

Principles and Practices of Cultural Competency:
A Review of the Literature

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EXECUTIVE SUMMARY

This paper explores the principles and practices of *cultural competency* which are currently being adopted in some of Australia's leading tertiary institutions. By developing curriculum and pedagogical frameworks to educate and train students to begin their journey of becoming culturally competent service providers, the model aims to prepare a future workforce that can begin to address the disparities in the access to services which continue to negatively impact upon the health and general wellbeing of Australian Indigenous peoples.

The current call for more culturally appropriate service provision for Indigenous Australians echoes previous endeavours. This is evidenced by past government policy documents and initiatives in the education sector which parallel those in the health care sector, all of which attempt to reduce the inequities in access to services. Proponents of the cultural competency model argue that it embraces and builds on the strengths of earlier concepts such as *cultural awareness*, *cultural security*, *cultural respect* and *cultural safety*, extending them further to facilitate changes in all dimensions of practice, including the levels of the practitioner, the organisation and the system.

While the notion of cultural competency remains a contested one, a frequently cited definition describes it as 'a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations' (Cross, Bazron, Dennis & Isaacs, 1989 or 1999, cited for example by Campinha-Bacote, Yahle, & Langenkamp, 1996; King, Sims, & Osher, n.d.; National Association of Social Workers. National Committee on Racial and Ethnic Diversity, 2001; The Lewin Group Inc., 2001). The process of becoming culturally competent is developmental in that practitioners, organisations and systems advance from *cultural destructiveness* toward *cultural proficiency*.

Drawing on the literature, the paper explores the principles associated with cultural competency. It presents a synthesised list of generic principles which can apply to a range of disciplines. However, they are intentionally specific to Indigenous cultural competency in recognition that Australian Indigenous peoples are uniquely positioned by their historical, colonial, social, political, cultural, economic and contemporary experiences. It is argued that while these principles may be specific to Indigenous people, they inform a pedagogical approach to service teaching that enhances the capability of students as future services providers to work with all clientele.

To illustrate the way in which tertiary institutions have modified their service teaching curricula, the paper describes programs in North America and Australia documented in the literature. Programs in nursing and midwifery, medicine, occupational therapy, psychology, mental health counselling, law and justice are summarised with respect to their approaches to their curricula as well as aspects relating to teaching, learning and assessment.

In addition, the paper draws on interviews conducted with scholars who have (respectively) made significant contributions to the development of three exemplary models of cultural competency curriculum frameworks. These include a description of the medical school program at the University of Western Australia, the psychology curriculum at the University of South Australia and the institution-wide approach to Indigenous cultural competency most recently developed at Charles Sturt University.

The benefits of implementing cultural competency frameworks are discussed in relation to Indigenous students, non-Indigenous students, the service organisations which will employ them, and importantly, the Indigenous and non-Indigenous clientele (and their communities) for whom the graduates of these programs will provide services. The paper concludes by highlighting the flexibility of the cultural competency model. The capacity of the framework to be adapted in the different university structures and systems of North America and Australia, as well as a wide range of specific academic disciplines, is demonstrated by the examples described in the paper. Also noted is the way in which many of these programs have been initiated at the grass-roots level through the collaboration of Indigenous and non-Indigenous academics and professionals with members of local Indigenous communities. However, the importance of the internal support from heads of schools, faculty deans and vice-chancellors and the need for policies to be put in place is requisite if cultural competency frameworks are to succeed and be sustained. This is evidenced by a program described in the paper in which a change of staff led to the abolition of foundation units. In addition, professional organisations and accrediting institutions also have a role in providing external reinforcement. As the conceptual model indicates, cultural competency must be implemented and embraced at all levels if disparities in the access to and provision of services are to be effectively addressed, mitigated and eventually eliminated.

1. INTRODUCTION

There is wide-spread recognition that the limited access that Australia's Indigenous¹ peoples have to culturally appropriate medical, social, educational, legal, justice and other services continues to impact upon the status of their health and general wellbeing. While service institutions must scrutinise the way in which their services are rendered, universities must re-examine their own role in preparing students for entry into the service professions.

In recent decades some service provider organisations overseas and in Australia, particularly those in the health care and social service sectors, have embraced *cultural competency* (CC) as a conceptual framework to facilitate more culturally inclusive service provision. A few universities in Australia have begun to put in place CC education and training, mainly in nursing, medical education and psychology courses. The potential benefits of adapting such programs and extending them to other disciplines such as education, business, social work, law and justice studies merits further exploration (Gower, Nakata, & Mackean, 2007, after Gerrish and Papadopoulos, 1999; Hagan & Huijser, 2008).

The overarching aim is for universities to facilitate the development of awareness, knowledge and skills required to enable students to begin the process of becoming culturally competent service providers. CC education and training can benefit Indigenous and non-Indigenous students as they undertake their studies and begin working in their chosen professions. As more culturally competent service providers enter the workforce, the communities they serve will benefit (Smith, 1998, cited by Kim-Godwin, 2001) and the organisations they work in can provide more rewarding work experiences (Paez, Allen, Carson, & Cooper, 2008).

With these overarching aims in mind, this paper surveys the literature to consider the way in which CC has been conceptualised and applied in practice in a range of different contexts. Following a brief description of the methodology used to inform this paper, a background on CC is provided to situate its development in the historical, social and political context in which they have emerged. It identifies related concepts and the key pedagogical principles that underpin curriculum frameworks designed to enable students to begin the career-long process of developing the CC necessary to deliver culturally appropriate services to Indigenous and other clientele.

The different ways in which CC components have been incorporated into courses for the education of various service professions are described with regard to approach, teaching and learning, assessment, and program quality assurance. Of particular interest are the CC frameworks designed to prepare students to work more effectively with Australian Indigenous clientele. Three such programs are examined in greater depth. The benefits of CC education and training in universities are then presented in relation to Indigenous students, all students, Indigenous and non-Indigenous clientele and workplace organisations. The

¹ The term *Indigenous* is used throughout this paper to refer to Australian Aboriginal and Torres Strait Islander peoples.

conclusion highlights the important aspects of implementing CC frameworks which emerged in the literature and interviews.

2. METHODOLOGY

The literature search undertaken for this paper focussed specifically on CC and the associated terms used in Australia, the United States, Canada and New Zealand. The databases explored include: ERIC, ATSIhealth, APA-FT, CINAHLPlus, Cochrane Library, Proquest, MEDLINE, PubMed, RURAL, ScienceDirect, A+Education, IngentaConnect, SAGE Journals Online, Education Full Text, and PsycARTICLES. Internet search engines such as Google Scholar.com were also used. Search terms included: *cultural competence; cultural competency; cultural security; cultural awareness; cultural safety; cultural respect; education + cultur**; *education + best practice*. In addition to the data base searches, references cited in articles and on websites also provided additional useful sources.

The types of references used in the paper include refereed journal articles, government policy statements as well as government and non-profit organisation publications. Documents commonly referred to as *grey literature* available from on-line sources are also included, e.g., reports, conference papers, key note speeches, discussion papers and websites such as those sponsored by the *National Center for Cultural Competence at Georgetown University* and the Carrick Institute funded project on the University of South Australia's website *Integrating Australian Indigenous content and pedagogies into psychology education*.

In addition to print and on-line sources, the paper also draws on information obtained by interviews conducted with scholars who have made significant contributions to the development of curricula at the University of South Australia, the University of Western Australia and Charles Sturt University. Interviews were supplemented by additional recommended sources of information about the programs including conference papers, journal articles and websites. These resources were further augmented by oral presentations delivered at the *Psychology and Indigenous Australians: Teaching, Practice and Theory Conference* held at the University of South Australia (14-15 July, 2008) and a workshop sponsored by the Australian Psychological Society on *Working with Indigenous Australians: Essential Foundations of Cultural Competence* also held in Adelaide, South Australia (16-17 July, 2008). This was supplemented by follow-up email communication with presenters regarding particular aspects about their programs. Conference presenters whose papers are cited and those who were interviewed were invited to review the way in which their respective programs are summarised in this paper.

3. BACKGROUND

This section looks at the historical, social and political climate in which the need to educate more culturally competent service providers became evident. It then examines how CC has been conceptualised.

3.1 Historical, social and political context

The lack of culturally appropriate health care and social services in North America, New Zealand and Australia has become apparent in the wake of the consistently appalling statistics on the health and general wellbeing of Indigenous populations and other minority groups in these regions (e.g., Australian Government. National Health and Medical Research Council, 2006; Betancourt, Green, & Carillo, 2002; Weaver, 1999; Wepa, 2005a). The tertiary institutions which prepare students to enter a range of health care and social service professions have for the most part assumed a 'one-size fits all' approach in the education and training they provide students, largely ignoring the historical and cultural experiences and the world views of Indigenous peoples which differ significantly from the mainstream population.

Many immigrant groups from culturally and linguistically diverse (CALD) backgrounds also experience difficulty in accessing culturally appropriate health, social, justice and educational services; however, because of the manner in which Australia was colonised, the positioning of Australian Indigenous peoples is historically, socially, economically and politically unique. This has continued to seriously marginalise each successive generation since the time of 'settlement'. While it is beyond the scope of this paper to explicate the complexities of these issues, it is fair to say that the health care, social, justice and other service orientated systems have failed to adapt to the needs of Australian Indigenous peoples. Consequently, Indigenous people are less likely to seek access, accept and/or comply with recommendations made by practitioners in government sponsored organisations because of a general lack of trust in the services provided (Health Department of Western Australia, 2003).

In light of the apparent need to adapt these systems to meet the needs of Indigenous communities, the inclusion of Indigenous perspectives and content within the disciplines associated with service teaching is imperative (e.g., Carpenter, Field, & Barnes, 2002; Nash, Meiklejohn, & Sacre, 2006; Nolan, 2008; Ranzijn, McConnochie, Day, Nolan, & Wharton, 2008; Ranzijn, McConnochie, & Nolan, 2007; Wepa, 2005b). Although the term *CC* appears to have emerged in the United States, the concept of developing competencies for interacting in cross-cultural contexts is not entirely new in Australia, having appeared in policy documents and curriculum frameworks in the education sector. Since the early 1990s policy documents in Australia have promoted culturally inclusive curricula and curriculum frameworks designed around competencies (Wyatt-Smith & Dooley, 1997).

While these frameworks have been useful, agreeing on exactly what constitutes knowledge and awareness of diverse cultures has generated considerable debate and contestation. For example, 'cultural understandings' was identified as one of six 'Key Areas of Competence' (Wyatt-Smith & Dooley, 1997, p. 269) in the 1991 Finn Report. Wyatt-Smith and Dooley analysed three prominent policy documents which attempted to characterise the nature of cultural understanding as a competency, i.e., the National Languages and Literacy Institute of Australia's 1994 *Cultural Understandings as the Eighth Key Competency*; Rumsey and Hannan's 1995 *Discussion Paper on the Redrafting of the Proposed Eighth Key Competency*; and their subsequent 1996 *Report to Ministerial Council on Education, Employment,*

Training and Youth Affairs on the Development of a Final draft of Cultural Understandings as a Key Competency. Their findings highlight the lack of consensus in determining the role and ‘status of cultural competence’ (p. 281) in education and workplace training that was going on during this period.

Almost concurrent with these policy debates was the development of workplace models that foreground the need for managers and workers to adapt to the increasing cultural diversity of the work environment. Cope and Kalantzis’s ‘Productive Diversity model of work and management’ (1997, p. 1), for example, seeks to change understandings of cultural diversity. By viewing diversity as a ‘resource’ to be nurtured, the authors maintain that productivity can be improved and equity in the workplace realised as a valued side benefit². Managing cultural diversity in the workplace and the nature of the competencies associated with it has also come to the attention of researchers in commerce and human resources (e.g., Chang & Tharenou, 2004a, 2004b). Acknowledging the school as a place of work, moreover, the competence of teachers interacting appropriately and effectively with students from CALD backgrounds is recognised as integral to their professionalism in the *National Framework for Professional Standards for Teaching* (Ministerial Council on Education Employment Training and Youth Affairs. Teacher Quality and Educational Leadership Taskforce, 2003).

Related to policy debates about how *cultural understandings* can be defined with respect to the education of those entering the workplace, are the discussions centring on the notion of *cultural knowledge*, in particular Indigenous knowledge systems. Issues associated with the documentation and/or presentation of Indigenous knowledge systems raise a number of questions, including, for example: What is meant by *Indigenous knowledges*? Who benefits from the dissemination of Indigenous knowledges? How can the integrity of the whole be maintained when elements are extracted? What are the (reflexive) effects of the commodification of Indigenous knowledges? (Nakata, 2002). One of the more challenging aspects of the ‘interface’ (Nakata, 2002, 2007) between Western and Indigenous cultural knowledge systems is how the Western notion of protecting intellectual property can be applied to the collective rights and ownership by Indigenous people, given the oral mode in which knowledge is shared across generations, the diverse nature of the corpus and the cultural rules which safeguard and restrict access to spiritual understandings and practices (Nakata, 2002).

