


# Reflexivity in the context of Cultural Safety: Critical considerations in building capacities and capabilities

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# Acknowledgement of Country

I recognise and pay my respects to the Peramangk people, sovereign Traditional Owners of the lands now known as the Adelaide Hills region, the lands I am grateful to call home, and where much of this work was carried out.

I also recognise and pay my respects to the Kaurna people, sovereign Traditional Owners of the lands now known as the Adelaide Plains region, the lands on which this work began.

I acknowledge and respect the ongoing connection of both Peramangk and Kaurna people to the lands, skies, and waters, and that I live and work on stolen lands.

I pay my respects to Peramangk and Kaurna Elders, past and present, and to all Aboriginal and Torres Strait Islander people across these lands. I acknowledge my own responsibility to walk softly on Country and to use my heart and my voice to make change.

**Aboriginal and Torres Strait Islander readers are advised that this thesis includes the names of deceased persons.**

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# Publications and presentations

## Publications

**Chapter 3**

Dawson, J., Laccos-Barrett, K., Hammond, C. & Rumbold, A. (2022). Reflexive practice as an approach to improve healthcare delivery for Indigenous peoples: A systematic critical synthesis and exploration of the Cultural Safety education literature. *International Journal of Environmental Research and Public Health, 19*(11), p. 6691, doi 10.3390/ijerph19116691

**Chapter 5**

Dawson, J., Augoustinos, M., Sjoberg, D., Canuto, K., Glover, K. & Rumbold, A. (2021). Closing the Gap: Examining how the problem of Aboriginal and Torres Strait Islander disadvantage is represented in policy. *Australian Journal of Social Issues, 56*(4), pp. 522-538, doi 10.1002/ajs4.125

## Presentations

Dawson, J., Augoustinos, M. & Crabb, S. (2014, March 1). *Closing the gap: A critical discursive analysis of the construction of Indigenous health problems in Government policy documents* [oral presentation]. Imagining Social Equity; Naarm (Melbourne), Australia. https://socialequity.unimelb.edu.au/#front

Dawson, J. & McDermott, D. (2018, July 15). *Effective Cultural Safety training: what does it look like, and how do we measure it? A qualitative systematic review of the literature* [oral presentation]. Pacific Region Indigenous Doctors Congress; Hilo, Hawai'i, USA. https://drive.google.com/file/d/1qxg2pXINyr7kkGCssPQ3ucua21ZRL0nm/view

Dawson, J. (2024, June 3). *Teaching and assessing reflexive practice as a core Cultural Safety capability: what can we learn from student reflexive assessments?* [oral presentation]. ANZAHPE 'Cultivating Innovation'; Tarndanya (Adelaide), Australia. Conference abstract available: https://eventstudio.eventsair.com/anzahpe-2024/abstract-book. Conference information available: https://eventstudio.eventsair.com/anzahpe-2024/

Dawson, J. (2025, July 2). *The Reflexivity in Cultural Safety Education (RICSE) framework: Development, use, and potential applications within tertiary education.* [oral presentation]. ANZAHPE 'Horizons: Embracing the Future'; Boorloo (Perth), Australia. Conference abstract available: https://eventstudio.eventsair.com/anzahpe-2025/abstract-book. Conference information available: https://eventstudio.eventsair.com/anzahpe-2025/

# Abstract

Reflexivity is a key Cultural Safety capability, facilitating a critical examination of personal and professional culture; internalised racism; power and privilege; and how these shape both relationships with Aboriginal and Torres Strait Islander people and contribute to ongoing racialised health inequities. As such, reflexivity could function as a potential precursor to engaging in antiracist praxis, however its conceptualisation and practice has not been well articulated in the Cultural Safety context. Informed by poststructuralist theory, this thesis presents three original studies examining separate but interconnected aspects of reflexivity.

The first study presented provides a critical synthesis of the Cultural Safety education literature to examine current conceptualisations of reflexivity and teaching approaches to support the development of student reflexive capacity, and whether these are adequate and appropriate to addressing racism. A total of 46 documents describing 43 different educational interventions were analysed. Findings demonstrate a lack of consistency in how reflexivity is conceptualised and taught and highlights a dearth of information regarding the assessment of reflexive capacity development.

The second study presented analysed student reflexive video assessments, with a total of 74 video files included. An analytic framework was developed, informed by the racism, Cultural Safety, and reflexivity literature. This framework was used in conjunction with critical discourse analysis to examine how and to what extent students demonstrate reflexivity in an assessment context, and to what extent this allows for the identification and challenging of racism. Analysis demonstrated that for students, there was a tension between meeting assessment expectations and preserving positive self-presentation. Additionally, while there was evidence that students were actively attempting to manage overt forms of racism, the more ideological aspects of racism remained largely unchallenged.

The final study presented explores the potential of using Carol Bacchi's 'What's the Problem Represented to Be?' (WPR) analytic framework as an approach to reflexively analyse Aboriginal and Torres Strait Islander policy. The original 'Closing the Gap' policy document was analysed using both WPR and critical discourse analysis to examine how the 'problem' of 'Indigenous disadvantage' was constructed. Findings demonstrated consistent slippage from structural to individual explanations for disadvantage, underpinned by deficit discourse and an absence of Aboriginal and Torres Strait Islander voices and aspirations.

Collectively, these studies demonstrate that reflexivity shows strong potential as a critical strategy for identifying and challenging individual, institutional, and systemic racism. However, more work is required to develop a conceptualisation of reflexivity relevant to Cultural Safety in the context of colonial Australia. Key recommendations for future research include the identification and development of pedagogical strategies which more effectively facilitate reflexive capacity building; ensure that racism-related content in Cultural Safety training includes consideration of ideological and structural forms of racism; and explore the potential utility of the WPR analytic framework as a tool for reflexive policy development and analysis to ensure that Aboriginal and Torres Strait Islander needs, priorities, and aspirations are met.

# Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint award of this degree.

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I give my permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

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# Preface

## Overview

I begin this thesis with an introduction – to myself, to my motivations for undertaking this work, and to the ways of knowing, being, and doing (Martin & Mirraboopa, 2003) that have informed this research. A common approach across the social sciences is to include a positionality statement (Finlay, 2002a; Folkes, 2023; Savolainen et al., 2023), to outline my own positionality, power, and privilege, and to examine their influence on the conduct and outcomes of my research. Arguably, however, positionality statements are somewhat limited, given that positionality, power, and privilege are situationally and contextually dependent, and negotiated within each interaction (Finlay, 2002b; Folkes, 2023). Moreover, Gani and Khan (2024) argue that in many instances, positionality statements risk reinforcing and reifying the very racialised power hierarchies they are intended to address.

Rather, to introduce myself I will follow the recommendations of Goenpul woman and distinguished Professor of Indigenous Studies at the Queensland University of Technology, Aileen Moreton-Robinson (Moreton-Robinson, 2000/2020), who states that "the protocol for introducing one's self to other Indigenous people is to provide information about one's cultural location, so that connections can be made on political, cultural and social grounds and relations established" (p. xv). As a white Australian, it would be reasonable to wonder why I am following Aboriginal and Torres Strait Islander protocols of introduction. I do so for two reasons. Firstly, as Carey (2008) argues, introducing myself in this manner is about respecting established protocols; in this way I am locating myself in relation to Aboriginal and Torres Strait Islander peoples and sovereignty. Second, in line with both Moreton-Robinson

(2000/2020) and Applebaum (2010), this is about establishing both my location and my complicity within the racialised systems which produce and maintain racialised inequities.

After introducing myself, I will provide a reflexive account of what led me to undertaking this research, including both my initial motivations and what I have learned along the way. This will be followed by a more specific consideration of the ontological and epistemological positions which inform the development, conduct, and results of this research. Finally, an overview of the thesis will be provided.

## Introducing myself

My name is Jess, and I am a white woman currently living on unceded Peramangk Watta. I was born on Ngarrindjeri Country at the time of the Ash Wednesday fires, to my mother Kathy, and my father Chris. I grew up in a small, predominantly white country town which, as far as I can tell from the *Map of Indigenous Australia* (Horton, 1996) sits at the meeting place of Ngarrindjeri, Kaurna, and Peramangk lands. While I am now lucky enough to live a comfortable life, throughout most of my childhood we lived only marginally above the poverty line, and these experiences significantly shape my own morals and politics.

Both sides of my family are of English descent. On my father's side, my grandfather migrated to Australia as a young child in the 1930s; less is known about my paternal grandmother's branch of the family, but what is known is that they migrated sometime in the 1800s and at least one generation was born and raised in Aotearoa (New Zealand). My mother's side of the family first came to Australia in the mid-1800s. Both my Nanna and Poppa's families originally came from St Yves in Cornwall, England. Like my paternal grandmother, my maternal grandmother's side of the family also lived in Aotearoa for several generations in the mid to late 1800s. My family history, and my existence in these lands, is tied to colonialism and reliant

on the ongoing dispossession of Aboriginal peoples across the Fleurieu Peninsula in South Australia, including Peramangk, Ngarrindjeri, and Kaurna peoples, as well as southern Victoria.

When I turned 18, I moved interstate to attend university in Lismore on Bundjalung Country, and several years later moved up to Meanjin (Brisbane) on Yuggera Country. It was not until nearly a decade later when I had moved back to South Australia and was living on Kaurna Yarta that I began to understand what it means to live on Aboriginal lands.

My first degree was in naturopathy, where perhaps the most important lesson I learned was to look at things holistically. While this was in relation to understandings of health and wellbeing, being able to look at the 'bigger picture' has been invaluable in developing my understanding of colonisation and its continuing impact on health and wellbeing. My second degree was in psychology, and it was during this time that I took my first steps on the path that eventually led me here, to this thesis and this work.

## The lightbulb moment

The catalyst for this thesis can be traced back to an undergraduate class on social psychology. We had a four-week block on intercultural psychology, two weeks of which were dedicated to discussion of issues relating to Aboriginal and Torres Strait Islander mental health. What I – like most classmates – expected was a rundown of relevant statistics on mental health outcomes, and perhaps some guidelines on culturally specific approaches we could utilise. Instead, Dr Yvonne Clark, guest lecturer for the two weeks, spoke of the legacy and ongoing impacts of colonisation, of racism as a driving factor in current health inequities, and the role of psychology as a profession in justifying and supporting many of the atrocities inflicted by

white Australia on Aboriginal and Torres Strait Islander people (Australian Psychological Society, 2017).

I remember the shock I felt, and the outrage and anger as each new piece of information was delivered like a hammer blow. I also remember the utter disbelief that any of this could have happened – could still be happening in Australia – a place I had experienced as ostensibly fair, equal, and accepting of diversity and multiculturalism. Looking back, I can recognise these feelings and reactions well; they are very similar to those experienced by many of the students I have taught in the years since. There was also a sense of betrayal, of feeling misled; that the truth of Australia had been hidden; and in some respect, this is true. Dominant narratives tend to whitewash the truth, to gloss over the horrific events of early colonialism, to deny the extent and impact of racism and social exclusion (Sherwood, 2013). My small, predominantly white school, in a small, predominantly white country town in the 1980s and 1990s provided little information on these realities, instead focusing on the "bravery" of the early "explorers", the hardships and achievements of early colonial life, with only passing references to the First Peoples of these lands. My first university degree had even less; in the four years I studied to become a naturopath I do not recall a single mention of Aboriginal and Torres Strait Islander people, cultures, histories, or healing practices.

I have heard many times in the years since that first lightbulb moment that "ignorance at this point is a choice". I agree with this to an extent; once you are aware that an issue exists, you have a choice to learn more or ignore it. Of course, this choice itself only really exists for those whose privilege protects them from experiencing the issue. I would also argue that you don't know what you don't know. If you are unaware of an issue, if you have been actively convinced there is no issue, then you are unlikely to go looking for information or understanding about it. These days, with the advent of the internet, social media, and instant access to a vast array of news, data, information, and personal experience, it is much harder to remain unaware of

racism. As a child of the 1980s, who grew up without these resources and without much exposure to the world beyond my small farming town, it was difficult to be aware beyond my own experience. I suppose this is why those two lectures felt like a slap in the face. They challenged so much of how I understood this country and my own place in it.

## After the lightbulb

The feeling generated by this lightbulb moment did not pass but rather continued to grow over time. It prompted an Honours thesis project in 2012, examining the discursive construction of Aboriginal and Torres Strait Islander people in political accounts of multiculturalism, followed by enrolment in the PhD program in 2013. While I had a lot of passion, I had little idea about what exactly I wanted to research; I only knew that I wanted to "help", to "make things better *for*" Aboriginal and Torres Strait Islander people. At the time, this seemed like a reasonable position, and I assumed I was being a "good ally" (Finlay, 2018).

I will forever remain grateful to Professor Martha Augoustinos, one of my original supervisors, who gently redirected me away from my initial (wildly unmanageable) ideas and suggested I start with a small project analysing policy. At the time, my understanding of racism was still limited to individual beliefs, attitudes, and practices. This limited understanding is reflected in the policy analysis paper presented in chapter 5, where racism is acknowledged as a driving factor in health inequities, but is not explicitly acknowledged as a driving factor in the policy itself.

It was not until I started teaching into a unit on Aboriginal and Torres Strait Islander health and Cultural Safety that I began developing a deeper understanding of racism as institutional as well as individual. It was also the time where I developed an interest in reflexivity, and the possibilities that this held for identifying and challenging racism. While the (at the time) newly

released Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2014) and Cultural Safety education literature (Bin-Sallik, 2003; Mahara et al., 2011; McDermott & Sjoberg, 2012; Ramsden, 2002; Williams, 1999) provided guidance in developing and delivering curriculum, I could find very little to guide my approach to teaching reflexivity. I wanted to help students have the same "aha!" moment that I had experienced, and while I suspect some did, I wanted to find ways to ensure that this was the experience of many rather than a few.

## Reflections on the lightbulb

I have learned a lot in the intervening years, about racism, reflexivity, and myself. In many ways, this thesis captures my own reflexive journey, and each of the studies presented reflect my growing understanding of racism and reflexivity. While I would be the first to admit that the policy analysis presented in chapter 5 is limited in its conceptualisation and analysis of racism, it was an important first step in developing my understanding of the links between racism, health, and broader political structures. It was not until much later, after I had completed the other two studies, and had come to understand racism as structural, that I realised the similarities between reflexivity and the analytic approach used in the policy analysis. This is explored in more detail at the start of chapter 5 and in the Discussion chapter.

More broadly, this thesis is concerned with turning the "white gaze" away from the "colonised other", instead focusing on the racialised systems, ideologies, and discourses which shape Australian society, and how non-Indigenous Australians might develop and utilise reflexivity to examine their own complicity within these systems (McDermott, 2020, p. 46). As a white researcher, it is imperative that I examine my own complicity in these systems of oppression, to examine how the norms of my lived experience reproduce and reinscribe racialised power

imbalances and inequities (Applebaum, 2010; Gani & Khan, 2024). There is an inherent complexity in this process, given both the invisibility of whiteness (Moreton-Robinson, 2015) and that, as Applebaum (2010) notes, "to critique norms is to risk one's own subjectivity in that one is constituted by the very norms that one needs to critique" (p. 163). Like the proverbial fish swimming unaware in the ocean, I must simultaneously become aware of that which is invisible and critique that which gives me shape. Perhaps a starting point, then, is to reflect on the varying ways that whiteness has shaped my relationship to and engagement with this research.

I have reflected a lot on that initial lightbulb moment, and my perception of that moment has changed somewhat over time. What is apparent from my current vantage point is that my reflexive learning journey has followed a relatively common trajectory outlined in the literature and within this thesis (Connelly, 2020; Gray et al., 2020; McDermott, 2015; Mills et al., 2021; Withall et al., 2021). My initial feelings of disbelief and anger were accompanied by a feeling of having been misled; that this information had been withheld or hidden. This feeling of righteous anger became a need to "do something", to "fix" what we (white people) had "broken" and provided the impetus for this thesis. I can now recognise that this urge to "fix things" was based on assumptions of white superiority (white people as agentic, experts, saviours; Bond et al., 2021; Connelly, 2020) and Aboriginal and Torres Strait Islander deficit (problematic, lacking agency; Fforde et al., 2013; Fogarty, Bulloch, et al., 2018).

As I learned more about racism and colonialism and how they create and sustain inequity, I started perceiving myself as a "good white person" (Applebaum, 2010; Connelly, 2020) while directing my anger outwards at racist "others" and systems. Looking back, this was in part due to an incomplete understanding of racism, where I still viewed it as an individual act carried out by those who ascribe to prejudicial beliefs and assumptions (Elias et al., 2021; Garner, 2010; Watego et al., 2021). I was not *like that*; I was not prejudiced, I did not say racist things,

I tried to use respectful terminology, and I actively taught other people to not be racist – surely that made me an antiracist? I told myself (and others) that I was "doing the work" and that I was willing to experience discomfort to address my own racism. But this was always underpinned by a level of comfort and reassurance that I was actively antiracist and a "good person", and ultimately this self-perception was a way for me to maintain my white hegemonic position.

Over time I developed a more critical understanding of racism, and I had what I think of as my second lightbulb moment, where it finally clicked that I, too, am part of the problem. That my very existence in this country contributes to ongoing colonialism and oppression, and that the same racialised discourses and ideologies I had been studying and critiquing also informed my own thinking. I have moments in my life where it feels like a puzzle piece has finally fallen into place, where knowledge shifts from abstract to embodied, and this was one of them. While it did not arrive as a parade of emotions like my first lightbulb, it was certainly the more profound of the two, and has facilitated the most significant changes in my thinking, being, and doing (Martin & Mirraboopa, 2003).

Arguably the most important learning has been the myriad ways in which racism manifests at all levels and in all aspects of society, and that as a white person many of these manifestations will go unnoticed because they constitute the "normative backdrop" of my everyday existence (Applebaum, 2010, pp. 167-168). This is not offered as an excuse, but as a recognition that addressing racism – especially my own – requires constant vigilance and a willingness to embrace uncertainty. The above account is a starting point and provides an insight into my journey of unpacking; however, it is also useful to examine the assumptions and presuppositions that inform this thesis.

## Theoretical positions and presuppositions that inform the current research

There are several key presuppositions that inform the current research that are important to articulate. From a theoretical perspective, this thesis draws on relativism and constructionism in recognition that "there are multiple constructed realities, rather than a single, pre-social reality" (Braun & Clarke, 2013, p. 27) and that what we know and understand about the world is constructed through the "various discourses and systems of meaning we all reside within" (Braun & Clarke, 2013, p. 30). This theoretical position is important for two reasons. Firstly, it recognises that we all interpret information, knowledges, and experiences through the lens of the social systems and structures that we exist within. This allows for the recognition that the ontologies, epistemologies, and knowledges that comprise my own worldview are shaped and constrained by whiteness, and that these are not universal. Second, it also recognises that language plays a fundamental role in the way that these worldviews and realities are constructed. Relatedly, a second key presupposition of this thesis is that race is not real but rather constructed through discourse and embodied practice, and while race is not a physical or biological reality, its social effects and consequences are (Green et al., 2007; Moreton-Robinson, 2015); this will be explored in more depth in Chapter 1.

Another key presupposition is that equity is a basic human right which recognises that individuals and peoples have unique needs, preferences, and aspirations and that universal approaches are not only inappropriate and ineffective but have historically worked to reinscribe and reinforce racialised power imbalances and the hegemony of whiteness (Moreton-Robinson, 2015). In this sense, reflexivity is an essential component of equity; it allows for the identification and challenging of assumptions about what is "right" and creates space for those most impacted by inequity to determine what is needed and wanted (Rix et al., 2014; Wilson, 2014)). That being said, there is some argument in the literature that equity is not enough, that

it does not adequately account for or recognise sovereignty (Mills, 2023; Moreton-Robinson, 2000/2020, 2015). This thesis does not seek to refute this argument; rather, what is hoped is that the results of this thesis will contribute to ongoing efforts for recognition of Aboriginal and Torres Strait Islander sovereignty.

Finally, an assumption that must be addressed is that as a white person, I have the right to undertake this research. As outlined above, my initial motivation to undertake this research was founded in whiteness, and while my motivations have changed over time, does this fundamentally change my right to ask these questions, interpret these findings, or make these assertions? There is debate in the literature about the role of white researchers in these spaces; on the one hand, white researchers are called on to "do the work" and be part of the solution (Geia et al., 2020). On the other hand, there is a risk that white researchers will reinforce racialised power dynamics and white hegemony (Emirbayer & Desmond, 2012).

Aboriginal and Torres Strait Islander researchers have asserted the right to self-determination, and that any research relating to Aboriginal and Torres Strait Islander people and communities must be led by and conducted with Aboriginal and Torres Strait Islander people and communities (Bond & Singh, 2020; Bond et al., 2020; Griffiths et al., 2021). In doctoral research, this is often achieved by having an Aboriginal and/or Torres Strait Islander supervisor, and preferably an Aboriginal and Torres Strait Islander governance group. My attempts to find a supervisor fell short; at the time there were none available in my university department. Through my primary supervisor's connections, I contacted several local Aboriginal community members and leaders with the hopes of establishing a governance group, or at the very least an additional supervisor. What I did not realise at the time was that I was doing what many non-Indigenous people had done before; requested the time, knowledge, and energy of people who were already stretched thin. Unsurprisingly, I was unsuccessful in establishing a governance group, and I acknowledge that this aspect was lacking in the early stages of this research.

However I have tried to ensure that my research is informed by the knowledge and expertise Aboriginal and Torres Strait Islander scholars and leaders.

Initially, this was primarily achieved by reading the works of prominent Aboriginal and Torres Strait Islander scholars, such as Professor Chelsea Watego (formerly Bond: Bond, 2014; Bond, 2005), Professor Yin Paradies (Paradies, 2006b, 2016; Paradies et al., 2015), Professor Aileen Moreton-Robinson (Moreton-Robinson, 2000/2020, 2004, 2015), as well as Māori scholar and founder of Cultural Safety, the late Dr Irihapeti Ramsden (Ramsden, 1992, 2002). However, over time I have developed both working relationships and friendships with a number of Aboriginal and Torres Strait Islander peers and colleagues, and these have deeply shaped my research questions, conduct, and interpretation of findings.

My first piece of research was the analysis of the *Closing the Gap* policy framework, and while the initial impetus for that study came from my supervisor, the analysis of the policy was informed by the work of Aboriginal and Torres Strait Islander scholars and leaders (Calma, 2005; Dodson, 2007; Mackean et al., 2008; McPhail-Bell et al., 2018; Paradies, 2006b). Additionally, the findings were reviewed by Aboriginal and Torres Strait Islander co-authors, Dr Kootsy Canuto and Karen Glover, who provided critical feedback on both the interpretation and presentation of the results.

In the early years, I was also incredibly fortunate to be mentored by the late Professor Dennis McDermott (McDermott, 2012, 2020; McDermott & Sjoberg, 2012), who introduced me to the concepts of Cultural Safety and reflexive practice, and encouraged me to pursue these as areas of research. The initial idea for the systematic critical synthesis of the Cultural Safety literature was developed within these conversations; later, the input of both my colleagues, Keera Laccos-Barrett and Courtney Hammond resulted in further refinement of the questions, as well as a critical lens to review data analysis and interpretation of the findings.

Similarly, the initial idea for the qualitative analysis of student reflexive assessments came about through conversations with the Aboriginal members of tutoring team, with further refinement of the research questions, analytic framework, and interpretation of results occurring in conversation with fellow educator, Keera Laccos-Barrett. More broadly, my understandings, positions, approaches, and findings have been informed – and challenged – by the generous conversations of my supervisor, Associate Professor Kalinda Griffiths, friends and colleagues in the Poche SA+NT team, as well as colleagues across Flinders University.

It is important to acknowledge that I have taken longer than intended to complete this thesis, and that this is for a range of both personal and professional reasons. However, I am grateful for the additional time, as it has allowed me to not just develop my knowledge, but to deeply reflect on my learning; to move from knowing to *being* and *doing* (Martin & Mirraboopa, 2003). As discussed above, my early thinking was steeped in white saviourism, and the time taken has allowed me to identify this and to more deeply examine my own complicity in racialised systems and inequities. While I have gained deep insights over this time, reflexive consideration of my complicity in systems of whiteness will require ongoing vigilance; as Ramsden (2002), Cultural Safety is a lifelong process, not a destination.

## A note on terminology

Given that language is central to the concepts, theories, and findings outlined in this thesis, it is important to acknowledge that the terminology used throughout is neither neutral nor apolitical. For example, the necessity of distinguishing between racial groups is both the product of and works to reproduce the very racialisation and racialised social structures this thesis seeks to challenge. Yet without these terms, we risk obfuscating the focus of this work (Heckenberg, 2020).

The table below provides working definitions of key terms and concepts used throughout the thesis. The definitions included here draw primarily on key Australian literature, and particularly from Aboriginal and Torres Strait Islander scholars and organisations, to ensure that they are contextually grounded. However, it must also be acknowledged that these definitions are not universal, and that there is substantial debate within the literature regarding the definition and conceptualisation of these concepts, which will be explored more in the following chapters.

***Table 0. 1 Definitions of Key Concepts***

| TERMINOLOGY | DEFINITION |
|---|---|
| **Aboriginal and Torres Strait Islander people(s)** | Most terminology guidelines produced by Aboriginal and Torres Strait Islander people recognise this form of reference as the most appropriate and acceptable (for example: Australian Indigenous HealthInfoNet, 2022; Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2020; Mohamed et al., 2024; Public Health Association of Australia [PHAA], n.d.). As such, this term will be used to refer collectively to the First Peoples of the Australian mainland, Tasmania, and the Torres Strait Islands.<br><br>Where relevant and appropriate, Aboriginal people, Torres Strait Islander people, or specific nation or language groups will be used. |

*Table 0.1 continued*

| | |
|---|---|
| **Indigenous** | The term 'Indigenous' is used extensively in Australia in government, organisations, and throughout the literature. However, many Aboriginal and Torres Strait Islander people have expressed concern regarding its usage (Australian Indigenous HealthInfoNet, 2022; AIATSIS, 2020).<br><br>In this thesis, it will be used in reference to Aboriginal and Torres Strait Islander people only when it is part of an organisational name, document, or direct quote.<br><br>It will also be used to refer collectively to Indigenous peoples globally; the names of specific Indigenous groups will be used where appropriate. |
| **Non-Indigenous** | This term will be used to refer collectively to people living in Australia, including those who may identify as Indigenous in their country of origin, who do not identify as either Aboriginal or Torres Strait Islander. |
| **White** | While the term 'non-Indigenous' encompasses all people in Australia who do not identify as Aboriginal and/or Torres Strait Islander, there is a need to explicitly recognise that white people occupy a particular space within racialised power hierarchies (Moreton-Robinson, 2004). Where these power dynamics are central to the discussion, white people will be referred to specifically as such. |

*Table 0.1 continued*

| | |
|---|---|
| **Whiteness** | Whiteness is a system of power and practices which functions to privilege those who identify with and ascribe to white sociocultural norms, and in the Australian context, reinforces colonialism and white hegemony and dominance (Moreton-Robinson, 2004). While it is not explicitly concerned with skin colour, those who are white or white-passing tend to experience higher levels of white privilege (Green et al., 2007; Moreton-Robinson, 2004). |
| **Race** | The original conceptualisation of race assumed that humans "can be organised into biologically distinct 'races' of people with defined physical and social traits and capacities" (Watego et al., 2021, p. 4). These groups were seen as existing in a hierarchy, where the 'white race' was seen as biologically, socially, and culturally more advanced than all other races (Elias et al., 2021).<br><br>While scientific advancements have demonstrated that 'biological race' does not exist, race continues to influence and shape human relationships, and is widely considered a social construct, produced and reinforced through everyday and discursive practices (Seet & Paradies, 2018). |
| **Racism** | Racism is a complex system of practices that operate at individual, interpersonal, institutional, and structural levels to create inequities in social, political, and economic opportunities and outcomes (Paradies et al., 2015). The operation of racism relies on and reinforces power differentials between racial groups (Garner, 2010). |

*Table 0.1 continued*

| | |
|---|---|
| **Ethnicity** | Ethnicity can be considered the shared geography, history, physical features, language, and cultural practices of a group of humans. There is some debate regarding the difference between ethnicity and race, however, a key difference is that race is an imposed category based on hierarchies and power differentials, rather than a self-determined shared identity (Kivisto & Croll, 2012). |
| **Culture** | Like racism, culture is a complex system enacted through and reinforced by people, places, and practices (Causadias, 2020). Cultural systems are founded on shared ideologies and expressed in the norms, knowledges, expressions, and symbols that indicate group belonging and cultural identity (Kagawa Singer et al., 2016). Cultural groups can range from small groups through to institutions, systems, and nations. |
| **Cultural Safety** | Cultural Safety is an approach to healthcare which requires healthcare professionals to reflect on and critically examine their own positionality, power, privilege, and internalised biases, and how these shape the provision of care (Mohamed et al., 2024). Cultural Safety is not about acquiring knowledges or competencies but rather is concerned with how healthcare is delivered. Importantly, only the recipients of care can determine whether it was culturally safe or not (Eckermann et al., 2010). |
| **Inequality versus inequity** | Berman & Paradies (2010) provide a useful distinction between inequality and inequity, where inequality is the "condition of being unequal" (p. 215) and is the result of unavoidable or chosen difference. In contrast, inequity is an avoidable, imposed, and unfair inequality. |

## Thesis overview and chapter summaries

Central to this thesis is an examination of reflexivity as a core Cultural Safety capability. Cultural Safety is seen by many as having the potential to identify and eliminate racism in the healthcare system (Ahpra & National Boards, 2020; Hall et al., 2023; McDermott, 2012; Mohamed et al., 2024; Power et al., 2021), with reflexivity playing a central role. While there is some literature exploring the potential role of reflexivity as a starting point for addressing racism (Kowal et al., 2013; McDowall, 2021; Pillow, 2003b), little is currently known about how it is conceptualised, taught, engaged in within the Cultural Safety context, and how it might be applied beyond the individual.

