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A qualitative evaluation of the implementation of a cultural competence project in rural Victoria

Olivia Mitchell,¹ Lisa Bourke,¹ Zubaidah Mohamed Shaburidin¹

Aboriginal and/or Torres Strait Islander Victorians continue to experience disparities in health and wellbeing compared to non-Aboriginal people.¹ These disparities have, in part, been attributed to a significant disadvantage of Aboriginal and Torres Strait Islander people to access culturally appropriate health and support services in mainstream settings.² Just over half of all Aboriginal and Torres Strait Islander Victorians live in rural areas, where access to and choice of services is further limited.³ Therefore, providing accessible, culturally appropriate health care and support services is particularly important in rural Victorian communities. Over the past decade, the Victorian Government has undertaken a variety of initiatives to improve the cultural competency of mainstream services, and in turn, the usability and accessibility of these services for Aboriginal and Torres Strait Islander people⁴⁻⁷ Despite these efforts, limited success has been achieved in improving the usage of mainstream public health and wellbeing services by Aboriginal Victorians.¹ This lack of improvement has been attributed to the underlying persistence of racism throughout Australian health and welfare systems, manifested in the social determinants of Aboriginal health and wellbeing.⁸

In 2013, Tynan et al.⁹ described the development of the Victorian Department of Health endorsed Aboriginal Health Cultural Competence (AHCC) Framework,¹⁰ part of the implementation of the Hume Close the Gap Health Plan (CTGP)⁵ in Victoria. Development of the CTGP was undertaken by the Hume Region Closing the Health Gap

Abstract

Objective: To explore the complex factors influencing the implementation of cultural competency frameworks for Aboriginal and Torres Strait Islander peoples within rural, Victorian, mainstream health and community service organisations.

Methods: Semi-structured telephone interviews were conducted with key individuals from 20 public health and community services in rural Victoria who had participated in the Koolin Balit Aboriginal Health Cultural Competence Project (KB-AHCC project). Interviews were recorded and transcribed verbatim and a content analysis was undertaken. The findings informed the selection of six case study sites for more in-depth analysis. Following this, an expert reference group provided feedback on the findings. Findings from the different data were triangulated to identify eight factors.

Results: Key factors acting as barriers and/or enablers to implementing cultural competence frameworks were: comprehensive, structured tools; project workers; communication; organisational responsibility for implementation; prioritising organisational cultural competence resourcing; resistance to focussing on one group of people; and accountability.

Conclusions: Embedding cultural competence frameworks within rural, mainstream health and community services requires sustained government resourcing, prioritisation and formal accountability structures.

Implications for public health: Findings will inform and guide the future development, implementation and evaluation of organisational cultural competence projects for rural public health and community services.

Key words: Aboriginal health, cultural competence, rural health, public health and community services

Steering Committee and identified five key priority areas for action, which included the need to increase the cultural competency of the public health and community service system across the Hume region.⁵ To address this priority, the Aboriginal Health Cultural Competence Working Party (AHCC Working Party) was convened, consisting of members from key Aboriginal health and Traditional Owner organisations, the Victorian Department of Health and mainstream health organisations from across the region.^{9,10}

The AHCC Framework¹⁰ and Audit tool were developed by the AHCC Working Party during four workshops in 2011⁹ and focussed on identifying actions for leadership and quality teams to improve cultural competence within rural health and community services.¹⁰ The AHCC Framework conceptualised cultural competence as defined by Cross et al.¹¹ and the National Health and Medical Research Council,¹² and evolved within the context of the Victorian Aboriginal Inclusion Framework,¹³ the Victorian Government

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Charter of Human Rights and Responsibilities Act¹⁴ and the Victorian Aboriginal Childcare Agency's Aboriginal Cultural Competence Framework.¹⁵

The AHCC Framework was implemented in the Hume Region as the Koolin Balit Aboriginal Health Cultural Competence Project (KB-AHCC project).^{2,9} Here, we present findings from the final evaluation of the KB-AHCC project. To date, research on *how* rural mainstream health and community service organisations implement cultural competency frameworks and tools, and the associated impact on organisations of this implementation, has been limited.⁹ Using the evaluation as a case study, we explore the complex factors involved in the implementation of this cultural competence framework and what lessons may be learned for the implementation of future cultural competence projects.

