what people should be comfortable with, or have some sort of understanding anyway that there are probably limitations to the relationship…[It’s] defining that there’s a relationship, but relationship can mean different things to different people, that’s all, and the nature of that relationship can be different and can be pretty dynamic depending on where you are, who you’re working with and who’s giving you the education, or who’s mentoring (CE in IHTP).

Interviewees were clear that CMs are to facilitate relationships rather than try to solve people’s problems.

I think that’s the principle, is that individuals in communities and Aboriginal communities themselves need to be able to do self-determination and all that that means, and that we are there to facilitate that, not to jump in and solve people’s problems for them. That can be quite an alien thing for doctors to do and I think the understanding that comes about from cultural awareness that there are other ways of thinking around these problem than the ones we have been taught in medical school, is the important one (Stakeholder).

One GPR participant believed that the cultural brokerage role of AHWs in IHTPs may at times require increased attention to providing feedback and teaching to the GPR.

Aboriginal Health Workers need to be conscious of getting back to GP Registrars, for example, when troubleshooting a communication issue between doctor and patient (GPR).

One interviewee reflected that within the IHTPs those doing the mentoring are often more used to taking direction from the GPR rather than giving them directions – the CM needs confidence to tell people when they are doing something wrong.

Another challenge is that the CM has to be supportive of the learner, yet he or she may not actually have much contact with the GPR. Some interviewees commented that establishing trusting relationships between CMs and GPRs and JDs may not always be easy, particularly when the GPR or JD holds beliefs and assumptions that are opposed to Aboriginal and Torres Strait Islander traditions and beliefs. Discomfort was also described when issues that have arisen for the GPR may be too sensitive to be comfortably discussed by someone in the community.
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity

Appendix 3: Interview and Focus Group Report

**Professional development, training and support**
Several participants noted that the roles of CEs and CMs are challenging and require high level skills and resilience, and are not something that can be undertaken by any person simply by virtue of being part of the community. The expectations and roles of CMs in particular were observed to be poorly defined and occasionally CMs may be uncertain about what it is that GPRs and JDs need and what is expected of them in their role. Adequate professional support and training was seen as likely to decrease role stress however the possibility of introducing CE and CM qualifications was seen as potentially controversial. (See Employment and Support for Cultural Educators and Cultural Mentors Section 3.2.2 below.)

**Relationships**
Several interviewees commented on the need for more collaborative relationships between IHTPs and RTPs, for example, in relation to budgetary planning. Other interviewees commented that structural change in GPET funding poses a challenge to Affiliates to develop better relationships with RTPs.

Some interviewees perceived that the value of the training provided to GPRs working in IHTPs was underappreciated at the RTP level, and that more organisational commitment to Aboriginal and Torres Strait Islander General Practice training was sometimes needed.

*He was working in an Aboriginal Medical Service as an area of need position, and joined the GPR training program, wanted to carry on, the AMS wanted him to carry on, and they said, ‘Oh no, the Aboriginal Medical Service isn’t a particularly good area for training’...so there’s varying commitment to it and I think it does require organisational commitment and understanding (Stakeholder).*

Because relationship building was seen as key to engagement between Aboriginal and Torres Strait Islander peoples and communities and non-Indigenous organisations, some interviewees commented that a significant challenge is to develop guidelines and sustainable funding in support of these relationships.

Some interviewees commented about the struggle to engage, educate, support and maintain the CEs and CMs with whom the organisation has developed relationships, emphasising that CMs and CEs were such scarce and valuable resource people that all efforts needed to be made to support them.

**3.2.2. Employment and support of Cultural Educators and Cultural Mentors**

*Employment of Cultural Educators*

Interviewees described a range of employment structures for CEs, including:
employment by and within the RTP;

contractual or other formal agreement between the CE and the RTP;

employment by the NACCHO Affiliate with part-time participation in CE with the RTP; and

employment by the IHTP with remuneration from the RTP.

**Employment of Cultural Mentors**

Interviews illustrate a range of occasionally formal, but more often informal, models of employment:

- Cultural Mentors working in IHTPs, for example, may be remunerated by the IHTP via funding provided by the RTP;
- Cultural Mentors may be employed by RTPs in dual CE/CM roles;
- Cultural Mentors may be employed by other organisations (for example by IHTPs) and be called upon to provide CM services to RTPs on an *ad hoc*, unremunerated basis;
- in some instances, paid community advisors attached to IHTPs provide cultural mentoring outside any funding structure provided by the RTP, for example, one RTP described drawing on the services of a CE/CM who is remunerated by the State/Territory Government;
- occasionally, unpaid community advisors provide cultural mentoring to GPRs and JDs, outside their usual employment; and
- in one instance a local community reference group was described as identifying community members appropriate to provide cultural mentoring.

More controversially, CM tasks were described to sometimes fall to the AHW within the IHTP. A significant number of AHWs stated that cultural mentoring is an important facet of their health worker role and argued that this aspect of their work needs to be supported in ways that are decided by the IHTP. A model suggested by some would be financially supported and planned teaching sessions within IHTPs similar to those provided by GP Supervisors. Other interviewees noted that this support does not necessarily mean payment, but could involve assignment of a designated role within the IHTP, which may also take into account AHWs who are not actually from that community, but who act as CMs.
As previously noted, several participants considered the CM role to be separate to the AHW role, primarily because of the resultant additional workload. These interviewees suggested that the CM should be a person who is outside the organisation or the health service.

**Remuneration of Cultural Educators and Cultural Mentors**

While CEs mostly appear to be remunerated for their work, the prevalent model of voluntary cultural mentoring is seen as unjust by many interviewees. While some people performing CM services may be willing participants, interviewees insisted that RTPs should not take advantage of this willingness by expecting people to perform CM tasks without remuneration. Many interviewees believe some kind of reimbursement for CMs is needed. They recommended this reimbursement should be sustainable and appropriate to the individual and the community, for example, by taking into account potentially detrimental impacts on other entitlements. As interviewees commented:

*In a sense it’s okay if they’re employed doing something else and the mentoring is an add-on, but to not be employed at all, but to be expected to do it, doesn’t seem right and that’s not sustainable (RTP ME)*

*Can I say, remuneration is more than just money. For instance, if you work in a community as a doctor you’re supplied with a house to live in, your electricity is paid, your phone is paid, your Internet is paid, your TV is paid for. But you work in a health centre with a health worker who is on call, they pay for their own telephone, they pay for their own electricity, they pay rent, they have their own vehicle that they drive there and they pay for their own fuel. Community people who are asked to do these things, they see these people come and go, and have plenty of advantages. It’s not unreasonable, I think, sometimes for them to expect that you might take your car hunting, when it’s provided for you. But – and things like paying the telephone bill for someone who is able to be a CM is a way of saying that you value that they are available on the telephone. And health centres don’t actually do that for Aboriginal people who come and go (RTP CE).*

While remuneration for CMs was seen as important, interviewees also acknowledged a range of challenges that may be encountered when establishing payment structures. For example, remuneration may imply an expectation that the CM is constantly available to provide CM services. This expectation can be particularly problematic when CMs have other, competing commitments and work in multiple settings. Burnout can be a possible outcome of this overload.
I think a lot of Aboriginal people work between three or four different places at any given time and manage it really well. I mean I don’t think – I think their ability to do that is fine. It’s how they see that role at different times around this formalised kind of approach. It’s just interesting I think that they’d like to see – like to be acknowledged for the – that work that they do. I think that’s – I don’t find anything challenging about that particularly, other than if you’re going to pay them you just might have to pay a flat rate, that’s all (IHTP)

It was noted that some people who act as CMs don’t want full-time employment, either because full time employment may impact on entitlements, and or because the CM is already committed to other responsibilities and activities.