The debates surrounding Indigenous knowledges, cultural understandings and the nature of competencies described above will undoubtedly continue and perhaps be expanded as the adoption of CC as a guiding framework gains momentum in other discipline areas.

3.2 The concept of cultural competency

This section looks at concepts that can be seen as precursors contributing to the development of CC frameworks, i.e., cultural awareness, cultural security, cultural respect and cultural safety as well as the more recent notion of transcultural competency in nursing education.

² The influence of this model is apparent in Queensland’s Productive Pedagogies curriculum model in which examples of valuing and including ‘cultural knowledge’ are incorporated into the Classroom Reflection Manual for teachers (Queensland Government. Department of Education Training and the Arts, 2002).

The ways in which scholars have defined CC is examined as well as three main dimensions in which CC can be addressed: the organisation, the system and individual practitioners.

3.2.1 Associated concepts

The concept of CC was developed in the United States as their health care system sought to improve access for the increasing diversity of its population (L. M. Anderson et al., 2003; Brach & Fraser, 2000) and to address inequities in the delivery of social services in Native American populations (Weaver, 1999). Although Australian institutions have drawn on the American model(s) to inform the development of frameworks currently in use, CC in the Australian context can also be seen to have evolved from developments of related approaches which have attempted to make its health care systems more inclusive for Indigenous clientele (Thomson, 2005).

3.2.1.1 Cultural awareness

Initial endeavours to make health care services more culturally appropriate relied on *cultural awareness* training programs. These programs aimed to heighten the service provider's consciousness about and sensitivity toward the way in which social, historical and cultural issues shape clients' values, understandings and practices and, importantly, how these issues need to be considered in the delivery of services (Smedley, Stith, & Nelson, 2002). Pre-service (and in-service) awareness programs generally include activities that encourage self-reflection to enable students (and practitioners) to understand how their own cultural values, understandings and practices are socially constructed and therefore non-neutral, to heighten awareness of personal biases and proclivities for stereotyping individuals. While awareness training for practitioners is useful (and is incorporated into CC models) it was found that awareness does not necessarily translate into changes in practices (Kai, Wilkes, & Gill, 1999) nor address the systemic issues that disadvantage Indigenous clientele (Health Department of Western Australia, 2003).

3.2.1.2 Cultural security

To address the need for changes in actual practices, the notion of *cultural security* was introduced (Health Department of Western Australia, 2003; Northern Territory Government. Department of Health and Community Services, 2007). Cultural security was defined as 'a commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health system administration' (Health Department of Western Australia, 2003, p. 3). Although some professional educational institutions have begun to integrate notions of cultural security into their programs, e.g., the medical school at the University of Western Australia (Paul, Carr, & Milroy, 2006), there is little evidence that the concept gained wide endorsement outside of Western Australia and the Northern Territory (Thomson, 2005).

3.2.1.3 Cultural respect

The *cultural respect* model appears to have gained more ground nation-wide as a framework that promotes behavioural changes by practitioner as well as modifications to the health care systems themselves (Australian Health Ministers' Advisory Council. Standing Committee for Aboriginal and Torres Strait Islander Health Working Party, 2004). Cultural respect is defined as the 'recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples' (p. 7, italics removed). The model entails four basic elements highlighting the importance of 'Knowledge and Awareness' that informs 'Skilled Practice and Behaviours' as well as the development of 'Strong Relationships' between (health) institutions, individuals and communities in order to achieve an 'Equity of Outcomes' (p. 10). The *Cultural Respect Framework for Aboriginal and Torres Strait Islander health, 2004-2009* recommended strategies that could be implemented to improve access to health care for Indigenous clientele as well as suggestions in a number of areas including education and training.

3.2.1.4 Cultural safety

Prior to the development of cultural awareness, cultural security and cultural respect models in Australia, the implementation of the cultural safety framework was well underway in New Zealand. The cultural safety model supplanted previous deficit understandings to improve health services for the Maori population (Wepa, 2005b). The notion of *cultural safety* was introduced into the training of nursing to complement the existing constellation of legal, ethical, clinical and content knowledge (Wepa, 2005a). Cultural safety has been defined by the Nursing Council of New Zealand to describe the care given to an individual or family from another culture by a practitioner

who has undertaken a process of reflection on [his or her] own cultural identity and recognises the impact of [his or her] own culture on [his or her] own nursing practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual. (Papps, 2005, p. 25)

By encouraging greater participation in the decision making processes in nurse-patient interactions, Papps maintains that the balance of power is a feature which distinguishes culturally safe nursing from *transcultural nursing*, a concept discussed in section 3.2.1.5 below.

Cultural safety has entered the discourse of culturally appropriate service delivery in Australia to some extent with regard to nursing and midwifery education (see section 5.1.2) in South Australia (Guerin, Wyld, & Taylor, 2008), Indigenous medical education in Victoria (Phillips, 2005), in medical practice (Belfrage, 2007; Williams, 1999) and higher education in general (Bin-Sallik, 2003); however, the concept appears to have gained little momentum. The term *competency* appears to have attracted more currency in that it 'implies a higher standard of proficiency than safety, whilst still encompassing safe practice' (Nash, Meiklejohn, & Sacre, 2006, p. 301). The notion of cultural safety and the previously mentioned concepts have largely been subsumed into the more comprehensive notion of

cultural competency. However, before examining the concept of cultural competency, it is important to consider its relationship with *transcultural competence*.

3.2.1.5 Transcultural competence

Transcultural competence is a term used by some scholars to refer to the ability to interact with clientele who come from a range of different cultural backgrounds (Gerrish & Papadopoulos, 1999; Trentham, Cockburn, Cameron, & Iwama, 2007). This is a relatively new term which has grown out of the older concept of *transcultural nursing*. Transcultural care has been described as an ‘American movement’ (Thomson, 2005, p. 6) with origins in the 1950s. It is informed by ethnographic understandings and encompasses ‘an evolving body of knowledge and practices regarding health-illness care patterns from a comparative perspective of at least two or more designated cultures in order to determine the major care features and health services of cultures’ (Leininger, 1976/1993, p. 32). Leininger’s transcultural nursing model highlights the need to consider both *emic* and *etic* perceptions about cultural practices (Leininger, 1976/1993), i.e., the need to understand from the perspectives of the community members themselves as well as from (expert) outsiders. The ‘Sunrise Model’ or ‘Culture Care Model’ (Leininger, 2002, p. 190) for health care includes seven dimensions which must be considered in order to gain a holistic understanding of the client. These include factors associated with the following:

- 1) cultural values, beliefs and life-ways;
- 2) politics and law;
- 3) kinship and society;
- 4) economics;
- 5) religious and philosophy;
- 6) education; and
- 7) technology

(Leininger, 2002; Leininger & McFarland, 2002).

More recently the term *transcultural competence* has been proposed to describe ‘the ability to work within a given role with people whose lived experience may be different from our own’ (based on Gerrish and Papadopoulos, 1999, Trentham, Cockburn, Cameron, & Iwama, 2007, p. S51). To address criticisms about the failure of the transcultural care model to acknowledge organisational or systemic issues (Polaschek, 1998), Trentham and colleagues introduce the term *transcultural effectiveness* to refer to the ability of organisations and systems ‘to acknowledge and respond to unique and diverse perspectives and support non-discriminatory practice’ (p. S51). These authors maintain, furthermore, that transculturally competent practitioners should recognise organisational and systemic obstacles and actively seek ways to modify them. Although the original Culture Care Model did not include these aspects, Leininger’s model of transcultural care has contributed to the development of CC and continues to see CC as one of its goals (Leininger, 2002).

3.2.2 *Defining cultural competency*

The term *cultural competence* first emerged in the health care literature in a 1989 article by Cross, Bazron, Dennis and Isaacs (Thomson, 2005). Not all scholars agree on definitions or conceptualisations of CC (Sue, 2001). Nonetheless, a frequently cited definition in the health care literature, which is useful in that it can apply to a wide range of service professions, describes CC as ‘congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations’ (Cross, Bazron, Dennis & Isaacs, 1989 or 1999, cited for example by Campinha-Bacote, Yahle, & Langenkamp, 1996; King, Sims, & Osher, n.d.; National Association of Social Workers. National Committee on Racial and Ethnic Diversity, 2001; The Lewin Group Inc., 2001).

In order for systems, organisations and practitioners to provide culturally competent services, moreover, proponents maintain that they must take into consideration the values, beliefs and practices of clientele and adapt their services to address the specific socio-cultural and language needs of individual users of the services (Betancourt, Green, & Carillo, 2002). In the field of psychology Sue (2001) goes further, maintaining that the delivery of culturally competent (mental health) services ‘must be about social justice’ (p. 801). Sue (2001) goes on to assert that the core principles of his Multiple Dimensions of Cultural Competency Model are those which form the basis of ‘a democratic and egalitarian society: inclusion, fairness, collaboration, cooperation and equal access and opportunity’ (p. 801). Sue’s definition of CC reflects these principles as ‘the ability to engage in actions or create conditions that maximize the optimal development of a client and client systems’ (p. 802). In this view a culturally competent counsellor must acquire ‘awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society’, i.e., develop the ‘ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds’ (p. 802).

Consistent with Sue’s (2001) definition of culturally competent (counselling) practices, his conceptual model includes four levels at which CC needs to be addressed: societal, organisational, professional and the individual. In the area of health care, however, most scholars and governmental organisations tend to focus on three levels at which CC practices can perhaps have the greatest effect on service delivery, i.e., at the organisational, systemic and individual practitioner levels (e.g., Betancourt, Green, & Carillo, 2002; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Campinha-Bacote, Yahle, & Langenkamp, 1996; King, Sims, & Osher, n.d.; National Association of Social Workers. National Committee on Racial and Ethnic Diversity, 2001; The Lewin Group Inc., Linkins, McIntosh, Bell, & Chong, 2001; U.S. Department of Health and Human Services. Office of Minority Health, 2001). Although professional organisations play an important role in providing institutions with accreditation guidelines to reinforce CC curriculum (Ranzijn, McConnochie, & Nolan, 2007), for the purposes of this paper, the three levels of organisation, system and individual practitioner are used to organise the discussion that follows.

3.2.3 *Organisational, systemic and practitioner dimensions*

Three major factors have been identified as obstructions to the delivery of culturally competent services, one at each of the three levels of service provision (Betancourt, Green, & Carrillo, 2002; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). These include:

- 1) *organisations* which fail to employ a sufficient number of personnel with CALD backgrounds in influential positions and other staffing levels;
- 2) *systems* which are inappropriately orientated and designed to meet the needs of CALD clientele; and
- 3) *practitioners* or individual service providers who lack the skills to communicate and engage effectively with clientele who come from CALD backgrounds.

In the subsections that follow, aspects relating to the organisational, systemic and practitioners dimensions are described to situate them in the context of a holistic perspective of CC. The assessment tools that have been developed for evaluating the extent to which organisations and systems are culturally competent are presented in the relevant subsections below; however, approaches to assessing individuals are discussed in sections 5 and 6 where curriculum frameworks of specific models described in the literature are outlined.

3.2.3.1 **Cultural competency in organisations**

In an in-depth investigation into CC practices, Betancourt and colleagues (2002) conducted interviews with medical professionals and examined an education program and health clinics with which they were associated. The authors maintain that increasing the cultural diversity among staff at all levels of the organisation can be achieved by introducing programs to develop management and leadership skills for minority students and staff. Such training can enable them to take up prominent positions in universities as well as public and private sector organisations. The authors note that in addition to increasing the diversity within the workforce at all levels, organisations need to engage representatives from local minority communities in planning processes.

The relationship between the higher representation of staff members from CALD backgrounds and the CC of the organisation was undertaken in a study which looked at the CC levels of primary care workers and the staffing profiles of the clinics in which they worked (Paez, Allen, Carson, & Cooper, 2008). Using instruments to assess attitudes, behaviours and knowledge, the results indicate that practitioners with higher scores in these categories tend to work in clinics characterised as having higher proportions of staff from CALD backgrounds.

