Communication and Cultural Knowledge in Aboriginal Health Care

A review of two subprograms of the Cooperative Research Centre for Aboriginal and Tropical Health's Indigenous Health and Education Research program

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Introduction

In 1997 the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) Board requested a review of the four subprograms of its Indigenous Health and Education Research program: Health Priorities and Communication of Health Information, Indigenous Education and Health Program, Health Ethics, and Cross-Cultural Education for Non-Aboriginal People. The review's findings were to inform decisions about future research directions for the program, and two research fellows were employed to conduct the investigation. The information and the three papers in this publication report on the review of the two subprograms Health Priorities and Communication of Health Information, and Cross-Cultural Education for Non-Aboriginal People conducted by the author during the first half of 1998.

The scope of the review

The original brief was restricted to a review of the relevant literature. However, particularly in the two subprograms addressed by this report, the formal literature is limited and reflects, predominantly, the perspectives of non-Indigenous researchers. The process was, therefore, broadened to provide an opportunity for the views of stakeholders, particularly Indigenous and non-Indigenous service providers, to also inform the review. Because of limited resources and time, the review's consultation process was not exhaustive, but rather opportunistic: a range of people from different regions and organisations were invited to participate in informal individual or small group discussions about the subprogram relevant to their interests. The investigation consisted of four stages:

- a literature search utilised major health and education databases as well as various internet search engines, and individuals and organisations were contacted to access published literature and to locate unpublished information related to the two subprogram areas
- discussions were held in three regions—Darwin, East Arnhem Land and Alice Springs—with a range of stakeholders, including Aboriginal and non-Aboriginal people working in a variety of health care settings, and others with expertise in relevant areas (see list of main organisations involved on next page)
- the synthesis of information from all of the above sources to identify key themes and specific project ideas
- the verification of findings and suggestions with a range of people who were involved in the consultations, and with others who responded to draft papers

The limitations of the review

There were a number of factors that restricted the extent and depth of the review of the two subprograms Health Priorities and Communication of Health Information, and Cross-Cultural Education for Non-Aboriginal People:

- insufficient time to consult all key stakeholders in all regions; an attempt was made to ensure a key interest group from at least one of each of the three regions was represented
- support and guidance for the two selected subprograms was limited due to the predominant focus by the CRCATH's Indigenous Health and Education Research program reference group and program management on research in the Indigenous Education and Health subprogram
- a review of literature related to the health priorities aspect of the subprogram Health Priorities and Communication of Health Information was not conducted even though its aim—'to promote Aboriginal participation in the two-way communication of health information and setting of health service priorities in the context of Indigenous beliefs about personal and cultural wellbeing' (CRC Commonwealth Agreement Schedule 1)—was central to the planning and process of the review
- because of the scarcity of published literature, written material was difficult and time consuming to locate, highlighting the serious lack of research which has occurred in this area, despite its central importance to health service delivery—the amount of useful written information located but no longer in circulation was also disturbing

The main organisations involved in the review process

Darwin
Territory Health Services: Darwin Rural (medical and allied health), Darwin Urban, Health Promotion, Aboriginal Cultural Awareness Program
Northern Territory Department of Education (Student Services, Aboriginal Education)
Northern Territory University (Faculty of Aboriginal and Torres Strait Islander Studies, Education Faculty, Centre for Indigenous Natural Cultural Resource Management)
Indigenous Education Council of the Northern Territory
Aboriginal Resource and Development Services
Menzies School of Health Research
Northern Territory Office of Aboriginal Development
Batchelor Institute of Indigenous Tertiary Education

East Arnhem Land
Territory Health Services: management, Aboriginal Liaison, Aged and Disability Services
Aboriginal Resource and Development Services
Northern Territory Department of Education: regional office and community school
Miwatj Health Service
Ngalkanbuy Health Centre
Miwatj Aboriginal and Torres Strait Islander Commission Regional Council
Aboriginal users of health services
Galiwin'ku Community Council
Marthakal Homelands Resource Centre
Galiwin'ku Women's Centre
Strong Women, Strong Babies, Strong Culture Program

Alice Springs
Territory Health Services: Allied Health, Hospital Liaison Team, Department of Rehabilitation and Physical Therapy, Aboriginal Cultural Awareness Program
Northern Territory Department of Education
Batchelor Institute of Indigenous Tertiary Education
Institute for Aboriginal Development: Aboriginal Translating and Interpreting Services, cross-cultural training program, language education program

Aboriginal interpreters and linguists working in various regions

The outcomes of the review

An initial draft set of papers, which documented in detail the findings of the review, was presented in May 1998. Based on this initial draft, three papers reporting the review findings and project suggestions were subsequently developed: 'Communication in Aboriginal health care: An overview', 'Communication in Aboriginal health care: Where are the interpreters?' and 'Cross-cultural education for service providers in Aboriginal health care'. These papers were written as independent documents; some repetition has resulted from bringing them together in one document.

Specific suggestions for possible CRCATH research identified as part of the review process were presented as project concepts for consideration by the CRCATH's Indigenous Health and Education Research program reference group. Some of these suggestions are:

- a research project to identify and document the extent and nature of miscommunication in acute health care settings
- an evaluation of employment of interpreters in a remote community clinic
- a workshop for the stakeholders in cross-cultural training
- participation in the development of a cross-cultural training program to meet the specific needs of a community-controlled health organisation
- development of multimedia training materials in cross-cultural communication

These and a range of other possible actions to address identified concerns are described in more detail in the papers that follow.

The three papers in this review were completed and submitted to the CRCATH's Indigenous Health and Education Research program leader in October 1998. The purpose of this plain-English publication, which has been delayed for various reasons, is to provide an overview of the two subprograms—Health Priorities and Communication of Health Information, and Cross-Cultural Education for Non-Aboriginal People—with a focus on identifying strategic directions for research in these two areas. Since1998, one of the suggestions for research related to miscommunication in health care has been approved by the CRCATH Board and will proceed early 2001. At the time of publication, none of the other actions identified through the review had been pursued.

The Papers

1. Communication in Aboriginal health care: An overview

A CRCATH Indigenous Health and Education Research program review paper

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Abstract

Communication difficulties because of linguistic and cultural differences between non-Aboriginal health staff and their Aboriginal clients are widely recognised as a major barrier to improving health outcomes. Miscommunication can have serious consequences at all levels of health service planning and implementation, education and research. Serious attempts to genuinely accommodate the specific and regionally diverse cultural needs of Aboriginal clients are few, as evidenced by the lack of an Aboriginal interpreter service in the Northern Territory, and by the poor levels of cultural education and language training for health staff. As a result, effective dissemination of health information—crucial in all areas of health care, from achieving accurate diagnosis and ensuring adherence to treatment through to changing health-damaging behaviours—is seriously and unnecessarily compromised. Optimal dialogue only occurs when staff and clients share the same linguistic and cultural background. Until this is achieved, strategies such as employment of trained interpreters and comprehensive training of staff in intercultural communication have the potential to dramatically improve health outcomes for Aboriginal people.