Several interviewees considered that the turnover and fluidity of positions in the CM sector may work against typical forms of remuneration, although it was clearly stated that remuneration remained an important consideration. Some interviewees commented that typical business practices (such as submission of time sheets) are seen as unnecessary formalisation when cultural mentoring may mean catching up informally with people. Interviews further confirmed the complexity of remuneration particularly those aspects relating to time and role boundaries, where in some settings cultural mentoring is provided opportunistically and without clear scope of employment.

There’s been great difficulty in sort of trying to set up the notion of the more formalised CM program, that’s when you start to talk about roles and responsibilities and available hours and then remuneration...It becomes impossible because...theoretically you want the person to be available “all the time”. You can’t pay someone to be available all the time because it’s just an impossibility, and so what is it that you need them to be able to do? And that’s why I say it’s got to be more of a local thing, but it is complicated and I think had it been less complicated it might have been sorted out before now...but I know that what happened with that sort of acknowledgement of that being the case, is that both the people are nominated as CMs, both go out of their way to say “hi” to [name] and catch up with her. So people are sort of taking it seriously but they’re not being paid. They are both employees of the health service, though, so I guess it could be included in their employment (Affiliate GP).

Support for Cultural Educators and Cultural Mentors

Interviews did not reveal many formal policies relating to support of CEs and CMs, an area of challenge noted above (Challenges of Cultural Education and Cultural Mentoring). A number of RTPs employ CEs or CMs, and other RTPs enter into ad hoc arrangements according to the need for cultural education and cultural
mentoring at a particular time. The latter arrangement would appear to negate a formal policy for support of these roles. Interviews indicated that support for CEs and CMs tends to be mostly informal and relationship based within RTPs.

The need for respect throughout the RTPs for those who voluntarily take on a CM role in communities was strongly advocated. Interviewees commented that informal, respectful, supportive, collegial relationships within the RTP are of great value, both in terms of the personal support they create but also because it affirms the importance of the role of CEs/CMs within General Practice training.

...just about having that belief and respect enough to say, “Well [name] is our Cultural Mentor for our organisation.” They’ve had respect for me to come in and talk to the GPRs about that. And they say to GPRs, “Do you have any issues about Aboriginal health? Well, call [name] (CE within RTP).

Many CE and CM interviewees commented on the critical importance of the support they receive from Elders, community members and family. This is needed to maintain their confidence and skills in cultural education and mentoring and to support them in the challenges they may face in their role.

The thing I do is, I go, as an Aboriginal person, I go back to family members. So I speak to my Elders a lot. I suppose I’m pretty lucky, I’m pretty strong in my culture being the eldest grandchild in my family, so I’ve been taught a lot (CE)

Some commented on the need, in light of the importance of this cultural connection, for adequate leave for bereavement and other important community activities.

The lack of remuneration for CMs’ work was noted as an example of a lack of formally supportive policies. Sustainable long-term funding was recommended to support proper planning by IHTPs with a suggested fiscal planning period of 5 to 10 years. Some interviewees recommended funding for cultural education should be core funding and not juggled between programs, nor removed from some programs in order to support other programs. Sustainable funding was said to enable appropriate payment for CEs and CMs. Some interviewees commented that the lack of payment for community-based cultural mentorship could be seen as particularly inappropriate when CMs were asked to provide unpaid support for GPRs and JDs, which contrasted with the significant financial incentives the GPRs and JDs received from the RTP.

Support was voiced for sharing strategies regarding policy support for CEs and CMs.
I think it would be lovely to know what the different RTPs are doing. So the regionalisation model means that they can all develop local staff, but in the context of Aboriginal health, I think some are really enthusiastic about it and some are less so (RTP).

One RTP interviewee recommended that national frameworks may address the need for consistency between remuneration policies; these policies could be then be specifically shaped to reflect particularities within regions. Similarly, interviewees indicated that encouragement for CEs and CMs to get together to share ideas would ultimately result in the provision of improved cultural education and mentoring programs.

**Professional support and development**

Interviewees agreed that CEs and CMs must be supported through relevant professional development opportunities to build their confidence in the roles. A number of interviewees were clear about the nature of the professional development that would be of benefit to the CE and CM role. Mentoring, teaching, presentation, communication and self-care skills were noted as essential to the CE role, and, to some extent, also to the CM role. It was also suggested CEs and CMs would benefit from skill development in managing confrontation and bias.

I think there needs to be something that we can give to these mentors to up-skill them on their personal development because...they have all the cultural knowledge, but some people just don’t have the skills of how to speak in front of a group of people or how to do a presentation on a PowerPoint, the latest technology stuff (RTP staff).

They’re acknowledged senior people, but they may not – what they need is training in mentoring. Because mentoring means different things to lots of people. You’d have to come to agreement on what mentoring is, and then people need training in it. What it is and what it isn’t. Not in their cultural knowledge and skills, but in what mentoring is (Affiliate GP).

Conversely, some interviewees were wary about training for CEs. Interviewees commented that a clear understanding of the expectations of the CE and CM roles is necessary before specific skill sets can be identified and supported. Cultural education skills were also noted to need to take account of the local context in which the cultural education takes place, for example, PowerPoint skills may not be relevant when the activity is presented outdoors.

I don’t think [formal CE training] will work for everyone because we all talk from the heart...especially if you’re doing an orientation, but if you have to sit them in a classroom it’d be the worst thing possible and I wouldn’t want to do it (CE).
One interviewee with experience in an educational context suggested that CEs and CMs may benefit from an understanding of cross-cultural stress. The recognition of cultural stress and its manifestations (for example it tends to lead to directive behaviours) in a non-Aboriginal person, was also seen as a necessary skill for the CE and CM.

*How to recognise cultural stress in a non-Aboriginal person, and for health professionals what it tends to do - they tend to get quite directive, because the world is not organised how they are used to it, and then they want to organise it; they want to do that, they start trying to organise all the people, and the Aboriginal mob just turn off, because they don’t - no one likes being told what to do.*” (Affiliate GP)

Training in counselling skills may be helpful for CMs: “...just on becoming a counsellor or becoming a teacher... the whole idea of congruence and real and ideal self - the person knowing who they are so they can help others” (Stakeholder). It was observed by one participant that, from the beginning, the right person needs to be chosen as the CM. This comment is congruent with other interviewees’ observation that there is a need to be selective about who can take on the CM role.

Though not a lot of information was provided in the interviews concerning other professional support, it appeared there was a specific focus on developing the teaching skills of CEs/CMs in some RTPs, such as through training in the use of role plays in adult education, and this had proven to be valuable to CEs and to the RTP.

There were a variety of perspectives on the possibility of introducing CE and CM qualifications. For some interviewees, qualifications were seen to provide opportunities for CEs to up-skill and increase their employability. Some interviewees recommended providing support for CEs to study at TAFE including identification of suitable courses and the need for assistance with assessment tasks.

Several interviewees clearly expressed the desirability of introducing a career pathway for CEs and CMs, believing it would make these roles more attractive.

*It basically was tapping someone on the shoulder saying will you be a mentor when we have students coming through your community, and can you do these kinds of things, and then paying people to do that. But there was no actual development of those people. And I think if we are going to say it’s a remunerated role that will be into the future, it needs to have a career path (CE in RTP)*
We’re actually classed as Cultural Educators and Cultural Mentors, so it’s a dual role...Everyone else had got a pathway but what about us? We don’t have a pathway. So [name] was saying it’s just like we have our jobs, but we don’t have a pathway and we should be able to get that pathway, we should be able to go through them. And I think that was a great idea. And then it becomes attractive from the beginning, if you know you have a career pathway (CE/CM in RTP).

Conversely, some interviewees cautioned that introducing CE qualifications may disenfranchise those who have cultural knowledge without high literacy or interest in formal training. Succession planning, guided by current experienced CEs and CMs, was seen as of equal importance to gaining formal qualifications. As one interviewee noted:

We’re pushing now, the younger ones in...I’m pushing them. I said, “Hey, [we] are not going to be around too much longer, so you’ve got to learn” (CE/CM).

