Traumatology Talks – Black Wounds, White Stitches

Summary Report

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Traumatology: the study of wounds and injuries caused by accidents or violence and the surgical therapy needed to repair the damage.

Aboriginal and Torres Strait Islander peoples' traumatology: Intergenerational trauma resulting from genocide, forced separations and removal with epigenetic, telomeric and associated biological changes that are exacerbated by re-traumatising events, poor social and cultural determinants of health, and narratives of desperation, disadvantage, marginalisation and vulnerability.

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The scientific underpinning of intergenerational trauma as experienced by First Nations' peoples commenced centuries ago with colonisation. Today, trauma is embedded in, and frames the lived experiences of, Aboriginal and Torres Strait Islander Australians.

When they present to emergency departments (EDs), the full manifestation of their trauma experience presents with them. In a previous study, Aboriginal and Torres Strait Islander people articulated that triaging for their experiences of embodied trauma is not generally effective, because the discipline of traumatology is premised on triaging for clinical severity and treatment.[1] It should instead be carried out through a lens of trauma-informed practice, as this is more likely to ease the burden of trauma-related vulnerabilities underpinning presentations to the ED by First Nations' peoples.

About this project

The Australasian College for Emergency Medicine (ACEM) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak body for emergency medicine, the College has a significant interest in ensuring that the highest standards of medical care for patients are maintained in EDs across Australia and New Zealand.

ACEM's vision is that the provision of culturally safe and quality acute health care in Australian hospital EDs is vital to true reconciliation with Aboriginal and Torres Strait Islander peoples. To achieve this vision, ACEM commissioned a research project to study cultural safety in ED settings from the perspectives of both service users and emergency service providers. Developed in partnership with Karabena Consulting and the Lowitja Institute, the project's aims were to develop a Cultural Safety Advocacy and Implementation Plan to improve emergency care delivery for Aboriginal and Torres Strait Islander people; to identify conceptions of cultural safety from both First Nations' peoples and ED staff; and to apply this information in further education and training opportunities for staff, future ED design, and ACEM's research strategies and investments. A full report has also been prepared, on which this summary report is based.

To achieve these aims, we facilitated a co-design process in the project's implementation and governance arrangements, established project governance structures, and sought clarity regarding reporting requirements so as to ensure that project findings were effectively communicated to a Reference Group and to ACEM. Strategies first devised to implement this project had to be amended due to the impacts of COVID-19 and the length of time it took to secure ethics approvals from the three pilot sites involved.

The project uses methodologies that are inclusive of First Nations' research leadership, narrative practices, cultural protection and data sovereignty, and that involve community members as co-creators in the processes of engagement, implementation, evaluation and knowledge exchange. As part of this approach we held two virtual stakeholder roundtables, one to initiate the project and a second as part of the project's exit strategy, and conducted interviews with ED staff. These greatly informed the development and delivery of the project progress reports and were used to validate themes for inclusion in the full report.

They listen to you when you are giving details about the reason why you are there, but they are not interested in who I am as an Aboriginal person...

We commissioned local Aboriginal male and female research teams based at the three chosen pilot sites – Lyell McEwin Hospital in Elizabeth, South Australia; Alice Springs Hospital in the Northern Territory; and Shoalhaven Hospital in Nowra, New South Wales – to recruit for patient interviews. In total, we interviewed more than 40 people, some of whom were new clients while others had been engaged with the ED for 5–10 years. They provided us with key information regarding patterns of ED use, social and cultural determinants of health and recommendations to improve services. Our interviews with ED staff, paramedics and Aboriginal Hospital Liaison Officers (AHLOs) gave them the opportunity to discuss the challenges they experience in implementing culturally safe emergency services and their recommendations for improvement.

The project methodology was primarily informed by a Literature Review that focused on the cultural safety needs of First Nations' patients, and on international research that can inform the development of both a cultural safety strategy and an implementation plan that advocates for the uptake of our recommendations in EDs across Australia and New Zealand.

A new approach: Social Emergency Care

In the ED, advocates are asking for a reimagining of emergency medicine, not only in diagnosing and treating wounds, infections and injuries, but also in expanding the role of diagnosing and treating the social and cultural determinants of health and wellbeing for all populations. They are advocating for the introduction of Social Emergency Care (SEC), an emerging field of practice that can be delivered in concert with emergency medicine, but one that can more appropriately respond to these determinants of health. This makes it a specialisation that can emphasise the particular requirements of Aboriginal and Torres Strait Islander peoples.