Introduction

> [T]here exists between the dominant [Non-Aboriginal] culture and the Yolngu[1] of East Arnhem Land a vast communication gap . . . This communication gap is cemented into the system so badly that it is not even recognised by the dominant culture as being there [Trudgen 2000]

The area of health communication is receiving increasing attention and includes doctor–patient communication, media advocacy and agenda setting for health issues, scientific communication related to health, as well as the design and implementation of preventative health-education communication programs (Rogers 1996). In the context of Aboriginal health care, ineffective dialogue, which can adversely affect health outcomes, can occur in the following interactions:

- between health staff and patients, e.g. identifying the health problem, obtaining informed consent for treatment, explaining diagnosis and treatment to patients
- between non-Aboriginal and Aboriginal staff, e.g. exchanging medical and socio-cultural information related to patient management, and in day-to-day workplace exchanges
- between educators and students, including primary, secondary and tertiary education systems as well as community-based health education programs
- between service users and service planners and administrators, e.g. determining health priorities, development and dispatch of appropriate and effective services
- between researchers and research participants and decision makers, e.g. concerning research agendas and ethical issues, and gaining consent from research participants

The importance of achieving a high level of communication between Aboriginal and non-Aboriginal people is recognised in many reports and policies related to health services. The Royal Commission into Aboriginal Deaths in Custody National Report: Overview and Recommendations specifically addresses this issue:

> Effective communication between non-Aboriginal health professionals and patients in mainstream services is essential for the successful management of the patients' health problems. Non-Aboriginal staff should receive special training to sensitise them to the communication barriers most likely to interfere with the optimal health professional/patient relationship. [Johnson 1991, Recommendation 247.e, p. 87]

[1] Aboriginal people of north-east Arnhem Land.

However, ensuring effective dialogue in planning and implementing health (and education) services and research is often problematic: in both remote and urban Aboriginal settings differences between the cultural and linguistic backgrounds of service providers and service users can range from minor to extreme. Even if Aboriginal people speak English or a dialect of English as a first language, serious comprehension difficulties can still occur due to the cultural differences that influence communication.

In reality, health and education services and research and training institutions implement a range of approaches to address communication problems with varying degrees of success. None of these approaches are currently adequate to ensure effective transmission of health information for Aboriginal people.

This paper is based on a review of the relevant literature as well as information obtained through discussions with health service providers, health researchers and Aboriginal users of health services, predominantly in the Darwin, East Arnhem Land and Alice Springs regions of the Northern Territory. This paper also draws on the experience of the author as a service provider and researcher in the areas of Aboriginal health and education, particularly in the field of communication.

The nature and extent of miscommunication in Aboriginal health care

Effective communication is recognised as crucial to achieving a high standard of health care. Extensive research has been carried out worldwide, particularly in the area of doctor–patient dialogue (Ong et al. 1995). However, there has been little research in the area of health communication for Indigenous Australians, despite the seriousness of the problems demonstrated by the few investigations which have been done (e.g. Mobbs 1986; Watson 1987). Even fewer evaluations of programs to improve communication in Indigenous health care, either in Australia or overseas (e.g. Copeman 1989; Kaufert et al. 1984) are available.

Watson's study of communication with Aboriginal patients in the maternity ward of Royal Darwin Hospital, for example, reported extensive communication problems. These problems resulted from both cultural and language differences between staff and patients, an inadequate use of interpreters and the hospital staff's inadequate sociolinguistic knowledge (Watson 1987). Extensive comprehension difficulties between medical staff and their Aboriginal patients were also found by Mobbs (1986) to be a source of distress and frustration. The only recent study specifically addressing this issue is currently being conducted with staff and Aboriginal patients in intensive care and their families in Alice Springs and Darwin hospitals (Kemp 1998).

Studies of other Aboriginal health issues have also identified serious concerns related to the interchange of health information (e.g. Devitt & McMasters 1998; Aboriginal Resource and Development Services 1997). Drawing on the findings of a study of Aboriginal mortality, Weeramanthri (1996) went beyond identifying the nature of communication problems to explore ways in which practitioners in Aboriginal health might improve transmission of health information.

All of the above-mentioned studies are based on interviews with service providers—and sometimes with Aboriginal clients—about their perceptions related to communication. However, this reliance on indirect methods for obtaining information about communication is likely to understate the extent of the problem. As studies in other areas (e.g. Cooke 1998) have demonstrated, misunderstandings often go unrecognised by those involved.

Although there has been little empirical research in the area, anecdotal evidence about communication problems in Aboriginal health care is abundant, some of which has been documented (e.g. Brennan 1979; Hill 1994; Shannon 1994; O'Connor 1994; Campbell 1995). The extent to which the conditions for effective transference of health information are met, and the problems inherent in achieving this, however, vary from setting to setting. All the health staff consulted for this paper expressed concern about the effectiveness of the discourse between Aboriginal clients and staff who do not share a client's cultural and linguistic background. Such problems—as well as communication difficulties between Aboriginal and non-Aboriginal staff—are often a source of great frustration, and concern.

Despite this concern, the extent of miscommunication and the potential seriousness of the consequences for Aboriginal patients is often not well understood by either service providers or their clients. This lack of awareness and an acceptance of 'a grossly deficient cross-cultural communication standard as the norm' have also been described in Central Australia (Devitt & McMasters 1998, p.147). Studies of the interactions in Aboriginal health care, similar to those undertaken in the criminal justice and education systems (e.g. Eades1992; Cooke1998; Lowell & Devlin 1998), are urgently needed if we are to better understand the nature and extent of misunderstanding in Aboriginal health care and how to reduce this barrier to effective service delivery. Concrete illustrations of communication breakdown, and documentation of the consequences of miscommunication in health care and education, are necessary if service providers are to understand and take appropriate action to address the serious and pervasive nature of information exchange difficulties in Aboriginal health care.

The consequences of miscommunication

> Yolngu are suffering a two-way crisis in communication. Balanda [Yolngu term for non-Aboriginal people] are unable to communicate even the most basic concepts which affect the life and well-being of each member of the community and Yolngu cannot explain what is happening in their lives or the wisdom which has been part of their culture for hundreds of centuries. [Trudgen 2000]

The health care implications of language and cultural differences between service providers and their clients who speak languages other than English have been widely recognised in Australia. For example, the National Health Strategy's Issues Paper No. 7 states:

> The lack of a common language between patient and health professional can have serious implications for their communication, for diagnostic accuracy and overall quality of care. It can inhibit describing symptoms effectively, asking questions and talking about fears and anxieties, leading to further distress, dissatisfaction with care and to adverse health outcomes for patients and their families. Likewise, health providers' limitations in talking with their patients lead to frustration with treatment regimes, perceived problems with compliance and negative attitudes toward people from non-English speaking backgrounds. [National Health Strategy 1993, p.19]

The consequences for patients who experience poor dialogue with health professionals are:

- taking prescribed drugs without a full knowledge of their purpose or side effects
- being admitted to hospital unaware of the type of medical treatment the patient was to receive
- receiving medical treatment without consent
- being mistaken for other hospital patients and receiving inappropriate treatment
- being returned home with a serious condition
- patients undergoing treatment at odds with their cultural beliefs

Anecdotal reports of such incidents in Aboriginal health care are common. The need to document such events is often discussed among those interested in improving communication in Aboriginal health care, but little investigation has yet been undertaken.