One interviewee however described a career pathway traversing the CM and CE roles and compared this with a medical career pathway, further noting this as a means of sustaining those in the roles.

People should have the opportunity to travel [on a career pathway] as a cultural mentor, to become a cultural educator, to become a senior cultural educator, and then to become a supervisor. And we should be looking at formulating a process where that can work, because we hear doctors talk about medical students, Junior Doctors, registrars, specialists, that’s a pathway, that’s something that Aboriginal don’t have and that is a way to access and attract Aboriginal people to be coming into these jobs (CE).

3.2.3. Nature and extent of cultural education and mentoring programs

In order to develop an understanding of the nature and extent of cultural education and mentoring programs, it is helpful to begin with an exploration of the various ways in which RTPs were found to engage with Aboriginal and Torres Strait Islander peoples and communities.

Engagement between Regional Training Providers and Aboriginal and Torres Strait Islander peoples and communities

In some RTPs, Aboriginal and Torres Strait Islander external reference and advisory groups were described as providing advice on organisational direction, culturally appropriate practice, and liaison with communities. An example of this is the 'Health Action Team', a community reference group that provides cultural direction to a
large centralised RTP. In another model, CEs were said to provide advice to RTP management and to IHTPs through an organisational arrangement.

The employment of CMs and CEs by RTPs or by RTPs in collaboration with other organisations, for example Affiliates, was seen as a model which had promoted positive engagement between RTPs and Aboriginal and Torres Strait Islander peoples and communities.

Interviewees remarked that respectful collaboration between RTPs and IHTPs at management and planning levels enables IHTPs in such areas as budget allocation and other forward planning and strategizing.

There was strong RTP management support for reconciliation action plans (RAPs), considered by some interviewees to be a systematic strategy for ensuring engagement with Aboriginal and Torres Strait Islander people and communities. Similarly, RTP funded educational initiatives with IHTPs, led by the community to meet the community’s needs, was seen as an important initiative in developing engagement.

Interviewees commented positively on the benefits of CEs providing cultural education to wider groups involved in General Practice education. For example, in some settings CEs provided education to all RTP staff as well as to non-IHTP staff including GP Supervisors and Practice Managers. Cultural Educators and AHWs who led weekly in-service activities promoting awareness and cultural competence for non-Aboriginal staff in IHTPs indicated that these opportunities help to promote engagement with Aboriginal and Torres Strait Islander peoples and communities.

Interviewees commented on the benefits associated with IHTPs maintaining well-developed processes and policies relating to cultural security such as adequate bereavement leave. These were said to enable strong connections with the community. Some interviewees noted the value of an integrated involvement of GPRs and JDs across IHTP’s involvement in non-health related areas such as court support, child protection, social health team, and social events.

Lastly, some interviewees from one RTP commented on the positive effect of the Aboriginal Health Manager providing cultural advice within a unique Medicare Local/ RTP and their role in supporting collaboration between this organisation and the IHTP.

**Cultural education activities for General Practice Registrars and Junior Doctors**

All RTPs reported formal requirements for GPRs to participate in some cultural education activities however the duration and content of the cultural education varied considerably from region to region.

Reasonably common cultural education activities for GPRs and JDs were reported to include:
• cultural immersion experiences of up to two days in duration led by CEs and, in some locations, RTP staff;

• cultural awareness workshops and programs;

• guided participation in cultural festivals including reflective activities;

• on-line or written information (seen by many as introductory rather than a replacement for face-to-face activities); and

• informal activities such as sharing meals with members of the local community or speaking to Elders in order to help the GPR or JD understand the local context.

A common comment from interviewees was that the best cultural education is experiential learning in an Aboriginal Medical Service (AMS) because this experience, conducted in the context of ongoing relationships, provides the GPR with multiple perspectives of Aboriginal health and the opportunity for AMS staff to provide feedback to the GPR about his or her approach to Aboriginal and Torres Strait Islander patients and their communities.

Learning strategies described by interviewees include role plays; reflexive activities such as preparing reflective statements in response to films and books; case discussions (including a reflective focus such as in supervisory discussions or teleconferences); community outreach with cultural activities; and meetings with community Elders including hearing the Elders’ stories. Another strategy was using peer discussion groups, facilitated by an Aboriginal and Torres Strait islander person, in which open and respectful discussion is used to examine any stereotypes, negative attitudes and racism which may be otherwise remain hidden.

Less common learning strategies described included external clinical teaching (ECT) visits with the CE or CM present. These were noted to be exceptionally effective learning opportunities for GPRs and JDs. Similarly interviewees commented that cultural immersion activities including camps, community outreach with cultural activities and participation in local festivals and other cultural activities help GPRs and JDs develop a practical understanding of the context in which they will be working, as do outings to the community and social activities such as dinners with RTP and IHTP staff including CE/CMs and Aboriginal and Torres Strait Islander GPRs.

It was observed that many GPRs and JDs may not have a great deal of contact with Aboriginal and Torres Strait Islander people and may not envisage this contact in their future careers. Engaging them with cultural education and enabling them to develop cultural competence that is clearly relevant to their setting was noted to be a challenge.
One interviewee noted that cultural mentoring is very dependent on the individual GPR, where ‘they’re at in life’, which is quite different for different people, and where ‘the CM is in life’. These variables tend to shape the mentoring relationship, and could be usefully considered when establishing and supporting mentorship relationships.

**Incorporation of Aboriginal and Torres Strait Islander health into current General Practice education and training**

Interviewees report that RTPs operating in areas where there are large populations of Aboriginal and Torres Strait Islander people and many IHTPs within their region are more likely to offer an integrated program, though this was not a universal finding. However, some RTPs with a relatively low proportion of Aboriginal and Torres Strait Islander people in their region did report an integrated approach to training. One such RTP was reported to ensure a case or teaching point relevant to Aboriginal and Torres Strait Islander health was included in every training workshop held with the GPRs and JDs.

Other examples provided of integration of cultural education and mentoring into “mainstream” General Practice education include the completion of at least one placement in an IHTP for all GPRs; fortnightly teleconferences facilitated by MEs and CEs with case-based learning and reflection during which cultural and communication factors are specifically considered as well as medical factors; case-based discussions which have both non-Aboriginal as well as Aboriginal and Torres Strait Islander cases as part of regular training days; exam preparation role-play activities with Aboriginal and Torres Strait Islander actors; and case-based reflective journals which include a requirement to address Aboriginal and Torres Strait Islander health cases.

**Recruitment and preparation of General Practice Registrars and Junior Doctors for working in Aboriginal and Torres Strait Islander Health Training Posts**

**Recruitment**

Interviews revealed a variety of ways of recruiting GPRs to IHTPs. In most cases the RTPs were reported to be responsible for the initial selection of GPRs for these posts. Placement was stated to be based on matching the needs of a GPR, with the supervisory/ mentorship capacity of the IHTP. Some RTPs reported only sending GPRs in their Advanced General Practice terms and specifically not allocating less experienced GPRs to IHTPs in recognition of the increased skills needed in an IHTP.

Some RTPs reported selecting the GPR according to an expression of interest in Aboriginal and Torres Strait Islander health. Others said they assign GPRs and JDs on the basis of requirements unrelated to GPR self-selection, such as the days on which they are available to work or geographical matching. Some RTP and IHTP staff described checking with IHTP staff regarding the suitability of the GPR/JD before confirming their
placement. In some cases, RTPs were noted to provide opportunity for the IHTPs to review the GPR/JD allocation and to decline that particular placement if it was not felt to be appropriate.

**Preparation**

Though it was noted that GPRs and JDs might come from different backgrounds and experiences in Aboriginal and Torres Strait Islander health, and may therefore have different preparation needs, interviewees reported that usually there was no specific process for preparing GPRs and JDs for working in an IHTP other than those used for non-Indigenous placements.

In the most common model, the RTP offers GPRs and JDs the usual cultural education program delivered to all GPRs/JDs. It is considered the role of the IHTP to provide an orientation to the IHTP, formulated with CEs and / or CMs and individualised to the particular IHTP needs.