An example of a CC assessment tool for organisations is the *School-Wide Cultural Competence Observation Checklist* which was developed for school counsellors (Nelson, Bustamante, Wilson, & Onwuegbuzie, 2008). The checklist is used to assess policies, programs and activities to determine the level of CC in a given school. Nelson et al. propose that school counsellors shoulder the responsibility of assessing CC with the aim of facilitating institutional change. The authors note that the instrument is only one of several approaches to

school ‘*cultural audits*’ (p. 209). Complementary methods of collecting data include conducting interviews, using questionnaires, examining records and analysing documents.

3.2.3.2 Cultural competency in systems

With regard to the structure of (health) service systems, Betancourt et al. (2002) foreground the need to assess the target minority communities and find ways to obtain feedback from its members to ascertain health issues. This is required to disseminate culturally and linguistically appropriate information related to health care services and maintenance. Among the recommendations that can apply to other types of service provision are:

- 1) the use of interpreter services with CC training;
- 2) making available written materials that suit the linguistic and cultural backgrounds as well as literacy levels of the targeted groups;
- 3) developing evaluation instruments to identify faults that result from a lack of CC in the system; and
- 4) identifying standards for assessing CC which can be used by oversight bodies to ensure quality control in the delivery of services across organisations.

Other strategies identified include:

- 5) making services available in appropriate locations (L. M. Anderson et al., 2003);
- 6) providing in-service CC training for practitioners;
- 7) involving community members as liaisons;
- 8) involving family (and in some cases, community) members in decision-making processes as appropriate; and
- 9) cultural immersion experiences for practitioners (Brach & Fraser, 2000).

While professionals believe that these initiatives can improve outcomes, two extensive reviews of the research (L. M. Anderson et al., 2003; Brach & Fraser, 2000) indicate that, with the exception of the involvement of interpreters, there is limited research evidence to support the interventions mentioned above. The authors concur in the view that more rigorous research may be required to motivate organisations to adopt CC practices.

A system wide approach for CC is promoted by the Center for Effective Collaboration, a branch of the American Institutes for Research, funded by the Office of Special Education Programs (OSEP), United States Department of Education (King, Sims, & Osher, n.d.). The Center’s website advocates for the enhancement of school systems to make them more culturally competent in dealing with children with emotional disturbances, many of whom come from CALD backgrounds. They cite five tactics that can contribute to improving CC at all levels of the system, including:

- 1) valuing diversity;
- 2) undertaking cultural self-assessment;
- 3) developing awareness of how cultural differences influence interactions;
- 4) incorporating cultural understandings at the organisation level; and
- 5) modifying services to make them culturally appropriate.

3.2.3.3 Practitioners/individual service providers

While some theorists view the development of CC at the level of individual practitioners as a developmental process, others appear to highlight the acquisition of a set of skills and/or focus on methodological approaches (Kim-Godwin, Clarke, & Barton, 2001; The Lewin Group Inc., Linkins, McIntosh, Bell, & Chong, 2001). However, both approaches appear to overlap in some areas and so should not be seen as mutually exclusive. Nonetheless, for organisational purposes, the discussion below focuses first on models which appear to foreground the developmental process of CC, followed by those which emphasise skills and methodological approaches to becoming culturally competent.

Process-orientated CC models. Orlandi (1992) identifies three stages of the developmental process of CC, including *cultural incompetence*, *cultural sensitivity* and *cultural competence* with each entailing cognitive, affective and skills-based components. The author maintains that the general effects of services delivered by practitioners who are culturally incompetent, culturally sensitive or culturally competent are (respectively) damaging, neutral or beneficial. However, a more detailed description of the process is offered by Cross et al. (1989, cited by The Lewin Group Inc., 2001) in which the continuum comprises six stages of development. In this model practitioners (as well as organisations and systems) advance along a continuum of *cultural destructiveness*, *cultural incapacity*, *cultural blindness*, *cultural pre-competence*, *cultural competence* and *cultural proficiency*. According to Cross and colleagues, in order to progress along the continuum, practitioners need to appreciate diversity, acknowledge their own cultural biases and be aware of what happens when cultures interact. Furthermore, their actions must take into account understandings about the cultural background of the individual.

Some models for developing CC use a three-pronged approach to ‘cross-cultural education’ focusing on ‘*attitudes, knowledge and skills*’ (Smedley, Stith, & Nelson, 2002, p. 203), which are associated with Bloom’s taxonomy of learning domains (Cuellar, Brennan, Vito, & de Leon Siantz, 2008). In Campinha-Bacote et al.’s (1996) model, developed for nurse education, four elements were initially identified, including *cultural awareness*, *cultural knowledge*, *cultural skill* and *cultural encounters*; later, a fifth component, *cultural desire*, was added to the model (Campinha-Bacote, 1999).

The first element, cultural awareness, requires self-reflection to understand that one’s own culture is not neutral, but socially constructed, i.e., the practitioner’s values, assumptions, perspectives and biases about all matters, including those relating to his or her own area of expertise, are shaped by his or her own cultural influences. The second, cultural knowledge, incorporates an understanding of the client’s beliefs, values and world views with particular regard to the relevant service provided.

Cultural skills relate to the ability to make ‘cultural assessments’ (p. 113). This notion is informed by Leininger’s model (discussed in section 3.2.1.5 above) in which a ‘culturological’ (1978, cited by Campinha-Bacote et al., 1999) approach is advocated to evaluate an individual client’s personal cultural beliefs, values, practices and views about (medical) interventions to avoid relying on generalisations about particular cultures.

Campinha-Bacote (1999) maintains, moreover, that in order for practitioners to truly understand a particular cultural group and the diversity within it, learner practitioners must actively look for opportunities to participate in cultural encounters with members.

Finally, in order to deliver culturally appropriate services, practitioners must have an inherent curiosity or drive to '*want to*, rather than *have to*' (Campinha-Bacote, 1999, p. 182) undertake the processes that enhance cultural (self) awareness, knowledge and skills and be interested in actively seeking opportunities to engage in encounters with those from other cultures.

Skills and methodological orientated approaches. Other models described as having a methodological orientation highlight the necessity for service providers to learn to 'assess' a client's individual cultural positioning when making decisions about recommendations. These models appear to be less process-orientated to the extent that they imply that CC can be achieved through the acquisition of skills (The Lewin Group Inc., Linkins, McIntosh, Bell, & Chong, 2001). Leininger's transcultural nursing cultural assessment 'Sunrise Model' or 'Culture Care Model' previously discussed in section 3.2.1.5 may be seen as one example of this (Leininger, 2002, p. 190).

Another frequently cited methodological approach is Davihizar and Giger's alternative cultural assessment model for the delivery of health care which identifies six factors for the practitioner to consider:

- 1) communication (verbal and non-verbal systems);
- 2) space (culturally appropriate distance between people) ;
- 3) social organisation (how cultural groups organise themselves around families, social roles and spiritual beliefs);
- 4) orientation with respect to time;
- 5) environmental control (beliefs about people's relationship to their environment); and
- 6) biological variation (genetic biological predisposition and diversity within groups)
(Davidhizar, Bechtel, & Giger, 1998; Giger & Davidhizar, 2002)

Education in how to apply these to individual cases is seen to enable practitioners to deliver more appropriate services.

A related though perhaps more complex methodological approach to assessing a client includes 12 domains for consideration (Purnell, 2002). The first five items in Purnell's list below are akin to those appearing in Davidhizar and Giger's model above, though the remainder are unique to Purnell's assessment schedule as follows:

- 1) communication;
- 2) social structure;
- 3) biological factors
- 4) spirituality,
- 5) the heritage of the cultural group;
- 6) workforce matters;
- 7) high-risk behaviours;

- 8) nutrition;
- 9) pregnancy and childbearing practices;
- 10) death rituals;
- 11) general health care practices and attitudes; and
- 12) the positioning of health care practitioners in general and with respect to gender issues.

These 12 issues were originally developed as an assessment instrument for nursing. It was later expanded to include four levels of CC: *unconsciously incompetent*, *consciously incompetent*, *consciously competent* and *unconsciously competent* (Purnell, 2002, p. 194, italics added). In the book *Transcultural health care: A culturally competent approach* (1998, cited by Purnell, 2002) Purnell provides information on 27 cultural groups to assist nursing assessments.

Carballeira's model LIVE (Like, Inquire, Visit, Experience) and LEARN³ (Listen, Evaluate, Acknowledge, Recommend and Negotiate) provides another approach (1997, cited by The Lewin Group, 1999). This model foregrounds the centrality of both the practitioner's and client's attitudes in cross-encounters interactions. In Carballeira's view, the practitioner's attitude can be seen as situated along a continuum of *superiority*, *incapacity*, *universality*, *sensitivity* with *competency* as the goal; in a similar manner, client attitudes also range from *resistance*, *accommodation* to *adaptation*. Although the model acknowledges a developmental process with respect to the practitioner, the client's attitudes must also undergo change. The LIVE and LEARN model is designed to provide a framework to enable the practitioner to achieve the goal of reaching an agreement that satisfied both practitioner and client regarding care.

While most of the above models have been applied in medical education, a related model has been developed for use in psychological counselling. The *Multicultural Counselling Competencies* matrix (Sue, Arredondo, & McDavis, 1992) comprises three areas of counsellor skills, i.e.,

- 1) awareness of one's own assumptions, values, biases;
- 2) understanding the world views of clients from diverse backgrounds; and
- 3) identifying culturally appropriate interventions.

These areas relate to the three learning domains of CC including attitudes/beliefs, knowledge and skills. Across the nine aspects of CC, 31 guidelines were initially identified (Sue, 2001; Sue, Arredondo, & McDavis, 1992) and later expanded to 34 (Arredondo et al., 1006, cited by Delphin& Rowe, 2008), all of which aimed to enhance the practitioner's capacity to provide (mental) health care services. Sue (2001) later extended this 4 x 3 model into a *Multidimensional Model for Developing Cultural Competence*. This framework consists of three categorical dimensions:

³ The LEARN component of the model appears to be an adaptation of one developed by Berlin and Fowkes (1983, cited by University of Michigan Health Systems. Program for multicultural health, n.d.). See also footnote 6 in section 5.2.2. below.

- 1) Race-and-Culture Specific Attributes of CC (with respect to African Americans, Asian Americans, etc.);
- 2) Components of CC (awareness, knowledge and skills); and
- 3) Societal, Organisational, Professional and Individual (as mentioned above in section 3.2.2. in relation to definitions of CC) (adapted from Figure 1 in Sue, 2001, p. 792).

While the more comprehensive model allows for refined analyses for clients from different cultural and ethnic backgrounds to develop an understanding of individual clients, the earlier 3 x 3 model of multicultural counselling competencies may be more useful for developing curricula (e.g., Delphin & Rowe, 2008).

To compliment the multidimensional model, the *Tripartite Framework of Personal Identity* was designed to enhance understandings about the way in which each client constructs his or her identity (Arredondo, 1999; Sue, 2001). This model is represented as three nested circles in which the universal level embraces the group level, which in turn encompasses the level of the individual as follows:

- 1) Universal Level: Homo Sapiens (self awareness, common life experiences, e.g., birth, maturation, death, etc);
- 2) Group Level: Similarities and Differences (across race, gender, socio-economic status, age, ethnicity, disability, etc.); and
- 3) Individual level: Uniqueness (genetic endowment and non-shared experiences) (Adapted from Figure 2 in Sue, 2001, p. 793).

The various disciplines may find different aspects of the models described above useful for their specific purposes. The discussion now turns to the evaluation instruments which have been developed to assess the level of CC in organisations and systems.

3.2.3.4 Assessments across the organisational and systemic levels

CC standards and assessment tools have been developed by health and social service associations to monitor the level of CC in the three dimensions of the model. For example, The Lewin Group (2002) designed the *Organizational Cultural Competence Assessment Profile* for the Health Resources and Services Administration, a branch of the United States Department of Health and Human Resources. The tool is designed with 'indicators' to evaluate the extent to which the organisation demonstrates aspects of CC in a range of domains, i.e. 'values', 'governance', 'planning and monitoring/evaluation', 'communication', 'staff development', 'organizational infrastructure' and 'services/interventions' (p. 5).

The National Association of Social Workers have developed a set of *Standards for Cultural Competence in Social Work Professions*, based on association policy statements (2001). Although no assessment framework has been developed as yet, the association indicates that the establishment of these standards can assist in the assessment of CC.

The National Center for Cultural Competence at Georgetown University in the United States provides guidelines and offers assistance in enabling organisations to develop self-assessments (Goode, Jones, & Mason, 2002). Their assessment models are guided by

principles which embrace a strengths-based non-judgemental approach, involving those who use the organisation's services as well as members of the community and 'key constituency groups' (p.2). Other principles refer to the formative nature of assessments and the need to share information obtained through during the process with those participating in it. The Center also recommends strategies for planning that need to be considered when designing organisational evaluations.