Methods

The Koolin Balit Aboriginal Health Cultural Competence Project

The KB-AHCC project stems from previous frameworks and projects that have been implemented in Victoria since 2008 and formerly began in December 2016.² In 2017, the KB-AHCC project was extended to include community services and was renamed the 'Koolin Balit Aboriginal Wellbeing Cultural Competence Project'. For simplicity, both projects are referred to as the KB-AHCC project throughout this paper.

The purpose of the KB-AHCC project was to target leadership and quality teams within rural health and community service organisations to improve their cultural competence and hence increase access for Aboriginal people to mainstream services. The KB-AHCC project process was undertaken in five stages.² The process involved completing the audit tool and developing an action plan over two workshops facilitated by Aboriginal cultural competence consultants with the assistance of the KB-AHCC project co-ordinator and project worker (the project team). The audit workshop reviewed current organisational policies and practices to identify gaps and prioritise areas for action, which were then documented in the service's KB-AHCC Action Plan during the Action Plan development workshop.² Each organisation's Action Plan was then reviewed and feedback was provided by the Aboriginal consultants and the project team.

The present study

In late 2017, the Victorian Department of Health and Human Services commissioned researchers to undertake an evaluation of the implementation of the KB-AHCC project. Ethics approval for the evaluation was obtained from The University of Melbourne, Human Research Ethics Committee (ID 1750749.1). A total of 16 public health services and six community services had participated in the KB-AHCC project. All organisations were asked to participate in the evaluation and a list of health and community services was provided to the research team by the KB-AHCC project team. Of the 22 organisations, 20 agreed to participate in the evaluation (14 rural public health services and six rural community services). The evaluation was conducted between February and July 2018 and relied on a three-phase, qualitative research approach. Data from the three phases of the study were analysed separately and then grouped around similar themes to provide detail about each theme from the different data.

Phase 1: Telephone interviews

To understand the experiences of implementing the KB-AHCC project, each of the participating organisations was asked to identify a key representative for an interview. Twenty semi-structured interviews¹⁶ were conducted with executive, senior and middle managers, quality and community engagement managers and administration and project officers (Table 1) from mainstream health and community services across the Hume region. Each participant was provided with an electronic copy of the Plain Language Statement and Consent Form. Interviews were undertaken by the first and third authors via telephone. Questions explored the process of undertaking the KB-AHCC project and the perceived impacts of its implementation. All interviews were audio-recorded and transcribed verbatim.

Phase 2: Case studies

The findings from the initial 20 interviews informed the selection of six case studies for Phase 2 of the study. Content analysis of key documents was undertaken to identify actions, outcomes and reporting from the project. Additional interviews with staff who had been involved in implementing the project in these services were undertaken. Similar questions were asked in these interviews, which were audio-recorded and transcribed verbatim.

Phase 3: Reference group

A reference group of experts across the study region was convened, including Aboriginal community members, academics and health professionals, representatives from health and community services, researchers, and representatives from government departments in health, community services and education. The reference group convened twice during the project to provide extensive feedback on the evaluation findings.

Data analysis

The interviews from Phase 1 were read and coded by authors 1 and 2 separately. The interviews from Phase 2 case studies were read and coded by authors 1 and 3. The authors then agreed on themes for the Phase 1 and themes for the Phase 2 interviews.¹⁷ Following, a content analysis of the 60 documents reviewed in the Phase 2 case studies was conducted to identify what each case study site had undertaken prior to and during the project. Based on this analysis, a report of the findings was drafted and after review by the project reference group was revised.