So many of those presenting to our EDs carry with them deep and pervasive societal wounds, which cannot be stitched back together by emergency medicine alone and thus will never heal. Although our EDs are well versed in identifying and addressing clinical interventions, they need to shift their practice to consider the social and cultural determinants underlying health and illness. To respond to this, the project proposes the introduction of an Australasian discipline of Social Emergency Care.

The diagram on pp.8–9 lays out how the current chain of command model operates in EDs and how a future Social Emergency Care approach might work.

Recommendations for inclusion in a Cultural Safety Advocacy and Implementation Plan for ACEM

For ACEM, there is no 'one size fits all' approach, but rather a range of strategies that advocates can employ. The advocacy plans can be topic based, deliberative, collaborative, nationally driven and/or locally applied. Careful consideration is required to determine what approach is likely to be most effective and to meet those priorities that are more likely to have a significant bearing and or impact on health. A key consideration for ACEM should also be on whether it has capacity and is best placed to advocate on all matters contained in the full report, or whether partnerships should be formed with other professional bodies involved in the delivery of emergency services.

Advocacy should improve ACEM's long-term standing and strength by way of establishing important networks, alliances, partnerships and profile in the policy arena. Although the full report combines a rich context for the implementation of the following strategies, it also highlights that more work needs to be done in the creation of an Australasian evidence base that is directly informed both by ED staff and by First Nations' peoples and communities.

Recommendation 1

Introduce a Social Emergency Care discipline

ACEM to introduce a Social Emergency Care discipline by developing curriculum to increase the number of SEC practitioners – clinicians who can treat clinical presentations, work to understand the experiences of those presenting, and ascertain the social and cultural determinants underlying Aboriginal (and other) people's ED presentations.

a ACEM is well positioned to develop, implement and evaluate the impact of an accredited Social Emergency Care Practitioner Certificate course, and the consequent work of the Fellows.

b In developing the curriculum for a SEC Practitioner Certificate, consider core modules, project-based activities and a community of practice approach over the course of a year. Different subjects could be developed to meet the needs of diverse groups such as Aboriginal Health Workers (AHWs); nurses and doctors; AHLOs, counsellors and psychologists; allied health and social worker staff; linguists and language speakers; administrators; transport drivers; ambulance paramedics; specialists and other professionals; and people who provide cultural supports in the patient journey.

c Create local, regional, State and national action research projects that can be completed by First Nations' researchers and consultants in association with agencies and practitioners engaged in the SEC Practitioner Certificate. As part of their assessment, course participants can complete position statements, organisational policies and practices, write up findings from projects and pilot programs, and deliver community-requested products on projects such as those identified by community people in this study.

d ACEM to engage Aboriginal and Torres Strait Islander professional associations and consultants to co-design, implement and evaluate the provision of cultural coaching, professional debriefing and support services to front-line responders and the emerging Social Emergency Care, cultural health and wellbeing workforce.

e Advocate for the discipline of Social Emergency Care to lead training strategies and identify alternative referral pathways to accommodate people with mental health issues, including psychosis.

Recommendation 2

ACEM education, training and accreditation

Social Emergency Care Training

- Create, in partnership with Aboriginal and Torres Strait Islander health professional peaks, an Aboriginal Emergency Health Practice Certificate specifically for First Nations' workers in the ED, or AHWs looking to enhance their emergency health practices, which can extend into the SEC Practitioner Certificate course (see Recommendation 1).
- Facilitate a pilot program of 'Social Emergency Care Summer (or Winter) School: Specialisation First Nations'. In this scenario, relationships could be developed between higher education institutions and professional peak bodies to organise a specialised First Nations' pre-employment program, which could also act as an orientation to the region for new employees. Coordinators and implementers of the Summer School could be a combination of businesses – an ABN workforce of First Nations' trainers, consultants, cultural awareness trainers, caterers, traditional healers, coaches, program designers and facilitators – universities and relevant peaks to introduce a six-week pre-employment internship, during which people participate in a structured program to learn and demonstrate capacity in the following:
    - Trauma-informed practice – understanding and responding to the issues of 'distrust' by patients of non-Indigenous staff in EDs.
    - Social and cultural determinants of health – historical context and the social and economic conditions impacting ED presentations.
    - Client-centred referral pathways – course participants engage with local agencies and understand referral pathways including visits to remote areas as needed.
    - Aboriginal and Torres Strait Islander people's understandings – of kinship, family obligations, public and private information and gendered information-sharing strategies.
    - Presentations to EDs – issues of safety (being culturally safe), sanctuary (addressing issues of homelessness) and service (throughput care for urban, regional and remote services).
    - Participating in partnerships and collaborative actions – how to work with First Nations' staff and clients (e.g. going to someone's home, wherever that is and however they get there).
    - Walking through the ED department – from the perspective of First Nations' people.

