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Cultural Competence – Transforming Policy, Services, Programs and Practice

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OVERVIEW

This chapter discusses some of the complex issues surrounding the notion of cultural competence—and the critical need for practitioners to develop knowledge, skills, understandings and attributes to be responsive in diverse cultural settings. The argument for culturally competent mental health practitioners and services is situated within a human rights framework which underpins the principles, standards and practice frameworks intended to facilitate/contribute to the capacity and empowerment of mental health practitioners and clients, families and communities. The *National Practice Standards for the Mental Health Workforce 2013 (*the *practice standards)*[1] outline core competencies (including cultural competence) regarded as essential for the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. The documented impact of these disciplines/professions on Aboriginal people requires new ways of working that are empowering, respectful and ethical. A case is made for the importance of practitioners providing more culturally inclusive and appropriate care to increase the likelihood that clients and their carers will experience a sense of cultural safety (as well as culturally appropriate services) for Aboriginal clients, their families and communities. The *practice standards* are complemented by professional guidelines and the *National Standards for Mental Health Services 2010 (*the *service standards).*[2] This chapter provides a range of tools and strategies and a Critical Reflection Framework for Analysis to assist students or practitioners to adopt a critical standpoint in order to develop key competencies (knowledge, skills, attitudes and values) to be culturally respectful and effective in their practice in Aboriginal and Torres Strait Islander mental health. Equally important is the need for strategies for self-care and support such as mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

INTRODUCTION

There are consistent and complementary themes identified in the literature for working effectively as mental health practitioners with Aboriginal and Torres Strait Islander peoples, such as adopting a community development/empowerment approach and using culturally responsive primary and preventative care models, and the crucial role of cultural competence. Importantly, enhancing individual practice is essential to ensure our ways of working with and across cultures are respectful and promote cultural security and achieve improved mental health and social and emotional wellbeing (SEWB) outcomes. However, it is also essential to ensure that systems and organisations and professions are also culturally responsive or competent.

The Framework aims to enhance practitioners' professional competence through critical reflection upon themselves, others, their discipline and professional codes of conduct and practice standards, and the broader contemporary and historical contexts in which practitioners, their clients, and their families and communities are situated, and in which policies are made and programs and services are delivered. It also discusses some of the cultural competence audit tools that can assist organisations to enact policies and processes intended to bring about system level change to enhance cultural competence across these sectors.

THE MENTAL HEALTH PRACTITIONER

Under the COAG mental health reform to improve Aboriginal and Torres Strait Islander health and wellbeing, health workers, counsellors and clinical staff in culturally-specific health services require the capacity and competence to identify and address mental illnesses and associated substance use issues and to recognise the distinctive and pervasive trauma, grief and loss experienced by Aboriginal people. They also need to work in accordance with the guiding principles contained in the *Ways Forward National Aboriginal and Islander Mental Health Policy Report*[3(pp19-20)] reinforced in the Charge by Rob Riley (page xvi) which asked all mental health practitioners to 'take on board' the understanding that:

- The Aboriginal concept of health is holistic.

- Self-determination is central to the provision of Aboriginal health services.

- Culturally valid understanding must shape provision of Aboriginal health (and mental health) care.

- The experience of trauma and loss contribute to the impairment of Aboriginal culture and mental health well-being.

- **The human rights of Aboriginal people must be recognised and enforced** (emphasis added)**.**

- Racism, stigma, adversity and social disadvantage must be addressed in strategies aimed at improving Aboriginal mental health.

- The strength and centrality of Aboriginal family and kinship must be understood and accepted.

- Diversity of groups needs to be recognised.

ADOPTING A RIGHTS BASED APPROACH TO MENTAL HEALTH

A recent national consultation to review the SEWB framework has reaffirmed the nine guiding principles which emphasise the centrality of human rights and self-determination. Human rights are moral, legal, and political devices for protecting the dignity, wellbeing and survival of human beings.[4(p95)] Recognition of human rights in mental health is particularly relevant in culturally diverse societies that include cultural minorities and particularly where Indigenous cultures have been displaced, marginalised, disenfranchised and forcibly assimilated by colonisers and settlers.[4(p96)] These rights are intended to 'assist individuals and communities to achieve the highest attainable standard of physical and mental health, including autonomy, information, education, and participation'[5] and are further reinforced by the *2007 United Nations Declaration on the Rights of Indigenous Peoples*.[6]

Culturally Appropriate Mental Health Services

In 2009, the Australian government formally endorsed the *2007 United Nations Declaration on the Rights of Indigenous Peoples.*[6] The Declaration outlines a set of principles and a framework that requires all states to provide accessible, quality health care to Indigenous peoples and to respect and promote Indigenous health systems. Article 24.2 states that:

> *'individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right'.*

Article 35 recognises the collective rights of Indigenous peoples to maintain, promote and develop their distinctive customs, spirituality, traditions, procedures and practices in pursuit of their right to health.[6] However, while the Declaration acknowledges Indigenous people's individual and collective rights to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures and practices (Article 34), it also acknowledges their right to access all social and health services without any discrimination (Article 24.1). These latter articles confirm the importance of both the role of Aboriginal Controlled Health Services and the need for culturally responsive mainstream services.

Culturally Responsive Health Systems

It is important to recognise that failure to instil culturally safe practices erodes fundamental cultural and human rights for all Indigenous peoples. There is a need to establish processes and protocols to ensure culturally safe practices that are culturally responsive for diverse Aboriginal community contexts in Australia. As Cunningham argues:

> *To improve the health situation of Indigenous peoples, there must thus be a fundamental shift in the concept of health so that it incorporates the cultures and world views of Indigenous peoples as central to the design and management of state health systems.[7(p156)]*

Enforcing human rights requires the relevant institutions having the mandate and the resources to 'respect, fulfil, protect, and promote such rights'. Many of the policies, principles and guidelines that can enforce these Indigenous rights already exist. However, as Crepeau and Gayet (2012) observe, such mechanisms *'will remain powerless unless sustained by cooperation between institutions, a mobilisation of civil society and the availability of human rights education for all.'[8(p548)]*

THE CONTEXTS OF WORKING

Traditionally, the roles of professionals in the mental health services, therapies and associated disciplines have been underpinned by implicit values and assumptions that reflect the norms of the dominant professions in Western culture. As discussed in Chapter 5 (Zubrick and colleagues), successive reviews confirm that Aboriginal and Torres Strait Islander mental health policy implementation has been largely ineffective. This is generally attributed to:

- silos within government agencies and services;

- inflexible role boundaries between different health professionals;

- a lack of culturally responsive and appropriate services and organisations to meet the needs of Aboriginal and Torres Strait Islander individuals, families and communities;

- the assumptions and attitudes of practitioners, particularly non-Aboriginal practitioners, that can affect their ability to understand and appreciate the pervasive, transgenerational impact of colonisation upon Aboriginal and Torres Strait Islander peoples' individual, family and community social and emotional wellbeing and mental health; as well as

- overt racism described in Chapter 1 (Dudgeon and colleagues).