In Australia, the *Cultural Competency Standards and Self-Assessment Audit Tool* was developed by the Multicultural Forum of Mental Health Practitioners in Western Australia for working with CALD clientele (2005). The instrument is designed to measure the extent to which mental health services comply with standards, and the principles that underpin them, outlined in the document. The assessment tool refers to policies, procedures and staff development programs that align with these standards and principles. As such, this assessment tool addresses issues relating to both organisational and systemic dimensions of the CC model.

4. PEDAGOGICAL PRINCIPLES OF CULTURAL COMPETENCY

In documents published by the United States Department of Health and Human Services (Campinha-Bacote et al., 2005) and The California Endowment (Gilbert, 2003), panels of experts outline a comprehensive list of principles to guide the process for developing standards for the education of health professionals. Although the Australian National Health and Medical Research Council (2005, p. 27) have also set out principles associated with CC, they are addressed to the health care service sector rather than educational institutions. While these principles generally aim to prepare health care providers to deliver culturally competent services to diverse communities, principles developed specifically for Indigenous CC must recognise the unique positioning of Australian Indigenous people regarding their historical, colonial, social, political, economic and contemporary experiences. To address the needs of Indigenous peoples, the Faculty of Health at Queensland University of Technology have set out principles for integrating CC into nursing and other health care courses (Nash, Meiklejohn, & Sacre, 2006). The School of Psychology and the David Unaipon College of Indigenous Education and Research at the University of South Australia have also proposed a set of principles for the CC education of students (Ranzijn, McConnochie, & Nolan, 2007).

The following set of pedagogical principles is a synthesis of those which have been used to underpin Indigenous CC curriculum frameworks for health care education programs (Mackean, 2005; Nash, Meiklejohn, & Sacre, 2006) and psychology (Ranzijn, McConnochie, & Nolan, 2007). The principles have been adapted to apply to a broad spectrum of disciplines relevant to the service professions across the university system, e.g., the full range of physical and mental health services, social services, education, law, justice studies and business. The principles are not prioritised and should be seen only as a starting point from which Indigenous CC principles can be further refined to articulate generic and/or discipline-specific principles.

1. Australian Indigenous people have distinctive needs with regard to service provision because of the unique colonial, social, cultural, economic, political, historical and contemporary experiences that set them apart from others with CALD backgrounds. Indigenous CC should therefore be set apart from multicultural CC.
2. The nature of these factors and their influence on Indigenous communities need to be included in foundational content. These units need to provide opportunities for students to critique the role of their respective (future) professions in the lives of Indigenous people both in the past and the present day.
3. The provision of services to enhance the wellbeing of Indigenous people is an integral component in the education of practitioners (and researchers).
4. Foundational content on Indigenous issues should be introduced in dedicated compulsory units. When this is not possible, at the very least, foundational content on Indigenous matters should constitute half of the material covered in units devoted to multicultural or cross-cultural matters.
5. Adopting a strengths-based perspective of culture, diversity and identity can facilitate learning and reflection on attitudes and values.
6. To maximise learning outcomes the integration of Indigenous CC content in curricula should be both horizontal and vertical. Issues and concepts introduced in foundational units should be revisited and integrated into a broad range of units taken later in the course.
7. The involvement of Indigenous staff members and formalised partnerships with representatives from Indigenous organisations and communities in the development of curricula is essential. This is to ensure that the teaching of Indigenous content and the presentation of Indigenous perspectives are both appropriate and respectful of Indigenous culture. Furthermore, Indigenous and non-Indigenous partnerships provide models of effective collaboration, bolster the credibility of the program in the eyes of students as well as Indigenous communities and organisations.
8. Learning (and research) settings should aim to foster positive encounters for all Indigenous and non-Indigenous participants.
9. A wide range of teaching and learning strategies, including the use of authentic case studies should be incorporated into an Indigenous CC curriculum.
10. Different learning styles and methodologies should be taken into consideration when designing assessment instruments. Such evaluation tools should be transparent and reflect articulated learning outcomes.
11. Activities that promote the development of reflective skills, self-awareness and critical analysis should be integral components of learning and assessments.
12. Reflection and self-awareness activities should provide opportunities for non-Indigenous students to explore their understanding of their own cultural values and attitudes along with the concepts of whiteness and privilege.
13. Support needs to be provided for Indigenous and non-Indigenous staff members involved in teaching.
14. Indigenous staff members need to be provided with support and strategies to deal with racism. They should not be routinely delegated the responsibility of dealing with Indigenous matters.

15. While Indigenous students can make valuable contributions to enhance learning in the classroom with appropriate support, they should not be assigned this responsibility nor seen as representatives of Indigenous people.

Proponents of CC education agree that the introduction of CC components to existing education programs and institutions should be done in increments (Campinha-Bacote et al., 2005; Gilbert, 2003). This can be achieved by establishing a dedicated unit on CC training and integrating CC content in more sophisticated forms in advanced levels of the program (Campinha-Bacote et al., 2005; Gilbert, 2003). This can be done as courses are scheduled for review so that first year units providing foundational content are available for a new cohort of students and subsequent upper level units are revamped and in place as the cohort progresses through the system (Paul, Carr, & Milroy, 2006). Alternatively, courses and units can be modified when they are due for periodic reviews (Nolan, 2008).

5. CURRICULUM FRAMEWORKS: TEACHING, LEARNING & ASSESSMENT

This section examines the literature describing how content associated with CC has been incorporated and implemented in service teaching in the areas of nursing, medicine, psychology, occupational health and mental health counselling and justice studies. In most (though not all) cases, the principles associated with CC underpin the curriculum frameworks described. Those which adopt concepts other than CC are identified in the overview of the program with an explanation justifying its inclusion.

In the sub-sections that follow, a brief overview of each program is provided along with a description of the general approach to CC education taken, the teaching and learning strategies, methods of assessing CC and the ways in which the quality of the program is assured.

5.1 Nursing and midwifery undergraduate programs

As noted in the background section to this paper, the nursing sector has a relatively long history of an awareness of the need for culturally appropriate service delivery. The literature demonstrates the development of programs in North America, New Zealand and Australia, with new initiatives currently underway (e.g., C. Andersen, 2008). Although there is a considerable volume of literature available on CC theories for the nursing sector, fewer publications detail the way in which CC content is incorporated into curricula. This section looks at three undergraduate programs: a four-year nursing course in an American liberal arts university and two three-year nursing programs at Australian universities.

5.1.1 Nursing program in an American university

Cuellar, Brennan, Vito and de Leon Siantz (2008) describe a four-year undergraduate nursing program which is situated within an American four-year university liberal arts program. The Master Teachers Taskforce for Cultural Competency drew on the Association of American Medical School's *Guidelines for Integration of Cultural Competency in the Curriculum* to

design the *Blueprint for Integration of Cultural Competence in the Curriculum* which was used to develop the program (p. 144).

Approach. The three areas of knowledge, skills and attitudes/awareness required for developing CC are integrated into nursing units across the course. A set of 'level objectives' (p. 146) or ability outcomes for each year level were established in relation to each CC learning domain. Examples of knowledge content include central concepts identified, e.g., diversity and social constructs (culture, gender, race, ethnicity); health disparities; making clinical decisions and cross-cultural communication frameworks; and research. Among the CC skills addressed are recognising and taking into consideration one's own biases and propensity for stereotyping and assessing the client's cultural understandings and practices, particularly in regard to health. Some components associated with attitudes and awareness include acknowledging one's own cultural values, beliefs and prejudice; understanding historical and contemporary institutionalised racism and discrimination; and showing respect during clinical interactions (Cuellar, Brennan, Vito, & de Leon Siantz, 2008).

Throughout the four-year program, students can choose from 205 units across the university departments to fulfil specific requirements; however, the distribution of electives is constrained by parameters imposed by the department such that units selected must include 'history and tradition, society, languages, arts and letters, formal reasoning and analysis, the living world, the physical world and a free elective' (p. 145).

The first year of the program integrates cultural diversity concepts into science and nursing units while additional foundation knowledge on social issues is developed through liberal arts units. The program also provides opportunities for students to hear about the workplace experiences of guest speakers on similar issues. Units in the subsequent years expand on this base and further develop the student's capacity to analyse and apply concepts relating to cultural diversity and sensitivity to the clinical knowledge and skills they are beginning to learn. Throughout the curriculum students learn to use a holistic perspective to assess clients as individuals in the context of a range of factors including culture and language. In the final year, students begin to consider the culture of health organisations themselves with respect to diversity issues.

Teaching and learning strategies. Various teaching and learning strategies are used, including didactic lectures, the discussion and analysis of case studies and critical incidents. Role plays provide opportunities for students to understand patient experiences by reversing roles and positioning them as patients who are physically restricted because of illness or the aging process. For example, students spend a day using wheelchairs, wearing adult diapers or opaque glasses. In addition, video tapes of scenarios are used to generate discussions about a range of topics (Cuellar, Brennan, Vito, & de Leon Siantz, 2008).

Assessments. Students' content knowledge, skills and awareness are assessed using multiple choice, multiple option and short answer questions in regular and comprehensive examinations. They are also required to demonstrate understandings through case study analyses, patient assessments and community-based projects.

Program quality assurance. At the end of the final year, students' attitudinal shifts are examined indirectly through self-assessments and teaching staff's evaluations of student clinical practices. In addition, the effectiveness of the program itself is investigated through CC assessments of each graduating cohort (Cuellar, Brennan, Vito, & de Leon Siantz, 2008).

5.1.2 Nursing and midwifery programs at Flinders University

The nursing and midwifery courses at Flinders University are underpinned by the cultural safety model, as it is currently the conceptual approach recommended by the Congress for Aboriginal and Torres Strait Islander Nurses (Guerin, Wyld, & Taylor, 2008). It assumes that health care recipients (and their families) will make their own decisions about culturally appropriate care and requires that the practitioner respond by adapting his or her services accordingly. This program is included here as it represents one of several curriculum framework models in nursing education which aim to enable practitioners to deliver culturally safe/competent services.

Approach. Cultural safety in the nursing and midwifery courses at Flinders University is introduced in a stand-alone foundational unit. It was initially launched in 2002 as an elective 'topic' or unit for nursing students and as a compulsory subject for midwifery students; as of 2008 it is now required for students in both courses. Indigenous and multicultural issues are also integrated into at least two other units which students must take, i.e., Introduction to Sociology (first year) and Health Psychology and Sociology (second year). The inclusion of Indigenous content and perspectives in these and other units is largely determined by unit coordinators (P. Guerin, email communication, 22 July 2008). The following description focuses on the Indigenous Health Issues for Nurses and Midwives unit.

Teaching and learning strategies. The Indigenous Health Issues unit is delivered on campus and in an on-line format to accommodate students with clinical placements (P. Guerin, email communication, 31 July 2008). This forum guides students through readings and provides them with focal points for discussion and reflection. The concept of cultural safety is introduced in the first week of the semester, followed by reading materials focusing on Indigenous issues as they relate to, for example, history, policies (past and present), racism, whiteness, cross-cultural communication, caring for Indigenous people and reflective practice. External students engage with discussion questions using interactive on-line discussion boards throughout the semester; internal students participate in weekly tutorials for the first eight weeks and then participate in on-line discussion boards for the remaining weeks.

Taught by either Indigenous or non-Indigenous tutors, tutorials are generally interactive, engaging (internal) students in activities that raise awareness and facilitate discussion, not only about Indigenous cultural world views and values, but also their own. In one tutorial, for example, students bring in 'cultural treasures' or items signifying an aspect of each student's cultural background (Guerin, Wyld, & Taylor, 2008). Tutors also use films to generate discussion in tutorials, e.g., *Kanyini*, and encourage students to view other such films. Students are also directed to information relevant to Indigenous issues available on websites, e.g., the Human Rights Commission and the Bringing Them Home report. Tutors have

flexibility in the materials they use and can adapt them to draw on individual interests, areas of expertise and community connections. One tutor, for example, invited a group of expert weavers from the local Aboriginal community. A weaving session was arranged, providing an informal setting and activity around which students could interact with the artisans on a personal level (Guerin, Wyld, & Taylor, 2008).

Assessment. Students are assessed on two assignments. The first comprises the weekly responses to readings, from which two entries are chosen at random for marking. The second is a 2000 word essay, requiring students to choose one of four topics to write on. Both assignments facilitate engagement with and reflection on aspects of culture and cross-cultural interactions that relate to Indigenous health, healthcare practices and/or institutions, providing a means through which teaching staff can monitor students' attitudinal changes and understandings about Indigenous health issues. In addition, a research project is planned to analyse changes in student responses to the materials in their on-line discussions. This may provide some insight into the way in which the course materials foster shifts in student understandings and attitudes as the course progresses.

