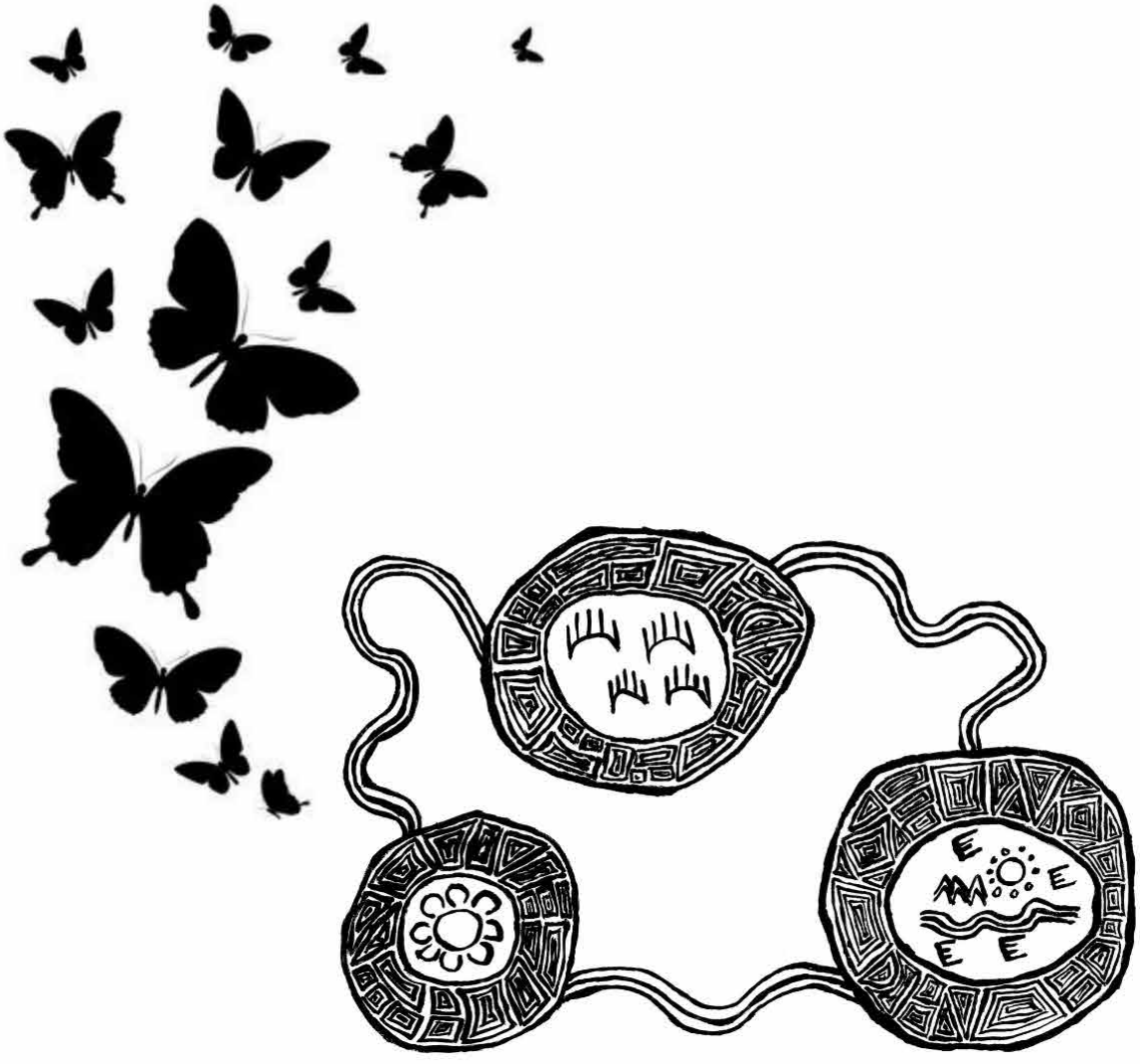
Loddon Mallee First Nations Emergency Care Best Practice Framework

Blak Butterfly



Blak Butterfly title is inspired by Tio Massing, permission David Bridie - Wantok Musik

Song link - https://youtu.be/fsyncbc6lpU?si=6pjr8E-eFaVMknto

Health, healing, happiness for self, for community is a long journey home for First Nations communities since colonisation, but *I still believe, I'm still living, I must sing for the voices that can't be heard anymore…Tio*

Acknowledgement of Country

We acknowledge and celebrate Aboriginal and Torres Strait Islander peoples across Victoria. Theirs in the oldest living and continuous culture on earth. Their deep relationship with and enduring care of Country is a gift to our nation. We pay respect to the elders past and present, their custodianship, their culture and their resilience. Sovereignty was never ceded. This was and always will be Aboriginal land. We would like to acknowledge the ongoing impacts of colonisation, acknowledging the deficit discourse and racism that exists within the fabric of our systems and structures since colonisation. We also acknowledge the invisible cultural load that Aboriginal and Torres Islander peoples hold everyday working across two worlds.

Title Page design: Mishel McMahon

Photography: Mishel McMahon and Phoebe Barton

Any queries should be directed to www.lmhn.org.au

Acknowledgements

Yorta Yorta Sisters:

- Dr Mishel McMahon – Principal Investigator | Lead Author
- Jean McMahon – Project Lead

First Nations led Research Team:

- Dr Mishel McMahon - Senior Research Fellow, La Trobe University | Principal Investigator | Lead Author
- Jean – Project Lead | LMHN First Nations Strategic and Partnership Lead | AI
- Tara White – Wiradjuri Researcher
- Pauline Nolan – Yorta Yorta Researcher
- Mark Richards - Wiradjuri Researcher
- Dr Yangama Jokwiro
- Prof Leigh Kinsman - Violet Vines Marshman Chair of Rural Health Research | Chief Principal Investigator
- Dr Angela Crombie - Director Innovation & Research, Bendigo Health |AI
- Amanda Collings - Senior Project Manager Innovation & Research, Bendigo Health | AI
- Leigh Read – Anti-Racism Lead, LMHN
- Nat Retallick - Project Lead ED/UCC Project, LMHN
- Di Newell – Interim General Manager, LMHN
- Abigail Place – Acting Manager Regional Programs, LMHN
- Tracy Barber – Regional Project Support Officer, LMHN

First Nations Voices: First Nations voices who have supported and contributed to Blak Butterfly, include First Nations researchers, Communities, ACCHOs, ACCOs, AHLOs, Managers and Directors. We also acknowledge the First Nations leadership, research methodology, relatedness and reciprocity present throughout Blak Butterfly.

Country and Traditional Owner Groups: We acknowledge Country and Traditional Owners as defined during Community conversations throughout the research project. LMR Traditional Owner Groups include Barapa Barapa, Barkindji, Bora Bora, Dja Dja Wurrung, Kureinji, Latjie Latjie, Mutti Mutti, Ngurai Illum Wurrung, Tatti Tatti, Taungurung, Wadi Wadi, Wemba Wemba, Wergaia, Wurrundjeri, and Yorta Yorta.

Loddon Mallee Region Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCOs): We acknowledge the ACCHOs and ACCOs in the LMR, and the pivotal role they hold with First Nations Communities. We also acknowledge that Blak Butterfly is grounded in the expert advice and shared knowledges and experiences provided from across these Aboriginal organisations. We thank them for their continued leadership, innovation and commitment in supporting First Nations Communities.

Aldara Yenara Aboriginal Corporation	Aldara Yenara
Bendigo & District Aboriginal Co-operative	BDAC
Mildura & District Aboriginal Services	MDAS
Murray Valley Aboriginal Cooperative	MVAC
Njernda Aboriginal Corporation	Njernda

Aboriginal Hospital Liaison Officers (AHLOs): We acknowledge the AHLOs who hold and support First Nations Communities when they are accessing care outside of an ACCHO. We acknowledge the importance of their role and show gratitude for their dedication, innovation and commitment to providing culturally safe spaces within our Health Services.

Loddon Mallee Region Health Services: Sincere thanks are extended to all of the Health Services across the LMR, not only for welcoming the Research Team, providing key data, sharing innovation and solutions but also for their desire to provide First Nations Communities with improved health outcomes and to free health care of racism for First Nations peoples.

Health Service (sub region)	Director/Manager/AHLO	Local ACCHO/ACCO
Mildura Base Public Hospital ED (Mallee)	1 x Director, 5 x AHLOs	MDAS
Mallee Track Health & Community Services UCC (Mallee)		
Robinvale District Health Service UCC (Mallee)	1 x AHLO	MVAC
Echuca Regional Health ED (Murray)	2 x AHLOs	Njernda
Swan Hill District Health ED (Murray)	1 x Manager, 2 x AHLOs	MDAS
Cohuna District Hospital UCC (Murray)	1 x AHLO shared with Kerang / Boort	
Kerang District Health UCC (Murry)	1 x AHLO shared with Cohuna/ Boort	MDAS
Kyabram District Health Service UCC (Murray)	1 x AHLO	Aldara Yenara
Rochester Elmore District Health Service UCC (Murray)		
Bendigo Health ED (Loddon)	1 x Manager, 4 x AHLOs	BDAC
Maryborough District Health Service UCC (Loddon)	2 x AHLOs	
Dhelkaya Health UCC (Loddon)	2 x AHLOs	
Heathcote Health UCC (Loddon)		
Inglewood District Health Services UCC (Loddon)		
Boort District Health UCC (Loddon)	1 x AHLO shared with Kerang / Cohuna	
Central Highlands Rural Health - Kyneton UCC (Hume Region)		
East Wimmera Health Service UCC (Grampians Region)		

Governance Group: We acknowledge all key stakeholders who have attended monthly Governance Group meetings and provided expert on-the-ground knowledge and supported collaboration towards system reform.

Loddon Mallee Health Network Board - The following Statement of Commitment reflects the Loddon Mallee Health Network's commitment to learning and unlearning at each of our health services, in support of the joint research initiative with La Trobe University, and for development of a Best Practice Framework to support discharge planning and reduce preventable ED/UCC presentations in the Loddon Mallee Region. The LMHN Board's invaluable commitment and support is acknowledged.

Statement of Commitment

The LMHN acknowledges its role as a healthcare group in continuing and intensifying its work towards reconciliation. To this end, The LMHN commits itself to transform itself into an actively anti-racist healthcare network, across all of its 15 health services in the region. Anti-racism entails deconstructing systems which implicitly or explicitly privilege certain people groups or cultures over others.

We acknowledge this means much more than embracing cultural awareness and cultural safety for all people groups. Rather it entails taking tangible and reportable steps towards creating culturally safe environments for our First Nations community, staff and those who seek our care. Importantly, cultural safety is met through actions from the non-First Nations majority position which recognise, respect, and nurtures the unique cultural identity and sovereign knowledges of Aboriginal and Torres Strait Islander people in Australia. Only the Aboriginal and Torres Strait Islander person who is a recipient of our care can determine whether our services are culturally safe.

To facilitate this transformation, the organisation commits to a process of deep listening, as part of a broader project of truth telling within the organisation and the community. Truth Telling is a crucial aspect of the Uluru Statement From the Heart and the proposed Makarrata Commission. It means acknowledging historic and continuing violence towards First Peoples committed since settlement, as well as adopting an abundance mentality, which amplifies and celebrates Aboriginal and Torres Strait Islander histories, cultures, languages, knowledges and processes.

Truth Telling will require a process of learning and unlearning for many of our staff, and the ability to sit in moments of discomfort. The organisation commits to finding opportunities to provide such cultural safety education.

We are committed to working collaboratively with our AHLOs, ACCHOs and First Nations Research Team to enact these changes. The Victorian Aboriginal Health, Medical and Wellbeing Research Accord will underpin our efforts to implement this transformation, meaning research creates tangible benefits for First Nations communities.

Contents

Acronyms & Terminology

ACCHO: Aboriginal Community Controlled Health Organisation

ACCM: Adaptive Continuous Care Model

AHC: Aboriginal Health Consultant

AHLO: Aboriginal Hospital Liaison Officer

AHPRA: Australian Health Practitioner Regulation Agency

AHU: Aboriginal Health Unit

AMHC: Aboriginal Mental Health Consultant

AMHCC: Aboriginal Mental Health Clinical Consultant

AMS: Aboriginal Medical Service

BPF: Best Practice Framework

DoH: Department of Health

ED: Emergency Department

FN: First Nations

FNVHH: First Nations Virtual Holistic Health

GP: General Practitioner

HS: Health Service

LMARG: Loddon Mallee Aboriginal Reference Group

LMR: Loddon Mallee Region

MHRT: Mental Health Regional Triage

NACCHO: National Aboriginal Community Controlled Health Organisation

PACS: Picture Archiving and Communications Systems

PFP: Pre-Fellowship Program

PHN: Primary Health Network

RAP: Reconciliation Action Plan

RDP: Rapid Discharge Plan

TOG: Traditional Owner Group

UCC: Urgent Care Centre

VACCA: Victorian Aboriginal Child and Community Agency

VACCHO: Victorian Aboriginal Community Controlled Health Organisation

Anti-racism is used throughout the document and its intended definition is aligned with the definition outlined in the Loddon Mallee Health anti-racism policy.

Consultant is being used for Aboriginal positions within health services to allow for the recognition of the high level of cultural expertise required and held.

First Nations, First People and **Aboriginal** are used interchangeably throughout Blak Butterfly Best Practice Framework. The decision to do so is a conscious stance taken to recognise the self-determination of individuals to self-identify.

Cultural Safety and **Cultural awareness** have their own definitions and it is important to understand they are two very different terms. For the sake of clear and conscience understanding, this document defines Cultural safety and Cultural Awareness have been aligned with the definition of AHPRA and is outlined on page 21.

Executive Summary

The *System Reform for First Nations Communities in Emergency Departments & Urgent Care Centres* research project throughout Victoria's Loddon Mallee Region (LMR), commenced in August 2023. Led by the Loddon Mallee Health Network (LMHN) and Violet Vines Marshman Centre for Rural Health Research, La Trobe Rural Health School, this project was funded by the Department of Health (DoH) AHII to address the high proportion (6% to 15%) of Aboriginal people leaving Loddon Mallee Emergency Departments (EDs) before being seen, and the lack of cultural safety reported by Aboriginal people.

Using an **Appreciative Enquiry methodology** with the intention of constructing a **Best Practice Framework** (BPF) for the LMR, the journey has been collaborative, with many stakeholders holding high engagement. An overarching principle for the study has been **privileging First Nations voices**. This principle has first been applied to who are the researchers, who is leading analysis, data collection or writing up findings. It has also been central to the articles reviewed, gaining **AIATSIS Ethics approval**, positioning First Nations people and organisations from health services and Aboriginal Community Controlled Health Organisations (ACCHOs) during data collection, and informed naming the BPF as **Blak Butterfly**.

Invited Stakeholders:		
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	5 ACCHOs / ACCOs	Loddon Mallee Aboriginal Reference Group (LMARG)
17 Health Services (4 Emergency Departments & 13 Urgent Care Centres)	24 Aboriginal Hospital Liaison Officers	Murray Primary Health Network (PHN)
Department of Health	1 Director Aboriginal Health	Ambulance Victoria
Safer Care Victoria	2 Manager Aboriginal Health	Primary Care Centre
La Trobe Rural Health School	Victorian Health Association	Weethunga Health Network

Engagement included:	
Monthly Governance Group meetings	9 x 1 hr meetings with 20-46 attendees
Project Touch Base sessions	42 x 30 minute 1:1 session with the above organisations to give each one an opportunity to ask questions and build rapport with the research team
Discovery Stage:	150 international articles reviewed
Dream Stage:	115 x 1:1 40-minute Blue Sky Thinking narrative interviews
Design Stage:	1 Round Table discussion for everyone, and 1 for First Nations people only

The Blak Butterfly BPF includes '**Culture as Health'** theoretical framework, 10 core values, 15 components, and required Actions (see Table of Actions - *Appendix A*). Implementation is the main focus of the Destiny meeting being held 15 July 2024.

There were social historical events which greatly impacted the context of Blak Butterfly, the experiences of being **post Covid-19**, **and post 2023 Federal Referendum**. This study identified that more research needs to be completed to understand the impact of these two events on First Nations communities. Aboriginal Community leaders explained some members of non-Aboriginal communities in the LMR are now expressing racism with less filters post Referendum. From this context some members of LMR Aboriginal communities, from young people to Elders are less willing to leave their homes to access health services. To address this Blak Butterfly includes an emphasis **health services to the home**.

There are areas of concern that also need to be highlighted. Understanding of **cultural safety** as an important area of professionality is not widely held throughout LMR Health Services. Interviews indicated learning is stagnated at the cultural awareness level, however throughout the interviews when the team discussed cultural safety there was demonstrated eagerness to learn. **Culturally informed Mental Health services**, assessments and processes for **high acuity** level First Nations patients were not present in the data. There were stories of First Nations patients experiencing adverse health outcomes because mainstream mental health processes did not include awareness of First Nations concepts and modalities related to experiences of Sorry Business, spirituality and cultural healing. Component 12 outlines a solution to embed cultural assessments for high acuity First Nations patients.

Alcohol use or the perception of use strongly influences the level of health care provided to First Nations people. Stories of First Nations people being 'left to sober' without alcohol blood tests or clinical observations being completed. Each health services clinical protocols require review, with a cultural safety understanding. **Transport** is also a huge concern, First Nations patients being discharged over night with no transport home, being taken by ambulance to an ED in a larger city then being discharged with no transport home, even though the distance could be hundreds of kilometres. Also, stories of First Nations pregnant women, chronically ill or Elders being transported via public buses between health services across long distances.

Another impediment to best practice is the number of Health Services in the LMR which still operate '**paper based'** instead of integrated electronic medical records. Many of the components of Blak Butterfly embed virtual health services and integrated health services to improve health outcomes for First Nations communities. Blak Butterfly **strongly advocates** for all LMR health services to receive system updates to provide integrated health services.

From Culture as Health foundation, Blak Butterfly positions **ACCHOs as a pivotal provider of triage categories 3, 4 & 5 health services,** for First Nations communities, considering First Nations peoples continued experience of racism and lack of cultural safety but also because of the strong connection ACCHOs hold to First Nations people's origins of health, our culture. ACCHO health services range from face to face, virtual, On Country and clinical settings.

Reviewing Blak Butterfly requires a balanced mindset. Yes, there are key areas which the research team positions as **adverse events** for First Nations health outcomes requiring immediate attention. However, at the same time the research team learnt and was grateful for the willingness of health professionals across to LMR to have frank and open conversations. An overarching finding of Blak Butterfly is that **LMR Health Services earnestly want to do things differently**. Of note is LMR Urgent Care Centres (UCCs); these health services in small rural towns are a valuable resource. The research team was fortunate to receive tours of many UCCs and listened to the 'openness' of staff for their grounds and buildings to be utilised by First Nations communities, ACCHOs and Traditional Owner Groups. However, in line with Yoorrook Justice Commission LMR Health Services must first hold **'truth telling'**, listen to the experiences of First Nations communities. Our Grandmothers giving birth on verandas, child removals and deaths in LMR hospitals. From listening, like a butterfly, then transformation, system reform, cleansing and healing. LMR Health Services in partnership with and following the leadership of Aboriginal Community Controlled Organisations can indeed shift First Nations health beyond Closing the Gap targets, to thriving, to Blak Excellence.

Dr Mishel McMahon Yorta Yorta First Nations Researcher July 2024

Background

The *System Reform for First Nations Communities within Emergency Departments and Urgent Care Centres: Loddon Mallee* project, was led by the research from both Loddon Mallee Health Network and Violet Vines Marshman Centre for Rural Health Research, La Trobe University.

This research project sought to reveal solutions for First Nations people's access to emergency care at all triage categories, their experience of cultural safety during treatment and discharge planning. Solutions for reducing preventable presentations in ED and UCC across the Loddon Mallee Region, are also presented through this framework.

First Nations (FN) patients face significant disparities in health outcomes. The experiences of institutional racism are felt by many FN patients. A 2017 survey identified that Aboriginal Victorians who have experienced racism, 40% was within the health system (Victorian Agency for Health Information, 2021).

Aboriginal self-determination articulated in the Victorian Aboriginal Affairs Framework 2018 – 2023 (State of Victoria, 2018) and the Aboriginal Self Determination Reform Framework (State of Victoria, 2019) supports that First Nations expertise should have opportunity to inform processes within emergency care. Also foregrounding this research project is First Nations communities experience of being over-researched without corresponding improvements in health outcomes, as explained by Clifford, McCalman, Bainbridge & Tsey, (2015).

Blak Butterfly project utilised existing research findings, narrative interviews and a Governance Group, to develop a Best Practice Framework (BPF) enabling system reform. An Appreciative Inquiry: First Nations Emancipatory process, inclusive of text analysis of up to 150 articles internationally were reviewed during the Discovery stage, then during **Dream stage 115 1:1 narrative 30-40 min interviews across the Loddon Mallee**, to learn their 'blue sky' strength-based components were conducted in health services and ACCHOs. **Two round table discussions (Design Stage)** were held where participants of the narrative interviews decided on components of a localised BPF for LMR, and **a final (Destiny Stage) when a sustainable BPF is finalized and submitted to Department of Health**. Throughout all stages, this project sought to privilege First Nations voices, first and foremost.

Preventable presentations to emergency care are a key area to be addressed, the Emergency Department Data Summary (see *Appendix B*) illustrates First Nations people are mostly presenting to emergency care, throughout the LMR, Triage categories 3,4 & 5. Blak Butterfly components incorporate solutions such as 'walk in' health services at ACCHO's in the LMR, within the conceptualisation of 'emergency care' for First Nations communities.

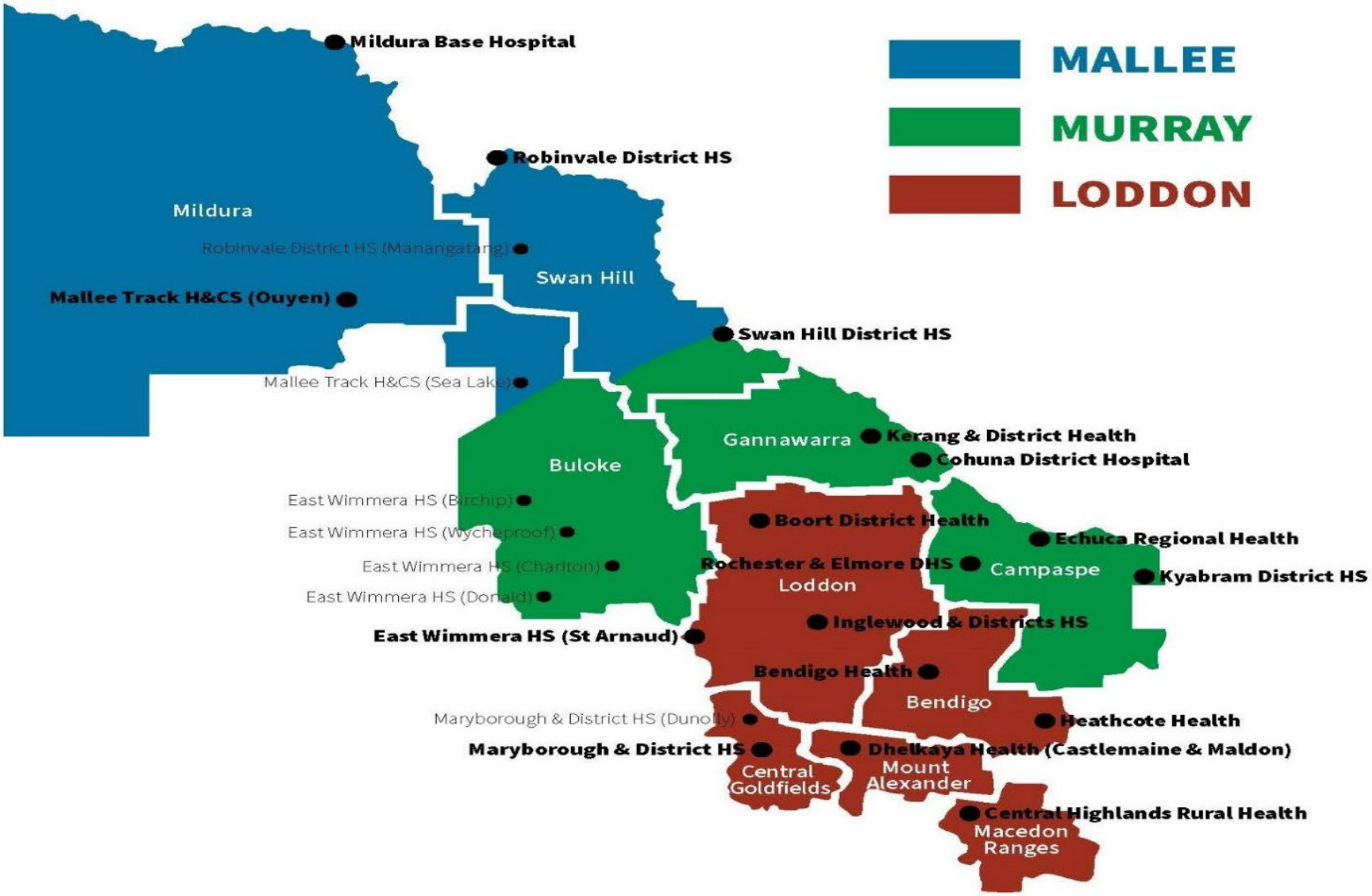


Figure 1: Loddon Mallee Region, Sub-Regions and Health Services

Research Aims

Strength based process, constructing a BPF which transforms ED's and UCC's practices, regarding cultural safety and health outcomes for First Nations communities.