Further, the impacts of monoculturalism have proved particularly challenging for policymakers and practitioners aiming to implement the reforms in successive National Mental Health Plans. This has highlighted the need to ensure that staff can acquire and maintain the competence and

skills to deliver service reform in new, culturally responsive ways. For instance, *The Roadmap for National Mental Health Reform 2012-2022* [9] identifies the need to:

> *Strengthen the cultural competency of frontline professionals, including police, education and early childhood providers and healthcare professionals, to detect and appropriately intervene early in mental health concerns for Aboriginal and Torres Strait Islander peoples. (Strategy 24)*

This is a far more extensive plan than highlighted in the previous strategy which identified 'the need for education and training initiatives to ensure an appropriately skilled workforce to work effectively with culturally diverse client groups, particularly Aboriginal and Torres Strait Islander peoples'.[10] Nevertheless the implementation phase remains limited. According to Cunningham (2005)[7], the dominant paradigms fail to recognise human rights and do not consider Indigenous conceptions of health, which extend beyond the physical and mental wellbeing of an individual to encompass spiritual balance and wellbeing of the community as a whole. For many Aboriginal and Torres Strait Islander peoples this is a concept of health and mental health that is holistic social and emotional wellbeing (see Chapter 4, Gee and colleagues).

A national study into incorporating cultural competence into psychology curriculum content identified some important issues which indicate why policy implementation continues to fail:

- lack of awareness among professionals about Indigenous clients, cultures and contexts;

- lack of specific skills and strategies for working in Indigenous contexts;

- lack of engagement in broader issues of justice and human rights; and

- the need for understanding of, and strategies for, challenging prejudice, ethnocentrism and racism.[11]

GUIDELINES, PROTOCOLS AND PRINCIPLES OF PRACTICE

In addition to the *practice standards*[1], each of the mental health professions—mental health nursing, occupational therapy, psychiatry, psychology and social work—is governed by codes of professional conduct, ethical guidelines and registration requirements to ensure workers provide culturally secure care. These are detailed in Chapter 11 (Walker). Each of these national and community-based ethical guidelines, protocols and principles of practice encourage practitioners to familiarise themselves with the local history, customs and ways of working, as well as the local mental health issues of their clients, their families/carers and communities.

The guidelines and codes of ethical conduct are invaluable resources for practitioners to engage in empowering safe and respectful intercultural relations. The values and principles underpinning these codes and guidelines also aim to guide the actions of mental health and other service systems to work in ways that encourage practitioners to consider their own values, attitudes and positionality—privilege and power. For example:

- The Australian Psychological Society has produced a code of ethical conduct and a set of guidelines for engaging in an empowering manner when researching within, or delivering health services to, Aboriginal and Torres Strait Islander peoples.[12]

- The Australian and New Zealand College of Psychiatrists' *Australian Indigenous Mental Health Ethics, Protocols and Guidelines*[13] outline strategies to address the physical, psychological, social, cultural and spiritual dimensions of Indigenous social and emotional wellbeing in the *'Dance of Life'* matrix. (See Chapter 16, p277)

However, despite these guidelines, Aboriginal people continue to experience unacceptable levels of racism; and policies and programs continue to fail people. As a consequence,

Aboriginal people are experiencing increased levels of stress, ongoing psychological distress, poor mental health outcomes and disturbed social and emotional wellbeing. While the various professional guidelines are designed to enhance professional practice, contemporary Aboriginal mental health requires that practitioners acknowledge the impacts of colonisation (past), the contemporary social circumstances (present) and effective strategies and practices to move forward. In effect this requires a genuine commitment for practitioners to take on a personal and professional responsibility to close the gap.

CULTURAL COMPETENCE IN THE AUSTRALIAN POLICY CONTEXT

The rationale for developing cultural competence in the health services is documented in a raft of policy guidelines and frameworks that aim to address the health inequities experienced by Aboriginal and Torres Strait Islander peoples. There is widespread recognition and evidence that existing services and approaches to improve the health and SEWB of Aboriginal Australians have not been successful.[14] There is increasing recognition that practitioners, service providers and policymakers in the health sector need to take account of the pervasive historical legacy of colonisation, diverse cultural and environmental experiences and contemporary social and economic circumstances of Aboriginal people.[15]

In 2005, the National Health and Medical Research Council (NHMRC) produced a document, *Cultural competency in health: A guide for policy, partnerships and participation in cross-cultural contexts.*[16] This policy guide puts forward a model with national application aimed at high-level policymakers to:

> *lead the way forward for the development of cultural competence in Australian healthcare—if it can galvanise action to make cultural issues 'core business at every level of the health system'.*[16(p1)]

In addition, the Australian Health Ministers' Advisory Council, national *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*,[17] set out a number of principles and examples of practice to guide both services and practitioners working with Aboriginal and Torres Strait Islander peoples. The *Cultural Respect Framework* encourages both services providers and practitioners to improve knowledge and awareness, skilled practice and behaviour, to develop strong intercultural relationships and create genuine equity of health outcomes. It aims to provide a nationally consistent approach to building a culturally competent health system that will improve access to, and responsiveness of, mainstream services for Aboriginal peoples.[14] The *Cultural Respect Framework* outlines strategies across a number of dimensions (system, organisational, professional and individual) to systematically lift the cultural competency of mainstream health services.[14] It builds on the recommendations put forward in several milestone reports detailed in Chapter 6 (Zubrick and colleagues) designed to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Despite the imperative for government policymakers and planners to take account of the specific needs and expectations of Aboriginal and Torres Strait Islander peoples, the planning and delivery of culturally secure and appropriate health and mental health services remains an ongoing challenge. It requires the commitment and recognition that cultural respect needs to be embedded across all sectors of the system including the corporate, organisational and care delivery levels to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes.[14]

Cultural Competence as a Contested Site

The concept of cultural competence has become an increasingly contested area. While it is widely accepted that cultural competence is a commitment to engage respectfully with people

from diverse cultures, there are concerns and criticisms that some approaches to cultural competence tend to essentialise culture.[18,19] Some writers go as far as to suggest that cultural competence is a form of new racism.[18] However, it is also widely acknowledged that existing health practices and policies and system-wide health delivery have failed to deliver fair and equitable health services to Aboriginal Australians and have actually contributed to the gap in health and mental health outcomes. Recent reports confirm that many health services remain inaccessible and unresponsive for Aboriginal people,[20] and that many are affected by systemic and individual racism.[21]

Working in ways that homogenise people by not acknowledging difference in culture, ethnicity or religious affiliation is discriminatory as it assumes that all peoples should respond to constructs, ideals, programs and interventions developed largely around euro or america-centric belief systems—philosophies, ideologies and ways of knowing and doing. These belief systems also assume that Western-based sciences can explain everything, which in itself leads to many discriminatory practices. It is well documented that people across the globe do not hold the same views, beliefs or attitudes about many issues, particularly health and wellbeing; and that culture and cultural difference play an important role in terms of the facilitation of health and wellbeing. It is therefore argued here that not undertaking education or professional training or development that improves understandings of cultural issues and that assist in the evolution of attitudes, beliefs and behaviours related to such issues is discriminatory.