To address the current gaps in the Cultural Safety literature, this thesis presents six chapters. The first two establish key theoretical frameworks and the evidence base underpinning the need for this research; the next three chapters report on three discrete original studies exploring various aspects of reflexivity; and the final chapter provides concluding remarks. A summary of the purpose and content of each chapter is provided below.

***Chapter 1***: The purpose of this chapter is to provide a conceptual framework for understanding racism in the Australian colonial context. It also provides an overview of the current evidence on experiences and impact of racism on the health and wellbeing of Aboriginal and Torres Strait Islander people.

***Chapter 2***: This chapter provides a theoretical framework for understanding Cultural Safety in the Australian context, as well as establishing a theoretical understanding of reflexivity in relation to culturally safe practice. It will seek to articulate current gaps in the literature, and outline the key aims and research questions informing this research.

***Chapter 3***: This chapter presents a systematic critical synthesis of the Cultural Safety education literature to examine how reflexivity is conceptualised, taught, and assessed within this context.

Drawing on studies from Australia, Aotearoa New Zealand, Canada, and the United States, this chapter identifies common patterns in how reflexivity is defined within Cultural Safety education, the pedagogical strategies used to facilitate student reflexivity, and the assessment methods used to determine growth in reflexive capacity. This work has been published (Dawson et al., 2022), with the published version included in Appendix 1.

***Chapter 4***: This chapter presents a qualitative analysis of the reflexive accounts of undergraduate health sciences students undertaking a unit on Aboriginal and Torres Strait Islander health and Cultural Safety. It utilises critical thematic and discursive analysis to identify how and to what extent students engaged in reflexivity, common patterns in how students expressed reflexivity, and how racism was challenged or perpetuated within these accounts.

***Chapter 5***: This chapter presents a qualitative analysis of the *Closing the Gap* policy framework utilising Carol Bacchi's (2009) *What's the Problem Represented to Be?* analytic approach in conjunction with critical discursive analysis. It identifies the underlying assumptions that inform the *Closing the Gap* policy, as well as the racialised discourses which shape how the "problem" of "Indigenous disadvantage" is constructed within policy measures. This study has also been published (Dawson et al., 2021), with the published version included in Appendix 3.

***Chapter 6***: This final chapter concludes the thesis and provides a discussion of common themes found across each of the three studies and their implications for practice and future research.

# Chapter 1: Racism as a key driver of Aboriginal and Torres Strait Islander ill-health and health inequities

## 1.1 Situating the current research: racism as a key driver of health inequities for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have recognised racism as a key driver of the health inequities since the early days of colonisation, although it has only attained mainstream attention relatively recently (Geia et al., 2020; Kairuz et al., 2021; Paradies et al., 2008). Racism operates at the interpersonal, institutional, and systemic level and negatively impacts health in a multitude of ways, both directly through physiological and psychological effects (Ferdinand et al., 2013; Kairuz et al., 2021; Paradies, 2006b; Paradies et al., 2015; Ziersch et al., 2011) and indirectly through reduced life opportunities and healthcare access (Elias et al., 2021; Gatwiri et al., 2021; Henry et al., 2004; Paradies, 2016; Paradies et al., 2008).

The purpose of this chapter is to provide an overview of racism and its impact on the health and wellbeing of Aboriginal and Torres Strait Islander people. Specifically, the following section will provide a discussion of concepts relevant to the existence and operation of racism, followed by a working definition of racism which will inform this thesis. This will be followed by a discussion of where and how racism operates in the Australian context, including a consideration of structural, institutional, and interpersonal forms of racism. Next, the impacts of racism on Aboriginal and Torres Strait Islander health and wellbeing will be discussed, including a specific consideration of racism within the healthcare context which can have an amplified impact on health and wellbeing outcomes (Truong & Moore, 2023). Finally, a brief overview of the antiracism will be provided, and will provide the foundation for the following chapter.

## 1.2 Defining and conceptualising racism

The definition and conceptualisation of racism has been a subject of much debate for over a century. Currently, there is no singular definition or conceptualisation of what racism is or how it operates, but rather a collection of definitions which reflect the varying historical, social, political, and disciplinary contexts in which they were produced (Bonilla-Silva, 1997; Elias et al., 2021; Garner, 2010). As a starting point, it is helpful to first understand some of the key concepts that are relevant to and underpin the operation of racism; these will be briefly outlined below, followed by a working definition of racism.

### 1.2.1 Race

Broadly speaking, *race* is an assumed category of human belonging, where each race group is defined by a shared set of characteristics. These often include phenotypical markers such as skin tone and facial features, as well as cultural practices, religion, and ancestry (Elias et al., 2021). Yet, the markers of racial belonging and the delineation between racial groups and what is considered to constitute race are not fixed, stable categories, but highly contested, contextually dependant, and discursively produced (Elias et al., 2021; Garner, 2010; Harris et al., 2013).

During the eighteenth and nineteenth centuries, where French philosophers were theorising that social inequality was the result of biological differences (Billig, 1982, p. 28), and medical science was developing a standardised conceptualisation of "normality" (Feder, 2014, p. 62), these ideas became associated with racial difference. These ideas became further entrenched through scientific racism, a body of research which postulated that physical, social, cultural, and intellectual differences were all the result of innate genetic difference (Watego et al., 2021).

In 2000, at the conclusion of the Human Genome Project's draft sequence. it was announced that "the concept of race has no genetic or scientific basis" (Venter, cited in Yudell, 2014, p.

204). While race is now largely considered a social construct, produced and maintained through social and discursive practices (Bonilla-Silva, 1997; Seet & Paradies, 2018), the concept of race continues to inform a substantial body of research (Bliss, 2012). It also continues to shape the lived realities of racialised groups through the legitimation of race as a category which shapes social, political, and economic practices (Watego et al., 2021).

### 1.2.2 Racialisation

Fundamental to the operation of racism is *racialisation*, the process by which human groups come to be understood and to understand themselves as distinct racial groups (Elias et al., 2021; Paradies, 2006a; Watego et al., 2021). Given that race has no biological or genetic basis, the process of racialisation is inherently one of social construction; that is, racialised groups do not have clear, distinct boundaries but are dependent on social, political, and historical contexts (Winant, 1994). As such, the process of racialisation is not simple or straightforward, but contingent on a range of factors.

Racialisation is often conceptualised as a process imposed on groups, for example in the context of colonisation where colonisers imposed racial identities on the Indigenous groups they encountered (Wolfe, 1998). This requires a level of power imbalance, where one group holds the State, ideological, and discursive power to impose racial categories (Garner, 2010). These racial identities are further reinscribed through State actions, such as policy formation and data collection on the basis of racial identity (Elias et al., 2021; Rowse, 2009). Conversely, racialised groups can engage in their own process of identity formation and meaning making, as a form of opposition and resistance (Garner, 2010; Paradies, 2006a).

### 1.2.3 Racial ideologies

The imposition of racial identities is not a simple process of categorisation but one intended to create racial hierarchies. In part, this is underpinned by *racial ideologies*, where ideology is

defined as a system of belief which is collectively shared, works to control and organise other socially shared beliefs, shapes cultural values and norms, and are relatively stable over time within a given context (van Dijk, 2006, p. 116). Ideologies can also work to maintain dominance and oppression, for example, where ideological knowledges become embedded within social systems and institutions (Seet & Paradies, 2018).

Racial ideologies are systems of belief which create and sustain racial hierarchies, which assumes a hierarchy of racial groups ranked according to perceived levels of physical, intellectual, social, and cultural evolution (Moreton-Robinson, 2004). These ideologies "function as [a] sociocognitive interface between social structures … and their discourses and other social practices" (van Dijk, 2006, p. 117). In this sense, racial ideologies are both an expression of and work to maintain racialised social structures and are expressed through racialised discourses and practices (Seet & Paradies, 2018; van Dijk, 2012). While racial ideologies remain relatively stable, racialised discourses and practices vary over time and according to changing social norms and legal structures (Seet & Paradies, 2018).

Despite the stability, longevity, and deeply embedded nature of racial ideologies, Van Dijk (2006) also argues that they also often lack consistency. Indeed, racism has been described as a "scavenger ideology" (Solomos & Back, cited in Seet & Paradies, 2018, p. 458), able to borrow the values, ideas, and discursive practices of other ideological frameworks according to need and context. Arguably, it is this particular aspect of racial ideologies which make them so difficult to identify and challenge.

### 1.2.4 Whiteness

A key racial ideology which exists within and shapes Western nations is white superiority, which is based on the fundamental assumption that those who identify as white are more evolved, and therefore sit at the top of the racial hierarchy (Green et al., 2007; Moreton-

Robinson, 2004, 2015). This ideology underpins *whiteness*, the system of power and practices which functions to privilege those who identify with and ascribe to white sociocultural norms (Moreton-Robinson, 2004).

Salter (2012, p. 30) notes that there is a distinction between white(ness) as a racialised identity and White(ness) as a social, political and economic system. The former is concerned with the social construction of white identity, which – like other racial categories – is discursively produced, although unlike other racial categories, white identity is often constructed in contrast to the 'racialised other', positioning whiteness as the 'universal norm' (Moreton-Robinson, 2004; Winant, 2015). The latter is concerned with how Whiteness operates "an invisible regime of power that secures hegemony through discourse and has material effects in everyday life" (Moreton-Robinson, 2004, p. 75). Notably, there is substantial overlap between these constructs, where white identity and White sociopolitical structures are co-constitutive and work to reinforce each other.

It is important to note that whiteness is not simply a matter of skin colour; like all racial categories, the boundaries of what counts as 'white' have changed substantially over time and according to context (Garner, 2010; Moreton-Robinson, 2015). Rather, whiteness is a set of practices which signal white belonging or proximity to whiteness, and which confers unfair privileges (Green et al., 2007; Moreton-Robinson, 2004). However, those who are visibly white or white passing will experience greater levels of privilege due to their ability to move through the world unquestioned and with the assumption of belonging (McIntosh, 2015).

### 1.2.5 Colonialism

While it has manifested differently at different times and in different contexts, colonisation is broadly understood as a range of processes and practices, where the aim is to "acquire land and to gain control of resources" (Glenn, 2015, p. 55). The methods of achieving this include war,

massacres, physical dispossession and relocation, disruption of food and resource supplies, and genocide (Glenn, 2015; Paradies, 2016). It also includes the broader project of assimilation through forced removal of children; banning of language and cultural practices; establishment of control over systems and institutions; problematisation of Indigenous peoples, cultures, and practices; and State control of marriage, employment, and education (Paradies, 2016; Sherwood, 2013).

Rather than a singular event, colonisation is ongoing, and this is encapsulated in the notion of *colonialism*, which, as Wolfe (1998) argues, "is a structure not an event" (p. 2). This aligns with Bonilla-Silva's (1997) notion of racialised social structures; both function to create social, political, and economic hierarchies through control of resources, knowledge, and sociopolitical systems. Indeed, racialised social systems – and the associated practices that sustain them – are fundamental to the ongoing project of colonialism.

In contemporary colonial societies, colonialism continues to inform the structure and function of social, political, economic, and knowledge systems, delineating what is deemed 'legitimate' and what is not (Moreton-Robinson, 2004). At its heart, colonialism is both underpinned by and relies on racial ideologies of white superiority, where whiteness is positioned as the universal norm while 'racialised others' are problematised and marginalised. As Strakosch (2015) argues, colonialism "seeks to enfold and recognise Indigenous difference in ways that foreclose Indigenous demands for substantive decolonisation" (p. 17).

### 1.2.6 Power

Central to the operation of colonialism and racism is *power*. As Garner (2010) notes, anyone can be prejudiced but racism is specifically the product of "unequal *collective* power" relations (p. 6, emphasis in original). It is only through the operation of power that racism moves beyond prejudice and becomes a mode of oppression (Bonilla-Silva, 1997). Likewise, colonialism is

dependent on the power of the State to define, control, and oppress Aboriginal and Torres Strait Islander peoples (Glenn, 2015; Sherwood, 2013). While power is a central feature of many definitions of colonialism and racism, how it is conceptualised varies. For example, Elias et al. (2021) describe racism as both derived from and operating as a system of power; Watego et al. (2021) speak of racialised power relations; and Moreton-Robinson (2004) articulates power as linked to whiteness and discourse. Bonilla-Silva (1997) defines power as "a racial group's capacity to push for its racial interests in relation to other races" (p. 470).

To understand the relationship between power and racialised social systems, the work of Foucault (Feder, 2014; Lynch, 2014) provides a useful framework. Foucault proposed that rather than being imposed from the top down, power operates primarily through what he termed force relations, which "consist of what ever in one's social interactions that pushes, urges, or compels one to do something" (Lynch, 2014, p. 19). While force relations can operate at the State level through physical domination and control of resources, such as the early stages of colonisation, they can also operate through individual level symbolic and discursive practices and the creation and normalisation of some knowledges as legitimate while others are silenced (Moreton-Robinson, 2004). Additionally, in contrast to top-down conceptualisations of power, force relations are multi-directional, with the location of power dependant on context (Lynch, 2014; van Dijk, 2012).

### 1.2.7 Working definition of racism

Drawing on the concepts outlined above, and the work of Paradies et al. (2015), Elias et al. (2021), Watego et al. (2021), Bonilla-Silva (1997), and Garner (2010), the following working definition is offered:

> *Racism is a dynamic and adaptable system of discursive, symbolic, and tangible practices which manifest at individual, interpersonal, institutional, and systemic levels. Racism is both a product of and works to reinscribe racialised social structures, ideologies, and power imbalances, Fundamentally, racism is a mode of oppression reliant on hierarchical racial structures and which causes inequities in opportunities, resources, and power.*

While this definition provides a starting point for conceptualising racism, it is also important to understand how racism manifests and operates within a specific context (Garner, 2010; Watego et al., 2021). As such, the following sections will provide a more detailed examination of racism in the Australian colonial context, including consideration of how it has impacted the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

## 1.3 Historical perspectives on racism and colonialism in Australia

There is currently a robust body of literature articulating the presence, operation, and outcomes of interpersonal and institutional racism in Australia (for example: Elias & Paradies, 2021; Ferdinand et al., 2013; Paradies, 2016; Paradies et al., 2015; Paradies et al., 2008; Ziersch et al., 2011). However, Hardeman (2022) argues that to articulate the nature and impact of structural racism, an understanding of historical context is required. Likewise, Sherwood (2013) argues that – much like taking a patient history – an historical account of colonialism in the Australian context is vital to understanding the current health inequities experienced by Aboriginal and Torres Strait Islander people. The following section will provide an overview of three sociopolitical eras in Australian history, to demonstrate how a relatively stable racial ideology changes in expression over time according to shifting social and political climates (Seet & Paradies, 2018).

### 1.3.1 First contact and early colonial rule

The eighteenth and nineteenth centuries were a time of substantial social and political change in western Europe, and this sociopolitical upheaval played a major role in shaping colonisation of the Australian continent. The rise of scientific racism, industrialisation, and changes in religious values that valorised individual achievement and equated material gain with human value shifted both the social and political landscape, as well as what was considered the hallmarks of a "civilised society" (Eckermann et al., 2010). By the time British colonialists landed on the eastern shores of the Australian continent in 1788, racialisation was a well-established practice used to justify colonial conquest and the taking of sovereign lands (Sherwood, 2013). This is reflected in the writings of early colonialists, who articulate an understanding of Aboriginal and Torres Strait Islander people as a distinct racial group, and specifically as inferior to the British (Eckermann et al., 2010).

The ideological underpinnings of colonisation are perhaps best illustrated by the way in which the British claimed ownership over the continent. At the time of British arrival, there were hundreds of diverse Aboriginal and Torres Strait Islander nations across the continent, who had survived and thrived for millennia. Social, political, economic, and trade systems were complex and varied between nations, and were deeply tied to Country and Dreaming (Elias et al., 2021; Reynolds, 2006). The *Endeavour* expedition first arrived in 1770, and the initial reports from sent back to England indicated that the land was inhabited by only a "few" people in "the rudest state of society" (Matra, cited in Reynolds, 2021, p. 23). On this basis, vast claims to land were made based on the principle of *terra nullius*, or land belonging to no one (Reynolds, 2021; Secher, 2007). While the subsequent expedition led by Arthur Phillip in 1788 revealed the inaccuracy of this report, initial perceptions of Aboriginal peoples as "miserable savages" living in "the rudest state of society" had taken hold and provided justification for claims to British sovereignty (Reynolds, 2021, pp. 23-24). In the years following the arrival of the First

Fleet, negative and dehumanising perceptions of Aboriginal and Torres Strait Islander people became further entrenched, bolstered by a growing body of scientific racism (Eckermann et al., 2010).

One of the primary mechanisms for establishing and maintaining dominance was through racial violence, including both interpersonal and state sanctioned (Elias et al., 2021; Reynolds, 2021; Sherwood, 2013). This is epitomised in the Frontier Wars, which began in the late eighteenth century and in some areas continued into the early twentieth century, and saw violent clashes between colonialists and Aboriginal nations, increasing as the frontier expanded further inland (Eckermann et al., 2010; Elias et al., 2021). Aboriginal nations across the mainland fiercely resisted colonial occupation and expansion, and in many instances successfully defended their lands and waters (See for example: Reynolds, 2021, 2022). Despite this resistance, ever increasing numbers of British colonialists, more powerful weaponry, widespread massacres, introduced infectious diseases, and the collective impact of dispossession had shifted the balance of power, with many Aboriginal people recognising that the colonialists were here to stay (Eckermann et al., 2010; Elias et al., 2021; Sherwood, 2013). Arguably it is this last point which had the most lasting impact and demonstrates how force relations at the micro (interpersonal) level can give rise to broader macro-structures of governance. The widespread disruption to social, political, and economic systems, as well as loss of lands, foods, and resources meant an increased reliance on white "benevolence", solidifying the social relationship with white colonialists in a position of dominance (Bonilla-Silva, 1997; Elias et al., 2021; Sherwood, 2013).

### 1.3.2 Consolidation of colonial rule and racial hierarchy

While the violence of the Frontier Wars was the initial mode of establishing racial hierarchy and British rule, another key mechanisms was through governance. Between the early nineteenth and mid twentieth century, a range of explicitly racialised and racist policies were

enacted against Aboriginal and Torres Strait Islander people (Australian Law Reform Commission [ALRC], 2010). Even where policies were ostensibly constructed with the intention of improving conditions for Aboriginal and Torres Strait Islander people, they were predicated on assumptions of racial inferiority and British colonial paternalism. For example, after half a century of brutal occupation, in the 1830s humanitarian concerns were finally raised regarding the treatment of Aboriginal and Torres Strait Islander people (Reynolds, 2021). However, this concern was based on racist assumptions that Aboriginal and Torres Strait Islander people were a "dying race" unable to survive in the "modern world" (Eckermann et al., 2010, p. 20).

After much debate regarding the legal status of Aboriginal and Torres Strait Islander peoples, a declaration was made in 1837 which stated that "all the natives (sic) inhabiting those Territories must be considered as Subjects of the Queen" (Bourke, cited in Reynolds, 2021, p. 60). That same year, recommendations were made to establish missions and appoint Protectors, whose role was to provide protection and limited rations for Aboriginal and Torres Strait Islander people (ALRC, 2010; Commonwealth of Australia, 1997). Despite this, the roots of racial ideology were well established and the views of colonialists regarding Aboriginal and Torres Strait Islander peoples firmly entrenched (Reynolds, 2021). Consequently, the powers of the Protectors was limited and by the mid-nineteenth century, their roles had been unofficially absorbed into the police force (ALRC, 2010).

It was not until the end of the nineteenth century that an official policy of *protectionism* was introduced, which was marked by segregation and a tightening of control over the lives of Aboriginal and Torres Strait Islander people (Commonwealth of Australia, 1997). Most Aboriginal and Torres Strait Islander people were relocated to reserves under the guise of "safety", however as Elias et al. (2021) note, reserves became sites of further oppression and control. This approach aligns with Bonilla-Silva's (1997, p. 58) notion of racialised social

structures, where the dominant white majority was able to draw distinct physical boundaries through a process of segregation. Protectionism marked the first in a series of overtly racialised policies which would control, oppress, and marginalise Aboriginal and Torres Strait Islander people, and entrench racialised disparities across social, economic, and political domains.

White racial dominance was further entrenched with the introduction of the *Immigration Restriction Act 1901*, commonly known as the White Australia policy (Elias et al., 2021). This policy was ostensibly to restrict the immigration of non-white people to Australia and create a "white nation". However, this was complicated by the presence of Aboriginal and Torres Strait Islander people, whose very existence challenged British claims of sovereignty (Macoun & Strakosch, 2013; Moreton-Robinson, 2015). The answer to this was an unofficial policy of assimilation, with the aim of removing all traces of Aboriginal and Torres Strait Islander languages and cultures (ALRC, 2010).

A key mechanism to achieve this was the forced removal of Aboriginal and Torres Strait Islander children, who were sent to missions, adopted by white families, or sent to work as domestic servants. Known as the Stolen Generations, an estimated 100,000 children were taken between 1905 and 1967 and represent the Australian government's attempt to commit cultural genocide through disruption of family connections, languages, knowledges, cultural practices, and the stripping of cultural identity (Commonwealth of Australia, 1997; Elias et al., 2021). By the 1950s, *assimilationism* was introduced as official government policy across multiple states, with the social and legal expectation that all Aboriginal and Torres Strait Islander people would adopt white sociocultural norms (Altman & Sanders, 1995; Commonwealth of Australia, 1997). As noted in the *Bringing Them Home Report* (Commonwealth of Australia, 1997), "assimilation was a highly intensive process necessitating constant surveillance of people's lives, judged according to non-Indigenous standards" (p. 27); while the underlying racial ideology remained largely the same, the practices associated with it had adapted to the changing

sociopolitical context in which Indigenous rights were becoming more salient both globally and locally (Eckermann et al., 2010; Reynolds, 2021).

In 1965, the policy was rephrased to recognise that assimilation should be a choice and stated a hope that "all persons of Aboriginal descent will choose to attain a similar manner of living to that of other Australians" (Commonwealth of Australia, Aboriginal Welfare Conference 1963, cited in Eckermann et al., 2010, p. 27). Often referred to as *integrationist* policy to denote the shift from forced to 'optional' assimilation, arguably there was very little choice involved (Altman & Sanders, 1995). Access to or engagement with State systems and institutions required conformity with the prevailing white sociocultural norms, and for many, after nearly two centuries of violence and displacement, there remained few other options (Altman & Sanders, 1995). There were also implicit legal pressures to conform, given that child removal was ongoing and many were forcibly removed for perceived infractions, which most often entailed a lack of adherence to imposed white sociocultural norms (Commonwealth of Australia, 1997; Eckermann et al., 2010). Moreover, these policies had normalised racial hierarchy within Australia, both legally and socially. While the coming years would challenge the legal aspects of inequality, racial ideologies of white superiority and Aboriginal and Torres Strait Islander deficit had become ingrained in the national psyche.

### 1.3.3 Egalitarianism and the quest for equality: neocolonial rule and the benevolent nation state

The move to integrationist policy occurred against the backdrop of the Civil Rights Movement in the United States, as well as growing calls to acknowledge and address the inequality experienced by Aboriginal and Torres Strait Islander people. These calls for equality were the result of decades of political activism by Aboriginal and Torres Strait Islander individuals and groups (Eckermann et al., 2010; IndigenousX & Australian Human Rights Commission, n.d.). This activism culminated in the successful 1967 Referendum, and resulted in amendments to

the Australian Constitution which ensured that Aboriginal and Torres Strait Islander people were counted in the census, and that the federal government would take on responsibility for policies relating to Aboriginal and Torres Strait Islander affairs (AIATSIS, 2024; National Archives of Australia, n.d.). With an overwhelming yes vote, many viewed the result as a significant win and a sign that Australia was moving towards racial equality.

On the back of the successful Referendum, there was public and political support for recognition of Aboriginal and Torres Strait Islander peoples' rights to self-determination (Foley, 2001). In 1972, *self-determination* became official government policy, followed closely by the introduction of *self-management* policy in 1975 (ALRC, 2010; Eckermann et al., 2010; Foley, 2001). Philosophically, the former was concerned with ensuring that Aboriginal and Torres Strait Islander peoples were provided the means and opportunities to "determine their own futures and ways of life" (Altman & Sanders, 1995, p. 190); in contrast, the latter had a more explicit focus on socioeconomic development (Eckermann et al., 2010). This marked a shift away from overtly racialised and racist policy towards policy based on the tenets of liberal egalitarianism.

However, nearly two hundred years of entrenched racial ideology and explicitly racist policy making was not easily undone. As Sherwood (2013) argues, regardless of surface rhetoric, both approaches utilised a top-down approach predominantly determined by non-Indigenous public servants, an assertion supported by Foley's (2001) interrogation of the relations between the Labor party and Aboriginal and Torres Strait Islander peoples. Arguably, then, these policies represent a form of assimilationism cloaked under the guise of egalitarianism, equality, and economic rationalism (Eckermann et al., 2010; Elias et al., 2021; Foley, 2001).