The findings from the three phases of the study generated similar themes in relation to the experiences of health and community services in undertaking the KB-AHCC project. Therefore, findings were triangulated to identify factors that impacted on the process of implementing strategies to improve cultural competency in these mainstream services.^{17,18} Not all of the factors were represented in each of the three phases of the study.

Results

A summary of the main findings from the case studies is provided in Table 2. Additional findings relating to the AHCC Project outcomes within each case study are summarised within Table 3. Analysis of data from the three phases identified eight key factors contributing to the complexity of implementing cultural competency frameworks within rural public health and community service settings. Some services found the KB-AHCC project particularly useful for identifying gaps, developing a formal Action Plan and focussing the direction for improvements. However, for approximately one-fifth of services, the project was found to

be a duplication of other processes already in place or undertaken previously. Furthermore, despite modification of the tools and action plan for implementation within community service organisations, it was indicated that the project remained too “health focused” (P1 Int 1).

Comprehensive, structured tools

The structured design of the KB-AHCC Audit Tool and Action Plan was consistently recognised throughout Phases 1 and 2 as valuable for identifying specific areas for action in both health and community services. Overall, the Audit Tool and Action Plan were found to be well structured for implementation of KB-AHCC Framework, incorporated the necessary structures and systems, and highlighted the importance of developing relationships with the local Aboriginal community. Many Phase 1 interviewees also indicated that the Audit Tool and Action Plan were comprehensive and required involvement across the organisation for development: “... it got us all around the table talking, that was one of the positives” (P1, Int 19). But for others, the Audit Tool and Action Plan were found to be “lengthy (P 1, Int 17);” “quite time

Table 1: Demographics of participants.

| Service Type and Size | Phase 1 Interview Participant | Case Study Site | Phase 2 Interview Participant Demographics |
|------------------------------------|---------------------------------------|-----------------|--|
| Youth and Family Community Service | Chief Executive Officer | 1 | Participant 1: Youth and Family Services Manager Participant 2: Administration Co-ordinator |
| Regional Tertiary Health Service | Aboriginal Health Liaison Officer | 2 | Participant 1: Quality Manager. |
| Small Rural Health Service | Director of Operations | 3 | Participant 1: Chief Executive Officer |
| Small Rural Health Service | Community Engagement Officer | 4 | Participant 1: Chief Executive Officer Participant 2: Quality Manager |
| Rural Health Service | Director of Community Health | 5 | Participant 1: Director of Clinical Services Participant 2: Quality and Risk Manager |
| Small Rural Health Service | Quality Manager | 6 | Participant 1: Chief Executive Officer Participant 2: Quality Officer |
| Youth and Family Community Service | Services Manager | | |
| Family Community service | Senior Project Manager | | |
| Community Service | Regional Director | | |
| Community Service | Chief Executive Officer | | |
| Community Service | Client Services Manager | | |
| Community Primary Health Service | Quality and Community Support Manager | | |
| Community Primary Health Service | Chief Executive Officer | | |
| Small Rural Health Service | Project Coordinator | | |
| Small Rural Health Service | Director of Clinical Services | | |
| Small Rural Health Service | Director of Community Services | | |
| Small Rural Health Service | Primary Health Manager | | |
| Small Rural Health Service | Quality Manager | | |
| Sub-Regional Health Service | Director of Community Health | | |
| Regional Tertiary Health Service | Community Engagement Manager | | |

Table 2: Summary of Case Study site information.