Cultural Safety Training

- Develop culturally safe, evidence-based training that is presented or co-presented by a First Nations' person with the appropriate authority in ways that encourage active participation and is specific to the region in which the hospital is located.
- Together with Indigenous businesses, consultants and service delivery agencies develop a national online evidence-based Cultural Safety Training course for practitioners, detailing key aspects of the findings contained in the full report, that includes but is not limited to the following:
    - the holistic model of care;
    - effective communication (including the use of simple, plain English);
    - social and cultural determinants of health;
    - the concept of promoting equality versus enhancing equity;
    - racialised health care;
    - reflective practice;
    - trauma-informed care;
    - gender issues;
    - comprehension issues – picture boards;
    - poverty simulation;
    - historic issues impacting presentations to ED;
    - acknowledging the roles and responsibilities of carers and people who accompany patients to hospitals (treat them as navigators);
    - issues around bereavement, grief, death dying, palliative care;
    - culturally safe pain management;
    - recognising when people are practising cultural safety; and
    - place-based responses to emergency medicine.
- Develop separate and specific Cultural Safety Training courses for doctors from other countries coming to Australia, as the specific knowledge and history of Australia's settlement is seldom known or understood.
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification with ACEM.
- Have regional-specific communication strategies incorporated into Cultural Safety Training programs to ensure the concept of 'shame' is well understood, as reducing people's exposure to shame is a key practice principle in Social Emergency Care work.

— Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes).

— Implement cultural safety survey tools to benchmark performance in meeting people's needs (see Recommendation 6).

— Work with communities where English is not the first language to enhance the accurate translation of complex medical issues and ensure gendered, cultural communication techniques are always understood and able to be accessed.

— Change the descriptors of individuals from negative or deficit-focused language to positive and strengths-based language. For example, the descriptor of Aboriginal people 'taking their own leave' focuses on individual capacity to participate in ED processes, rather than on cultural safety in the ED and their experiences of institutional care.

Other training

— Implement an orientation program introducing social and cultural determinants of health to emergency workers. This could include a poverty simulation, and visits to homeless and other shelters, addiction clinics, outpatient clinics, aged care homes and, in agreement with local community people, places where patients live and/or are referred to and from. A 'Walk in their shoes' program could also be part of the program, perhaps with elements of the orientation led by a frequent service user.

Cultural training is all done from people above, the big bosses and executives. So we don't get a lot of say in that training, and that's maybe something that should change. It's us on-the-ground workers, the AHLOs and allied health staff, who need more say in the development of the cultural safety programs. That's because [we] know what's going on in the emergency departments and the big bosses don't.

Recommendation 3

Workforce advocacy

Innovation

— Advocate for more First Nations' staff to be employed by EDs, as Aboriginal patients and their families have asked for cultural relationship-styled support at this point in the patient journey. For example, First Nations' people could be employed under the banner of Enhanced Patient Experience roles as advertised by NSW Health.

— Appoint First Nations' people to roles in pre-ED services (ambulatory), triage and discharge. For example, Aboriginal Health Workers with prescribing rights could make a valuable contribution to a small triage team by supporting Aboriginal and Torres Strait Islander people needing access to medication and other ambulatory services at peak times during the day. They could also enhance cultural safety in the triage and waiting room process, ensure the comfort of people in situ (retrieve bedpans, answer buzzers, etc.) and support patients who are on their own in the ED. This is expected to reduce waiting times, minimise people's exposure to racism in ED waiting rooms, cut through any negative stereotyping (unconscious bias) and enhance accessibility.

— Work with local Aboriginal Medical Services (AMSs) and GP services based in community-controlled organisations to see if AHWs could be employed during the evening shifts in the ED, so as to increase the hours in which Aboriginal and Torres Strait Islander staff can be accessed by First Nations' patients and their families.