Policy making between the 1970s and 1990s swung between the seemingly progressive stance of Labor who advocated for improved Aboriginal and Torres Strait Islander rights, and the more

conservative stance of the Liberal party (Aldrich et al., 2007; Altman & Hunter, 2004; Foley, 2001). The election of the Howard Coalition government in 1996 saw another shift in policy making; Howard definitively rejected the idea of symbolic reconciliation and the recognition of Aboriginal and Torres Strait Islander rights, instead promoting what he termed *practical reconciliation* (Gunstone, 2008; Sherwood, 2013). Here, the focus was addressing so-called "Indigenous disadvantage" through measures targeting socioeconomic outcomes and underpinned by government-determined mutual obligations (Gunstone, 2008; Sherwood, 2013). Arguably, this represents a clear shift in political rhetoric from rights-based to a more paternalistic, deficit-based approach.

The Howard years were marked by several significant changes in the Aboriginal and Torres Strait Islander policy space, including the abolishment of the Aboriginal and Torres Strait Islander Commission (ATSIC) in 2005 (Sherwood, 2013). It also included the introduction of the Northern Territory Emergency Response (NTER), a policy based on what were later revealed to be false allegations of paedophile rings and widespread child sexual abuse in remote Northern Territory Aboriginal communities (Brull, 2017). The NTER came under considerable fire, most notably because enactment of the NTER required suspension of the *Racial Discrimination Act 1975*. Critiques of the NTER note the disconnect between stated policy aims and the measures included, with several arguing that the policy was nothing more than an opportunity to consolidate government control of Aboriginal communities and lands (Dodson, 2007; Mansell, 2007). Proudfoot and Habibis (2015) argue that the introduction of the NTER would not have been possible without a complicit media, where sensationalist reporting drew on and reinforced negative stereotypes of Aboriginal and Torres Strait Islander people and communities, and worked to garner public sentiment (Brull, 2017).

Nearly a year after the NTER was implemented, with growing pushback from Northern Territory Aboriginal communities and mounting evidence that the policy was doing more harm

than good, public sentiment had shifted. In this context, the Rudd Labor government was elected on the back of two major election promises. The first was a National Apology to the Stolen Generations, which was delivered publicly on 13 February 2008 and was considered by many to be a watershed moment in Australian politics (Department of the Prime Minister and Cabinet, 2023). The second was a major reform to Aboriginal and Torres Strait Islander policy. Known as *Closing the Gap*, the policy brought together all portfolios and levels of government under the National Indigenous Reform Agreement (NIRA) and remains the current government policy framework (Department of Families Housing Community Services and Indigenous Affairs [DFHCSIA], 2009).

While Closing the Gap was touted as a new approach, Pholi et al. (2009) argue that there is very little which differentiates Closing the Gap from previous policy. Moreover, Rowse (2009) argues that a focus on the "gap" between Aboriginal and Torres Strait Islander people and the non-Indigenous population works to reinforce notions of racial hierarchy and normalise whiteness as the yardstick against which Aboriginal and Torres Strait Islander people are compared and found wanting.

While the original iteration of Closing the Gap was much the same as previous policies, one thing that did set it apart was the whole-of-government, bipartisan support it received (DFHCSIA, 2009). Where previous policies changed with every new government, Closing the Gap has weathered multiple changes of government and leadership. Despite its longevity, Closing the Gap has made very little progress against the stated targets (National Indigenous Australians Agency, 2024). In 2020 Closing the Gap underwent a significant refresh, and in perhaps the first real instance of self-determination, this refresh was led by the Coalition of Peaks, a collective of leading Aboriginal and Torres Strait Islander organisations with expertise across a spectrum of policy areas (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2020).

While the recent Refresh is a significant step in the right direction, enactment of this policy still relies on a political bureaucracy mired in white sociocultural norms and practices, and given the history outlined above, it seems unlikely that progressive rhetoric will be matched by genuinely progressive action. Indeed, the results of the recent Voice to Parliament Referendum highlight the limits of so-called progressivism. Established in response to one of the key recommendations outlined in the Uluru Statement from the Heart (Mayo & O'Brien, 2023), the Referendum proposed that an Aboriginal and Torres Strait Islander Voice to Parliament be enshrined in the Australian Constitution, to ensure genuine self-determination and representation, and that unlike ATSIC, the Voice cannot be dismantled at the whim of the current government (Mayo & O'Brien, 2023). Despite early public support, the Voice was resoundingly defeated, with several potential explanations offered, including public distrust in voting systems (Carson et al., 2024), diffuse *Yes Campaign* messaging (Phillips et al., 2024), and voter disengagement (Cole, 2024). While each are likely factors, Berry (2024) argues that the No result is a combination of both racism and the complex interplay of racial, liberal, and egalitarian ideologies which framed the Voice as divisive and a threat to individual rights.

What is evident in this history is that, with the exception of the most recent *Closing the Gap* framework, each successive government policy is underpinned by the same racial ideology used to justify and legitimise colonisation. Each policy relies on an assumption of the inherent right to control, subjugate, and oppress Aboriginal and Torres Strait Islander people, either through explicitly racist policies like segregation and assimilation, or through policies which are more paternalistic and based on liberalist notions of equality and egalitarianism, as seen in practical reconciliation and the original iteration of *Closing the Gap*. Ultimately, these racialised systems and institutions produce and are maintained through an ideology of racial hierarchy in which whiteness is normalised and Aboriginality is problematised.

### 1.3.4 Discourse as racism-in-practice

The racial ideologies which organised much of Western scientific and political thinking, and the resulting "knowledges" produced during the nineteenth and early twentieth centuries have had pervasive and long-reaching effects on how the non-Indigenous population perceives and thinks about Aboriginal and Torres Strait Islander peoples, cultures, perspectives, and histories (Fforde et al., 2013; Moreton-Robinson, 2004, 2015). This provides a plausible explanation for why many who claim – and undoubtedly believe – that they are non- or anti-racist still engage in racialised thinking (Augoustinos & Every, 2007; Elias et al., 2021). Growing social awareness of the rights of Aboriginal and Torres Strait Islander peoples and the need to address systemic inequities has generated a counter ideology based on notions of anti-racism and equity (van Dijk, 2006). However, racialised knowledges are ubiquitous, and until relatively recently, most sources of information about Aboriginal and Torres Strait Islander people, cultures, and histories were written by non-Indigenous people, where racial ideologies remained unchallenged. Even now, many non-Indigenous people do not socialise, work, or otherwise interact with Aboriginal and Torres Strait Islander people (Australian Reconciliation Barometer: Reconciliation Australia, 2022). As such, even in the context of antiracist ideology, many non-Indigenous people still engage in deficit-based thinking and draw on paternalistic notions of "protection" and "white saviourism" (Augoustinos et al., 2005; Augoustinos et al., 1999; Dunn et al., 2004; Fforde et al., 2013; Fogarty, Bulloch, et al., 2018), both of which are presupposed by an assumption of racial hierarchy and white superiority.

The previous sections have outlined the structural and ideological conditions necessary for racism to exist and operate. On an everyday level, racism is enacted through discursive practices, which aligns with Bonilla-Silva's (1997) thinking, where he conceptualises racism as "the segment of the ideological structure of a social system that crystallizes racial notions and stereotypes" (p. 474). That is, racism is the enactment of race relations in context; relies

on and reinforces power dynamics; and shapes both interpersonal interactions and the operation of systems and institutions; in other words, through discursive practices.

While the term *discourse* can refer to various aspects of speech and communication, from a social sciences perspective, discourses are organised systems of thinking which "shape reality by systematically constructing the subjects and the worlds of which they speak" (Kerin, cited in Fforde et al., 2013, p. 162). In turn, these discourses are shaped by various discursive practices, the modes of speaking which justify, legitimate, reify, challenge, or call into question the veracity of the speaker's position (LeCouteur & Augoustinos, 2001; Potter, 1996; Wodak, 1989). Hook (2001) notes that "the effect of discursive practices is to make it virtually impossible to think outside of them … discursive rules are hence strongly linked to the exercise of power; discourse itself is both constituted by, and ensures the reproduction of, the social system" (p. 522). Notably, unlike ideologies which are relatively stable over time, discourses are more adaptable and dynamic; they can be variously deployed and drawn on according to contextual demands and adapted in response to changing social norms (van Dijk, 2006). As such, while the ideology of racial hierarchy remains relatively unchanged in the Australian context, the discursive construction of this ideology has changed substantially, and is a contributing factor in the ongoing debate about what 'counts' as racism (Elias et al., 2021; Garner, 2010).

Deficit discourse is perhaps one of the most widely documented discourses in relation to Aboriginal and Torres Strait Islander people and is defined as a "mode of thinking that frames and represents Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency, and failure" (Fogarty, Bulloch, et al., 2018, p. 3). Earlier research in the field of social psychology used critical discursive analysis to examine the way that "race talk" was managed by speakers to evade, deny, or downplay potential accusations of racism towards Aboriginal and Torres Strait Islander people (Augoustinos & Every, 2007; Augoustinos et al.,

2002; Augoustinos et al., 1999; Rapley, 1998). A range of rhetorical devices and discursive strategies were identified which were used to construct racist stereotypes as "true", "factual", and "common sense". While the focus of these studies was the management of 'race talk', what they highlight is the pervasiveness of racist stereotypes and deficit narratives in everyday speech.

Deficit discourse and negative stereotypes are also prevalent in mainstream media reporting and policy relating to Aboriginal and Torres Strait Islander people. For example, in a critical analysis of media reporting on Aboriginal and Torres Strait Islander policy in the early to mid-2000s, McCallum (2013) found that disadvantage and inequality were predominantly constructed as issues of poor individual choices and widescale community dysfunction. Likewise, Proudfoot and Habibis (2015) found that, in contrast to Aboriginal and Torres Strait Islander media sources, non-Indigenous media reporting on the NTER homogenised Aboriginal and Torres Strait Islander people and communities as dysfunctional and lacking in capacity.

In the policy context, Fogarty et al. (2018) identified that deficit narratives informed a range of health and socioeconomic policies, including the NTER and *Closing the Gap*. This echoes earlier work by Pholi et al. (2009), who noted the deficit framing of *Closing the Gap* and critiqued the reliance on comparisons between Aboriginal and Torres Strait Islander and non-Indigenous people, which works to implicitly reinforce notions of racial hierarchy (Rowse, 2009). The work of McCallum (2013) also highlights the interconnectedness of policy, media, and everyday talk. Interviews with policy makers and government bureaucrats found that the policy making process and governmental positions on key policy issues were heavily influenced by media framing. Thus, the racialised discourses which shape media reporting also shape the policy landscape, and both contribute to the normalisation of these discourses. Collectively, these studies demonstrate the pervasive stereotypes which shape non-Indigenous

people's thinking about Aboriginal and Torres Strait Islander people and cultures, and these are evident across political media, and everyday talk.

## 1.4 The operation and impact of racism on the health and wellbeing of Aboriginal and Torres Strait Islander people

The previous sections provide important theoretical and historical context to understand the embedded and complex nature of racism in Australian society. The following sections will provide an overview of how racism operates at structural, institutional, and interpersonal levels, as well as the impact this has on health and wellbeing for Aboriginal and Torres Strait Islander peoples. While racism operates across all areas of Australian society, the focus here will be on the operation and impact of racism in relation to the healthcare system, given the evidence that suggests racism experienced in this setting has an amplified impact on health and wellbeing (Truong & Moore, 2023).

### 1.4.1 Modes of impact: health outcomes and health inequities

It is important to distinguish between the two pathways through which racism impacts the health and wellbeing of Aboriginal and Torres Strait Islander people.

The first pathway is direct impact, where the experience of racism has a direct effect on the physiological, psychological, or social wellbeing of individuals or groups. This type of impact is more likely to be experienced as a result of interpersonal racism but can occur in response to both institutional and structural racism (Ferdinand et al., 2013; Kairuz et al., 2021; Paradies, 2006b; Paradies et al., 2015; Paradies et al., 2008).

The second pathway is through the creation of health inequities, defined as "avoidable and imposed" inequalities (Berman & Paradies, 2010, p. 215). In the Australian context, racism creates health inequities through the differential and inequitable access to opportunities, power,

and resources across all systems and institutions such as healthcare, education, employment, housing, and the justice system (Elias et al., 2021; Priest et al., 2024). While structural and institutional racism are more likely to create health inequities, there is emerging evidence to suggest that they may also occur as a result of interpersonal racism (Priest et al., 2024; Thurber et al., 2022).

### 1.4.2 Structural racism: the impact of colonialism on health and wellbeing

Health and wellbeing are deeply connected to where "we are born, grow, live, work, and age … these social determinants of health are shaped by policy choices, social values, and the systems we create and sustain" (World Health Organization [WHO], 2025, p. iii). The WHO (2025, p. xi) classifies racism as a structural determinant of health, which shapes the conditions of daily life such as social connection, education, housing, and employment. These can, in turn, create health inequities through unequal and unfair access to the social, cultural, and economic resources required to sustain health and wellbeing, and an increase in exposure to health risk factors (Griffiths et al., 2016; Paradies et al., 2008).

The structural racism inherent in the Australian healthcare system has created inequities in the acceptability and accessibility of healthcare services for Aboriginal and Torres Strait Islander people. Like all systems in Australia, the healthcare system was founded according to white knowledge systems and practices, and from the very beginning has excluded and dismissed Aboriginal and Torres Strait Islander health systems and knowledges (Gatwiri et al., 2021; Paradies, 2016; Sherwood, 2013). The current system is predominantly informed by an individualist biomedical model of health, with a focus on disease diagnostics and treatment. This sits in contrast with Aboriginal and Torres Strait Islander models of health, where there is a greater focus on wellbeing and health is broadly defined as:

> *‘“... not just the physical well-being of an individual but ... the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.’*
> (National Aboriginal Community Controlled Health Organisation, n.d.)

Aboriginal and Torres Strait Islander peoples have well established healing methods, including Traditional Healers and locally available bush medicines (McKendrick et al., 2017; Oliver, 2013), yet these are not recognised or included in the Australian healthcare system, except on an ad hoc basis (Panzironi, 2013).

Aboriginal Community Controlled Health Organisations (ACCHOs), primary health care services which are run by and for Aboriginal and Torres Strait Islander communities, provide an important alternative to mainstream health services (Coombs, 2023). Evidence suggests that ACCHOs improve equitable access to healthcare through the provision of holistic, accessible, and culturally safe care (Gomersall et al., 2017) and represents a genuine example of self-determination (Coombs, 2023). Despite the evidence of their efficacy in improving healthcare access, federal funding for ACCHOs remains complex in comparison to mainstream services, with a reliance on short term, fragmented, and uncertain funding (Dwyer et al., 2009). Additionally, ACCHOs are particularly vulnerable to the ideological and political priorities of government, where self-determination and holistic care are seen as less of a priority (Coombs, 2023). Consequently, many Aboriginal and Torres Strait Islander people have little choice but to utilise mainstream services which do not necessarily align with healthcare needs and preferences.

Like the healthcare system, health policy is also informed by racialised understandings, and as demonstrated above (section 1.3), the cumulative effect of government policies has been to

create and entrench disadvantage. While government policies since the late 1960s have ostensibly been developed to address this disadvantage, little progress has been made in achieving equitable outcomes (National Indigenous Australians Agency, 2024). There have been several critiques offered which identify potential explanations for ongoing policy failure, many of which note issues in funding level and allocation (Altman et al., 2009; Donato & Segal, 2013; Holland, 2018; Hoy, 2009). While these are likely contributing factors, arguably a bigger factor is the fundamental lack of self-determination and Aboriginal and Torres Strait Islander control within the policy making process. Until recently, Aboriginal and Torres Strait Islander people have had very little say in how policy is developed, meaning that it is predominantly non-Indigenous people setting policy agendas and developing key indicators and approaches (Eckermann et al., 2010; Elias et al., 2021; Sherwood, 2013).

Notably, analyses of policies designed to "address disadvantage" and improve the lives of Aboriginal and Torres Strait Islander people demonstrate that they are underpinned by white, neoliberal notions of what it means to live a "good life" (Altman, 2018; Howard-Wagner, 2019) and consistently draw on deficit discourse to position Aboriginal and Torres Strait Islander people as a "problem to be solved" (Fforde et al., 2013; Fogarty, Bulloch, et al., 2018). Indeed, some have argued that these policies are no more than thinly veiled assimilationism, given the underlying deficit discourses and assumptions of white superiority (Bond & Singh, 2020; Bond et al., 2020; Fogarty, Bulloch, et al., 2018; Pholi et al., 2009). Ultimately, policies will determine where and how funding is allocated, and it is questionable what impact policy can have when it does not align with Aboriginal and Torres Strait Islander worldviews, needs, and aspirations.

To date, relatively few studies have attempted to articulate or measure the direct impacts of colonisation and structural racism on health outcomes. In a review of the international literature, Paradies (2016) identifies historical and transgenerational trauma as causal factors

in ill-health. Evidence of these transgenerational impacts were detailed in the *Bringing Them Home Report* (Commonwealth of Australia, 1997), with a growing body of international literature demonstrating links between historical trauma, transgenerational trauma, and ill-health (for example: O'Neill et al., 2018; Phillips-Beck et al., 2019). More recently, a review of the Australian literature by Griffiths et al. (2016) explored how colonialism contributes to ill-health, and like Paradies (2016), transgenerational trauma was identified as a contributing factor, as well as the ongoing legacy of interpersonal and institutional racism.

### 1.4.3 Institutional racism: operation and impact

Institutional racism operates through the policies, practices, and operational processes of an organisation, and can occur regardless of the individual beliefs and attitudes held by staff (Elias & Paradies, 2021; Paradies, 2016). As Elias and Paradies (2021) argue, institutional racism can be difficult to detect and often is not the product of explicitly racist policies, but simply "business as usual". Evidence of institutional racism is predominantly seen in racialised disparities in service access and outcomes, although these are generally not detected unless intentionally investigated (Elias & Paradies, 2021; Henry et al., 2004).

Arguably, institutional racism is evident across all aspects of the healthcare system, from the educational institutions which train new healthcare professionals to the services that provide healthcare. Within the higher education sector, there is evidence that racial ideology and deficit narratives are embedded within healthcare programs of study. For example, a recent review of 165 learning outcomes across 31 Australian nursing programs by Laccos-Barrett et al. (2022) found that the majority were informed by an ideology of white superiority and the problematisation of Aboriginal and Torres Strait Islander people. Given that nurses are the largest group of health professionals in Australia and work across all levels of the healthcare system (Australian Institute of Health and Welfare, 2024), the potential impact of racialised healthcare education is substantial. Relatedly, Vass and Adams (2021) found that medical

educators tasked with teaching students about race, white privilege, and reflexive practice felt unprepared and uncomfortable, and questioned whether this learning was relevant to medical practice. Arguably, if educators do not value this type of teaching, then it is unlikely that students will.

Student attitudes across a range of health sciences students have been examined and have found that learning about Aboriginal and Torres Strait Islander health is often considered "optional", "unnecessary", or as a "soft subject" (Hollinsworth, 2016; Thackrah & Thompson, 2013). If health educators are operating from a position of whiteness and unexamined racial ideology, then this will influence student learning and each new generation of healthcare professionals.

Racism is also embedded throughout the healthcare sector in the policies and practices of services and organisations, and has been shown to impact service availability, accessibility, funding, and delivery (Bourke et al., 2019; Elias & Paradies, 2021; Henry et al., 2004). One of the key indicators of institutional racism is the existence of racialised disparities, where patterns of inequitable outcomes exist across racial groups. In Western nations like Australia, these patterns tend to favour the dominant white majority while disadvantaging racial minorities, including Aboriginal and Torres Strait Islander people (Elias & Paradies, 2021). A series of studies demonstrate that when all other factors are accounted for, including disease severity, Aboriginal and Torres Strait Islander people experience lower cancer survival rates (Moore et al., 2014; Valery et al., 2006), lower likelihood of receiving cancer-related chemotherapy, radiation, or surgery (Cunningham et al., 2008), are less likely to receive a coronary angiography in acute hospital care (Tavella et al., 2016), and were less likely to be scheduled for genetic counselling services (Luke et al., 2022) in comparison to their non-Indigenous counterparts. An earlier study by Henry et al (2004) identified several examples of institutional racism, including inequitable and insufficient funding allocation, differing performance criteria for mainstream versus Aboriginal and Torres Strait Islander Community Controlled services,

inadequate treatment provision, and a lack of culturally appropriate and relevant care options. A more recent review of South Australian Local Health Networks (LHNs) by Marrie and Bourke (2020) found that institutional racism was endemic throughout the state's healthcare system, evidenced by a lack of Aboriginal and Torres Strait Islander representation in leadership and governance, a lack of community consultation and information sharing processes, a lack of funding transparency, and a lack of Cultural Safety training for the LHN workforce.

Inequitable health care and outcomes can also be the result of institutional policies based on racialised understandings of Aboriginal and Torres Strait Islander people. For example, Hine et al. (2023) note that within some perinatal care settings, "Indigenous status" is included as a risk factor, resulting in Aboriginal and Torres Strait Islander women being subjected to increased monitoring and invasive treatments, and is linked to higher rates of child protection notifications. Similarly, Tunnicliffe et al. (2023) recommended the removal of Indigenous status as a risk factor in chronic kidney disease (CKD) evaluation. In both Tunnicliffe et al. (2023) and Hine et al. (2023), the argument is that inclusion of Indigenous status as a risk factor works to reinforce assumptions that Aboriginal and Torres Strait Islander people are inherently prone to disease and engage in health risking behaviours, rather than understanding and addressing the broader social determinants at play.

### 1.4.4 Interpersonal racism: The prevalence and impact of racist attitudes and behaviours on physical, mental, and socio-emotional wellbeing

The prevalence and impact of interpersonal racism against Aboriginal and Torres Strait Islander people is arguably one of the most well researched areas of race scholarship in Australia. Studies demonstrate that a substantial portion of Aboriginal and Torres Strait Islander people have experienced racial discrimination across a range of settings, including healthcare services, the education system, the justice system, in shops and recreational spaces, and in public

(Ferdinand et al., 2013; Gentile et al., 2022; Reconciliation Australia, 2022; Thurber et al., 2021; Ziersch et al., 2011).

Racism experienced in the healthcare system can have compounding effects on health and wellbeing, in that it can have an immediate impact on physical and mental wellbeing as well as long term impacts through reducing access to healthcare services (Truong & Moore, 2023). The recent Australian Reconciliation Barometer found that 60% of Aboriginal and Torres Strait Islander respondents had been subjected to racism in the last 12 months, with 20% indicating that they had been racially discriminated by healthcare staff (Reconciliation Australia, 2022). This echoes the earlier findings of Ferdinand et al. (2013) who surveyed Aboriginal people living in Victoria and found that 97% of respondents had experienced at least one instance of racism in the last 12 months, and approximately 21% of respondents had experienced racism when accessing healthcare. Several qualitative studies have also documented Aboriginal and Torres Strait Islander people's experiences of racism in both the healthcare system (Askew et al., 2021) and in everyday life (Hickey, 2016). Notably, Askew et al. (2021) found that racism was a key reason for Aboriginal and Torres Strait Islander people to self-discharge from hospital, impacting treatment outcomes and broader accessibility to the healthcare system. These studies collectively indicate the pervasiveness of racism in Australia, and that racist encounters are a common aspect of many Aboriginal and Torres Strait Islander people's lives.

The experience of racism has a range of detrimental effects on the health and wellbeing of Aboriginal and Torres Strait Islander people. Several studies have demonstrated significant impacts on mental, social, and emotional wellbeing (Ferdinand et al., 2013; Gentile et al., 2022; Kairuz et al., 2021; Thurber et al., 2022; Thurber et al., 2021; Truong & Moore, 2023; Ziersch et al., 2011). A cross-sectional analysis of national survey data found that approximately 47% of the difference in psychological distress experienced by Aboriginal and Torres Strait Islander people compared to non-Indigenous people could be attributed to racial discrimination

(Thurber et al., 2022). While the impact of racism on psychological health is well documented, there is also some evidence that the impacts of racism have flow on effect to physical health, including self-reported poor health, increased BMI, and engagement in health damaging behaviours such as smoking (Kairuz et al., 2021; Paradies, 2006b; Paradies et al., 2015; Ziersch et al., 2011).

The impact of racism is particularly evident in health and wellbeing outcomes, which show marked disparities between Aboriginal and Torres Strait Islander and non-Indigenous people in life expectancy, mortality rates, physical health indicators, and social and emotional wellbeing (Australian Indigenous Health*InfoNet*, 2023; Australian Institute of Health and Welfare, 2023). It is estimated that approximately 34% of the health gap is attributable to social determinants such as employment, housing, and education, with another approximately 19% attributable to health risk factors such as smoking, alcohol consumption, overweight and obesity, poor diet, and lack of physical activity (Australian Institute of Health and Welfare, 2018, p. 343). This leaves approximately 47% of the health gap unexplained, and while some of this gap may be explained by early life events not captured in the data (Australian Institute of Health and Welfare, 2018), Bourke et al. (2019) and Elias and Paradies (2021) note that a likely explanation is the impact of racism. Arguably, however, the cumulative impacts of colonialism, racialised social systems and institutions, and exposure to interpersonal racism means that even within the 53% of "explained" health gap, racism is a substantial contributing factor.

## 1.5 Antiracism approaches and the potential role of Cultural Safety

In response to the recognised harms of racism, a range of antiracism approaches have been developed. Bonnet (2000) identifies six types of antiracism, including everyday antiracism,

psychological antiracism, multicultural antiracism, radical antiracism, anti-fascist antiracism, and the representative organisation. Watego et al. (2021) build on this work to identify an additional four types of antiracism praxis, including statistical, embodied, the use of art, and the collective action of the Black Lives Matter movement. Common antiracism strategies can include training and education, intergroup exposure and interaction, media and social campaigns, and institutional and political policies (Elias et al., 2021; Watego et al., 2021). What is clear from the antiracism literature is that approaches cannot be singular, but must target individual attitudes and behaviours, intergroup dynamics, institutional policies and practices, and social and political structures (Trenerry et al., 2024).

There is relatively limited literature examining the impact of antiracism training and approaches (Brondolo et al., 2023; Durey, 2010), and some have questioned whether antiracism training and approaches work to reinforce and reinscribe racial categories (Hartzell, 2023; Sonn, 2008), and relatedly, whether it risks reifying false binaries and ignoring the intersection of racism with other systems of oppression (Bonnett, 2000). Additionally, given that racism underpins and structures societies, including political and other social systems (Watego et al., 2021), there is some question as to whether antiracism efforts should aim to oppose, work in parallel, or work within current sociopolitical structures (Lentin, 2004).

Cultural Safety, and the reflexive practice that underpins it, provides a potential starting point for antiracism which may address some of these tensions. Founded on principles of social justice and equity, Cultural Safety recognises the intersectional and dynamic nature of culture and identity, allowing for the recognition of racial identity and belonging while avoiding essentialism and othering. It also requires a reflexive consideration of personal, professional, and institutional cultures, how racism shapes personal and professional knowledges, and the colonial systems that maintain racial inequities. It also requires the redistribution of power through shared decision making and accountability to end-users of a service. In this sense,

Cultural Safety has the potential to be utilised within current sociopolitical systems while also actively critiquing and working to challenge those systems. While Cultural Safety provides an overarching conceptual framework, the reflexive praxis which facilitates culturally safe practice is not well explored or articulated, and this will be the focus of the following chapter.

# Chapter 2: Cultural Safety and reflexive practice as a starting point in addressing racism

## 2.1 Chapter overview

As demonstrated in Chapter 1, racism structures and impacts all aspects of Aboriginal and Torres Strait Islander people's lives and is a key driver of ill-health and health inequity. Racism experienced in the healthcare system can compound the health impacts (Truong & Moore, 2023); as such, approaches to target racism in healthcare – including the education of healthcare professionals – are required.