Program quality assurance. The quality of individual units is monitored through routine student evaluations of the unit content and teaching.

5.1.3 Nursing program at Queensland University of Technology

Nash, Meiklejohn and Sacre (2006) describe an undergraduate nursing course within the Faculty of Health at the Queensland University of Technology (QUT) which was developed through the Yapunyah project. The course aimed to integrate Indigenous perspectives into the content of health care provider courses using CC models developed by Campinha-Bacote and Cross, Bazron, Dennis and Isaacs (described above). A project team was assembled comprising representatives from the different health courses, the university's Indigenous Unit and an Indigenous lecturer in Indigenous Health. A reference committee consisting of members of the local Indigenous community and university staff provided advice during the development of the course.

Approach. Similar to the 'level objectives' (Cuellar, et al. 2008, p. 145) established in the American program (described in section 5.1.1 above), the framework was developed to outline the 'capabilities' of students for each of the three years of the program. Referred to as a 'Graduate Capability: Social and ethical responsibility, understanding of Indigenous and International Perspectives' (Nash, Meiklejohn, & Sacre, 2006, p. 304), the capabilities include aspects relating to knowledge, awareness and skills in the delivery of CC services. As the name implies, the main focus of the list of graduate abilities is on Indigenous CC; however, student feedback motivated the architects of the program to expand the framework to acknowledge 'international perspectives' (p. 316). Nonetheless, Indigenous CC remains the focus. This is evidenced by the supporting principles and organising concepts of the program.

The list of ‘core/generic concepts’ (p. 314) were established to guide the incorporation of Indigenous perspectives in seven existing units in the nursing program, five of which were practicum units. Concepts are categorised into four basic areas, as follows:

- 1) culture, self and diversity;
- 2) understanding and valuing Aboriginal and Torres Strait Islander cultures;
- 3) health & wellness within an Aboriginal and Torres Strait Islander context; and
- 4) working together for optimal health outcomes for Aboriginal and Torres Strait Islander peoples. (Nash, Meiklejohn, & Sacre, 2006, p. 314)

Teaching and learning strategies. To enable teaching staff to upgrade their skills to teach renovated units, workshops were co-presented by an Indigenous lecturer and the manager of the Yapunyah⁴ project to familiarise staff with the new embedded content. Pre- and post-assessments of staff members demonstrated positive changes in their knowledge, awareness and skills with regard to Indigenous perspectives⁵. In addition, staff members are encouraged to seek assistance from Indigenous consultants and non-Indigenous staff who have extensive experience working with Indigenous clientele. Additional internal and external support is available to staff on the Yapunyah website where a list of experts in Indigenous health who are willing to give guest lectures is provided.

Nash and colleagues note that the Yapunyah website also serves as a teaching and learning tool by providing on-line resources and learning materials developed for the units. Included are videotapes of scenarios with clinical interviews with Indigenous clientele and their families which can be used for making assessments and decisions about health care.

In the initial feedback received from students, they indicated interest in being placed in Indigenous communities for their clinical practicum units. Although these units now have Indigenous perspectives integrated into their learning components, information regarding the extent to which students take part in them is not available.

Assessments. A self-assessment instrument was administered at the beginning and end of units to measure changes in understandings of Indigenous perspectives. It is not clear of the extent to which these tools continue to be used or how CC is otherwise evaluated, though the authors indicate a need for assessments throughout the course.

Other than regular student end of semester feedback on units, Nash and colleagues (2006) do not describe how the quality of the program is evaluated.

⁴ The authors explain that *yapunyah* is a Gunya term for ““eucalyptus trees that grows up from the river bank”” (Dixon, Ramson & Thomas, 1990, cited by Nash, et al. 2006, p. 296). The term was selected (with permission) as the project name to represent the development of understandings about Indigenous perspectives, a process cultivated initially in the university setting but one that will continue to expand.

⁵ The Indigenous Perspectives Tertiary Educator’s Awareness Knowledge and Skills (IPTEAKS) Scale with questions is available in Nash, Meiklejohn and Sacre, 2006, p. 310.

5.2 Medicine

This section looks at two medical programs in the United States including: a residency program in which CC training is incorporated into a workshop and the curriculum; and a workshop for third-year medical students in the Uniformed Services University of Health Sciences. (A description of a third medical program is described in greater detail in section 6.1 below.)

5.2.1 Residency program in a family practice setting in the United States

Betancourt, Green and Carrillo (2002) conducted assessments of sites identified by experts as recognising and implementing culturally competent care. One site identified in which teaching and learning take place was a hospital in which a residency program was involved in providing health services to the local Mexican American community. No details are provided regarding the extent to which the doctors in the residency program had received CC training in medical schools prior to their residency; however, during the residency program, CC is integrated into the curriculum and the concept enshrined in a manual.

Upon embarking on their residency, doctors undergo almost 30 hours of a month-long orientation in the local community in which CC is the focus. This includes learning about the role of traditional healers and the nature of the primary care required in the community. Teaching staff also participate in annual workshops to enable them to integrate CC into their teaching areas.

Teaching and learning strategies. During the orientation process, the residents (doctors) participate in group discussions, read assigned materials, undertake reflective activities and present clinical case studies in which socio-cultural issues are foregrounded. Following their assessment of the site, Betancourt, Green and Carrillo recommended integrating CC components into other teaching and learning activities including lectures, seminars and workshops.

Assessments. The medical centre assesses the outcomes of CC training programs for teaching staff as well as for the residents. Betancourt and colleagues (2002) recommended that residents entering the program to undergo needs assessments prior to the start of their residency so that the curriculum can be appropriately adjusted. The authors also suggested that such programs be evaluated at the levels of awareness, knowledge and skills.

5.2.2 Workshop for third-year students in an American military university

As a part of its efforts to provide more culturally competent health care training for United States military medical students, a four-year CC curriculum was developed at the Uniformed Services University of Health Sciences. While the details on the whole curriculum are unavailable, a description of one component is described in a study reporting on the effectiveness of the Cultural Proficiency Workshop (Carter, Lewis, Sbrocco, & Tanenbaum, 2006).

Approach. The workshop is designed to prepare third-year medical students for the required six-week family medicine clerkship. The three-hour workshop adopts the objectives set out by the Society of Teachers of Family Medicine:

- 1) to raise awareness levels about disparities in health status and access to health care among minorities;
- 2) to change attitudes and understandings regarding cultural influences on the delivery of health care services; and
- 3) to improve cross-cultural communication skills.

Teaching and learning strategies. Strategies employed in the workshop include: lectures on the disparities in access to health care between mainstream and marginalised groups; lectures about CC; self-assessment activities regarding current levels of CC; and small group activities to enhance awareness of each student's multifaceted identities with respect to race, ethnicity, religion and other aspects that contribute to identity construction. Students also observe the differences between *culturally incompetent* and *culturally competent* cross-cultural communication skills using scenarios with the facilitator playing the role of the practitioner and an actor assuming the patient role. Students also use the LEARN and ETHNIC mnemonics⁶ to critique the cross-cultural interactions and develop a plan to coach the 'practitioner' and 'patient' for next consultation. In addition, students are provided with opportunities to practice skills with 'patients'.

Assessments. Instruments for the study were designed to evaluate pre- and post-workshop cultural attitudes, beliefs, biases, and understandings about CC. They were also asked to evaluate the workshop itself using Likert scales. (Carter and colleagues (2006) also noted that open-ended questions were used to elicit responses about the best component of the workshop, the most valuable aspect for their professional development and how the workshop could be improved; however, these aspects were not reported in the study.) Students participating in the program over the course of 18 months were included in the study. The results of the self-report component shows increases in cultural awareness and participants' evaluation of the program indicate that a majority believed the workshop was valuable (55%), appropriate (71%) and effective (66%). It is not clear of the extent to which these assessments are included as a regular part of the program.

5.3 Occupational therapy

5.3.1 *An undergraduate course at the University of Toronto*

Trentham, Cockburn and Cameron (2007) describe an occupational therapy program at the University of Toronto which integrates 'transcultural competence' (p. S51) components into units throughout the four-year program. As mentioned previously (section 3.2.1.5), the authors' description of transcultural competency shares values and objectives promoted in CC

⁶ The LEARN mnemonic is described in section 3.2.3.3 above in relation to Carballeira's LIVE and LEARN model. The ETHNIC mnemonic refers to Explanation (from patient), Treatment (desired by patient), Healers (consulted), Negotiate (options), Intervention (negotiated decision), Collaborate (with patient, family, healers, health care team, resources in the community) (Levin, Like, Gottlieb, 1997, cited by University of Michigan Health Systems. Program for multicultural health, n.d.)

models. It is included here because it appears to be a workable model for integrating cultural components into an undergraduate education program to address the needs of the multicultural population of Toronto and the university itself.

Approach. In addition to integrating cultural elements throughout the curriculum offered by the Department of Occupational Therapy, it sought to increase the ‘transcultural effectiveness’ (p. 552) of the course itself by involving teaching staff with culturally diverse backgrounds.

Teaching and learning strategies. At the start of the course, students take part in a workshop as part of the Assessment in Occupational Therapy unit. Reflection activities encourage students to consider how their own cultural worldviews can shape their interpretations of the experiences of others during (clinical) assessment and decision-making processes. Further, they are trained to look first at the whole individual to see them within their socio-cultural context. Because of the diversity within cohorts, students work together to develop ‘transcultural discussion guidelines’ (p. S53) which are then used to facilitate positive group interactions throughout the program.

Occupational health students also take a foundational mental health unit which includes readings and discussions on an ‘anti-oppression framework for professional practice’ (p. S53). This engages students in exploring issues associated with racism, feminism, sexual orientation, discrimination and privilege and encourages them to consider how these can have an impact upon therapeutic interactions and decision making. They also explore matters associated with the way in which organisational structures may impose barriers to equitable care. Additionally, students begin to learn skills that will enable them to advocate and provide support for disadvantaged groups.

Issues relating to diversity are presented in other units in lectures, seminars, panel discussions and case studies. The authors note that the importance of diversity content is emphasised so that it remains a salient aspect of the course as other topics are introduced. Moreover, students are encouraged to focus on the way in which clients make meanings out of their occupational therapy experiences. In addition, five fieldwork opportunities enable students to engage with clientele from diverse groups, including those for international placements.

To ensure that teaching staff have a full understanding of transcultural competency, they are required to undergo training in half-day workshops. In addition, the recruitment and retention of staff members from diverse backgrounds is promoted.

Assessments. The evaluation of students’ transcultural competence throughout the program was not described; however, the authors note the need for and challenge of developing evaluation instruments to measure the ‘effectiveness, benefits, costs and other outcomes’ (p. S54) of such programs.

Program quality assurance. A ‘tracking tool’ (p. S54) designed by the Professional Curriculum Committee has been established within the department to monitor the extent to

which diversity content was included in teaching (as well as research and conference presentations).

5.3.2 Component of an undergraduate course at Curtin University

The occupational therapy course at Curtin University of Technology incorporates a ‘service learning placement’ (Goddard & Gribble, 2006, p. 1) to provide immersion field experiences for students to facilitate the development of CC. The four-week field experience takes place at the Shanghai Boai Children’s Rehabilitation Centre in China. The program is designed to enable students to fulfil three graduate attributes requirements to: 1) ‘demonstrate *cultural awareness and understanding*’, 2) ‘*recognise and apply international perspectives*’; and see their vocation as 3) ‘*life long learning*’ (p. 1).

Approach. Groups of eight students participate in the placement program which engage them in making occupational therapy assessments for children with cerebral palsy to determine interventions. Before travelling overseas, students undertake a course in Mandarin Chinese and take part in a cultural orientation program. This involves exploring China’s social, technological, environmental, economic and political landscape to consider how these affect health care and those with disabilities. They also engage in critical thinking activities by maintaining journals that focus on their personal growth and professional development as they reflect on events and their experiences. They also participate in group activities that promote reflection and collaborative learning. Support from peers is seen as important as supervision of the group activities occurs only in the initial stages of the program so that students can assume responsibility for their own learning.

Assessments. Although the authors indicate that collaborative group discussions provides opportunities for student self-assessment and that practitioners are also involved in assessment practices, no description is given about how or whether these assessments extent to CC.

Program quality assurance. As is the case of student assessments, no detail is provided about program evaluation; however, the authors note that both teaching staff and clinical practitioners are involved in the evaluation of the program.