Individual Cultural Competence

A commitment by both individuals and organisations to cultural competence is the beginning of an ongoing process that requires motivation and willingness to improve cross-cultural communication and practice. Cross, Bazron, Dennis and Isaacs (1989) proposed the most widely accepted definition of cultural competence as:

> *a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.*[22]

Importantly, for individuals, cultural competence requires far more than becoming culturally aware or practising tolerance. Cultural competence is the ability to identify and challenge one's own cultural assumptions, values and beliefs. It is about developing empathy and connected knowledge, the ability to see the world through another's eyes, or at the very least to recognise that others may view the world through a different cultural lens.[23] Cultural competence encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety. Cultural competence encompasses the knowledge, awareness and skills aimed at providing a service that promotes and advances cultural diversity and recognises the uniqueness of self and others in communities.[24-27] The focus on cultural competence is a response to ongoing health inequalities and related disparities in access to health services and experiences in health for different communities. It recognises the importance of acknowledging the influences of culture, ethnicity, racism, histories of oppression and other contextual factors in the experiences of individuals and communities. To this end, considerable attention has been paid to the development of models and guidelines for delivering culturally competent and safe health services.

The aim of cultural competence is to foster constructive interactions between people of different cultures. Importantly, cultural competence may not translate easily or appropriately from one culture to another, rather it is a commitment to an ongoing process developed in a particular intercultural context.[28,29]

Cultural Awareness

Cultural awareness requires practitioners to take responsibility for their own biases, stereotypes, values and assumptions about human behaviour generally, and recognise that these may differ from those held by other cultural groups. Importantly, they need to develop appropriate practices and intervention strategies that take into account their client's historical, cultural and environmental context.[30]

Cultural Respect

Cultural respect is a fundamental element of cultural competence that involves the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal peoples. It requires the health system to be a safe environment for all people, where cultural differences are respected and where the health care system and services respect the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of cultural respect is to uphold the rights of Aboriginal peoples to maintain, protect and develop their culture and achieve equitable health outcomes.[14]

Cultural Safety

Cultural safety extends beyond cultural awareness and cultural sensitivity. The notion of cultural safety has its roots in nursing research in Aotearoa, New Zealand, and is in part about Maori asserting their legitimacy and diversity and challenging Western-based models of nursing.[31] According to Ramsden (2002), '*cultural safety developed from the experience of colonisation and recognizes that the social, historical, political diversity of a culture impacts on their contemporary health experience*'.[32(p112)] The corresponding impacts of colonisation on Aboriginal social and emotional wellbeing and mental health are discussed in several chapters within this book together with the critical need for cultural safety. The concept of cultural safety has further been refined and extended to the concept of cultural appropriateness in health practices. Clear (2008) makes the crucial point that while culturally safe practice focuses on '*effective clinical practice for a person from another culture*', unsafe cultural practice '*diminishes, demeans or disempowers the cultural identity and wellbeing of an individual*'.[33(p2-4)] This is a critical area of practice where as Morgan (2006) states '*serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions*', particularly in remote communities.[34(p203)]

Cultural safety is about practitioners and services working to enhance rather than diminish individual and collective cultural identities, and empower and promote individual, family and community wellbeing. Culturally safe service delivery is crucial in enhancing individual and collective empowerment and more effective and meaningful pathways to Aboriginal self-determination.

Creating a culturally safe space involves a high level of critical reflexivity (a concept that is explored later in this chapter), as practitioners may not be aware of how their behaviours and interactions could make people from different cultures feel unsafe, or how the way services are provided can have negative consequences for client access and continuity of care.

Importantly, cultural safety is not something that the practitioner, system, organisation or program can claim to provide but rather it is something that is experienced by the consumer/client. Cultural safety focuses on the effective clinical practice for a person from another culture as it is experienced and perceived by them. While cultural competence contributes to a service recipient's experiences, cultural safety is an outcome. Cultural safety requires us to ask the client or service recipient whether they felt they were treated with respect, and had their culture, values and preferences taken into account—whether they felt safe.

ELEMENTS OF CULTURAL COMPETENCE

Cultural competence should be considered an ideal that is strived for rather than an end point that can be reached, ticked off and forgotten about. Cultural competence involves the knowledge, skills, attitudes and values necessary for effective intercultural transactions within diverse social, cultural and organisational contexts.[35] Sue's model encompasses elements of knowledge, values and beliefs, and skills considered necessary to enhance the cultural competence of practitioners.[35] These elements have been further articulated by psychologists such as Ranzijn et al 2008[11] and McConnichie et al 2008[36] in the context of education and training in Australia. These different dimensions need to be understood within a nested system that operates simultaneously at both individual, professional, organisational and system levels, recognising that a culturally incompetent system can undermine culturally competent practitioners.

Elements that Enhance Cultural Competence in Practitioners

Knowledge	• Broad or generic understanding of the nature of worldviews and culture, and the implications of culture for understanding human behaviour. (For further discussions, see Chapter 4, Gee and colleagues; and Chapter 30, Hovane and colleagues.)
	• An understanding of the specific cultural and historical patterns that have structured Aboriginal and Torres Strait Islander lives in the past and the ways in which these patterns continue to be expressed in contemporary Australia (see Chapter 1, Dudgeon and colleagues).
Values	• An awareness by professionals of their personal values and beliefs
	• A capacity and willingness to move away from using their own cultural values as a bench-mark for measuring and judging the behaviour of people from other cultural backgrounds
	• An awareness of the values, biases and beliefs built into the practitioner's profession and an understanding of how these characteristics impact on people from different cultures (see Chapter 3, Dudgeon and colleagues).
Skills	The mental health practitioner requires a mix of generic skills to carry out their role; they also need to develop a repertoire of skills that build on their knowledge and values to work effectively as a professional in intercultural contexts. These skills include the ability to:
	• carry out all aspects of triage/intake practice including mental status examination
	• work as a team member
	• work collaboratively with a broad range of health services and providers
	• incorporate the principles of culturally sensitive practice in mental health care
	• self-monitor and critically self-reflect.
Attributes	Reflecting on our individual values and attitudes involves the skill of critical reflexivity, which includes, among other things, developing an understanding of:
	• the nature and dynamics of power as it operates in many levels from practitioner–client interaction, to organisational and political systems and between various professions and disciplines
	• the nature and impacts (on both Aboriginal and non-Aboriginal people) of unearned or ascribed privilege
	• the nature and effects of racism at individual, institutional and ideological and discipline levels
	• the history of relationships between Aboriginal Australians and systems and professions and the effects of this history on Aboriginal perspectives about the professions
	• the extent to which each profession is constrained by the culturally constructed models and disciplinary knowledges/theories used by the profession
	• the effects of white privilege, racism and cultural blindedness.