| | Case Study 1 | Case Study 2 | Case Study 3 | Case Study 4 | Case Study 5 | Case Study 6 |
|---|---|---|---|--|---|--|
| Type of Service | Rural Youth Focused Community Service | Regional Tertiary Health Service | Small Rural Health Service | Small Rural Health Service | Small Rural Health Service | Rural Health Service |
| Services Provided | Youth and Family Welfare services In-house and outreach services | <ul style="list-style-type: none"> Community health, Allied health, dental and rehabilitation care Cancer Services Cardiology Services Emergency and Intensive Care General Medicine Acute Inpatient care Mental Health Surgery Maternity and neonatal care | <ul style="list-style-type: none"> Acute inpatient care Community health Aged Care Urgent care | <ul style="list-style-type: none"> Maternity care Acute Inpatient Care Subacute Care Home based care | <ul style="list-style-type: none"> Acute Subacute Aged Maternity | <ul style="list-style-type: none"> Primary Health Care Acute inpatient care Surgical Services Community Dental Aged Care |
| Population | Youth | Widely geographically dispersed | Aging, socio-economically disadvantaged and geographically dispersed | Widely geographically dispersed | Widely geographically dispersed | Aging, socio-economically disadvantaged and geographically dispersed |
| Identified Aboriginal positions | No | Yes | No | No | No | No |
| Aboriginal Staff employed at the service | Unknown | Yes | Unknown | Unknown | Unknown | Unknown. |
| Resources available For example: Financial, Human, Relationships with ACCHO's | Limited financial resources | WIES ^a based funding for Identified Aboriginal Health positions Relationship with local ACCHO | Limited financial and human resources No relationship with ACCHO Relationship with Primary Care Partnership Closing the Health Gap worker | Limited financial and human resources Relationship with Primary Care Partnership Closing the Health Gap worker | Limited WIES funding No relationship with ACCHO or local community Relationship with Primary Care Partnership Closing the Health Gap worker | Limited Some relationship with local ACCHO Good relationship with local Aboriginal community |
| Commitment level | Board of Directors, Senior Management | Board of Directors, Senior Management | Board of Directors, Senior Management | Board of Directors, Senior Management | Senior Management | Board of Directors, Senior Management |

Note: a = Weighted Inlier Equivalent Separation

Table 3: Key AHCC Project Outcomes at each Case Study Organisation.

| Case Study Site | 1 | 2 | 3 | 4 | 5 | 6 |
|---|--|--|---|---|--|--|
| Documents used prior to AHCC Audit Project | Local Aboriginal Corporation Audit Tool from 2008. | Improving Care for Aboriginal Patients (ICAP) Continuous Quality Improvement (CQI) Tool: Aboriginal health in acute health services and area mental health services. Statewide tool. | Diversity Plan | Local Aboriginal Corporation Audit Tool from 2008. | Improving Care for Aboriginal Patients (ICAP) Continuous Quality Improvement (CQI) Tool: Aboriginal health in acute health services and area mental health services. | Improving Care for Aboriginal Patients (ICAP) Continuous Quality Improvement (CQI) Tool: Aboriginal health in acute health services and area mental health services. |
| AHCC Audit completed | No | Yes | Yes | Yes | Yes | Yes |
| AHCC Action plan developed | Yes | Yes | Included in Cultural Diversity Plan | Yes | Yes | Included in Cultural Diversity Plan |
| Action Plan items linked to key organisational documents: | Quality Plan, Operational Plan, Strategic Plan, Business Plan, key policies and strategies | Statement of intent, Statement of Priorities, NSQHS standards, ICAP CQI Tool, Position Descriptions, Aboriginal Employment Plan, Koolin Balit Strategic Directions | Not specifically linked in the Action Plan but are mentioned in Statement of Priorities, Cultural Frameworks and Diversity Frameworks | Diversity Plans, Statement of Priorities, Diversity Frameworks, Operational Business Plan | Statement of Priorities, ICAP CQI Tool, Cultural Responsiveness Plan, Consumer Participation Plan, | Not specifically linked in the Action Plan but are mentioned in Statement of Priorities, |
| Progress against Aboriginal Health Actions and outcomes is reported in: | Annual Report, Report to Board | Quality Account, Report to Board | Quality Account, Report to Quality and Safety Committee | Quality Account, Report to Community Advisory Board | Quality Account, Cultural Diversity Committee and Board | Quality Account Annual Report |
| Timeline for AHCC Action Plan review | Reviewed at monthly staff meetings | Not specifically stated | Not specifically stated | Not specifically stated | Not specifically stated | Bi-monthly |
| Changes made as part of AHCC project for service to be more welcoming | Artwork, Display of Aboriginal and Torres Strait Islander Flags, Acknowledgement of Traditional Owners on website and email signatures | None identified. Some items in place prior to AHCC project. | Waiting area materials, Welcome and Acknowledgement of Traditional Owners plaque and on website, Display of Aboriginal and Torres Strait Islander Flags | Books, Display of Aboriginal and Torres Strait Islander Flags | None identified. Some items in place prior to AHCC project. | Books, Display of Aboriginal and Torres Strait Islander Flags |
| No. of policies/procedures updated as part of AHCC Audit Project | 7 | 6 | 8 | 7 | 3 | 3 |
| No. of new policies/procedures developed | 1 | None Specified | 3 | 1 | 1 | 2 |
| Timeline for policy Review | Bi-Annually | Annually and Bi-annually | Not specified | Not Specified | Not Specified | Not Specified |
| Aboriginal Employment Plan Developed | Included in action plan and is currently being developed | Updated as part of AHCC Audit Project | In development | Included in action plan and is currently being developed | Acknowledgement and Welcome to Country, | Including Acknowledgement and Welcome to Country |
| No. of personnel responsible for implementation of Action items | Leadership Team, Executive Officer, managers, all staff | CEO, Aboriginal Health Team, Quality Manager and committee, clinical educators, area managers | CEO, Executive Team | CEO, Community Engagement Officer, Health Action Groups | Executive Managers across community and acute health (3) | Community Engagement Officer, Primary Health Manager, Executive Committee, Education Co-ordinator, Quality Team |