5.4 Mental health counselling workshop

Delphin and Rowe (2008) describe an introductory CC workshop for mental health practitioners in the United States. One and two-day workshops are organised with the aim of increasing awareness and knowledge of culture in relation to service provision and to examine how this can enhance the abilities of mental health counsellors and outreach workers to deliver more effective services to clients from a wide range of socio-cultural backgrounds.

Approach: The program draws on the Multicultural Counselling Competencies matrix framework (Arredondo, 1999; Sue, 2001; Sue, Arredondo, & McDavis, 1992) outlined above in section 3.2.3.3. Attention is drawn to three areas of counsellor skills:

- 1) acknowledging one's own assumptions, values and biases;
- 2) understanding the world views of clients; and
- 3) identifying interventions that are culturally appropriate for the individual client.

Activities in the workshop facilitate examinations of the concept and principles of CC and how understandings of the client's cultural identity/ies and world views can be applied to the counsellors' areas of expertise. Participants are guided as they examine how stereotyping and automatic thinking can influence the approach taken during counselling sessions as well as decision making with regard to treatment. Additional activities are implemented to further enhance understandings about the experiences of disadvantaged groups as well as the notions of whiteness and privilege.

Teaching and learning strategies. Using mainly 'experiential learning techniques' (p. 184) the workshop uses film excerpts, interactive tasks and different size groupings to generate discussion and elicit personal knowledge and experiences that can contribute to understanding the principles of CC.

Program quality assurance. Participants fill out evaluation forms indicating aspects of the workshop they enjoyed the most and areas requiring improvement. The authors indicate that at the time of publication, they were examining data regarding participants' satisfaction levels as well as the long-term effectiveness of the program.

5.5 Law and justice studies

The search for CC programs in law and justice studies was unsuccessful; however, this is not an indication that there is no interest among academics in bringing Indigenous perspectives and understandings into these disciplines. The literature indicates a shift among scholars in these areas about the need to make the curriculum more culturally inclusive for Indigenous students to facilitate their involvement in tertiary education and in the legal and justice professions. Considering the extent to which Indigenous people have contact with law and justice institutions, the need for initiatives designed to increase enrolment and retention of Indigenous students in these disciplines cannot be understated.

Two programs are worth examining because they aim to create a more culturally inclusive curriculum and to develop cultural respect among all students. Although these programs are not underpinned by all the principles associated with CC, they do share important elements with CC frameworks, e.g., Indigenous participation in planning and the incorporation of Indigenous perspectives in curriculum content. Both the law program at Griffiths University (Falk, 2007) and the justice studies courses at Queensland University of Technology (Carpenter, Field, & Barnes, 2002) are included in this paper because they represent initiatives in disciplines which prepare professionals who can have an enormous influence in the lives and wellbeing of Indigenous people, their families and communities. The law program at Griffith University is advantaged by the employment of fulltime Indigenous academic staff members. The program at Queensland University of Technology highlights the importance of policies to be put in place and administrative support from above to ensure the success and sustainability of such programs.

5.5.1 *The Indigenous Law Program at Griffith University*

Indigenous senior law lecturer Phil Falk (2007) observes that the shift in the pedagogical paradigm at Griffith University's School of Law gained momentum in 2000 when the School embarked on a working alliance with the Gumurrii Centre, a support unit for Indigenous students. This collaboration led to establishing a fulltime position for an Indigenous academic (funded by both entities), followed by second similar appointment as Indigenous student enrolments increased. The School's 2004/2005 review of the law curriculum characterised the inclusion of Indigenous perspectives as largely 'ad hoc', 'unplanned' (Falk, 2007, p. 14) and subject to the understandings of individual law lecturers. This conclusion provided further justification for a systematic approach to incorporating Indigenous content and perspectives. Measures have since been taken to develop a more culturally inclusive law curriculum and to provide training and support for staff enabling them to develop a more "culturally aware" pedagogy (p. 28).

Approach. The Indigenous Law Program was developed through the collaborative efforts of staff from the School of Law and the Gumurrii Centre. 'Indigenous-specific' and 'Indigenous-inclusive' (p. 8) units were created through the introduction of new units and the renovation of those already established. The units were developed through a consultation process involving Indigenous academics from other discipline areas in the university as well as Elders from the community. (Examples of these units are provided below.)

More recently, the core units throughout the law program have been redesigned as "Indigenous Vertical Subject" integration' (Falk, 2007, p. 17) was introduced. The aim is to incorporate Indigenous content and perspectives into these units incrementally in order to provide opportunities for all students to gain an understanding of how the various dimensions of law have impacted upon Indigenous people and continue to do so. The purpose is to provide students with a graduate attribute that reflects understandings about 'the interface between the white Australian legal system and Indigenous legal systems, and to be aware of the historically privileged nature of white institutions and the impact of white law on Indigenous people' (Griffith Law School Curriculum Review Committee, 2005, p. 56, cited by Falk, 2007). Furthermore, the vertical approach seeks to ensure a coherent approach to address 'questions and issues of Indigeneity in Australian legal thought and of the intersections of Indigenous and Australian jurisprudences' (p. 56, cited by Falk, 2007).

Teaching, learning and assessment. An example of an Indigenous-specific unit is the *Practical Legal Training for Indigenous Australians: Semester Bar Practice*. This elective unit was developed by the author to provide Indigenous students with opportunities to experience legal workplace settings while at the same time learning through culturally appropriate ways, i.e., observing, participating and talking with mentors (Falk, 2007). In addition, the Indigenous convenor meets with students to provide cultural and academic support as well as discuss their overall progress and career goals. Students are assessed on an oral presentation, a written paper and entries in journals as well as by their mentors, i.e., the barrister, solicitor, or supervisor with whom they are placed.

The Law and Practice of Native Title unit is an example of an elective which was originally taught by a non-Indigenous lecturer, but has since been revamped as an Indigenous-inclusive unit. Taught by an Indigenous lecturer, the unit explores issues associated with native title and how it relates to other Indigenous rights with respect to cultural heritage and intellectual property, for example (Falk, 2007). Students also engage in scenario-based negotiations drawn from authentic cases under the guidance of a professional negotiator. In addition to working on negotiation skills, students learn to conduct research on specific aspects of native title as they extend and apply their understandings about the way in which native title legislation has affected Indigenous communities and Australian society at large.

Indigenous vertical subjects generally aim to provide students with opportunities to explore Indigenous issues as they apply to specific topic areas through readings, activities and assessment tools. Over the course of the three-year law program, all students are required to undertake at least three assessments in which Indigenous content and issues are the main focus. First year units which have undergone renovation to incorporate Indigenous content include: *Law and the Modern State*, *Introduction to Public Law* and *Introduction to Legal Theory*. Revisions to second and third year core units were under development at the time of writing (Falk, 2007).

5.5.2 Justice studies at Queensland University of Technology

In alignment with the 2001 Reconciliation Statement at Queensland University of Technology, a number of initiatives have been undertaken to make the curriculum more inclusive for Indigenous students. With the overarching aim of increasing the success rate of Indigenous students, it was determined that faculty curricula needed to be revamped to incorporate Indigenous knowledge and perspectives (Hudd & Field, 2006). These endeavours were undertaken in a number of faculties, including the Faculty of Law, the Faculty of Education and the Faculty of Creative Industries; however, this section focuses on curriculum developments in the School of Justice in the Faculty of Law (Carpenter, Field, & Barnes, 2002; Hudd & Field, 2006).

Approach. Limited by the fact that the Faculty of Law had only one Indigenous staff member, a partnership was established with the Oodgeroo Unit (Hudd & Field, 2006). Since most teaching staff in the School of Justice were non-Indigenous, staff members were aware of the importance of exploring their own position in relation to Indigenous Australians. In addition to foregrounding the concept of *whiteness* in relation to the perspectives presented in the curriculum, the teaching strategies implemented were also examined (Hudd & Field, 2006).

The cultural construction of whiteness was seen as a means through which Indigenous perspectives could be explored in the curriculum (Carpenter, Field, & Barnes, 2002; Hudd & Field, 2006). Issues relating to the ‘universality’, ‘invisibility’, ‘inherent privilege’, ‘dichotomies’ and ‘Western-ness’ (Hudd & Field, 2006) of whiteness were therefore incorporated into two first year units in law and two units in sociology and criminology on a trial basis (Carpenter, Field, & Barnes, 2002). It was noted, however, that Indigenous perspectives would need to be embedded across the three years of the course.

Teaching, learning and assessment. In the initial stages of embedding Indigenous content, the focus was on assessments because they could guide the development of curriculum content. In addition, teaching and learning strategies would also be re-examined (Carpenter, Field, & Barnes, 2002). Assessment strategies used in other faculties and tertiary institutions were investigated with the view of adapting them for use in Justice Studies courses. The assessment instruments, also seen as teaching and learning tools, were to be implemented in the first year of the course. The aim was to facilitate reflection on, and to evaluate student understandings of, the cultural construction of whiteness. Assessments were to include:

- 1) continuous reflective activities;
- 2) portfolios including examples from the media and descriptions of personal critical incidents;
- 3) identity narratives (about self and others); and
- 4) case studies.

In addition to improving the learning outcomes of non-Indigenous and Indigenous students in the program, the project initially sought to employ Indigenous staff on a fulltime, part-time and casual basis to assist in developing the curriculum further. Future plans also included staff development programs and designing an appropriate assessment framework to be used as a model in the Faculty of Law.

By 2006 concerns emerged about the extent to which progress was being made on embedding Indigenous understandings in the curriculum (Hudd & Field, 2006). Sensitivities were heightened further by an article published in the *Indigenous Law Bulletin* (Watson, 2005)⁷ in which it was noted that the university's law program had no Indigenous staff members at the time, maintained no relationship with the Aboriginal Legal Service, and completely ignored Indigenous perspectives and experiences when issues relating to Queensland's legal history, the *Native Title Act 1993* and other matters were presented.

A pilot survey was undertaken to elicit responses from students about their experiences in law and Justice Studies courses at the university (Hudd & Field, 2006). The preliminary results indicated that Indigenous students continued to feel discriminated against and language remained an obstacle to their education. Many felt that although Indigenous people are recognised in the curriculum, the presence of Indigenous knowledge and perspectives remained largely invisible. Students reported being called on in class to speak on behalf of all Indigenous peoples and many remained concerned about racism on campus. On a positive note, the students believed that the ongoing support provided by staff at the Oodgeroo Unit enabled them to persevere.

Since the introduction of the program, two of the foundation units have been removed from the courses (R. Field, email communication, 21 June 2008), highlighting the fragility of such

⁷ The author, a member of the Birri Gubba language group from Central Queensland, also describes her experience as a student sitting in a lecture hall in another university in Queensland in which a senior law lecturer shared a racist joke, eliciting laughter from her fellow students.

initiatives and the need for policies to be applied across the university rather than introducing changes through ad hoc projects of short duration (Hagan & Huijser, 2008).

6. THREE MODELS OF CULTURAL COMPETENCY CURRICULUM FRAMEWORKS

The descriptions of the programs in the previous section demonstrate how a number of Australian universities have already adopted CC (or related) frameworks as others are also moving in this direction, e.g., the University of Tasmania (C. Andersen, 2008), University of Southern Queensland (Hagan & Huijser, 2008). Cuellar et al. (2008) note that evidence of best practice for teaching CC content (in nursing), however, has not yet emerged. In the area of psychology, a best practice model in undergraduate curricula is currently underway in doctoral research⁸.

Nonetheless, there are (at least) three curriculum models in different stages of development in Australian universities which are worthy of close examination. Presented below are descriptions of a medical curriculum and two undergraduate psychology programs, each of which has adopted a different approach to CC education and training. The variation demonstrates that CC curriculum can be adapted to suit the needs of different disciplines as well as the structures of existing courses while at the same time augmenting the capabilities and attributes of graduates.

6.1 University of Western Australia's medical program

The undergraduate medical program at the University of Western Australia (UWA) began to introduce Indigenous health perspectives and content into medical courses for the cohort of students entering the program in 2000 (Paul, Carr, & Milroy, 2006). Components of the Indigenous health curriculum were implemented in increments as the cohort progressed through the program, with further enhancements subsequently added. The initiative has developed through the collaboration of the Centre for Aboriginal Medical and Dental Health (CAMDH), the School of Indigenous Studies and the Faculty Education Centre. Importantly, it receives support from the vice-chancellor and the faculty executive dean.

6.1.1 Approach

Although cultural security was the original concept to underpin the initiative (Paul, Carr, & Milroy, 2006), the program has since embraced the more comprehensive notion of CC. The program undergoes continual augmentation in its aim to accommodate and support Indigenous medical students as well as facilitate the development of the CC of all students throughout the six-year course.