- Build relationships, inclusive of Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Hospital Liaison Officer's (AHLO), Hospital staff, Primary Health Networks, Ambulance Victoria and Department of Health (DoH), through formation of a Governance Group of professionals working in emergency care (see *Appendix C* for Governance Group – Ground Rules).
- Enable 'blue sky' conversations regarding First Nations experience of emergency care.
- First Nations communities of the LMR receive tangible direct benefits from this research project.

Research Design

An Appreciative Inquiry: First Nations Emancipatory Process design, based on a theoretical perspective of FN theorists Rigney (2001), Nakata's (2006), Moreton-Robinson's (2006), and an Appreciative Inquiry (AI) process Cram (2010). AI is a research tool used to facilitate organisational change and transforming relationships. AI is a strength-based, asset-based, strategic planning research method, including all key stakeholders within a system-wide approach.

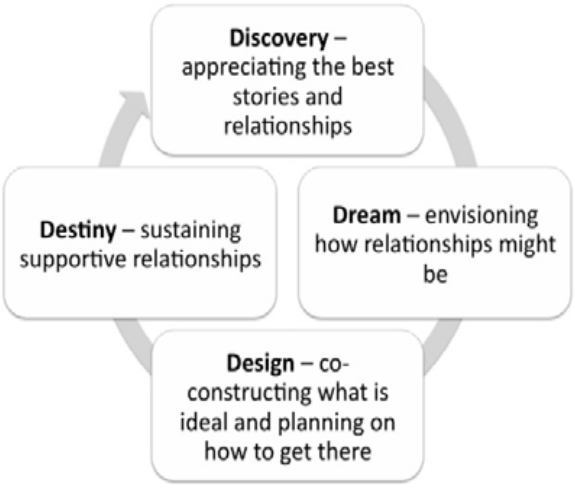


Figure 2: Appreciative Inquiry relational 4-D cycle. Adapted from Truschel (2007), Stavros & Torres (2005)

Benefits

- Implementation of the BPF in emergency care throughout the LMR for FNs people which aims to significantly benefit First Nations people's health outcomes.
- Governance Group members become a 'new community' throughout the research project, enabling both ways working (First Nations and Western) and increased mutual understandings.
- First Nations health workforce in the LMR positioned for their expertise and strengthened in numbers and leadership opportunities.
- Cultural safety and anti-racism skillsets for all health professionals within emergency care in the LMR are better understood, better addressed through training and system reform.
- All patients First Nations, and other cultural identities experience emergency care which enables high levels of engagement with health diagnosis and treatment.

As discussed by Governance Group members of this project, a Working Group should be established to oversee the implementation of Blak Butterfly: Best Practice Framework.

Culture as Health: Theoretical Framework

Salutogenesis (Antonovsky, 1996) flips our perspective, instead of limiting understanding of health to pathogenesis; causes of disease. Salutogenesis understands, what is a person's **origins of health**?

Salutogenic Model of Health (SMH) positions **Sense of Coherence (SOC)** at the core of each person's origins of health. Sense of Coherence comes from

Comprehensibility: a belief that life events happen in a predictable way, a person understands events in their life and can reasonably predict what will happen in the future.

Manageability: a belief that each person has the skills, the support or the resources to take care of things, and that things are manageable and within your control.

Meaningfulness: a belief that things in life are interesting and a source of satisfaction, that things are worthwhile and that there is good reason or purpose to care about what happens.

Salutogenesis positions that experiencing a strong sense of coherence, predicts **positive health outcomes**. Antonovsky, (1996) further explains that **culture is integral** to each person's level of SOC and relationship to, their unique origins of health. Culture influences each person's meaning associated to being healthy, culture provides people with their lived experiences, the resources needed to perceive life as comprehensible, manageable and meaningful, the three elements integral to the SOC. Antonovsky, (1996) positioned **cultural stability vs instability**, suggesting cultural stability leads to a strong SOC, whereas cultural instability and rapid culture change leads to a weak SOC. People groups experiencing cultural instability are also constantly confronted with foreign information from the dominant cultural group which they are told to adhere to, they do not have the legitimacy to be heard.

Antonovsky, (1996) further explained minority groups often experience inadequate access to healthcare, lower chances of survival from mainstream health services cultural deficits, and poorer overall health related to discrimination. Being part of a minority, especially a minority not accepted by the majority, **inhibits a strong SOC and thereby threatens experience of health.**

Through the lens of salutogenesis, origins of health and the interplay between culture and health outcomes necessitates that Blak Butterfly components are presented theoretically through a strength-based **culture is health** framework.

Health services predominantly focus on pathology and prevention of disease, Blak Butterfly inverts the focus to origins of health and the urgent call to understand the interplay between First Nations people experience of cultural instability while accessing mainstream health care.

Yamane and Helm (2022) developed a 'Culture as Health' framework which is useful to understand the different components of Blak Butterfly and how they address the origins of health for First Nations people.

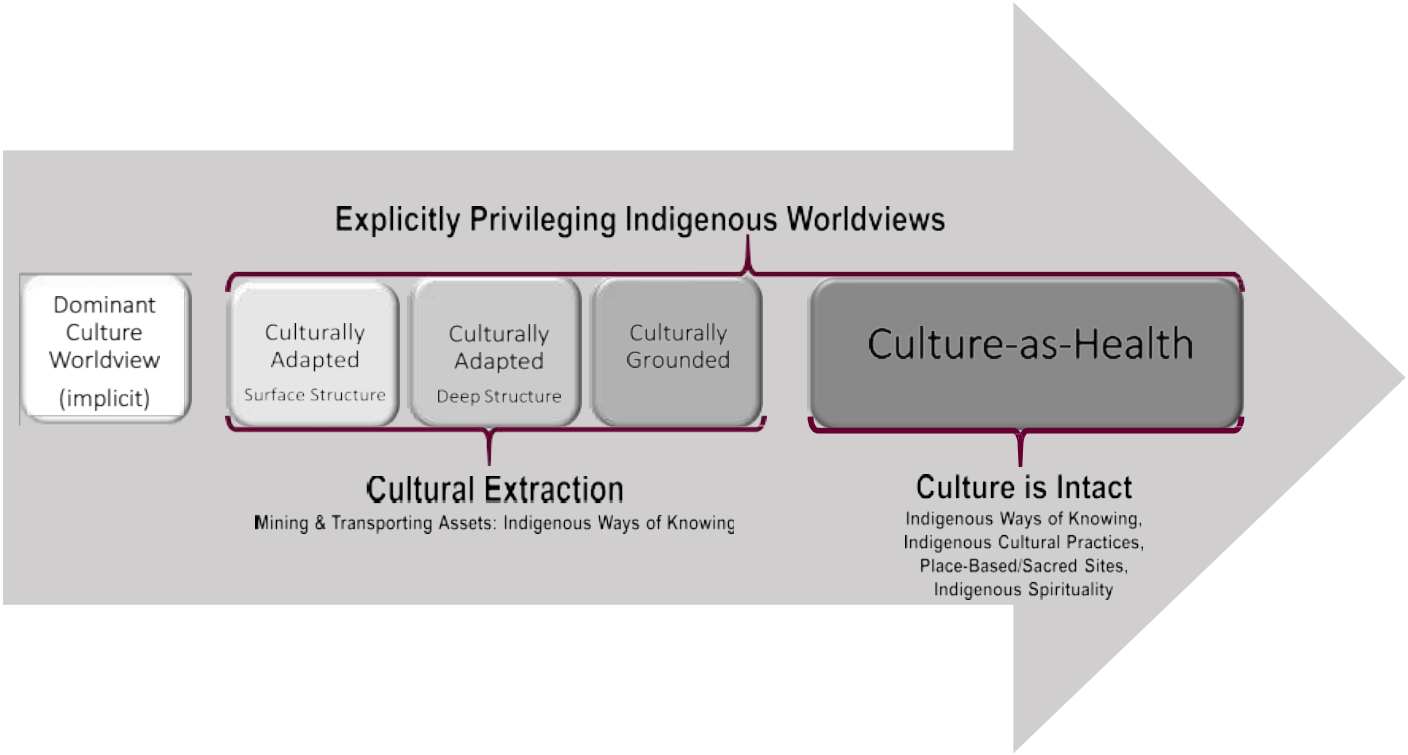


Figure 3: Cultural Interventions Continuum–Expanded to include Culture-as-Health

At the '**Culture as Health'** end of this spectrum, these health initiatives are where First Nations people experience the highest level of cultural stability, personal sense of coherence and meaningful connection to First Nations origins of health. These modalities are present: **1) Indigenous Ways of Knowing, 2) Indigenous Cultural Practices, 3) Place-Based/Sacred Sites, and 4) Indigenous Spirituality.** A key aspect of health initiatives at Culture as Health, is they are implemented intact within an Aboriginal space, organisation or Traditional sacred landscape.

At the other end of the spectrum **culturally adapted** interventions occurs when existing mainstream health interventions are adapted for a specific cultural group or there is an 'add on' aspect to existing mainstream service. This type of health initiative holds a level of benefit, but benefits are also limited for First Nations peoples because the adapted interventions retain the worldviews and perspectives of the dominant culture.

Culturally grounded interventions located within the middle of the spectrum are designed strong, often First Nations led, from First Nations culture from the ground up, positioning relational epistemologies, cultural values, beliefs and processes. As much as culturally grounded health interventions hold promising health outcomes for First Nations communities, they still involve extraction of key cultural elements to be used in health interventions not situated in First Nations spaces, and through the process of extraction cultural authenticity and elements of Culture as Health can be lost, such as nuanced meanings connected to cultural processes.

Acknowledging origins of health as a cultural phenomenon, it makes sense that health interventions be transparent as to how they are culturally positioned within the spectrum. **Culture as-Health** framework proudly recognises First Nations health perspectives and processes have existed for a millennium and do not require the addition of western empirical evidence for effectiveness. The framework also broadens health discourse from simply empirical ways of knowing, dominant in the evidence-based practices. To include First Nations culturally based, community-defined evidence, and practice-based evidence, which

Yamane and Helm (2022) state is an intentional act of sovereignty and liberation for First Nations health outcomes.

Components within the Blak Butterfly Best Practice Framework sit at different positions of this spectrum. Understanding that the strongest experience of Culture as Health occurs in First Nations culturally strong spaces, where extraction to a mainstream health service is not required, components which enable and strengthen ACCHOs delivery of health services are prioritised, and Aboriginal Health Units within health systems are pivotal for all initiatives held within Blak Butterfly.

Values

Repair Trust Gap Understanding First Nations patients are possibly already anxious or nervous before entering a hospital, based on past traumatic experiences, personal or from their family or community. Medical staff hold awareness they are 'repairing the trust gap' through their language, body language and hospital processes as soon as a First Nations person presents for treatment.

Reciprocity is a value central to all interactions or communication for First Nations people. How they introduce themselves, how medical staff introduce themselves, how they listen to medical staff, how medical staff listen to them. Reciprocity is at the interpersonal level as well as the organisational level, between Aboriginal health and Western health organisations.

Culture as Health is a health value which positions our self-determination and sovereignty. Our Ancestors held knowledges for living a good life, for wellbeing, for healing, for balance of being, between people, nature and the spirit world. Health initiatives endeavour to position culture as health for First Nations communities, as it holds strong, positive health outcomes.

Care on Country is a literal First Nations health value. First Nations communities accessing health care on their traditional land, or on land which they call home holds the highest health outcomes. It can also mean health care involving nature, First Nations patients experiencing healing which includes being in the bush, or near a waterway or traditional bush medicine.

Cultural Safety as a value acknowledges and addresses an individual's racism, their own biases, assumptions, stereotypes and prejudices to provide health care that is holistic, free of bias and racism. Cultural safety in health care is determined by the patient; First Nations individuals, families and communities. This value requires the ongoing critical reflection of each health practitioner.

Systems Reform reimagining systems of society such as health, for the benefit of being more inclusive of all people, being innovative, being more effective, more efficient and being willing to do things differently, willing to feel uncomfortable, from the understanding we are all constantly learning and unlearning, creating new communities.

Cultural Humility is a strong value enabling respect between people**.** It is a demonstration of cultural safety, a professional on their learning journey demonstrates they don't always know, they are ready to learn, to listen. Humility in healthcare encourages multiple cultures to hold space, to be celebrated and inform health care innovation.

Transformational Accountability is a value which says enough is enough. Investing National and State funds, time and resources in areas such as health, without evaluation or evidence of effective change, is system failure. First Nations health holds at its core the value of transformational accountability. System reform through mainstream health and Aboriginal health sector collaboration demonstrating improved data for First Nations communities is required.

Blak Excellence value is the recognition, renumeration and positioning of First Nations knowledges, processes, practices, innovation, creativity and decision making. Blak excellence is First Nations sovereignty, and it does not require another corpus of knowledge such as Western knowledge to exist.

Two Worlds value is a space, when a health professional from any background or culture interacts with a First Nations person. In this space there is always *Two Worlds*, the beliefs, knowledges, cultures, normality and processes of both the health professional and the First Nations person.

BLUE SKY THINKING

Yorta Yorta Country

Best Practice Framework Components for First Nations Emergency Care in the Loddon Mallee Region

Refer to ***Appendix A*** for a Table of Actions for each component.

1. First Nations Emergency Care Governance

The overarching component for the Blak Butterfly framework is First Nations governance. From a relational worldview held by First Nations communities, which understands the oneness and interdependency between the seen and the unseen worlds, between the spirit world, nature and communities, our Ancestors are always respected and positioned. This is what occurs during an Acknowledgment of Country. In line with this protocol Blak Butterfly first and foremost positions **Ancestors from all the Aboriginal communities throughout the Loddon Mallee Region** within a First Nations governance structure.

Following this, Blak Butterfly positions and expresses gratitude to LMR Traditional Owner Groups:

Barapa Barapa	Latjie Latjie	Wadi Wadi
Barkindji	Mutti Mutti	Wemba Wemba
Bora Bora	Ngurai Illum Wurrung	Wergaia
Dja Dja Wurrung	Tatti Tatti	Wurrundjeri
Kureinji	Taungurung	Yorta Yorta

Our **Traditional Owner Groups** continue to Care for Country, culture, sacred sites, our water ways and our languages. All of which hold our health services, our hospitals, our Aboriginal Community Controlled Health Organisations and our communities. Our Traditional Owner Groups also facilitate our Welcome to Country, NAIDOC events, Smoking Ceremonies and local cultural awareness training.

First Nations Governance for the health and wellbeing of First Nations communities in the LMR begins with Aboriginal Community Organisations, who hold a pivotal role in the provision of and ongoing advocacy for safe holistic care for their communities through delivery of health and wellbeing services, from a strong **Culture as Health**, Blak spaces. In addition to this localised governance, BDAC, MDAS, MVAC and Njernda provide a collective governance voice through their partnership as Loddon Mallee Aboriginal Reference Group (LMARG). **Aldara Yenara** as an ACCO in the LMR also provides governance for First Nations health through the training and community programs they provide. At a state level, this governance is supported and strengthened through the Victorian Aboriginal Community Controlled Health Service (VACCHO). In addition to VACCHO working at a state level Blak Butterfly also recognises the **Department of Health – Aboriginal Health Leadership team** for First Nations health in the LMR.

Building on the above First Nations governance, the following First Nations Workforce component recommends additional roles within the LMR:

1. **Executive Director** Aboriginal Health for the LMR,
2. **Director Cultural Safety Education & Accountability**,
3. **Director of Aboriginal Mental Health**, and
4. Three **Directors of Health** located in Loddon, Murray and Mallee.

The addition of the above First Nations governance is most suitable for various reasons outlined throughout Blak Butterfly, to take charge of the planning, management, delivery and funding of health programs and decision-making responsibilities for First Nations health in the LMR.

A necessity for effective First Nations governance is **Indigenous Data Governance & Sovereignty** for First Nations health data. A finding throughout this project is ACCHOs expressing limitations in servicing their communities effectively because they don't hold the **data which defines 'presentations to emergency'**, and thus the inability to develop their services in line with the health needs of local Aboriginal communities. A second frustration connected to data is **referrals to ACCHOs**. Hospitals in the LMR do not effectively capture through their data input during triage and treatment ACCHO services such as Medical Clinics, Integrated Care teams, Alcohol and Drugs or Social and Emotional Wellbeing programs, services of which Aboriginal patients may already be receiving, or could possibly be referred to. This break down in **data communication** between health services and ACCHOs is to the detriment of First Nations health outcomes.

The Australian Government in May 2024, released the Framework for Governance of Indigenous Data to inform and support the work in this space. Framework for Governance of Indigenous Data (niaa.gov.au)

Figure 4: A depiction of First Nations governance within health systems is found through WACHS Cultural Governance Framework (2021) below.

WACHS-Cultural-Governance-Framework-2021.pdf (health.wa.gov.au)

2.2. Cultural, Corporate And Clinical Governance

As already stated, corporate and clinical governance will be ineffective if they are not integrated with cultural governance.

To summarise these three elements must come together:

- **Corporate governance** holds our service accountable for operating effectively and ethically, in line with the organisation's legislative obligations, policies, practices, code of conduct and other guidelines that apply.
  It informs and guides due diligence across all aspects of the organisation, including finance, workforce development, and models of practice, programs.
- **Clinical governance holds** our service accountable for optimising the quality of their clinical services and safeguarding high standards of care.
  It requires that employees are delivering clinical practice according to recognised best practice.
- **Cultural governance** holds our service accountable for ensuring that policies and practices are as effective for Aboriginal people as for all other clients[7].
  It requires that employees are working in ways that achieve optimum outcomes for Aboriginal people, families and communities.

To serve Aboriginal people as effectively as other Western Australians, all three governance elements need to be strong and integrated. Cultural Governance does not replace clinical or corporate governance, it is integrated into both. It will only occur if there is recognition across the organisation as essential and non-negotiable.

7. Whilst this document is about cultural governance from an Aboriginal perspective it could serve as a guide for other marginalised, and/or culturally and linguistically diverse groups and individuals.

Figure 3: Current view of Governance

Figure 4: Incorporating Cultural Governance

Action: The different levels of First Nations Governance communicate collaboratively, despite the Western competitive model which strongly encourages funding opportunities of which different First Nations health organisations must competitively apply for.

Action: First Nations data governance and sovereignty is monitored and evaluated within the LMR to create processes for the optimal health outcomes for First Nations communities.

Action: To align to the Framework for Governance of Indigenous Data.

2. Health Services Staff Cultural Safety & Anti-Racism Education

Outlined below are some of the many clinical practice standards, accreditation expectations, Department of Health frameworks and policies which require health services and health service staff to provide culturally safe care, **free of experiences of racism**.

We are using the word **education** rather than training, as training may lean into a mindset of 'done'. This is lifelong learning and unlearning, **there is no done**. This is **education** like western systems of learning from kindergarten, to primary, secondary, tertiary, and ongoing professional development in workplaces and beyond.

There are **many definitions** of what is cultural safety and what is cultural awareness? It is important to **not get stuck here** and continue to **not hold accountability to support** the work. We are using the National Safety and Quality Health Service Standards, the DoH Aboriginal and Torres Strait Cultural Safety Framework and AHPRA's definition. The impacts of not doing the work of Cultural Safety Education is impacting at a life and death level and is tied to accountability measures in reporting and funding requirements (see key polices below).

Key findings from this study:

- urgent need for **ongoing education, support and accountability** in Cultural Safety Education to **all health care staff including agency and locum staff** across the Loddon Mallee Region (LMR). Cultural Safety Education is currently not offered to **all** health care staff and agency or locum staff within Loddon Mallee HS (clinical, non-clinical, CEOs, Executive, management, administration, security, marketing, finance, people and culture, cleaners, agency / temp staff etc)
- this lack of Cultural Safety Education is alarming esp. with all of the policies in place to hold accountability (see policies below)
- there is no **standardisation** across the LMR in relation to Cultural Safety Education
- health service staff struggled to explain the **difference between** Cultural Safety and Cultural Awareness Education. There was also confusion about what training participants have accessed and/or confusing Cultural Safety Education with Cultural Awareness Training
- training completed by most participants interviewed occurred online via LMS module *Cultural Awareness E- learning 'Share our Pride' modules* Wandeat Bangoonagan which focuses on Cultural Awareness training and limited Cultural Safety Education. These online models alone **are not enough** to **support** health care staff to be Culturally Safe using AHPRA's definition of Cultural Safety outlined below
- there is a lack of **health literacy** pertaining to Cultural Safety and Anti-Racism skillsets within emergency care practice and necessitates an urgent need for Cultural Safety Education
- there is a lack of Aboriginal Health Sector literacy that necessitates an urgent need to skill up health service staff's knowledge of the Aboriginal Health Sector e.g. who and what is an ACCHO?
- throughout the Narrative interviews, health care staff frequently stated "**they treat everyone the same"** when the research and data shows they don't treat everyone the same. It also demonstrates the lack of education and awareness health care staff hold around why they shouldn't treat everyone the same
- health care staff across all HS have limited working **knowledge of what racism** is. If health care staff are unable to acknowledge racism exists, they are in urgent need of **ongoing support and education**

To note:

- having partnerships with Aboriginal organisations, RAPS and/or celebrating First Nations events are important actions for creating culturally safe health services **but of themselves** are not Cultural Safety Education

- First Nations workers and First Nations communities are **not responsible** for addressing and eliminating **systemic and individual racism from HS**, and therefore increasing organisations capacities to meet AHPRAs definition of Cultural Safety. It is the responsibility of management, People and Culture, Health Services and organisation Boards and all health professionals to eliminate racism. First Nations people can assist if they choose but it is not their core responsibility

Key actions requiring <u>urgent action</u>:

- LMR and HS implement a **change management approach** to introducing Cultural Safety and Anti-racism Education addressing potential resistance from staff to undertaking the training
- HS **action** AHPRA definition of Cultural Safety acknowledging it is the work of individuals developing a critical consciousness and understanding of themselves
- all health service staff and agency/temp staff have **ongoing Cultural Safety Education built into their key responsibilities** and are **tracked / supported** using the DoH Cultural Safety Continuum Domain 1: Creating a culturally safe workplace and organisation (individual level)
  To support a common foundation for learning all staff are to start at an **unaware level** due to the level of racism that exists in HS and the lack of existing Cultural Safety Education offered. **Accountability** for this is to be held through **current HS accountability systems**.
- HS develop and embed **key accountability processes** including policies, documentation and mitigation strategies to enable a systematic approach to reporting and addressing racism incidents
- health care staff and agency/temp staff are **supported** to build their Anti-Racism skill sets, enabling the detection and elimination of racism in all its forms from services
- creation of LMR Cultural Safety dashboard to **track progress** to strengthen accountability.
  This will include if HS choose not to support individuals to access Cultural Safety Education and use AHPRAs definition they need to state this up front in their RAPs, Cultural safety plans etc.
- all HS **add racism** as a component to their People Matters survey
- all HS develop and implement **racism policies** to hold accountability to racism
- all health service staff are supported in understanding and connecting to the Aboriginal Health Sector in culturally safe ways
- **AHPRA states to ensure culturally safe and respectful practice, health practitioners must**:
  - acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health
  - acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide health care that is holistic, free of bias and racism
  - understand cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities
  - understand culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. (AHPRA - Aboriginal and Torres Strait Islander Health Strategy (2022-2025)

Potential sources of Cultural Safety and Anti-Racism Education providers (not exhaustive) Some examples of providers who offer Cultural Safety Education – who represent AHPRAs definition and support individuals to move from unaware to emerging along the Cultural Safety Continuum:

- VACCHO, ACCHOs and Traditional Aboriginal organisations who offer Cultural Safety Education
- LMHN 'Open invitation for those that are ready' – Cultural Safety Education through ongoing education, support and accountability for those that are ready. Currently free to HS within LMHN (2024 - 2025)
- Weenthunga Health Network – Cultural Safety and Critical Conscious training
- Indigenous X - Anti-Racism Training

- CATSiNAM – Provide training (nurses and midwives)
- Guwanda Education Cultural Safety Training
- Indigenous Allied Health Australia (IAHA) - Culturally Responsive Training (Mental Health/Allied Health)

Potential sources of Cultural Awareness Training (not exhaustive)

- Traditional Owner Organisations
- Local Aboriginal and Torres Strait Islander community members, Elders etc. To be determined by the First Nations community
- VACCHO, ACCHOs, ACCO, AHC
- Aboriginal organisations that offer Cultural Awareness training

Aboriginal Health Sector

It is vital that all health service staff have support to understand and engage with the Aboriginal Health Sector such as knowing key organisations, governance, services provided, legislation and at basic level learning First Nations acronyms.