consuming" and "a bit repetitive" (P1, Int 12). While some participants suggested that such a lengthy process to undertake the Audit was unnecessary, others suggested that time taken to complete the Audit was advantageous in delivering a comprehensive and detailed Action Plan.

For community service organisations, participants suggested that a separate project would have been more appropriate for their sector: "... this is clearly developed for the health sector and ... it appeared that a community service organisation was just an add-on" (P1, Int 1). Some felt the Audit Tool and Action Plan was too rigid and inflexible, believing cultural competence could not be achieved through an audit approach, but should rather develop organically over time:

... a lot of what [our organisation]'s done hasn't been against a plan, it hasn't been a tick the box... It's been a really organic, hard to articulate kind of, more than a plan that says you will have this and you will have that and tick this box because you've completed it; but more a conversation with, you know, our Aboriginal staff and what does community find useful. (P1, Int 5)

Furthermore, participants suggested that a clearly articulated alignment with the national standards would have added greater value to the KB-AHCC Framework.

Project workers

Both the Aboriginal and non-Aboriginal KB-AHCC project workers were universally identified throughout Phases 1 and 2 as valuable in the implementation of the KB-AHCC project. Project workers were valued for their knowledge of the project, cultural knowledge, and for their assistance in identifying gaps and developing action plans. This was felt to be important for maintaining motivation and momentum in the project:

... it did instil some drive and motivation into it by having that external support ... mainly having that project team in there to support you through the process. There's [a] lot to be said for the motivation and support that they gave us. (P1, Int 15)

Many case study interviewees commented that the workers responded to questions or concerns quickly and provided helpful information or guidance when undertaking the Audit and developing the Action Plan. This was a consistent finding, irrespective of the organisation's overall experience of the project.