Cultural Safety has emerged as an approach to healthcare with the potential to create systems and practices that are free from racism (Ahpra & National Boards, 2020; Phillips, 2014; Ramsden, 2002). Cultural Safety is concerned with identifying and critiquing the power imbalances, cultural norms and values, and racialised assumptions which underpin both individual healthcare practice and the operation of the healthcare system more broadly. The capacity to engage in reflexivity is foundational to culturally safe practice as it facilitates a critical, reflective consideration of the self in relation to others and to the broader social context (Finlay, 2002a; Wilson, 2014). As such, reflexivity offers a potential method for identifying and challenging racism at the individual, interpersonal, institutional, and structural level (Vass & Adams, 2021). Despite its centrality, reflexivity within the context of Cultural Safety remains largely unexamined. This chapter will provide an overview of Cultural Safety theory, practice, and education, with a focus on reflexivity and identification of key gaps in the current literature.

## 2.2 Cultural Safety

Since the late 1980s, Cultural Safety has been gaining traction as an approach to healthcare delivery and training which recognises the centrality of culture in health and wellbeing and seeks to create healthcare systems and practices that are free from racism (Ramsden, 2002). Eckermann et al. (2010) note that Cultural Safety can be difficult to define, "because it is a philosophy or an approach to healthcare that is not so much about *what* you do but rather *how* you do it" (p. 185, emphasis in original). To this end, Cultural Safety is concerned with healthcare professionals developing open-mindedness and flexibility in thinking and attitudes, rather than a set of knowledges or practices (Ramsden, 2002; Williams et al., 2021). It challenges the long-standing assumption that care should be provided regard*less* of difference, instead recognising that care should be grounded in respect for and honouring of difference (Eckermann et al., 2010; Williams et al., 2021). Fundamentally, Cultural Safety is an approach which works towards equitable healthcare outcomes and is founded on social justice principles (Williams et al., 2021).

Cultural Safety was originally developed in Aotearoa (New Zealand) by the late Irihapeti Ramsden (Ramsden, 1990, 2002), a Māori nurse practitioner and educator. Building on her experience as a nurse educator, Cultural Safety was developed as a theoretical framework to guide nursing and midwifery practice and curricula development. In her seminal thesis, Ramsden (2002) traces the development of these ideas, drawing on her experience as both nurse and educator. As a nurse, Ramsden observed how racism and a sense of powerlessness impacted Māori engagement in healthcare, how the attitudes and practices of nursing staff resulted in inadequate care, and how a Western biomedical health system was insufficient to provide culturally appropriate care. As a nursing educator attempting to educate predominantly

Pākehā[1] nurses and midwives on colonial history, racism, and how these create health inequities, Ramsden (2002) realised the need for a more structured theoretical framework on which to hang these ideas.

Ramsden's (2002) Cultural Safety model was strongly supported by the New Zealand Nursing Council, and within a few years was included as a mandatory part of nursing and midwifery curricula as well as professional practice standards (Papps & Ramsden, 1996; Ramsden, 2002). Since then, Cultural Safety has been further developed as a theoretical framework in Aotearoa, and has been taken up and adapted internationally, including in Australia (Ahpra & National Boards, 2020; Australian Indigenous Doctors' Association [AIDA], 2022; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives [CATSINaM], 2021). It has also been expanded beyond the fields of nursing and midwifery, with varying levels of engagement across a variety of health professions including medicine (Australian Medical Council, 2024; Carriage et al., 2017; Medical Board & Ahpra, 2020; Paul et al., 2019), physiotherapy (Bolton & Andrews, 2018), psychology (Chiodo et al., 2014), and health sciences (Delbridge et al., 2021; Durey, Taylor, et al., 2017; Gray et al., 2020; Jackson et al., 2013; Kickett et al., 2014; Mills et al., 2022; Sjoberg & McDermott, 2016). The following sections will provide an overview of the uptake and adaptation of Cultural Safety in Australia, and an overview of the key underpinning principles.

### 2.2.1 A note on the term 'culture'

In its initial conceptualisation, Ramsden (2002) was clear that "culture" was not simply a synonym for ethnicity. Rather, culture encompasses a broad range of human experience, including ethnicity as well as nationality, geographic location, socioeconomic status, religion, gender, sexuality, and disability, among others (Taylor & Guerin, 2019; Williams et al., 2021).

[1] Pākehā is a Māori term for New Zealanders of European descent.

In this sense, Ramsden's (2002) definition of culture shares similarity with the concept of positionality, which recognises that each person occupies many social positions that influence sense of identity and social belonging, including the relative levels of privilege and power a person may occupy (Soedirgo & Glas, 2020). Given that each person's culture is unique to them, Ramsden (2002) argued that all care encounters are bi-cultural, even where the health professional and patient ostensibly share the same ethnic background.

The notion of a bi-cultural healthcare relationship is a useful starting point, however, this conceptualisation overlooks both the shared cultural practices of groups and societies, as well as the broader power dynamics that structure relations between dominant and minoritised groups (Causadias, 2020; Elias et al., 2021). As such, while healthcare interactions may be considered bi-cultural, there must be recognition that this interaction occurs within both a micro- and macro-level power dynamic.

In the Australian context, whiteness underpins social structures and relations and is directly linked to racialised power structures and the assumption of white superiority (Eckermann et al., 2010; Elias et al., 2021; Watego et al., 2021). Dominant white sociocultural norms and practices underpin all systems and institutions in Australia, including the healthcare sector, with Aboriginal and Torres Strait Islander norms and practices often positioned as "other", inferior, or problematic (Eckermann et al., 2010; Moreton-Robinson, 2004; Sherwood, 2013). While the broad conceptualisation of culture which informs Cultural Safety holds the potential to improve care for all minoritised groups, Cultural Safety has predominantly been adopted in the Australian context by and for Aboriginal and Torres Strait Islander peoples as an attempt to address the impact of racialised and racist healthcare provision (Bin-Sallik, 2003; CATSINaM, 2021; Mohamed et al., 2024; National Aboriginal and Torres Strait Islander Health Workers' Association [NATSIHWA], 2016). This uptake – as well as the potential risks of this approach – will be discussed below.

### 2.2.2 Uptake and adaptation of Cultural Safety in Australia

The original development of Cultural Safety was grounded in Māori ways of knowing, being, and doing, and was tailored to the colonial context of Aotearoa. While there are some broad similarities in the colonial histories and current health inequities of the two nations (Freemantle et al., 2007), there are also substantial historical, cultural, social, political, and contextual differences that need to be considered. For example, Te Tiriti O Waitangi (the Treaty of Waitangi) provided an important foundation for the development of Cultural Safety and was critical in providing a legal basis for the inclusion of Cultural Safety into health professions curricula and practice standards in Aotearoa (Ramsden, 2002). However, there is no such treaty between Aboriginal and Torres Strait Islander nations and the Australian government, and this perhaps at least partially explains the slower uptake of Cultural Safety in Australia.

Dr Sally Goold OAM, in her role as Chair of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN; now Congress of Aboriginal and Torres Strait Islander Nurses and Midwives [CATSINaM]), is attributed with introducing Cultural Safety in the Australian context (CATSIN, 1998; Indigenous Nursing Education Working Group [INEWG], 2002). This early work drew predominantly on the Nursing Council of New Zealand's (NCNZ) definition of Cultural Safety as:

> *The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on [their] own cultural identity and recognises the impact of the nurse's culture on [their] own nursing practice. Unsafe cultural practice is any action which diminishes or disempowers the cultural identity and well-being of an individual* (NCNZ, cited in INEWG, 2002, p. 50)

Since the early 2000s, organisations like the Indigenous Australian Health Association (IAHA: 2019), Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM:

n.d.), and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NATSIHWA: 2016) have worked to develop a model of Cultural Safety by and for Aboriginal and Torres Strait Islander peoples. However, many of these more recent definitions and conceptualisations have drawn on the earlier Williams (1999) definition, the NCNZ Cultural Safety definition (Nursing Council of New Zealand, 2011), or the critical theoretical work being done in Turtle Island (Canada: Smye & Browne, 2002). Lock et al. (2021) argue that this is potentially problematic because the source definitions are developed from epistemologically and ontologically different positions, and within different contexts.

During this time, Cultural Safety has increasingly been included in professional practice and accreditation standards for health professions in Australia. As in Aotearoa, nursing and midwifery were the first professions to recognise the value and utility of Cultural Safety and were early adopters of the new approach (CATSIN, 1998). This is exemplified by the work of CATSINaM, who advocated for the inclusion of Cultural Safety into nursing and midwifery education and practice (CATSINaM, 2018). Cultural Safety also provides the theoretical basis for the Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2014), which outlines a scaffolded learning framework for health sciences curricula.

More recently, the Australian Health Practitioner Regulation Agency (Ahpra & National Boards, 2020) undertook a nation-wide consultation process to develop a contextually meaningful and relevant Cultural Safety definition. This consultation process specifically sought the knowledge and expertise of Aboriginal and Torres Strait Islander health organisations, leaders, educators, and practitioners, and in 2020, Ahpra released their *Cultural Safety Strategy 2020 – 2025* (Ahpra & National Boards, 2020), which provided the following definition:

> *Cultural Safety is determined by Aboriginal and Torres Strait Islander individuals, families, and communities.*
>
> *Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism.* (p. 9)

Following the release of their *Cultural Safety Strategy*, Ahpra also released a Shared Code of Conduct (Ahpra & National Boards, 2022) for twelve allied health professions, with Cultural Safety listed as Principle 2:

> *Practitioners should consider the specific needs of Aboriginal and Torres Strait Islander Peoples and their health and Cultural Safety, including the need to foster open, honest, and culturally safe professional relationships.* (p. 9)

Cultural Safety is also included in codes of conduct for medical professions (Medical Board & Ahpra, 2020), nursing (Nursing and Midwifery Board Ahpra, 2022b), and midwifery (Nursing and Midwifery Board Ahpra, 2022a), and in the accreditation standards for all registered health professions. As such, Cultural Safety is in the initial stages of becoming institutionally embedded in both health practice and health education.

Parallel to these developments in healthcare education and practice has been an increased uptake of Cultural Safety in the policy space. This is exemplified in the most recent *Aboriginal and Torres Strait Islander Health Plan 2021–2031* (Australian Government Department of Health, 2021), which makes explicit calls to embed Cultural Safety throughout all levels and aspects of the healthcare system. Likewise, the most recent iteration of the national *Closing the Gap* (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2020) policy framework makes the call for Cultural Safety to be embedded across all areas of service and organisational operation. It is also a key focus area in the most

recent Universities Australia (2022) *Indigenous Strategy 2022–2025*, where the creation of culturally safe universities is seen as an important foundation for addressing racism in the university sector. Cultural Safety is increasingly being recognised as necessary to creating systems and institutions that are free from racism and culturally responsive to the needs and aspirations of Aboriginal and Torres Strait Islander people.

### 2.2.3 Alternative approaches to healthcare provision and training

While Cultural Safety is gaining prominence in Australia, there are a range of alternative approaches which aim to incorporate or consider culture within care provision and training. The most common alternatives include cultural awareness, cultural competency, cultural respect, cultural security, and cultural responsiveness (Downing et al., 2011; Mohamed et al., 2024). These terms are often used interchangeably, resulting in conceptual confusion regarding what Cultural Safety is and is not (Downing et al., 2011; Mohamed et al., 2024). The following sections will provide a brief overview of these approaches, including the theoretical limitations of each.

#### *2.2.3.1 Cultural Awareness*

Cultural awareness is one of the most common training approaches used in Australia and has been used to train future and practicing healthcare professionals since the 1980s (Downing et al., 2011; Kerrigan et al., 2020; Mohamed et al., 2024; Rissel et al., 2022). Cultural awareness has a central focus on becoming aware of cultural differences, which can include awareness of both cultural practices as well as collective histories and experiences of cultural groups (Mohamed et al., 2024; Taylor & Guerin, 2019). It is often posited as the first step towards culturally safe practice (Heckenberg, 2020; Taylor & Guerin, 2019).

While cultural awareness can facilitate deeper knowledge and understanding of localised contexts (Rissel et al., 2022), it has been widely critiqued for its narrow focus on the "cultural other" (Downing & Kowal, 2011; Mohamed et al., 2024). Downing and Kowal (2011) offer a

postcolonial analysis of cultural awareness, noting that this type of training risks cultural essentialism, creating a "false dichotomy of cultures – 'us and them'" (p. 8). It also largely avoids any critical consideration of structural and systemic inequities, focusing instead on individual level processes, which risks pathologizing cultural difference (Downing & Kowal, 2011; Mohamed et al., 2024).

#### *2.2.3.2 Cultural Competency*

Broadly speaking, cultural competency is the development of a set of knowledges, behaviours, attitudes, and policies (competencies) to effectively acknowledge and incorporate cultural beliefs and practices into healthcare provision and systems (Betancourt et al., 2003; Cross, 1989). The initial scope of cultural competency was individual knowledge, practice, and behaviour, but this has expanded to consider organisational and institutional competencies (Curtis et al., 2019; Truong et al., 2014).

In a critical review of the cultural competency and Cultural Safety literature, Curtis et al. (2019) identify several key concerns regarding cultural competency. Like cultural awareness, cultural competency is largely focused on the 'cultural other', where culture is largely seen as synonymous with race and ethnicity (Betancourt et al., 2003; Cross, 1989). Cultural competency relies on the underlying assumption that a healthcare professional can become 'proficient' in the cultural beliefs and practices of their clients, and as such risks essentialising culture and reinforcing stereotypes (Curtis et al., 2019; Mohamed et al., 2024). As Mohamed et al. (2024) note, cultural competence is not specific to Indigenous peoples, and in Australia, may not adequately take into account the experience and impact of colonialism and racialised power dynamics. More broadly, in a multicultural nation such as Australia, the possibility of becoming proficient and competent in all possible cultural practices is debateable.

#### *2.2.3.3 Cultural Respect*

Cultural respect is defined as "recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people" (Australian Health Ministers' Advisory Council [AHMAC], 2016, p. 1), and was designed to improve the efficacy, safety, and accessibility of the healthcare system for Aboriginal and Torres Strait Islander people. The approach is outlined in the Cultural Respect Framework 2016-2026 (AHMAC, 2016), which maps out five key principles (leadership and responsibility; health equality and a human rights approach; Aboriginal and Torres Strait Islander community and consumer engagement; partnerships; and monitoring and accountability) and six domains (whole of organisation approach and commitment; communication; workforce development and training; consumer participation and engagement; stakeholder partnerships and collaborations; and data, planning, research and evaluation).

Like Cultural Safety, cultural respect requires an understanding of colonialism, racism, and their collective impacts on health and wellbeing; encourages individual reflection on bias; and is aimed at individual, institutional, and structural level change (AHMAC, 2016). However, there is no requirement to identify or challenge racialised power dynamics, and it is questionable whether genuine transformative change can occur without this. Additionally, cultural respect seems to be positioned as the outcome of culturally safe and responsive care (AHMAC, 2016, p. 4).

#### *2.2.3.4 Cultural Security*

Like cultural respect, cultural security was developed in Australia as an approach to healthcare service design and delivery which "honour[s] the legitimate cultural rights, values and expectations of Aboriginal people [providing] a safe environment where Aboriginal people are empowered to make decisions that affect their lives without fear of judgement or discrimination" (Northern Territory Government, 2018, p. 5). In contrast to most other

approaches, cultural security is predominantly focused on organisational change; while frameworks such as the Northern Territory Government's (2018) *Aboriginal Cultural Security Framework* outline the intended outcomes, to date there is little information on how staff might be trained in or supported to enact these changes (Downing et al., 2011; Mohamed et al., 2024).

Coffin (2007) proposes that cultural security is the product of both Cultural Safety and cultural awareness; the former facilitates a reflexive consideration of individual and institutional practices and an openness to transformative change, while the latter facilitates an understanding of what type of change is required. A recent qualitative evaluation of health services in Western Australia demonstrated that while nearly three quarters of participants described their service as culturally secure, only around a third of participants felt that staff had an adequate understanding of the concept (Gubhaju et al., 2020). Key recommendations included increased cultural awareness and Cultural Safety training to improve training to ensure culturally safe care delivery (Gubhaju et al., 2020).

#### *2.2.3.5 Cultural Responsiveness*

Originating in the United States and Canada, cultural responsiveness has been adapted in the Australian context, primarily through the critical work of Indigenous Allied Health Australia (IAHA, 2019). Cultural responsiveness and Cultural Safety are seen as interrelated: "if cultural safety describes the state we are aiming to reach … cultural responsiveness is the practice to enable it" (IAHA, 2019, p. 4). The IAHA (2019) *Cultural Responsiveness in Action Framework* outlines six key capabilities (respect for the centrality of culture; self-awareness; proactivity; inclusive engagement; leadership; responsibility and engagement); for each capability, relevant knowledge and understanding (knowing), actions and practices (being), and organisational outcomes (doing) are outlined (Martin & Mirraboopa, 2003).

#### *2.2.3.6 Cultural Safety*

While each of the approaches outlined above have the potential to improve healthcare for Aboriginal and Torres Strait Islander people, arguably Cultural Safety provides the most appropriate foundation for learning. It addresses the key criticisms of approaches like cultural awareness and cultural competency and provides the necessary theoretical and practice foundation for other approaches, such as cultural respect, security, and responsiveness. More broadly, the increasing inclusion of Cultural Safety in national policies (for example: Commonwealth of Australia, 2021; Universities Australia, 2022), and in health professional registration and accreditation requirements (for example: Ahpra & National Boards, 2022; Australian Medical Council, 2024; Nursing and Midwifery Board Ahpra, 2022a, 2022b) supports the need for additional research in this space. For these reasons, Cultural Safety was chosen as the most appropriate focus for investigation in this thesis.

### 2.2.4 Principles of Cultural Safety

In her original conceptualisation of Cultural Safety as a theoretical framework for nursing and midwifery education, Ramsden (2002, p. 94) outlined four key principles:

1. To educate student nurses and midwives not to blame the victims of historical process for their current plight.

2. To educate student nurses and midwives to examine their own realities and the attitudes they bring to each new person they encounter in their practice.

3. To educate student nurses and midwives to be open minded and flexible in their attitudes towards people who are different from themselves, and to whom they deliver service.

4. To produce a workforce of well educated, self-aware registered nurses and midwives who are culturally safe to practice, as defined by the people they serve.

These principles have provided the foundation for a substantial body of international and Australian literature on Cultural Safety theory, practice, and educational strategies. In Australia, Cultural Safety researchers have used the theoretical foundations outlined in Ramsden's (2002) original thesis to more explicitly articulate the role of power, racism, and structural change. There are now several key texts which have outlined versions of these principles (for example: Eckermann et al., 2010; Mohamed et al., 2024; Taylor & Guerin, 2019; Williams et al., 2021). While there is no consistently agreed upon set of principles, there are some common threads which can be identified. The following sections will provide a synthesis of the Australian literature to outline six relatively consistent principles, highlighting links to Ramsden's (2002) seminal thesis.

#### *2.2.4.1 Address the power differentials between healthcare provider and recipient of care.*

Power imbalance is an inherent aspect of healthcare relationships, in that healthcare professionals hold the knowledges and skills required by those seeking care, as well as control over the decision-making process (Eckermann et al., 2010; Heckenberg, 2020; Williams et al., 2021). While healthcare professionals are trained in evidence-based practice, this does not prevent individual beliefs, assumptions, and biases from influencing decision-making. Cultural differences between healthcare professionals and those seeking care can compound this issue, where assumptions and stereotypes about various cultural groups can impact how healthcare professionals assess, diagnose, and treat those seeking care (Taylor & Guerin, 2019; Williams et al., 2021). For example, a case study by Fenwick and Stevens (2004) demonstrated that the post-operative pain management provided to Aboriginal patients was substantially less than recommended because the nursing staff misinterpreted Aboriginal patient's expressions of pain. Even where these biases and stereotypes do not influence care, there is often an assumption that healthcare professionals should "treat everyone the same", rather than provide individualised and equitable care (Taylor & Guerin, 2019). Arguably, the collective impact of

these assumptions and biases is healthcare that is at best ineffective, and at worst, negligent, harmful, and fatal.

Cultural Safety, therefore, requires that healthcare professionals reflect on and address these power differentials. A primary means of addressing power differentials is through shared decision-making, where those receiving care are provided with sufficient information to make informed decisions about care options (Williams et al., 2021). This broadly aligns with the principles of person-centred care, which recognises that "best practice" must be tailored to the individual and their circumstances for it to be achievable and effective (Taylor & Guerin, 2019). To practice in a culturally safe manner, healthcare professionals must be aware of the inherent power imbalances and be mindful of imposing their opinions, preferences, beliefs, or assumptions onto those seeking care. To this end, another key aspect of Cultural Safety is that only those receiving care can determine whether it is appropriate and safe, and this will be discussed further in section 2.2.4.4.

#### *2.2.4.2 The focus is on the healthcare professional rather than 'cultural others'.*

Cultural Safety is based on the premise that the only culture a healthcare professional can – and should – know is their own individual culture and that of the healthcare profession to which they belong (Phillips, 2014; Ramsden, 2002; Williams et al., 2021). This is perhaps best summarised by Cox and Best (2022), who state that "individuals' cultures are informed by, reflected by, expressed in, and reproduce professional, institutional, and societal cultures" and that health professionals must "take a critically informed, historical view of themselves as persons, to acknowledge privilege, and to accept and know themselves as cultural beings" (p. 76). This highlights the interconnectedness between positionality, relationality, and context, and that an understanding of self requires a consideration of the self in context.

The focus on the health professional's own cultural identity and positioning is important for several reasons. Firstly, it challenges the notion that healthcare delivery is a neutral and

objective process. If healthcare professionals can begin to understand themselves as having personal and professional culture, and that they operate within both an organisational and broader professional culture, they can also begin to identify where and how these shape healthcare beliefs and practices (Ramsden, 2002; Taylor & Guerin, 2019). It also opens the potential for healthcare professionals to understand that their own ways of knowing, being, and doing are not universal, which may help them to be more "open minded and flexible in their attitudes" (Ramsden, 2002, p. 94).

Consideration of personal and professional culture also presents opportunities for health professionals to become cognisant of their own privilege and positions of power, the potential biases and racialised stereotypes which inform their thinking and practice, and the collective impact of these on care delivery (Cox & Best, 2022; Williams et al., 2021). Colonialism, whiteness, and racism shape the institutions, systems, and broader social structures that healthcare professionals exist within, and consequently shape their own beliefs, attitudes, and practices, and these can have substantial negative effects on the quality and efficacy of healthcare delivery (Gatwiri et al., 2021; Truong & Moore, 2023). As such, healthcare professionals must go beyond simple 'self-awareness' to a deeper reflexive consideration of positionality, power, relationality, and context.

#### *2.2.4.3 Create a healthcare system that is free from racism.*

Given the demonstrated ways in which colonialism, whiteness, and racism shape both the healthcare system and individual healthcare practice, it is imperative that steps are taken to identify and challenge racism (Gatwiri et al., 2021; Parter et al., 2021; Phillips, 2014; Truong & Moore, 2023). The power imbalances inherent in the healthcare encounter mean that the racialised assumptions, attitudes, and practices of healthcare professionals can have a substantial influence on the type and quality of care provided (Cox & Best, 2022). Likewise, the power of systems and institutions to shape the delivery of care and the distribution of

resources plays a fundamental role in the creation and maintenance of racialised health inequities (Bourke et al., 2019; Henry et al., 2004). As such, it is necessary to identify and critique the racialised assumptions that inform both the operation of the healthcare system and the individual attitudes and practices of healthcare professionals.

Cultural Safety aims to address these racialised and racist assumptions in two ways. First, it requires healthcare professionals to develop a critical understanding of the underlying structural causes of health inequities. In colonised nations such as Australia, this includes an understanding of colonialism and its ongoing effects, the nature and impact of racism, and how these have shaped and continue to shape the structure and operation of socioeconomic and political systems and institutions (Williams et al., 2021). By doing so, healthcare professionals can start to challenge their own assumptions about the causes of health inequity, shifting from an individualised and deficit-based understanding to one that recognises the substantial impact of broader social, political, historical, and economic determinants of health.

Second, Cultural Safety requires that healthcare professionals reflexively engage with their own internalised racism and racialised assumptions. Healthcare professionals need to identify and challenge their own racism, understand how it impacts their ability to provide equitable and appropriate care, and examine the roots of their own racialised beliefs and assumptions. The act of "tracing [racist assumptions and attitudes] to their origins" (Ramsden, 2002, p. 121) also allows for a more critical examination of the systems and institutions which maintain racialised inequities, including the systems that educate and employ healthcare professionals (Cox & Best, 2022; Williams et al., 2021).

#### *2.2.4.4 Ensure that the safety and appropriateness of care is determined by the recipient of care.*

A central tenet of Cultural Safety, and one that sets it apart from most other cultural care approaches, is that only the recipient can determine whether care was culturally safe or not

(Heckenberg, 2020; Ramsden, 2002; Williams et al., 2021). As such, the quality of care is determined not by level of knowledge or capabilities, but how safe the recipient of care feels with the healthcare professional and within the broader healthcare system, and whether they are able to navigate both without assault or denial of their cultural identity (Taylor & Guerin, 2019; Williams et al., 2021). In this sense, healthcare professionals must be accountable not just to their workplace, but to the people they provide care to.

The shifting of accountability works to redress some of the power imbalances that exist within healthcare encounters. It is also a vital mechanism to identify and address racism in healthcare encounters and within the healthcare system more broadly. Often those perpetrating racism are either unaware of or in denial of their own racism (Augoustinos & Every, 2007; Bullen & Roberts, 2019; Wicks et al., 2024; Wicks et al., 2023). As such, a reliance on healthcare professionals to be able and willing to identify and address their own racism means that some will either go unnoticed or ignored. By shifting the power to recipients of care, who are often intimately familiar with the spectrum of racist practices, it is more likely that these practices will be identified and called out. Ideally, this would not be the responsibility of those receiving care, but the embeddedness of racialised ideologies and beliefs means that for many – especially those in the dominant sociocultural group – their understandings of the world are not racist but simply "common sense" (Augoustinos & Every, 2007; Connelly, 2020). Therefore it is vital that recipients of care have the final say in whether their experience was racist or culturally safe.

#### *2.2.4.5 Cultural Safety is both an individual practice and an opportunity for systems change.*

While individual level changes in understanding and practice are important aspects of Cultural Safety, they must also occur as part of broader changes to institutional and structural practices (Ramsden, 2002; Williams et al., 2021; Wilson, 2014). All aspects of the healthcare system, including the paradigmatic underpinnings, policy, governance structures, research and

diagnostic methods, physical spaces, and service delivery (Fredericks, 2010; Phillips, 2014; Wilson, 2014) are sites in which racialised understandings, deficit narratives, and whiteness are embedded. Patient experience of culturally safe care is not determined solely by the interaction with the healthcare professional, but in all aspects and stages of their interaction with the healthcare service and system.

As outlined in chapter 1, the knowledges, attitudes, and practices of individuals are both reflections of and work to reinforce broader social structures; as such, change is required in both to fully realise the potential of Cultural Safety. This is made apparent in Mohamed et al.'s (2024) discussion paper on Cultural Safety in Australia, where they trace the decades of advocacy for inclusion of Cultural Safety in Australian health education and practice. What is clear from this history is that, while individuals were trying to introduce change in their own spheres of influence, the most substantial changes have occurred with the inclusion of Cultural Safety within professional practice and accreditation standards. While this provided a national picture, the same is true at the service level. For example, in a study by Wilson et al. (2022) which sought to build a model for translating Cultural Safety to practice, a key finding was the importance of organisational leadership and institutional commitment to change.