- What is an Aboriginal Community Controlled Organisation?
- Who the Traditional Owner groups are in your area?
- Who are the ACCHOs and ACCOs in your area and most importantly what services do they provide for First Nations communities?
- Who are the First Nations Governance bodies relevant to LMR? – VACCHO, First Peoples Assembly, LMARG
- Who represents the health sector in Victoria, or nationally – VACCHO, VACCA, Lowitja Institute & NACCHO.
- Who are the First Nations medicine, nursing and allied health national organisations? Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA), Australian Indigenous Doctors' Association (AIDA) & Australian Indigenous Psychologists Association (AIPA)
- What the State and Federal acts /legislation such as Section 18, Aboriginal Family-led Decision Making relevant to working in the health industry?
- Introductory understanding of First Nations sovereign cultural knowledges and processes for healing, health and wellbeing.

Figure 5: Key Policies that Health Services are accountable to.

National Safety and Quality Health Service Standards:

User guide for Aboriginal and Torres Strait Islander Health **definitions**

Cultural Safety: identifies that health consumers are safest when clinicians have considered power relations, cultural differences and patients' rights. Part of this process requires clinicians to **examine their own** realities, beliefs and attitudes.

Cultural Safety is defined not by the clinician but by the health consumer's experience – the **individual's experience** of the care they are given, and their ability to access services and to raise concerns.

The essential features of cultural safety are:

An understanding of **one's** culture

An acknowledgement of **difference**, and a requirement that **caregivers are actively mindful and respectful** of difference(s)

Informed by the theory of **power relations**; any attempt to depoliticise cultural safety is to miss the point

An appreciation of the **historical context of colonisation**, the practices of **racism at individual and institutional levels**, and their impact on First Nations people's living and wellbeing, in both the **present and the past**

That its presence or absence is **determined by** the experience of the **recipient of care** and not defined by the caregiver.

Cultural Awareness: a basic understanding of **Aboriginal and Torres Strait Islander histories, peoples and cultures**. There is no common accepted practice to reflect cultural awareness, and the actions taken depend on the individual and their knowledge of Aboriginal and Torres Strait Islander culture. Cultural awareness is generally accepted as a foundation for further development, but not sufficient for sustained behaviour change.

United Nations Declaration on the Rights of Indigenous Peoples

Article 2: Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity.

Article 24:

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous 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 realization of this right.

cultural respect: the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people.

Cultural respect is about shared respect. It is achieved when the health system is a **safe environment** for Aboriginal and Torres Strait Islander people, and cultural differences are respected.

It is a commitment to the principle that the construct and provision of services offered by the Australian healthcare system will not knowingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander people.

The goal of cultural respect is to uphold the rights of Aboriginal and Torres Strait Islander people to maintain, protect and develop their culture, and achieve equitable health outcomes.

NSQHSS definition of Cultural respect.

Figure 6: National Safety and Quality Health Service Standards – definitions, and United Nations Declaration on the Rights of Indigenous Peoples

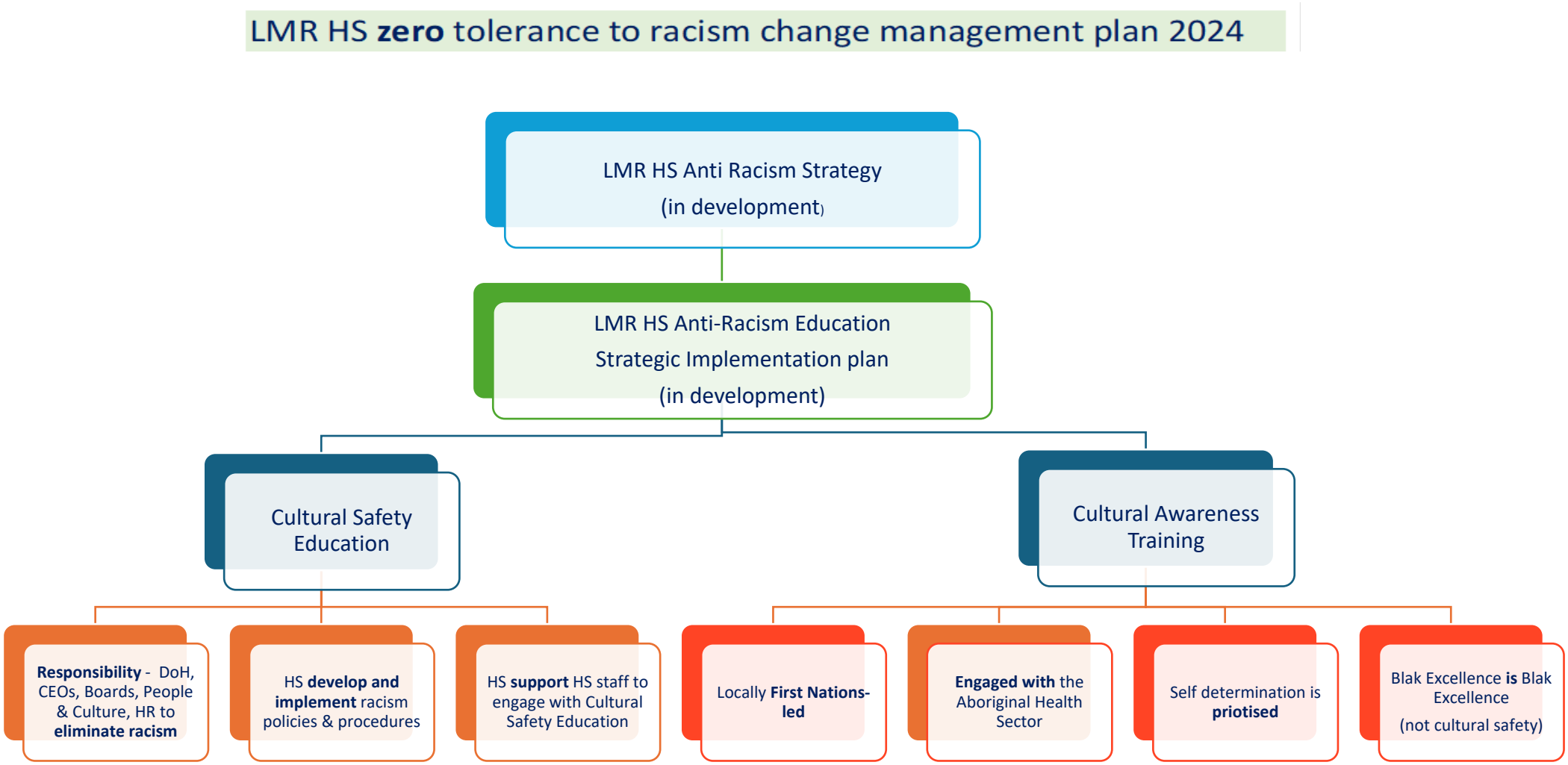


Figure 7: Loddon Mallee Region Health Services – Zero Tolerance to Racism: Change Management Plan 2024

Figure 8: Cultural Safety Education and Cultural Awareness Training

3. First Nations Culturally Safe Building Designs

Evidence based design for cultural safety in hospitals for First Nations communities is well understood in both the literature and through various Victorian Government frameworks. The publication Good Design + Health (2024) from the Office of the Victorian Government Architect conveys some of the key elements such as applying a **human rights framework**, environmentally **sustainable**, salutogenic focus for **origins of health**, building **relationship to local landscape**, human centred **intuitive pathways** through hospitals and **biophilic** design. Literature indicated incorporating these elements improved pain reduction, reduced medication, lowered blood pressure, faster recoveries and decreased all-cause mortality in general. Also, a profound impact on supportive care for patients suffering experiences psychological distress, fatigue, anxiety, or depression (Tekin, Corcoran and Gutierrez, 2023).

The uptake of these elements throughout the LMR was various, however health services which included these principles in design have already taken positive steps towards improving health outcomes for First Nations people through relationship to building design. Below are key elements specifically for First Nations communities however they may hold high applicability for other cultures.

First Nations Culturally Safe Building design:

- Redesigning hospital spaces to show cultural safety, including **safe waiting environments** with a 'calming' atmosphere as achievable. This may include seating set up 'sectionally' enabling a degree of privacy for patients who know other patients from difficult relationships.
- An understanding of **First Nations men's and women's business** in the design, enabling triage and treatment privacy if requested.
- Waiting areas connected to the outside, understanding **First Nations people access to nature**, the earth, tress, hearing water or seeing the sky as innate cultural self-soothing techniques.
- High priority of **larger spaces** for extended family, community to be with First Nations patients during their time in hospital.
- An area to **wait safely outside near emergency**, understanding waiting taking a break outside may be a process used as an alternative to leaving before full treatment for First Nations patients whose anxiety or stress has escalated.
- **Signage communicating that First Nations Cultural Healing services** are an integral part of emergency care provision, and First Nations patients can request information, a referral to or service from local Cultural Healing Practitioner. Cultural healing services are defined by each local First Nations community.
- **First Nations localised leadership** included in health service designs or re-designs.
- First Nations patients' **proximity to large windows** with views of nature to reduce stress of being in a mainstream health service.
- Improve the **comfortability of waiting room chairs**, with ability to tilt back to relieve some types of pain and arrange chairs so patients (at times) can position themselves with a degree of separation from other patients if required.
- Outdoor **community garden, bush medicine, fire pit for smoking ceremonies** for community engagement, relationship building and cultural healing services.
- **Access** to water, phone charging facilities, free wi-fi and areas for children to play.
- Signage in the local **Aboriginal language and flags, Aboriginal artwork** in public spaces.

Action: Future builds and rebuilds to ensure First Nations leadership is sought from health services and community.

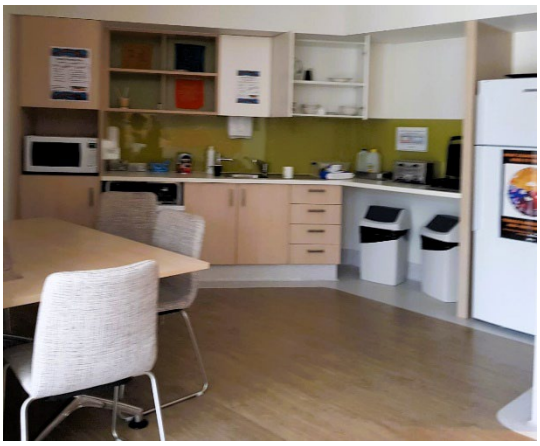
Action: The publication Good Design + Health (2024) from the Office of the Victorian Government Architect, including biophilic design principles are considered when designing building designs.

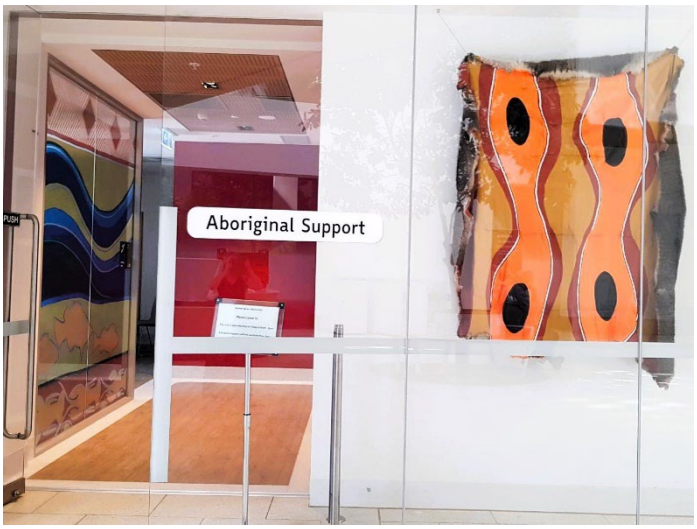
Action: Ensure First Nations Culturally Safe Building designs are considered in all builds and rebuilds.

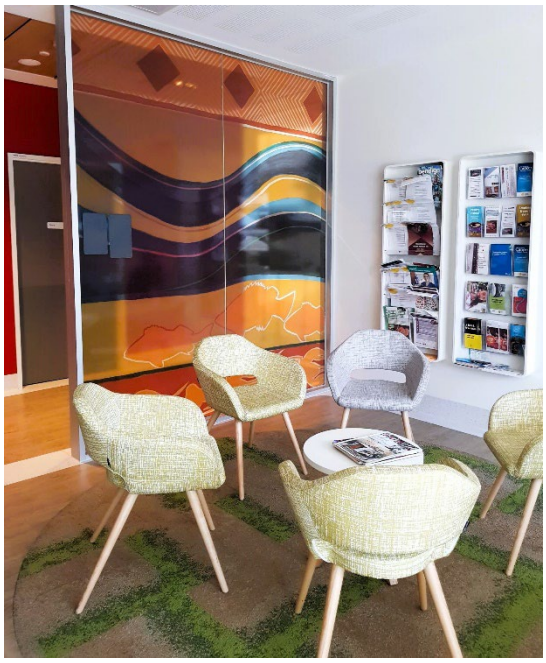
Bendigo Health

Aboriginal Health Unit

Proximity to Emergency / Colour & Art / Family & Community area/ access to nature / sacred space / natural light / kitchen / celebration of culture







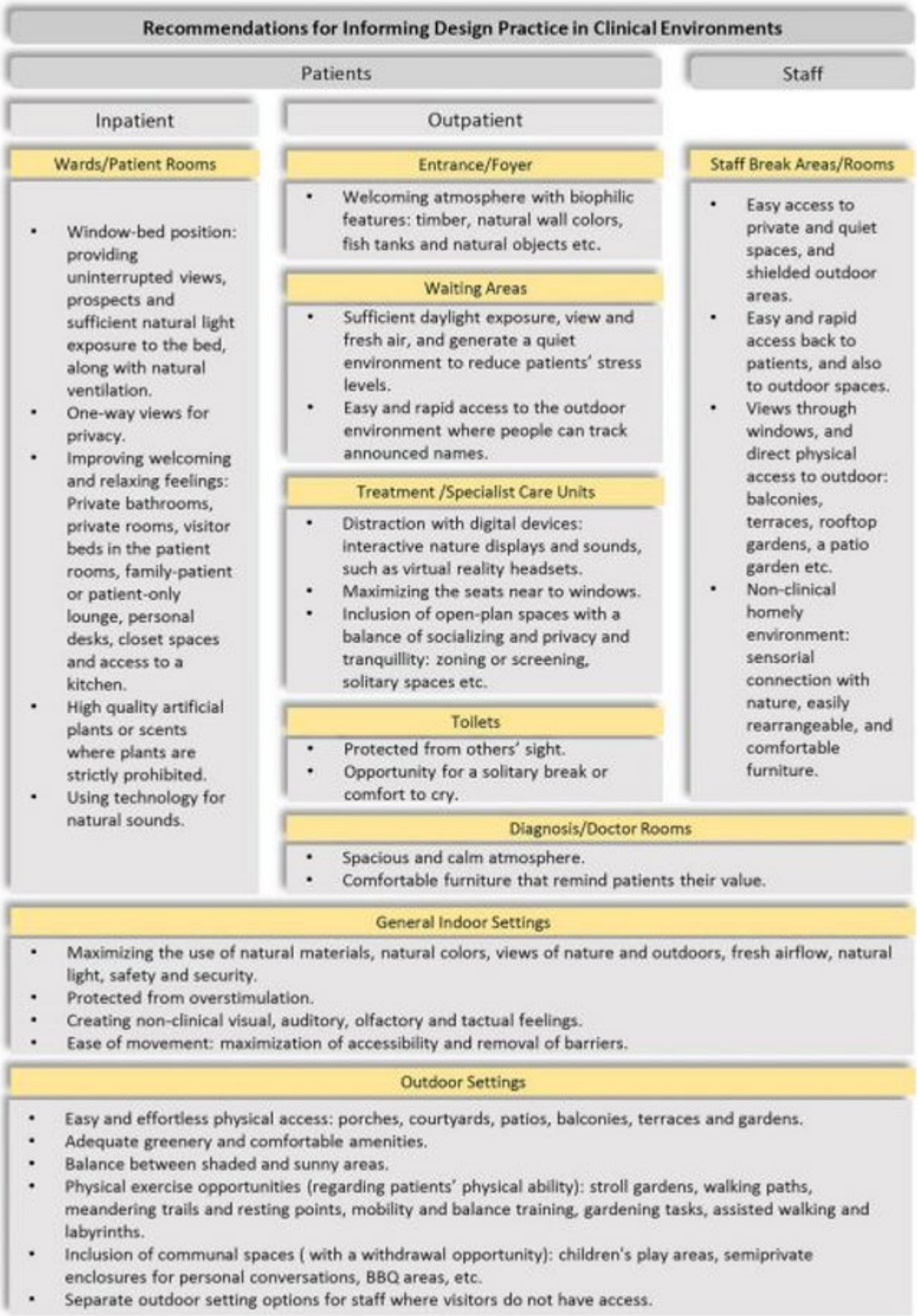


Figure 9: Recommendations for informing design practice in clinical environments

4. First Nations Triage Design & Process

Triage Environment

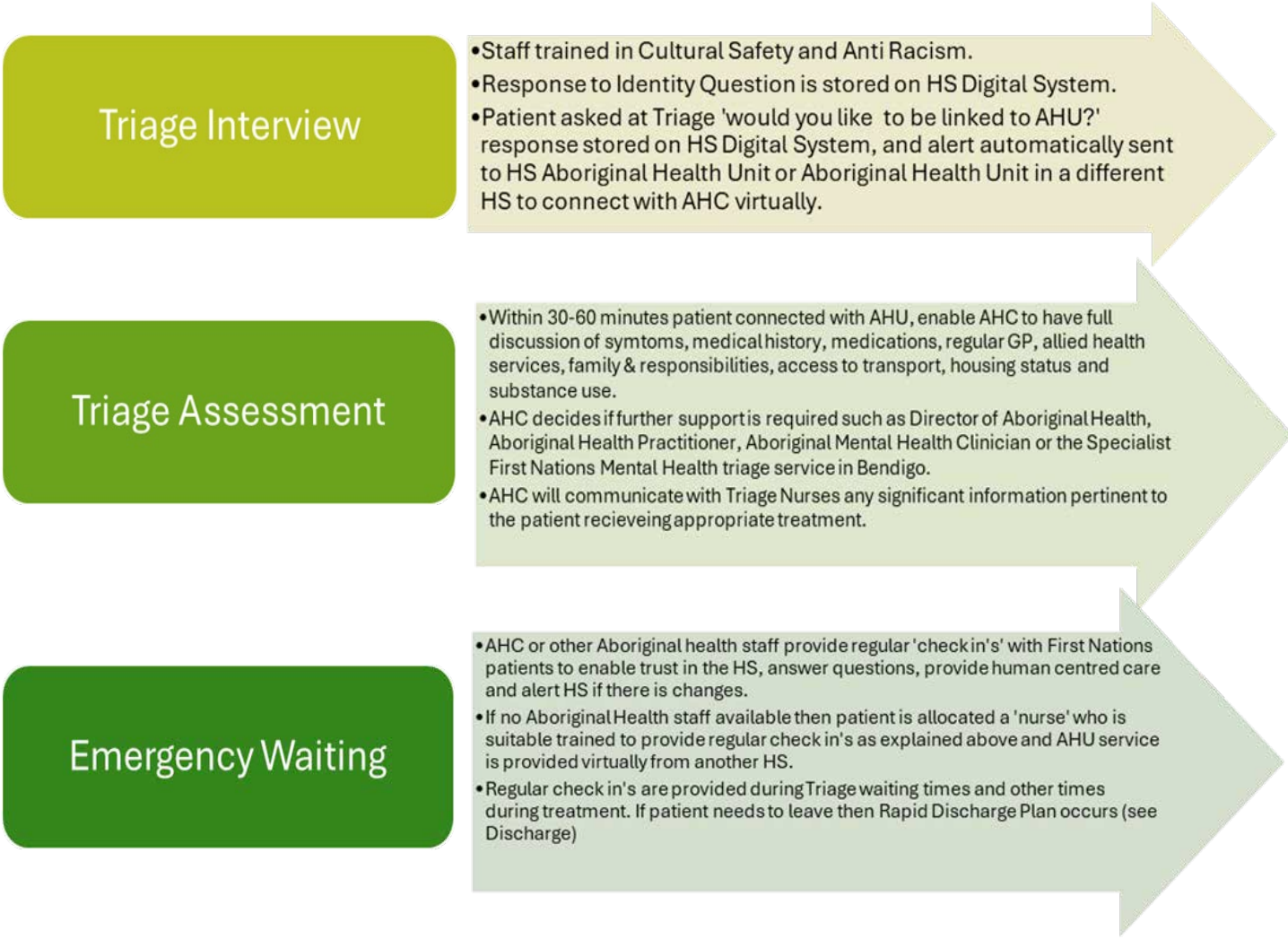
- ED and UCC triage hold understanding of First Nations men's and women's business in the environment and process design, (may hold applicability for other cultures).
- Connecting ED and UCC's waiting areas to nature with the outside area or plant life is imperative for de-escalating stress and anxiety and incidence of Code Greys.
- Safe outside areas near ED and UCC, understanding patients who are anxious and who may leave before treatment may first try to self soothe themselves by stepping outside for a period.
- Providing space for extended family, community to be with or visit First Nations patients during their time in ED is required to ensure inclusive collective cultural design, (may hold applicability for other cultures).
- Improve the comfortability of waiting room chairs, with ability to tilt back to relieve some types of pain. Seating is also arranged so patients can position themselves with a degree of separation from other patients if required.
- Access to water, phone charging facilities, free wi-fi and safe areas for children to play.
- Communicating clearly and with innovation (signage or text messaging) triage categories, expected wait times and the reasons for prolonged waiting.

Triage Process

Actions:

- Expediate the care of First Nations patients through triage system, as long waiting times is significantly linked to First Nations patients leaving emergency care without being seen.
- Identity status as Aboriginal or Torres Strait Islander is stored in health service digital system enabling referrals to other hospital departments. Identifying as Aboriginal or Torres Strait Islander prompts the next Triage question, do you wish to be linked with Aboriginal health services within the hospital. Answering 'yes' triggers digital referral to Aboriginal Health unit.
- Independent audits undertaken to include 'asking the identification question' as an ongoing continuous quality improvement process.
- Triage administration clerks trained in and understand the clinical benefits of kindness and human centred professionality, specific for working in crisis environments.
- Process for First Nations people, either connected to Aboriginal health unit staff or a specific nurse at triage, for regular check ins.

- Offer “slow track,” staffed by an interdisciplinary team of clinicians, nurse practitioners, and social workers, to better address the root causes of some patients’ primary care needs, for health and social conditions.
- Innovative triage process enables First Nations people who attend ED or UCC multiple times receive continuity of care across multiple visits.



5. First Nations Continuous Care (including Discharge)

Best practice: First Nations person walks out of emergency care with safe transport home, they have follow-up referrals for their ACCHO, other health service or specialist and during their time accessing emergency care they always had a culturally safe designated person such as an Aboriginal Health Consultant if they required an urgent Rapid Discharge Plan.