The most extensive and up-to-date paper about communication in Aboriginal health care is currently in press. In this paper, Trudgen identifies disparity in cultural knowledge and world view, as well as language differences, as the sources of communication difficulty between Yolngu and the dominant non-Aboriginal culture. Such barriers prevent health service providers from:

- diagnosing patients' complaints in a normal question and answer manner
- informing Yolngu patients of their condition—sometimes life threatening—and obtaining proper consent before carrying out medical procedures
- accomplishing health education and prevention in a timely and cost-effective way
- accurately assessing the overall problem and developing culturally sensitive health education programs
- evaluating these and modifying the programs so they become more effective (Trudgen 2000)

Trudgen believes that up to 95% of interchanges between Yolngu patients and their doctor or other health service providers fail, whether there is an Aboriginal health worker present or not. He suggests that similar levels of miscommunication occur in consultations between other government personnel and Yolngu (Trudgen 2000).

The position taken by Trudgen is supported by the findings of a patient survey conducted in East Arnhem Land for Territory Health Services (Aboriginal Resource and Development Services 1997). Some of that study's findings related to communication include:

- Aboriginal patients felt that, although they were generally treated with respect, most staff where very ignorant of key cultural understandings
- most Aboriginal patients were dissatisfied with the explanations about diagnosis and treatment—this was an area with the most apparent linguistic and cultural barriers to good communication
- most Aboriginal patients were totally unaware of the purpose of their medication

Such communication difficulties between health staff and their Aboriginal clients have also been identified in other regions. In their study of the social and cultural dimensions of end-stage renal disease among Aboriginal people of Central Australia, Devitt and McMasters (1998) described communication—or rather the absence of it—between Aboriginal patients and their non-Aboriginal carers as a core issue. The extent of verbal interaction was minimal and even when it did occur, there was a lack of effective comprehension; as a result, communication within renal patient care was found to be 'seriously fragmented and deficient' (Devitt & McMasters 1998, p.164).

The sources of miscommunication

Linguistic, cultural, social and political factors all impact on communication, and differences between patients and carers in any of these areas are a potential source of communication breakdown. Differences in life perspectives, expectations, understanding and interpretations (phenomenological differences) are one source of communication failure. As well, differences between Standard Australian English and Aboriginal languages, and between Standard Australian English and Aboriginal English, are manifold (Christie & Harris 1985). Social and attitudinal factors (e.g. power relationships, motivation) as well as an individual's specific intercultural negotiation skills (e.g. knowledge of potential areas of difficulty, ability to recognise communication breakdown when it occurs and employment of repair strategies) also influence the effectiveness of communication.

Health staff in remote areas often express interest in learning one of the languages used in the community or communities in which they work. This is sometimes viewed as a sufficient strategy to achieve effective commune with the staff's Aboriginal clients and coworkers. However, broad differences in cultural knowledge and world view cannot be bridged simply by reaching a greater level of shared linguistic knowledge (e.g. Clyne 1994).

The influence of cultural differences on communication in addition to, or independently of, language differences is widely recognised (e.g. Clyne 1994). In an unpublished paper about Aboriginal health care written in 1971, Hamilton recorded the following observation:

> The communication difficulties between medical staff and Aborigines are not merely a result of language difficulties: in order to give meaning to medical instructions and the reasons for them it is necessary to find concepts which overlap the two cultural systems. If this cannot be done the result is simply a chain of apparently arbitrary orders and a kind of bullying to see they are carried out. [Hamilton 1971, p.2]

This has been reiterated more recently by Devitt and McMasters (1998, p.165) who state that the less patients understand what it is they must do and why, ' the more compliance itself becomes simply an issue of 'obedience''. They described the communication problem between renal patients and carers as 'one that resulted from a deep cultural gap, both profound and pervasive' (p.164).

Cultural influences on communication are complex and extensive, and an understanding of how perceptions—both Western and Indigenous—of health and sickness are culturally constructed is essential to ensure effective clinical and educational interactions. Beliefs about causation are just one cultural feature that can critically influence health communication (e.g. Berndt 1982; Weeramanthri 1996), particularly the way in which information is interpreted. This was illustrated by an example given by Yolngu in one Top End community who explained that providing warnings—or even statistics—about potential health problems could be construed as a 'threat', because predicting an illness can imply involvement with sorcery to cause the illness in the first place. The constraints of kinship, age and gender in regard to who has the right to know and discuss health information with or about another person also affects exchanges between patients and health staff in complex ways which need to be addressed. In Central Australia, serious gaps in communication between patients and their family networks have also been identified, although the underlying reasons for this remained unclear (Devitt & McMasters 1998).

Another barrier to effective communication which is repeatedly identified by both Aboriginal and non-Aboriginal staff is the imbalance of power within health services. In a study of interactions amongst Aboriginal health workers and remote area nurses, Willis (1998) described how power relations ebbed and flowed, influenced by a hierarchy of discourses operating within both groups who operated alongside each other. The issue of 'control' and the manner in which it is expressed and interpreted—or misinterpreted—was identified as a central concern by a number of health workers consulted for the paper. As Weeramanthri (1996) pointed out it should be self-evident that communication of information is critical in addressing the imbalance of knowledge and, therefore, power between policy makers, health practitioners and community members. An understanding of the relationship between communication and control is not often reflected, however, in practice.

Repeatedly, Aboriginal health workers stress the importance of a balanced approach in which Aboriginal and non-Aboriginal staff work collaboratively—'in partnership'—to accommodate the needs of their Aboriginal clients. This desire for a shared role in providing health care to their communities has also been reported in research with health workers employed by both government and independent health services in Central Australia (Tregeneza & Abbot 1995). However, ineffective communication between Aboriginal and non-Aboriginal staff remains the major barrier to achieving this partnership, even when both groups are highly motivated.

Weeramanthri (1996) and many others have stressed the need for practitioners to reflect on the values and structural forces underlying communicative practices in health care. A better understanding of the complex nature of the barriers to conveyance of health information between Aboriginal and non-Aboriginal people, and between Aboriginal people themselves, would contribute substantially to improving health care outcomes. This is important not just for clinical interactions, but to inform health education practice through a better understanding of the processes involved in the acquisition of knowledge related to health: popular health promotion strategies based on simplistic content would quickly be abandoned if the conditions for effective communication of health information were well understood.

Accommodating the needs of the client—or the provider?

Where there is any cultural and/or language difference between groups the communication style of both must be accommodated for effective understanding to occur. There are a number of perspectives on how intercultural exchanges can be improved. At one end of the continuum, accommodation is predominantly made by the (Aboriginal) service users; at the other end of the continuum, accommodation is predominantly made by the services and service providers. In practice the various services and individual service providers are placed at various points along the continuum, and are constantly shifting depending on many factors. The theoretical models or philosophies of particular services and their actual practices can also be placed at very different points.

The strategy that requires the least degree of accommodation by either group, and can, therefore, be implemented with a greater degree of cultural comfort, is the employment of a trained interpreter to meet the communicative needs of both participants. Currently in the Top End, the government-funded interpreter services cover many languages, none of which are Indigenous Australian languages, despite the availability of trained interpreters from many Aboriginal language groups (Northern Territory Office of Aboriginal Development 1997).

Alternatively, one or both groups must accommodate the other by acquiring the relevant linguistic and cultural knowledge. There are a number of mechanisms for achieving this which range from a predominantly enabling educational process to one which requires such a degree of acculturation that it becomes what is often described as a process of assimilation.

At one end of the spectrum, the onus for change is predominantly on Aboriginal people themselves. One view, for example, is that by improving (Western) educational outcomes (i.e. to speak, read and write in English) Aboriginal people will have access to more (English language) information about their health problems and will be able to utilise existing (dominant culture-based) health services more effectively. Although it is often assumed that Aboriginal people will eventually all speak English, the evidence suggests that this is not occurring and that the current situation will not change in the short to medium term (Northern Territory Office of Aboriginal Development 1997).