Some RTPs were however reported to provide specific preparation for GPRs undertaking placements in IHTPs. This was noted to include personalised advice by the CE employed by the RTP to the GPR/JD prior to their arrival at the IHTP; organised handovers by previous GPRs to incoming GPRs; new GPRs “buddying” with another doctor with experience in Aboriginal and Torres Strait Islander health at the commencement of the term (particularly useful in more isolated regions); and mandatory on-line cultural education modules prior to starting in the IHTP.

Some interviewees suggested that it should not be presumed that anyone outside the IHTP, including RTPs and NACCHO State and Territory Affiliates, has the authority to prepare a GPR for a term in an IHTP. However, one interviewee commented that “while it’s reasonable to have guidelines for cultural education and cultural mentoring, there is a place for an external Aboriginal mentor, a person who’s appropriate to whom that registrar can talk to who’s outside the organisation” (Stakeholder), and this view was echoed by other interviewees.

The orientation was said to be provided within the IHTP varied greatly. One IHTP reported a three-day orientation of all new staff. This activity usually scheduled early in the GPR term, included a Welcome to Country and facilitation from community Elders and board members whose time is remunerated, visits to places of significance and teaching about local history.

Other examples provided of orientation to IHTPs are cultural camps with a specific focus on cultural education and orientation to the community; the induction of GPRs by the CM team, orientation provided by IHTP GP Supervisors and AHWs (including in one IHTP the Bringing Them Home Worker) and printed orientation manuals. The orientation activities were reported to include explanation of IHTP policies and procedures, governance, local history, key people, and practical advice regarding local community politics and events.
Cultural education in Regional Training Providers for staff and other stakeholders

In some RTPs, staff were able to attend cultural education activities, sometimes with GPRs and JDs also in attendance. Depending on location, these activities were reported to take place several times each year, annually, or every few years. Examples of shared cultural education within RTPs include workshops, cultural immersion activities, shared morning teas with the CE, as well as discussion and celebration of significant Aboriginal and Torres Strait Islander days (National Aborigines and Islanders Day Observance Committee, Aboriginal and Islander Children’s Day). Some RTP staff members were reported to be engaged in developing and maintaining RTP RAPs.

Some interviewees commented that working with a CE on site at the RTP facilitates cultural education for staff and contributes to relationship building, which may be more effective in promoting the cultural competence within the organisation than sending RTP staff to formal cultural education activities only.

3.2.4. Assessment and evaluation of cultural education and cultural mentoring

No formal feedback mechanisms apart from those which would apply to all training activities and GPR/JD placements were identified, although in RTPs where Aboriginal and Torres Strait Islander health is highly integrated, such as those RTPs in geographical locations where there are a large proportion of Aboriginal and Torres Strait Islander people, this is not a useful distinction.

Evaluation

Identified feedback processes comprised standard teaching evaluations, for example, participation evaluations after workshops and other teaching activities, usually paper-based. Standard feedback mechanisms were reported also for GPR/JDs undertaking a term in an IHTP, such as through ME or ECT contacts and through GP Supervisor teaching sessions, as well as through mid and end of placement feedback opportunities.

Some interviewees noted that evaluative processes can sometimes be rather perfunctory. It was suggested by one participant that questions such as “Are you happy?” are not the most effective questions to ensure rigorous reflection which can lead to more effective and culturally appropriate action.

...that as a result of some black box of cultural education, cultural mentoring, as a result of doing that, we’re producing doctors that patients go, “Oh, these guys I can trust.” And then it would lovely to open up the lid of a black box and say, “Okay, what are the components of this that we know produce those outcomes?” At the moment, all we’re asking is, “Are you happy? Are you happy that we did that?” And I, sort of, don’t care that
much whether they’re happy to go, but actually, some of the most effective education won’t make them happy, it will make them uncomfortable and question what they’re doing, because we’ve got it wrong for 200 years” (IHTP GP Supervisor).

Assessment of General Practice Registrar learning

Interviews evidenced that there are two distinct groups undergoing General Practice training: those who have completed an Aboriginal and Torres Strait Islander health placement in an IHTP and those who have not and who are receiving cultural education as provided to all GPRs within the RTP. While the focus of this section of the report is on the assessment of all GPRs, the role of AMS staff in providing feedback to the GPR undertaking a placement in such an IHTP is noted in the section above.

Interviewees noted the importance in any assessment process of recognising that cultural competence requires a commitment to lifelong learning, the antithesis of the “tick box” approach to completing mandatory tasks. Additionally, it is important to note that the assessment of GPR learning is the responsibility of both ACRRM and RACGP. Their assessment processes and policies have not been considered in the discussion below.

A variety of formative assessment models were described as providing opportunity for learning whilst assessing GPR competence in this area. Models of assessment said to be used include a group assessment approach during cultural education workshops, with facilitators then teaching to specific, identified needs; talking circle led by an Elder who guides participants through a reflective process thus finding a balance between reflection and learning; local Aboriginal and Torres Strait Islander people taking the part of actors in case-based teaching events, with assessment and feedback to GPRs part of this process; and mock exams during which Aboriginal and Torres Strait Islander actors participate in role plays and give feedback to GPRs.

Interviewees also noted the learning and assessment benefits associated with ECT visits involving a ME and a CE; a consultation process within IHTP staff regarding GPR performance; teleconferences with JDs during which JDs are asked to provide reflective statements which are discussed within the group; and reflective tasks during cultural education workshops utilizing YouTube clips, videos, films and books relating to cultural competency.

Challenges associated with assessment and evaluation

Interviewees commented that cultural education is complex and variable and that assessment needs to reflect this complexity. While interviewees acknowledged that knowledge is, and should be assessed in exams, assessment and evaluation of the subjective areas of values and attitudes was described as being more challenging.
Some interviewees warned against formal assessment against national frameworks of GPR and JD cultural education, believing this may lead to a ‘tick-and-flick’ check-list approach which might give the GPR the impression that he or she has now passed a test for cultural competence and is deemed to be culturally competent.

3.2.5. The future

A number of key themes were identified in the comments of interviewees regarding best ways forward for cultural education and cultural mentoring. These are discussed below with reference to the research questions in the GPET contract.

Building sustainable cultural education and cultural mentoring capacity to meet General Practice training needs

Formalising Regional Training Provider policies regarding cultural education and cultural mentoring
Several RTPs reported need for guidance regarding questions such as:

- What is the ideal – or minimum – cultural education and cultural mentoring which should be delivered?
- How should Aboriginal and Torres Strait Islander health training be better integrated into GPR teaching?
- What support should RTPs provide for CEs and CMs?

In some regions, RTP interviewees noted less frequent CE involvement in program development, delivery and evaluation. These interviewees were particularly aware of the lack of a formal relationship with a CE whose time and expertise could be drawn upon in this way and requested advice about resolving this situation.

Respectful engagement with Aboriginal and Torres Strait Islander Health Training Posts
Interviewees noted the need for respectful engagement, recognising the authority of IHTPs and their roles not only in providing experiential learning opportunities for GPR/JDs, but also in facilitating effective cultural mentoring and providing guidance to RTPs.

Some cultural education/cultural mentoring strategies noted to be effective in the IHTP context include assignment to a GPR/JD of an identified CM or CM team; designation of formal supervision time with care taken regarding scope of supervision (including both clinical and cultural focus); recognising and strengthening of the involvement of AHWs in delivery of cultural mentoring to GPR/JDs; and increasing recognition and respect for the CM role as discussed below.
Improving understandings of roles of Cultural Educators and Cultural Mentors
As noted above there is much confusion about the roles of CEs and CMs. Even within one organisation some staff refer to CEs while others refer (to the same staff) as CMs. In addition there is contention about the roles of AHWs in cultural education and mentoring and the burden cultural mentoring tasks place on AHWs.