Discharge planning commences at the point of admission through holistic care, learning relevant health information such as GP, ACCHO health service (if applicable), access to transport, immediate caring responsibilities and to enable transfer of care to an ACCHO or other health service. First Nations patients are given discharge summaries for their own information, which are also emailed (with consent) to patients ACCHO medical clinic so ACCHO can follow up with patient. Holistic discharge includes nursing staff completing **First Nations Discharge checklist** (see details below) **completed on discharge** for duty of care.

Action: Holistic discharge planning commences at admission.

Action: On discharge at end of care discharge summary provided to the patient and sent to their preferred primary health service provider. First Nations discharge checklist is completed.

Findings also challenged the word discharge, the term does not integrate health care for First Nations patients, participants explained it 'drops you into nothing, you just walk out'. Discharge needs to incorporate a '**Adaptive Continuous Care Model' (ACCM)**. On exiting emergency care your health care is handed over to your GP, ACCHO or other health professional. **Aboriginal Health Consultants (AHC) play a key role in navigating First Nations community members between primary, secondary and tertiary care**. ACCM is an ethical duty of care initiative for First Nations people, considering continuing experiences of racism and lack of cultural safety in the health system.

Action: AHC given a key role in supporting First Nations community to navigate the health system.

Action: ACCM is implemented as a duty of care.

Innovation for continuous care includes a **mobile app that connects First Nations people with the Loddon Mallee Integrated Aboriginal Health system (either in person or virtually)**. From visiting family, attending Sorry Business, caring responsibilities and cultural events First Nations people can possibly be in different parts of the district at different times. Through this mobile app an individual can find their closest Aboriginal Health Consultant (AHC) located in either an ED or UCC. They connect with their AHC to notify their plan to present to the health service, the AHC involvement is either in person or virtual.

Action: Development of the First Nations Integrated Loddon Mallee Aboriginal Health system and supporting mobile app.

The AHC meets them on arrival, participates in the triage and enables a **holistic assessment** conversation, including patients access to transport. As this patient transitions from triage to treatment they can remain in communication with their designated AHC, if required. On discharge or handover to primary health care the AHC ensures the patients GP, and possible ACCHO, community services or allied health programs are part of the patient's referrals.

Action: No First Nations person can be discharged without safe transport home, this is also duty of care.

Action: The AHC and discharge nurses implement the **First Nations patients safe transport home plan**. (see detail below)

If patient's anxiety increases, such as not feeling:

- culturally safe,
- experienced of racism,
- frightened,
- loss of transport option if they remain longer, or
- there is an urgent request to return home because of caring responsibilities,

the patient can alert their AHC via the mobile app their intent to exit, the AHC will locate patients and utilising an ACCM approach arranges a **Rapid Discharge Plan (RDP),** see more details below.

Patients who simply 'walk out' are at increased risk of re-presentation, increased morbidity or death. This also incurs additional resource costs to the health system. Enacting RDP's address First Nations patients who 'walk out' of emergency care because of the reasons stated. The patient now has an alternative option of discussing with the AHC their situation and maintaining continuous care. A fantastic example of this is the St Vincents (Sydney) Dalarinji Flexi Clinic model (Preisz, 2022). Patients can designate a later time to return to the health service or make an appointment at their ACCHO medical clinic or other health service. The RDP also includes asking the First Nations patient **why they are exiting early**, vital information / data which needs to be captured to monitor a health service delivery of culturally safe care.

Action: First Nations patients are either

- fully discharged on completion of treatment with necessary referrals to their ACCHO medical clinic, primary health care or GP, or
- leave with RDP; or
- with a RDP inclusive of alternative arrangements for receiving health care or returning to the ED or UCC at a later time.

First Nations Discharge Checklist

1. Are you feeling okay about getting home safely?
2. Is there anything regarding your treatment you didn't understand?
3. Your AHC connected with you as early as you needed, and nursing staff enabled your AHC to be part of conversations as much as you would have liked? (if patient consented for Aboriginal Health Consultant as they connected to health service).
4. During your stay, hospital staff asked about your other health services / specialists, and you feel confident your discharge referrals are being sent to the right people?
5. During your stay you felt comfortable around the people who cared for you, but if you didn't you knew who you designated person was to talk to?

Rapid Discharge Plan

A card is presented to Aboriginal patient stating:

1. Treating team AHC / nursing / medical, contact number.
2. Patients' main health reason for presenting
3. Where patient got to in their treatment, any urgent next steps.
4. Patient immediate medical plan, later time patient intends to return or alternative health service patient is planning to present to.
5. Main reason patient is exiting early.
6. Patient understands they have not been fully medically discharged yet (signed).
7. Patient presents the card on return to the health service and continues treatment or keeps card for their own information.

First Nations patients **safe transport home plan** is implemented.

6. First Nations Integrated Health Services

Integrated health services, a component which holds intersectionality between all the other areas. The construction of Primary, Secondary and Tertiary health system may hold advantages for strategy and funding purposes however for human centred, preventative health care these separated blocks, which people must jump between, holds potential for poor health outcomes. This context is compounded when it is First Nations people, already hesitant, anxious or holding traumatic memories of accessing hospitals, trying to navigate different levels of a health system which does not coherently communicate between itself.

This study learnt that many health services in the Loddon Mallee Region are still paper based.

Action: All health services in the LMR are equipped with electronic health record systems that can communicate with referral stakeholders such as GP's and ACCHO medical clinics.

ACCHOs in the LMR offer multiple medical, health, wellbeing, housing, justice, family services programs, however a significant number of health service staff were not able to explain what the acronym ACCHO or ACCO meant, or that some First Nations patients GPs were in an ACCHO Medical Clinic. This complete lack of awareness regarding First Nations health systems impedes First Nations people experiencing any degree of integrated health care.

Action: Health services learn what ACCHO or ACCO are in their area, and what health services do they provide for First Nations communities.

The Blak Butterfly framework positions integrated health services for First Nations communities as a key step forward in meeting Closing the Gap targets. A First Nations person transitions seamlessly between their ACCHO health service accessing preventative health care, non-acute care, an Aboriginal Health Unit located in a health service when accessing emergency care, or specialist health care either virtually from their ACCHO or home, or in person, through a **Loddon Mallee Integrated Aboriginal Health System.** Enabling an integrated health pathway which is culturally safe without gaps First Nations people are required to jump.

The following model is an example of integrated care. The primary purpose of an EMR-Integrated Software for Automated Discharge Referrals to Aboriginal Community Controlled Health Organisations (ACCHOs) is to improve the continuity of care and health outcomes for Aboriginal and Torres Strait Islander patients.

How It Works

Integration with EMR Systems

- The software integrates with existing EMR systems used by hospitals and healthcare facilities to access patient records and discharge information.
- It maps relevant patient data from the EMR, such as demographics, medical history, discharge summaries, and care plans, to the fields required for the referral process.

Automated Referral Process

- Upon patient discharge, the software automatically triggers the referral process based on predefined criteria, - 1. patient identification as Aboriginal or Torres Strait Islander, 2. Patient GP service is located at an ACCHO Medical Clinic

- Generates a comprehensive referral form that includes all necessary patient information, care plans, and specific instructions for follow-up care.
- Ensures the secure and confidential transfer of patient information to the relevant ACCHO and health service Aboriginal Health Unit, using encrypted communication channels.

Communication with ACCHOs

- Sends notifications to both the discharging facility, the ACCHO and health service Aboriginal Health Unit, confirming the referral and providing details for follow-up.
- Facilitates coordination between health service administration, health service Aboriginal Health Unit and the ACCHO to schedule follow-up appointments, arrange transportation if necessary, and ensure the patient understands the next steps in their care plan.

Feedback and Reporting

- Allows healthcare providers to track the status of referrals and receive updates on patient follow-up care.
- Collects data on patient outcomes, readmission rates, and other key metrics to evaluate the effectiveness of the referral process.
- Provides tools for generating reports and insights to help healthcare providers and policymakers improve the system and address any gaps in care.

7. Systems Accountability to First Nations Communities

In the Loddon Mallee racism and lack of cultural safety in EDs and UCCs creates delivery of delayed health care. This delay in health care can result in increased morbidity, leading to early mortality and contribute to Adverse Events for First Nations people leading to mortality. The Project team listened to multiple interviews indicating delayed care, and stories of mortality (Sorry Business).

Items of Delayed Care

First Nations patients:

1. Travelling long distances to reach health service with Aboriginal Health Unit, passing local UCCs.
2. Presumption that alcohol or drug use is a contributing factor without testing, patients are left waiting in chairs. This also can result in no clinical observations taken during this period as the patient is "left to sober period'. This behaviour has been documented by the coroner's office as being a contributing factor to early mortality.
3. During assessment for mental health concerns if found to have drug or alcohol use patient can fail the admission requirement, and as a result even with an acute mental health condition and risk is present, can be discharged because they do not meet criteria during assessment, pertinent to dual diagnosis.
4. Needing to present to ED as ACCHOs unable to offer same day appointments to relieve ED presentations; Triage category 3,4 & 5 because Modified Monash Model applied to the ACCHO restricts health service delivery.
5. Traveling or be transported over long distance due to rurality to access the closest acute Mental health service, not able to access 'Care on Country'.
6. Not presenting to emergency or leaving emergency care early because of lack of cultural safety or experience of racism.
7. Do not present to ED when they have a medical need due to fear of mandatory reporting mechanisms within health service by professionals. Being Aboriginal or Torres Strait Islander on its own, automatically places you in a higher risk category. If you have staff who have not undergone the correct training, you are a risk of over reporting as they do not understand the process and do not seek professional First Nations expertise before reporting.
8. Fear of unnecessary Code Gray's due to staff not understanding First Nations communication or have biased perceptions of First Nations people. This results in undue escalation and increase involvement by security and/or police. This issue is of paramount importance because leads to unrequired escalation which results in undue involvement with the legal system. In the situation if it relates to mental health this can be the difference between voluntary admission an involuntary so the consequences for First Nations peoples is substantial.
9. The Loddon Mallee covers large distances many of it being categories as rural. To access the Tertiary health services First Nations people may have travelled hours off Country to get to the service provider either by Ambulance, or other transport systems. Currently the discharge system from the acute Tertiary hospital does not always take in to account the distance the patient has to travel to get home. Discharge from Eds can happen at all hours of the day and night. First Nations patients who have travelled by ambulance from up to two hours away without personal items (wallet) or even shoes can be at risk of being discharged after hours without a way to get home. It is also important to note that only patients who have remained until medically discharge by physician are eligible for some transport options. So, if you are experiencing racism and need to leave before being medically discharged or (leaving against medical advice) this can result in you losing your safe travel to home option.

Key Accountability Areas

Anti-Racism Policy implemented within each Health Service in line with Victoria Governments Anti-Racism Taskforce initiative and the Australian Human Rights Commission Campaign Racism. It Stops with Me. Literature and data from the consultations conducted indicated direct link between experiences of racism in the health care system and poorer health outcomes.

Racism has been researched and within Australian workplaces it is understood to be present in the following forms: race as a historical / political construct, racism as structural, personal with relationships to power. The personal and societal harm caused by racism and its impacts have had an increased spotlight with growing acceptance and understanding over recent years. It has now been documented that systemic racism will not just disappear but requires deliberate intentional action to address and remove racism in all its forms. This action includes how a person and organisation need to behave to become anti-racist, which requires learning and deliberate actions.

Anti-racism policy includes a process for staff and patients to report racism, without fear of ramification and staff involved are accountable for racist behaviours. Antiracist policy is implemented in health service, with a monitoring mechanism to evaluate its ongoing effectiveness. Health service has signage indicating they are an anti-racism organisation and process for reporting incidents of racism. AHPRA acknowledged the ongoing harm to First Nations Peoples from racism in the health and justice systems, following the national tragedy, the death of Ms Dhu in Western Australia.

Action: Loddon Mallee Anti-Racism Policy implemented in each Health Service inclusive of process of reporting and Anti-racism signage in health service.

Funding Transparency and Accountability

Tertiary Health Services (Hospitals) receive specific funding to address the health needs of First Nations Patients. This funding is aligned to the Closing the Gap Funding which is reported against under the Improving Care for Aboriginal Patients (ICAP) program. It was interesting to note that from the 115 interviews conducted across 17 health services in the Loddon Mallee no one that was interviewed was able to discuss how this funding was allocated instead Aboriginal and non-Aboriginal staff we interviewed seemed confused. This highlights the need to be transparent about not only how much funding each service receives but more importantly how each health service uses National Weighted Activity Unit (NWAU) funding for the Improving Care for Aboriginal Patients (ICAP) program. This aligns to the recent recommendation from the Productivity Commission on Closing the Gap and Recommendation 4: Stronger accountability is needed to drive behaviour change and Recommendation 3: Mainstream systems and cultural need to fundamentally rethought.

Funding for each health service is unique depending on the geographic location, if they are an ED or UCC in addition to being Activity based. ICAP enables a 4% loading to cover the clinical costs for Aboriginal patients and an additional 26% loading that is accessible to services through the Cultural Safety Grants. The Grants enable hospitals/health services to undertake a whole of health service response to strengthening the cultural safety of patients, their families and Aboriginal staff.

System reform which enables implementing strength-based solutions which are more effective and efficient is underpinned by transparency and accountability with funding. From participants feedback this sentiment is shared across health services.

Team: An annual **ICAP Report** from each health service available for public review indicating what (if any) funding they receive through the Improving Care for Aboriginal Patients (ICAP) program, how they have utilised these funds to enable cultural safety in each health service to address lack of transparency and accountability.

Preventable Presentations to Emergency Care

Reduce preventable presentations to EDs through providing an **Exemption to the Modified Monash Model (MMM**) for ACCHOs in Loddon Mallee district, so ACCHO health services providing care to First Nations people are not limited in their access to funding or services due to their location. An exemption enables ACCHOs to provide coordinated health and medical services across the Loddon Mallee to a population health group that is vulnerable to our current health system due to systemic racism. The Modified Monash Model indicates whether a location is metropolitan, rural, remote or very remote, to distribute the health workforce better and assist people in rural and remote areas to access doctors and other health services. The rational for this recommendation is that the MMM does not consider the population accessing the service, it only considers the geography of where the service is located. Geography is not the only variable which can reduce access to health services. This model does not suit ACCHOs as it is known that their service reach can be up to 2hours outside of the post code of the location of the building of their service. In addition to MMM classification as a barrier to service access. First Nations communities experience poorer health outcomes including increased morbidity and early mortality as mainstream health services are currently, to varying degrees, not culturally safe. In fact, presenting to a mainstream health service could possibly be detrimental. To reduce **Preventable Presentations** to ED's the solution needs to support a two-pronged approach, an MMM exemption to enable access to primary health service care currently not available without the exemption and Western health services addressing the duty of care they hold to First Nations communities, considering the continuing impacts of colonisation.

Action: Continue improving the cultural safety within Loddon Mallee health services for staff, patients and broader communities.

Action: Enable a MMM exemption for Loddon Mallee ACCHOs Bendigo & District Aboriginal Co-operative, Njernda Aboriginal Corporation, Murray Valley Aboriginal Cooperative, Mallee District Aboriginal Services and Aldara Yenara Aboriginal Corporation, so these ACCHOs (if each ACCHO / ACCO so chooses), can offer walk in medical appointments, and any other health resource required to enable preventable presentations to EDs.

Safe Health Transport

Across the Loddon Mallee for First Nations community's patient transport is currently ad hoc and confusing. It can range from taxi vouchers, Royal Flying Doctors transport service, community transport options such as Sunassist Volunteer Helpers in Mildura or no transport options. Time of day and week is also a variable, with transport options greatly reducing at nights and weekends. Eligibility also added to confusion, with some services only available for patients who had remained at the health service until they are medically discharged, not taking account of First Nations patients currently walking out for a valid reason such as anxiety/racism. To address this the development of a First Nations Health Services Framework including the following **Key Elements.**

- Transport assistance is recorded on entry to health service at Triage 'Do you have safe transport home', this information is communicated to the Aboriginal Health Unit to give AHC staff optimal time to organise a transport plan for the patient.
- Eligibility for transport is not impacted by how far the First Nations patient got to, before exiting the emergency care journey (triage, waiting, treatment, discharge), in consideration of current levels of cultural safety and First Nations peoples experience of anxiety and fear in Western health systems, or caring responsibilities at home.
- Health Services do not, as protocol discharge First Nations patients at night or on weekends when they do not have a safe transport home plan.

Action: To support First Nations communities to access emergency care, a Loddon Mallee First Nations Health Services Transport Framework needs to be developed.

Mental Health First Nations Cultural Assessments

From this review First Nations involvement in assessment and treatments of First Nations mental health patients in the Loddon Mallee area has minimal involvement of First Nations Health staff. Multiple guidelines (below) state an Aboriginal mental health practitioner / clinician / social worker should participate in assessment and treatment planning to enable culturally informed understanding, decision making and practice.

- National Practice Standards for the Mental Health Workforce 2013
- Australian Psychological Society Guidelines for the Provision of Psychological Services for Australian and Torres Strait Islander People of Australia, 2003.
- Aboriginal Indigenous Psychology Association Framework for Assessment
- Royal Australian and New Zealand College of Psychiatrists' Guidelines: Dance of Life' Matrix

These guidelines state a dual lens, inclusive of cultural understandings is required in areas such as dual diagnosis and cultural / spiritual factors pertinent to mental health assessments for First Nations people.

Action: First Nations mental health workforce and cultural mental health assessments need to be implemented across the Loddon Mallee so First Nations communities can safely access mental health services.

Health Service Standards

Across the Loddon Mallee **health services need to evidence implementation of Department of Health, Aboriginal and Torres Strait Islander Cultural Safety Framework (2019)** for patient care, through periodic service-wide cultural safety audits.

Action: The cultural safety audits need to be linked to health service accreditation.

Action: Staff experiences of racism or lack of cultural safety added to Health Service People Matter surveys, as an option for staff to choose.

Health services need **external monitoring and assessment mechanism regarding health equity**. Hospitals stating 'We treat everyone the same' does not hold the level of clinical professionality required to provide health services appropriate for priority groups who have historically and currently experience racism, and traumatic circumstances when accessing emergency care. There needs to be accountable processes in place for persistent poor outcomes for First Nations patients, considering Closing the Gap Targets 1: **Close the Gap in life expectancy within a generation, by 2031.**

- EDs quality standards and KPI includes equity measurements and audits to include equity measures in reports.
- Link best practice for First Nations communities accessing emergency care to medical accreditation, addressing health profession's 'duty of care' to First Nations peoples.
- Human Resources within Health Services include recruitment / interview questions regarding level of cultural safety education of prospective staff member.
- Cultural safety training, and cultural awareness training about local Aboriginal communities, their culture, languages, land and waterways, and training regarding Aboriginal Community Controlled Organisations, the services they provide, is also part of induction to the health service.

Action: Health services need external monitoring and assessment mechanism regarding health equity.

Mandatory Reporting in Health Services

Mandatory Reporting related to First Nations people, by health service staff within emergency care setting is complex for everyone. However, fear of health professionals not understanding cultural aspects of First

Nations childrearing or seeking consultation within the health services Aboriginal Health Unit can lead to delayed care for First Nations families. The Children Youth and Families Act 2005 states health professionals make a report when they form **a belief** on reasonable grounds that a child needs protection. Definition for 'a belief' for health professionals *(accessed https://providers.dffh.vic.gov.au/mandatory-reporting).*

A belief is a belief on reasonable grounds if a reasonable person, doing the same work, would have formed the same belief on those grounds.

Our beliefs and perceptions of what we think we understand can be so misconstrued, consistently, for all people. We are all seeing the world through our own subjective, cultural understandings.

Considering Closing the Gap target 12; **Aboriginal and Torres Strait Islander children are not overrepresented in the child protection system**. First Nations families should feel confident that when accessing emergency care, they are in a culturally safe space, and cultural knowledge and expertise will be available regarding all aspects of their care.

Action: Endorsement and implementation of a Health Service Standard that mandatory reporting about Aboriginal children while families are accessing emergency care must seek cultural expertise from the Aboriginal Health Unit. First Nations cultural expertise must be included in decision making whether a report to child protection is made or a referral to a community service is required.

Dungala Yorta Yorta Country

8. Aboriginal Health Consultant Position

Whether it is a virtual service, a desk, an office or a whole unit, every hospital in the LMR needs an Aboriginal Health Unit (AHU), which is connected to other AHUs across the region. This is an act of sovereignty, of self-determination for First Nations health. Since the early 1980's staff within the AHU have been called **Aboriginal Hospital Liaison Officers (AHLO).** From the both the literature and interviews undertaken inclusive of many AHLO staff, it was discussed the term AHLO is not reflective of the level of cultural expertise, or local Aboriginal community engagement these employees are providing health services. From data collected through this project AHLO are providing (few examples)

- Health Service strategic and policy consultation regarding First Nations health initiatives.
- Leading health service First Nations cultural events
- Facilitating or organising health service all staff training for cultural safety, 'Asking the Identity question', cultural awareness of Aboriginal culture both local Traditional Owner and national,
- Patient transport to hospital, getting home and between hospitals, including metropolitan.
- Community outreach to schools and other organisations.
- First Nations expertise input regarding health service builds / rebuilds.
- Patient cultural care in wards, emergency and waiting areas.
- Patient advocacy to hospital staff and other health professionals.
- Health service First Nations specific programs 'palliative care', Birthing on Country'.
- Health service Reconciliation Action Plans (RAP); development, implementation and review.
- ACCHO partnerships and referrals for Aboriginal patients.

The variety of functions, tasks and skills required for this breadth of work is not represented through the term liaison officer, nor is liaison officer satisfactory for cultural experience or education level held by many AHLO currently. Many AHLO hold many years' experiences working with their local Aboriginal communities, and many hold diploma, bachelor and post graduate qualifications. Different titles were suggested such as Aboriginal navigator, clinician or consultant, with **Aboriginal Health Consultant (AHC)** being used for this report. The title consultant in hospitals recognises specialised expertise of a healthcare professional, who provides advice, guidance, and support to healthcare organisations, and will be used for this report. However, this change would be a VACCHO, LMARG and health service's Aboriginal Governance Groups decision.

Early Engagement of AHC

A unanimous finding was that engaging a AHC needs to be early, some suggesting before the First Nations person even enters the hospital. Through a mobile application or telehealth option the patient connects with their closest, available AHC from home discussing their intent to present to emergency care.

The AHC position provides culturally specific; emotional, health literacy and advocacy support for First Nations patients, their families and communities. AHC are a strong enabler of First Nations patients accessing emergency care because their practice is relationship-based, as Aboriginal people they can shift the power imbalances and reduce the experience of shame for First Nations patients. From this level of expertise, the AHC is more likely to learn all the patient's health symptoms, all the patient's medical history and any urgent matters which may prevent the patient from completing full treatment. At discharge the AHC provides a 'culturally safe link' between the health service and referrals to ACCHOs or other health service.

Actions

- Early AHC engagement, when the patient first walks in 'front of house' to the hospital is vital during triage, assessment, treatment and discharge.
- Upskill AHC to understand clinical language and processes, to be part of the health team in EDs and on clinical rounds to First Nations patients.

- If AHC is not available on site then enable this service to be made available for First Nations people via a telehealth option from another health service.

Access to AHC

Access to AHC needs to be at the beginning of patient journey (on arrival) or early access via telehealth/On call service across region. A fulltime AHC based within the ED team, so they are accessible when First Nations patients present. Literature indicated Aboriginal specific services should be available within 30-60 minutes of presentation. It would also be beneficial to have the AHC hours extended later in the evening and over 7 days to include weekends, as data shows these times hold higher rates of presentations for First Nations communities. The other area discussed was gender-based services, from the cultural privacy aspect of men's and women's business, best practice would include a female and male AHC available, and that male and female nursing staff are also available if requested.

Actions: AHC service at front of house, AHC located in EDs, AHC service extended hours and 7 days per week. AHC male and female available.

Communication of Aboriginal Health Unit Services

Human Resources orientation for new staff needs to include information regarding AHC role, expertise and the process for engaging AHC services. Signage could go up around the hospital articulating benefits of engaging with AHC for staff and visitors. It was also suggested this information could be displayed on health service screen savers as education for staff.

The other communication initiative is to display photos of each AHC working at the health service, so Aboriginal communities know AHC staff available, which mob each AHC comes from, which days they are available and in which hospital department is each AHC primarily located.