#### *2.2.4.6 Cultural Safety is a lifelong learning process*

A final – but important – principle of Cultural Safety is the recognition that it is not an end point or an achievement, but a lifelong learning process (Williams et al., 2021). In contrast to acquiring a set of knowledges or competencies, Cultural Safety is relational and contextually dependent, meaning that what "counts" as culturally safe practice will vary between each healthcare encounter (Ramsden, 2002; Williams et al., 2021). It also requires a constant process of reflexivity to monitor, examine, and address racialised beliefs, attitudes, and behaviours. In practice, this means that healthcare professionals will need to become comfortable with being uncomfortable and be open to critiques of their own attitudes and practices (McDowall, 2021;

Wilson, 2014). Additionally, it means that healthcare professionals need to develop a sense of humility and occupy a space of "learner" rather than "expert", acknowledging that their knowledge and expertise are limited to their field of healthcare and does not include expertise in the lives of their patients, or in their experiences of care.

### 2.2.5 Critiques of Cultural Safety

While Cultural Safety has gained traction both in Australia and internationally, it is not without critique. One of the main criticisms, and particularly in Australia, is that there is a lack of clarity regarding what Cultural Safety is and how to operationalise it in a practice setting. In an earlier qualitative study, Johnstone and Kanitsaki (2007) interviewed Australian healthcare practitioners and consumers to better understand professional and public understandings of Cultural Safety. Findings demonstrated that participants lacked clear or consistent understandings of what Cultural Safety is, and for healthcare practitioners there was uncertainty regarding how to put it into practice. More recent reviews of the Cultural Safety literature highlight consistent conceptual slippage, with terms such as 'cultural awareness', 'cultural competency', and 'culturally conscious' used interchangeably with Cultural Safety (Cox & Best, 2022; Lock et al., 2021; Mohamed et al., 2024).

The more recent consultation process conducted by Ahpra (2020) goes some way to addressing this lack of clarity, providing a definition developed through extensive community consultation. However, there are questions as to whether a new definition was required; during the consultation phase, Cox and Best (2022) cautioned that attempts to redefine Cultural Safety risk what Ramsden (2002) described as "the consistent redefinition of Cultural Safety from a political to an ethnographic and idealised view" (p. 179). While Cox and Best (2022) were responding to the draft definition, their concerns were arguably well founded. The finalised definition takes a relatively narrow focus on individual knowledges, attitudes, and practices, and while it does recognise racism, it does not include considerations of the institutional and

structural change required of a culturally safe healthcare system (Cox & Best, 2022; Mohamed et al., 2024; Williams et al., 2021). What implications this definition will have on the understanding and practice of Cultural Safety is yet to be seen.

The other main critique of Cultural Safety is that there is a lack of evidence as to its efficacy in improving healthcare accessibility and outcomes. In large part this is because Cultural Safety can only be determined by the recipient of care, and what counts as culturally safe care will vary for each person (Ramsden, 2002). As such, it is challenging to develop any kind of standardised measure to capture patient experiences of culturally safe care. Given the difficulty in measuring experiences of culturally safe care, it is also difficult to determine what – if any – impact it has on healthcare outcomes. In a recent qualitative study, Withall et al. (2021) interviewed Australian nurses and midwives who had undertaken Cultural Safety training as part of their undergraduate studies to evaluate both understanding and implementation of culturally safe care. Results indicated that while most participants were able to articulate an understanding of Cultural Safety, it largely centred on the incorporation of patient cultural practices into care provision. Additionally, participants indicated varying levels of readiness and capacity to implement Cultural Safety into their own care practices. While the study by Withall et al. (2021) provides useful insights into both understanding and practice of Cultural Safety, arguably, the reliance on self-reporting by nurses and midwives rather than the perspectives of those receiving care limits the relevance of these results.

More recently in Canada, Smylie et al. (2024) conducted a randomised controlled trial, where physicians and nurse practitioners participated in intensive or short Cultural Safety training or standard professional education. The impact of these educational interventions was measured using a patient experience of care provision measure, likelihood of patients recommending clinicians to friends and family, and clinician adherence to clinical practice guidelines, providing a predominantly patient-centred measure of culturally safe care provision. Those

participating in the intensive and short Cultural Safety training received significantly higher patient experience scores and were significantly more likely to be recommended to friends and family in comparison to the control group. While the Smylie et al. (2024) study had a relatively small sample size, these results are a promising indication of the value and efficacy of Cultural Safety training on healthcare provision, although to date there are no comparable studies in the Australian context.

There is also limited literature on the efficacy of Cultural Safety education in respect to student learning outcomes. A systematic review by Hardy et al. (2023) identified 13 Cultural Safety education evaluation studies from Australia, Canada, Aotearoa (New Zealand), and the United States. Meta-analysis of educational impact was not possible due to the wide variation in evaluation approaches, although the authors note that 12 of the 13 studies included reported some level of learner impact. However, the reliance on self-assessment, variability in terminology and underpinning theory, as well as the relatively small sample sizes of several studies mean that these results arguably do not provide a clear picture of the efficacy and potential clinical impact of Cultural Safety education (Hardy et al., 2023).

Assessing educational efficacy presents several key challenges. As noted above, Cultural Safety is not about what you do, but how you do it, making it difficult for students to adequately demonstrate their ability to be culturally safe. Additionally, Cultural Safety is a process of learning rather than an end point, which means that it is difficult to assess whether students have learned “enough” to be culturally safe practitioners. There are questions about who is qualified and best suited to determine learning outcomes, given that Cultural Safety is determined by the recipient of care. The study by Smylie et al. (2024) suggests that there are ways to measure educational efficacy, however this also relies on learners having direct interaction with patients to assess culturally safe practice capacity. How this might be adapted

for students who are engaging in predominantly classroom-based learning is still unknown. Collectively, then, there are several significant gaps in the literature that require attention.

Despite the above critiques, Cultural Safety arguably represents one of the most promising approaches to addressing racism in healthcare and achieving equitable health outcomes (Curtis et al., 2019; McDermott, 2012; Mohamed et al., 2024).

### 2.2.6 Cultural Safety capabilities

The journey to becoming a culturally safe healthcare professional requires the development of two key capabilities: critical thinking and reflexivity (Hall et al., 2023; McDermott, 2020; Mohamed et al., 2024; Wilson, 2014). These capabilities work dynamically and synergistically to enable deep, critical, reflective praxis. Critical thinking without reflexivity risks an impersonal critique of systems which does not recognise the self as a product of and producer of racialised social systems. Reflexivity without criticality risks a shallow and self-congratulatory process of naval gazing introspection (Pillow, 2003a).

There is currently a substantial body of literature on critical thinking theory, praxis, and education practices, with numerous texts exploring pedagogical and assessment approaches in higher education (for example: Davies & Barnett, 2015; Seal & Smith, 2021), as well as those with a more explicit focus on the intersection between critical thinking, bias, and reflection (for example: Horvath & Forte, 2011; Sternberg & Niu, 2025). In contrast, the literature on reflexivity is more limited, with the majority focused on theoretical explorations of reflexivity within various disciplinary and sociopolitical contexts (for example: Alcoff, 1988; Finlay & Gough, 2003; Pillow, 2003a, 2003b; Wilkinson, 1988), or on the use of reflexivity as a research methodology (for example: Mauthner & Doucet, 2003; Rix et al., 2014; Wilson, 2014). To date, teaching, assessment, and the potential utility of reflexivity in creating institutional change remains relatively unexplored.

While both are necessary capabilities in culturally safe practice, the relative lack of research examining reflexivity in the context of Cultural Safety must be addressed. For this reason, the focus of the following sections will be on reflexivity in this context; articulating what is currently known, and the current gaps in the literature.

## 2.3 Reflexive practice

Broadly speaking, reflexive practice utilises critical reflection to consider positionality and power, the influence of these on intersubjective interaction, and the relationship between self and context (Alcoff, 1988). There is currently no universally accepted definition of reflexivity, but rather an array of definitions that reflect the context and purpose of its use. Indeed, Gough (2003, p. 22) suggests using the term *reflexivities* to acknowledge the many and varied ways that reflexivity is defined and operationalised. For the purposes of this thesis, an adapted version of the Olmos-Vega et al. (2023) definition will be utilised, to recognise the specific context of Cultural Safety and Aboriginal and Torres Strait Islander health, including the underlying colonial structures which create and maintain health inequities:

> *a set of continuous, collaborative, and multifaceted practices through which* ***healthcare professionals*** *self-consciously critique, appraise, and evaluate how their subjectivity and the* ***colonial*** *context influence the* ***delivery of healthcare****.* (p. 242, emphasis added to indicate adaptation)

There is also debate in the literature regarding the relationship between reflexivity and critical reflection, with some conceptualising reflexivity as an aspect of critical reflection (Landy et al., 2016) and some viewing it as one end of a continuum of reflective practices (Finlay, 2002a). Alternatively, May and Perry (2017) argue that reflexivity is "not a method. It is a critical ethos and set of dispositions" (p. 149) which facilitates a deeper, critical consideration of the nexus

between knowledge, context, and practice. In this conceptualisation, critical reflection is a tool or process that can be utilised to engage in reflexivity. Perhaps most relevant to the current thesis is the distinction outlined by Elizabeth Chiseri-Strater, who argues that "to be reflective does not demand an 'other', while to be reflexive demands both an other and some self conscious awareness of the process of scrutiny" (Chiseri-Strater, cited in Pillow, 2003a). In the context of this thesis, reflexivity is conceptualised in line with both May and Perry (2017) and Pillow (2003a).

Conceptualisations of reflexivity also vary considerably, and a range or typologies or categories of reflexivity have been proposed (see for example: Finlay, 2002a; Lumsden et al., 2019; Wilkinson, 1988). This variability reflects the ways that differing disciplines define and utilise reflexivity, as well as the focus and purpose of engaging in reflexivity. An in-depth exploration of the various disciplinary interpretations of reflexivity is beyond the scope of this thesis (although see Lumsden et al., 2019, pp. 1-24 for an overview of reflexive theories and conceptualisations), however the work of Finlay (2002a) provides a useful starting point for considering the relationship between reflexivity and Cultural Safety. Finlay (2002a) outlines five reflexive variants, which include introspection, intersubjective reflection, mutual collaboration, social critique, and discursive deconstruction. These variants describe differences in the focus, purpose, and process of engaging in reflexivity, and while Finlay (2002a) proposes these varying conceptualisations of reflexivity as "different routes through the swamp" (p. 212) of research practice, arguably each have application in the context of Cultural Safety.

*Introspective* reflexivity is concerned with the self as contextually situated, where individual subjectivity and positionality are the product of broader historical, cultural, social, and political factors (Finlay, 2002a; Pillow, 2003a; Wilkinson, 1988). This has direct implications for Cultural Safety, where there are similar expectations for healthcare professionals to critically

reflect on and identify their own positionality, how this is the product of sociopolitical contexts, and how this influences and shapes their provision of care (Ramsden, 2002; Rix et al., 2014; Williams et al., 2021; Wilson, 2014). Specifically, there is a need to critically consider how positionality is a product of and shaped by colonialism, and how the healthcare professional and broader healthcare system contribute to the maintenance of colonial systems and racialised healthcare practices.

The *intersubjective* and *mutual collaboration* variants of reflexivity are primarily concerned with the relationship between researcher and participant, with the former involving a reflective consideration of how the researcher's own "inner world" shapes the researcher-participant relationship, and the latter recognising that knowledge and experience are co-created by both researcher and participant in each interaction (Finlay, 2002a; Kohl & McCutcheon, 2015; McCutcheon & Kohl, 2019). In the context of Cultural Safety, relationality plays a key role in developing culturally safe healthcare relationships, including an awareness of how the healthcare professional's own inner world shapes how they interpret and behave towards those seeking care. This includes the healthcare professional's own culturally informed understanding of health, as well as the racialised biases and assumptions that influence how they interpret the healthcare needs and concerns of people from differing cultures (Ramsden, 2002; Rix et al., 2014; Wilson, 2014).

Reflexivity as *social critique* is centrally concerned with identifying and critically examining the impact of power dynamics within and on the research process. This approach draws on earlier feminist work (for example Wilkinson, 1988), which recognised that within the research relationship, researchers inhabit a position of power and influence, which can impact both how they engage with participants as well as how knowledge is created and distributed. Likewise, a similar power dynamic can be seen in healthcare relationships (McDermott, 2020; Williams

et al., 2021), and as such, a reflexive approach which identifies, examines, and challenges these power dynamics is required.

Finally, *reflexive deconstruction* is primarily concerned with reflecting on the multiple meanings embedded in language and the way that both researcher and participant present themselves (Finlay, 2002a). In the research context, this provides an avenue for reflection on the multiple layers of meaning embedded in everyday discourse; in Cultural Safety, this provides an avenue for unpacking racialised discourses as well as reflecting on how healthcare professionals and those seeking care construct meaning in relation to concepts of health and wellbeing (Sjoberg & McDermott, 2016). While Finlay (2002a) offers each variant of reflexivity as a different approach to reflexive research, arguably the complexity of culturally safe practice requires elements of all five, to more comprehensively identify and critically examine the personal and professional self; the knowledge and social systems that influence and shape practice; and the way that these collectively shape engagement with the "racialised other" (Curtis et al., 2019; Ramsden, 2002; Williams et al., 2021).

### 2.3.1 Critiques of reflexive practice

While reflexivity is increasingly being recognised as an important aspect of research, curricula design, and healthcare delivery, there are three common critiques worth noting. The first relates to the concept of reflexivity itself, and the somewhat confusing array of definitions, conceptualisations, and terminology used (Finlay, 2002a; Lynch, 2000). As noted previously, definitions and conceptualisations tend to reflect the ontologies and epistemologies of the disciplines in which they are utilised, and how and to what purpose reflexivity is utilised will differ accordingly. Even within disciplines, there is often variation in how, when, and why reflexivity is utilised. This lack of conceptual clarity presents a substantial challenge for those attempting to become reflexive and engage in reflexive practice. Walsh (2003) and others (Gough, 2003; Lumsden et al., 2019) recommend using the term 'reflexivities' to reflect the

multiple and varying typologies, and that conceptualising the various typologies as "methodological responses to different questions" may help to determine the appropriate reflexive approach in any given context (Walsh, 2003, p. 52). Yet in itself, this requires a broad understanding of the reflexive theory and practice literature to determine which is the appropriate methodological response.

Further, some have questioned whether reflexivity is realistically achievable (Applebaum, 2010). There is an expectation that researchers, educators, or health professionals will be able to identify their "blind spots". By their very definition they are unseen, so how do we become aware of them? A body of literature highlights the role of reflexive catalysts, where an experience of difference can work to make visible the norms or blind spots that would otherwise remain invisible (see for example: Bolton & Andrews, 2018; Delbridge et al., 2021; Fleming et al., 2017; Gray et al., 2020; Kickett et al., 2014; Mills et al., 2022). Notably, reflexivity is not something done once, but is a skill developed and practiced over a lifetime; singular experiences, therefore, are unlikely to make visible all blind spots. However, by engaging in this process consistently, layers of biases, assumptions, and worldviews can be gradually unpacked and deconstructed (Denniston, 2023).

Another common critique of reflexivity relates to how people engage in reflexivity. Ideally, reflexivity should be action-oriented and seek to critically examine the interaction between self, context, and practice. However, many have noted a tendency toward a descriptive listing of positionality within reflexive accounts (Folkes, 2023). This is particularly evident in positionality statements, where researchers demonstrate what Pillow (2003a) describes as a type of "self-indulgent, narcissistic" (p. 176) navel gazing. In these types of accounts, reflexivity stops short of critically examining the self as socially located, or the impact of social position, instead focusing on laying bare the layers of privilege experienced. The risk here is that practitioners engaging in this type of reflexivity will assume they have "done the work" of

critically examining their own positionality without having actually done it. Moreover, Gani and Khan (2024) argue that for many authors, reflexive statements work to reify their privileged positions and the socially constructed hierarchies and power imbalances they seek to critique. What reflexive scholars have argued for is to shift focus from identifying privilege to understanding complicity in racialised systems (Applebaum, 2010), and to understand that reflexive accounts will not be neat, straightforward accounts of positionality, but messy, uncertain accounts that are contextually situated and variable (Gani & Khan, 2024; McDowall, 2021; Pillow, 2003a; Wilson, 2014).

## 2.4 The Reflexive Black Hole of Cultural Safety

Despite the centrality of reflexivity to culturally safe practice, there is a surprising dearth of literature on how to define, conceptualise, or operationalise reflexivity within the context of Cultural Safey and culturally safe praxis. To date, most of the research on reflexivity is concerned with its theorisation and application within research methodology, particularly within the social science fields (Finlay, 2002b; Finlay & Gough, 2003; Lumsden et al., 2019; Pillow, 2003a). There is also a growing body of research exploring the use of reflexivity in curricula development, particularly where curricula include a focus on disadvantaged or minority groups and those involved in its development and delivery identify with the dominant sociocultural majority (see for example: Cash et al., 2013; McGloin, 2009). The following sections will provide an overview of what is currently known about reflexivity in the context of Cultural Safety, followed by a consideration of key gaps in the literature.

### 2.4.1 What we do know about reflexivity in relation to Cultural Safety

Reflexivity is perhaps most often articulated in descriptions of Cultural Safety curricula as a part of the learning process (see for example: Chiodo et al., 2014; Fleming et al., 2017; Hall et

al., 2023). In most cases, reflexivity is articulated as a way to engage with new learning, although how reflexivity is utilised as a learning approach varies. For example, Mills et al. (2021) note the role of reflexivity in identifying and working through the often-challenging emotions associated with learning about colonialism, racism, and the need for culturally safe care, and this perspective is reflected throughout the Cultural Safety education literature (see for example: McDermott, 2020; McDermott & Sjoberg, 2012; McDowall, 2021; Mills & Creedy, 2019; Thackrah & Thompson, 2013). Reflexivity is also articulated as a way of identifying and critically engaging with racialised knowledges, biases, and the way that these shape attitudes and behaviours (see for example: Castell et al., 2018; McDowall, 2021; Power et al., 2021; Rix et al., 2014).

While there are references to reflexivity in the Cultural Safety education literature, in most cases there is little critical consideration of what reflexivity is, or consideration of whether students are knowledgeable about or able to engage in reflexivity. One exception is the theoretical paper by Hall et al. (2023), who provide a critical examination of what they term *critical consciousness*, which requires that "participants critically reflect on not only the individual but the social, political and environmental factors, which impact upon Cultural Safety" (p. 5). The concept of critical consciousness as articulated by Hall et al. (2023) shares substantial similarity with conceptualisations of reflexivity, and as such, plays a similar role in developing culturally safe practices. Hall et al. (2023) also note that additional research is required to identify appropriate pedagogies to support the development of critical consciousness, an area which is similarly lacking in the reflexive Cultural Safety space.

Beyond the education literature, there are very few studies which have explicitly considered reflexivity as an aspect of culturally safe practice. Wilson (2014) describes the reflexive process she utilised as part of her research with Aboriginal and Torres Strait Islander communities, in an attempt to engage in culturally safe research practices. Similarly, Cash et al. (2013) used

reflexive writing in an effort to articulate and conceptualise what it means to create culturally safe learning environments. Of the two, only Wilson (2014) provides a clear articulation of reflexivity and its relevance to Cultural Safety. However, she also notes that despite the calls from Aboriginal and Torres Strait Islander scholars for non-Indigenous people to more critically examine their own positionality, there is a lack of literature on what this might look like in the Australian colonial context. In the intervening decade, little has been done to address this gap.

#### *2.4.1.1 Reflexivity as a starting point for addressing racism*

While there is limited literature exploring reflexivity in relation to Cultural Safety, there is a body of work which has examined the potential of reflexivity in identifying, critiquing, and reducing racism. For example, in their critique of standard approaches to diversity and inclusion training, Kowal et al. (2013) propose a *reflexive antiracism* approach. This approach acknowledges that learning about diversity is not adequate in addressing racism and runs the risk of reinforcing stereotypes and essentialising cultural practices. Instead, what is required is a deeper exploration of power, whiteness, privilege, and the racialised foundations of society, and how collectively these produce and maintain racialised inequities. Similar to Ramsden (2002), Kowal et al. (2013) note the importance of moving beyond simple binaries of "privileged" and "disadvantaged", instead seeing individuals as complex, multifaceted, and agentic, and as occupying multiple, often contradictory positions. The theoretical foundations of reflexive antiracism are similar to those of reflexive Cultural Safety and holds potential as an approach that could be utilised within Cultural Safety education to more effectively foster reflexive capacity.

Similarly, several self-identified white scholars have provided accounts of engaging in reflexivity, where the primary motivation is to improve their teaching and research practice (Cash et al., 2013; McGloin, 2009; Rix et al., 2014; Simon, 2023; Wilson, 2014). Several

educators have utilised reflexivity in their attempts to improve their curricula, where reflexivity is seen as an effective way to identify, critique, and challenge the influence of their own white privilege, power, and racialised knowledges on the development and delivery of curriculum (for example: Cash et al., 2013; McGloin, 2009). Others have taken a similar approach to their research practices, using reflexivity to understand how their white privilege, power, and knowledge practices have shaped research processes, practices, and outcomes (for example: Rix et al., 2014; Wilson, 2014).

In the healthcare context, Simon (2023) provides a critical consideration of the role of reflexivity within systems therapy, noting that current therapy practices are dominated by white Eurocentric norms and that therapists must reflexively engage not only with their own positionality, but their location within and contribution to colonial systems of power and oppression. Similarly, Rix et al. (2014) details the reflexive process utilised in a study to improve the provision of haemodialysis for Aboriginal people in rural Australia, a space they note is rife with racism and assumptions of "non-compliance". While this article is primarily about how reflexivity was used as part of the research process, the lead researcher also positions themselves as a white nurse practitioner, and the analysis highlights the role of reflexivity in healthcare delivery (Rix et al., 2014).

The above research highlights the potential utility of reflexivity in reducing racism across research, education, and healthcare. However, given the concerns raised by Gani and Khan (2024), Emirbayer and Desmond (2012), and Pillow (2003a), regarding the potential for reflexivity to become a process of confession which reinforces rather than challenges privileges and racialised power imbalances, arguably there is a need to further develop our understanding of reflexivity in relation to racism.

### 2.4.2 Reflexivity in relation to Cultural Safety: current gaps in the literature

While reflexivity is considered a core aspect of culturally safe practice, very little attention has been given to its theorisation within this context. As such, there are gaps in our current understanding of how reflexivity relates to and contributes to culturally safe practice, some of which have been outlined above. The following sections will outline three key gaps in the literature relevant to this thesis.

#### *2.4.2.1 Defining and conceptualising reflexive practice in relation to Cultural Safety*

Ramsden's (2002) original call for healthcare professionals to examine their prejudices and biases "and tracing them to their origins" (p. 121) requires a deep, critical examination and deconstruction of the racialised knowledges that inform a healthcare professional's personal and disciplinary knowledges and practices. Yet what is described in the Cultural Safety theory and education literature often varies considerably. A variety of terminology is used to describe the process of reflexivity, such as self-awareness (for example: Bernhardt et al., 2011; Lucas et al., 2021), self- or critical reflection (for example: Hardcastle & Bradford, 2006; McCartan et al., 2021), reflexivity (for example: Bolton & Andrews, 2018; Mills et al., 2022), and critical consciousness (Hall et al., 2023). Likewise, there are a multitude of definitions, resulting in substantial conceptual slippage and a lack of clarity. In part, this likely stems from similar theoretical issues within the reflexive theory literature and the variable way in which reflexivity is conceptualised (Finlay, 2002a; Landy et al., 2016; May & Perry, 2017).

However, it also likely reflects differing understandings and conceptualisations of Cultural Safety, and what is required to practice in a culturally safe manner. In the last three decades, there has been substantial uptake, engagement with, and theoretical development of Cultural Safety across a range of disciplines and within a variety of sociopolitical contexts. Like many theoretical frameworks, there is the potential for elements to be "lost in translation" between contexts and over time. Additionally, given that many academics who have undertaken this

work are non-Indigenous, it must be acknowledged that much of the Cultural Safety literature has been filtered through the various lenses of Eurocentric, western thinking. As Drummond (2020) notes, the work and thinking of Aboriginal and Torres Strait Islander scholars is often softened, filtered, and watered down by non-Indigenous scholars and institutions to make them more "palatable", and Cultural Safety is not immune to this process.

The variability in how reflexivity is defined and conceptualised means that there is little consistent guidance regarding how healthcare professionals should engage in reflexivity or what the outcome of this process would look like in the context of Cultural Safety. For example, Bernhardt et al. (2011) refer to a process of self-reflection in which health professionals reflect on their own cultural identity and how this influences their ability to provide care. In contrast, Fleming et al. (2017) conceptualise the process as a more critical examination of personal privilege, biases, and power, and the potential impact of these on patient engagement and outcomes. This presents potential difficulties for healthcare professionals attempting to develop or enhance their reflexive capabilities, and for health professions educators attempting to develop curricula or pedagogy to support students. If Cultural Safety is to be included as an accreditation requirement, then there is a need to develop a more consistent definition and conceptualisation of reflexivity in this context, to provide a basis for teaching and assessment of reflexive capacity.

#### *2.4.2.2 Teaching and assessing reflexive practice as a core Cultural Safety capability*

Likewise, there is also a need to develop best practice education approaches to building reflexive capabilities. There is currently a body of literature discussing and evaluating best practice approaches to Cultural Safety education more broadly, including empirical studies (for example: Brumpton et al., 2023; Smylie et al., 2024) and evidence-based frameworks (for example the Aboriginal and Torres Strait Islander Health Curriculum Framework: Department

of Health, 2014). However, there is no equivalent body of research exploring how to effectively teach and assess the development of reflexivity as a core Cultural Safety capability.

There is a small body of literature on teaching reflexive capabilities in other contexts. Most of this literature is related to teaching reflexivity as part of research methodology and practice (Gerstl-Pepin & Patrizio, 2009; Hsiung, 2008; Orange, 2016; Pope & Shelton, 2023), with a few examples from other fields, such as teacher education (Matthews & Jessel, 1998), and health professions education (Denniston, 2023; Landy et al., 2016). Among the latter is a scoping review by Landy et al. (2016), which summarised the available literature on educational strategies used to develop reflexive capacities in student and practicing health professionals. While Landy et al. (2016) identified a moderately sized body of research in this space, notably, there was a wide variation in how reflexivity was conceptualised and taught.

Of the 68 studies in the scoping review (Landy et al., 2016), five specifically discussed reflexivity in relation to Cultural Safety education, although an additional 14 studies specifically discussed reflexivity as part of broader cross-cultural education approaches. Of those five studies, one was abstract only (Ash et al., 2010), one utilised reflexive journalling as a research methodology to explore Cultural Safety educator's experiences (Wepa, 2003), one was a plenary speech with little detail regarding approaches to teaching reflexivity (Greenwood et al., 2006), one makes the case for greater focus on Cultural Safety without any specific consideration of reflexivity (Williams, 1999), and the fifth study provides a critical consideration of the complexities of translating culturally safe healthcare from theory to practice (Browne et al., 2009). While none provide specific consideration of pedagogical approaches to developing reflexive capabilities, Browne et al. (2009) note that "we have come to realize that using Cultural Safety to translate critically oriented knowledge in practice settings requires different considerations than when using Cultural Safety in the contexts of research and teaching" (p. 171). Arguably, this applies equally to the translation of reflexivity

from research and teaching contexts to learning and healthcare practice, and as such, there is a need for more critical consideration of what reflexivity looks like in these contexts.