Increasing confidence of Aboriginal and Torres Strait Islander people to assume the roles
It was suggested that people who work in the ‘third space’ (e.g., cultural brokerage/mentor space) need to be encouraged to confidently refer to themselves as CEs or CMs.

Some interviewees commented that they would like to see community consultation with the aim of better appreciating the terminology and scope belonging to cultural mentoring, including what cultural mentoring is and how the local community sees it happening. Such a consultation and determination would empower those who assume CM roles.

Interviewees expressed strong support for CEs and CMs to be given opportunities to participate in professional development, for example, teaching skills training. In particular the need for CE/CMs to be knowledgeable about program requirements for GPR/JD training was noted. Interviewees cautioned, however, that training would need to be localised, taking into account distinctions such as remote communities and Aboriginal Community Controlled Health Services (ACCHSs) which are themselves Registered Training Organisations.

Some interviewees cautioned that training for CMs must be approached sensitively, and in particular that training must avoid creating feelings of incompetence in CMs or judgement of those who choose not to engage in this training.

Another suggestion for increasing CE/CM capacity was the mentoring of junior CEs and CMs by senior CEs and CMs. Similarly interviewees noted that career pathways may provide opportunities for increased qualifications and greater job satisfaction and sustainability of CE/CM positions, however these pathways were strongly recommended to be flexible and not a requirement for CE/CMs.

Some interviewees commented on the benefits to be gained from greater reliance on technology in teaching, for example, videoing GPR consultations and CE feedback, though interviewees acknowledged that this can be a resource-draining activity and is not applicable in all contexts.

Valuing and respecting the Cultural Educator and Cultural Mentor roles
Interviewees recommended addressing GPR attitudes to the CE and CM roles perhaps by shifting focus from the medical models of care and of training. This shift could be initiated and supported by senior management in the RTPs through establishment of organisational principles and policies, and should be reflected at all levels and by all staff of the organisations.
Collaborative relationship building, including modelling partnerships between non-Indigenous and Aboriginal and Torres Strait Islander educators was seen as essential in demonstrating valuing and respect of the CE and CM roles. Combined CE/ME ECT visits were noted as one strategy for this collaborative way forward. Use of the “Balint Method” for shared CE/ME reflection on teaching was seen as another potential method to support CEs in their teaching and professional role.

Many interviewees indicated that some kind of reimbursement for cultural mentoring is needed, arranged in such a way that is appropriate to the individual and the community and without detrimental impact on other entitlements.

There’s mentoring going on in the IHTP, no question. We know that, but we don’t employ them. It just happens. And they’re not getting paid for it. They’re just a health worker and they have to fit that in with all the other thousand things that’s required of a health worker (RTP staff).

Yeah, well it [cultural mentoring] happens for nothing at the moment. And, as you said, it happens because someone in the community will see that someone is struggling, and they’ll be – some bond will form with the health worker or an Aboriginal member of the community, and that’ll often happen, not always...health workers are definitely culture brokers in healthcare, and need to be, and the system doesn’t work well if they’re not there. But that additional role of CM is too much...People have to think clearly about what it is, and then secondly they have to acknowledge that it’s a special set of skills, and that people should be paid for it (Affiliate staff).
Interviewees observed that increasing the way CEs and CMs are valued and respected may include role advocacy. Interviewees suggested that RTPs might consider publishing a brochure describing the role of the CE and the CM. This action was seen to affirm the value of these roles.

Movement away from the current GP-centric teaching and supervision model was also seen to be necessary to strengthen cultural education.

**Strengthening and expanding cultural education and cultural mentoring**

Recommendations addressed to the RTPs included a strong view that Aboriginal and Torres Strait Islander involvement in General Practice training must be seen as normal and that value be attributed, from the outset, to local community input regarding the design and delivery of cultural education and mentoring. Similarly, the need for Aboriginal and Torres Strait Islander health to be taught throughout the GPR/JD training including, from the outset, in the GP Start program was noted.

The RTP expectation that GPR/JDs attend cultural education activities was suggested as not being matched by similar expectations regarding cultural mentoring activities. Addressing a similar theme, interviewees commented that GPR/JDs need to be engaged in cultural education and mentoring in a way that extends beyond the basic expectation of passing exams. Some interviewees wondered about the possibility of creating new ways of assessing cultural education and mentoring, ways that are helpful to communities and are not unnecessarily onerous.

Interviewees commented that cultural education is more effective when adapted to the experience of the GPR, for example, GPRs who have completed an IHTP term, or who have had multiple experiences in Aboriginal and Torres Strait Islander health, may require different content and/or learning approaches. Interviewees warned against the same people attending the same cultural education program repeatedly. Meanwhile interviewees also noted that CM and CEs must have a reasonable understanding of the context within which the GPR is working so that cultural mentoring is targeted in a way that is congruent with both the CE/CM and the GPR/JD needs.

Overall the method of delivery of cultural education was recommended to be flexible, drawing on formal or informal processes which impart relevant knowledge and best safeguard the cultural safety of participants. It was also noted that cultural education provided in one region might not be relevant to another region. Hence a GPR who has completed a cultural awareness program in urban Australia may not have information or skills relevant to remote Australia. Therefore cultural education and cultural mentoring must reflect the local community and the GPR or JD working context.
Promoting motivation, enthusiasm and opportunities for GPRs and JDs to be involved in Aboriginal and Torres Strait Islander health was seen as important. Increasing experiential opportunities for GPRs, for example by the creation of more IHTP places (particularly in places where demand exceeds supply) was seen by interviewees to be a high priority when considering how to improve cultural education for GPRs and JDs. Outreach placements including shorter outreach postings were suggested as another means of enhancing exposure to experiential learning.

The particular importance of cultural education and cultural mentoring for GPR/JDs working in IHTPs was observed by some interviewees, who commented on the need for opportunistic cultural advice which could be addressed by the presence of the CE and/or CM in the IHTP workplace, even if only on a part-time basis. This was supported by another suggestion regarding engagement of more than one person in a community or service to provide CM. This enhanced CM engagement was observed to be of particular benefit when the CE or CM has to attend community and family commitments. Availability of more than one CM was also noted to have the important advantage of providing peer support for CMs within the organisation.

Involvement of NACCHO State and Territory Affiliates in program development was also noted by some interviewees to be important.

Better preparation of General Practice Registrars for working in an Aboriginal and Torres Strait Islander Training Post

Interviewees suggested a range of strategies that may help prepare GPRs for working in an IHTP. Recommended strategies included a more formalised relationship with a local CM (or CMs), some learning of local language when appropriate, more experiential learning rather than classroom learning and more outreach opportunities into communities. Some interviewees noted that the Aboriginal and Torres Strait Islander tradition of story-telling involving Elders can be one valuable way of orienting GPRs to the local community. Others advocated for embedding of systems, for example, regarding handover between GPRs and induction to health services.

Some interviewees suggested GPRs would be better prepared for working in an IHTP if cultural orientation were to be instituted as mandatory across Australia. However, interviewees cautioned that presentation of cultural education delivery needs to be improved. This was seen as particularly important when considering cultural training for GPRs who may express reluctance to complete cultural education programs.

Interviews clearly indicated that the integration of teaching on Aboriginal and Torres Strait Islander health topics throughout the whole of General Practice training would be a positive movement towards better preparing GPRs for working in an IHTP.
Strengthening evaluation and assessment
The importance of involving Aboriginal and Torres Strait Islander people in evaluation and assessment was clearly highlighted as below:

*Patients need to be asked and communities, “Is this doctor any good? Can you trust them? Can you trust them more after this intervention that we’ve done?” And that’s really hard and quite a long term thing to be able to measure, so it’s not done, but that’s what we need to demonstrate, I think (IHTP GP Supervisor).*

Partnerships with Aboriginal and Torres Strait Islander peoples and communities
Interviewees stressed the importance of RTP whole-of-organisation commitment to building meaningful relationships with Aboriginal and Torres Strait Islander communities. This was said to require time, patience, commitment and understanding by RTPs, IHTPs and State Affiliates and a recognition that they could learn from each other.