AHLOs provide a referral service to divisions across the network, including Aboriginal Maternal and Infant Care, Aged Care, Rehabilitation and Palliative Care Aboriginal Cultural Advisor and referrals to Cultural Healing Services and practitioners.

AHC Standards

Aboriginal Health Consultants and Aboriginal Mental Health staff need their positions to be paid at an **appropriate Award Rate, including a Cultural Workload Allowance**, like other Australian organisations which is up to an extra $8,944 per year. The Award Rate for First Nations staff who are employed in hospitals needs to recognise each staff members level of education and experience. Currently Aboriginal people are working in AHC roles, so they are available for their local communities but receiving a pay rate less than their educational / experience level.

From the findings as a standard AHC also request **regular cultural supervision from more senior staff from AHU,** even if it is offered virtually from an AHU located in a different health service. To be able to de-brief and access Aboriginal specific professional development from a Senior Aboriginal staff member would bring significant benefits for wellbeing and experiences of burnout.

AHC staff also requested health services protocols which position **AHC expertise and decision making, enabling a higher level of self-determination during practice**, especially when patients' safety is a concern, and the AHC must act quickly. Allow AHLOs to get on with their work, if non-Aboriginal staff or management don't understand and require cultural information to learn, then this could be provided at another time.

9. First Nations Emergency Care Workforce

Overall, this research found the need for higher First Nations staff involvement in EDs and UCCs, and for **First Nations expertise to be recognised**, creating a two-way working model between health service staff and the Aboriginal Health Unit. There is also an absence of First Nations representation on health service **Boards and Executive** across the Loddon Mallee.

First Nations staff in Loddon Mallee health services need time together, they time **On Country** for their own healing, in recognition of their work in emergency care for First Nations communities, within Western health systems.

In addition to the **Aboriginal Health Consultant** position the following list and diagram depicts some of the core positions required to create improved outcomes in emergency care for First Nations communities however various other First Nations roles were discussed, including non-clinical and clinical such as:

- **Aboriginal Health Care Coordinator** in ED's, for complex-needs patients providing advocacy, connecting them to other services.
- **Cultural Healing Team (CHT)** provide a culturally responsive service inclusive of traditional healing modalities and bush medicine, especially to support First Nations people with severe mental health illness and psychological distress.
- Health service **First Nations ACCHO – Health Service Clinical Lead** to transition First Nations patients between hospital care and community health care from ACCHOs, also working with District Nursing service outreach care at home.
- **First Nations staff in reception and Ward Clerks**
- **First Nations Volunteers** (Elders & Community members) in waiting areas.
- Urgent need for **First Nations security staff**.
- **First Nations Justice Advocate** in health services to support/be engaged when social issues involving i.e. child protection/mandatory reporting / police occur. To enable health services to practice higher level of cultural safety and not add to unnecessary overrepresentation statistics, in line with Closing the Gap targets.
- **First Nations Navigator** a position in larger health services and moves across the different departments, navigating the continuity of care for First Nations patients.
- **First Nations Culturally Safe Birthing Coordinator to** support Aboriginal patients through their pregnancy and birthing journey while visiting hospital.

Important factors for First Nations workforce are **nights and weekend service required** to address period when highest level of First Nations people leaving before full treatment is complete. There also needs to be strategies to address psychological burden on Aboriginal staff balancing accountability to both hospital and community, to prevent burnout, one initiative suggested is **access to cultural supervision** for all First Nations staff, another suggestion is First Nation staff in hospitals are paid **Cultural Workload Allowance**, like other Australian organisations which is up to an extra $8,944 per year.

Non-Aboriginal staff supervising First Nations workers need First Nations supervision, as they are on their own cultural safety learning journey.

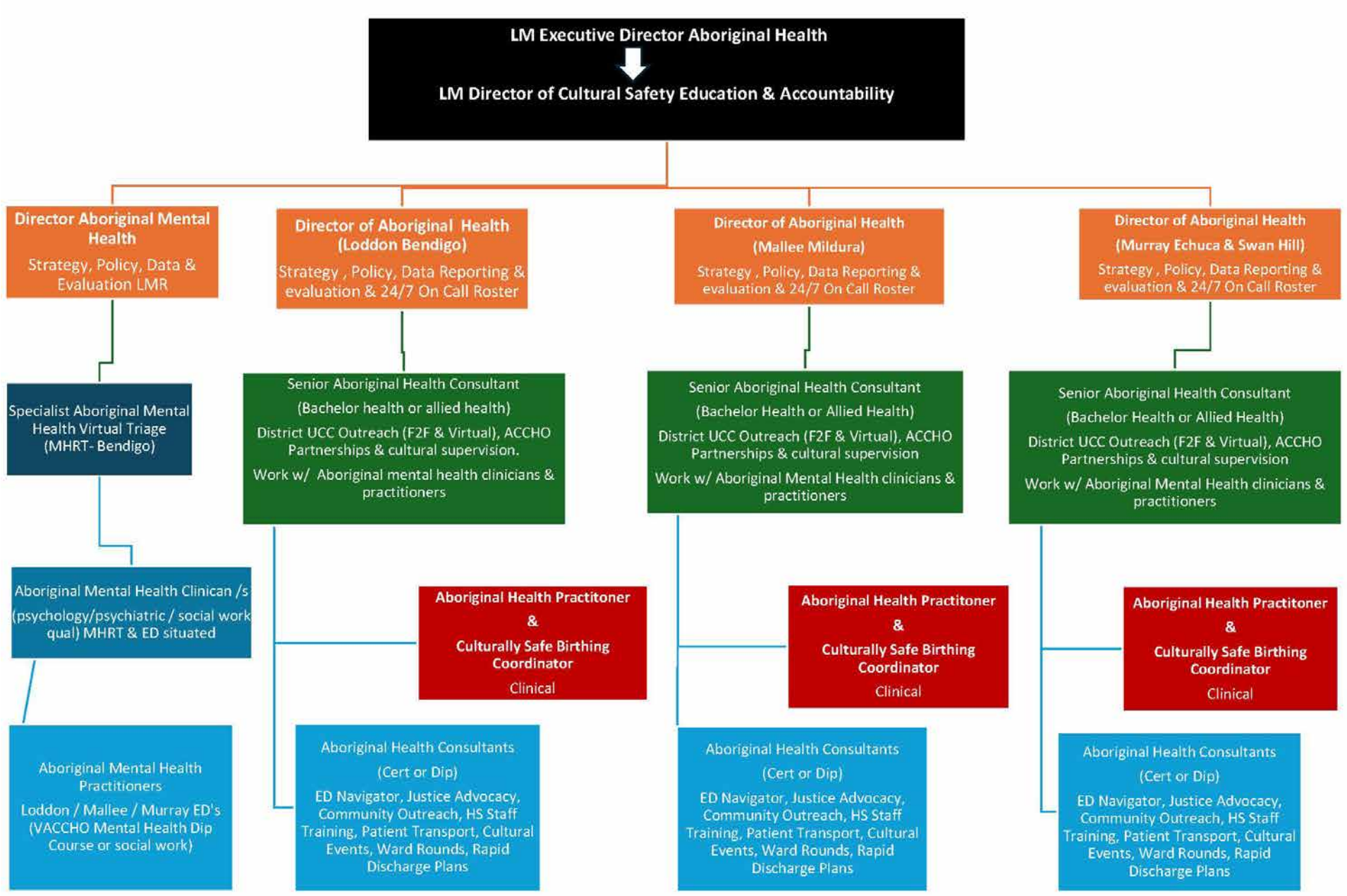
Increased **Aboriginal Health Practitioners** in health services across Loddon Mallee; this position can work as a part of a multidisciplinary team and provide services including screening, assessment, brief intervention, referrals, health education, early detection and intervention for well-being issues. Health

services can support their First Nations staff to complete **Aboriginal Health Practitioners** training at Certificate and Diploma level through VACCHO Education. https://www.vaccho.org.au/learning-hub/courses-aboriginal-health/

An **Aboriginal Health Unit** for Loddon, Mallee and Murray districts within the Loddon Mallee includes Director of Aboriginal Health, reporting to Loddon Mallee Executive Director of Aboriginal Health, then Senior Aboriginal Health Consultants, Aboriginal Health Practitioners, Aboriginal Health Consultants and Aboriginal Mental Health Clinicians / Practitioners, with the capability to provide men's and women's specific service if requested. Across the Loddon Mallee there needs to be a **professional network** for First Nations staff to address isolation.

Sorry Day Sunset Ceremony - Dja Dja Wurrung Country

Figure 10: First Nations Emergency Care Workforce



Action: All First Nations staff in LMR belonging to Aboriginal Health Units need to be connected and involved in peer supervision.

Action: Increase of current workforce/services to 24/24 across 7/7 to meet demand and access. This could be face-to-face or virtual.

Action: Renumeration review of current award rate for all Aboriginal Health Consultants across LMR.

Action: Implementation of Blak Butterfly includes review of First Nations clinical and non-clinical workforce across LMR.

Action: Needs for a **professional network** for First Nations staff to address isolation across the LM.


Yorta Yorta Country

10.Community Engagement for First Nations Health

During interviews across the LMR many participants, Aboriginal and non-Aboriginal, discussed the need for community engagement. There is a discord between local emergency care processes and services available, and the understanding community members hold. There were also conversations regarding racism in the LMR within the general public, and the role hospitals hold in disrupting archaic racist mindsets. Community engagement was also mentioned as a tool for raising the profile of Aboriginal Health Units across the LMR, informing community of the health services available. Finally, rural health services are the hub of rural communities, we experienced this as the research team spent a day at each health service. Innovative thinkers suggested this be leveraged more, use health services for relationship building, reimagine the role of rural health services through increased community engagement.

Areas where increased community engagement could enable improved health outcomes for First Nations communities, and possibly communities in general:

Hospital and Ambulance Processes

- Information sessions in schools and community events regarding triage categories, differences between EDs and UCCs and services available at each hospital either in person or through telehealth options. Handouts are also provided.
- Information sessions in schools and community events regarding **Ambulance Victoria services**; MICA Paramedics, air ambulance and patient transport. Many patients taken to ED/UCC via ambulance think they will be seen quicker because they attend via ambulance. Community education regarding Ambulance Victoria / Emergency triage processes requires clarification.

Anti-Racism Outreach

- Outreach into schools and community organisations celebrating initiatives occurring in the local health service which proudly positions First Nations communities, language and culture.
- Invite general community to attend First Nations events such as NAIDOC on hospitals grounds, begin to repair the Trust Gap for First Nations communities.
- Hold community Truth Telling sessions, listen to stories of past First Nations community members being forced to give birth on hospital verandas, hospitals being used as a place for child removal during Stolen Generations, and deaths associated to acts of racism. Understanding that First Nations children, grandchildren and great grandchildren know these stories as they enter local health services in the LMR.

Aboriginal Health Unit Services

- Outreach into schools and community organisations sharing information regarding Aboriginal Health Units, even if the service is a virtual link up with AHU in larger health service. Develop information regarding the services available through the AHU, and who are the local Aboriginal Health Consultants.
- AHU partners with **District Nursing Services** and **Royal Flying Doctors Service** with home visits and patient transport. In areas of the LMR both services are very active in community however not integrated well with AHU in health services.

Relationship Building

- Hold community consultations between health service staff and community members to learn what the local community would like **their health service to become**. Invite school children and other community organisations to visit health services and participate in art displays, community gardening, alternative therapies, art therapy, de-tox services and bush medicine initiatives on hospital grounds.
- Through relationship building with each local ACCHO, hospitals invite ACCHOs to use available spaces on hospital grounds or buildings for ACCHO services, or Aboriginal cultural healers to provide services. This initiative was discussed for areas where the closest ACCHO was a distance, and health services opened their spaces for ACCHOs to use.
- Create formalised relationships and processes between the governance structures of LMR Health Services, Department of Health, Murray PHN and LMARG.

Action: Increased community engagement:

- Hospital and Ambulance Processes
- Anti-Racism Outreach
- Aboriginal Health Unit Services
- Relationship Building

11.ACCHO – Culture as Health

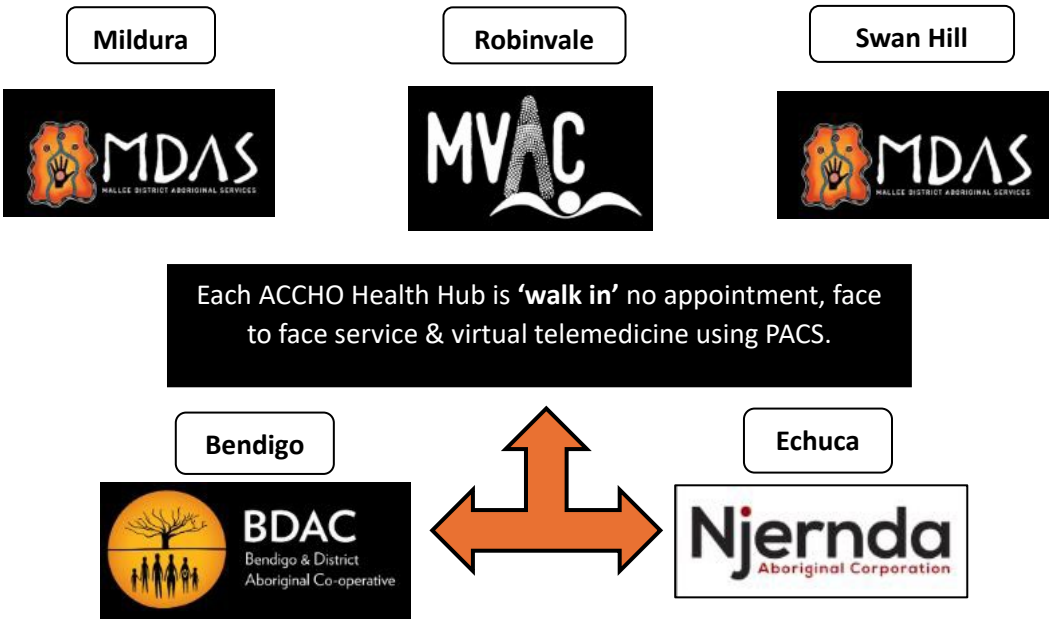
There are currently five Aboriginal Community Controlled Health Organisations (ACCHOs) / Aboriginal Community Controlled Organisations (ACCOs) across the LMR, with MDAS in Mildura, Swan Hill and Kerang, MVAC in Robinvale, BDAC in Bendigo, Njernda in Echuca and and Aldara Yenara located in Kyabram. All these **ACCHOs/ACCOs are Aboriginal spaces, so fit the criteria for Culture as Health**, because First Nations ways of knowing, being and doing are not extracted to become an add on to mainstream health services. As such, First Nations people experience a **high level of cultural stability**, deeply connected to sense of coherence or salutogenesis; **origins of health**. Aspects of culture are outlined in Lowitja Institute's Culture is Key: Towards cultural determinants-driven health policy publication (2020). See below.

Figure 2:
Domains and sub domains for describing culture specific to Aboriginal and Torres Strait Islander peoples in Australia as identified in the Mayi Kuwayu literature review. From We Nurture Our Culture for Our Future, and Our culture Nurtures Us, Close the Gap Campaign 2020, p.1

This research study learnt that **Culture as Health** is one reason why ACCOs are pivotal for emergency care for First Nations communities. The other aspect is the current lack of culturally safety within mainstream health services. As outlined in the cultural safety component previously there are numerous policies and frameworks establishing cultural safety in our hospitals, and from the interviews conducted through this study there are non-Aboriginal health staff willing to learn and develop professional skills in cultural safety. However, some stories heard through this research which resulted in very poor health outcomes for First Nations people, indicates strongly, we are not there yet. So, a **key recommendation of Blak Butterfly is to equip ACCHOs in the LMR to deliver emergency care for non-acute triage category 3,4 and 5 First Nations patients** through walk in appointments, with Aboriginal Health Practitioners (AHP) holding significant roles, in partnership with GP services either in person or virtual.

ACCHO Health Hubs

One innovative solution is for the four ACCHOs in the Loddon Mallee to provide 'walk in' GP services, chronic care and primary health care, to address the use of emergency care presentations triaged at categories 3,4 and 5. ACCHO Health Hub initiative includes AHP, nursing and GP's staff located at each ACCHO, and virtually through telemedicine using Picture Archiving and Communications Systems (PACS) at each ACCHO, or if required linked to a First Nations Virtual Holistic Health (FNVHH) service, and health specialists located in larger hospitals. ACCHO Health Hubs in the Loddon Mallee can also link up virtually so Aboriginal patients can access services from other ACCHOs, if appropriate. Ideal, these ACCHO Health Hubs would be open 6 days per week, 8am – 6pm Monday – Friday, 8am – 1pm Saturday.



First Nations Virtual Holistic Health Service

Virtual GP / Nurse Practitioner Service with Aboriginal Health Practitioners & cultural referrals.

Virtual Specialist Medical Appointments

First Nations people from home or from their ACCHO Health Hub using PACS to attend specialist appointments virtually.

Action: ACCHOs in LMR are equipped to provide walk in GP and specialist appointments, face to face or virtually.

Best practice would be a **system of continuous care** for First Nations patients between ACCHO & emergency care visits. However, this research revealed that very few mainstream Health Service staff understood that ACCHOs hold Medical Clinic's with GP services, creating a break down in continuous care for First Nations patients. Another solution heard through Blak Butterfly interviews is the **Credentialing of ACCHO GPs** to their closest ED or UCC, so ACCHO Doctors hold admitting rights. This solution is already occurring in LMR.

Action: A system where First Nations patients access ED/UCC through **ACCHO Medical Clinic referrals**, linking directly to AHU and Health Service clinical staff.

Considering multiple long standing Closing the Gap Targets, there needs to be a process for **ACCHO exemption** from the **Modified Monash Model (MMM),** so throughout LMR there is coherent and integrated health services for First Nations communities. It seems contrary to restrict some ACCHOs from providing health services to First Nations communities because of their geographic location, when it is well documented that even in cities Aboriginal people experience reduced health outcomes in comparison to non-Aboriginal people.

MMM exemptions would enable all LMR ACCHOs to provide walk in services to reduce preventable presentations to ED's which is a **multilateral outcome** sought by both mainstream health systems and Victorian Aboriginal health sector. It would also enable ACCHOs to provide a 'Culture as Health' walk in service for non-acute medical and mental health presentations, through virtual and face to face initiatives.

Collaboration

Multiple discussions that **ACCHOs need to provide leadership** within existing Health Services, as strong partners in emergency care improvements. This could be implemented through **regular meetings fostering relationships** between ACCHO Medical staff & ED/UCC Management at the local level, or between LMARG and LMHN at the regional level. Health Services need to learn and implement local ACCHO health priorities within local ED & UCCs, and vice versa ACCHOs gain ED and UCC health services data so they can match their services to emergency care needs of their community. Another initiative is **shared workforce** between ACCHO and health services, with processes introduced where interns, GPs and nurses complete **clinical placement at ACCHOs**. **Data Sharing** between ACCHOs and health services was raised as a focus multiple times, so effective and efficient continuous health care is provided for First Nations communities. Lastly ACCHOs could implement community-based education and **awareness-raising** on ED and UCC services and processes so First Nations people are better equipped to navigate mainstream health systems.

ACCHO GP Services

Again, contrary to Closing the Gap targets ACCHOs are navigating to high cost of locum GP's. Best practice would include ACCHO medical clinics becoming a priority for registrar doctors completing their training. The Federal Government **Pre-Fellowship Program (PFP)** launched 2024 requires effective co-ordination through Rural Workforce Agency Victoria to enable more doctors to take up this opportunity within an Aboriginal Medical Service (AMS) or Aboriginal Community-Controlled Health Service. **Both of AMS and ACCHOs are listed as eligible practices for the PFP.** The incentive of PFP is to give medical clinics the opportunity to recruit from a pool of previously unavailable doctors. Findings also discussed **housing** for GPs working at ACCHOs, needs to be addressed within any programs.

Action: Medical clinics within ACCHOs in the LMR access more GPs through PFP.

Another area raised, significant to addressing preventable presentations to EDs and UCC is time allowed for GP visits in ACCHO medical clinics. Medicare currently funds GP appointments to be 6 -15 minutes long, meaning a doctor is required to see approximately 6 patients per hour, which is not practicing culturally safe. ACCHOs are needing to cover this funding gap when a doctor practices from a more holistic, relationship-based practice, which has been evidence to enable the best health outcomes for First Nations people. Best practice would include **Medicare recognising cultural safety as a priority and fund Aboriginal patients' standard consultations as 30-40 minutes** rather than the average 10 minutes. Findings suggested especially for a First Nations patients initial visit, patients with chronic conditions or mental health history. Federal Government and Department of Health, Victoria saves funds through increasing preventable presentations to ED and UCC, initiatives which increase ACCHOs medical clinics presentations, services which meet Culture as Health standards, need to be enabled.

Action: ACCHO Medical Clinic standard GP consultation time is increased to enable Doctors to practice cultural safety standards with First Nations patients.

ACCHO Home Services

First Nations Round Table Discussions:
"We are living in a different world post the referendum. The referendum has given mainstream the nod to treat us like we don't exist again and it's affecting the anxiety levels of our people".

ACCHO staff discussed how there is an increase in the presentation of anxiety within First Nations communities, people are struggling to leave their homes and attend appointments due to poor mental health, post national Referendum and Covid-19. This context is delaying engagement with health care. ACCHO staff expressed they need to now reinstate **ACCHO GP home visit**, as a health service. GP Home Visits addresses the increase in poor mental health but also assists parents, patients with chronic illnesses and our Elders. A solution stated across the LMR was for a **ACCHO Medical Bus**, providing GP medical care in homes, to homeless, transient, people struggling with social and emotional wellbeing, people with chronic illnesses and our Elders. This service would also be like an **ACCHO Community Nursing** service for First Nations patients discharged from hospital. ACCHO Home Services would also need to be equipped to provide telemedicine services.

Action: Further research conducted to understand the impact of Covid and the National Referendum for First Nation communities accessing health services.

Action: Implement ACCHO Health Home Services, integrated with local Health Service discharge and referrals.

12.First Nations Emergency Care Mental Health Process

Through the Royal Commission into Victoria's Mental Health System (RCVMHS) First Nations communities improved access to **low acuity mental health** services is positioned, enabling First Nations communities improved access to social and emotional wellbeing services within ACCHOs. Blak Butterfly project listened to stories connected to **high acuity First Nations mental health patients** not receiving culturally informed clinical assessment and management by health services, which at times resulted in devastating outcomes for First Nations patients. Principles of practice in mental health assessment with Aboriginal Australians (Adams, Drew & Walker, 2014, pg. 278), outline **Culturally Appropriate Assessments** include:

- First Nations client's worldview and their understanding of mental health issues
- Understanding of First Nations client's family background
- First Nations cultural explanations of illness for the individual
- First Nations client–Clinical Practitioner relationship dynamics, reflecting an understanding of practitioner's positioning related to power and privilege.

A Culturally Appropriate Assessment (Adams, Drew & Walker, 2014, pg. 281) also includes a First Nations culturally informed Mental State Examination, see diagram below.

Appearance	Understand the person's 'usual' standard of self-care and appearance. Identify any changes that may indicate a mental health issue. Consider cultural influences and manifestations such as grief.
Behaviour	Have a good understanding of Aboriginal culture as it relates to a person's behaviour. Behaviours can be culture-specific.
Affect	Affect can take on cultural forms as not all human emotions are universal. Anxiety and depression for example, may be difficult to diagnose as the manifestation of these conditions could be vastly different to that of other people.
Mood	An Aboriginal person's mood may not be expressed in the same way as a non-Aboriginal person. Language may not have meaning for Aboriginal people and may need to be translated into meaningful terms.
Speech and thought form	Thought disorders may be difficult to detect if the client does not have good English. The clinician would then need to rely on the services of an AMHW.
Thought Content	Aboriginal spirituality may display as delusional or otherwise cultural. The clinician needs to ascertain whether the primary symptoms pre-date the culturally based retrospective attributions.
Perception	These may be pathologically or culturally based. It is advisable to seek advice from the AMHW. Auditory hallucinations are less commonly sited and may be indicative of a mental disorder.
Cognition	Assessing cognition is difficult due to the lack of culturally appropriate assessment tools— assessments of function and activities of daily living are not appropriate in remote communities where living in collective in nature. It is not uncommon for families to seek help as a last resort.