Communication

The need for effective communication from DHHS to services and clear expectations of what was required at the beginning and throughout the KB-AHCC project was a consistent theme to emerge. Many respondents from the Phase 1 interviews commented that communication at the outset of the KB-AHCC project had been unclear. Some were uncertain about what the project was and confused it with previous cultural competency projects and/or were unsure if the project was mandatory. Others were confused about the difference between the KB-AHCC Audit Tool and other cultural competency projects and tools, such as the Victorian DHHS CQI Tool.⁴ Participants generally felt that direction from DHHS lacked clarity and consistency and some indicated the lack of clearly articulated expectations by DHHS was stressful:

... I think the whole process around communication was quite poor from the get-go. Yeah, once they're in the room with the project officers, that was different ... But prior to that, just thinking about, well, what are we doing? Why are we meeting? What's the expectation here and what's being asked of us? It was pretty poor. (P1, Int 1)

There were also varying perspectives on whether the project was too rigid or lacking in direction; some organisations wanted more flexibility to adapt the KB-AHCC Action Plan to their local context and existing plans while others wanted more direction.

Responsibility for implementation

In many services, either a single staff member or small team were assigned responsibility for the implementation and progression of the organisation's KB-AHCC Action Plan. While this was identified by participants across Phases 1 and 2 as leading to successful implementation, it was also suggested that entrusting the responsibility for cultural competence to one or a few individuals was problematic and undermined engagement across the organisation. Momentum for implementation of the Action Plan could wane when staff changes occurred, if these positions remained unfilled for some time, or when individuals were responsible for multiple portfolios across the organisation. There was also a general sense from participants that the action plan could get "lost" (P1 Int 18) among other organisational responsibilities.

Prioritising cultural competence

Prioritising cultural competence within organisations as part of the implementation of the KB-AHCC project was expressed as "challenging" and "difficult" when participants were trying to conceptualise balancing the KB-AHCC Action Plan with other organisational priorities. For some, the KB-AHCC project was viewed as another thing to do for DHHS, while others struggled to complete all the required plans and reports for their service. There was a consensus that the KB-AHCC Action Plan could get deprioritised among the other responsibilities within a very crowded environment of organisational reporting requirements:

... and I guess priorities when you've got, I guess, other ... whole of organisation stuff takes a priority. And certainly, the work we do around Aboriginal as well as the other cultural groups come into play in that broader overarching accreditation for the organisation around our cultural safety and cultural diversity and so forth, so it's not lost in those other processes, but as a specific action plan for the Aboriginal project and so forth, yeah, it just hasn't been a priority. (P1, Int 4)

Of the Action Plans reviewed in Phase 2, some actions had been started or completed but many had not been initiated and others had been abandoned altogether. Over time, it was reported that enthusiasm for new activities was replaced by other priorities within the service. This de-prioritisation was accompanied in many instances with a tension between the importance of cultural competency to improve access for Aboriginal people and the perceived size of the Aboriginal population within the community. Of the 20 Phase 1 interviewees, 12 raised the 'issue' of the size of the local Aboriginal population. Of these, many suggested the KB-AHCC project required significant investment to generate outcomes for a small percentage of the overall population:

Oh, look some of it was certainly needed and that stuff's still very meaningful that we're now doing, the welcoming ceremonies, but it is very much a ... you know, it's hard to see, when it's only 1% it's hard to see the outcome for the level of work that's required, I'm not saying it shouldn't be, but it's hard to see that. (P1, Int 9)

Interestingly, within these same discussions, only four of the twenty Phase 1 interviewees questioned the assumption that indicators of Aboriginal population size within their area were accurate or that Aboriginal people

were perhaps not identifying within their service because they did not feel culturally safe to do so. Only one of the interviewees reflected on the burden of disease within their local Aboriginal community and stated that the local Aboriginal population should be over-represented, rather than under-represented within their service. Overall, it was implied that Aboriginal health was not prioritised in relation to other 'more pressing' organisational requirements. The reference group for the evaluation identified this de-prioritisation as a form of institutional racism and wanted it to be specifically named so that it could be addressed.