Workplace collaboration was recommended as one means of building these relationships, for example, through creating shared experiences and learning for Aboriginal and Torres Strait Islander staff and non-Indigenous people via small group learning including staff from the IHTPs such as AHWs, together with RTP staff, GPRs and JDs in a collaborative and supportive environment.

Interviewees also suggested that collaborative determination of IHTP needs would not only strengthen relationships but would increase the likelihood IHTP needs are addressed. Adequate financial support for IHTPs was noted as key to establishing and maintaining strong partnerships.

Strengthening relationships between IHTPs and RTPs is needed to increase the confidence and focus of IHTPs on their role as training organisations.

*The practice [IHTP]) has to have an approach that’s recognising its role as a training organisation, and that’s quite tricky (Medical Educator RTP).*

Interviewees commented on the importance of identifying and building on individual and community passion for involvement in cultural advice and or cultural supervision of health or teaching projects, for example, through use of community reference groups.

*I’ve thought about a long time, whether it’s chicken or egg, do we have a great relationship because we consult with them [community reference groups] regularly, or were they strong to start with so they insisted on being consulted with, but I think the*
answer is somewhere in between. That it’s a really — it’s a relationship that works for whatever reason, and that is the core of how successful it can be (IHTP GP).

Several interviewees commented on the need for guidelines from GPET so that RTPs understand better how to facilitate these connections and partnerships.

**Core principles identified in the interviews**

Although many interviewees found it difficult to identify core principles which would be important in a future framework for cultural competence in the context of General Practice vocational training, interview data supported the following principles.

**Understandings of cultural competence:**

- cultural competence is a lifelong process supported at organisational level and shaped by continuous cultural education, experience and evaluation and assessment;
- cultural competence is best facilitated by respectful listening to community and individuals and requires open communication and respect for autonomy; and
- cultural competence must be characterised by culturally safe relationships, whether these relationships are between organisations such as RTPs and the local communities or more formal relationships recognised by Memorandums of Understanding between RTPs and IHTPs and / or community groups.

**Delivery and content of cultural education and cultural mentoring:**

- cultural education is everyone’s responsibility, not simply the responsibility of CEs and or CMs;
- cultural education benefits from the active engagement of Aboriginal and Torres Strait Islander communities in their development and delivery;
- cultural education programs and processes must include the history and the impact of this history on Aboriginal people;
- cultural education recognises regional community cultural differences which are reflected in the cultural education and cultural mentoring related to those communities;
- cultural education is best supported by feedback about the cultural training process, for example, between learners and CEs and CMs;
- cultural education should address learners’ needs including those of the more experienced and culturally competent GPR/JD to be aware of his or her inability to provide a service without Aboriginal and Torres Strait Islander mentoring and community direction and continuing self-reflection; and

- vertically integrated cultural learning is required between universities, RTPs and Medicare Locals.

Support and resourcing of cultural education and cultural mentoring:

- cultural competence training, whether in the form of cultural education or cultural mentoring, requires adequate resourcing including time and funding;

- effective General Practice training in Aboriginal and Torres Strait Islander health requires informal and formal acknowledgement of the role of CEs and CMs and a recognition of the need to provide cultural training alongside medical training in a two-way learning approach; and

- cultural competence is strengthened by support and sharing of knowledge via such groups as the GPET CE and CMs’ Network and the IGPRN.
4. Findings in relation to overarching research questions

In the sections below the emergent themes from the interview data with regard to the four overarching research questions are summarised. These emergent themes have been explored further through surveys and the literature review and will serve as a basis for the development of core principles to inform a proposed *National Framework for Cultural Competence in Prevocational and Vocational General Practice*.

4.1 What is currently understood to be cultural education and cultural mentoring?

Most participants agreed that the current definitions used by GPET to describe cultural education and cultural mentoring were appropriate. However, participants identified the difficulties of defining these often overlapping activities and roles. Interviewees further noted the impact of varying contexts and community and organisational expectations and advised on respecting the rights of Aboriginal and Torres Strait Islander people and IHTPs to define their work and their role in General Practice education in a way that feels comfortable to them.

A variety of models of cultural education delivery were identified including a range of content. Interviewees identified cultural respect, humility and cultural competence as essential elements in any cultural education program and noted that programs should include an explanation of Aboriginal and Torres Strait Islander culture and history and how they interact with health and health care. Though online and distance learning approaches were sometimes used, face to face interaction with Aboriginal and Torres Strait Islander people and communities was noted to be a critical element of effective cultural education.

Interviewees agreed that while roles performed by CEs vary according to location, the principal role of the CE engaged in General Practice training is to provide information that can assist GPRs and JDs in their communication and relationships with Aboriginal and Torres Strait Islander people and communities. Cultural education was seen by all as an important component of Aboriginal and Torres Strait Islander health training for GPs, particularly in view of the need to ensure that GPRs and JDs have at least an introductory level of knowledge and awareness of issues which promote a culturally respectful approach when they start their IHTP placements.
Interviewees described many models and delivery processes related to the CM role, depending on the local context and with decisions often made by the IHTP. Cultural mentoring appears to be less consistently provided to GPRs and JDs than cultural education.

While roles of the CM were described as sometimes including cultural education activities, such as facilitation of cultural education workshops and opportunistic on-the-job teaching, interviewees highlighted cultural mentoring as needing to be specific to a local context.

In some RTPs, CE/CMs were described as providing advice on organisational direction, culturally appropriate practice, and liaison with communities.

A range of challenges for cultural education and cultural mentoring were described by interviewees. These challenges range across the need to better understand the CE and CM roles and the kinds of support that strengthen those roles; engagement of CEs and CMs; embedding cultural education in organisations and valuing those who deliver the education; re-balancing the medical model of teaching and ensuring cultural education was equally valued compared to clinical teaching in a two-way learning approach; adaptation of cultural education to local communities and to individual learner needs; ensuring sufficient time for learner reflection in a safe learning environment; and engagement of CEs and CMs in evaluation of teaching programs including IHTP placements, and assessment of GPRs and JD learning.

4.2 Employment and support of Cultural Educators and Cultural Mentors

A range of employment models has been described in this report. Employment or engagement with CMs appears to be less formal than that described for CEs. At times CM tasks were described to fall to the AHW within the IHTP. Sometimes Aboriginal and Torres Strait Islander GPs were described as fulfilling the CM role.

While CEs mostly appear to be remunerated for their work, the prevalent model of voluntary cultural mentoring was seen as unjust by many interviewees. Many interviewees believed some kind of reimbursement for CMs is needed, arranged in such a way that is sustainable and appropriate to the individual and the community, for example, taking into account potentially detrimental impacts on other entitlements.

Interviews did not reveal many formal policies relating to support of CEs and CMs, particularly where RTPs enter into ad hoc arrangements according to the need for cultural education and cultural mentoring at a particular time. Interviews indicated that support for CEs and CMs tends to be largely informal and relationship based. Interviewees commented that in addition to support from within the training organisations, CE/CMs often draw support from Aboriginal and Torres Strait Islander communities and that the
support and the connection with communities needs to be respected in the terms and conditions of their employment.

Interviewees agreed that CEs and CMs must be supported through relevant professional development opportunities to build CE/CM confidence. For example, CEs may benefit from skill development in managing confrontation and bias as well as in relevant teaching skills. Whilst identification and support of career pathways for CE/CMs was generally supported, interviewees cautioned about requiring professional development and progression as a prerequisite for employment. Mentoring of new CEs and CMs was observed to be important for the sustainability of the roles.

4.3 Nature and extent of cultural education and cultural mentoring programs

Engagement between RTPs and Aboriginal and Torres Strait Islander communities and organisations was noted to be critical to delivery of effective cultural education for GPRs and JDs. The employment of CMs and CEs by RTPs or RTPs in collaboration with other organisations, for example NACCHO Affiliates, was seen as a means of achieving this and of enhancing collaborative organisational planning. Similarly RAPs were noted to enhance RTP engagement with Aboriginal and Torres Strait Islander people and communities including CE/CMs working with the RTP.