At the other end of the continuum the aim is to accommodate the cultural, environmental, intellectual and social realities of Aboriginal people themselves. Eckermann and others (1992) argue in Binang Goonj that it is easier for health care providers, from their position of relative power, to adapt to the differing needs of their clients and that failure to do so will endanger the social, cultural, physical and mental health of Aboriginal people.

The current situation

Equity of access implies accommodation of the needs of specific cultural and linguistic groups (Pauwels 1991). The National Health Strategy Issues Paper No. 7 (National Health Strategy 1993) recognises the importance of the mismatch between the culture of the health system, which essentially operates within a Western medical model, and the needs and expectations of people from non-English speaking backgrounds. The paper suggests that the onus for change lies with the mainstream health bureaucracy and institutions.

Most health and education services, particularly organisations under Indigenous control, have attempted to accommodate the needs of Aboriginal clients with varying degrees of commitment and success. Such attempts include strategies such as employment of people from the clients' linguistic and cultural group (e.g. Aboriginal health workers) through to restructuring of services to be more culturally appropriate and accessible to their client group.

In practice, however, Aboriginal people are generally required to accommodate the existing health service structures and practices, most of which are strongly grounded in a Western medical model with English as the dominant language; control rests, in real terms, with non-Aboriginal staff. Johnson (1983?) argues that the emphasis continues to be placed 'on Aboriginal failure to assimilate to our norms [which] should rather be placed on our failure to devise strategies that accommodate to their world view' (p. 47). Devitt and McMasters (1998) also uncovered an attitude among service providers that 'Aboriginal patients were somehow culpable in their linguistic difference' (p. 148).
The need for structural changes to the current health care system to enable a genuine shift in control and to better accommodate Aboriginal people's needs, including those of Aboriginal service providers, is recognised by both Aboriginal and non-Aboriginal staff and has been extensively documented (e.g. Reid 1982; Humphery et al. 1998). As one Yolngu health worker has urged:

> [Non-Aboriginal people] need to recognise Yolngu dhukarr[2] as the foundation in primary health care and health promotion.

The same health worker argues that it is essential to 'dig' for Aboriginal cultural knowledge which will provide the guidelines and framework for an effective health care practice. A deep level of reciprocal cultural understanding is required to achieve sustainable improvements in Aboriginal health care. Positive outcomes are dependent on effective communication at every level, from control of service planning and development to clinical interactions and the design and delivery of educational programs.

[2] Road or pathway--used metaphorically in this context

Summary

A number of key themes related to communication of health information have emerged from the literature referred to above, as well as from discussions with health staff and their Aboriginal clients of both government and community-controlled organisations, mainly in the Darwin, East Arnhem Land and Alice Springs regions of the Northern Territory. These themes are:

- communication difficulties are widely recognised as a major barrier to effective health service delivery, but understanding of the extent and nature of these difficulties is limited
- the onus for change has generally been on Aboriginal people who are required to accommodate the constraints of health services, while health services have implemented few substantial changes to accommodate the communication needs of their Aboriginal clients
- more effective support is urgently required to address the widely reported and serious communication difficulties encountered in the provision of health services to Aboriginal people, including the provision of trained interpreters and improved staff training in intercultural communication
- current levels of cultural education of both Aboriginal and non-Aboriginal staff are generally considered to be inadequate, and better access to more extensive linguistic and cultural training opportunities is needed
- communication difficulties between non-Aboriginal staff and their Aboriginal coworkers are a serious additional barrier to improved health care, compounding communication problems between staff and clients

Creating the conditions for improved communication

The communication of health information in Aboriginal health and education services can be improved through:

- an increased understanding of sources of miscommunication and the potential consequences for all staff and clients
- equity of access to trained interpreters by providing a government-funded Aboriginal languages interpreter service, such as the service currently available to non-Indigenous people who speak languages other than English
- the provision of specialised training programs in medical interpreting
- the development of skills in intercultural communication, including how to work effectively with interpreters
- more extensive and regionally specific cultural and language education opportunities
- the provision of training in working collaboratively with coworkers of a different cultural and linguistic background
- a change in policy and practice so that a genuine accommodation of the communication needs of Aboriginal clients and staff is met
- formal requirements within work practices to ensure that interpreters are used at all necessary times

Specific suggested actions for Aboriginal health service providers emerged from the review:

- initiate research to identify and clearly document the extent, nature and consequences of miscommunication in health service interactions with a view to inform cultural education program development and to encourage improvements in current practice
- reduce the barriers to effective communication between non-Aboriginal staff and their Aboriginal clients and coworkers by advocating for:
    - access to, and effective use of, interpreters with specialised health training (see 'Communication in Aboriginal health care: Where are the interpreters?' on page 19)
    - improved cultural education programs which incorporate intensive training for health staff in intercultural communication
    - the recognition of the value of specialised communication skills relevant to specific health care environments

- the development of guidelines for health staff including ethical and legal issues related to communication; strategies for identifying potential communication difficulties, e.g. comprehension checks when obtaining consent, and suggestions for minimising the risks from miscommunication

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2. Communication in Aboriginal health care: Where are the interpreters?

A CRCATH Indigenous Health and Education Research program review paper

Anne Lowell

October 1998

AUTHOR'S NOTE: This paper was written in 1998; in mid-2000 a government-funded Aboriginal interpreter service was established in the Northern Territory. This is an important step forward. However, a high level of commitment to development and utilisation of this service will be necessary on the part of all stakeholders if substantial and sustainable improvements in communication in Aboriginal health services are to occur. Two years on, most of the issues raised in this paper are still relevant.

Abstract

Effective communication is of crucial importance in all areas of health care. Difficulties are inevitable when service providers and their clients do not share the same cultural and language background. Current practices in Aboriginal health care do little to address the communication problems which are widely acknowledged to be pervasive. Access to interpreter services, equivalent to those available to other people from non-English speaking backgrounds, remains limited or non-existent for Aboriginal people. Strategies to meet the communication needs of Aboriginal clients in the context of health care have been clearly identified and include: equity of access to trained interpreters, specialised training programs in medical interpreting, training for users of interpreter services, increased awareness among service providers of the ethical and legal requirements for ensuring effective communication, and increased awareness by Aboriginal clients of the role of, and their right to, an interpreter. The need for a professional, government-funded Aboriginal interpreter service has been extensively documented; the advantages in terms of improved health outcomes and cost-effectiveness are also clear. However the situation in the Northern Territory remains unchanged: a non-Aboriginal person who does not speak English as a first language has free access to an interpreter when using a government service; an Aboriginal person does not.

Introduction

> Communication is both the most basic and the most powerful vehicle of health care. It is the fundamental instrument by which the patient–provider relationship is crafted and by which therapeutic goals are achieved. Without the talk that organises a patient's history and symptoms and puts them in a meaningful context, complicated technology and sophisticated treatment are of limited value. [Roter & Hall 1997, p. 206]

Effective communication of health information is essential for people to understand the factors influencing their health, and to take appropriate action to address their health needs. Aboriginal and non-Aboriginal people, who come from very different cultural and language backgrounds, constantly need to communicate with each other in health service, health education and training settings. The effectiveness of their exchanges will profoundly influence the health outcomes.

However, effective communication requires a level of shared linguistic and cultural knowledge between the participants which often does not exist in interactions between service providers and their Aboriginal clients. As a result, the risk of *mis*communication is high and the potential consequences serious.