In summary, Aboriginal and Torres Strait Islander mental health and SEWB is situated in social justice and human rights frameworks. Mental health practitioners need to show a commitment to natural justice and the fundamental rights of each individual. They need to be able to show respect and empathy and demonstrate discretion and the ability to uphold confidentiality. This requires balancing the rights of the individual with the rights and needs of the community. It requires sensitivity, tolerance, and importantly, the ability to request assistance if necessary. Finally, mental health practitioners are expected to demonstrate good practice standards by adhering to the ethical codes and policies of the Department of Health in their state, as well as National Codes of Practice.

Mental health practitioners are also expected to comply with language services policy; they have an obligation to determine the need for, and provide, a qualified interpreter where required. They are strongly encouraged wherever possible to use professional interpreter services rather than family members or unqualified personnel when conducting a mental health assessment.

WORKING IN PARTNERSHIP

There is broad agreement from both clients and practitioners that practitioners need to work in genuine partnership with Aboriginal people to be effective. This model of working has important implications for practice, including adopting protocols for working with Aboriginal people such as:

- Recognising that the individual 'client' (in the case of individually-oriented practice), their family and community, Aboriginal co-workers and other professionals are equally 'experts' in the process. Letting go of the 'expert' role and being willing to share resources can be very difficult and involves being critically self-reflective of the possible barriers due to the unequal power inherent in the therapist–client relationship.

- Developing an effective partnership takes time, trust and personal relationship. For most Aboriginal Australians, *who* you are is more important than *what* you are.

- Having regard for Aboriginal protocols in community contexts. Often a process of vouching is required, in which one or some of the community members will attest to the person wishing to enter the community.

- Working in collaboration with cultural consultants, who will advise about cultural matters, provide guidance in appropriate behaviour, and mediate between the practitioner and the family/carer and community.

CULTURAL COMPETENCE AS A CONTINUOUS PROCESS

There is widespread agreement within the literature that the development of cultural competence is a continuous process—cultural competence is an ideal to strive towards and an ongoing process which continually evolves.[38] Wells elaborates on the continuum provided by Cross et al., who offer a model that links the elements of cultural competence (knowledge, attitudes and skills) to a developmental framework.[22,39] They identify a sequence of stages along a continuum:

- *Cultural incompetence:* lack of knowledge of the cultural implications of health behaviour.
- *Cultural knowledge:* learning the elements of culture and their role in shaping and defining health behaviour.
- *Cultural awareness:* recognising and understanding the cultural implications of behaviour.
- *Cultural sensitivity:* the integration of cultural knowledge and awareness into individual and institutional behaviour.
- *Cultural competence:* the routine application of culturally appropriate health care interventions and practices.
- *Cultural proficiency:* the integration of cultural competence into one's repertoire for scholarship (e.g. practice, teaching and research).

At the organisational level, cultural proficiency is an extension of cultural competence into the organisational culture. For the individual and the institution, it is mastery of the [five preceding] phases of cultural competence development. Although, importantly, it needs to be emphasised that cultural proficiency is about being in a constant state of learning dependent on our willingness to remain forever vigilant and reflective.[22,39] We suggest that cultural competence is about adopting a particular standpoint—a state of mindfulness, humility, sensitivity, authenticity and a willingness to really listen and learn from others.

Cultural Competence – A Dynamic Process

Cultural competence is a dynamic and interdependent process constructed by, and within the context of, human relations and their environments. Cultural competence can be understood within the context of the individual, the family and peers, the school and social or sporting clubs, ethnicity, class, race, gender and the broader policy, social, cultural and historical context. Cultural competence needs to be considered within a broader system-wide social, historical, political and economic context as well as at the level of individual professional practice. This notion of situating SEWB within the broader social, cultural, historical context is a recurrent theme throughout this book (and is discussed in Chapter 4, Gee and colleagues; and Chapter 13, Schultz and Walker and colleagues.)

By connecting cultural competence with the notion of social ecology, we need to consider different levels of a system that must be considered in promoting culturally competent practice and service delivery. At a system level, all health sector and organisational personnel need to develop significant aspects of cultural competence; and organisations need to respect and cater for cultural diversity, through both the physical layout and presentation, and the implementation of policies, procedures and practices that promote culturally safe, responsive environments (see the *service standards*[2]).

EXTENDING COMPETENCE THROUGH CRITICAL PRAXIS

Within the current health, education and workforce systems, great emphasis and recognition is placed on achieving qualifications and gaining experience in a specialised area of health, mental health and/or social and emotional wellbeing. Ongoing professional development, peer review and incremental promotion are mechanisms that can reinforce and recognise our professional and clinical competence and expertise in respective roles. It requires practitioners to:

- make a commitment to critical self-reflection;
- adopt a stance of resource-sharing;
- recognise the unequal power inherent in the practitioner–client relationship;
- acknowledge what that means for the client's sense of wellbeing; and
- empower their clients to address their mental health and SEWB issues, and ongoing psychological issues including grief, loss and trauma.

Indigenous Knowledges and Whiteness Studies

Several authors have demonstrated how mainstream services and practices work in exclusionary ways to the detriment and disadvantage of Indigenous populations. Oxenham (2000) and Rigney (1997) highlight the importance of incorporating and applying Aboriginal terms of reference (i.e. values, aspirations and ways of being and doing) into policies, practices and processes that impact on Aboriginal people.[30,40] This work shows how health service systems can be made more responsive and sensitive to Indigenous Australians and their particular needs. The work of ethnic minorities, women's studies and whiteness studies also shows how

mainstream systems and practices produce normativity—that is, the standards, regulations and protocols intended to provide uniformity of service and best practice can also undermine cultural competence by dispelling the importance of difference. In combination, this interdisciplinary work offers resources, standpoints and frames of reference that can be used to ask pertinent questions about race relations, histories of oppression, and constructions of health and mental health and wellbeing, which ultimately are crucial understandings and activities that affect health and mental health service delivery.

Sonn and Green[41] examined the notions of subjectivity and reflexivity identified by Aboriginal and Maori scholars for working towards liberation and decolonisation. Central to engaging in transformative practice across intercultural spaces is the requirement that we understand histories of colonialism and the role racism has played in the oppression of Indigenous peoples. This work offers a way in which cultural competence can specifically engage with issues of power and privilege, and the power that we are afforded because of our different group memberships, including our professions.