Resourcing

Appropriate and sustained resourcing was identified as essential for effective implementation of the KB-AHCC Action Plan and developing cultural competence. Resources were said to be important in prioritising actions for implementation, such as the purchasing of local Aboriginal artwork, cultural awareness training for staff, employing Aboriginal staff and being able to backfill staff while they were undertaking culturally related activities. When implementing their Action Plans, many services began with the "small wins" (P1, Int 11); that is, "smallish, very practical" (Phase 1, Int 1) actions towards demonstrating inclusion that could be implemented with minimal cost, for instance, the addition of an Acknowledgement of Country and the Traditional Owners within staff email signatures and displaying the Aboriginal and/or Torres Strait Islander flags. Many services were unsure how to develop working relationships with their local Aboriginal communities and suggested that additional resourcing for Aboriginal professionals to undertake consultation with services, or to employ Aboriginal people in identified roles within the service, would have enabled further implementation of the KB-AHCC project.

Resistance to focusing on one group of people.

Within the Phase 1 interviews and Phase 2 case studies, there was tension about the importance of focusing on improving access and cultural competency for Aboriginal people specifically. Some participants questioned why there needed to be specific actions, systems or resourcing to increase the inclusion of Aboriginal patients/clients

compared to other culturally diverse groups. In some cases, respondents felt that creating an individual plan for Aboriginal people was somehow then excluding or taking focus away from other culturally diverse groups, but at the same time, these respondents acknowledged that improving Aboriginal health, wellbeing and access to services was important.

But I find it a little bit that if I was going to have an overt statement about Aboriginal health, then I would need an overt statement about all the communities that we service ... (P1, Int 5)

The reference group named this resistance as "racism" (P3, Mtg2).

Lack of accountability

There was general agreement from respondents that services were not held to account for the implementation of their KB-AHCC Action Plan. Around half the respondents spoke about the lack of reporting on their Action Plans:

... when it came to this (KB-AHCC Action plan) it's not mandated to do it. So, we're not going to double report ... I'm going to report my CQI because I have to, which the government hasn't asked for that again. (P1, Int 18)

Although many of the organisations had new actions and had revised or written new policies as part of the KB-AHCC project (Phase 2), this did not translate into these services having comprehensive, long-term commitments in other key organisational documents. Of the six organisations, five had incorporated cultural competency into their statement of priorities but only one had specifically identified actions within their strategic plan. There was also substantial variation identified in progress reporting on the KB-AHCC Action Plan, and cultural competency more broadly, across organisations. This ranged from no structured reporting mechanism through to mandatory, annual reporting to senior management, board of directors or other governance committees. This variation appeared to impact organisations in different ways. Some organisations seemed relieved that their service did not have to report either internally to leadership or externally to government, and some were resistant to having to complete multiple, related reports. At the end of the project, organisations were left accountable only to themselves for the continued implementation of the KB-AHCC Action Plan.

Discussion

The KB-AHCC project was designed to assist health and community services to improve their cultural competency, and in so doing to improve access to, and usage of, health and social services by Aboriginal Victorians. The KB-AHCC Audit Tool and Action Plan did, in most organisations, generate a process and identify areas for action. All services involved in the evaluation identified cultural competence gaps, listed areas for improvement and took some action towards addressing those areas. Whether the project achieved deeper systemic cultural change within these services is yet to be assessed. However, the present study identified key factors that impact on the ability to effectively implement cultural competence initiatives in rural, mainstream health and community services.

The ability to seek advice from project workers and the application of comprehensive, structured tools suggests that these features enable and focus organisational attention on actions for improvement. But a degree of flexibility is also needed to acknowledge work already undertaken towards cultural competence to decrease repetition with other cultural competence tools and to minimise reporting requirements.

The perception of participants relating to the overall lack of communication, direction and clear expectations communicated from DHHS at the outset of the project prevented many services from fully engaging in the project. Clear, effective communication articulating what the project is, *why* it is important and what the governing body clearly expects the services to do appears to be of particular importance to the engagement of services in cultural competence projects. Similarly, a lack of available resources for organisations to implement longer-term changes listed within their Action Plans suggests that cultural competence projects need to be effectively resourced for sustained implementation.