Miscommunication can impact at every level of health management, with consequences such as misdiagnosis, procedures carried out without a genuinely informed consent, poor adherence to treatments, persistent health-damaging behaviours, and ineffective health promotion strategies.

Where there is any cultural and/or language differences between groups, the communicative needs of both must be accommodated for effective dialogue to occur. The strategy which requires the least accommodation by either party to the needs of the other is the employment of a professional interpreter: neither group is required to change their language, beliefs, values nor behaviour, other than to recognise a need for improved understanding which, with the use of an interpreter, can be achieved quickly and with minimal threat to cultural safety.

In the Northern Territory, health and education services and research and training institutions implement a range of communication strategies with varying degrees of success, none of which are currently adequate to ensure effective transmission of health information for Aboriginal people. The role of interpreters in improving such communication and, as a consequence, improving health outcomes for Aboriginal people, is the subject of this paper.

This paper is based on a review of the relevant literature including research and government reports, as well as information obtained through discussions with Aboriginal and non-Aboriginal health staff employed by Territory Health Services, community-controlled health services and Menzies School of Health Research, Aboriginal interpreters and linguists, and Aboriginal users of health services, predominantly in the Darwin, Alice Springs and East Arnhem Land regions of the Northern Territory. The paper also draws on the experience of the writer as a researcher and service provider working with Aboriginal people, including interpreters, with a particular interest in communication.

Interpreters working in health care: The current situation in the Northern Territory [1]

> Interpreters are an essential link in the chain of comprehensive health care . . . Even people who seem to speak and understand English fairly well can be out of their depth when faced with complex or distressing situations. Unfamiliar concepts from a language other than our own are often perceived only in their most concrete meaning and this may not be immediately evident . . . [Pollack & McCarthy 1984, pp. 6–7]

Professional interpreter services

Throughout Australia, government-funded interpreter services are available for many non-Aboriginal languages: in the Northern Territory the Northern Territory Interpreter and Translator Service provides a free service for non-Aboriginal people who need an interpreter when accessing government services. As well, two interpreters (Greek and Chinese) are employed on site at the Royal Darwin Hospital. There is also a telephone interpreting service funded by the Commonwealth Government which provides a 24-hour service for more than 100, non-Aboriginal, languages.

Interpreter services for Aboriginal people, however, range from inadequate to non-existent, despite the fact that in the Northern Territory 70% of Aboriginal people, who comprise approximately 27.5% of the population, speak a language other than English at home (Northern Territory Office of Aboriginal Development 1997).

Limited professional interpreter services for some Aboriginal languages are available in some regions of the Northern Territory. However, in most cases users must pay; in contrast, the cost of interpreters for non-Aboriginal people using government services is met by the Northern Territory Government.

In Alice Springs, the Institute for Aboriginal Development administers the Aboriginal Translating and Interpreting Services. This service can provide accredited interpreters in eight Central Australian Aboriginal languages on a fee-for-service basis. Interpreter services are also available at Alice Springs Hospital: Aboriginal liaison officers are required to be speakers of an Aboriginal language, although they are not necessarily trained interpreters.

In Katherine, the Katherine Regional Aboriginal Languages Centre and in Tennant Creek the Papulu Apparr-kari Language and Cultural Centre also provide some interpreter services, but, again, these services are either on a user-pays basis or are funded from other programs.

In the East Arnhem Land region, the Aboriginal Resource and Development Service offers some support for facilitating intercultural exchanges in health care environments, but there are not enough trained interpreters available in the region, and those that are trained are often employed in other positions.

Even where some form of interpreter service exists, the service is usually seriously under-resourced and under-utilised. For example, a recent study of renal patients (Devitt & McMasters 1998) identified a medical interpreting service as one measure to address a communication gap between patients and service providers which they described as ‘profound and pervasive’. The Aboriginal people interviewed in the study, repeatedly suggested a greater use of interpreters, but such a strategy was rarely employed; for example, one senior renal nurse had used an interpreter only once in seven years (Devitt & McMasters 1998).

Similarly, the patient survey conducted at Gove Hospital found that most of the Aboriginal patients expressed a need for an interpreter, but use of interpreters was rare despite their availability (Aboriginal Resource and Development Services 1997).

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[1] See author’s note, p 19

Family members as interpreters

In the absence of government-funded interpreter services for Aboriginal people, the communication strategies used by health staff in interactions with their Aboriginal clients range from ineffective to unethical.

It is common practice, particularly in town-based services which do not have speakers of Aboriginal languages on staff, to use family members as interpreters; this is despite the ethical implications and the possibility that family members might not have the level of English proficiency and cultural knowledge—as well as an understanding of medical concepts and terminology—necessary to prevent serious miscommunication. When family members are used as interpreters '[t]here is a high risk that the health professional's and the patient's messages are translated inaccurately, leading to miscommunication and communication breakdown' (Pauwels 1991, p.156–7).

In hospitals there is sometimes an expectation that the 'escort', who is usually a member of the patient's family, is there to work as an interpreter. However, the 'escort' is unlikely to be trained, is not being paid to provide an interpreting service, and may have insufficient cultural and linguistic knowledge to ensure effective communication.

Using family members and other unqualified people as interpreters with other populations 'has resulted in documented cases of miscarriages of justice, fatal and near-fatal medical consequences, denial of rights and undue suffering' (Gentile 1996, p. 83). Anecdotal accounts of such consequences for Aboriginal people were disturbingly common during consultations for this review, and the need to document such incidents was often suggested.

Health workers as interpreters

In remote communities it is often assumed that it is the role of the health workers to work as interpreters. Again, this is based on assumptions about the health workers' English competence and Western cultural knowledge which are often incorrect. Such assumptions also reflect a lack of understanding of the highly specialised skills required for effective interpreting, particularly in a medical setting.

The unreasonably high expectations placed on Aboriginal health workers are described by Trudgen (2000):

> [T]hey are . . . expected to understand complicated medical terminology without any training at all in this area . . . everybody expects them to be experts at everything from interpreting, to managing clinics; from being clinicians to health promotion and education experts. All these responsibilities rolled up into the one job . . .

Inevitably, health workers will be called on to facilitate communication between other health staff and their Aboriginal clients. There are many different views on the extent to which this is appropriate, and if so, how health workers may be supported to fulfil this role effectively in addition to their other demanding and specialised roles. This is a complex issue, but one which impacts continually on Aboriginal health workers, their coworkers and their clients. It has been suggested that this issue needs to be explored in depth by the health workers in collaboration with relevant professional and training bodies.

Liaison officers as interpreters

As with Aboriginal health workers, unrealistic demands are often made of Aboriginal liaison officers, particularly in town-based services which are used by Aboriginal people from many different cultural and language backgrounds. Only Alice Springs Hospital has a requirement that liaison officers must speak a local Aboriginal language, and it is intended that they have interpreter training, although this is not always the case. In many settings, liaison officers are expected to deliver effective communication with people with whom they may share little, if any, cultural and linguistic background.

A study of renal patients in Central Australia (Devitt & McMasters 1998) described the tendency for many Aboriginal and non-Aboriginal people to blur the distinction between the roles of health worker, liaison officer, support person and interpreter. They also argued that interpreters must be both trained and paid for their work. However, the use of untrained—and often unpaid—Aboriginal people as interpreters continues to be accepted as standard practice in health services throughout the Northern Territory.