For instance, Smith[29] in New Zealand and Gilbert[18], Martin[42], Moreton-Robinson[43] and Nakata[44] in Australia, reveal how different disciplines, including psychology, public health practice and policy and service provision, have participated in the construction of knowledge about Aboriginal and other ethnic groups, often as an inferior or exotic 'other'. These constructions have implications for how individuals and communities are treated in different social settings, including health and mental health contexts. A shared feature of anti-colonial writing is the focus on decolonisation which examines and deconstructs the various ways in which ethnic and racial minority communities are presented as problematic and often blamed for their own misfortunes. At one level, this deconstructive work is aimed at understanding the assumptions, ideologies, motives and values that inform research and practice.[29] At another level, it is about developing and promoting ways of knowing, being and doing that are anchored in the lived social and historical realties of indigenous peoples.[45] Among other things, this work demands that we ask critical questions about what we know of different groups of people:

- Whose standards have we accepted as the key standard for comparison?
- Whose ways of living are privileged?
- What are the implications of imposing understandings on people?
- Is the voice of 'the other' noticeable, acknowledged and respected?

A related area of work is concerned with understanding how dominance and privilege is constructed and maintained.[46] At a broad level, whiteness studies are concerned with examining the production of dominance and understanding the complex interplay of privilege and power afforded by whiteness in the context of race relations—and how to undo it.[47] Green, Sonn and Matsebula (2007) have identified three mechanisms by which whiteness is produced and maintained, including the production of privilege through:

- the construction of knowledge and history;
- national identity construction and belonging; and
- in racist practice.[46]

In terms of knowledge and history construction, Western views and ways of knowing and doing have been privileged at the expense of other ways of knowing and doing.[48] For example, Sarra[49] and Dudgeon, Mallard and Oxenham[50] have discussed the powerful and oppressive effects of externally imposed definitions of self and community on Aboriginal people—often negative representations serve to reproduce racism. McKinney (2005)[51] theorised that anti-racism practice for white people will require a shift in focus from prejudice reduction to an awareness of systemic and inherited privilege and a commitment to challenge racist behaviour.

This important area of work allows us to examine at a deeper level the basic assumptions that inform disciplinary research and practice, including those we hold about notions of personhood. As Riggs (2004) and others have noted, some of the assumptions about universality of human psychological processes may benefit those who share this view, but they exclude other cultural understandings of self (and collective conceptions of health) and can be detrimental and harming.[48] To this end, critical whiteness studies offer a set of resources that may enable researchers and practitioners to make visible their normative assumptions, thereby opening up spaces for negotiation and interrogation.[52,53] Green and Sonn, for example, identified several narratives that informed non-Aboriginal people's engagement in reconciliation.[54] Among them were those that viewed Australian Indigenous culture as deficient, those that viewed other white people as racist, and those that blamed the system and history for Indigenous people's disadvantage. These narratives are not mutually exclusive but have different implications for intervention, and they can also work to reproduce the privilege of non-Indigenous people.[53]

Therefore, engaging in critically reflective practice and crossing intercultural boundaries involves different challenges: it is generally acknowledged that people make sense of their social world by creating categories of in-groups and out-groups. There is a tendency for people to exaggerate differences between some groups and similarities with others and to unconsciously favour one's in-group over the out-group—contributing to privileging the in-group and marginalising or othering the out-group. This auto processing and categorisation is problematic where there is a dominant group with more power than the other group and where the resources are not distributed equitably to all groups. Within the professions, this can result in assumptions, values, and beliefs and expectations of the dominant discourse being imposed on other groups.

Being critically reflexive in this context often means letting go of certainties and being prepared to negotiate with clients and communities. Letting go of certainties and foreclosing recipes for action can be emotionally challenging and leave one feeling vulnerable, powerless and out of place—having the ability to work outside one's own comfort zone is crucial. In addition, being able to negotiate and bring together and work with different knowledges and expertise within specific contexts are also important skills.

Safety, Self-care and Support

Mental health practitioners wanting to work competently in diverse cultural contexts may find themselves confronted by the potentially challenging nature of engaging in decolonising practice at the individual level, at the same time as supporting the complex and traumatic circumstances that clients and communities may be experiencing. This can be fraught with uncertainty. It is therefore important to have strategies for self-care and support. These may include mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

Ethical Engagement and Exiting Strategies

As practitioners it is pertinent that we remain mindful that we have the ability to leave the client/practitioner relationship when we see fit or when funding for the research or programs ends. Aboriginal and Torres Strait Islander individuals, families or communities that we are working with may not be able to leave. Therefore we as practitioners need to ensure that when we leave, the appropriate steps and processes are in place to be of benefit to the individuals, families and communities with whom we have been working. If we cannot leave a positive legacy we must consider our own personal agendas or reasons for involvement in the first instance.

CRITICALLY REFLECTIVE PRACTICE

There are a range of reflective activities and learning processes that can give mental health practitioners skills, techniques and understandings to enhance their work in cross cultural settings. These activities and processes assist them to develop a clearer understanding of their roles and the power relations operating within their work and to develop strategies to address the issues and concerns they are facing. The transformative potential of critical reflexivity resides in interrogating the political, social and cultural positioning of Aboriginal people in temporal terms (historical and contemporary) and geographic contexts (including community contexts) to affirm and validate Aboriginal identity and difference. The intersection of these different elements is reminiscent of Sue's multidimensional elements of cultural competence.[55] These are explicit competencies that will enable students or practitioners to navigate the cultural interface to understand how they can make a genuine difference to Aboriginal mental health and social and emotional wellbeing.

Viewing cultural competence as a dynamic-in-interaction requires us to consider critical reflection/reflexivity as central to culturally competent practice. It involves both interrogating and integrating Indigenous and Western knowledge systems and critically reflective practice at the cultural interface.[56] Critical reflection/reflexivity is an essential skill for all professional practitioners working at the highly politicised, complex and dynamic Indigenous/non-Indigenous interface.[45] This is in line with the idea of knowledge as 'knowing how to act'. As Greenwood and Levin (2005) note '*To act is to contextualize behaviour, and being able to act skilfully implies that actions are appropriate to a given context*'.[57(p51)] Here, new knowledge and ways of being are produced in the act of reflection-on-action in the real world. Critical reflection is a key principle for ethical practice, as Walker, McPhee and Osborne (2000) state:

> *All practitioners, both Indigenous and non-Indigenous, tend to operate according to a complex interaction of their own values, beliefs and experience and the values, assumptions and paradigms of their professional discipline or field. The way individual practitioners carry out their roles, and the way they act with clients and other professionals depends largely on their interpretation of that discipline which is largely influenced by their own beliefs and values, knowledge and experience.*[56(p322)]