These frameworks plus the *National Practice Standards for the Mental Health Workforce 2013*, *Provision of Psychological Services for, and the Conduct of, Psychological Research with Australian and Torres Strait Islander People of Australia, 2003*, *Aboriginal Indigenous Psychology Association Framework for Assessment* and the Royal Australian and New Zealand College of Psychiatrists' Guidelines *The Dance of Life*' matrix all indicate the necessity for **system reform regarding standards of practice in assessment for First Nations people.**

Action: Mental Health ECATT triage, assessment and referral frameworks, policies and procedures are reviewed and updated to ensure they align to National Frameworks regarding First Nations mental health assessments, creating systemic change and reform.

To enable Culturally Appropriate Assessment for First Nations patients presenting with high acuity mental health conditions, the above mental health practice guides state **Aboriginal mental health clinicians need to be present during assessment and treatment** to enable Culturally Appropriate Assessments. To support this increased need in clinical First Nations workforce, the ABS data (Census, 2021) indicates that 11.4% of the Victorian Aboriginal and Torres Strait Islander population has a bachelor's degree or above.

Action: Aboriginal mental health clinicians to participate in assessment and treatment of high acuity First Nations mental health patients.

A key area presented through the findings was misinterpretation of **First Nations spirituality**. First Nations patients who could have been treated culturally, through holistic services were escalated to involuntary admission to Adult Acute Unit. An **Aboriginal mental health clinician** could have learnt if Sorry Business, connection to Ancestors, responsibility to Country or community were impacting the patient's presentation. Treatment plans inclusive of Aboriginal mental health clinicians' input could be unchanged, slightly altered or re triaged and referred to an ACCHO social and emotional wellbeing team for intervention.

Blak Butterfly revealed a **gap in service** for all LMR patients, but again stories of devasting outcomes for First Nations people. First Nations patients presenting to Bendigo ECATT with Dual Diagnosis (Mental Health & AOD) are at times discharged in line with clinical protocols, however they are still at risk of harm. The Royal Commission into Victoria's Mental Health System's recommended **Emergency Department mental health, alcohol and other drugs hubs**, which enables fast tracked specialist care, where patients can access 'short stay' during a crisis. Bendigo Health ECATT Mental Health services cover a large geographic region where all acute mental health patients are transferred to Bendigo Health, including Murray River areas with high Aboriginal community populations. Despite this, they were not successful in obtaining for funding for an ED Mental Health & AOD Hubs, see https://www.vhba.vic.gov.au/mental-health/hospital-based-care/emergency-department-mental-health-alcohol-and-other-drugs-hubs. Therefore, Blak Butterfly advocates:

Action: Bendigo Health is successful in obtaining funding for ED Mental Health & AOD Hubs, for the safety of First Nations people experiencing mental health / AOD crisis, and who have possibly been transported hundreds of kilometres to Bendigo Health for treatment.

The following best practice solution isn't prohibited if there is alcohol or drug use, understanding First Nations patients may use substance to self-deescalate their condition or to overcome anxiety associated to accessing mental health services because of past experiences of racism. The principle of '**Care on Country'** is prioritised.

First Nations Mental Health workforce includes **Aboriginal Mental Health Consultants** who have completed VACCHO Diploma or Cert IV Mental Health courses, and **Aboriginal Mental Health Clinical Consultants** who have completed undergraduate psychology, nursing, psychiatry or social work courses.

This model introduces **Specialist First Nations Mental Health Triage Service** provided virtually through **Bendigo Health Mental Health Regional Triage Service (MHRT)**. For this speciality service staff are trained in cultural safety, anti-racism, cultural awareness, especially First Nations modalities of cultural healing, spirituality, cultural experiences of psychosis & use of substance to self-regulate due to both their mental health and experiences of racism.

First Nations patient may be 'On Country' at home, their local UCC / ED or at their ACCHO. The Specialist First Nations Mental Health triage service will be staffed by a First Nations person /s with suitable mental

health qualifications. This service will triage acute cases, arranging 24/7 transport to Adult Acute Unit (AAU) (Bendigo) if required in partnership with Aboriginal Mental Health staff in regional EDs. If patient doesn't require Code A acute care, then a referral to Aboriginal Mental Health Clinical Consultant for virtual or face-to-face assessment in Bendigo, Echuca, Swan Hill or Mildura EDs to occur.

Action: Introduction of **Specialist First Nations Mental Health Triage Service** provided virtually through **Bendigo Health Mental Health Regional Triage Service (MHRT)**.

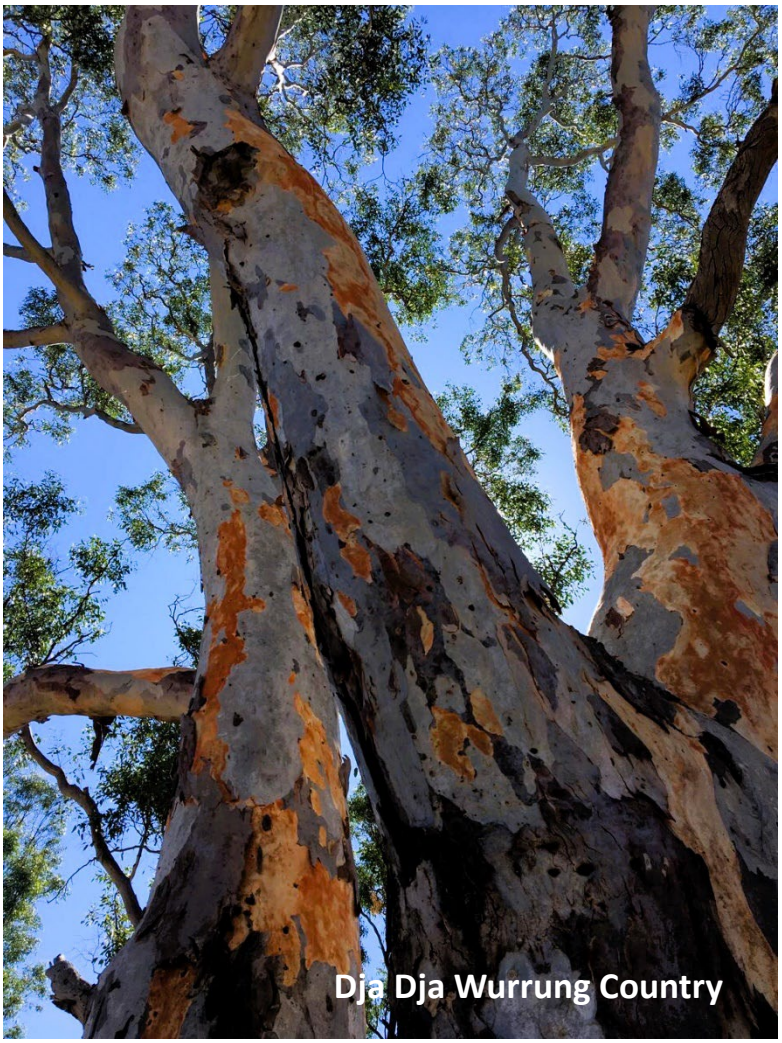
Aboriginal Mental Health Clinical Consultant in partnership with Aboriginal Mental Health Consultants will organise referral to local ACCHO Social Emotional Wellbeing service or other health service. If First Nations patient assessed as low acuity mental health and requires overnight 'short stay' with counselling before discharge with referral plan, then this is organised. If required Aboriginal Mental Health Clinicians can also refer to local detox service, followed by culturally appropriate local rehabilitation service.

The following model uses State-wide mental health triage scale Guidelines (2010):

AMHCC- Aboriginal Mental Health Clinical Consultant (located MHRT & ED)

AMHC – Aboriginal Mental Health Consultant (located Health Service)

ACCHO SEWB – Aboriginal Community Controlled Health Organisation, Social Emotional Wellbeing Service.



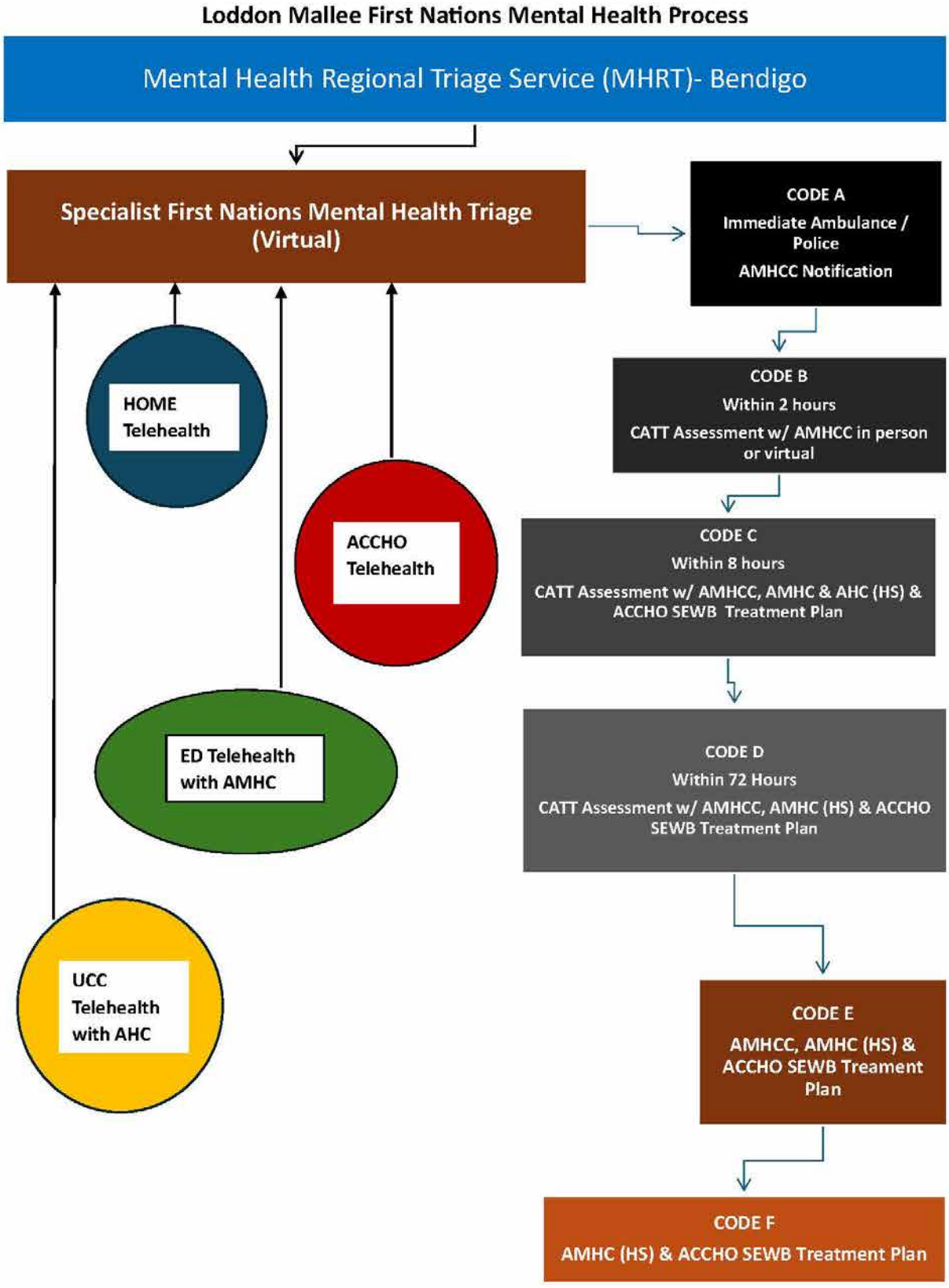


Figure 11: Loddon Mallee First Nations Mental Health Process

13.First Nations Safe Transport Home

Across the Loddon Mallee for First Nations community's patient transport is currently ad hoc and confusing. It can range from taxi vouchers, Royal Flying Doctors transport service, community transport options such as Sunassist Volunteer Helpers in Mildura or no transport options. Time of day and week is also a variable, with transport options greatly reducing at nights and weekends. Eligibility also added to confusion, with some services only available for patients who remained at the health service until they are medically discharged, not taking account of First Nations patients currently walking out for a valid reason such as anxiety, racism and urgent caring duties at home.

From interviews this research team learnt that in the LMR due to lack of safe transport home services First Nations people leave hospital prior to being treated, to catch the last public transport available or catch a ride with someone who can take them home.
AHU staff stated during interviews, they need a safe transport service, there are currently people with chronic conditions, Elders and pregnant women using public buses travelling long distances, between hospitals in the LMR.

The current push towards placing people on public transport to attend appointments which require long distances of traveling is not always a safe option for numerous reasons including increase Covid, the patients' health and possibly their immune systems being at high risk due to cancer treatments and also due to concerns related to their mental health.

Across the LMR health services there needs to be **safe transport protocols,** so it is clearly understood by all staff and there is no excuse for not providing safe transport. These protocols need to consider the number of First Nations patients which live in NSW in border towns along the Murray River.

Two points to consider related to transport is the number of First Nations patients who are provided an impromptu telehealth appointment due to transport options not being available, but these patients do not have the equipment or knowledge to attend the telehealth appointment. If a telehealth service is provided as an alternative, due to transport issues, there needs to be support accessing these online appointments, and assistance explaining medical terminology during the appointment. The second issue is when non-Aboriginal women are pregnant, having Aboriginal babies, and they are told they are not eligible for transport through Aboriginal health services. This challenge is complex, however as many health policies focus on safe outcomes for the child, it is recommended safe transport to hospital and home is provided.

Key Elements:

- Transport assistance is recorded on entry to health service at Triage 'Do you have safe transport home', this information is electronically shared with the Aboriginal Health Unit to give AHC staff optimal time to organise a transport plan for the patient.
- Eligibility for transport is not impacted by how far the First Nations patient got to, before exiting the emergency care journey (triage, waiting, treatment, discharge), in consideration of current levels of cultural safety and First Nations peoples experience of anxiety and fear in Western health systems, or caring responsibilities at home.
- Health Services do not, as protocol discharge First Nations patients at night or on weekends when they do not have a safe transport home plan.

Action: To support First Nations communities to access emergency care, **a Loddon Mallee First Nations Safe Transport Protocols** needs to be developed.

14.First Nations Holistic Cultural Care

First Nations patients presenting to ED's and UCC's in the LMR hold the human right to access Cultural Healing services during health assessments and treatment, in line with **United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) Article 24**

Indigenous peoples have the right to their traditional medicines and to maintain their health practices.

Aboriginal and Torres Strait Islander Healing Programs (McKendrick, Brooks, Hudson, Thorpe & Bennett, 2017) explains First Nations people hold different views of health and illness to Western medicine. Aboriginal people around Australia are diverse culturally and linguistically, however there are also strong similarities in concepts associated to modalities of healing. Each person is seen to exist in a relational world of interrelationships, with other people, with the environment (land, animals, plants, waterways, skies, seasons) and with the unseen spirit world and our Ancestors. Cultural healing methods is both traditional healing in some areas of Australia and blended healing modalities in other areas, meaning a combination of traditional healing, cultural practices and techniques drawn from Western and Eastern complementary therapies such as massage, meditation and narrative (McKendrick, et al. 2017, pg. 23).

The Hand in Hand: Report on Aboriginal Traditional Medicine (Panzironi, 2013) presents evidence that hospitals including First Nations cultural healing services builds community trust, fosters Aboriginal patients access to emergency care, increases cost effectiveness in the provision of health care, provides holistic two-way health care model, delivers culturally appropriate health care and reduces incidence of misdiagnosis.

Emergency Recovery Victoria: **Strategy for Aboriginal Community-led Recovery** (2023) stipulates the importance of Victorian Aboriginal communities recovering, accessing and leading cultural healing practices. This strategy positions Traditional Owner Groups and Aboriginal Community Controlled Organisations leadership for this recovery process.

Blak Butterfly findings were **unanimous**, the research team discussed cultural healing with Aboriginal Health Unit staff, emergency care staff, hospital management or ACCHO staff, **everyone agreed to First**

Nations patients accessing cultural healing services. Some health services responded so positive that they were ready to allocate space in their hospital immediately for such a service.

Further cultural consideration is also needed regarding how to best manage **First Nations women's and men's business** during emergency care, **First Nations peoples the fear of dying off Country**, the significance of being **in buildings where loved ones have passed**, or **children have been removed** and when **community lateral violence** exists between individuals.

Cultural as Health is a strengths-based approach, acknowledging culture as a strong protective factor. A continued connection to culture creates resilient individuals within their collective identities, builds self-esteem and pride in their identity.

Action: Traditional Owner Groups and ACCHOs lead discussions regarding 'what are recognised modalities of cultural healing' in LMG, with the aim of creating a LMR Cultural Healing Protocol for health services.
Action: LMR Health Services make available traditional healers, traditional healing practice or blended healing practices, adhering to the above protocol.
Action: Posters letting patients know that First Nations cultural healing and traditional medicines are respected and can be included in their care.

Holistic cultural care also includes important aspects for **nursing, medical and allied health clinical practice**. Prioritising that cultural care is addressed, is core business during emergency care. First Nations patients and patients from other cultural backgrounds may

1. Leave health service without being treated
2. Not completely explain their medical history, or current medication
3. Experience emergency care as a traumatic event.

Holistic cultural care includes value-based conversations, working together, social emergency care, patient centred care, trauma informed care and slow track.

- Engaging in **value-based conversation** which builds rapport with patients, families and carers, where they feel listened to and there is shared decision making to help build health literacy, and empower patients, families and carers engagement and decision making.
- The balance of **working together** bringing Aboriginal ways of knowing, being and doing alongside Western health practice.
- **Social emergency care**, delivering emergency medicine, but also responding to the social and cultural determinants of health. Enabling social factors such as housing status inform triage category, treatment and referrals.
- Promoting **patient-centred care** by using communication to explore the patients' and relatives' rationale for wanting to leave, wanting to do things a bit differently, better understanding a patient holistic needs and responsibilities, communicating compassion through body language.
- Clinical practice underpinned by **trauma informed care**, including empathy and patient agency or self-determination during care.
- Understanding the benefits of **slow track** for patients with complex needs, allowing longer consultation time for relationship building, multidisciplinary assessments including allied health, justice and transport.

Holistic cultural care understands that health outcomes are significantly improved when First Nations patients **experience clinicians as humans**, instead of clinical degree of separation historically encouraged. Holistic cultural care is more **effective and efficient** even though it may involve more time and resources in

the first instance, in the long term, it saves health funds because a patient is less likely to return to emergency care multiple times trying to resolve their health concerns. As data currently indicates.
Action: Health services emergency care introduce relationship-based 'slow track' service, staffed by an interdisciplinary team of clinicians, nurse practitioners, and social workers, to address the **root causes** of some patients' primary health care needs.
Action: First Nations patients without ACCHO or family support flagged as possibly requiring extra support, and insecure housing seen as criteria for more urgent triage category.

Pain & Substance Use Alert
An area of uncertainty in emergency care from both the literature and interviews involved First Nations pain care and substance use. For patients **perceived to be at risk of misusing medications**, or under the **influence of other substances** increased the chances that decisions were influenced by stereotypes based on ethno- cultural identity.
Blak Butterfly heard stories of First Nations patients being left in pain from medical staff perceived beliefs, **without blood alcohol testing** and **without clinical observations** completed. Instead, First Nations patients are left to sober up first.
Clinical practice in health services needs to address patients' concerns of **dismissal or diminishment of their health issues** because of how they are "read" by medical staff, unconscious bias needs to be addressed. Even if alcohol use is present, clinical observations and pain management is still required.

Action: Clear protocols within clinical practice ensuring First Nations pain management or use of substances, is not impacted by bias opinion or actions.

15.Loddon Mallee First Nations Virtual Care

The number one value for virtual health care for First Nations communities, is **Care on County**. When First Nations communities receive health and mental health services while remaining with their local mob, on Country or the Country which has become their home, the findings discussed multiple benefits for First Nations communities. They are in proximity to aspects of nature whether it's the bush, the river or the local park which they connect with for healing. They are also close to their support networks and cultural healing modalities, with their family, friends and community.

This framework has outlined various components of virtual care which will be summarised.

1. **Electronic Medical Record (EMR)-Integrated Software for Automated Discharge Referrals for First Nations patients whose GP service is located at an Aboriginal Community Controlled Health Organisations (ACCHO) medical clinic**. Mapping patient data from the EMR, such as demographics, medical history, discharge summaries, and care plans, for the provision of continuous care at ACCHO Medical Clinic, following discharge.

   EMR Integrated Software automatically triggers

   A. Referral process based on predefined criteria, - 1. patient identified as Aboriginal or Torres Strait Islander, 2. Patient GP service is located at an ACCHO Medical Clinic.
   B. Notifications to both the discharging health service, the ACCHO and health service Aboriginal Health Unit, confirming the referral and providing details for follow-up.
   C. Facilitates coordination between health service administration, health Service Aboriginal Health Unit and the ACCHO to schedule follow-up appointments, arrange transportation if necessary, and ensure the patient understands the next steps in their care plan.

   Reporting

   • Allows healthcare providers to track the status of referrals and receive updates on patient follow-up care.

   • Collects data on patient outcomes, readmission rates, and other key metrics to evaluate the effectiveness of the referral process.

   • Provides tools for generating reports and insights to help healthcare providers and policymakers improve the system and address any gaps in care.

2. One innovation creates **continuous care** for First Nations communities a **mobile app that connects First Nations people with the Loddon Mallee Integrated Aboriginal Health system (either in person or virtually)**. Through this mobile app an individual can find their closest Aboriginal Health Consultant (AHC) located in either an ED or UCC. They connect with their AHC to notify their plan to present to the health service, the AHC involvement is either in person or virtual. Also, through this Mobile app patient can alert Aboriginal Health Consultant if they need to leave health service early and receive a **Rapid Discharge Plan**.

Action: Development of the First Nations Integrated Loddon Mallee Aboriginal Health system and supporting mobile app.

3. An Aboriginal staff **Community of Practice** initiative enables AHC who may be isolated to have **regular cultural supervision** from a senior Aboriginal Health Unit (AHU) staff member, offered virtually from an AHU located in a different health service. This initiative would also connect AHC from health services across the Loddon Mallee region to debrief, network and learn about applicable resources.

Action: Establish Loddon Mallee Aboriginal Health Unit's virtual Community of Practice.

4. The **ACCHO Health Hub** initiative enables walk in appointments for Aboriginal patients who are triaged non-critical categories 3, 4 and 5 through a **First Nations Virtual Holistic Health** service. The staff at ACCHO health hubs include Aboriginal Health Practitioners (AHP), nursing and GP's. Aboriginal people either see a health practitioner in person or using PACS, are **linked virtually to health professionals** located in larger hospitals. ACCHO Health Hubs can also link up virtually between each other, so Aboriginal patients can also access services from other ACCHOs, if appropriate.

Action: Establish a **First Nations Virtual Holistic Health** service for triaging Aboriginal and Torres Strait Islander patients in the Loddon Mallee.

Action: ACCHOs in Loddon Mallee hold PACS, and other required resources and staff training to provide ACCHO Health Hub services.

Action First Nations Virtual Care Medicare Item Number, considering the reduction of Emergency presentations this initiative will result in.

5. This model introduces **Specialist First Nations Mental Health Triage Service** provided virtually through **Bendigo Health Mental Health Regional Triage Service (MHRT)**. For this speciality service staff trained in cultural safety, anti-racism, cultural awareness, especially First Nations modalities of cultural healing, cultural experiences of psychosis & use of substance to self-regulate due to both their mental health and experiences of racism.

   First Nations patient may be 'On Country' at home, their local UCC / ED or at their ACCHO. The Specialist First Nations Mental Health triage service will be staffed by a First Nations person /s with suitable psychology/psychiatric qualifications. This service will triage acute cases, arranging 24/7 transport to Adult Acute Unit (AAU) (Bendigo) if required in partnership with Aboriginal Mental Health staff in regional EDs. If patient doesn't require Code A acute care, then a referral to First Nations Mental Health Clinicians virtually or Face to face assessment in Bendigo, Echuca, Swan Hill and Mildura ED's to occur.

Action: Within MHRT develop **Specialist First Nations Mental Health Triage Service** which services the Loddon Mallee region, as a First Nations specific service addressing multiple nationally professional frameworks such as APA Cultural Formulation Interview standards for First Nations people.

Thank you for reviewing components and actions of Blak Butterfly, and progressing implementation across LMR health services.