Despite the recognition that 'interpretation is complex and fraught with possibilities of misinterpretation because of differing values, lack of or limited linguistic competence, lack of impartiality or lack of knowledge relevant to specialist areas such as health' (Territory Health Services 1997, p. 37) the constant use of untrained people for medical interpreting is rarely challenged in Aboriginal health services in the Northern Territory.

The users of interpreters

> It is important to acknowledge that the communication problems are reciprocal. It is not simply that the patient group was failing to grasp the information given. but that carers were failing to understand what patients were 'telling' them—verbally or otherwise. [Devitt & McMasters 1998, p. 147]

Although most health services in the Northern Territory have a high percentage of Aboriginal clients whose first language is not English, training in working with interpreters is not provided. An excellent video about working with Aboriginal interpreters has been produced by Katherine Regional Aboriginal Language Centre called 'No Mo Humbug', but there are currently no mechanisms to ensure that staff develop such skills.

Another barrier to effective communication is that health staff are not trained to recognise when an interpreter is needed. It is often assumed that competence in conversational English is sufficient for effective impartment of highly complex medical information. In fact, without the benefit of an interpreter, a high level of shared linguistic and cultural knowledge is necessary for effective exchange of such information to occur. As Brennan (1979) explained, the need for interpreter services remains submerged until the use of such services provides a means for identifying the need.

Another obstacle is that few Aboriginal people have any experience of professional interpreting services. They may be unaware of the potential benefits of using an interpreter, and unaware that interpreter services are available to other people from non-English speaking backgrounds. A discussion with two senior Aboriginal health workers illustrated what happens when Aboriginal people learn about the benefits of interpreters in the health system. On a visit to a large interstate hospital the two health workers had witnessed the role of interpreters and their availability to non-Aboriginal people. On their return, they proposed that interpreters should be employed in their own community clinic.

It is also common for participants in intercultural exchanges to not realise that miscommunication has occurred. This is particularly likely when the participants are from very different cultural backgrounds (Steffensen & Colker 1982). Simple strategies for checking comprehension can be easily employed but once again, there is no formal mechanism to develop such skills within health services. In the legal system, however, guidelines for assessing a client's comprehension before taking instructions are currently being developed to assist lawyers in identifying a client's need for an interpreter. Development of similar strategies for health staff, for example, when obtaining consent for a treatment or as part of research, could serve to reduce the practical and possible legal consequences of miscommunication.

According to the High Court's interpretation, 'informed consent' requires that a doctor discuss the side effects of treatment, even if only a remote possibility, and provide a patient with information about alternatives when obtaining consent for treatment. Current communication practices that do not include employment of a trained interpreter cannot guarantee that consent obtained from many Aboriginal patients is truly 'informed'. Similarly, when conducting health research it is an ethical requirement that informed consent is obtained from participants in the research. However, as with health care, when obtaining such consent, it is not standard practice to employ professional interpreters, again raising questions about the extent to which any consent given could be considered informed.

Policies, recommendations and implementation—the gap

> [Y]ou will not really hear what the people are saying or they will not really hear what you are saying unless you can communicate intellectually with them in their own language. Of course, the other way of dealing with these communication problems is to have a competent interpreter service so that doctors and sisters in hospitals, or visitors to communities, be they consultants, educators or even politicians, can have full and meaningful dialogue with the client group . . . [Trudgen 2000]

The importance of achieving a high level of communication between Aboriginal and non-Aboriginal people has been repeatedly recognised in government reports and policies (e.g. Territory Health Services 1996, Public Health Strategy Unit 1998). The crucial role of Aboriginal interpreters in achieving this level of communication also has been identified. For example, the Royal Commission into Aboriginal Deaths in Custody recommended:

> That the non-Aboriginal health professionals who have to serve Aboriginal people who have limited skills in communicating with them in the English language should have access to skilled interpreters. [Johnson 1991, Recommendation 249]

In the most recent published report on implementation of the Royal Commission into Aboriginal Deaths in Custody recommendations by the Northern Territory Government (Northern Territory Government 1997), Territory Health Services identifies the development of more effective methods of communication between service deliverers and Aboriginal people as a high priority, but does not include the use of trained interpreters as one of their strategies to achieve this. The *Information Privacy Code of Conduct* (Territory Health Services 1997) states that 'In principle, it is not desirable to utilise untrained interpreters, children, other relations or friends to interpret for clients/patients' (p.37) but recognises there is no alternative 'until a technical Aboriginal language interpreter/translator service is developed' (p.37).

Long-term stakeholders recount discussions over many years about the crucial need for an Aboriginal interpreter service. For example, a comprehensive report on the need for an Aboriginal interpreter service in the Northern Territory was completed by the research section of the then Department of Aboriginal Affairs (Brennan 1979), but resulted in little action and the concerns expressed twenty years ago remain valid today. More recently, during the 1994 election campaign, the Northern Territory Government made a commitment to 'develop a technical interpreter/translator service within all service delivery Departments, commencing with Health and Community Services and Education' (Carroll 1995, p. 9). Subsequently, a report was commissioned by the Northern Territory Office of Aboriginal Development to recommend options for an Aboriginal languages interpreter service (Carroll 1995) and another project, funded by the Northern Territory Employment and Training Authority, was undertaken to develop a strategy for interpreter training in Aboriginal languages (Phelan 1997). Despite these comprehensive reports and a trial interpreter service conducted in 1997 (see below), little, if any, sustainable improvement in access to interpreter services for Aboriginal people has occurred.

A trial Aboriginal languages interpreter service

During the first six months of 1997, a trial Aboriginal languages interpreter service was implemented by the Northern Territory Office of Aboriginal Development in Darwin. The service was available free of charge to health and legal services in the Darwin and Katherine regions and was funded by the Commonwealth Attorney-General's Department. There were 87 interpreters registered with the service covering 67 languages, which countered the common argument that the number of Aboriginal languages is too great to be covered.

A high level of satisfaction was reported by those who used the service; users experienced a marked improvement in the quality and depth of various transactions. Since the trial finished some Territory Health Services staff have continued to employ interpreters using their existing budgets (which do not have provision for such expenditure) because of their conviction that the employment of interpreters results in more ethical and effective work practice and greatly improved outcomes.

The draft evaluation of the trial (Northern Territory Office of Aboriginal Development 1997) concludes that 'the potential cost to Government of not providing and accessing interpreters in Aboriginal languages far exceeds the cost of providing them' (p. 3). As an example, the potential liability for a claim where informed consent has not been obtained for a medical procedure which results in injury to the patient may be as high as $6 million.

The future of interpreter services for Aboriginal people

The draft report evaluating the trial Aboriginal languages interpreter service (which was not publicly released, Northern Territory Office of Aboriginal Development 1997) concluded that the use of an interpreter can facilitate early and accurate diagnosis, result in shorter hospital stays, reduce hospital costs, improve communication between doctors and patients about ongoing treatment on discharge from hospital, and might also result in reduced readmissions and expensive evacuations. The report recommended that a central funding and coordinating agency is needed and should become part of Northern Territory Interpreter and Translator Service at an expected cost of $370,000 per annum for the Top End. Some stakeholders have expressed concerns about such a centralised model, with considerable support given to an alternative model which supports existing regional language centres in administering and extending their interpreter services, and progressive development of language centres in other areas. Such regionalisation is considered essential to meet the level of training and support which is required for a professional interpreting service. A greater use of telephone interpreting, with its potential to minimise costs, and team interpreting to cover a broad range of cultural and linguistic knowledge required in specialised circumstances, have also been advocated.

