THE UNCOMFORTABLE ROAD TO CULTURAL EASE

Shifting Focus to 'Close the Gap'

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Associate Professor Dennis McDermott, Flinders University

I'll begin by posing three questions – questions that should help frame the issues I'm going to talk about today:

- Does it matter that a pivotal, national report , 'Overcoming Indigenous Disadvantage' - running to some hundreds of pages and underpinning government 'Closing the Gap' initiatives - found no use for the word 'racism'?
- What lessons to strengthen Aboriginal and Torres Strait Islander Health arise from strategies to combat climate-change denial?
- What can Andrew Bolt teach us about creating a culturally-safe Indigenous health workforce?

I think I'll leave Andrew till the end.

In July 2009, Chairman Don Banks summarised some hundreds of pages of a Productivity Commission report on Overcoming Indigenous Disadvantage in a speech that, as with the report itself, found no use for the word 'racism'. His speech did contain a number of assertions about Indigenous mothers, tobacco use, personal responsibility, the baby bonus and (couched in different terms) people 'trashing' their houses. [SLIDE TWO] The report had been released a week before to coincide with the Council of Australian Governments (COAG) meeting which added six Headline Indicators and seven Strategic Areas for Action to the existing six National Targets relevant to 'Closing the Gap' between Aboriginal and Torres Strait Islander peoples and Non-Indigenous Australians. [SLIDE THREE] The chosen issues and areas are worthy, potent and ripe for real action. A major contention of this lecture – and one that I believe resonates with the spirit of Charles Duguid's work, is that well-funded initiatives to address such specific targets are necessary, but insufficient. [SLIDE FOUR] Echoing Banks, the target of the COAG interventions to address Indigenous disadvantage is, simply – simplistically - Indigenous Australia. Little emphasis is placed on addressing the wider Australian context in which those Indigenous lives are lived out, yet this is the ground upon which all endeavours to 'Close the Gap' succeed or flounder. [SLIDE FIVE] I should drop in a reminder, here, that the Indigenous-led 'Close the Gap' campaign, with its emphasis on partnership, is not the same beast as the 'Closing the Gap' set of initiatives to which I refer in this

lecture. COAG version: Closing the Gap / enough dot points to make case for doing something (positive and worthwhile) *to* Indigenous Australia / Calma et al version: Close the Gap / doing positive and worthwhile things *with* Indigenous Australia. [SLIDE SIX]

With public accountability in mind – and examples of poor governance to the fore - an earlier COAG meeting had noted that *"[s]ustained improvement in outcomes for Indigenous people can only be achieved by systemic change"*2. This is apt, but can be construed in a different way to its original intent, which arises from a discourse that presumes poor Indigenous governance, automatic family nepotism and a kind of 'prehistoric' set of collectivistic values that must conflict with the mandates of our contemporary, globalised market economy. This is a mind-set familiar to even occasional readers of The Australian newspaper. Rather, the spotlight could shift to illuminate crucial systems that lack visibility in the COAG initiatives. [SLIDE SEVEN] Such a change of focus would foreground: workforce education, the health bureaucracy, the research translation process and the policy implementation process.

Let's look at them separately, in the light of their constraining effects on 'Closing the Gap'. The first one is the continuing, unsatisfactory way that health professionals are taught – including the way we deal with considerable resistance, even hostility, to engaging with Indigenous health training. The second notes the sad reality of the peppering of health bureaucracies with 'gate-keepers', nay-sayers who have trouble finding their keys at crucial moments of initiative's progress. The third draws our attention to the need for a greater proportion of Indigenous health research to lead to real change 'on the ground'. The final point relates to the impact of what Michelle Gratton has called the recent return of a *bi-partisan paternalism.* She's neatly captured the tendencies we've seen at work in the Northern Territory Emergency Response, the Intervention, from both sides of politics. The result has been a side-lining of Aboriginal and Torres Strait Islander perspectives in policy formulation and a diminishing of Indigenous agency – the crucial 'control factor' – along with a demeaning Indigenous identity through such processes of policy implementation as income sequestration. These are profound 'sleeper' issues. They may, in fact, interweave to create a primary barrier to success: a 'fence' in the way.