As practitioners, we need to consider how our own social, cultural and professional positioning will influence the relations we have with people who seek our assistance in any context—but in this instance in the mental health setting. Thus, reflexivity in one sense is about recognising and critically engaging our own subjectivities in the context of relating across cultural boundaries. It means examining our own social and cultural identities and the power and privilege we have because of these identities. It also requires that we engage with the political and ideological nature of practice and knowledge production and consider the implications of these for those we aspire to work with. Therefore, as Parker suggests:

> *Reflexivity should not be a self-indulgent and reductive exercise that psychologizes phenomena and psychologizes your own part in producing them. Instead, the reflexive work is part of action, and in action research much of that reflexive work is undertaken alongside and in collaboration with [clients, and their families].*[58(p35)]

The process of critical reflection is a powerful tool for producing new knowledge and processes, and has the potential to improve fundamental social justice outcomes for Aboriginal people.[56] It encourages practitioners to embrace a human rights framework and the nine guiding principles which underpin Aboriginal social and emotional wellbeing (page xxiv). In reflecting on these elements, we become more conscious of the power that inheres in our own practice in order to democratise relationships, interactions and processes and to promote a culturally secure process and environment that will improve health and wellbeing outcomes for Aboriginal clients and communities. As Walker and colleagues[56] state, our desire and commitment to be ethical,

effective, culturally competent practitioners requires that we:

- analyse and understand the broader cultural, social, political and economic environment and how it impacts on, or influences, our professional and personal practice and the lives of the people with whom we are working;

- make our own disciplinary and professional practice the subject of our inquiry in order to analyse and, where necessary, change so that our actions are more culturally responsive, relevant and effective for the specific individuals and groups with whom we are working;

- draw information from a broader social and historical context as well as our professional context to better inform and interpret our own and our clients' actions and responses.

While the focus is about our professional practice in context, explanations need to extend beyond our taken-for-granted practice. We need to look at how relations of power in the broader social and political context impact on issues of race, culture, gender and class and, in turn, how they may influence our own and [others] beliefs, values and behaviour.[56]

Figure 12.1 below depicts the multidimensional and iterative nature of critical reflection and illustrates how our understandings of self, others and the particular profession interact with the broader cultural, social, historical, political and economic contexts; our understandings and how the formal and informal theories underpinning our professional practice are informed by a complex interaction of values, beliefs, assumptions, experiences and contextual factors.

Figure 12.1: Critical Reflection Framework of Analysis
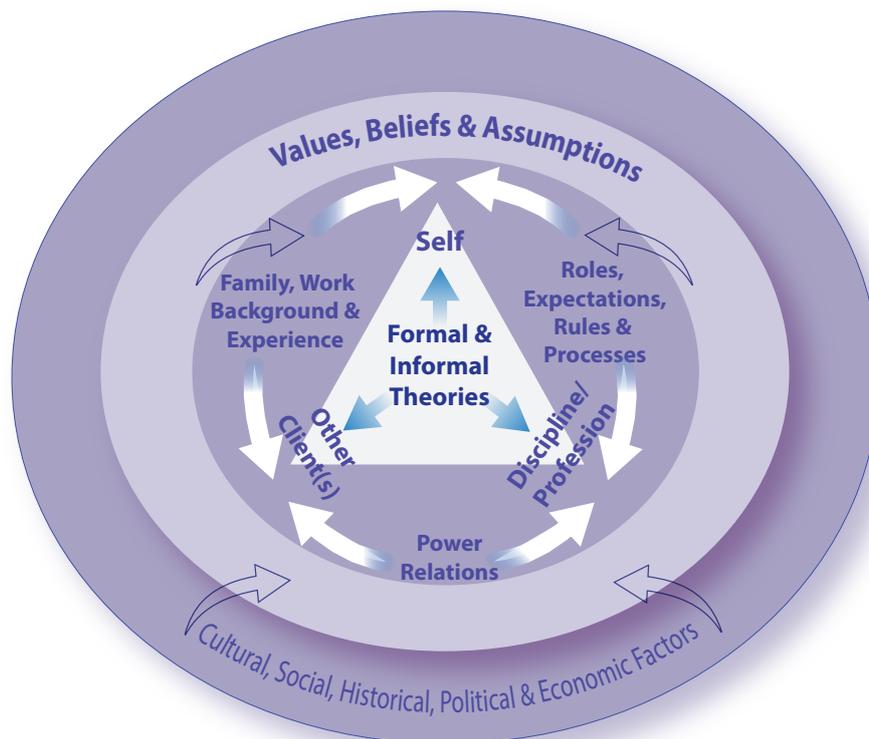
© R. Walker 1999

This figure also depicts the tensions and interacting elements that occur at an individual level and that are experienced by those people who recognise and acknowledge that they are working within the cultural interface and attempt to understand their own relationship with the various elements within it.

TOOLS AND TECHNIQUES FOR CRITICAL REFLECTION

The tools and techniques developed to facilitate the process of critical reflection enable practitioners to make more conscious decisions in their work to support the interests of the groups with whom they are working. Many of these tools and techniques of critical reflection have been developed, refined and applied over several years by staff and students or practitioners in the Indigenous Community Management and Development (ICMD) program as part of the transformative and decolonising project to improve the overall circumstances of Aboriginal Australians.[52] These same tools and techniques can help practitioners to identify and take account of Aboriginal terms of reference in their work in community management, policymaking and social services and community health and mental health areas.[30]

The main tools and techniques developed for the ICMD course materials were summarised in *Working with Indigenous Australians: A handbook for psychologists* (Dudgeon and colleagues) as follows:[56]

Questioning	Helps us to generate new knowledge about ourselves, others, the context and their interconnecting influences. Questions should uncover: reasons, factors, links, possibilities, intentions, consequences, feelings (*how* others feel and *why*).
Analysing	Requires looking behind what's happening for underlying issues, causes and effects, identifying own/others' assumptions, and deconstructing complex situations into specific issues. Analysis helps make meaning of situations, events, issues and practices, both at a personal and professional level, privately and publicly.
Defining the issue	Means identifying issues that cause concern or require further exploration and/or evaluation. The issues may be related to our own practice, someone else's response, or feelings of uneasiness or uncertainty with respect to an interaction or intervention.
Seeking other perspectives	Involves reading widely, talking with relevant people, and 'stepping into the shoes' of clients/others to see how situations and ideas appear for them.
Mapping	Helps to draw links between different perspectives and ideas to reveal how taken-for-granted things fit together. It can help to clarify the problem and situate it within the bigger picture.
Critical reflection through dialogue	Takes place formally or informally between the practitioner's personal experience and the shared understandings, discipline, knowledge and professional rules and practices that inform their experience. These different perspectives are underpinned by values and assumptions that may differ substantially from, and challenge, those of the practitioner.
	Approaching critical reflection as a kind of dialogue helps us to work through our own mental processes and to see other perspectives we might not come up with on our own. As such, critical dialogue can assist practitioners to use tools and discourses to challenge the accepted boundaries of traditional or dominant theories and practices. It helps practitioners to identify, critically assess and articulate how their own informal theories about working at the cultural interface contribute to, and have the potential to transform, their understandings about their own practice as well as assist in their self-care and support.[59]
Recording activities/ observations	Keeping a diary or journal or using tape-recordings can be a useful way to record activities or observations or pose questions relating to specific differences between cultural values, beliefs and those of discipline and self. These observations can form a basis for self-reflections, further discussions or assessment, although issues of confidentiality need to be acknowledged.