References

Adams, Yolonda & Drew, Neil & Walker, Roz. (2014). Principles of Practice in Mental Health Assessment with Aboriginal Australians.

Antonovsky A. (1996). The salutogenic model as a theory to guide health promotion. Health Promotion International. 11: 11–18 https://doi.org/10.1093/heapro/11.1.11

Arabena, K., Somerville, E., Penny, L., Dashwood, R., Bloxsome, S., Warrior, K., Pratt, K., Lankin, M., Kenny, K. & Rahman, A. (2020). *Traumatology Talks – Black Wounds, White Stitches*. Karabena Publishing: Melbourne.

Atkinson, P., Baird, M., & Adams, K. (2023). Intersectionality Based Policy Analysis of How Racism is Framed in Medical Education Policies Guiding Aboriginal Health Curriculum. Vol. 4, 2, Article 4. https://doi.org/10.14221/aihjournal.v4n2.4

Australasian College for Emergency Medicine. (2015). *Statement on culturally competent care and cultural safety in emergency medicine*. Document S63. V2.

Australasian College for Emergency Medicine (2020). *Indigenous Health Liaison Workers and Language Interpreters in Australian Emergency Departments*. Position statement.

Australasian College for Emergency Medicine (2023). *Annual Site Census 2022 Report – Part 1: Emergency Department Staffing*. ACEM Report: Melbourne.

Australasian College for Emergency Medicine. (2018). *Aboriginal and Torres Strait Islander and non-Indigenous Presentations to Australian Emergency Departments – AIHW ED Presentation 2014-2015*. ACEM Report: Melbourne.

Australasian College for Emergency Medicine. (2021). *Rural Health Action Plan.*

Australasian College for Emergency Medicine. (2022). *Australasian College for Emergency Medicine Innovate Reconciliation Action Plan May 2022-April 2024.*

Australasian College for Emergency Medicine. (2022). *He Ara Tiatia ki te Taumata o Pae Ora Manaaki Mana Pathways to Achieving Excellence in Emergency Care for Māori.*

Australasian College for Emergency Medicine. (2022). *Te Tiriti o Waitangi me Te Rautaki Manaaki Mana.*

Barnabe C. (2021). *Towards Attainment of Indigenous Health through Empowerment: Resetting Health Systems, Services and Provider Approaches.* BMJ Global Health, 6. https://doi.org/10.1136/

Barnes, D., Phillips, G., Mason, T., & Hutton J. (2022). *Working towards equity: An example of an emergency department project for Aboriginal and Torres Strait Islander health and cultural safety.* Emergency Medicine Australasia, 34, 644–647. https://doi.org/10.1111/1742-6723.14003

Bateman., Arnold-Chamney., Jesudason., Lester., McDonald., O'Donnell., Owen., Pearson., Sinclair., Stevenson., Williamson & Kelly. (2002). *Real Ways of Working Together: Co-creating Meaningful Aboriginal community Consultations to Advance Kidney Care*. Australian and New Zealand Journal of Public Health, vol. 46, 5. https://doi.org/10.1111/1753-6405.13280

Benz C, Bull T, Mittelmark M, Vaandrager L. (2014). Culture in salutogenesis: the scholarship of Aaron Antonovsky. Global Health Promotion. 21(4):16-23. http://dx.doi.org/10.1177/1757975914528550

Biles, K. (2022). Racism: The Age-old Elephant We Need to Start Acknowledging in Every Room. *Emergency Medicine Australasia*, 34, 112-113. https://doi.org/10.1111/1742-6723.13915

Bnads., Orr & Clements. (2021). Improving the Service to Aboriginal and Torres Strait Islanders through Innovative Practices Between Aboriginal Hospital Liaison Officers and Social Workers in Hospitals in Victoria, Australia. British Journal of Social Work, 51, 77–95. https://doi.org/10.1093/bjsw/bcaa03

Bourke, Truong, Jones, Hunyor & Lawton. (2020). *Addressing racism to improve healthcare outcomes for Aboriginal and Torres Strait Islander people: a case study in kidney care*. Deeble Institute for Health Policy research. No.9 date: 01/05/2020

Bovill, Chamberlain, Bennett, Longbottom, Bacon, Field, Hussein, Berwick, Gould & O'Mara. (2021). *Building an Indigenous-Led Evidence Base for Smoking Cessation Care among Aboriginal and Torres Strait Islander Women during Pregnancy and Beyond: Research Protocol for the Which Way? Project*. International Journal Environmental Research. Public Health, 18. https://doi.org/10.3390/ijerph18031342

Boyer JD. (2017). Healing Racism in Canadian Health Care. CMAJ, 189: E1408-9. https://doi.org/10.1503/cmaj.171234

Boyle, J., Hollands, G., Beck, S., Hampel, G., Wapau, H., Arnot, M., Browne, L., Teede J.H., & Moran, L.J. (2017). *Process evaluation of a pilot evidence-based Polycystic Ovary Syndrome clinic in the Torres Strait*. Australian Journal of Rural Health, 25, 175-181. https://doi.org/10.1111/ajr.12288

Browne, A.J., Smye, V.L., Rodney, P., Tang, S.Y., Mussell, B., & O'Neil, J. (2011). *Access to Primary Care From the Perspective of Aboriginal Patients at an Urban Emergency Department*. Qualitative Health Research, 21(3), 333-348. https://dOI.org/10.1177/1049732310385824

Brumpton, K., Ward, R., Evans, R., Neill, H., Woodall, H., McArthur, L., & Sen Gupta, T. (2023). *Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study*. BMC Medical Education 23:306. https://doi.org/10.1186/s12909-023-04249-6

Bruno, G., Bell, R.C., Parlee, B., Lightning, P., Bull, I., Cutknife, B., & Oster, R.T. (2022). *Mâmawihitowin (bringing the camps together): Perinatal healthcare provider and staff participation in an Indigenous- led experiential intervention for enhancing culturally informed care—a mixed methods study.* International Journal for Equity in Health 21:164 https://doi.org/10.1186/s12939-022-01764-8

Carey, T.A., Arundell, M., Schouten, K., Humphreys, J.S., Miegel, F., Murphy, S., & Wakerman, J. (2017). *Reducing hospital admissions in remote Australia through the establishment of a palliative and chronic disease respite facility.* BMC Palliative Care, 16:54. https://doi.org/10.1186/s12904-017-0247-3

Chapman, R., Martin, C., Smith, T. (2014). *Evaluation of staff cultural awareness before and after attending cultural awareness training in an Australian emergency department*. International Emergency Nursing 22 179–18.

Chapman, Smith & Martin. (2014). *Qualitative exploration of the perceived barriers and enablers to Aboriginal and Torres Strait Islander people accessing healthcare through one Victorian Emergency Department.* Contemporary Nurse, 48:1, 48-58, https://doi.org/10.1080/10376178.2014.11081926

Clinical Excellence Commission & NSW Centre for Aboriginal Health (2020). *Diagnostic Report: Understanding contributing factors for Take-Own-Leave in NSW Health organisations*. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0010/583741/Take-Own-Leave-Diagnostic-Report-May-2020.pdf

Copeland, S., Muir, J., & Turner, A. (2017). *Understanding Indigenous patient attendance: A qualitative study*. Australian Journal Rural Health 25, 268–274. https://doi.org/10.1111/ajr.12348

Commonwealth of Australia (2024) Framework for Governance of Indigenous Data. Framework for Governance of Indigenous Data (niaa.gov.au)

Cresp, R., Clarke, K., McAuley, K.E., McAullay, D., Moylan, C.A., Peter, S., Chaney, G.Ml., Cook, A., Edmond, K.M. (2016). *Effectiveness of the Koorliny Moort Out-of-Hospital health care program for Aboriginal and Torres Strait Islander children in Western Australia*. MJA 204 (5). https://doi.org/10.5694/mja15.00827

Crocetti AC, Cubillo (Larrakia) B, Lock (Ngiyampaa) M. (2022). *The commercial determinants of Indigenous health and well-being: a systematic scoping review*. BMJ Global Health, 7, e010366. https://doi.org/10.1136/bmjgh-2022-010366

Dell, E.M., Firestone, M., Smylie, J., & Vaillancourt, S. (2016). *Cultural Safety and Providing Care to Aboriginal patients in the Emergency Department.* CJEM, 18(4):301-305. https://doi.org/10.1017/cem.2015.100

Dingwell, K.M., Povey, J., Sweet, M., Friel, J., Shand, F., Titov, N., Wormer, J., Mirza, T., & Nagel, T. (2023*). Feasibility and Acceptability of the Aboriginal and Islander Mental Health Initiative for Youth App: Nonrandomized Pilot With First Nations Young People*. JMIR HUMAN FACTORS vol. 10. https://doi.org/10.2196/40111

Diplock, G., Ward, J., Stewart, S., Schuffham, P., Stewart, P., Reeve, C., Davidson, L., & Maguire, G. (2017). *The Alice Springs Hospital Readmission Prevention Project (ASHRAPP): a randomised control trial*. BMC Health Services Research, 17:153. https://doi.org/10.1186/s12913-017-2077-7

Dossetor, P.J., Fitzpatrick, E.F.M, Glass, K., Douglas, K., Watkins, R., Oscar, J., Carter, M., Harley, D., Jeffery, H.E., Elliott, E.J., Martiniuk, A.L.C. (2021). *Emergency Department Presentations by Children in Remote Australia: A Population-based Study*. Global Paediatric Health, 8 1-11. https://doi.org/:10.1177/2333794X21991006

Duggan M, Harris B, Chislett WK & Calder R. (2020). *Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments*. Mitchell Institute Commissioned report, Victoria University.

Duncan, C., Williams, K., Nathanson, D., Thomas, S., Cottier, C., O'Meara, M., & Zwi, K. (2013). *Emergency department presentations by Aboriginal children: Issues for consideration for appropriate health services*. Journal of Paediatrics and Child Health 49. https://doi.org/10.1111/jpc.12225

Emergency Recovery Victoria. (2023). Strategy for Aboriginal Community-led Recovery. Victorian Government.

Fatima Y, Hays R, Neilson A, Knight S, Jatrana S. (2022). *Why patients attend emergency department for primary care type problems: views of healthcare providers working in a remote community.* Rural and Remote Health, 22, 7054. https://doi.org/10.22605/RRH7054

Gadsden, T., Wilson, G., Totterdell, J., Willis, J., Gupta, A., Chong, A., Clarke, A., Winters, M., Donahue, K., Posenelli, S., Maher, L., Stewart, K., Gardiner, H., Passmore, E., Chasmore, A., & Milat, A. (2019). *Can a continuous quality improvement program create culturally safe emergency departments for Aboriginal people in Australia? A multiple baseline study.* BMC Health Services Research 19:222, https://doi.org/10.1186/s12913-019-4049-6

Good Design + Health (2024) https://content.vic.gov.au/sites/default/files/2022-10/OVGA-Good-Design_Health.pdf

Haynes, M., O'Rourke, T., Nash, D., Baffour, B., York, S., Chainey, Ca., Betros, G., & Memmott. P. (2020). *Aboriginal and Torres Strait Islander preferences for health care settings: effective use of design images in survey research*. Australian Health Review, 44, 222-227. https://doi.org/10.1071/AH18196

Hutton, J., Gunatillake, T., Barnes, D., Phillips, G., Maplesden, J., Chan, A., Shanahan, P., Zordan, R., Sundararajan, V., Arabena, K., Quigley, A., Pynor-Greedy, T., & Mason, T. (2023). *Characteristics of First Nations patients who take their own leave from an inner-city emergency department,2016–2020*. Emergency Medicine Australasia, 35. 74-81. https://doi.org/10.1111/1742-6723.14057

Jacinta Kim Elston, Vicki Saunders, Barbara Hayes, Roxanne Bainbridge & Brian Mccoy (2013) *Building Indigenous Australian research capacity*. Contemporary Nurse, 46:1, 6-12. https://doi.org/10.5172/conu.2013.46.1.6

Jameel, A., Penny, L., & Arabena, K. (2023). *Closing the miscommunication gap: A user guide to developing picture-based communication tools for Aboriginal and Torres Strait Islander peoples in emergency departments*. Emergency Medicine Australasia, 35, 873-875. https://doi.org/10.1111/1742-6723.14274

Johnson, R., & Withers, M. (2018). *Cultural competence in the emergency department: Clinicians as cultural learners*. Emergency Medicine Australasia, 30, 854-856. https://doi.org/10.1111/1742-6723.13197

Laverty, M, McDermott, D.R., & Calma, T. (2017). *Embedding cultural safety in Australia's main health care standards*. MJA, 207, (1). https://doi.org/10.5694/mja17.00328

Lim, J. CJ., Harrison, G., Raos, M., & Moore, K. (2021). *Characteristics of Aboriginal and Torres Strait Islander peoples attending Australian emergency departments.* Emergency Medicine Australasia, 33, 672-678. https://doi.org/10.1111/1742-6723.13701

Lowitja Institute 2020, Culture is Key: Towards cultural determinants-driven health policy – Final Report, Lowitja Institute, Melbourne. DOI: 10.48455/k9vd-zp46

McKendrick, Brooks, Hudson, Thorpe & Bennett. (2017). Aboriginal and Torres Strait Islander Healing Programs: A Literature Review. Healing Foundation.

Northern Adelaide Local Health Network (2021). *Aboriginal Health Framework and Action Plan 2021-2026.* Access https://www.sahealth.sa.gov.au/wps/wcm/connect/93ca5703-e0f9-4c4c-8f1f-53129c9d883d/NALHN01+Action+Plan+Web.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-93ca5703-e0f9-4c4c-8f1f-53129c9d883d-nQCVVsr

Panzironi, F. (2013). *Hand in Hand: Report on Aboriginal Traditional Medicine*. Anangu Ngangkari Tjutaku Aboriginal Corporation.

Preisz, P., & Preisz, A. (2020). *Supporting black lives 'mattering' with flexible health care*. Journal of Paediatrics and Child Health, 56, 1848-1850. https://doi.org/10.1111/jpc.15128

Quilty, S., Wood, L., Scrimegeour, S., Shannon, G., Sherman, E., Lake, B., Budd., R., Lawton, P., & Moloney, M. (2019). *Addressing Profound Disadvantages to Improve Indigenous Health and Reduce Hospitalisation: A Collaborative Community Program in Remote Northern Territory*. International Journal of Environmental research and public health, 16. https://doi.org/10.3390/ijerph16224306

Rahman MA, Huda MN, Somerville E, Penny L, Dashwood R, Bloxsome S, Warrior K, Pratt K, Lankin M, Kenny K, Arabena K. (2023). *Understanding experiences of Aboriginal and/or Torres Strait Islander patients at the emergency departments in Australia*. Emergency Medicine Australasia, 35(4):595-599. https://doi.org/10.1111/1742-6723.14172

Tekin, Corcoran, Gutiérrez. (2023). A Systematic Review and Conceptual Framework of Biophilic Design Parameters in Clinical Environments. *HERD.16(1):233-250*. doi: https://10.1177/19375867221118675

Yamane, S. & Helm, S. (2022). Indigenous Culture-as-Health: A Systematized Literature Review. Journal of Prevention. 43(2):167-190. https://doi.org/10.1007/s10935-022-00666-3

APPENDICES

Appendix A - TABLE OF ACTIONS

Component	Action
1. First Nations Emergency Care Governance	1. The different levels of First Nations Governance communicate collaboratively, despite the Western competitive model which strongly encourages funding opportunities of which different First Nations health organisations must competitively apply for. 2. First Nations data governance and sovereignty is monitored and evaluated within the LMR to create processes for the optimal health outcomes for First Nations communities. 3. To align to the Framework for Governance of Indigenous Data.
2. Health Services Staff Cultural Safety & Anti-Racism Education	1. LMR and HS implement a **change management approach** to introducing Cultural Safety and Anti-racism Education addressing potential resistance from staff to undertaking the training. 2. HS **action** AHPRA definition of Cultural Safety acknowledging it is the work of individuals developing a critical consciousness and understanding of themselves. 3. All health service staff and agency/temp staff have **ongoing Cultural Safety Education built into their key responsibilities** and are **tracked / supported** using the DoH Cultural Safety Continuum Domain 1: Creating a culturally safe workplace and organisation (individual level). To support a common foundation for learning all staff are to start at an **unaware level** due to the level of racism that exists in HS and the lack of existing Cultural Safety Education offered. **Accountability** for this is to be held through **current HS accountability systems.** 4. HS develop and embed **key accountability processes** including policies, documentation and mitigation strategies to enable a systematic approach to reporting and addressing racism incidents. 5. Health care staff and agency/temp staff are **supported** to build their Anti-Racism skill sets, enabling the detection and elimination of racism in all its forms from services. 6. Creation of LMR Cultural Safety dashboard to **track progress** to strengthen accountability. This will include if HS choose not to support individuals to access Cultural Safety Education and use AHPRAs definition they need to state this up front in their RAPs, Cultural safety plans etc. 7. All HS **add racism** as a component to their People Matters survey 8. All HS develop and implement **racism policies** to hold accountability to racism.

	9. All health service staff are supported in understanding and connecting to the Aboriginal Health Sector in culturally safe ways. 10. **AHPRA states to ensure culturally safe and respectful practice, health practitioners must**: - acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health. - acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide health care that is holistic, free of bias and racism. - understand cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. - understand culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. (AHPRA - Aboriginal and Torres Strait Islander Health Strategy (2022-2025).
3. First Nations Culturally Safe Building Designs	1. Future builds and rebuild to ensure First Nations leadership is sort from health services and community. 2. The publication Good Design + Health (2024) from the Office of the Victorian Government Architect, including biophilic design principles are considered when designing building designs. 3. Ensure First Nations Culturally Safe Building designs are considered in all builds and rebuilds.
4. First Nations Triage Design & Process	1. Expediate the care of First Nations patients through triage system, as long waiting times is significantly linked to First Nations patients leaving emergency care without being seen. 2. Identity status as Aboriginal or Torres Strait Islander is stored in health service digital system enabling referrals to other hospital departments. Identifying as Aboriginal or Torres Strait Islander prompts the next Triage question, do you wish to be linked with Aboriginal health services within the hospital. Answering 'yes' triggers digital referral to Aboriginal Health unit. 3. Independent audits undertaken to include 'asking the identification question' as an ongoing continuous quality improvement process. 4. Triage administration clerks trained in and understand the clinical benefits of kindness and human centred professionality, specific for working in crisis environments.

	5. Process for First Nations people, either connected to Aboriginal health unit staff or a specific nurse at triage, for regular check ins. 6. Offer "slow track," staffed by an interdisciplinary team of clinicians, nurse practitioners, and social workers, to better address the root causes of some patients' primary care needs, for health and social conditions. 7. Innovative triage process enables First Nations people who attend ED or UCC multiple times receive continuity of care across multiple visits.
5. First Nations Continuous Care (including Discharge)	1. Holistic discharge planning commences at admission. 2. On discharge at end of care discharge summary provided to the patient and sent to their preferred primary health service provider. First Nations discharge checklist is completed. 3. AHC given a key role in supporting First Nations community to navigate the health system. 4. ACCM is implemented as a duty of care. 5. Development of the First Nations Integrated Loddon Mallee Aboriginal Health system and supporting mobile app. 6. No First Nations person can be discharged without safe transport home, this is also duty of care. 7. The AHC and discharge nurses implement the **First Nations patients safe transport home plan**. 8. First Nations patients are either: - fully discharged on completion of treatment with necessary referrals to their ACCHO medical clinic, primary health care or GP, or - leave with RDP; or - with an RDP inclusive of alternative arrangements for receiving health care or returning to the ED or UCC at a later time.
6. First Nations Integrated Health Services	1. All health services in the LMR are equipped with electronic health record systems that can communicate with referral stakeholders such as GP's and ACCHO medical clinics. 2. Health services learn what ACCHO or ACCO are in their area, and what health services do they provide for First Nations communities.
7. Systems Accountability to First Nations Communities	1. Loddon Mallee Anti-Racism Policy implemented in each Health Service inclusive of process of reporting and Anti-racism signage in health service. 2. Continue improving the cultural safety within Loddon Mallee health services for staff, patients and broader communities. 3. Enable an MMM exemption for Loddon Mallee ACCHOs Bendigo & District Aboriginal Co-operative, Njernda Aboriginal Corporation, Murray Valley Aboriginal

	Cooperative, Mallee District Aboriginal Services and Aldara Yenara Aboriginal Corporation, so if each ACCHO / ACCO chooses, they can offer walk in medical appointments, and any other health resource required to enable preventable presentations to EDs. 4. To support First Nations communities to access emergency care, a Loddon Mallee First Nations Health Services Transport Framework needs to be developed. 5. First Nations mental health workforce and cultural mental health assessments need to be implemented across the LMR so First Nations communities can safely access mental health services. 6. The cultural safety audits need to be linked to health service accreditation. 7. Staff experiences of racism or lack of cultural safety added to Health Service People Matter surveys, as an option for staff to choose. 8. Health services need external monitoring and assessment mechanism regarding health equity. 9. Endorsement and implementation of a Health Service Standard that mandatory reporting about Aboriginal children while families are accessing emergency care must seek cultural expertise from the Aboriginal Health Unit. First Nations cultural expertise must be included in decision making whether a report to child protection is made or a referral to a community service is required.
8. Aboriginal Health Consultant Position	1. Early AHC engagement, when the patient first walks in 'front of house' to the hospital is vital during triage, assessment, treatment and discharge. 2. Upskill AHC to understand clinical language and processes, to be part of the health team in EDs and on clinical rounds to First Nations patients. 3. If AHC is not available on site then enable this service to be made available for First Nations people via a telehealth option from another health service. 4. AHC service at front of house, AHC located in EDs, AHC service extended hours and 7 days per week. AHC male and female available.
9. First Nations Emergency Care Workforce	1. All First Nations staff in LMR belonging to Aboriginal Health Units need to be connected and involved in peer supervision. 2. Increase of current workforce/services to 24/24 across 7/7 to meet demand and access. This could be face to face or virtual. 3. Renumeration review of current award rate for all Aboriginal Health Consultants across LMR. 4. Implementation of Blak Butterfly includes review of First Nations clinical and non-clinical workforce across LMR.

	5. Needs for a **professional network** for First Nations staff to address isolation across the LMR.
10. Community Engagement for First Nations Health	1. Increased community engagement: - Hospital and Ambulance Processes - Anti-Racism Outreach - Aboriginal Health Unit Services - Relationship Building
11. ACCHO – Culture as Health	1. ACCHOs in LMR are equipped to provide walk in GP and specialist appointments, face to face or virtually. 2. A system where First Nations patients access ED/UCC through **ACCHO Medical Clinic referrals**, linking directly to AHU and Health Service clinical staff. 3. Medical clinics within ACCHOs in the LMR access more GPs through PFP. 4. ACCHO Medical Clinic standard GP consultation time is increased to enable Doctors to practice cultural safety standards with First Nations patients. 5. Further research conducted to understand the impact of Covid-19 and the National Referendum for First Nation communities accessing health services. 6. Implement ACCHO Health Home Services, integrated with local Health Service discharge and referrals.
12. First Nations Emergency Care Mental Health Process	1. Mental Health ECATT triage, assessment and referral frameworks, policies and procedures are reviewed and updated to ensure they align to National Frameworks regarding First Nations mental health assessments, creating systemic change and reform. 2. Aboriginal mental health clinicians to participate in assessment and treatment of high acuity First Nations mental health patients. 3. Bendigo Health is successful in obtaining funding for ED Mental Health & AOD Hubs, for the safety of First Nations people experiencing mental health / AOD crisis, and who have possibly been transported hundreds of kilometres to Bendigo Health for treatment. 4. Introduction of **Specialist First Nations Mental Health Triage Service** provided virtually through **Bendigo Health Mental Health Regional Triage Service (MHRT)**.
13. First Nations Safe Transport Home	1. To support First Nations communities to access emergency care, **a Loddon Mallee First Nations Safe Transport Protocols** needs to be developed.
14. First Nations Holistic Cultural Care	1. Traditional Owner Groups and ACCHOs lead discussions regarding 'what are recognised modalities of cultural healing' in LMR, with the aim of creating a LMR Cultural Healing Protocol for health services.