Notably, within the available literature on educational strategies to develop reflexive capabilities, there is a focus on pedagogical approaches and teaching practices, but very little literature which explores the assessment of learning outcomes. Within the Cultural Safety literature, there are several studies that utilise student reflective assessments as data, but these are predominantly concerned with overall efficacy of the curricula in changing student knowledge, understanding, and attitudes towards Indigenous peoples (Fleming et al., 2017; Min et al., 2021; Power et al., 2020). There is almost no literature which seeks to theorise, develop, or evaluate best practice approaches to assessment of reflexive capacity development; rather, much of the Cultural Safety literature borrows from the work of transformative learning theory (Mezirow, 1997), and reflective models such as Gibbs (1988) and Kolb (2015). While these are robust theoretical models for reflective practice, arguably they do not capture the unique aspects of reflexive practice.

A possible explanation for this lack of literature on teaching and assessing reflexive practice can be found within the reflexive theory literature. Lumsden et al. (2019) argue that attempting to use standardised approaches to teaching or assessing reflexivity risks turning it into a check box approach. Likewise, Glass (2015) notes the potential risk that students – particularly those just beginning their reflexive learning journey – will be limited in their understanding and therefore practice of reflexivity. Indeed, it has been argued that attempts to teach or assess reflexivity in any kind of standardised manner have the potential to render the process meaningless (Glass, 2015; Lumsden et al., 2019). However, this thesis argues that, as a core Cultural Safety capability, there is a need to develop approaches to teaching and assessing student learning and skill development, just as it is a requirement to teach and assess a range of other health-related knowledges, skills, and competencies. Therefore, it is important to

develop a range of evidence-based educational strategies to both facilitate reflexive capacity development, and appropriate methods for assessing growth in learning.

#### *2.4.2.3 Extending reflexive practice beyond the self: possibilities for systemic and institutional reflexivity*

Finally, there seems to be a disjuncture between the centrality of reflexive practice within culturally safe practice, and the calls – particularly in the Australian context – to see Cultural Safety as an institutional as well as an individual process. Phillips (2014) argues that Cultural Safety must go beyond individual practice to shift institutional norms and processes, to ensure that the healthcare system as a whole is culturally safe (Williams et al., 2021). However, if we consider reflexive practice to be a core Cultural Safety capability, how then can we apply this capacity at the system level? Some attempts have been made to apply the principles of Cultural Safety to the policy making level (Mackean et al., 2020). Similar efforts have been made to apply and evaluate Cultural Safety within institutions, such as hospitals (Bourke et al., 2019; Marrie & Bourke, 2020). However, this limited literature does not specifically consider the role of reflexivity.

Given that reflexivity by its very definition requires a level of consciousness and ability to "turn the gaze back", and that systems and institutions are not conscious subjects, there is a question as to whether and how this process is possible in this context. Gopal (2022) argues for *structural reflexivity*, which they describe as "an institutional commitment to race-conscious medicine, such as … questioning the evidence behind race-based clinical guidelines" (p. 1582). Similarly, Denniston (2023) argued the need for institutional reflexivity, and suggested "building in an expectation for reflexivity (and structures to support it) within teams, departments and institutions, where deep questioning and self-conscious critique are part of collegial exchanges, might be a start" (p. 93).

The examples provided here align with what Finlay (2002a) terms reflexivity as *discursive deconstruction* (p. 222). While Finlay discusses this in the context of research, this conceptualisation can be extended more broadly to consider the socially constructed meanings which inform our knowledge and understanding of health and wellbeing. Similarly, Wilkinson (1988) talks about *disciplinary reflexivity*, which is "the requirement for a discipline or sub-discipline to explain its own form and influence, utilising a developed form of the sociology of science" (p. 495). While both Finlay and Wilkinson provide a useful theoretical starting point, to date there has been little consideration of how to put this into practice. Notably, the versions of reflexivity outlined above are still reliant on individuals engaging in this process. This raises several questions: Can we develop processes within systems and institutions to facilitate a process of reflexive engagement? What are the limitations of this? For example, in colonial systems of oppression, how effective will within-system processes be, or will they be yet another attempt to appear to be "doing the work" without having to make any substantial change?

### 2.4.3 Discourse as central to reflexivity

Reflexivity is at its core a deconstruction and critical examination of discourse. Arguably, our own sense of identity – our cultural practices, social norms, knowledges, racism, stereotypes, history – everything is expressed through discursive practices (Hook, 2001; van Dijk, 1992, 2006). If we approach reflexivity from this stance, we are in effect identifying, deconstructing, and critiquing the discourses that shape our lives, both at the individual and societal level.

## 2.5 Thesis aims and research questions

Given the gaps in the literature identified in the previous sections, the current thesis seeks to address three broad research aims. These are outlined below, along with the approach and research questions of each associated study.

**Aim 1:** To examine how reflexive practice is defined, conceptualised, taught, and assessed within the Cultural Safety education literature.

Given the current paucity of literature, this study will provide an important foundation for developing a baseline understanding of how reflexivity is understood in relation to Cultural Safety, and whether current conceptualisations and approaches are adequate to the task of identifying, critiquing, and challenging racism.

To address this aim, a systematic review and critical synthesis of the Cultural Safety literature was conducted, addressing the following research questions:

1. How is reflexivity conceptualised within Cultural Safety educational interventions?
2. Where and how is reflexivity included as part of learning outcomes in educational interventions?
3. What types of pedagogical approaches are used in Cultural Safety educational interventions to help students develop reflexive skills?
4. How is the development of reflexivity as a skill assessed?

**Aim 2:** To critically examine how students engage in and express reflexivity within an Australian undergraduate health sciences curricula with a focus on Aboriginal and Torres Strait Islander health and Cultural Safety and identify opportunities to improve curricula and assessment approaches.

Building on the findings of the systematic review, this study will seek to explore the potential of reflexivity as a mechanism for identifying and challenging internalised, interpersonal, institutional, and structural racism.

To address this aim, an analysis of student reflexive video assessments was conducted, utilising critical discourse analysis and an analytic framework informed by the Cultural Safety, reflexivity, and Australian race scholarship. Three specific research questions were addressed:

1. To what extent to students demonstrate reflexivity within their accounts of learning, and how does this align with the grade received?
2. How do students discursively construct their reflexive accounts of learning?
3. How do students discursively express, manage, and challenge racism within their reflexive accounts of learning?

**Aim 3:** To explore the use of a critical analytic framework to examine national Australian policy, as an exemplar of how reflexivity could be engaged in at the systematic level.

While reflexivity is almost exclusively conceptualised as an individual practice, Cultural Safety requires transformative change at the institutional and structural level as well. This study represents an attempt to identify and utilise an established analytic framework as mode of structural reflexivity.

To address this aim, the national *Closing the Gap* policy was analysed using Carol Bacchi's *What's the Problem Represented to Be?* framework, and addressed the following questions:

1. How is the 'problem' of 'Indigenous disadvantage' produced within national policy?
2. What are the potential lived effects of these types of problematisations?

# Chapter 3: Reflexive practice as an approach to improve healthcare delivery for Indigenous peoples: A systematic critical synthesis and exploration of the Cultural Safety education literature

# Statement of Authorship

| | |
|---|---|
| Title of Paper | Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature |
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**Principal Author**

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| Name of Principal Author (Candidate) | Jessica Dawson |
| Contribution to the Paper | Conceptualisation; data collection, review, and analysis; draft of manuscript for publication. |
| Overall percentage (%) | 70% |

| | | | |
|---|---|---|---|
| Certification: | This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper. | | |
| Signature | | Date | 13/12/2023 |

## Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

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| Name of Co-Author | Keera Laccos-Barrett | | |
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| Signature | | Date | 12/12/2023 |

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## Abstract

Cultural Safety is increasingly being taught in tertiary programmes of study for health professionals. Reflexivity is a key skill required to engage in culturally safe practice, however, there is currently limited literature examining how reflexivity is taught or assessed within Cultural Safety curricula. A systematic review of the literature up until November 2021 was conducted, examining educational interventions which aimed to produce culturally safe learners. Studies were limited to those with a focus on Indigenous health and delivered in Australia, Aotearoa New Zealand, Canada, and the United States. A total of 46 documents describing 43 different educational interventions were identified. We found that definitions and conceptualisations of reflexivity varied considerably, resulting in a lack of conceptual clarity. Reflexive catalysts were the primary pedagogical approaches used, where objects, people, or Indigenous pedagogies provided a counterpoint to learners' knowledges and experiences. Information regarding assessment methods was limited but indicates that the focus of existing programmes has been on changes in learner knowledge and attitudes rather than the ability to engage in reflexivity. The results demonstrate a need for greater conceptual clarity regarding reflexivity as it relates to Cultural Safety, and to develop methods of assessment that focus on process rather than outcomes.

## 3.1 Introduction

The beliefs, attitudes, and biases that healthcare professionals hold can substantially influence the way they interact with and provide care to people. This is particularly relevant to the health and well-being of Aboriginal and Torres Strait Islander Australians, where healthcare professional attitudes are seen as a major factor in whether care is considered safe, adequate, and acceptable (Awofeso, 2011; Jennings et al., 2018; Power et al., 2021). Dismissive, rude,

and outright racist behaviours have been reported by Aboriginal and Torres Strait Islander people in their encounters with non-Indigenous healthcare professionals. These experiences can result in inadequate or negligent care provision and deter recipients of care from further engaging with a healthcare system that is perceived as culturally unsafe (Kairuz et al., 2021; Temple et al., 2019; Ziersch et al., 2011). In turn, this can have significant flow-on effects for healthcare access and outcomes and contributes to the health inequities experienced by Aboriginal and Torres Strait Islander people. Parallels can be seen in Aotearoa New Zealand, Canada, and the United States, where racial discrimination and culturally unsafe care contribute to inequities in healthcare access and outcomes for Indigenous peoples (Findling et al., 2019; Phillips-Beck et al., 2020; Reid et al., 2019).

Cultural Safety is recognised as an approach to healthcare with the potential to improve the experience of care for Indigenous peoples in Australia, Aotearoa New Zealand, Canada, and the United States. The concept of Cultural Safety was originally developed in Aotearoa New Zealand by Māori nurses and midwives, to address the racism experienced by Māori patients being cared for by a largely non-Indigenous health workforce (Papps & Ramsden, 1996; Ramsden, 1990). Cultural Safety in healthcare delivery recognises the centrality of culture to health and well-being and seeks to ensure that healthcare is respectful and non-discriminatory. To provide culturally safe care, healthcare professionals need to engage in critical reflexivity, whereby they examine their own cultural identity, positioning and power, the values, attitudes, and biases they carry, and the potential consequences of these for the people they provide care to (Ahpra & National Boards, 2020; Curtis et al., 2019; Laverty et al., 2017; Withall et al., 2021).

The importance of Cultural Safety as an approach to healthcare provision is now well established, with a substantial body of literature exploring the application of Cultural Safety across a range of health professions, including nursing and midwifery (Arnold et al., 2008;

Fleming et al., 2017; Hart et al., 2015; Hulko et al., 2021; Kelly et al., 2016; Mahara et al., 2011; Power et al., 2020; Thackrah & Thompson, 2013), medicine (Carriage et al., 2017; Crampton et al., 2003; Hudson & Maar, 2014; Paul et al., 2019; Ryder et al., 2013), psychology (Chiodo et al., 2014), physiotherapy (Bolton & Andrews, 2018), occupational therapy (Demers et al., 2021; Jamieson et al., 2017), and nutrition (McCartan et al., 2021). As such it is increasingly being included in health sciences curricula at the tertiary level in Australia, Aotearoa New Zealand, Canada, and the United States (Kurtz et al., 2018) and developed as short continuing professional education courses (for example: Australian Indigenous Doctors' Association, 2022; Royal Australian College of General Practitioners, 2011; San'yas, n.d.). While there is a growing body of literature exploring best practice approaches to the development and delivery of Cultural Safety education, this predominantly focuses on overall curriculum structure and content (for example: Delbridge et al., 2021; Demers et al., 2021; Kelly et al., 2016). Currently, however, there is little guidance on the most appropriate pedagogical approaches to teach students how to be reflexive, or on how educators should assess student learning outcomes concerning reflexivity. Given the centrality of reflexivity to culturally safe practice, we argue that there is a need to develop best practice approaches to the teaching and assessment of reflexivity within Cultural Safety education.

### 3.1.1 Reflexivity and Cultural Safety

The way reflexivity is defined, conceptualised, and operationalised varies both across and within fields and disciplines, depending on the purpose to which it is being put (Lumsden et al., 2019; Pillow, 2003a). At its core, reflexivity involves an awareness and examination of the ontological and epistemological foundations that inform our existence and shape our thoughts and behaviours (Lumsden et al., 2019; May & Perry, 2017). Notably, reflexivity is concerned with the self in relation to others; that is, how our ways of knowing, being, and doing shape our interpretation of and behaviour towards people (Pillow, 2003a; Wilson, 2014). Despite its

centrality to culturally safe practice, reflexivity has not been specifically defined or conceptualised in this context. In her account of reflexive, culturally safe research, Wilson (2014) draws on the broader research literature to define reflexivity as a tool "to gain greater understanding of the self/other positionalities and the experience of research" (p. 219). How this might be adapted into healthcare contexts and included in Cultural Safety education is yet to be determined.

In the context of Cultural Safety, reflexivity serves several purposes, and each presents challenges for educators and students alike. Perhaps the most cited purpose of reflexivity is the examination of own cultural worldviews and values and how these might influence delivery of care to people from different cultural backgrounds (McGough et al., 2022; Ramsden, 2002). Notably, there is an acknowledgement that "culture" is a complex intersection of factors such as race, ethnicity, gender, age, socioeconomic status, disability status, geographical location, and sexual orientation, among others (Kurtz et al., 2018; Ramsden, 2002; Taylor & Guerin, 2019). Arguably, this complexity presents students with a significant challenge of understanding their own intersectional nature. Given the tendency of Cultural Safety education to focus on Indigenous health, there is a risk that this type of curricula reinforces a false dichotomy of Indigenous and non-Indigenous identity, resulting in a curriculum more akin to cultural competency training (Beagan, 2015; Curtis et al., 2019). It also risks diminishing the complexity of Indigenous identity, which encompasses more than ethnicity on its own (Cromb, 2021; Heckenberg, 2020). Further, as Lumsden (2019) notes, there is an inherent risk that reflexivity can easily become entangled in notions of individual identity, "while failing to recognize the wider disciplinary, institutional, and political context(s) in which reflexivity…takes place, and in which knowledge is constructed, situated, and (re)negotiated" (p. 3). In Cultural Safety education, and specifically in the context of Indigenous health,

considerations of these broader contexts and the sites and methods of knowledge (re)production are essential.

The development of reflexive skills and the exploration of own cultural identity most often occurs in conjunction with learning about the social determinants of Indigenous health. In colonised countries like Australia, Aotearoa New Zealand, Canada, and the United States, this includes developing an understanding of historical and ongoing processes of colonisation, and the resulting interpersonal and institutional racism, whiteness, and power differentials. Students also need to develop an understanding of how these factors intersect with other social determinants such as education, employment, housing, and food security to produce the health inequities that Indigenous people experience (Curtis et al., 2019; Lock, 2019; Ramsden, 2002). In part, this learning is intended to help students understand that health is the product of social, economic, political, and historical forces (Ramsden, 2002). It is also an opportunity for students to become aware of and challenge their own internalised stereotypes, assumptions, and biases through exposure to new learning. Yet this can be a challenging process for students, one which has been consistently shown to produce feelings of discomfort for students (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Mills et al., 2018). These feelings of discomfort can range from disengagement in class to outright hostility towards content, learning, and educators. This discomfort, if carefully managed, can produce transformative learning experiences for students. Conversely, poorly managed discomfort may serve to reinforce negative attitudes towards learning, content, and Indigenous people themselves (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Mills et al., 2018).

Additionally, students are expected to engage in this complex, deeply personal, and potentially uncomfortable learning process in the context of a tertiary educational institution. While educators might strive to provide genuinely transformative learning experiences, the reality for students is that they need to pass their studies. Faced with the task of engaging reflexively,

there is a risk that students will simply provide the responses they think educators want. This has been acknowledged as a potential issue in the literature (Castell et al., 2018; Drummond, 2020; Faulkner & Crowhurst, 2014; Lumsden et al., 2019; Mills & Creedy, 2019) but has not been explored in-depth regarding whether and to what extent this occurs within Cultural Safety education.

While there is a growing body of literature on Cultural Safety education, at present, there is little guidance on the best approach to teach or assess reflexivity in the context of Cultural Safety. Currently, most Cultural Safety education literature falls into three broad categories: qualitative explorations of student learning experiences (Bolton & Andrews, 2018; Duthie et al., 2013; Hart et al., 2015; Jackson et al., 2013; Kickett et al., 2014; Lucas et al., 2021; Oosman et al., 2019; Power et al., 2020), evaluations of student learning outcomes (Bernhardt et al., 2011; Chiodo et al., 2014; Dowell et al., 2001; Fleming et al., 2017, 2020; Gray et al., 2020; Hudson & Maar, 2014; Hulko et al., 2021; Jamieson et al., 2017; McCartan et al., 2021; Mills et al., 2018; Min et al., 2020; Nash et al., 2006; Thackrah & Thompson, 2013, 2018; Thorpe & Burgess, 2012), and descriptions of curricula development and delivery (Arnold et al., 2008; Crampton et al., 2003; Delbridge et al., 2021; Demers et al., 2021; Hardcastle & Bradford, 2006; Herzog et al., 2021; Joyce, 1996; Kelly et al., 2016; Mahara et al., 2011; Ramsden, 1992; Richardson et al., 2017; Richardson & Carryer, 2005; Ryder et al., 2013; Sjoberg & McDermott, 2016). In evaluations of curricula and learning outcomes, student reflective journals are a common source of data. However, these articles tend to focus on whether and how the curricula have produced transformative learning, with little information provided on the specific pedagogical approaches used to teach students reflexivity, nor how assessments are structured to capture the reflexive process.

The dearth of literature on teaching and assessment of reflexivity may be reflective of the diversity of definitions, conceptualisations, and ways of operationalising it as a concept.

Lumsden (2019) warns against using standardised instructions for learning how to engage in reflexivity, as this implies a "correct" and "incorrect" way of going about the process, and risks reducing it to a checklist approach. In the absence of such instruction, how do educators help students develop the skill of reflexivity? Further, in the tertiary education system, where educators are required to assess the learning outcomes of students in a standardised manner, how do they assess whether students have effectively demonstrated these skills? The current research aims to address these questions through a systematic synthesis and exploration of the Indigenous Cultural Safety literature, with a specific focus on reflexivity, and aims to address the following questions:

1. How is reflexivity conceptualised within Cultural Safety educational interventions?
2. Where and how is reflexivity included as part of learning outcomes in educational interventions?
3. What types of pedagogical approaches are used in Cultural Safety educational interventions to help students develop reflexive skills?
4. How is the development of reflexivity as a skill assessed?

## 3.2 Materials and methods

### 3.2.1 Data Sources and Search Strategies

An initial systematic search of the following databases was conducted: CINAHL, PubMed, Scopus, Informit, PsycINFO, and Embase. Consultation with a research librarian determined that, due to the specificity of the search parameters and the limitations this placed on using indexing terms, a simplified set of search terms was most appropriate. Therefore, all searches across the databases used the following search terms: "Cultural Safety" and "culturally safe".

Where the databases provided the option, searches were limited geographically to Australia, Aotearoa New Zealand, Canada, and the United States of America, and to articles in English.

Additionally, a targeted internet search was also conducted, specifically to capture data produced by Indigenous and other non-government organisations (NGOs) as well as any available information on CPE. These data sources represent an important but often overlooked source of information not captured in other literature reviews, as they are often direct accounts of the educational process and often centre Indigenous experiences, knowledges, and aspirations.

### 3.2.2 Eligibility Criteria

Data sources were included if they described an educational programme or intervention that fitted the following inclusion criteria: (1) aimed to develop culturally safe learners; (2) was delivered as either part of an undergraduate or postgraduate degree or as continuing professional education (CPE); (3) had a focus on Indigenous health outcomes; and (4) was delivered in Australia, Aotearoa New Zealand, Canada, or the United States of America. The latter criteria were employed as these countries share similar historical and ongoing colonial processes, with resulting similarities in health inequities experienced by Indigenous peoples. The inclusion criteria were designed to allow for the inclusion of all Cultural Safety education literature and the identification of variations in how and where reflexivity was included or excluded.

Data sources were excluded if they were published in a language other than English, described an educational approach other than Cultural Safety, or a full-text article was not available.

### 3.2.3 Article Review

The initial search of the databases returned a total of 2860 results, which were exported into Endnote (The EndNote Team, 2013). Duplicates were removed (n = 1125), leaving 1735

results. Initial screening of titles was carried out by the lead author (JD), and identified a further 852 for removal, due to either irrelevance (for example, most of those excluded discussed a "culture of safety" rather than Cultural Safety), or duplicates missed by the Endnote sorting function.

Titles and abstracts of the remaining articles (n = 883) were reviewed by JD and CH according to the inclusion/exclusion criteria; 738 articles were excluded, leaving 145 articles for full-text review. Full-text review resulted in the identification of another two articles, bringing the total number of articles reviewed to 147. JD conducted all full-text reviews, with a 10% cross-check provided by CH. Where agreement could not be reached on an article, it was discussed with AR until a decision could be made. An additional 29 articles were identified in the grey literature. An updated search conducted in 2021 identified an additional 17 articles for inclusion.

It should be noted that the targeted internet search identified a wide range of Cultural Safety training modules available via organisational websites, such as Australian Indigenous Doctors' Association (Australia) and San'yas (Canada). Most of these organisational websites contained publicly available information about the expected learning outcomes of the training module but were excluded from analysis due to insufficient information on other aspects of learning.

### 3.2.4 Data Extraction

Data in the current research are descriptive and primarily sourced from the introduction and background sections of articles where information about the educational intervention is provided as a preface to evaluation or measurement of student learning and outcomes. Data were analysed using a two-stage thematic analysis process. In the first stage, data were coded under four major themes drawn from the research questions: definition and conceptualisation of reflexivity; where and how reflexivity is included in learning outcomes; pedagogical

approaches used to develop reflexivity; and assessment methods used to measure reflexivity development. The second stage of analysis used inductive thematic analysis, where learning is generated from the data itself rather than guided by existing theoretical frameworks (Braun & Clarke, 2013). Data in each of the major themes were iteratively analysed and coded according to the sub-themes that emerged.

Additionally, discursive analysis (Braun & Clarke, 2013) was used to provide a more nuanced understanding of how language practices shape the definition, conceptualisation, and practice of reflexivity within Cultural Safety education. Analysis of how reflexivity is defined drew on constructivist theory (Potter, 1996) to examine how language shapes our understanding of both the nature and purpose of reflexivity. Analysis of how reflexivity is conceptualised primarily drew on existing Cultural Safety and reflexivity literature (for example: Curtis et al., 2019; Lumsden et al., 2019; Pillow, 2003a; Ramsden, 2002), and analysis of the pedagogical approaches drew on the object-based learning literature (Gaunt, 2016; Salmon & Kevin, 2017). Throughout the analysis, we also drew on the work of Indigenous educators who operate at the Cultural interface (Nakata, 2007) and whose writings and approach to teaching are informed by Indigenous ways of knowing, being, and doing (Bond, 2014; Drummond, 2020; Drummond et al., 2021; Duthie et al., 2013).

Data and analysis were managed using NVivo12 software (QSR International Pty Ltd., 2018).

## 3.3 Results

### 3.3.1 Summary of Educational Interventions

A total of 46 documents were analysed, describing 43 different educational interventions. The majority ($n$ = 35) of documents described university-based educational interventions (Arnold et al., 2008; Bernhardt et al., 2011; Bolton & Andrews, 2018; Carriage et al., 2017; Chiodo et

al., 2014; Crampton et al., 2003; Delbridge et al., 2021; Demers et al., 2021; Dowell et al., 2001; Duthie et al., 2013; Gray et al., 2020; Hart et al., 2015; Herzog, 2017; Herzog et al., 2021; Hudson & Maar, 2014; Jackson et al., 2013; Jamieson et al., 2017; Joyce, 1996; Kickett et al., 2014; Lucas et al., 2021; Maar et al., 2020; Mahara et al., 2011; McCartan et al., 2021; Mills et al., 2022; Min et al., 2020; Nash et al., 2006; Oosman et al., 2019; Paul et al., 2019; Power et al., 2020; Ramsden, 1992; Ryder et al., 2013; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012; West et al., 2021), with one set of documents describing a short vocational training course (NSW Government Family & Community Services, 2007a, 2007b, 2007c), and the remainder ($n$ = 8) describing continuing professional education (CPE) courses for practicing health professionals (Durey, Halkett, et al., 2017; Fleming et al., 2017; Hardcastle & Bradford, 2006; Hulko et al., 2021; Kelly et al., 2016; Richardson et al., 2017; Royal Australian College of General Practitioners, 2011; The Royal New Zealand College of General Practitioners, n.d.).

Just over half of the documents analysed ($n$ = 28) were from Australia (Bolton & Andrews, 2018; Carriage et al., 2017; Chiodo et al., 2014; Delbridge et al., 2021; Durey, Halkett, et al., 2017; Duthie et al., 2013; Fleming et al., 2017; Gray et al., 2020; Hardcastle & Bradford, 2006; Hart et al., 2015; Jackson et al., 2013; Kelly et al., 2016; Kickett et al., 2014; Lucas et al., 2021; McCartan et al., 2021; Mills et al., 2022; Nash et al., 2006; NSW Government Family & Community Services, 2007a, 2007b, 2007c; Paul et al., 2019; Power et al., 2020; Royal Australian College of General Practitioners, 2011; Ryder et al., 2013; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012; West et al., 2021), with the rest from Aotearoa New Zealand ($n$ = 5) (Crampton et al., 2003; Dowell et al., 2001; Joyce, 1996; Ramsden, 1992; The Royal New Zealand College of General Practitioners, n.d.), and Canada ($n$ = 13) (Arnold et al., 2008; Bernhardt et al., 2011; Demers et al., 2021; Herzog, 2017; Herzog et al., 2021; Hudson & Maar, 2014; Hulko et al., 2021; Jamieson et al., 2017; Maar et al., 2020;

Mahara et al., 2011; Min et al., 2020; Oosman et al., 2019; Richardson et al., 2017); there were no documents from the United States. Table 3.1 provides a summary of key characteristics of the documents included for analysis.