The enrichment of the medical curriculum with Indigenous health components has increased student exposure to Indigenous health issues from 2 hours of instruction in the final year of

⁸ Wendy Nolan, a Senior Lecturer of Indigenous Education in the Centre for Indigenous Studies at Charles Sturt University, is currently completing her doctoral research on *Changing Paradigms, Changing Practices: The Construction of a Best Practice Model of Cultural Competence Training for Undergraduate Psychology Students*.

courses in 1984 to the current minimum requirement of 40 to 45 hours across the six-year course (depending on the course). For students who are interested in expanding their understandings further or specialising in Indigenous health, additional options are available providing over 150 hours of engagement with Indigenous health issues (Paul, Carr, & Milroy, 2006).

The medical program uses a stepwise learning pathways approach to Indigenous health with year-level learning outcomes articulated with respect to the Aboriginal health curriculum. For example, first year students are required to take foundational units. The expectation is that they will be able to understand and describe the way in which the status of Indigenous peoples' health and their access to culturally appropriate health care services have been affected by the dynamics of a range of historical, colonial and socio-cultural influences. By the end of the third year, students must be able to identify the distinctive health care needs of Indigenous people and describe appropriate strategies to address them. Upon completion of their fifth year, students should be able to plan and explain a comprehensive and multidisciplinary approach to the delivery of health care services for members of Indigenous communities. At the end of the final year of medical courses, students are expected to be able to display a working knowledge and understanding of the socio-cultural context of Indigenous health care as well as demonstrate the skills required to plan and provide comprehensive, multidisciplinary and culturally appropriate health care interventions (Paul, Carr, & Milroy, 2006, p. 523).

6.1.2 Teaching and learning strategies

Since 2001 the medical education courses at UWA have adopted a problem-based approach to teaching and learning. Strategies include lectures, reflective journals, film and other media to generate discussion. Presentations are generally delivered in teams of Indigenous and non-Indigenous academics. Guest lecturers or speakers include Indigenous medical scholars, professionals, or prominent members of the Aboriginal community who present alongside other Indigenous colleagues. Panel presentations are useful in bringing a range of perspectives to the forum, but it can also provide support for the speaker in addressing occasional expressions of racism from members of the student audience.

Practica and field visits to clinics serving Indigenous communities are options available to third and fifth year students. Fifth year students can undertake training in rural locations linked to Aboriginal health services. Alternatively, students can take advantage of opportunities organised by the university's Rural Clinical School in which students take up one-year places in designated hospitals and clinics in country towns.

6.1.3 Assessments

Students are assessed on Indigenous health issues in end of year examinations throughout the course. Each of these includes at least one exam question which provides an opportunity for students to demonstrate their knowledge and understandings about factors affecting Indigenous health issues in relation to the Aboriginal health curriculum outcomes for each year level. These questions are usually marked by staff from the Centre for Aboriginal and

Medical Dental Health (CAMDH); alternatively, a marking guide is provided by CAMDH staff for others to follow. For example, the exam question may present a clinical scenario for students to analyse and display their ability to take into consideration socio-cultural factors in describing a plan for culturally appropriate health care. In addition, reflective journals are required in a number of optional units. These are also marked by CAMDH staff members and are seen as good indicators of changes in student understandings about Indigenous health and health care.

In the women's health unit in the fifth year of the course, two tutorials provide opportunities for students to undertake self-directed research. Although these are not assessed as such, most students complete them. They provide a good source for monitoring interest and understanding about Indigenous women's health issues.

6.1.4 Resistance

Staff members indicate that although resistance to the Indigenous health curriculum is not wide-spread among students, it is expected that a few with limited knowledge and understanding about the importance, relevance and purpose of the program will object to their need to engage with the content.

It was noted that the inevitability of this occurring is due to minimal, if any, exposure to Indigenous studies in primary and secondary schools. It is very likely that the foundation unit in the first year of the program may be the first encounter students have with the content. Moreover, the opportunities provided in the program to meet with Indigenous people may also be the first time that the non-Indigenous students have ever engaged in a conversation with an Indigenous person.

To address resistance at the outset, the induction of students into the program commences with a traditional Aboriginal welcome in recognition of the Aboriginal land on which the university is located. Moreover, in overviews of the various medical courses, rather than defending or apologising for the need to include Indigenous health content as an integral part of medical courses, it is simply presented as the way good medical education is done.

Staff members also point out that for Indigenous health curricula to succeed in medical schools, support must come from above. It is therefore crucial for vice-chancellors, faculty deans and heads of schools to adopt a sense of 'ownership' so that an Indigenous health care curriculum is demonstrably valued at all levels of the institution. Additional support for such programs comes from professional and accrediting associations which provide valuable reinforcement to counter resistance by enshrining it as a required component of accreditation.

6.1.5 Program quality assurance

Formal evaluations of units and the course as a whole are used to assess the effectiveness of individual units and courses. Experienced Indigenous and non-Indigenous staff at the School of Indigenous Studies and CAMDH strive to build and maintain partnerships with professional and lay members of the local Aboriginal communities who work with the curriculum committee. Staff members from CAMDH also sit on faculty committees and

maintain a 'hyper-vigilant' stance to prevent the dilution or deletion of Indigenous health content in medical education units and courses.

An early comparative study was undertaken on two cohorts of students in the final year of each of their medical courses when the integration of Indigenous health content into courses was beginning to take place (Paul, Carr, & Milroy, 2006). The first cohort (completing the course in 2003) had engaged in a total of 7 hours of learning about Indigenous health issues, while the second (completing the course in 2004) participated in 11 hours. Although the difference in the number of hours is relatively small, the study indicates that even an incremental increase in exposure to Indigenous health issues can lead to significant changes in attitudes, the acknowledgement of responsibilities regarding Indigenous health and self-perceptions of being prepared to contribute to the improvement of Indigenous health.

More recently, staff members report observing more dramatic changes in cohort perceptions. Shifts in attitudes, indicated in end-of-course evaluation instruments, appear to reflect the increased minimum number of hours that medical students engage with Indigenous health issues. Of the 2003 cohort (exposed to only 7 hours of Indigenous health issues), only 29% believed they had the ability to communicate appropriately with Indigenous people and only 14% felt they could apply their knowledge to provide culturally secure health care. In contrast, 66% of the 2006 cohort (exposed to a minimum of 40 to 45 hours of Indigenous health issues) believed they could communicate appropriately with Indigenous clientele and 71% thought they could provide culturally secure health care (D. Paul, email communication, 10 June 2008). These positive results bode well for a new generation of medical health providers and their Indigenous clientele.

6.2 University of South Australia's undergraduate psychology program

The motivation to develop a CC pedagogical framework which incorporates Indigenous content in the School of Psychology courses at the University of South Australia (UniSA) was two-fold: 1) to make psychology courses more relevant to Indigenous students with the aim of increasing recruitment and retention levels; and, 2) to equip all students with the understanding, knowledge and skills that will enable them to engage effectively with Indigenous and other clientele so that they can provide culturally appropriate professional services (Ranzijn, McConnochie, Nolan, Day, & Severino, 2005; Ranzijn, McConnochie, Nolan, & Day, 2007).

In 2004 a pedagogical framework was developed by senior Indigenous academic Wendy Nolan and Associate Professor Keith McConnochie and trialled in the School of Psychology at UniSA. As a result of the success of the program, UniSA established the 'Indigenous Content in Undergraduate Programs' policy (A. Cleland, email communication, 31 July 2008) requiring that by 2010 Indigenous Australian Studies would be taken by all students prior to completing their degrees. The framework has since been enhanced with curriculum guidelines established through the Carrick Institute Project, *Disseminating strategies for incorporating Australian Indigenous content into psychology undergraduate programs throughout Australia* (Ranzijn, McConnochie, & Nolan, 2007). The project was a collaborative endeavour undertaken by staff from UniSA's School of Psychology and the

David Unaipon College of Indigenous Education and Research. Developed for the Australian Psychological Society and approved by the Australian Psychology Accreditation Council (APAC), the curriculum guidelines can be adapted for other institutions. In the sections below the implementation of the framework is described in relation to psychology courses as of 2007.

6.2.1 Approach

The curriculum framework is informed not only by the concept of CC, but also the notions of whiteness, world view and decolonisation. It also draws on critical psychology to further enhance the skills required by culturally competent mental health professionals (Ranzijn, McConnochie, & Nolan, 2007). Throughout the course Indigenous content is taught from a strength-based perspective to enable students to gain an understanding of Indigenous world views and develop insights into Indigenous mental health issues in order to deliver culturally appropriate services.

The program encompasses a blend of ‘stand-alone’ and integrated units across the three-year course. The foundation unit is an example of a stand-alone unit offered as a ‘required elective’ for first year students. It introduces learners to Indigenous culture as well as the historical, colonial, political and social processes, movements and events that affect the health and psychological wellbeing of Indigenous people. A third-year elective is another stand-alone unit which focuses on skills and strategies for working with Indigenous clientele. Other existing units across the course have been revamped to include Indigenous content, perspectives and issues; however, oversight of the course ensures that coherence is maintained throughout the program.

6.2.2 Teaching and learning strategies

Indigenous involvement in teaching course units is seen as crucial to presenting Indigenous perspectives and world views correctly. This is achieved through non-Indigenous and Indigenous lecturers working together in teams. An added benefit of the approach is that it routinely presents a model of Indigenous and non-Indigenous working partnerships. In addition, because most non-Indigenous students have had little or no personal contact with Indigenous people, Indigenous tutors work with small student groups to provide them with valuable experiences of engaging with an Indigenous person on a personal level (Ranzijn, McConnochie, & Nolan, 2007).

Because of the paucity of Indigenous psychologists in Australia, Indigenous guest lecturers from different disciplines or professional backgrounds and guest speakers from the local Aboriginal community are invited to give presentations. Indigenous guests and students are briefed in advance about how the presentation complements and/or expands on the content area. This assists speakers in tailoring their talks to enrich student understandings about particular topic areas and avoids making their presence and contribution into acts of tokenism. Moreover, the unit team of lecturers take steps to ensure that possible student reactions of ‘guilt, self-blame or sentimental pity (‘these poor people’)’ are well managed in

the understanding that such responses are demeaning and non-constructive (Ranzijn, McConnochie, & Nolan, 2007).

Student learning can be further enhanced by undertaking cultural field trips with guided tours of museums or art centres. In addition, the third year elective can involve visits to a nearby camp can be arranged with members of the resident Aboriginal community.

Another important teaching and learning strategy is the use of reflective journals. One of the variations of journal tasks is the requirement for students to reflect on their readings and learning experiences by making regular (weekly) entries into their journals throughout the term. Depending on the unit, these can be reflective responses to particular issues in the unit content and/or be used to enable students to explore and engage with their emotional and intellectual journey throughout the unit and course. Journals use on-line formats available with on-line course materials (Ranzijn, McConnochie, & Nolan, 2007).

6.2.3 Assessments

Because developing empathy and being emotionally engaged is integral to the therapeutic counselling professions, the reflective journal is both a useful learning tool and assessment instrument. The journal is used to complement other standard types of exams and essays that evaluate the degree to which students grasp core concepts and understand Indigenous world views.

Essay questions make it necessary for students to engage with the literature and to explore and reflect on ideas presented. In addition, case studies are used as a point of departure for reviewing the research and identifying the real world policies and current practices of relevant (Indigenous) organisations. The information gleaned from these sources can be critically analysed and synthesised to support a selected theoretical approach which is presented along with effective strategies useful for the case example (Ranzijn, McConnochie, & Nolan, 2007).

6.2.4 Resistance

The designers of the renovated course (Ranzijn, McConnochie, & Nolan, 2007) highlight the need to make the content relevant to Indigenous and non-Indigenous students to avert resistance. They note the importance of explicitly pointing out to students that developing the knowledge, awareness and skills for working effectively with Indigenous clientele strengthens their capacity to work with all people. Underscoring the connections between Indigenous issues and relevant theoretical concepts and frameworks in psychology can also be a meaningful exercise. Importantly, employing techniques to enhance students' self-awareness about their own cultural values, attitudes and world views can help them to see them as socio-cultural constructs. This awareness can assist in challenging the notion that Western cultural perspectives and practices are neutral, which is crucial for critiquing the academic discipline of psychology itself as well as the professions students are planning to enter.

The belief that students arrive at university with sufficient understandings about Indigenous issues is sometimes posed as an argument by students, departmental staff or university management. The course designers and lecturers observe that in their experience the knowledge about Indigenous issues that students bring to the course is usually either inaccurate or simply lacking in depth, coherence and a grounding in theory. Much of the feedback from students who have completed these units confirms this view. Moreover, those who do bring some knowledge also report benefiting from the course in that they were able to extend existing understandings and discover alternative perspectives (Ranzijn, McConnochie, & Nolan, 2007).