NEGOTIATING THE CULTURAL INTERFACE

In this section, adopting an anti-colonialist, decolonising standpoint, we consider the concepts of white privilege/colonial hegemony, Aboriginal knowledge, power and positionality and multi-disciplinarity. Walker (2000) encourages practitioners to employ the theoretical construct of the Indigenous/non-Indigenous interface as part of a practice framework that is both decolonising and transformative.[52] The chapters in this book exemplify how:

> *the incorporation of Aboriginal and non-Aboriginal knowledges and practices can decolonise and transform disciplinary practices that have traditionally oppressed, marginalised and otherwise harmed Indigenous interests (and legitimised the process) in the name of Anthropology and Psychology.*[52(p187)]

Working Together is an example of transdisciplinarity—drawing on and sharing understandings, methods and experiences across a range of disciplines to interrupt, inform and transform these disciplines and knowledges. It inserts Aboriginal ways of knowing, being and doing firmly into the disciplines of psychology as well as each of the disciplines that influence Aboriginal mental health and SEWB.

Multidisciplinarity: Working with Multiple Discourses

Practitioners need to interrogate and integrate reflective processes on Indigenous terms of reference. It is important to acknowledge and maintain the tensions between the different standpoints and discourses underpinning critical, ethical, socially just practice in Aboriginal mental health contexts. These include the various critical positions available to the mental health practitioner as a consequence of the interactivity between the different disciplines, standpoints (Indigenous, feminist and post-structuralist) as well as the multiple and competing discourses of community psychology, social psychology, psychiatry and primary health care 'which are critiqued through the discourse of Indigenous cultural values and protocols' for mental health practice in diverse contexts.[52(p188)]

These multiple critical positions embrace the diverse and complex politics operating across the intersections of race, class and gender within both Indigenous and non-Indigenous domains, enabling the mental health practitioner to identify the level of complexities at the intersection of ideas and practices and their own potentially ambiguous location within them.[52] In other words it is possible to interrogate the potential positive and negative effects of different disciplinary discourses from different subject positions. These dialectics avoid simple, uncomplicated notions of cultural difference, subsuming some of the broader and general imperatives of social transformations. Practitioners need to acknowledge the complexity of the cultural politics of difference, and incorporate processes to problematise, dialogue and negotiate around this difference within their professional practice in order to initiate a more inclusive and effective practice.[30,45,60]

All practitioners working in the mental health area need to be aware of, and take into account, the complex nuances of cultural politics operating at the cultural interface in order to address the relations of power and issues of social justice and fundamental human rights.[52] Negotiating the interface is underpinned by the idea that a decolonising and transformative potential resides in that space.[45,52,61] Incorporating human rights principles to inform our work at the cultural interface enables new ways of working that recognise and facilitate equal power relations and partnerships.[52]

Power, Knowledge, Culture and Politics

Part of the critique of the cultural competence discourse is around the unequal power relations that operate within and between the various service delivery and policy sectors as well as between the professions/disciplines and between dominant and minority populations. As

Kessaris (2006) argues:

> 'cultural awareness' and 'anti-racism' type training can no longer focus primarily on seeking to 'understand' the 'other'. Emphasis must be placed on understanding the self in the midst of unbalanced power relationships.[42(p358)]

Australia's colonial history, Aboriginal contemporary circumstance, lack of access to services and resources and lack of control over the most fundamental aspects of their lives are key determinants of Aboriginal health, mental health and SEWB (see Chapter 1, Dudgeon and colleagues; and Chapter 6, Zubrick and colleagues).

Applying Conceptual Frameworks

The conceptual frameworks of critical reflection and the cultural interface are frameworks of analysis which enable practitioners to identify, acknowledge and critique the historical and political factors and existing power relations operating in their interactions with clients, their families and communities. The enduring realities of colonial domination require practitioners to operate in an ethical, conscious and critically reflective manner and with regard to the power, responsibilities and expectations inscribed within their professional and personal (and community) roles.

The application of these analytical and reflective tools will enable students and practitioners to recognise the relations of power operating within the political structures and the way they influence policies, standards and resources and services in the sectors that affect how people's needs are attended to. The deconstruction of knowledge and power entails looking at:

- how the various discourses (including public policy discourses and paradigms around quality assurance and best practice) and the disciplines that support mental health and wellbeing can operate to serve both positive and negative ends; and

- how and why they operate in ways that do not always serve interests and achieve positive outcomes for Aboriginal clients, families and communities.

See, for example, Kowal and Paradies[62]—the results of workshops that apply similar concepts and tools confirm that the understanding and competence developed through critical reflection allows practitioners to identify their areas of ambivalence and reach a level of proficiency over time to identify strategies to change and/or reinterpret institutional and social policies, practices and processes that impact negatively on Indigenous people.

As Kirmayer (2012) notes:

> The self-reflexivity of practitioners and systems opens the door to reorganizing the delivery of services and the conduct of clinical work in ways that share power and control over health care but the details of how this is achieved must be worked out for specific contexts.[63(p158)]

CONCLUSION

This chapter has aimed to consolidate ideas regarding the professional responsibilities of working as part of a multidisciplinary team, engaging in ethical practice, facilitating cultural safety and acquiring cultural competence. It has demonstrated how practitioners must provide cultural safety and care (as well as culturally appropriate services) for Aboriginal clients, their families and communities. Practitioners are encouraged to adopt strategies for self-care and support as they question some of their own ways of thinking and doing while engaging in self-reflective, transformative practice.

Cultural competence has been explored within a human rights framework which situates the process within a decolonising paradigm to ensure Aboriginal people's right to culturally secure care rather than as a new form of colonisation and racism. Central to this chapter is the *Critical Reflection Framework of Analysis*, which offers a process to enhance professional competence through reflection upon self, others, the discipline and professional codes of conduct and the broader contemporary and historical contexts in which their work is situated. Such a process can help individuals and professions avoid the pitfalls of a newer colonial voyeurism through superficial cultural awareness training.