However, the final evaluation report (Northern Territory Office of Aboriginal Development 1998), released almost one year after the completion of the trial, makes no recommendation about future service development. Inquiries to government about plans for an Aboriginal interpreter service have met with evasive responses. For example, in answer to a question asked in the Northern Territory Parliament (Hansard 21/4/1998) about when such a service will be introduced, the Attorney-General stated that the service 'is still being evaluated' and that 'interpreters are available in health and also in the legal system'. (The names and contact details of some Aboriginal interpreters are available from the Office of Aboriginal Development, but most service providers are unaware of this, and there is no funding or administrative support for employment of these interpreters such as that available for languages other than Indigenous languages.)

An Aboriginal interpreter service lobby group was established at the end of the trial and a number of health and legal professionals are actively involved. But one year after the completion of the trial there is no indication from the Northern Territory Government that any further support will be provided for Aboriginal language interpreters in health care services, and frustration is increasing among service providers who recognise that effective communication with their Aboriginal clients is essential if health outcomes are to improve.

Interpreter training

In recent years general interpreter training courses have been run by the Institute for Aboriginal Development and by Batchelor Institute of Indigenous Tertiary Education, including a one-year diploma course as well as some community-based short courses. In 1998 only Batchelor Institute provided interpreter training. The majority of interpreters in Aboriginal languages are accredited by the National Accreditation Authority for Translators and Interpreters at level 2 (para-professional) and further training to facilitate accreditation at the professional level (preferred for medical and legal interpreting) has not been available. In a recent report on strategies for training of interpreters in Aboriginal languages (Phelan 1997, p. 5), the following training options were recommended:

- initial interpreter training for bilingual and bicultural people, both Indigenous people and others
- post-initial training, including the possible future training at professional level
- training of professionals and government officers who work with interpreters
- training of bilingual people who interpret 'incidentally' as part of their work
- training in cross-cultural communication and specifically in Aboriginal language and culture

The report also identified the need for general education to raise awareness and understanding of the role of the interpreter, which would in turn contribute to the development of a professional interpreter service that was understood by clients.

The final Aboriginal languages interpreter service evaluation (Northern Territory Attorney-General's Department 1998) also identified:

- the need for ongoing inservice training for interpreters, and specialised training in health terminology and procedures
- the need to negotiate with relevant training bodies for the development of support aids such as videos and courses for people using interpreters

Training in medico-legal issues and the structure and function of the health system has also been identified as important. Both the Aboriginal Resource and Development Service (pers. comm., May 1998) and the Northern Territory Office of Aboriginal Development (1997) point out that there are insufficient trained interpreters to meet the needs of some language groups so recruitment of additional interpreters, supported by adequate training, is urgently required.

The training needs summarised above were repeatedly verified in discussion with service providers, Aboriginal interpreters and Aboriginal people. Concerns were widely expressed by those stakeholders experienced in training and/or working with interpreters, and interpreters themselves, that the specialised training and support that is required to work effectively in health care settings must be integral to any established interpreter service if it is to succeed.

Future action

The use of professional interpreters is a relatively simple strategy that has the potential to substantially improve health outcomes for Aboriginal people; to be successfully implemented the following goals must be achieved:

- increased understanding of the nature and extent of miscommunication and its potential consequences for all staff and clients
- equity of access to trained interpreters through provision of a government-funded professional interpreter service, such as the service which is available to non-Indigenous people who speak languages other than English
- provision of specialised training programs in medical interpreting
- development of service providers' skills in intercultural communication, including how to identify when an interpreter is needed and how to work effectively with interpreters
- a change in policy and practice to emphasise genuine accommodation of the communication needs of Aboriginal clients and staff
- formal work-practice requirements to ensure that interpreters are used at all required times to achieve effective communication, particularly when obtaining informed consent in clinical and research environments

A number of possible actions emerged from the review which could be pursued through the CRCATH or alternative funding sources. These include:

- a research project to investigate current communication practices and document the needs of Aboriginal users of health services; research would have a number of components:
    - a 'snapshot' of communication needs, and strategies currently employed to address these needs, in a range of health services throughout the Northern Territory, i.e. document the number of patients who could benefit from interpreter services in a given period and the level and nature of interpreter services provided (including both Aboriginal and non-Aboriginal patients for comparison)
    - detailed case studies to identify and clearly document the extent and nature of miscommunication in interactions between service providers and their Aboriginal clients using objective techniques such as discourse analysis
    - development of guidelines and/or training programs for improving communication in health services, including education and training programs

- a trial clinic-based interpreter service in a remote community health centre which has identified a high level of need for interpreter support for their full-time doctor and visiting specialists; the trial would lead to the development of a model for community-based and controlled interpreter services, and training strategies to meet the specific and increasing needs of such health services
- the development of specific guidelines for use by health staff to determine whether an interpreter is needed (such as those recently developed for use by lawyers)
- the implementation of strategies through which the CRCATH partners can support the development of effective interpreting services and training, e.g. demonstrating good practice by requiring CRCATH research projects to use professional interpreters where appropriate

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3. Cultural education programs for service providers in Aboriginal health care

A CRCATH Indigenous Health and Education program review paper

Anne Lowell

October 1998

Abstract

The centrality of cross-cultural understanding in effective service delivery is acknowledged in Aboriginal health policy. In practice, however, the level of cross-cultural understanding required for effective provision of services is rarely achieved by current staff training methods, despite substantial improvements in recent years. Some of the recurrent themes arising from discussions with both health staff and providers of cultural education programs in the Northern Territory include the need for: greater resources to enable training programs to meet demand; extension of training programs in terms of depth as well as specific regional and professional relevance; improved cultural education opportunities for Aboriginal staff; and improving the understanding of health staff about how their own values, behaviour and perspectives are culturally constructed. More extensive training in intercultural communication to improve interactions between Aboriginal and non-Aboriginal staff, as well as between non-Aboriginal staff and their Aboriginal clients, is repeatedly identified as a priority. Although the importance of cultural education is reflected in health service policies, the degree of commitment leading to implementation is questioned by both providers and staff as effective cultural education is not yet available within most health services in the Northern Territory.

Introduction

> There is concern, there is care, but there needs also to be better reciprocal understanding that is grounded in authentic knowledge. [Devitt & McMasters 1998, p. 165]

In any discussion about this topic the first challenge is to clarify the terminology. Concerns are often expressed about the use of 'cross-cultural' as it does not acknowledge the importance of understanding one's own cultural influences. In this paper, the term 'cultural education' is used to encompass all aspects of education and training concerned with improving the knowledge and skills of people working in an intercultural environment.

This paper is based on a review of the relevant literature identified through searches of relevant databases, discussions with stakeholders (both cultural education program providers and health staff) predominantly from Darwin, Alice Springs and East Arnhem Land regions, and on the writer's experience as a service provider and researcher in the fields of Aboriginal health and education.

A brief overview of the training programs currently available to health staff in the Northern Territory is provided in the next section. This is followed by a summary of the key issues which emerged from discussions with stakeholders. The final section then outlines some specific strategies that could contribute to improving cultural education for health staff working with Aboriginal people.