The lack of accountability within organisations for everyone to take responsibility for cultural competence was mirrored by the lack of accountability by the services to DHHS to demonstrate the implementation of the Framework and progress towards improving cultural competence. The question of accountability and whether or not the implementation of the Framework should be made

compulsory was identified by Tynan et al.⁹ as a potential issue for implementation during the development of the KB-AHCC Framework. Members of the AHCC Working Party suggested that if the adoption of the Framework was made compulsory, then this may elicit a 'compliance response' where the project is approached from the perspective of 'ticking the box' rather than engaging in a deeper, self-reflexive process.⁹ Rather, it was suggested that aligning the KB-AHCC Framework with accreditation standards would create the necessary motivation and accountability for services to implement the Framework effectively.⁹ Findings from the present study do not support this approach. Some organisations were continuing their journey towards cultural competency slowly and reporting on their progress to DHHS would not have altered this. For others, however, the lack of accountability to DHHS enabled participants who were less engaged with the project to dismiss it as lacking importance, thereby de-valuing the project and allowing services to not fully engage in the project's aims. This also contributed to the loss of momentum for the implementation of the more complex areas, such as the development of working relationships with local Aboriginal communities and the increased employment of Aboriginal people, which require longer-term commitment and persistence. Without a transparent accountability structure or definitive consequences for not demonstrating improvements in cultural competence throughout the project, racism – as named by the reference group – was passively allowed to continue.

Furthermore, the deficiency of ongoing, government resourcing to support organisational cultural change, the lack of organisational prioritisation for improving cultural competence, the resistance to change and the lack of accountability all support the idea that institutional racism remains prevalent in the Victorian healthcare¹⁹ and welfare systems. Institutional racism exists when the systems of organisations allow the perpetuation of actions, policies and practices that result in racial inequities.^{8,20} Institutional racism can be expressed in covert⁸ ways, embedded within everyday interactions and practices.²¹ Griffith et al.²² suggest that institutional racism occurs at three levels: extra-organisational in interactions with the environment; intra-organisational through internal hierarchies, power relationships and

systems; and at the individual level of staff interactions.²² In the present study, comments regarding the size of the local Aboriginal community, the 'relevance' of cultural competence and the suggestion that cultural competence is not a 'priority' all reflect a deep misunderstanding of institutional racism within Victorian health and community service organisations. The intention here is not to be critical of respondents whose good intentions towards improving cultural competence for Aboriginal people appeared genuine. Rather, the intention is to demonstrate the need to address institutional racism when implementing cultural competency frameworks or projects. Neither the KB-AHCC Framework nor any of its contemporary frameworks engaged with concepts of racism or how these could be addressed. Instead, these frameworks focussed on changing organisational culture,¹³ preserving the rights of Aboriginal peoples,¹⁴ acknowledging and respecting Aboriginal culture¹⁵ and improving organisational cultural competence. More recent government frameworks^{23,24} name and seek to address racism, representing an important shift in the evolution of Victorian Government Aboriginal health frameworks. The impact of their implementation, however, is yet to be determined.

Limitations of the study

The present study examines the experience of undertaking the KB-AHCC project only from the perspectives of the health and community services involved. Due to time constraints, the research did not involve the perspectives of Aboriginal and Torres Strait Islander people who may use these services or, importantly, their views on the cultural competence of the organisations involved. Aboriginal and Torres Strait Islander people are best placed to assess the cultural competence of a person or organisation.⁸ For this reason, the researchers did not seek to assess the cultural competence of the health and community health services involved in the evaluation, only their experience of the KB-AHCC project.

Conclusion

The findings from the present study suggest that future cultural competence projects need to be structured, planned and resourced for long-term implementation. Further, implementation needs to be

prioritised and supported by appropriate accountability mechanisms requiring the regular demonstration of improvement in organisational cultural competence over time. Such programs need to continue to engage leadership within organisations but also to engage staff from across all areas and levels of the organisation to work towards breaking down racism and developing meaningful relationships with the local Aboriginal community.

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