***Table 3.1: Summary of key characteristics of the educational interventions included.***

| **Reference**<br>**Country** | **Learner level and field of study** | **Site and type of educational intervention** | **Duration.**<br>**Delivery method** | **Level of Indigenous involvement** |
|---|---|---|---|---|
| Arnold et al (2008)<br>Canada | Undergraduate nursing students | University.<br>Reciprocal partnership, including community placements. | Not specified.<br>Face-to-face. | Initiated, co-designed, and co-delivered. |
| Bernhardt et al (2011)<br>Canada | Undergraduate speech-language pathology and audiology students | University.<br>Unit of study, including community placement. | 8-month teaching period.<br>26 hours in-class teaching time.<br>26 hours out of class time.<br>Face-to-face with some online components. | Advisory Group established.<br>Co-designed and co-delivered. |
| Bolton & Andrews (2018)<br>Australia | Doctor of Physiotherapy students | University.<br>Field trip within a unit of study. | Not specified.<br>Face-to-face | Co-designed and co-delivered. |
| Carriage et al (2017)<br>Australia | Fifth year medical students | University.<br>Rural and remote placements. | Half-day lecture followed by 5-week placement.<br>Face-to-face. | Aboriginal Medical Service host organisations, including cultural mentoring. |
| Chiodo et al (2014)<br>Australia | Undergraduate psychology students | University.<br>Unit of study. | 6-week teaching period.<br>2-hour weekly lectures.<br>1-hour weekly tutorials.<br>Face-to-face. | Includes a 'diverse teaching group' and involvement of 'Indigenous guest speakers.' |

*Table 3.1 continued*

| Reference<br>Country | Learner level and field of study | Site and type of educational intervention | Duration.<br>Delivery method | Level of Indigenous involvement |
|---|---|---|---|---|
| Crampton et al (2003)<br>Aotearoa New Zealand | Third-year medical students | University.<br>Cultural immersion placement. | 1 week<br>Face-to-face. | Consultation and collaboration with local community. |
| Delbridge et al (2021)<br>Australia | Undergraduate and postgraduate health professions students | University.<br>2 x discipline specific PBL modules.<br>1 x inter-professional simulation session. | PBL modules:<br>Pre-workshop online learning, 1-hour seminar, and 3-hour workshop.<br>Simulation:<br>Pre-session online learning, length of session not specified.<br>Face-to-face with some online components | Co-designed involving expert knowledge holders |
| Demers et al (2021)<br>Canada | Undergraduate occupational therapy students | University.<br>Fieldwork placement. | Pre-placement self-paced learning.<br>8-week placement.<br>Face-to-face with some online components. | Partnership was initiated by a community-based Indigenous OT. |
| Dowell et al (2001)<br>Aotearoa New Zealand | Third-year medical students | University.<br>Cultural immersion placement; part of a unit of study. | 1 week<br>Face-to-face. | Consultation and collaboration with local community. |
| Durey et al (2017)<br>Australia | Health professionals (radiation oncology) | CPE.<br>Workshop. | 2-hour workshop.<br>Face-to-face. | Co-presentation. |
| Duthie et al (2013)<br>Australia | Master of Social Work Students | University.<br>Field experience; part of a unit of study. | 1-day.<br>Face-to-face. | Co-designed and co-delivered. |

*Table 3.1 continued*

| Reference<br>Country | Learner level and field of study | Site and type of educational intervention | Duration.<br>Delivery method | Level of Indigenous involvement |
|---|---|---|---|---|
| Fleming et al (2017)<br>Australia | Midwifery academic educators | CPE.<br>Workshops and Yarning Circles. | 2 half-day workshops and 5 yarning circles; held over a 12-week semester.<br>Face-to-face | Co-designed and co-delivered. |
| Gray et al (2020)<br>Australia | Undergraduate allied health students | University.<br>Workshop. | 1-day.<br>Face-to-face. | Co-designed and co-delivered. |
| Hardcastle & Bradford (2007)<br>Australia | Nurses and other health professionals | CPE.<br>Online module. | 6 self-paced learning modules.<br>Online (web-based training program) | Initiated, co-designed, and co-delivered. |
| Hart et al (2015)<br>Australia | Undergraduate nursing students | University.<br>Pre-placement unit.<br>Placement (urban, rural, and remote locations). | Pre-placement semester unit of study.<br>Placement (5 weeks).<br>Face-to-face. | Collaboration and consultation with Aboriginal Medical Services to set up placements. |
| Herzog (2017)<br>Canada | Fourth year medical students | University.<br>Elective unit of study. | 4-weeks.<br>Face-to-face. | Development and delivery of learning. |
| Herzog et al (2021)<br>Canada | Second year medical students | University.<br>Class activity. | Not specified.<br>Face-to-face | Not specified. |
| Hudson & Maar (2014)<br>Canada | First year medical students | University.<br>Pre-placement preparation.<br>Placement in community. | 4 weeks (total)<br>2-week placement in Aboriginal community.<br>2-week follow-up on campus.<br>Face-to-face with some online components. | Co-designed, co-delivered, and co-evaluation. |

*Table 3.1 continued*

| Reference<br>Country | Learner level and field of study | Site and type of educational intervention | Duration.<br>Delivery method | Level of Indigenous involvement |
|---|---|---|---|---|
| Hulko et al (2021)<br>Canada | Health professionals (nurses working with dementia patients) | CPE.<br>Module. | Self-paced, equivalent to 8-10 hours completed over 8-weeks.<br>Online and face-to-face components. | Co-designed and co-delivered. |
| Jackson et al (2013)<br>Australia | Masters-level postgraduate health professions students | University.<br>Workshop within a compulsory subject. | 1 day; 7 discrete sessions.<br>Face-to-face. | Co-designed and co-delivered. |
| Jamieson et al (2017)<br>Canada | First year occupational therapy students | University.<br>Modules included in a first year OT course. | 3 x 1-hour modules.<br>Face-to-face. | Co-designed and co-delivered. |
| Joyce (1996)<br>Aotearoa New Zealand | Undergraduate nursing students | University.<br>Scaffolded and integrated curriculum across undergraduate program. | 3-year curriculum. Approximately 252 hours total across 3600 hours of teaching.<br>Face-to-face. | Co-delivery of teaching. |
| Kelly et al (2016)<br>Australia | Renal health training for new and current nursing staff | CPE.<br>Workshop (pilot and evaluation). | Aim is to offer a 1-day workshop.<br>Face-to-face. | Not specified. |
| Kickett et al (2014)<br>Australia | First year health sciences students | University.<br>Integrated curricula. | 12-week semester.<br>2-hour weekly tutorials.<br>Offered in two formats: fully online; and face-to-face with some online components. | Co-coordination.<br>Delivery of teaching. |
| Lucas et al (2021)<br>Australia | Master of Pharmacy students | University.<br>Immersive workshop. | 8-hours.<br>Face-to-face. | Co-designed and co-delivered. |

*Table 3.1 continued*

| Reference<br>Country | Learner level and field of study | Site and type of educational intervention | Duration.<br>Delivery method | Level of Indigenous involvement |
|---|---|---|---|---|
| Maar et al (2020)<br>Canada | Pre-clerkship medical students. | University.<br>Simulated clinical scenarios. | 15-min interview and 20-min debrief interview.<br>Face-to-face. | Co-designed and co-delivered. |
| Mahara et al (2011)<br>Canada | Baccalaureate nursing students | University.<br>Proposed curriculum.<br>Scaffolded, & integrated curriculum across the program; includes a community placement. | 4-year curriculum. Total amount of time not specified.<br>Proposed activities would be face-to-face. | Conceptualisation, planning, and development. |
| McCartan et al (2021)<br>Australia | First year nutrition science students. | University.<br>Integrated curriculum across first year. | Integrated across 4 semester-long first-year subjects.<br>Face-to-face. | Co-designed. |
| Mills et al (2022)<br>Australia | Undergraduate health sciences students. | University.<br>Semester-long unit of study. | Four 3-hour workshops across a 12-week unit.<br>1 face-to-face workshop; 3 online workshops (due to covid-19). | Co-designed and co-delivered. |
| Min et al (2020)<br>Canada | Third- and fourth-year pharmacy students. | University.<br>One-semester unit of study; includes experiential learning activities. | 3-hours per week; 36 hours total.<br>Face-to-face. | Co-designed and co-delivered. |
| Nash et al (2006)<br>Australia | Undergraduate nursing students. | University.<br>Scaffolded and integrated curricula across the program of study. | Seven units across the program had content embedded; five were practical placements.<br>Face-to-face with online components. | Consultation and collaboration in the development. |

*Table 3.1 continued*

| Reference<br>Country | Learner level and field of study | Site and type of educational intervention | Duration.<br>Delivery method | Level of Indigenous involvement |
|---|---|---|---|---|
| NSW Government Family & Community Services (2007)<br>Australia | Not specified | Vocational training.<br>Units of study within a Certificate III in Aged Care. | 5-day workshop.<br>Face-to-face. | Contributed to resource development.<br>Required as assessor(s). |
| Oosman et al (2019)<br>Canada | Master of Physical Therapy students | University.<br>Pre-placement orientation session.<br>Placement in community. | Varied length,<br>2 – 4-week placements.<br>2 days per week in a health facility, 3 days per week in community.<br>Face-to-face. | Design and delivery of community practicum. |
| Paul et al (2019)<br>Australia | Medical students, first to fourth year | University.<br>Vertically and horizontally integrated curriculum. | Activities included in the curriculum vary between 1-hour (Smoking Ceremony and Welcome to Country) and 8-weeks (Rural GP & Psychiatry rotation).<br>Face-to-face. | Aboriginal Health Team responsible for coordination, development, implementation and evaluation. |
| Power et al (2020)<br>Australia | Third year nursing students | University.<br>Elective clinical placement. | Not specified.<br>Face-to-face. | Written and facilitated. |
| Ramsden (1992)<br>Aotearoa New Zealand | Undergraduate nursing and midwifery students. | University.<br>Proposed curriculum framework. | Not specified, but curricula to be scaffolded and embedded throughout the programs.<br>Not specified. | Conceptualisation of framework. |
| Richardson et al (2017)<br>Canada | Child and youth mental health workers | CPE.<br>Short course. | 5-day training program.<br>Face-to-face. | Co-designed and co-delivered. |

***Table 3.1 continued***

| Reference<br>Country | Learner level and field of study | Site and type of educational intervention | Duration.<br>Delivery method | Level of Indigenous involvement |
|---|---|---|---|---|
| Royal Australian College of General Practitioners (2011)<br>Australia | Medical practitioners | CPE.<br>Framework for delivery; to be developed and delivered on a case-by-case basis by accredited trainers. | Minimum 6 hours, up to 10 hours of structured learning.<br>Must also include preparatory activities.<br>Mandatory 6-hours face-to-face; can also include online components. | Planning, delivery, and evaluation of the program. |
| Ryder et al. (2013)<br>Australia | Second- and third-year medical students. | University.<br>Structured clinical simulations. | 3-hour session.<br>Face-to-face. | Co-designed and co-delivered. |
| Sjoberg & McDermott (2016)<br>Australia | Health professions students (undergraduate and postgraduate) | University.<br>Assessment included within a semester-long unit of study. | Not specified.<br>Face-to-face. | Development. |
| Thackrah & Thomson (2013)<br>Australia | First year midwifery students | University.<br>Semester-long unit of study. | 12-week semester.<br>2 contact hours per week.<br>Face-to-face. | Co-designed and co-delivered. |
| The Royal New Zealand College of General Practitioners (n.d.)<br>Aotearoa New Zealand | Practicing General Practitioners | CPE.<br>Online training module. | Self-paced training module.<br>Online. | Development and presentation. |
| Thorpe & Burgess (2012)<br>Australia | Undergraduate preservice teachers | University.<br>Semester-long unit of study. | 12-week semester.<br>Weekly contact time not specified.<br>Face-to-face. | Co-designed and co-delivered. |
| West et al (2021)<br>Australia | Final year undergraduate podiatry students | University.<br>Immersive clinical placement. | Minimum of four 1-day placements over the final year of study.<br>Face-to-face | Clinic is staffed by Aboriginal health professionals. |

### 3.3.2 Definitions of Cultural Safety

While an exploration of Cultural Safety definitions was not a central aim of this study, it was notable that several definitions included did not contain any reference to reflexivity or similar processes, such as critical reflection or self-awareness. Six of the documents included for analysis made no reference to reflexivity or similar in either the definition of Cultural Safety or in the educational intervention (Carriage et al., 2017; Durey, Halkett, et al., 2017; Hulko et al., 2021; Paul et al., 2019; Richardson et al., 2017; Ryder et al., 2013). One of these documents referred to practicing Cultural Safety skills learned in a previous topic via structured simulation workshops (Ryder et al., 2013), but the Cultural Safety skills are not outlined so it is unclear whether this includes reflexivity. An additional eight documents included in the analysis did not include reflexivity in the definition or conceptualisation of Cultural Safety but did include reflexivity as part of the educational intervention described (Delbridge et al., 2021; Jackson et al., 2013; Jamieson et al., 2017; Kickett et al., 2014; McCartan et al., 2021; Min et al., 2020; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012).

### 3.3.3 Definition of Reflexivity

Inductive thematic analysis of the data found a lack of consistency in the terminology used to name and describe the reflexive process within Cultural Safety educational interventions. Of the 46 documents analysed, 40 described some form of reflexive process. Ten documents specifically referred to a process of *reflexivity*, either as part of the Cultural Safety definition (Bolton & Andrews, 2018; Chiodo et al., 2014; Crampton et al., 2003; Demers et al., 2021; Fleming et al., 2017; Hart et al., 2015; Hudson & Maar, 2014; Mills et al., 2022) or as part of the educational intervention (Delbridge et al., 2021; Thackrah & Thompson, 2013). The remaining 30 documents used variations of the following terms: *(self) awareness* (Bernhardt et al., 2011; Duthie et al., 2013; Joyce, 1996; Kelly et al., 2016; Lucas et al., 2021; Maar et al., 2020; Min et al., 2020; Nash et al., 2006; Oosman et al., 2019; The Royal New Zealand College

of General Practitioners, n.d.); *(critical and/or self) reflection* (Hardcastle & Bradford, 2006; Herzog, 2017; Herzog et al., 2021; Jackson et al., 2013; Jamieson et al., 2017; Kickett et al., 2014; Lucas et al., 2021; Maar et al., 2020; Mahara et al., 2011; McCartan et al., 2021; Mills et al., 2022; Min et al., 2020; Nash et al., 2006; NSW Government Family & Community Services, 2007a, 2007b, 2007c; Oosman et al., 2019; Power et al., 2020; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012; West et al., 2021); *(self) examination* (Arnold et al., 2008; Dowell et al., 2001; Joyce, 1996; Nash et al., 2006; Ramsden, 1992; Sjoberg & McDermott, 2016). None of the documents analysed used the term reflexivity as a standalone concept; the 10 documents that used the term reflexivity did so interchangeably with the other terms listed above.

Where documents described the process of reflexivity, a variety of terms was used. The most common descriptors included *reflect on* (Bolton & Andrews, 2018; Demers et al., 2021; Durey, Halkett, et al., 2017; Hardcastle & Bradford, 2006; Herzog et al., 2021; Jamieson et al., 2017; Kickett et al., 2014; Maar et al., 2020; Mahara et al., 2011; McCartan et al., 2021; Nash et al., 2006; Paul et al., 2019; Power et al., 2020; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012); *examine* (Arnold et al., 2008; Crampton et al., 2003; Dowell et al., 2001; Fleming et al., 2017; Joyce, 1996; Ramsden, 1992); *become aware of* (Delbridge et al., 2021; Durey, Halkett, et al., 2017; Fleming et al., 2017; Gray et al., 2020; Hart et al., 2015; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016); *explore* (Delbridge et al., 2021; Durey, Halkett, et al., 2017; Fleming et al., 2017; Gray et al., 2020; Hart et al., 2015; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016); *consider* (Chiodo et al., 2014; Delbridge et al., 2021; Jackson et al., 2013; Thorpe & Burgess, 2012); *understanding* (Lucas et al., 2021; Royal Australian College of General Practitioners, 2011;

West et al., 2021); and *identify* (Mahara et al., 2011; Min et al., 2020; Ramsden, 1992; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012). What is notable about these descriptors is that most – including all the most commonly used – describe a passive process of identification, observation, and awareness. In contrast, some descriptors contain a call to action, for example, the requirement to use this new knowledge and understanding of self to enact attitude change (Jackson et al., 2013; Joyce, 1996; Ramsden, 1992; Royal Australian College of General Practitioners, 2011; Thackrah & Thompson, 2013), and to contest and deconstruct previous understandings (Chiodo et al., 2014; Sjoberg & McDermott, 2016).

### 3.3.4 Conceptualisations of Reflexivity

Four sub-themes emerged relating to how the purpose and focus of reflexivity was conceptualised. These sub-themes included self-identity; held beliefs; relationality; and context, with each sub-theme encompassing a suite of factors that learners were expected to reflect on. These factors are outlined in Table 3.2, below, although it should be noted that conceptualisations of reflexivity varied considerably across the data and inclusion of a sub-theme did not guarantee inclusion of all factors. All documents included for analysis conceptualised reflexivity using at least one sub-theme, but usually two or more sub-themes were present.

***Table 3.2: How the purpose and focus of reflexivity is conceptualised: sub-themes identified in the data.***

| Self-Identity | Held Beliefs | Relationality | Context |
|---|---|---|---|
| Identity<br>Culture and ethnicity<br>Worldview<br>Values | Assumptions<br>Biases and stereotypes<br>Internalised racism<br>Power and privilege | Impact of self-identity and held beliefs on relationships with others | Impact of context on self-identity, held beliefs, and relationality |

#### *3.3.4.1 Sub-theme 1: Self-identity*

The sub-theme of self-identity was primarily concerned with students reflecting on their own identity, culture, worldviews, and values, and was seen in 30 of the documents analysed (Arnold et al., 2008; Bernhardt et al., 2011; Bolton & Andrews, 2018; Chiodo et al., 2014; Demers et al., 2021; Dowell et al., 2001; Fleming et al., 2017; Gray et al., 2020; Hardcastle & Bradford, 2006; Hart et al., 2015; Herzog, 2017; Hudson & Maar, 2014; Jamieson et al., 2017; Joyce, 1996; Kelly et al., 2016; Lucas et al., 2021; Mahara et al., 2011; McCartan et al., 2021; Min et al., 2020; Nash et al., 2006; NSW Government Family & Community Services, 2007c; Oosman et al., 2019; Power et al., 2020; Ramsden, 1992; Richardson et al., 2017; Royal Australian College of General Practitioners, 2011; Ryder et al., 2013; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012). The primary purpose of reflecting on self-identity was broadly described as developing an understanding that identity, culture, worldviews, and values are not universal, exemplified in the following extracts:

> *"Participants were therefore encouraged to…explore their own culture, values, and beliefs [and] acknowledge difference"* (Fleming et al., 2017, p. 248)

> *"[Cultural Safety] requires registered nurses to reflect on their own cultural identity and practice in a way that affirms the culture of clients and co-workers"* (Mahara et al., 2011, p. 3)

Further, learners were required to develop an understanding that their own self-identity shapes and influences understanding, attitudes, and behaviours, as demonstrated in the following extracts:

> *"This includes understanding your own worldview and how your values and beliefs influence the way you perceive other people"* (Lucas et al., 2021, p. 88)

> *"[Students will] reflect on their own cultural background and their life experiences including the development of values and attitudes that have shaped their thinking and behaviours"* (Thackrah & Thompson, 2013, p. 120)

#### *3.3.4.2 Sub-Theme 2: Held Beliefs*

Thirty-five of the documents analysed described the sub-theme of held beliefs, where learners were required to identify and articulate their current knowledge, attitudes, biases, power, and privilege specifically in relation to Indigenous peoples (Arnold et al., 2008; Bernhardt et al., 2011; Bolton & Andrews, 2018; Chiodo et al., 2014; Crampton et al., 2003; Delbridge et al., 2021; Demers et al., 2021; Dowell et al., 2001; Durey, Halkett, et al., 2017; Duthie et al., 2013; Fleming et al., 2017; Gray et al., 2020; Hardcastle & Bradford, 2006; Herzog, 2017; Hudson & Maar, 2014; Hulko et al., 2021; Jackson et al., 2013; Joyce, 1996; Kelly et al., 2016; Lucas et al., 2021; Maar et al., 2020; Mahara et al., 2011; McCartan et al., 2021; Min et al., 2020; Nash et al., 2006; NSW Government Family & Community Services, 2007c; Oosman et al., 2019; Power et al., 2020; Ramsden, 1992; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012; West et al., 2021). In most of

these educational interventions, learners were required to reflect on both self-identity and held beliefs, and these were conceptualised as related. However, eight of the educational interventions only included a requirement to identify, reflect on, and in some cases actively critique held beliefs (Crampton et al., 2003; Delbridge et al., 2021; Durey, Halkett, et al., 2017; Duthie et al., 2013; Hulko et al., 2021; Jackson et al., 2013; Maar et al., 2020; The Royal New Zealand College of General Practitioners, n.d.).

A closer examination of the language used to describe the sub-theme of held beliefs found that the process and focus of reflexivity was often couched in neutral terms that glossed over the inherent racism underpinning beliefs and attitudes, as seen in the following extracts:

> *"...highlighted the importance of health providers reflecting on and questioning their own assumptions about Aboriginal people that can impact on the care they provide."* (Durey, Halkett, et al., 2017, p. 3, emphasis added)

> *"...learners were encouraged to reflect on their own cultural values or emotional responses to diverse histories, cultures, worldviews, values, and contemporary events related to Indigenous people"* (Jamieson et al., 2017, p. e2, emphasis added)

Notably, across the educational interventions, there was minimal expectation that learners would reflect on their future or current professional culture, and the norms, beliefs, and values that would inform their practice. Three exceptions to this are Demers et al. (2021), Kelly et al. (2016), and Ramsden (1992). Demers et al. (2021) note that Cultural Safety "requires exploration of cultures and identities, on both a personal and professional level" (p. 184). Similarly, Kelly et al. (2016) argue that culturally safe nurses are "aware of their own culture and that of the hospital" (p. 110), and Ramsden (1992) states that nurses and midwives must become aware of "the cultural boundaries which surround [the] traditional nursing and midwifery role" (p. 23).

#### *3.3.4.3 Sub-Theme 3: Relationality*

Half of the educational interventions ($n$ = 23) described the sub-theme of relationality (Arnold et al., 2008; Bernhardt et al., 2011; Chiodo et al., 2014; Crampton et al., 2003; Demers et al., 2021; Dowell et al., 2001; Duthie et al., 2013; Fleming et al., 2017; Hardcastle & Bradford, 2006; Hart et al., 2015; Joyce, 1996; Kelly et al., 2016; Lucas et al., 2021; Mahara et al., 2011; Nash et al., 2006; NSW Government Family & Community Services, 2007c; Oosman et al., 2019; Power et al., 2020; Ramsden, 1992; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012). In this sub-theme, learners were required to reflect on how self-identity and held beliefs impact on engagement with and care for others, and how this contributes to poor health and social outcomes, as exemplified by the following extracts:

> *"...students reflected on their own place-based identity (i.e., who they were, where they came from) and recognized how their own personal biases were unintentionally but significantly brought into practice and how those biases influenced their work and social interactions"* (Demers et al., 2021, p. 187)

> *"...notice our own cultural practices and individual behaviours and the impact these may have on Aboriginal and Torres Strait Islander people"* (NSW Government Family & Community Services, 2007c, p. 23)

#### *3.3.4.4 Sub-Theme 4: Context*

The fourth sub-theme identified in the data was context and was included in 10 of the educational interventions analysed (Arnold et al., 2008; Bernhardt et al., 2011; Chiodo et al., 2014; Demers et al., 2021; Duthie et al., 2013; Oosman et al., 2019; Power et al., 2020; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012). Context was described as a process of reflecting on how self-identity, held beliefs, and relationality have been shaped by historical, social, political, and economic forces. Like relationality, reflection

on context takes the process of reflexivity beyond introspection and allows a more critical analysis of the self as socially located. In some cases, this was a passive analysis, as in the following extract:

> *"Become aware of their own social conditioning, their (often privileged) status, and how their conditioning and status can affect their interactions with clients"* (Bernhardt et al., 2011, p. 179)

In contrast, other conceptualisations of reflexivity recognised the opportunity to actively challenge and deconstruct (Chiodo et al., 2014) this social conditioning, a process that Sjöberg and McDermott (2016) refer to as "disassembling planks of belief" (p. 30).

All educational interventions included content on contextual factors such as colonisation, racism, and sociopolitical processes, and their impact on the health and well- being of Indigenous peoples. It is notable that while there is ubiquitous recognition of how colonialism and racism have impacted on Indigenous health and well-being, there is comparatively less recognition of how these factors have shaped non-Indigenous self-identity, held beliefs, and relationality.

The varying conceptualisations of reflexivity can be seen as existing on a spectrum, ranging from basic reflection on self-identity at one end, to more critical reflection on self-beliefs and relationality in the middle, and reflexive analysis of the self as contextually situated at the other end. This can be seen in Figure 3.1, below:

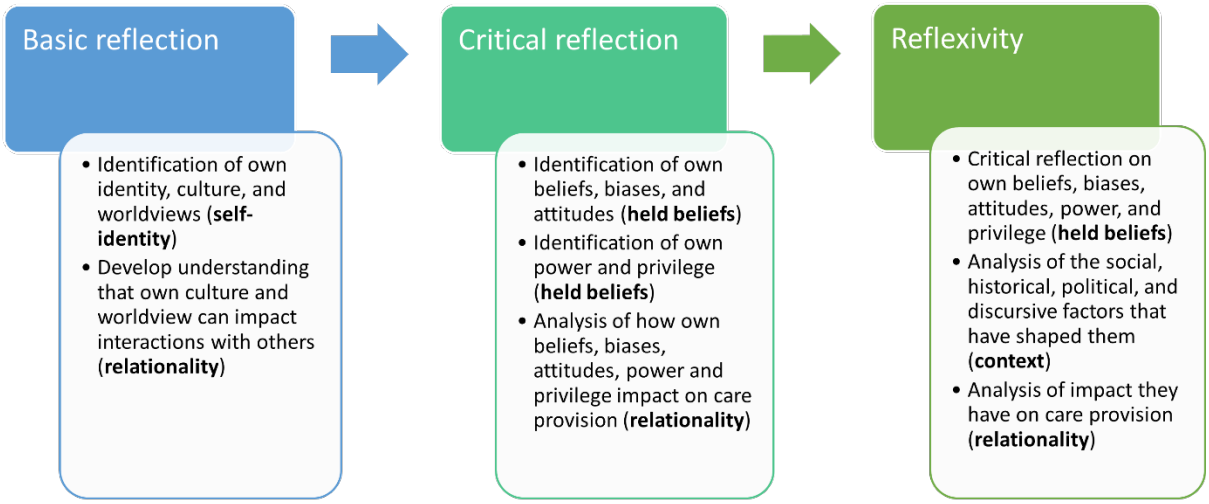


***Figure 3. 1: Spectrum of reflexive practice***

### 3.3.5 Where and How Reflexivity Is Included as a Learning Outcome

None of the educational interventions included learning outcomes that explicitly required students to develop knowledge of or ability to engage in reflexivity. Instead, reflexivity was operationalised as a method for achieving other learning outcomes, such as developing awareness and knowledge of self-identity, held beliefs, relationality, and/or context. Of the documents included for analysis, only 15 explicitly stated the learning outcomes of the educational intervention, and of these, 10 included learning outcomes relating to reflexivity (Bernhardt et al., 2011; Chiodo et al., 2014; Duthie et al., 2013; Fleming et al., 2017; Jackson et al., 2013; Kickett et al., 2014; Nash et al., 2006; NSW Government Family & Community Services, 2007a; Ramsden, 1992; The Royal New Zealand College of General Practitioners, n.d.). An example of this can be seen in the following extract, which outlines two of the learning aims of a one-day workshop for Australian postgraduate health sciences students:

*Specific aims of the day were to facilitate students in:*

> *"Recognising and acknowledging their own views and frames of reference in relation to Indigenous Australians";*
>
> *"Critically reflecting on the impact of ongoing colonisation and its pervasive discourse on the health and well-being of Indigenous Australians."* (Jackson et al., 2013, p. 106)

In most of the other documents included for analysis ($n$ = 31), expected learning outcomes could be inferred from the description of the educational intervention. For example, the extract below describes the intended learning outcomes of a community placement for master of physical therapy students in Canada:

> *"Our goal was to study whether expanding the clinic beyond the classroom and into a Métis community would make the students more aware of their own identity and worldviews, how they may be different from those in that community, and how they shape their stereotypes and misperceptions of peoples from other cultures."* (Oosman et al., 2019, p. 147)

The conceptualisation of reflexivity as an approach to learning can be traced back to Ramsden's early work on Cultural Safety education. The learning objectives outlined by Ramsden (1992) specifically require students to "examine their own reality and…attitudes", "be open minded and flexible in their attitudes toward people", and to become "self-aware" (p. 22), learning requirements that are reflected throughout the Cultural Safety education literature. While there were a range of pedagogical approaches used to facilitate reflexivity, there is no mention of whether students were explicitly taught about the concept and purpose of reflexivity, or how to go about being reflexive. It may be that some of the facilitated activities included instruction on the concept and process, but this is not outlined in any of the literature included for analysis.