— Employ trained interpreters who can work with complex medical issues and promote language development across different language groups around these core concepts.

— Ensure ED staff can provide accessible and available gender appropriate care and support to respond to both men and women in emergency services from pre-ED through to discharge.

— Create opportunities for cultural engagement, supervision and 'buddy' arrangements for people on the floor during shifts, with ED-based cultural mentors to enhance staff capacity to provide cultural care that is aligned to the opening hours of the ED.

— Ensure all security staff in EDs have Cultural Safety Training to understand their impact on the health and wellbeing of those in the ED and in waiting areas. Include information on the de-escalation and safe removal of people who are in heightened states of emotion.

Recommendation 4

Empowering Aboriginal and Torres Strait Islander businesses

- ACEM to work with Reconciliation Australia and Indigenous business networks to invest in a sustainable ABN peer workforce of AHLOs, interpreters, translators fluent in First Nations' languages, cultural greeters and mentors, healers and bush medicine providers, cultural awareness trainers and supervisors, orientation service specialists, transport workers and recruitment agents. This workforce activates the requirements for hospitals and other services to spend 1–3 per cent of their entire budgets on for-profit Indigenous businesses through the national Indigenous Procurement Policy.
- Work with Indigenous businesses and institutes to create and support a peer workforce that also includes peer supports, researchers and educators to undertake surveys and work with different stakeholders to enhance understanding between patients and practitioners.

Recommendation 5

Emergency department design

- Investigate alternative triage models, e.g. Triage and Treat, Team Triage approaches and ensure Rapid Assessment and other models of early engagement with Aboriginal and Torres Strait Islander patients is done with and by First Nations' staff.
- Where possible, seek to promote the principles of cultural safety in ED settings, and activate strategies to enhance rights-based and First Nations-led initiatives, particularly in the planning of the built environment and introducing innovative programs.
- Implement environmental improvements to enhance cultural safety, including the display of Aboriginal and Torres Strait Islander posters, health brochures, local artwork, etc., and increasing the number of private areas (wider, curtained cubicles and sound-proofed rooms) for patients and their families to gather. Also needed are separate, gendered places for men and women in the ED to allow for culturally appropriate emergency care.
- Create designated spaces for Aboriginal and Torres Strait Islander patients, and/or provide more comfortable and secure places outdoors where people can wait and be called inside for treatment.
- Trial the development and implementation of a suite of translation resources into EDs (illustration boards, language resources, interpreters) to enhance the patient journey.
- Facilitate the development of accessible information – TV advertisements, social media, short videos in different languages, brochures with art designs from the region – to show to community and other services and in ED waiting rooms.

Need to have an Aboriginal person there at every visit – not once you are admitted but when you are actually in the emergency department. That would make me feel heaps more comfortable.

Recommendation 6

Research

Develop an ACEM cultural safety research program based around discrete projects as identified by community people in this study. The research programs advocated for include:

- Co-designing care models for people living in remote and regional areas and for at-risk and vulnerable communities: for example, adolescents with heightened anxiety, people who are ice addicted, exhibiting suicidal behaviour, have had gender reassignment surgery or are transitioning, and older single women living complex lives.
- Trialling picture- and illustration-based communication techniques in pre-ED and ED settings to enhance culturally safe communication with people who speak English as a second or third language.
- Providing culturally appropriate outreach emergency services to people experiencing homelessness.
- Supporting people who want to die on Country and providing culturally safe patient palliative care choices in EDs, including support for families through an ED-based palliative care and early bereavement process: for example, an 'Into the Dreamtime' project to manage early grief in ED settings and the adoption of names such as 'Walking with the Ancestors' for palliative care rooms.

— Acknowledging the cultural roles and responsibilities of the carer or person attending the ED with the patient, learning how to respond to their advocacy, and recognising and responding to these relationships.

— Designing physical spaces in the ED and surrounds, including 'extended' EDs (café-styled waiting rooms with peer supports on the grounds, community ambulatory services in community hubs).

— Learning to recognise and respond to people who are practising culture and cultural respect in ED contexts.

— Facilitating culturally safe pain management in ED waiting rooms.

— Ensuring gendered approaches to emergency care.

— Creating culturally safe referral pathways for Aboriginal and Torres Strait Islander people from the ED to other areas of the hospital campus, their transportation to other ED-ordered services, and upon discharge. These projects could emphasise strategies to enhance patient and family outcomes and reduce readmission rates.