6.2.5 Program quality assurance

Although student feedback can contribute to monitoring the quality of courses, the program has established an Indigenous advisory board which oversees and approves new Indigenous content in each course. Another important issue not to be overlooked is the lecturer(s) who actually teach the units. The 2008 first year course is delivered by Indigenous lecturers with non-Indigenous staff involved as tutors and guest lecturers; additionally, non-Indigenous teaching staff are brought in from the School of Psychology to present specific content (A. Cleland, email communication, 31 July 2008). Ranzijn, McConnochie and Nolan (2007) note that it is essential to ensure that those who teach Indigenous perspectives and content have appropriate CC training and that Indigenous staff members are involved as equal partners.

6.3 Charles Sturt University's institution-wide undergraduate policy & plan

Charles Sturt University is adopting a cultural competence pedagogical framework across all 'onshore' undergraduate curricula. Using the recommendations in the literature as well as guidelines developed by Ranzijn, McConnochie and Nolan (2007), the Centre for Indigenous Studies at Charles Sturt University has developed a systematic approach to introduce foundation units and include Indigenous content in all undergraduate courses (Nolan, 2008). The description below provides an overview of the negotiated plan, which is supported by policies to implement the pedagogical framework across the university.

6.3.1 Approach

In order to provide sufficient time for faculties and schools to prepare for the renovation of courses to include Indigenous content, the roll-out will coincide with existing five-year review cycles. Modifications of relevant course documents and templates as well as graduate attributes will be undertaken in consultation with staff from the Centre for Indigenous Studies (Nolan, 2008).

Indigenous perspectives and content will be implemented across courses in units adopting four basic formats:

- 1) *Indigenous Australian Studies*;
- 2) *Discipline-specific Indigenous Australian Studies*;

- 3) *Hybrid Indigenous Australian Studies*; and
- 4) *Restricted Indigenous Studies*.

While the fourth type of unit is designed solely for Indigenous students, the first three are options which allow for flexibility in the modification of the courses as they are adapted to include Indigenous CC components (Nolan, 2008).

Indigenous Australian Studies is a compulsory foundation unit taken by students in the first semester of the first year of the course. As such it includes understandings about Australian Indigenous knowledges and covers a broad range of historical, cultural, colonial, and social issues that are relevant to contemporary Indigenous peoples. In addition, current matters that impact upon the wellbeing of Indigenous people and their communities, such as education, health, justice, land rights and native title, are also addressed and adapted for the specific discipline areas (Nolan, 2008). The theories and practices associated with these issues are investigated by students in greater depth in Discipline-specific Indigenous Australian Studies. Depending on the discipline, these are delivered either in stand-alone units or integrated into relevant units across the whole course curriculum. The third 'hybrid' format can be seen as a synthesis of the first two and offered as an option for courses which already have 'crowded' programs (Nolan, 2008).

6.3.2 Teaching

At the March 2008 meeting of the National Indigenous Higher Education Network (NIHEN) the issue of the dominance of non-Indigenous academics in the field of Indigenous Studies was raised. In light of the fact that the increasing numbers of Indigenous university graduates in recent years has led to a greater number of Indigenous academics assuming positions in universities, NIHEN made a number of determinations (Nolan, 2008). Included in these was the need for Indigenous academics to teach Indigenous Studies when possible and that non-Indigenous academic staff who teach Indigenous Studies should be required to have appropriate and extensive knowledge and understanding about Indigenous cultures, histories and the lived experiences of contemporary Indigenous peoples, in general and with regard to the discipline area. In addition, professional development opportunities in CC and Indigenous Studies should be provided for all non-Indigenous staff members so that Indigenous issues can be appropriately addressed in the units they teach. Indigenous staff should also have relevant educational background and qualifications to teach Indigenous Studies. Moreover, Indigenous and non-Indigenous academics should work in partnership when teaching hybrid and discipline-specific Indigenous Studies units (Nolan, 2008).

The principles and policies adopted by the CC framework align with the position established by the NIHEN and underpin the recommendations for the teaching of the Indigenous Australian Studies, Discipline-specific Indigenous Australian Studies and Hybrid Indigenous Studies formats. The Centre for Indigenous Studies will maintain control over the content of Indigenous Studies units taught in other faculties. In addition, the Director of the Centre (as well as the faculty dean) will approve the lecturer assigned to teach the unit to ensure the individual has the requisite qualifications. (Funding for the teaching position remains within the relevant school.)

Although Discipline-Specific Indigenous Australian Studies units are administered and taught through the respective schools, when possible they will be taught by Indigenous academics. Hybrid units will be taught by the relevant school's staff member in partnership with an academic staff member from the Centre for Indigenous Studies. Both the Director of the Centre and the relevant Head of School will maintain oversight of teaching. (Funding is proportionally shared according to teaching load.)

6.3.3 Program quality assurance

In order to ensure the coherence and quality of teaching Indigenous perspectives across the university, an Indigenous Studies Academic Board will be formed. The Board will comprise staff from the Centre of Indigenous Studies as well as two Indigenous staff members from each faculty. Chaired by the Centre for Indigenous Studies, the Board will approve units, monitor Indigenous content and oversee the manner in which the material is taught.

7. BENEFITS

The implementation of Indigenous CC curriculum frameworks can provide benefits to Indigenous university students, non-Indigenous students and future recipients of the services provided by the graduates of CC education and training programs. Specific benefits for each group are described in the sub-sections that follow.

7.1 Indigenous Students

Although some Indigenous students have benefited from growing up in strong families in which Indigenous culture has been acquired through the narration of experiences across the generations; however, as Nolan (2008) points out, not all Indigenous students are aware of the impact that historical, colonial, social and political processes have had on Indigenous peoples. Not only has the school system failed to address these issues adequately, but the policies and practices of governments have damaged generations of Indigenous families to such an extent that the transmission of culture has been severely disrupted (Nolan, 2008). As a result not all Indigenous students have a full understanding of Australian Indigenous cultures, world views and ways of being.

The integration of Indigenous CC content into programs can assist these students to explore and acquire new understandings about their culture and heritage. Moreover, the opening up of discursive 'spaces' at the 'interface' of Indigenous and Western knowledge systems can provide opportunities for Indigenous students to situate themselves and develop new ways of understanding (Nakata, 2002, 2004, 2007). These experiences can further 'empower' Indigenous students in terms of their own cultural identities (W. Nolan, personal communication, 19 June 2008).

Many Indigenous tertiary students find it difficult to stay in programs beyond the first year of courses because curricula based solely on Western models makes it difficult for them see themselves in the curriculum. The relevance of the subject matter in an Indigenous CC curriculum can assist in increasing Indigenous student enrolment and retain them in discipline areas offering CC as part of the curriculum (W. Nolan, personal communication, 19 June

2008). Additionally, if CC programs are taught correctly and involve Indigenous staff as instructors for foundation units and in partnerships with non-Indigenous staff in later discipline-specific advanced level units, Indigenous students will be provided with role models that can inspire continued involvement in their studies and facilitate increased completion rates (Wendy Nolan, personal communication, 19 June 2008).

7.2 All students

Students from non-Indigenous backgrounds who undertake courses with an Indigenous CC curriculum will be better prepared for and gain greater satisfaction from working with Indigenous clientele. Moreover, such training provides practitioners with a broader spectrum of skills and an extended knowledge base to draw on to give them more confidence when working with all clients.

Research demonstrates that service providers from mainstream backgrounds whose stance is informed by understandings about the disparities between privileged and disadvantaged groups and who can show genuine interest in and appreciation and respect for the values and traditions of other cultures, tend to be more comfortable and confident when providing services to those from disadvantaged groups (Paez, Allen, Carson, & Cooper, 2008).

One can argue, furthermore, that simply being able to interact in culturally appropriate ways with people from Indigenous or CALD backgrounds, whether at work or elsewhere, is simply a part of good citizenship (Wendy Nolan, personal communication, 19 June 2008). Most universities incorporate good citizenship skills as strategic goals for their graduates. Moreover, such goals are also consistent with the vision statement set forth by the Australian Vice-Chancellors' Committee for tertiary education in the AVCC Response on Indigenous Education Advisory Council Conference Report with respect to meeting the needs of Indigenous Australians through education and the provision of services in the community (2006, cited by Nolan, 2008).

7.3 Service organisations and communities

The increased numbers of Indigenous people with CC education and training entering the workforce can result in more culturally appropriate services for Indigenous and other clientele. More Indigenous people in the workforce translates into more effective service organisations. This notion is supported by research which demonstrates that organisations which include staff from diverse backgrounds tend to be more culturally competent than those which do not (Paez, Allen, Carson, & Cooper, 2008).

But there are also other advantages as well. Smith (1998, cited by Kim-Godwin, 2001) identifies at least seven benefits in outcomes (in relation to health) when practitioners are culturally competent in the delivery of services. These include:

- 1) increased sense of empowerment in clientele and greater appreciation for the service providers;
- 2) the reduction in client angst and apprehension about the system;

- 3) an increase in the proportion of community members seeking services and complying with recommendations of service providers;
- 4) higher satisfaction levels among clients;
- 5) enhanced educational experiences of service providers;
- 6) improvements (in health) community-wide; and
- 7) a greater valuing and esteem among staff members for one another (p. 921).

Although some research suggests that culturally competent (health care) services results in superior outcomes (e.g., Leininger & McFarland, 2002 and Smith, 1998, Zoucha, 1998, cited by Kim-Godwin, Clark & Barton, 2001) it is important not to overlook the need for more qualitative and quantitative research (Kim-Godwin, Clarke, & Barton, 2001). Nonetheless, Betancourt, Green and Carillo (2002) observe that most professionals whose organisations promote CC and encourage their employees to undertake CC training tend to link CC with improving the quality of services and reducing disparities in the delivery of services.

8. CONCLUSION

This paper has explored the historical, social and political context in which the demand for more culturally competent health care, social, education, justice and other services has arisen. As the literature suggests, the need for culturally appropriate service provision is not new in Australia. This is evidenced by government policy documents and initiatives in the education sector as well as earlier conceptual models mainly in health care such as cultural awareness, cultural security, cultural respect and cultural safety. These approaches have been valuable in that they have raised the awareness of practitioners of the need for more culturally appropriate services to address the disparities in the access to services by Indigenous people.

The effectiveness of these approaches, however, has been constrained by their limited ability to translate into actual behavioural changes of individual practitioners and their failure to adequately address the barriers that exist at the organisational and systemic levels of service provision. The CC model which first emerged in the United States holds promise in that it encompasses and builds on the strengths of the principles and practices of previous approaches. Moreover, it takes a more comprehensive stance in promoting change in policies, attitudes and actual practices at the organisational, systemic as well as practitioner levels of service provision.

As some organisations and systems (mainly in the health care sector) have begun to recognise the need for culturally competent services, the tertiary education sector has also responded. Examples of CC orientated programs have been developed in the United States and Canada to address the needs of their diverse populations. Australian universities are also beginning to introduce Indigenous CC curricula predominantly in nursing, medicine and psychology programs. CC initiatives are also emerging in other discipline areas, e.g., in education and creative industries at Queensland University of Technology (Carpenter, Field, & Barnes, 2002) and across the undergraduate courses at Charles Sturt University (Nolan, 2008).

The variety of these programs demonstrates that an Indigenous CC framework is flexible enough to be adapted to a range of discipline areas. Moreover, the literature demonstrates that

CC models can be developed to suit different university structures and systems such as those in Canada, the United States and Australia. Furthermore, the three models of CC described in detail show how the commitment and ingenuity of Indigenous and non-Indigenous academics working in partnerships can bring about promising changes at the institutional level to provide CC education and training for students. Such transformations can contribute to the development of a new generation of culturally competent professionals with benefits for the Indigenous clientele they will serve.

Much of the work contributing to the effectiveness of the Australian Indigenous CC models described in this paper have been initiated at the grass roots level through the collaboration of members of Indigenous communities, Indigenous and non-Indigenous academics and professionals. Nevertheless, perhaps one of the most important lessons to come out of the discussions with staff involved in the three Australian model programs described is the importance of internal support received from vice-chancellors, faculty deans and heads of school in making such programs work. The additional external reinforcement from professional associations and accrediting institutions is also necessary. As the conceptual model indicates, cultural competency must be implemented and embraced at all levels if disparities in the access to and provision of services are to be effectively addressed, mitigated and eventually eliminated.

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