All RTPs reported formal requirements for GPRs to participate in cultural education, though the nature and extent of the programs provided varied greatly. There was not a lot of evidence that cultural mentoring and education is tailored for the varying needs and experience of GPRs and JDs. For example, Aboriginal and Torres Strait Islander GPRs and JDs may receive the same cultural support and training as other GPRs and JDs. In the most common model of GPR cultural education, the RTP offers GPRs and JDs (including those undertaking IHTP placements) the usual cultural education program delivered to all GPRs/JDs. It is considered the role of the IHTP to provide an orientation to the IHTP, formulated with CEs and/ or CMs and individualised to the particular IHTP needs.

In general, there was reported to be less reach of these programs to JDs and to RTP staff and other stakeholders such as GP Supervisors. Some RTPs reported integration of cultural education into “mainstream” teaching.

Challenges noted included the tailoring of learning to individual learner need; engagement of learners who believed cultural education was less relevant to them; and recruiting and preparing GPR/JDs for IHTP placements. It seems that there is also a need to increase planning and delivery of cultural education and mentoring to meet the needs of Aboriginal and Torres Strait Islander JDs and GPRs.
4.4 Assessment and evaluation of cultural education and cultural mentoring

Few formal, regular feedback mechanisms specific to cultural education or mentoring or indeed for GPR/JDs undertaking IHTP placements were identified, though a variety of formative assessment and evaluation models were suggested. Interviewees commented that cultural education is complex and variable and that assessment and evaluation needs to reflect this complexity. While interviewees acknowledged that knowledge should be and is assessed in exams (set by the RACGP and ACRRM), the more subjective areas of values and attitudes were described as being more challenging. Some interviewees warned against formal assessment and national frameworks of GPR and JD cultural education believing this may lead to a ‘tick-and-flick’ check-list approach which might give the GPR the impression that he or she has now passed a test for cultural competence and is deemed to be culturally competent.
5. Appendix A: Interview Guide for Aboriginal and Torres Strait Islander Health Training Posts, RTPs, Stakeholders, Cultural Educators and Mentors

A: INTRODUCTION

(spoken by INTERVIEWER following consent process)

General Practice Education and Training Limited (GPET) has commissioned the University of Western Sydney, in partnership with Urbis, to conduct research into cultural education and cultural mentoring. This study aims to gain a better understanding of Aboriginal and Torres Strait Islander cultural education and mentoring.

As part of the research, we are surveying and interviewing Aboriginal and Torres Strait Islander Health Training Posts (IHTPs) including Aboriginal community-controlled health services (ACCHSs), Regional Training Providers (RTPs), GP Registrars and Junior Doctors, Cultural Educators and Cultural Mentors, NACCHO, the Royal Australian College of General Practitioners, and the Australian College of Rural and Remote Medicine. At the end of our consultations with people, we will be writing a report for GPET suggesting principles to inform a framework for cultural education and cultural mentoring for GP training.

We are very keen to hear from you about your perspective. We would like to ask you a few questions but you are free to answer or not as you prefer. You can also stop the interview at any time if you wish. With your permission, I would like to take notes [or record this interview] but what you say will remain confidential to the research team and no one else will know what you have said. Your name will not be used in any report without your permission and we will not publish what you have told us in any way that can identify you or your organisation.

This interview will last for about 45 minutes. Are you happy to continue with the interview? Do you have any questions before we begin?

B: A LITTLE BIT ABOUT YOU

FIRST NAME: _______________________________________________________

ORGANISATION: ____________________________________________________

ROLE WITHIN ORGANISATION: _______________________________________

LOCATION OF ORGANISATION (STATE/ TERRITORY): ______________________

AREA OF ORGANISATION: CAPITAL/REGIONAL/REMOTE ___________________
C: DEFINITION OF CULTURAL EDUCATION AND CULTURAL MENTORING

I would now like to talk to you about cultural education and cultural mentoring.

1. Firstly, the following descriptions of cultural education and cultural mentoring are provided by the Australian General Practice Training (AGPT) in the Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health. [INT: If face-to-face, allow interviewee to read description, if over the phone, read out loud.]

   **Cultural education** addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health.

   **Cultural mentoring** refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander Health Training Post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe general practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

2. How familiar are you with these definitions? What do you think of these definitions?

3. From your view, is there a difference between cultural education and cultural mentoring? If so, what is this difference?

D: CULTURAL EDUCATION

I would now like to talk a little bit more about cultural education. After this section, I will ask you a few questions about cultural mentoring.

*When you think about cultural education...:*

4. Which kinds of cultural education does your organisation/health service provide?
   - Prompt: Who is involved in cultural education at your service? Are they employed as Cultural Educators or is it one of other roles in your service?
     [INTERVIEWER: If there is a mix of cultural education and mentoring programs, please focus first on the education programs. Section E focuses on mentoring programs]

5. How many Cultural Educators and mentors work with your organisation/health service?
   - Prompt: Does it tend to be a consistent group of people or is there a high turnover?
   - Prompt: How many Cultural Educators work as mentors as well?

6. Who takes part in the cultural education you provide?
   - Prompt: Is it only GP Registrars or are there others who take up the opportunity (e.g. Junior Doctors, practicing GP Supervisor, medical students, GP Supervisors, medical educators, other staff)?
7. What do you think, is the purpose of providing cultural education?
   - Prompt: What outcomes is your organisation/health service seeking in providing these forms of cultural education?
   - Prompt: How well is this working?

E: CULTURAL MENTORING
The next few questions are about cultural mentoring. You mentioned earlier that you define cultural mentoring as .... (INTERVIEWER: refer to section C)

8. Does your service provide mentoring?
   - Prompt: Who provides this mentoring? Are they employed as CMs or do they do it in addition to other duties?

9. Who takes part in the cultural mentoring you provide?
   - Prompt: Is it only GP Registrars or are there others who take up the opportunity (e.g. Junior Doctors, practicing GP Supervisor, medical students, GP Supervisors, medical educators, other staff)?

10. What do you think, is the purpose of providing cultural mentoring?
    - Prompt: What outcomes is your organisation/health service seeking in providing these forms of cultural education?
    - Prompt: How well is this working?

11. Can you describe what the processes are for mentoring GP Registrars and Junior Doctors?
    - Prompt: What type of contact do mentors have with the GP Registrar and Junior Doctors?
    - Prompt: How often do they see each other? When? Where? What do they do?

F: DEVELOPMENT AND EVALUATION OF CULTURAL PROGRAMS

12. Does your organisation/health service develop cultural education and mentoring programs?
    - Prompt: What processes are in place to develop cultural education and mentoring programs?
    - Prompt: Who is involved?
    - Prompt: How well do these processes work?

13. From your perspective, how can GP Registrars and Junior Doctors be encouraged to engage with Aboriginal and Torres Strait Islander communities?
    - Prompt: And how can they be assisted in this?

14. What, if any, processes are in place to evaluate cultural education and mentoring programs?
    - Prompt: In what ways are the Cultural Educators and Cultural Mentors involved in this aspect of the training?
15. In what ways, if any, could the delivery/effectiveness of cultural education and cultural mentoring be improved?

G: FOR CULTURAL EDUCATORS/CULTURAL MENTORS ONLY

16. In what ways does your organisation/health service support the work you do?
   - Prompt: communication channels / support for attending meetings (e.g. within the RTP & GPET conference / CE-CM meetings)
   - Prompt: what support or opportunities to participate in professional development is provided – for example, teaching skills such as small group facilitation?

17. What processes are in place to look after the welfare of the Cultural Educators and mentors?

H: FUTURE

18. From your perspective, what challenges do Cultural Educators and mentors face in their roles?
   - Prompt: In what ways, if any, could the training system be improved to better embed cultural education and cultural mentoring into GP Registrar and Junior Doctors training?
   - Prompt: If you could change one thing about the current system of providing cultural education and mentoring, what would that be?