— Establishing and sustaining an ACEM-led Social Emergency Care, cultural health and wellbeing workforce, cultural safety networks, and communities of practice instigated regionally but supported and reported on nationally.

— Implementing the Cultural Safety Survey Scale in EDs, a tool for measuring cultural safety from the perspective of First Nations' patients.[6]

Recommendation 7

Place-based strategies, external partnerships and advocacy

— Work with pre- and post-ED services to adopt strategies that will enhance their capacity to be culturally safe. Trial different regionalised approaches to triage events including models that extend and include ambulance services, police and other first responders, GPs, community clinics and alternative referral pathways. This could be achieved through the adoption of Social Emergency Care as a discipline to address the social and cultural determinants of clients' health needs (see Recommendation 1).

— ACEM and others to auspice the development of a peak body for AHLOs and Aboriginal and Torres Strait Islander people involved in SEC to create professional development opportunities, establish regional communities of practice and promote career advancement to ensure client care along the patient journey from pre-ED to discharge and home again.

— Work with other institutions frequented by Aboriginal and Torres Strait Islander people – including in detox or 'dry-out' shelters, women's shelters and emergency accommodation – for the co-location of emergency services to alleviate cultural issues and promote different access points for ambulatory and emergency care.

— Engage national 'lived experience' organisations, including those that represent the interests of people affected by mental health – such as Black Dog Institute Aboriginal Lived Experience Group, Culture is Life (Aboriginal Youth Suicide Prevention Organisation), First Peoples Disability Network Australia, Thirrili (National Post Suicide Postvention Service) and Gayaa Dhuwi Proud Spirit Australia) – to revise elements of the ED Design Guidelines and facilitate discussions on advising the development of models, triage systems, content for Cultural Safety Training and workforce development strategies (see Recommendation 5).

— Build these strategies into place-based, regionalised responses that engage a range of services in the uptake and advancement of SEC, and cultural health and wellbeing strategies.

— Hold annual summits on regional cultural safety in the ED based on national standards and facilitated in partnership with local ABN holders, Traditional Owner groups and service delivery agencies. The summits will facilitate understanding and work towards addressing the gaps and barriers to, and celebrating the enablers for, cultural safety in the ED ecosystem, which extends from a person's home base to the hospital and other secondary and primary health care pathways.

— Strengthen ties with a first responders' network to enhance the pre-ED cultural safety experience, and create opportunities for ambulance paramedics, police, fire fighters and child protection workers, for example, to join this network. Develop regional plans for the activation of SEC work to cut through silos.

— Increase ED engagement with AMSs and other First Nations' community organisations in the hospital's region by developing relationships and holding regular forums to develop culturally safe transitional services.

A Social Emergency Care approach to emergency medicine

Community narratives of traumatology	Triage categories 1–5		Staff narratives of traumatology
Had a good experience. *Had all the information I needed.* *Was transferred to another hospital well.*	Triage category 1	Conditions that are a threat to life requiring aggressive intervention.	Chain of command Hierarchical Body parts approach Male dominated
Was picked up by ambulance and was happy to hear the ambos talking to the ED. *Got straight through out the back area and didn't have to wait in the waiting room.* *Got a comfortable chair but was left in rooms on my own.*	Triage category 2	Imminently life threatening, deteriorating so rapidly or organ failure if not treated within 10 minutes of arrival, or work to make significant effect on clinical outcomes or very severe pain.	Traumatic and exhausting Exciting and different Adrenaline rush Saving lives Families provide details Shift work and few resources Busy, making judgments Categories 3–5 take up time
You really know you are Aboriginal when you go into places like this. *When you only have $60 left for the next three days then going to ED costs a lot by the time you pay for petrol.* *Don't want to interrupt people because they are busy.* *Knew I would have to wait a long time so I tried to get in by ambulance because I will get out the back quicker.* *The doctors don't explain things properly to patients, they scare us and we don't feel comfortable.* *Need to have an Aboriginal person there at every visit – not once you are admitted but when you are actually in the ED. That would make me feel heaps more comfortable.* *Cultural training is all done from people above, the big bosses and executives… It's us on-the-ground workers, the AHLOs and allied health staff, who need more say in the development of the cultural safety programs. That's because [we] know what's going on in the ED and the big bosses don't.*	Triage category 3	People who need to have treatment within 30 minutes are categorised as having a potentially life-threatening condition. People in this category are suffering from severe illness, bleeding heavily from cuts, have major fractures or are severely dehydrated.	Poverty drivers Lack of transport Homelessness 'They should take better care of themselves' Too many family members in the room Frequent flyers here for the blankets and sandwiches Too busy to get people bedpans Nowhere else to send them Can't comprehend whether they know about consent
	Triage category 4	Condition may deteriorate, or adverse outcome may result, if assessment is not commenced within one hour of arrival in ED. Whether symptoms are moderate or prolonged, humane practice mandates the relief of discomfort or distress within one hour.	Domestic violence Stereotyping Aboriginal people as intoxicated Asking for pain relief akin to lying drug users Derogatory labels drive assumptions of worthiness Frustrated with families as advocates
	Triage category 5	Condition is chronic or minor enough that symptoms or clinical outcomes will not be significantly affected if assessment and treatment are delayed for up to two hours from arrival because of clinic–administrative problems.	Social issues recognised as contributing to presentations. Providing safety to those who need it Getting angry at bearing the brunt of people's wait time