An overview of cultural education programs available to health staff

In discussions with health staff, inadequate specialised training to meet the demands of their workloads is often identified as a major barrier to effective delivery of health services to Aboriginal people. This is supported by the little research which has been conducted in the area. For example, in a random sample of 10% of Territory Health Services staff, 82% who have contact with Aboriginal clients reported some difficulty in their interactions with them. The same survey found that 100% of Territory Health Services Aboriginal staff sampled had difficulty interacting with non-Aboriginal staff (Territory Health Services 1997). The seriousness of the situation in north-east Arnhem Land, for example, is explained by Rev. Dr Djiniyini Gondarra:

> Balanda and Yolngu3 do not understand each other. The Balanda are confused about how Yolngu society works and Yolngu are confused about Balanda society—they are missing each other all the time . . . [Trudgen 2000]

The need for improved cultural education is also a recurring recommendation in government reports such as the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989) and the Royal Commission into Aboriginal Deaths in Custody (1991) and a Northern Territory report on cross-cultural awareness programs in the public service (Carroll 1993). For example, the *Royal Commission into Aboriginal Deaths in Custody National Report: Overview and Recommendations* states:

> Many non-Aboriginal health professionals at all levels are poorly informed about Aboriginal people, their cultural differences, their specific socio-economic circumstances and their history within Australian society. The managers of health care services should be aware of this and institute specific training programs to remedy this deficiency, including by pre-service and in-service training of doctors, nurses and other health professionals, especially in areas where Aboriginal people are concentrated . . . [Johnson 1991, Recommendation 247.a, p. 87]

In recent years Territory Health Services has responded to such recommendations with the development of the Aboriginal Cultural Awareness Program. This program consists of four workshops and three learning packages that were developed in conjunction with the Institute for Aboriginal Development in Alice Springs. The program has since been extended to Darwin. Only stage 1, which is compulsory for all staff, at least in theory, has been available in Darwin. However, implementation of Stage 2 has commenced recently. The Aboriginal Cultural Awareness Program is delivered as part of orientation for remote area staff or as independent workshops for other staff.

Other providers of training programs which are sometimes accessed by health staff include the Faculty of Aboriginal and Torres Straight Islander Studies at Northern Territory University, Nungalinya College and Flinders University Northern Territory Clinical School, as well as private providers, of which there are an increasing number in the Territory.

Aboriginal Resource and Development Services also conduct cultural awareness workshops which are compulsory for Territory Health Services staff in East Arnhem Land, and which are also used by other professionals in the region including independent health service staff.

Another source of cultural education for health staff is through individual courses of study, such as units related to cultural issues in Aboriginal health care through Flinders University postgraduate courses in remote area health practice (currently under development), and various masters' programs.

Informal cultural education which occurs in some workplaces is also identified by many people as an important and effective source of training, but this is highly dependent on individual motivation and goodwill. As well, many cultural education materials have been produced, some of which, such as Binang Goonj (Eckermann et al.1992), are excellent. However, staff are often unaware of, or unable to get hold of, these materials and many useful publications are no longer available.

The key issues in current cultural education practices

> Equity of access implies that people of cultural and linguistic backgrounds other than that of the majority group (whose culture is reflected in its institutions) are accommodated in the nature of the service provision. Professionals should be trained to deal with this cultural diversity. [Pauwels 1991, p. 151]

A number of recurrent themes emerged during discussions with providers of cultural education programs and health staff in both urban and remote settings. In all regions the critical importance of cultural education to effective health service delivery is widely acknowledged and comprehensive training in working in a cross-cultural environment, rather than 'cross-cultural awareness' is often advocated as the minimum acceptable standard for all health staff, including management.

However, health staff consistently described their level of training as inadequate to meet the demands of their specific work environments. Even those cultural education programs described as excellent by their clients were still considered insufficient to meet their needs. Common limitations identified include inadequate depth and range of information and/ or inadequate regional or professional specificity. Another common concern is that although very informative in theoretical terms, training programs do not sufficiently cover the practical needs of the workplace. Long delays in securing a place on programs also occur in some regions.

These concerns are generally recognised by providers who are frustrated in their efforts to meet the demand for frequent and wide-ranging courses because of inadequate resources. Follow-up workshops and self-directed learning materials could address some of these needs. Such strategies are being implemented to an extent in some programs, most notably Territory Health Services' Aboriginal Cultural Awareness Program.

There also remains an urgent need for specific training for both Aboriginal and non-Aboriginal staff in how to work collaboratively, with particular attention to cultural influences on communication and work practices. For example, Aboriginal staff stressed a need for non-Aboriginal staff to better understand—and implement—their role as one of support rather than control. In both health and education sectors, training strategies related to 'working together' have been developed but not sustained.

Many Aboriginal health staff want to increase their understanding of Western cultural influences on health and education services, to further develop their English proficiency and/or develop skills and confidence in communicating in the workplace. More cultural education and languge programs are needed to meet the need.

Training for non-Aboriginal staff to recognise the ways in which their culture influences their attitudes, interpretations and practices (i.e. cultural reflexivity) is widely recognised as crucial, particularly by cultural education providers. Some programs are reported to be effective, but again, are often considered insufficient.

Developing skills in cross-cultural communication has been proposed as a key aim in cultural education programs (Kalowski 1991; Pauwels 1991). However, it appears that existing cultural education programs, at best, sensitise staff to some of the possible sources of intercultural communication difficulties but cannot impart the level of cultural and linguistic knowledge necessary to reduce the extremely high probability of miscommunication in Aboriginal health services. Access to relevant language programs, in addition to regionally specific, in-depth training in cross-cultural communication would help address this problem. This should not be seen as an alternative to the employment of trained interpreters, but as an additional strategy to improve the ability of health staff to recognise potential communication difficulties and to take appropriate action.

Greater support for community-based learning opportunities would improve access to informal cultural education through one-to-one contact with Aboriginal people, often described as the most effective learning strategy. Opportunities for staff in regional centres to work in their clients' home communities also need to be supported and sustained.
Although the limitations of current cultural education programs received the greatest focus in discussions with staff, the benefits of good cultural education, when available, were also described. These included decreased staff turnover, reduced stress, more effective work practices, and improved workplace relationships between Aboriginal and non-Aboriginal staff.

Despite recent improvements, including attempts by providers to address many of the issues identified above, effective cultural education cannot be achieved with the inadequate resources currently committed to the area. It requires a sustained commitment to implementing cultural education policies including active workplace support and enforcement of mandatory training requirements.

Future actions

A number of research and/or development possibilities were identified through discussions with stakeholders which could contribute to improving cultural education programs for health staff working with Aboriginal people:

- build a comprehensive database of the cultural education programs and materials available to service providers, who are often unaware of such resources (expanding on existing publications, e.g. *Cross-Cultural Communication Guide* (National Centre of Vocational and Educational Research 1992))
- develop resources to support self-directed learning that:
    - can be easily accessed by staff to meet their changing needs
    - are regionally specific
    - address specific workplace needs

Interactive multimedia training materials are a currently under-utilised option which can be accessed on CD-ROM and/or the internet, as well as through the Northern Territory Government intranet, therefore, accessible to all Northern Territory Public Service staff at any time at no cost.

- an evaluation of current cultural-education practices across a range of Aboriginal health services; such an evaluation could be productive given the concerns of both users and providers about current inadequacies in cultural education services
- documentation of good practice in cultural education and its consequences to inform future developments in this area
- a workshop for cultural education providers to improve the coordination of programs and communication between the increasing number of providers; currently, there is no network

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