19. What would you identify as core principles which should support the provision of cultural education and cultural mentoring for GP Registrars and Junior Doctors?

*Thank participant for time and cooperation.*
### Examples of cultural education and cultural mentoring programs

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The Remoteness Area (RA) classification system
The Remoteness Area (RA) classification system is a geographical classification which defines locations in terms of remoteness, i.e. the physical distance of a location from the nearest Urban Centre (access to goods and services) based on population size.

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B: Interview Guide for GP Registrars and Junior Doctors

A: Introduction

(spoken by INTERVIEWER following consent process)

General Practice Education and Training Limited (GPET) has commissioned the University of Western Sydney to conduct research into cultural education and cultural mentoring. This study aims to gain a better understanding of Aboriginal and Torres Strait Islander cultural education and mentoring.

As part of the research, we have sent out a survey to all GP registrars and junior doctors enrolled in PGPPP through AGPT, and are also surveying and interviewing cultural educators and cultural mentors, Indigenous Health Training Posts, Regional Training Providers (RTPs) representatives, NACCHO, the Royal Australian College of General Practitioners, and the Australian College of Rural and Remote Medicine. At the end of our consultations with people, we will be writing a report for GPET suggesting principles to inform a framework for cultural education and cultural mentoring for GP training.

We are very keen to hear from you about your own experiences as a [GP registrar/junior doctor]. We would like to ask you a few questions but you are free to answer or not as you prefer. You can also stop the interview at any time if you wish. With your permission, I would like to take notes [or record this interview] but what you say will remain confidential to the research team and no one else will know what you have said. Your name will not be used in any report without your permission and we will not publish what you have told us in any way that can identify you or your RTP.

This interview will last for about 45 minutes. Are you happy to continue with the interview? Do you have any questions before we begin?

B: A little bit about you

FIRST NAME: ___________________________________________________________

RTP: _________________________________________________________________

YEAR OF TRAINING: ___________________________________________________

C: Definition of cultural education and mentoring

The first two questions are about Aboriginal and Torres Strait Islander cultural education and cultural mentoring. [INTERVIEWER, PLEASE USE THE DEFINITIONS OF CULTURAL EDUCATION AND CULTURAL MENTORING IF PARTICIPANT NEEDS MORE INFORMATION]

1. How would you describe cultural education?
Building Aboriginal and Torres Strait Islander Cultural Education and Cultural Mentoring Capacity
Appendix 3: Interview and Focus Group Report

2. And how would you describe cultural mentoring?

D: Cultural education programs

I would now like to talk a little bit more about cultural education. After this section, I will ask you a few questions about cultural mentoring.

When you think about Aboriginal and Torres Strait Islander cultural education...:

3. What cultural education programs / opportunities are available to you in your RTP?
   a. Prompt: are these voluntary or compulsory?
   b. How is cultural education organised in your RTP? (e.g. Is it part of every course or is it a stand-alone course?)
   c. Prompt: Are Aboriginal Health Training Posts or placements available through your RTP? How does your RTP prepare and support doctors undertaking these placements?

4. How do you hear about cultural education opportunities available to you through your RTP?
   • Prompt: How is this received by [registrars/junior doctors]?

5. When you think about the cultural education programs you are participating in, can you describe what these involve?

6. From your perspective, how well does cultural education work?
   • Prompt: What works well? What works not so well?
   • Prompt: Are there any barriers in how cultural education programs are delivered? What are these barriers?

7. What do you think [registrars/junior doctors] really need in cultural education?
   • Prompt: What kind of education is important for them to receive?
   • Prompt: How does this help them in their work and training?
   • Prompt: Is it an important part of GP training to you?

E: Cultural mentoring programs

The next few questions are about cultural mentoring. You spoke earlier about what cultural mentoring involves, such as .... [INTERVIEWER: refer to section C]

8. How is Aboriginal and Torres Strait Islander cultural mentoring promoted within your RTP?
   • Prompt: How is this received by [registrars/junior doctors]?

9. When you think about your experience of cultural mentoring, can you describe what cultural mentoring involves?
   • Prompt: What type of contact do you have with your mentor?
   • Prompt: How often do you see each other? When? Where? What do you do?

10. From your perspective, how well does cultural mentoring work?
• Prompt: What works well? What works not so well?
• Prompt: Are there any barriers in how cultural mentoring programs are delivered? What are these barriers?

11. What do you think [registrars/junior doctors] really need in cultural mentoring?
• Prompt: What kind of support is important for them to receive from a cultural mentor?
• Prompt: How does this help them in their work and training?

F: Feedback

12. When you think about the cultural education and mentoring programs you have participated in, are there any processes in place to give feedback about the programs?

*If so:* What are these processes?
• Prompt: To whom do you give feedback?
• Prompt: Is this mandatory or optional?

*If not:* Do you wish to give feedback about the programs you have participated in?
• Prompt: What kind of feedback do you wish to give?

G: Impact

13. How has your exposure to Aboriginal and Torres Strait Islander cultural education impacted your ideas about practicing medicine?
• Prompt: In what ways, if any, has this changed overtime?
• Prompt: What about your exposure to cultural mentoring...

14. In what ways, if any, could the delivery / effectiveness of cultural education and cultural mentoring be improved?

15. Should the cultural competence of [registrars/junior doctors] be assessed in your view?
• Prompt: and in what way should this be done?

H: Future

16. If you could change one thing about the current system of providing cultural education and mentoring, what would that be?

17. What would you identify as core principles which should support the provision of cultural education and cultural mentoring for [registrars/junior doctors]?

*Thank participant for time and cooperation.*
Notes for the interviewer (background information for reference)

**Definition of cultural education and cultural mentoring**

Descriptions of **cultural education and mentoring** as provided by the AGPT in the *Guide to General Practice Training in Aboriginal Health and Torres Strait Islander Health*.

**Cultural education** addresses the diversity of Aboriginal and Torres Strait Islander peoples’ cultures, experiences, histories and geographical locations. It provides medical health professionals and students with the abilities, skills and knowledge to deliver quality patient care in Aboriginal and Torres Strait Islander health.

**Cultural mentoring** refers to a developmental relationship between an Aboriginal and Torres Strait Islander community member and a GP Registrar undertaking the optional experiential training at an Aboriginal and Torres Strait Islander health training post. This relationship is driven by the Aboriginal and Torres Strait Islander community’s need for culturally safe general practice, and the registrar’s need to receive that knowledge and experience in a mutually supportive manner.

**Examples of cultural education and mentoring programs**

- General information about Aboriginal and Torres Strait Islander health as part of a workshop or a short training
- Advice about Aboriginal and Torres Strait Islander health from a non-Aboriginal health professional (e.g. GP supervisor, Medical Educator) with experience in this field
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7. References


ACRRM – see Australian College of Rural and Remote Medicine

AGPT – see Australian General Practice Training

AHCWA – see Aboriginal Health Council of Western Australia

AHMAC – see Australian Health Ministers’ Advisory Council

AHRC – see Australian Human Rights Commission

AIDA – see Australian Indigenous Doctors’ Association


Australian Indigenous Doctors’ Association. (2013). *Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients.* Position Paper. Published by AIDA and made available to the authors electronically on 27 November 2013.


**GPET- See General Practice Education and Training**


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NACCHO - See National Aboriginal Community Controlled Health Organisation


NCCC – see National Center for Cultural Competence


NHMRC – see National Health and Medical Research Council


RACGP – see Royal Australian College of General Practitioners

RACP – see Royal Australian College of Physicians


Royal Australian College of General Practitioners. (2011b). *RACGP Aboriginal and Torres Strait Islander Health curriculum statement*. Melbourne: RACGP National Faculty of Aboriginal and Torres Strait Islander Health.


WAGPET – see Western Australian General Practice Education and Training