The changing relations of power between the disciplines/professions and Aboriginal people and the role they have played in critiquing the history of the disciplines of psychology, psychiatry and the social sciences are part of the context that has given rise to new ways of working that are empowering, respectful and ethical. This chapter has argued that cultural competency is a dynamic that is contingent and contextual—it is not an end state, but rather an iterative process to ensure sensitive, democratic, just and transformative practice. The policy terrain needs to be inclusive and respectful of Aboriginal cultural needs, priorities and aspirations. It needs more than to require practitioners and services to be culturally competent—it needs to address the various forms of racism that are still evident and pervasive in Australian society, its people, the structures, the system and practices.

REFLECTIVE EXERCISES

Throughout this chapter we have highlighted the importance of being critically self-reflective as well as engaging in more critical reflection on the disciplinary practice in which mental health practitioners are located. We have suggested that, among other things, this work demands that we ask a number of important questions. These exercises are designed to assist student/practitioners to do just that.

1. Reflect on your own position of privilege

Tannoch-Bland (1998) wrote that racism is dialectical: there are those who are disadvantaged by it and those who benefit from it. White race privilege is taken for granted and reproduced in everyday institutions.[64] Privilege refers to a variety of situations which disproportionately benefit white people; it ranges from being in control of the economic and political system to more simple forms such as being able to buy bandaids and cosmetics suitable for white skin, and watching television programs that are representative of white people.[64,65] Tannoch-Bland provides 40 examples of the kinds of invisible privilege and unearned benefits associated with whiteness. We have selected 10 examples for illustrative purposes.

- I can be reasonably confident that in most workplaces my race will be in the majority, and in any case that I will not feel as isolated as the only, often token, member of my race.

- When I am told about Australian history or about 'civilisation', I am shown that people of my colour made it what it is.

- I can send my children to school in unironed uniforms without it reflecting on their race.

- I can dress down, or get drunk in public without reinforcing negative stereotypes about my race.

- When I speak in public my race is not on trial.

- When I'm late, my lateness isn't seen as a reflection of my race.

- When I win a job or a scholarship, I am not suspected of doing so because of my race rather than my merit.

- When I need legal or medical help, my race doesn't work against me.

- I expect that neighbours will be neutral or friendly to me.

- From among the people of my race, I can choose from a wide range of professional role models.[64(pp34-36)]

Read the examples above and list three examples of benefits that you believe come from your race/ethnicity/gender/position/location.

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2a. Undertake an individual cultural competence audit

According to Campinha-Bacote (2002), 'As we begin, continue, or enhance our journey towards cultural competence, we must continuously address the following question, "Have I ASKED myself the right questions?"'[66] Campinha-Bacote has developed a mnemonic 'ASKED' which poses some critical reflective questions regarding one's awareness, skill, knowledge, encounters and desire.[66] These questions have been adapted with permission to encompass working with Aboriginal and Torres Strait Islander peoples.

Awareness	Am I aware of culturally appropriate and inappropriate actions and attitudes?
	Does my behaviour or attitudes reflect a prejudice, bias or stereotypical mindset?
Skill	Do I have the skill to develop and assess my level of cultural competence?
	What practical experience do I have?
Knowledge	Do I have knowledge of cultural practices, protocols, beliefs, etc?
	Have I undertaken any cultural development programs?
Encounters	Do I interact with Aboriginal and Torres Strait Islander persons?
	Do I interact with culturally and linguistically diverse persons?
	Have I worked alongside Aboriginal and Torres Strait Islander persons?
	Have I worked alongside culturally and linguistically diverse persons?
	Have I consulted with Aboriginal and Torres Strait Islander persons or culturally and linguistically diverse groups?
Desire	Do I really want to become culturally competent?
	What is my motivation?

Consider each of these questions honestly.

_____

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2b. Consider these additional questions:

What do I know about the culture, values, beliefs, individual and collective history and social circumstance of the clients/families/communities with whom I work?

_____

_____

Whose standards have we accepted as the key standard for comparison?

_____

_____

Whose ways of living are privileged?

_____

_____

What are the implications of imposing my understandings on people?

_____

_____

3. Undertake organisational cultural competence audit

Westerman's research findings related to organisational cultural competence highlight the need for practitioners to reflect critically on the organisation in which they are working in terms of organisational competence.[67] Westerman makes the point that:

> *We've had organisations where 80 percent of their staff have had training in cultural knowledge or cultural awareness but that has had no relationship whatsoever to cultural competence and service delivery.*[48]

Westerman lists five key components of organisational competence:

1. local Indigenous-specific knowledge

2. skills and abilities for being able to adapt or utilise mainstream training in a way that will be effective with Indigenous clients

3. resources and linkages for the use of cultural consultants, cultural guides, having lots of links with the local community

4. organisational structures, ensuring that those are actually consistent with culturally appropriate practice

5. beliefs and attitudes—which is the most important?

Consider an organisation or service in the mental health service you work with or are familiar with. Conduct a cultural competence audit by identifying those issues that you believe contribute to, or diminish, the sense of cultural safety and responsiveness for Aboriginal clients and families and staff that the organisation or service may or may not be aware of.[48] Taking into account the five components identified by Westerman, consider the following elements of organisational cultural competence:

Context (organisational environment)

In relation to the organisation:

- Does it promote and foster a culturally friendly environment?

- Is it located in an area where Aboriginal and Torres Strait Islander persons and culturally and linguistically diverse persons may wish to access services?
- Do the staff display attitudes and behaviours that demonstrate respect for all cultural groups?

Practices (culturally inclusive)

Does the organisation:

- involve or collaborate with Aboriginal and Torres Strait Islander persons or groups or culturally and linguistically diverse persons/groups when planning events, programs, service delivery and organisational development activities?
- develop policies and procedures that take cultural matters into consideration?
- provide programs that encourage participation by Aboriginal and Torres Strait Islander persons and culturally and linguistically diverse persons?
- use appropriate communication methods and language, e.g. appropriate and relevant information communicated through user and culturally-friendly mediums?

Relationships (collaborative partnerships)

Does the organisation:

- have knowledge of local Aboriginal and Torres Strait Islander groups?
- have knowledge of culturally and linguistically diverse groups in the community?
- have knowledge of local Aboriginal and Torres Strait Islander protocols?
- have knowledge of the protocols for communicating with culturally and linguistically diverse groups in the community?
- actively involve Aboriginal and Torres Strait Islander persons or groups and culturally and linguistically diverse persons or groups in the community?
- have a strategy for community engagement?

Service delivery (outcomes)

Does the organisation:

- develop and/or implement a collaborative service delivery model with other organisations relevant to the specific cultural needs of the clients?
- provide culturally responsive services that meet the cultural needs of clients?

4. Key concepts

Provide a brief definition for each of the following key concepts:

Social ecology

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Subjectivity

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Reflexivity

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Power

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_____

Cultural interface

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_____

Whiteness

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_____

Privilege

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