Let's take the last three points first, attempt to tease out some relevant factors, then return to the workforce issue – and what we might usefully do about it. The clear objectives of the COAG initiatives have to contend with what Nicholas Rothwell has called, in the Northern Territory context, the "fog" enveloping much public life4 – cronyism, careerism, paternalism and, particularly, racism, can constitute potent barriers to change. [SLIDE = EIGHT] Important as bio-medical research is, a greater proportion of limited research funds may be more-usefully deployed in politically-unattractive areas: making inroads into the social determinants of Indigenous health, addressing racism in health settings, embedding cultural safety as a quality assurance issue, and furthering Health in All Policies research. The wider Australian context may be as important as improved funding and more services. In a

speech of a different stripe to that of Don Banks, delivered at the *National Indigenous Health Equality Summit* in March 2008, Tom Calma went to the core of this issue in noting, succinctly:

A little bit more of the same will not close the gap[1]

[SLIDE NINE] So, not only a 'fence', but 'gatekeepers' – often invisible - and a dearth of strategies to deal with them. It's difficult to underestimate the widespread nature of careless, culturally unsafe or racist practice within the health bureaucracy and the health professions alike. [SLIDE TEN] It's affect on Indigenous accessing of services, retention and treatment compliance, even Taking Own Leave from hospital, is profound. A particular difficulty in addressing racism in the workforce is the denial of its existence in wider Australia. [SLIDE ELEVEN] Such denial undermines attempts to train a culturally-safe workforce. Maybe there are lessons here to be learned from another current national phenomenon: climate change denial. It's almost as if, in both cases, there is an active discounting of a thick accumulation of evidence. [SLIDE TWELVE] Like alcoholic denial, there is an almost palpable fear of what one might find if you really looked or listened – there are defence mechanisms at play here that mean that our attempts to deal with racist phenomena need concerted research. As Linda Connor notes, we could do with better theories of cultural change to inform our actions.

[SLIDE THIRTEEN] The adequacy of the current workforce to deal with the demonstrated needs of Indigenous patients, clients and communities is central to success in 'Closing the Gap'. An obvious shortfall is in the insufficiencies in recruiting, funding places for, financially supporting and mentoring to graduation, Indigenous practitioners of all kinds. The less-obvious inadequacy is the need for innovation in modes of non-Indigenous practitioner training. Health professional education to better deliver Aboriginal and Torres Strait Islander health services can founder, firstly, on a lack of means to address barriers to accepting and incorporating Indigenous perspectives. [SLIDE FOURTEEN] I, and a range of colleagues at Flinders, have been evaluating student response to a number of Indigenous health-related Topics (often called Courses at other universities). To these we've added evaluation data from around seven years of profession development workshops conducted by myself and a Melbourne-based colleague, Diane Gabb. This is indicative research only, at this stage, but we're noting the emergence of distinctive modes of responding to the challenging material that many students are meeting for the first time in a comprehensive way.

[FROM HERE TO END OF SLIDES, THE NOTES BELOW ARE ONLY A ROUGH SUMMARY OF WHAT WAS SAID - FROM HERE ON SLIDES WERE USED TO FRAME EXTEMPORANEOUS COMMENTS AND TEASE OUT THE ISSUES. SOME PERTINENT POINTS ARE MADE BELOW THAT AREN'T APPARENT IN THE SLIDES]

[1] Calma T, *National Indigenous Health Equality Summit*, Canberra, 18.3.08, accessed May, 2010 at http://www.hreoc.gov.au/about/media/speeches/social_justice/2008/20080318_health_summit.html

[SLIDES FIFTEEN ON …] Students and practising professionals alike showed evidence of four response styles. The first could be characterised by its openness and willingness to engage – a desire to know and learn, no matter the difficulty of some of the material. In the second, there was some head-hanging – a perception of a national shame. The third introduced a belief that participants were being judged – and found guilty – along with some continuing reluctance to take in what was being offered - sense that one ear plug remained firmly in place. The final group left me with the distinct impression that both ears were firmly blocked – possibly with the Australian flag.

Which brings me to Andrew Bolt.

What can he teach us about better preparing the health workforce? An examination of just one incident, his description of Uncle Rupert Peters and Uncle Toby Ginger, respected Ngunkaris, traditional healers, as 'magicians, their work as 'guff' and an increase in NT Government approval of traditional healer usage as 'madness … Are these people nuts?' informs the attitudes of the students and practitioners Indigenous health academics need to deal with.

Models of cross-cultural training need go beyond de rigeur cultural awareness, to encompass, in some integrated, mutually reinforcing way, aspects of cultural competence, cultural safety, and a tenet I've tagged cultural ease. The last-mentioned builds on a developing familiarity with Aboriginal protocols and an incorporation, where possible, of Aboriginal cultural notions and 'ways' into practice – in essence, an Indigenising of praxis (McDermott and Gabb 2009). Much current training still under-prepares the non-Indigenous health workforce to work effectively with Indigenous Australians.