	2. LMR Health Services make available traditional healers, traditional healing practice or blended healing practices, adhering to the above protocol. 3. Posters letting patients know that First Nations cultural healing and traditional medicines are respected and can be included in their care. 4. Health services emergency care introduce relationship-based 'slow track' service, staffed by an interdisciplinary team of clinicians, nurse practitioners, and social workers, to address the **root causes** of some patients' primary health care needs. 5. First Nations patients without ACCHO or family support flagged as possibly requiring extra support, and insecure housing seen as criteria for more urgent triage category. 6. Clear protocols within clinical practice ensuring First Nations pain management or use of substances, is not impacted by bias opinion or actions.
15. Loddon Mallee First Nations Virtual Care	1. Development of the First Nations Integrated Loddon Mallee Aboriginal Health system and supporting mobile app. 2. Establish Loddon Mallee Aboriginal Health Unit's virtual Community of Practice. 3. Establish a **First Nations Virtual Holistic Health** service for triaging Aboriginal and Torres Strait Islander patients in the Loddon Mallee. 4. ACCHOs in Loddon Mallee hold PACS, and other required resources and staff training to provide ACCHO Health Hub services. 5. First Nations Virtual Care Medicare Item Number, considering the reduction of ED presentations this initiative will result in. 6. Within MHRT develop **Specialist First Nations Mental Health Triage Service** which services the LMR, as a First Nations specific service addressing multiple nationally professional frameworks such as APA Cultural Formulation Interview standards for First Nations people.

Appendix B – EMERGENCY DEPARTMENT DATA SUMMARY

There are four health services in the Loddon Mallee Health Network (LMHN) that have an Emergency Department (ED) and twelve health services that have an urgent care centre (UCC). Each of the four health services with EDs employ Aboriginal Hospital Liaison Officers (AHLOs) with between 2.2 and 3.6 full-time equivalent (FTE) staffing. Three UCCs also employ AHLOs, with FTE ranging from 0.1 to 1FTE.

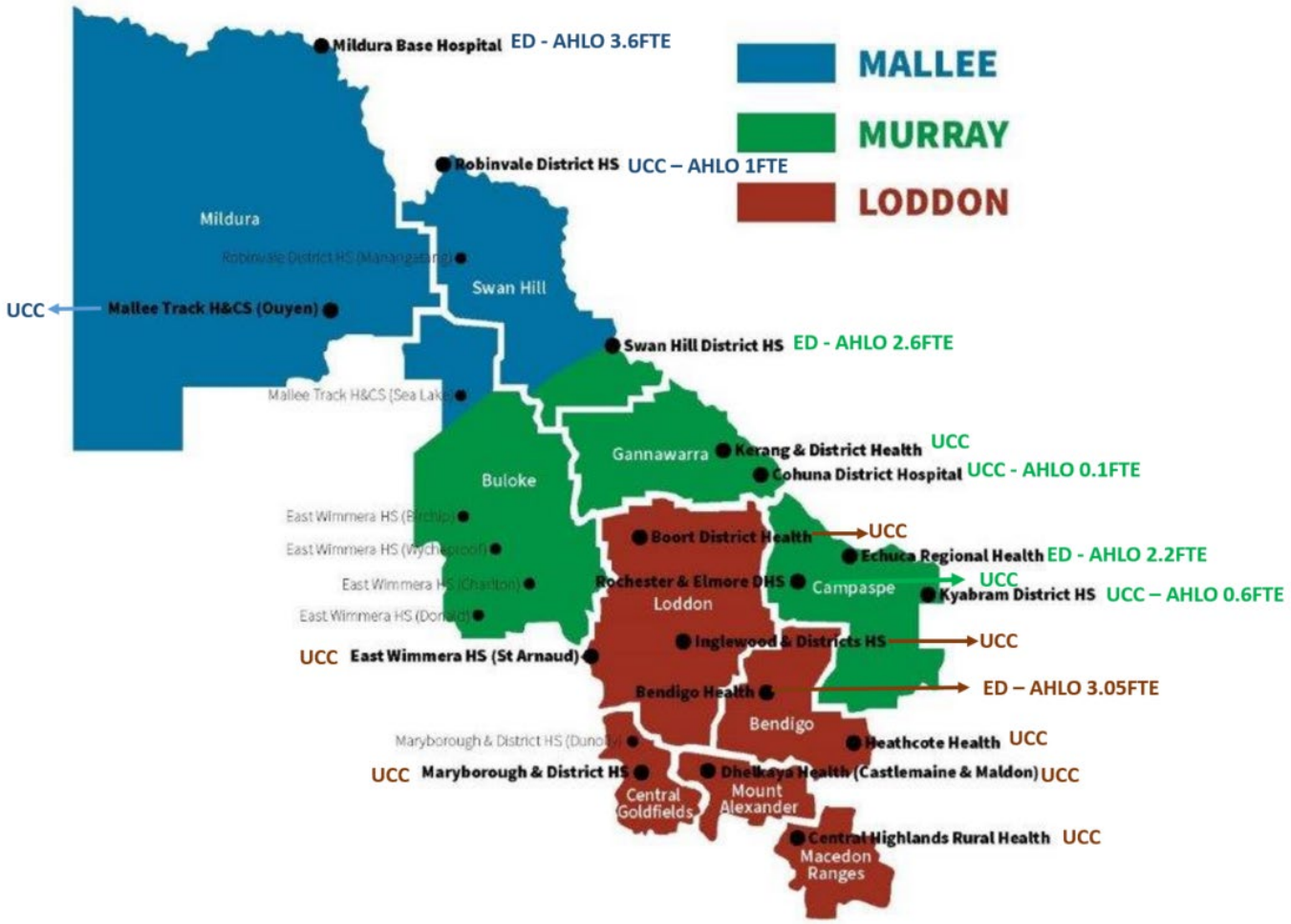


Figure 1 Emergency department and urgent care centres with AHLO FTE

The four health services with EDs provided data for the period July 2023- May 2024. The data reporting: 1] the total number of presentations to the ED; 2] total number of those presenting to EDs who identified as being Aboriginal and/or Torres Islander people; and 3] their triage category is presented in the tables below. Data from UCCs is not available in a consistent format and is only available in hard copy format in some centres therefore could not be included in the analysis.

The percentage of people who left the ED without being seen (recorded in the data as 'Left at own risk' or 'Did not wait to be seen') for the total presentations and for those who identified as being Aboriginal and/or Torres Islander people, and their triage category is presented in the graphs below.

The age and gender of all Aboriginal and/or Torres Islander people who presented to the ED in that time period is also provided in the graph form.

Bendigo Health emergency department data

Number of presentations		
Data Point	**Total**	**Identified as Aboriginal &/or Torres Strait Islander**
ED Presentations	55,333	3,030
Cat 1	917	52
Cat 2	11,085	545
Cat 3	21,527	1,214
Cat 4	17,230	954
Cat 5	4,572	265

Table 1 Bendigo Health total number of presentations by triage category

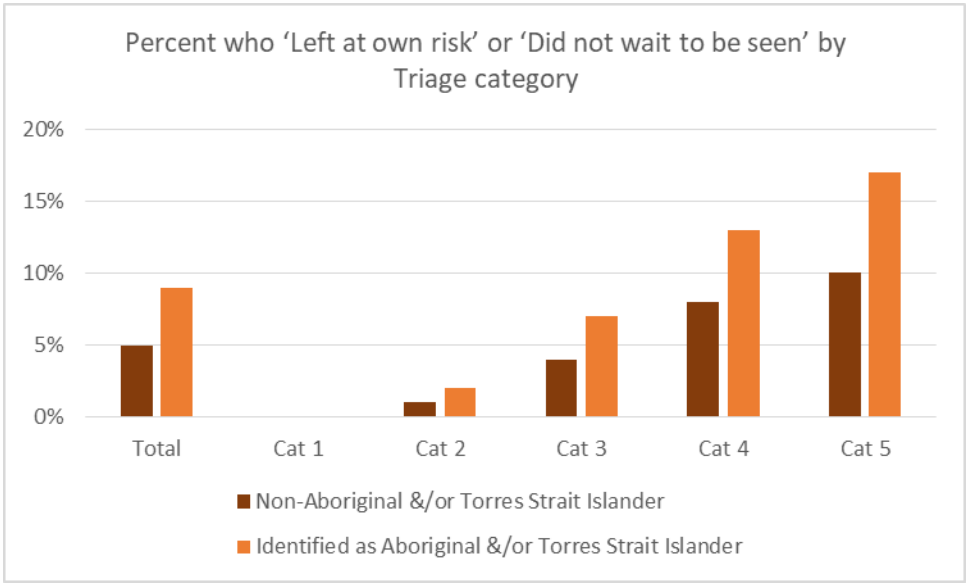


Figure 2 Bendigo Health percent who left without being seen

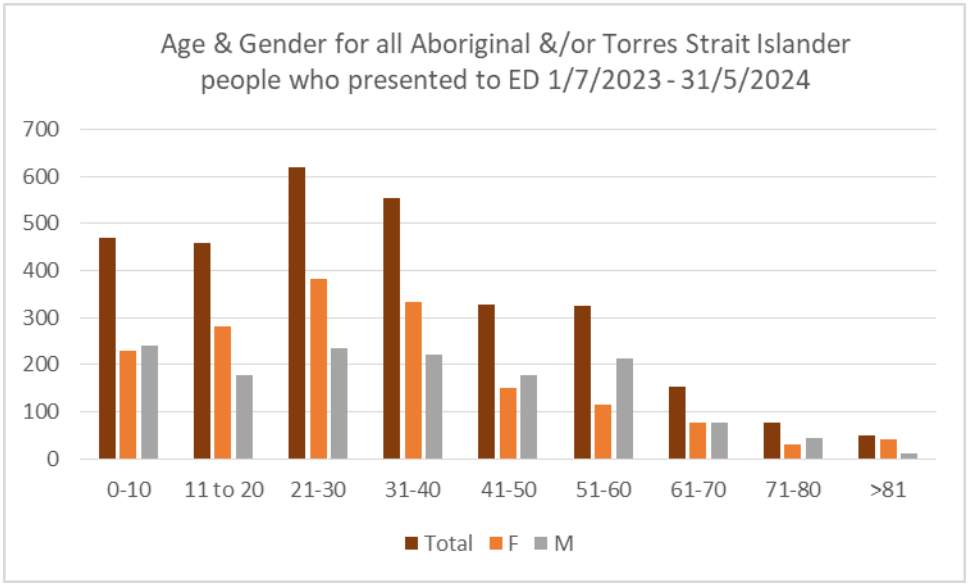


Figure 3 Bendigo Health age and gender of all Aboriginal and/or Torres Islander people who presented to the emergency department

Echuca Regional Health emergency department data

Number of presentations

Data Point	Total	Identified as Aboriginal &/or Torres Strait Islander
ED Presentations	26,405	1,484
Cat 1	39	6
Cat 2	2,647	166
Cat 3	7,848	437
Cat 4	13,079	731
Cat 5	2,792	144

Table 2 Echuca Regional Health total number of presentations by triage category

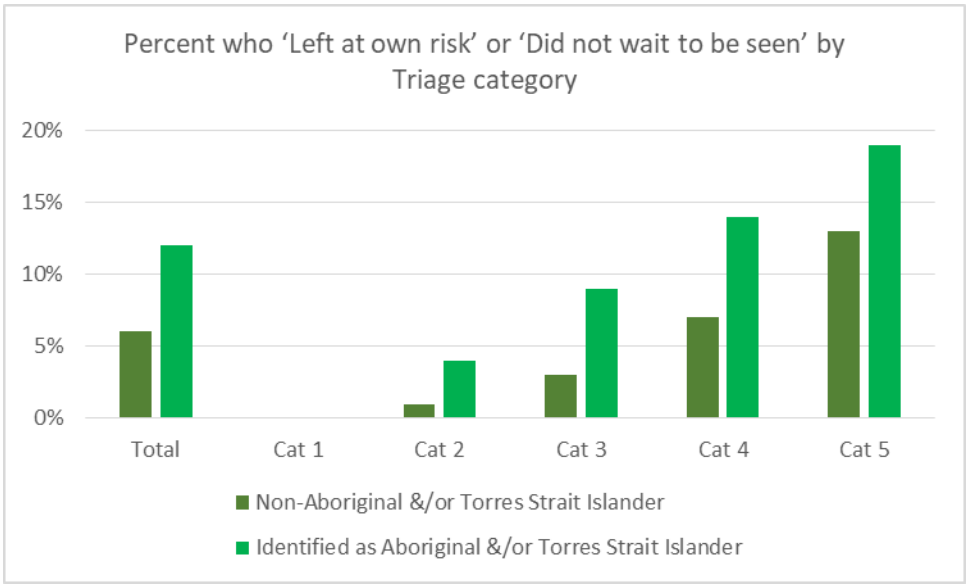


Figure 4 Echuca Regional Health percent who left without being seen

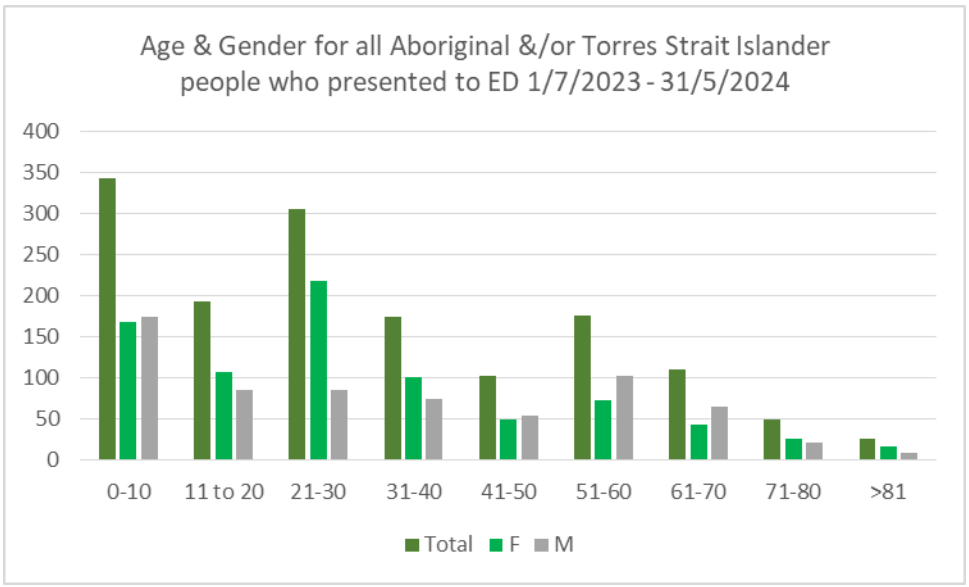


Figure 5 Echuca Regional Health age and gender of all Aboriginal and/or Torres Islander people who presented to the emergency department

Mildura Base Public Hospital emergency department data

Number of presentations

Data Point	Total	Identified as Aboriginal &/or Torres Strait Islander
ED Presentations	30,049	3,435
Cat 1	170	15
Cat 2	3,909	441
Cat 3	11,663	1,326
Cat 4	12,790	1,488
Cat 5	1,485	163

Table 3 Mildura Base Public Hospital total number of presentations by triage category

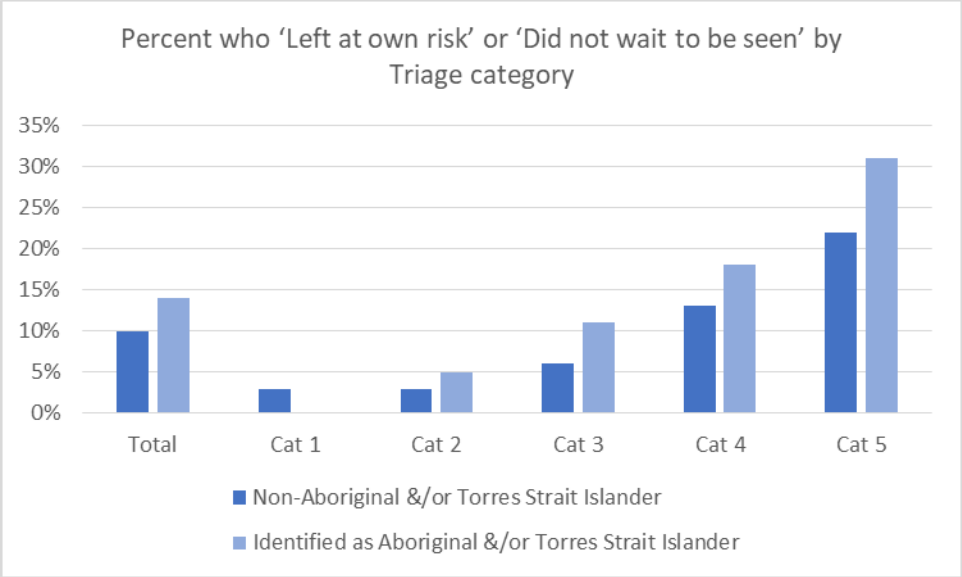


Figure 6 Mildura Base Public Hospital percent who left without being seen

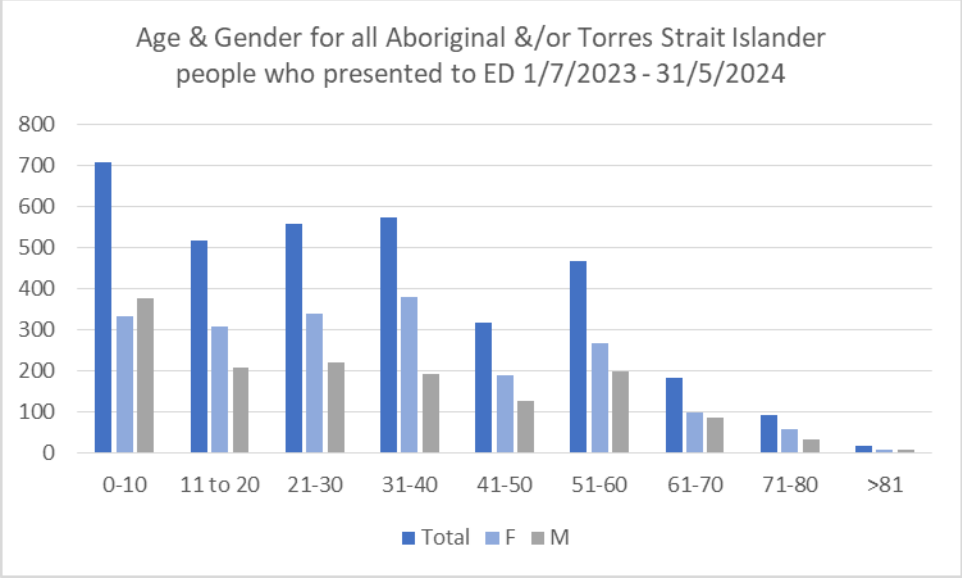


Figure 7 Mildura Base Public Hospital age and gender of all Aboriginal and/or Torres Islander people who presented to the emergency department

Swan Hill District Health emergency department data

Number of presentations		
Data Point	**Total**	**Identified as Aboriginal &/or Torres Strait Islander**

ED Presentations	15,148	1,189
Cat 1	54	1
Cat 2	2,148	179
Cat 3	4,525	381
Cat 4	6,035	458
Cat 5	2,386	170

Table 4 Swan Hill District Health total number of presentations by triage category

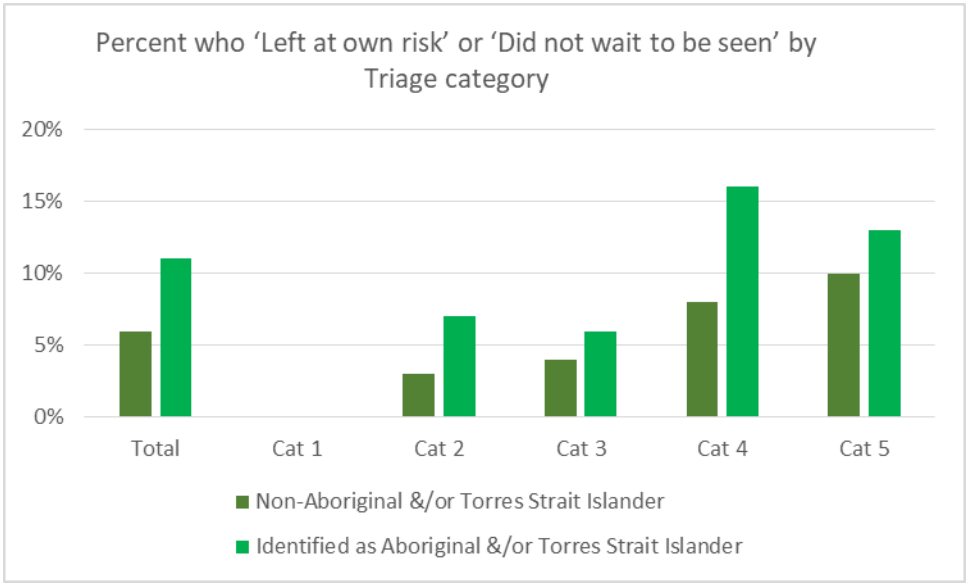


Figure 8 Swan Hill District Health percent who left without being seen

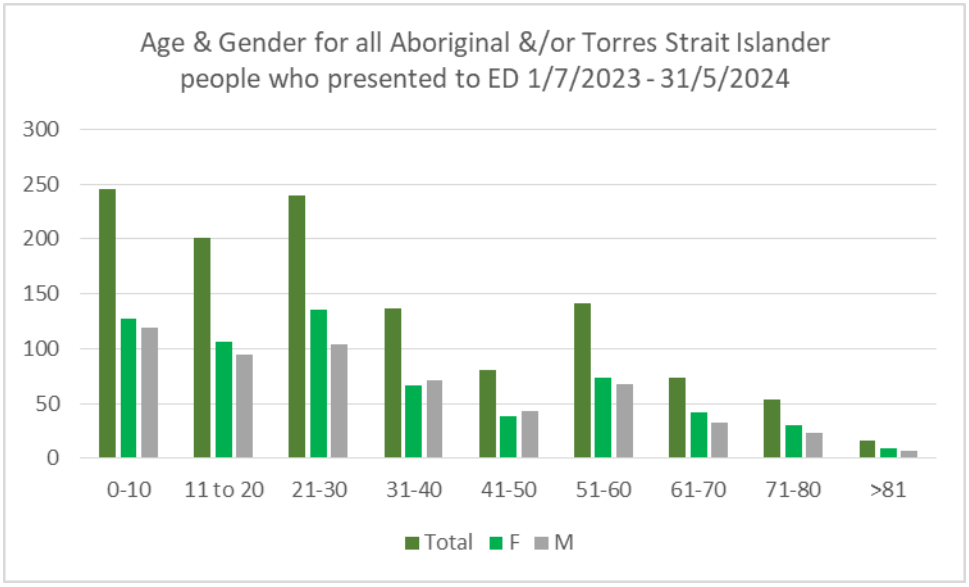


Figure 9 Swan Hill District Health age and gender of all Aboriginal and/or Torres Islander people who presented to the emergency department

LMHN EDs and UCCs First Nation Research Project Governance Group Meetings:

Ground rules, expectations and our collective responsibility.

1. A safe place

- Cultural Safety for First Nations people is the highest priority in this research.
- We need the research team and participants to not be constantly worrying/making sure that it is not 'upsetting' white Australians (White Fragility).
- The meetings are a safe place for the sharing of experiences and feelings, remember everyone's experience and expertise are different and bring diverse viewpoints to the group.
- Tackle problems not people and be prepared to discuss and address challenges as this is for the benefit of the research.
- It is ok to make mistakes, show our vulnerability.

2. Listening and learning

- Be present, be curious and be respectful.
- Listen (it's a gift when others share their experiences).
- Speak from your own experience instead of generalizing ("I" instead of "they," "we," and "you").
- Lean-into-discomfort – great learnings, discoveries and transformations can be made when this occurs.
- The goal is not to agree or disagree but to gain a deeper understanding.

3. Set the standard

- Speak up when we hear or see racist moments. 'Silence is violence'. (Mayne Wyatt monologue on racism 2020 – LMHN Truth Telling session 2023).
- Be conscious of body language and nonverbal responses -- they can be as disrespectful as words.

4. Do you want to follow-up?

Feedback

Project feedback can be provided to the research team's La Trobe University investigator, Professor Leigh Kinsman: l.kinsman@latrobe.edu.au

R = Take Responsibility for what you say and feel without blaming others.

E = Use Empathetic listening.

S = Be Sensitive to differences in communication styles.

P = Ponder what you hear and feel before you speak.

E = Examine your assumptions and perceptions.

C = Keep Confidentiality.

T = Trust that greater truth comes through diversity.