Current model
Chain of command medicine

Future model
Chain of command medicine

Workplace cultural congruence

Work is aligned to values and motivation

Reasons to work in ED and experience of being in ED become discordant

Narratives of who is a legitimate patient come to the fore

Realisation that precision medicalised structures cannot facilitate clinical interventions for social determinants of health, but ED system too rigid to introduce alternatives

Workplace cultural congruence

Work is aligned to values and motivation

New approach: Social Emergency Care

Introduction of Social Emergency Care (SEC)

SEC research strategy

SEC certificates

Aboriginal staff certification

New roles and responsibilities

Establish peak bodies to support ALOs and other Aboriginal workers

Provide supervision and support for all emergency medicine workforce

Ongoing locally relevant cultural awareness training

Trial social prescribing place-based strategies to action SEC

Social prescribing

Alternative triages

Aboriginal workforce and IPP targets met

Safe Haven-styled models work with community to improve comprehensions issues

Locally relevant, practical cultural awareness training

Certification aligned with SEC

Thorough 'buddy' systems and workforce support through Indigenous business

Place-based SEC strategies creating greater integration pre-ED, at the ED and in post-ED services strengthening

Research and evidence generation to drive new interventions in medicine

Final word

Aboriginal and Torres Strait Islander cultures are a mix of abstract worlds – of mind and spirit; of reality; of land, kinship and cultural activities. Culture is as much a language of the spirit, the spirit of Country and the spirit inherent in cultural practices. ED workplace cultures are busy, chaotic and a place in which emergency medicine is practised. This culture is informed by precise medicine, surgical interventions and relationships founded on hierarchical structures and chain of command approaches to resolving critical issues in as quick and efficient a time as possible. ED culture has its own language, rituals, gestures and ways of connecting patients through triage and waiting rooms to the experience of seeing a practitioner.

Together, these knowledge cultures have become a bastion of light for Australia in the twenty-first century. Aboriginal and Torres Strait Islander people were intervening in the productivity of this nation and what has been learned through that process over many thousands of years will be useful to us all today.[3] The ED culture is a civilisational barometer demonstrating a genuine commitment to human rights and the provision of services and sanctuary for those experiencing vulnerability. For this ED culture to work actively towards addressing social and cultural determinants of health and wellbeing with First Nations' peoples, we are likely to see the acquisition of skills that can greatly impact on the future wellbeing of all Australians.

References

1. Australian Institute of Health and Welfare (AIHW) 2019, *Insights into Vulnerabilities of Aboriginal and Torres Strait Islander People Aged 50 and over: In Brief*, AIHW, Canberra.
2. E. Elvidge, Y. Paradies, R. Aldrich & C. Holder 2020, Cultural safety in hospitals: Validating an empirical measurement tool to capture the Aboriginal patient experience, *Australian Health Review*, 44(2):205–11. Available at: https://doi.org/10.1071/AH19227.
3. Pascoe, B. 2018, *Dark Emu: Black Seeds – Agriculture or Accident?*, Magabala Books, Broome, WA, p. 156.

Note

In this summary report, the term 'Aboriginal' is most often used in relation to this project, as no Torres Strait Islanders were involved as clients, patients or workers. However, more generally we refer to Aboriginal and Torres Strait Islander and First Nations' peoples.

For more information

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