### 3.3.6 Pedagogical Approaches to Facilitate Reflexivity

The analysis revealed that reflexivity was facilitated through a range of pedagogical approaches, all of which involved some type of reflexive catalyst (Salmon & Kevin, 2017). These catalysts were used as a counterpoint to the learner's own lived experiences and worldviews, with the intention that exposure to difference would result in some level of reflexivity. Pedagogical approaches can be seen as grouped into three broad categories, depending on the type of catalyst used: objects, people, and Indigenous pedagogical practices.

#### *3.3.6.1 Objects*

Object catalysts were described in 27 of the educational interventions analysed, and included things like readings, case studies, stories, visual art, and films (Bernhardt et al., 2011; Bolton & Andrews, 2018; Carriage et al., 2017; Chiodo et al., 2014; Delbridge et al., 2021; Demers et al., 2021; Durey, Halkett, et al., 2017; Fleming et al., 2017; Gray et al., 2020; Hardcastle & Bradford, 2006; Herzog et al., 2021; Jamieson et al., 2017; Joyce, 1996; Kelly et al., 2016; Kickett et al., 2014; McCartan et al., 2021; Mills et al., 2022; Min et al., 2020; Nash et al., 2006; NSW Government Family & Community Services, 2007a, 2007c; Richardson et al., 2017; Royal Australian College of General Practitioners, 2011; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012). Reflexive engagement with object catalysts was most often depicted as small or large group discussions, where new knowledge and understanding was co-produced through the sharing of beliefs, experiences, and interpretations. Examples of this can be seen in the following extracts:

> *"... the session includes a semi-formal lecture in a quieter space of the gallery ... student literature reviews, gallery exploration, and a group reflective discussion."*
> (Bolton & Andrews, 2018, p. 37)

*"The tutorial format was tightly structured and included the viewing of a vodcast (prepared specifically for the unit and featuring Aboriginal speakers), discussion of issues arising, case studies, and periodic presentations by students. ... Guidelines [were] developed by students [to facilitate classroom discussions, to ensure] that con- sideration be given to experiences and background that may influence attitudes ex- pressed."* (Thackrah & Thompson, 2013, pp. 115-116)

#### *3.3.6.2 People*

Twenty-six educational interventions analysed included people as a reflexive catalyst (Arnold et al., 2008; Bernhardt et al., 2011; Carriage et al., 2017; Crampton et al., 2003; Delbridge et al., 2021; Demers et al., 2021; Dowell et al., 2001; Duthie et al., 2013; Fleming et al., 2017; Gray et al., 2020; Hart et al., 2015; Herzog, 2017; Hudson & Maar, 2014; Hulko et al., 2021; Jackson et al., 2013; Joyce, 1996; Kickett et al., 2014; Lucas et al., 2021; Maar et al., 2020; Mahara et al., 2011; Mills et al., 2022; Min et al., 2020; Oosman et al., 2019; Paul et al., 2018; Power et al., 2020; Royal Australian College of General Practitioners, 2011; Ryder et al., 2013; West et al., 2021). Immersive, community-based placements or field trips were the most common ($n$ = 16), where predominantly non-Indigenous students visited (and sometimes stayed in) Indigenous communities or health services (Arnold et al., 2008; Bernhardt et al., 2011; Carriage et al., 2017; Crampton et al., 2003; Demers et al., 2021; Dowell et al., 2001; Duthie et al., 2013; Hart et al., 2015; Herzog, 2017; Hudson & Maar, 2014; Lucas et al., 2021; Min et al., 2020; Oosman et al., 2019; Paul et al., 2019; Power et al., 2020; West et al., 2021). The educational interventions that took this approach shared similar theoretical underpinnings, where exposure to difference was described as an opportunity for reflection and growth. The extract below is exemplary of this theory:

*"Cultural immersion is an experiential approach to learning about culture and social situations. In medical education this type of approach is beginning to be*

> *recognized for its potential to raise consciousness among students; expose tacit inappropriate biases, including racism; help students learn about themselves and other cultures; and assist students in their preparation for work in culturally diverse settings."* (Hudson & Maar, 2014, p. 3)

In 13 of the educational interventions analysed, Indigenous educators were positioned as the reflexive catalysts, either as core teaching staff (Delbridge et al., 2021; Fleming et al., 2017; Jackson et al., 2013; Joyce, 1996; Kickett et al., 2014; Mills et al., 2022; Royal Australian College of General Practitioners, 2011) or in ad hoc roles such as guest speakers (Bernhardt et al., 2011; Hulko et al., 2021; Mahara et al., 2011; Min et al., 2020) or patient simulation actors (Gray et al., 2020; Maar et al., 2020; Ryder et al., 2013). Indigenous educators were frequently described as providing learners with an opportunity to challenge their own stereotypes and beliefs about Indigenous peoples, as exemplified in the following extract:

> *"Having the opportunity to be taught by and interact with an Indigenous academic is thought to have a major role in reducing stereotypes and negative attitudes about Indigenous Australians … Our objective was to present an Indigenous informed perspective filling in the gaps of knowledge that have resulted from silencing Indigenous peoples, their stories and experiences. We wanted to provide students with some positive and affirming images of the strength and resilience of Australian Indigenous peoples."* (Jackson et al., 2013, pp. 105-107)

Simulated patient scenarios involving Indigenous people as "patients" were all described as an opportunity for learners to practice and refine communication skills and develop their Cultural Safety skills. This was seen as providing a safe, controlled environment for both learners and patients where feedback could be provided to facilitate learner reflection (Gray et al., 2020; Maar et al., 2020; Ryder et al., 2013).

#### *3.3.6.3 Indigenous Pedagogical Practices*

Eighteen of the educational interventions analysed described the inclusion of Indigenous pedagogies as a method of facilitating learner reflexivity (Arnold et al., 2008; Bolton & Andrews, 2018; Delbridge et al., 2021; Dowell et al., 2001; Duthie et al., 2013; Fleming et al., 2017; Hart et al., 2015; Herzog, 2017; Herzog et al., 2021; Hulko et al., 2021; Jamieson et al., 2017; Kickett et al., 2014; Mills et al., 2022; Nash et al., 2006; Paul et al., 2019; Richardson et al., 2017; Sjoberg & McDermott, 2016; West et al., 2021). In some educational interventions this was an integral aspect of immersive community placements, where learners engaged in a variety of cultural and community events (Arnold et al., 2008; Dowell et al., 2001; Duthie et al., 2013; Hart et al., 2015; Herzog, 2017; Paul et al., 2019). In other educational interventions, this was described as a process of engaging with Indigenous ways of knowing, being, and doing through activities such as *talking (or yarning) circles* (Fleming et al., 2017; Herzog et al., 2021; Kickett et al., 2014; Richardson et al., 2017), *storytelling* (Bolton & Andrews, 2018; Delbridge et al., 2021; Hulko et al., 2021; Jamieson et al., 2017; Mills et al., 2022), and *Indigenised spaces* (Bolton & Andrews, 2018; Nash et al., 2006; West et al., 2021). In these educational interventions, Indigenous pedagogies were described as providing a counterpoint to deficit-based understandings that may be held by learners, or to legitimate Indigenous knowledges, as demonstrated in the following extracts:

> *"field experiences can provide students with a first-hand account of the 'ways of knowing, being, and doing' ...that is, communicating with and listening to Aboriginal Elders, practitioners and community members provides a deeper analysis of social work practice through assessing the cultural context, yarning and storying"* (Duthie et al., 2013, p. 199)

> *"A yarning circle approach was used to privilege First Peoples' culture and voice. First Peoples have recognised yarning as a method of sharing stories, information and knowledge for generations."* (Fleming et al., 2017, pp. 247-248)

### 3.3.7 Assessment of Reflexivity

Of the 46 educational interventions analysed, only 22 provided information on the assessment of reflexivity, and in most instances only a brief description of the assessment task(s) was provided (Bernhardt et al., 2011; Carriage et al., 2017; Chiodo et al., 2014; Delbridge et al., 2021; Duthie et al., 2013; Hart et al., 2015; Hudson & Maar, 2014; Jackson et al., 2013; Joyce, 1996; Kickett et al., 2014; McCartan et al., 2021; Mills et al., 2022; Min et al., 2020; NSW Government Family & Community Services, 2007a; Oosman et al., 2019; Paul et al., 2019; Power et al., 2020; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012; West et al., 2021). The most common forms of assessment were written reflections in the form of *journals* (Bernhardt et al., 2011; Carriage et al., 2017; Chiodo et al., 2014; Kickett et al., 2014; Thackrah & Thompson, 2013; West et al., 2021), *essays* (Delbridge et al., 2021; Oosman et al., 2019; Power et al., 2020; Sjoberg & McDermott, 2016; Thorpe & Burgess, 2012), and *portfolios* (Hudson & Maar, 2014; McCartan et al., 2021; Paul et al., 2019). Other forms of assessment included *structured reflective questions* (Duthie et al., 2013; NSW Government Family & Community Services, 2007a), *oral presentations* (Hart et al., 2015), and *arts-based reflection activities* (Bernhardt et al., 2011; Min et al., 2020).

A common theme throughout assessments is the requirement for students to reflect on their learning, and how this applies to them personally and professionally, as demonstrated by the following extracts:

> *"Students subsequently submitted a critical self-reflection exploring their personal learnings, including reflections on assumptions, discomfort and realisations."* (Delbridge et al., 2021, p. 6)

> *"The idea that students would be given a 'real world' experience, be required to reflect on what they had observed and what they had learnt, with supporting literature, was vital to identifying elements of changing attitudes and effectiveness of learning. Furthermore, students then had to plan how they would use their new knowledge in future practice contexts."* (Duthie et al., 2013, p. 201)

The above extracts demonstrate the two different ways that learners were required to reflect on their learning. In the first extract (Delbridge et al., 2021), the purpose of the assessment is described as assessing what students have learned about themselves, demonstrating an inward focus on self-identity and held beliefs. In the second extract (Duthie et al., 2013), assessment is described as having a more applied focus; students must reflect on what they have learned and consider the implications for practice.

Two documents included for analysis focused specifically on the assessment of reflexivity in their respective educational interventions, with descriptions of how these assessments connect to learning outcomes and are supported via learning activities. Sjöberg and McDermott (2016) discuss what they call the *deconstruction exercise*, where students are required to critically examine and "deconstruct" their chosen question rather than answer it directly. The aim is to expose the racialised assumptions and stereotypes that inform the question and how this links to broader social, historical, and political contexts. By externalising this critique, Sjöberg and McDermott (2016) argue that the deconstruction exercise provides learners with an "opportunity to reflect on the everyday language in which they may be immersed, to see behind

the dominant Australian lexicon to the colonial, discursive position from which it has been constructed" (p. 31).

Power et al. (2020) describe a reflective essay assignment in which students were required to complete three online reflections before, during, and after their 3-week placement. Students were provided with "trigger questions" to prompt their online reflections, and these reflections formed the basis of their submitted reflective essay. The trigger questions step students through the reflective process, prompting them to think about their current knowledge and expectations (pre-placement), new learnings about themselves (mid-placement), and how this applies to future practice (post-placement).

What is notable about the educational interventions described by Sjöberg and McDermott (2016) and Power et al. (2020) is that learners are supported to complete these assessments in several ways, including clear links made to topic content, scaffolded activities to support reflexive skill development, and prompting questions to guide the reflexive process. Several other educational interventions described similar approaches to support learner reflexivity, although only limited information was provided. For example, Chiodo et al. (2014) note that learners were required to keep a reflective journal in which they "reflect upon the topics covered in class and in the set reading material … to think about what the issues/concepts/theories … meant for them both in their personal and professional lives" (p. 184). Here, assessment requirements are clearly tied to learning content and instructions regarding the focus of reflexivity; this was described in eight documents analysed (Chiodo et al., 2014; Delbridge et al., 2021; Duthie et al., 2013; Hudson & Maar, 2014; Min et al., 2020; Power et al., 2020; Sjoberg & McDermott, 2016; Thorpe & Burgess, 2012).

## 3.4 Discussion

The current study analysed a total of 46 documents, which described 43 different educational interventions. Definitions and conceptualisations of reflexivity varied; in many definitions, reflexivity was conceptualised as a passive process of observation rather than an active process of analysis, critique, and change. Four sub-themes were identified: self-identity, held beliefs, relationality, and context, with conceptualisations of reflexivity drawing on varying combinations of these sub-themes.

In all educational interventions analysed, reflexivity was considered an approach to learning rather than a learning outcome itself. Only 15 of the documents included for analysis specifically outlined syllabus learning outcomes, so it is possible that the other educational interventions include learning outcomes related to the development of reflexivity as a skill. Pedagogical approaches relied on three types of reflexive catalysts: objects, people, and Indigenous pedagogies. The use of reflexive catalysts was premised on the assumption that exposure to difference would engender understanding and respect for perspectives, beliefs, and experiences different to those of the learners. There was limited information available on the assessment of reflexivity, although most assessments focused on new knowledges and understandings gained through the educational intervention, including knowledge of self, and how these apply to students' personal and professional lives.

It is noteworthy that 14 of the documents analysed included a definition of Cultural Safety that did not include reflexivity as a core aspect of culturally safe practice, with eight of those documents positioning reflexivity as additional to Cultural Safety, and six documents making no reference to reflexivity at all. Definitions that lack reference to reflexivity tend to align more with cultural competency models, which emphasises learning about other cultures and has been criticised as taking a more tick-box approach that risks essentialising culture and reinforcing stereotypes (Beagan, 2015; Curtis et al., 2019). Cultural Safety specifically moves away from

this model of learning, with the emphasis placed on students learning about themselves and their own culture, and how power imbalances impact healthcare provision. Notably, there were several documents included in the analysis that used the terms 'Cultural Safety', 'cultural awareness', and 'cultural competency' interchangeably (for example: Mahara et al., 2011; Thackrah & Thompson, 2013) or conceptualised them as aspects or stages of the same process (for example: Fleming et al., 2017; Maar et al., 2020; Royal Australian College of General Practitioners, 2011). This potentially highlights a lack of understanding of core Cultural Safety concepts, and arguably, results in less effective teaching.

Variations in how Cultural Safety is conceptualised may provide some explanation for the variations in how reflexivity was defined and conceptualised. As noted by Lumsden (2019), definitions of reflexivity differ according to context and purpose. The analysis showed that where the purpose of the educational intervention was to increase recognition and respect for diversity, reflexivity tended to be conceptualised as a process of understanding self-identity, held beliefs, and in some cases, relationality (Arnold et al., 2008; Bernhardt et al., 2011; Bolton & Andrews, 2018; Chiodo et al., 2014; Crampton et al., 2003; Delbridge et al., 2021; Demers et al., 2021; Dowell et al., 2001; Durey, Halkett, et al., 2017; Duthie et al., 2013; Fleming et al., 2017; Gray et al., 2020; Hardcastle & Bradford, 2006; Hart et al., 2015; Herzog, 2017; Hudson & Maar, 2014; Hulko et al., 2021; Jackson et al., 2013; Jamieson et al., 2017; Joyce, 1996; Kelly et al., 2016; Lucas et al., 2021; Maar et al., 2020; McCartan et al., 2021; Min et al., 2020; Nash et al., 2006; NSW Government Family & Community Services, 2007c; Oosman et al., 2019; Power et al., 2020; Ramsden, 1992; Royal Australian College of General Practitioners, 2011; Ryder et al., 2013; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; The Royal New Zealand College of General Practitioners, n.d.; Thorpe & Burgess, 2012; West et al., 2021). Where educational interventions were conceptualised as a way to address colonialism, privilege, and power imbalances, reflexivity was defined as a process of

identifying and critiquing self-beliefs and the structural, institutional, and discursive factors that contribute to them (Arnold et al., 2008; Bernhardt et al., 2011; Chiodo et al., 2014; Demers et al., 2021; Duthie et al., 2013; Oosman et al., 2019; Power et al., 2020; Sjoberg & McDermott, 2016; Thackrah & Thompson, 2013; Thorpe & Burgess, 2012).

As outlined in Figure 3.1, reflexivity could be conceptualised as existing on a spectrum. At one end, reflexivity was concerned with acknowledging and exploring self-identity and held beliefs, while at the other end, reflexivity was concerned with contextualising the self as socially located. Most of the documents analysed fell into the 'basic' or 'critical' reflection portions of the spectrum, with a greater focus on identification and understanding of self-identity and held beliefs, and to a lesser extent relationality. Expectations that students will identify and critique their self-identity and held beliefs would arguably be a contributing factor to student feelings of discomfort and resistance (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Mills et al., 2018). While discomfort is a necessary part of transformative learning, this discomfort needs to be carefully managed (Faulkner & Crowhurst, 2014; McDermott & Sjoberg, 2012; Mills & Creedy, 2019). We would argue that a greater focus on the social, historical, political, and discursive forces which inform and shape students' self-identity and held beliefs are an important part of the reflexive process. This would provide students the opportunity to understand that these are not immutable aspects of their own identity, but rather changeable aspects that have been shaped by problematic, inequitable, and racist systems (Sjoberg & McDermott, 2016). If adequately managed, students may feel empowered to change problematic beliefs and attitudes while critiquing the systems that produced them.

All educational interventions analysed included information about the social determinants of health, so it is possible that learners were assisted to reflect on the connections between their own worldviews and broader contextual factors during learning. This is common throughout the Cultural Safety education literature, where learning about social determinants is positioned

as a method for challenging and critiquing racialised beliefs, assumptions, and stereotypes that may negatively impact on care provision (Delbridge et al., 2021; Jackson et al., 2013; Joyce, 1996; Kelly et al., 2016; Kickett et al., 2014; McCartan et al., 2021; McGough et al., 2022; Ramsden, 1992, 2002). However, this was not evident from the available data, where discussion of the social determinants was explicitly described as developing an understanding of their impact on health outcomes for Indigenous peoples. Arguably this works to construct social processes as unidirectional, only impacting on Indigenous peoples' health, without acknowledgement of how learners themselves are embedded within and shaped by these processes. This potentially limits the extent to which learners can engage in reflexivity, directing greater attention to self-identity and held beliefs and how they impact on behaviours and attitudes towards others.

The pedagogical methods used to facilitate reflexivity are also worth greater examination. More than half ($n$ = 26) of the documents analysed used people as the catalyst for reflexivity, where exposure to people with different cultures and life experiences provided learners with a counterpoint to their own culture, beliefs, assumptions, and stereotypes. Cultural immersion theory aligns with a pedagogy of discomfort (Mills & Creedy, 2019), in that learners are taken out of their comfort zones and confronted with new knowledges and experiences that may challenge their preconceptions. What is notable here is that, while many of the immersion-based curricula were designed and delivered by Indigenous community members, there was little consideration given to the Cultural Safety of this experience for the community itself. In contrast, learner needs were paramount in discussions, with a range of strategies employed to manage student discomfort and create culturally safe learning experiences. For example, Gray et al. (2020) describe an Indigenous health workshop for fourth-year allied health students, in which students interviewed local Aboriginal Elders and other community members to develop culturally safe communication skills. Gray et al. (2020) note that "this process provided a 'safe

space' for students to interact with an Indigenous Australian person" (p. 3). Arguably, however, there is at least as much risk for Elders and other community members in the potential exposure to the racism, dismissive attitudes, and resistance to learning that often accompanies student feelings of discomfort (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Thackrah & Thompson, 2013). Gray et al. (2020) indirectly acknowledge the potential for this to occur, noting that educators are taught how to de-escalate situations, and "post-workshop debrief sessions were held for teaching staff, to allow for the 'venting' of concerns" (p. 3).

In other immersive-based curricula, efforts were made to ensure that reciprocity was an underpinning principle, where communities received as much benefit as students did. This is exemplified by Hudson and Maar (2014), who note that their placement experience was informed by a social accountability model, where "the obligation of medical schools is to direct education, research and service activities towards addressing priority health concerns in the community" (p. 2). While laudable, it does not explicitly address the potential risks for the community members hosting students; there is an expectation that the risk to educators and other community members is worth the educational gains for students. Only two educational interventions explicitly addressed the issue of safety for Indigenous educators and community members (Jackson et al., 2013; Maar et al., 2020), acknowledging the potential for Indigenous people to be exposed to racism. The culturally unsafe nature of the classroom for Indigenous educators is well recognised (see for example: Bond, 2014; Drummond, 2020; Drummond et al., 2021) yet there are currently limited strategies put in place to address this risk. Most educational interventions analysed had some level of Indigenous involvement in development and/or delivery (see Table 4.1), yet on its own this does not guarantee the safety of Indigenous educators or community members. There is a need for more research to develop strategies that minimise the risk for Indigenous people working in this space (Bond, 2014).

Finally, the lack of information on the assessment of reflexivity within Cultural Safety curricula highlights a significant gap in the literature. Reflexivity is a fundamental aspect of being culturally safe; presumably, then, it is important to determine whether learners have developed the necessary reflexive skills to become culturally safe. Yet assessment is often glossed over in curricula descriptions, with only brief summaries provided of what is being assessed. In all instances where information on assessments was provided, learners were expected to demonstrate reflection on learning and how this applied to them personally and professionally. There were no examples that required students to explicitly demonstrate reflexive skills; in other words, assessment was of content rather than process. Arguably there are issues with this approach; as noted previously, focusing on what students have learned about themselves is potentially problematic and could be a causative factor in student feelings of discomfort, disengagement, and resistance (Bond, 2014; Mills & Creedy, 2019; Sjoberg & McDermott, 2016). Additionally, the potential for students to game their reflections also calls into question the efficacy of these types of assessments. A possible solution is to shift the focus of assessment from content to process, where learners' ability to demonstrate reflexivity is assessed, although currently there is very little research to indicate what this might look like (for example: Dune et al., 2018), and none within Cultural Safety education. Arguably then, there is a need for more research to determine how best to assess reflexive skills within Cultural Safety education without reducing it to either a checklist approach or a navel-gazing exercise (Pillow, 2003a).

While the results of this study are specifically concerned with reflexivity in the context of Indigenous Cultural Safety, Cultural Safety is increasingly being adopted in other discipline and population contexts. In particular, there is growing interest in how Cultural Safety might improve care provision and health outcomes for marginalised and disadvantaged populations, for example the LGBTIQA+ community (Crameri et al., 2015; Peters et al., 2022), racial and cultural minority groups (Gopal et al., 2022; Plaza Del Pino et al., 2022), and Indigenous

populations globally (Engnes et al., 2021). In an increasingly globalized and multicultural society, the importance of Cultural Safety and the ability to engage reflexively is fundamental to the provision of equitable, non-discriminatory care.

### 3.4.1 Limitations

A potential limitation of the current study is the type of literature that has been included. Most articles included in the analysis were evaluations of all or part of a Cultural Safety curriculum, with information on the learning outcomes, pedagogical approaches, and assessment options provided in the introduction or methodology sections. Articles were included where they provided sufficient information on at least three of the four key areas of analysis. The reliance on this type of data may explain the paucity of information on assessment approaches, as this was not a key feature of curriculum evaluations, where most of the focus was on changes in learner attitudes and knowledges, or learner experiences. However, the inclusion of this literature also means that a much broader picture of Cultural Safety education can be gleaned, compared to only including articles that focus on curriculum description.

Another possible limitation is that literature was only sourced from Australia, Aotearoa New Zealand, Canada, and the United States. It is possible that additional insights and perspectives might have been gained from other countries, broadening our current understanding of Cultural Safety curricula. Given the similarities in colonial history and Indigenous experiences of health and social inequity, it was felt that the Cultural Safety curricula literature would be comparable across these four countries, whereas this may not be the case for other countries.

## 3.5 Conclusions

While there is a substantial body of research exploring pedagogical approaches to teaching Cultural Safety in the context of Indigenous health, relatively little work has been done to

determine best practice approaches to teaching and assessing reflexivity as a core Cultural Safety skill. Indeed, the above analysis demonstrates that even within the Cultural Safety education literature, there is substantial variation in whether and how reflexivity is included within definitions of Cultural Safety, and how reflexivity itself is conceptualised. This lack of conceptual clarity presents issues for educators when trying to develop Cultural Safety curricula and suggests that more work is required to develop a more cohesive model of reflexivity specifically aligned with the aims of Cultural Safety curricula and practice. Additionally, more thought must be given to the pedagogical and assessment approaches utilised within Cultural Safety education. A range of strategies were utilised during learning to manage student discomfort, yet almost no attention was given to how that discomfort might manifest in the context of assessments. Likewise, while there was a substantial focus on student safety within the educational interventions, relatively few educational interventions considered the Cultural Safety of Indigenous educators and community members involved in the development of delivery of these programmes. Further research is required to provide greater conceptual clarity, consistency in skills development, and safety of learners and educators alike.

# Chapter 4: Critiquing the system from the outside: A thematic and discursive analysis of reflexive practices demonstrated by students in the health professions.


## Abstract

Cultural Safety is considered an approach to healthcare delivery with the potential to reduce the racism experienced by many Aboriginal and Torres Strait Islander people in the Australian healthcare system. Reflexivity is essential to engaging in a culturally safe manner, facilitating the identification and challenging of both personal and institutional racism. Despite its centrality to culturally safe practice, little is currently known about how students engage in and express reflexivity in the context of Cultural Safety education, or whether and to what extent this allows students to identify and challenge both personal and institutional racism. The current research analysed a total of 72 video reflection assessments from 36 students, participating in a unit on Aboriginal and Torres Strait Islander health and Cultural Safety within an Australian undergraduate health sciences program. A Levels of Reflexive Practice (LRP) analytic framework was developed, drawing on the Cultural Safety, reflexivity, and racism scholarship, and this was used to assess how and to what extent students demonstrated reflexive capacity. Additionally, a fine-grained analysis was conducted using critical discourse analysis to examine how students construct reflexive accounts of learning, including the identification and challenging of racism. Findings of the study indicate that students' reflexive capacity existed along a spectrum from basic description to more complex, nuanced reflexivity, and that this broadly aligned with the overall grade received. There were common gaps in how students engaged in and expressed reflexivity, coupled with consistent attempts to preserve positive self-presentation. Additionally, while there was evidence of students attempting to identify and

manage more overt expressions of racism, accounts of learning continued to draw on deficit discourse and to problematise Aboriginal and Torres Strait Islander people. These findings suggest that targeted pedagogical approaches are required to facilitate deeper reflexive capacity development, including ways to navigate the discomfort of unpacking racialised beliefs, attitudes, and practices. Additionally, Cultural Safety education must include a critical consideration of all forms of racism, including institutional and structural as well as interpersonal. Finally, further research is required to explore the utility of the LRP Framework in the development and assessment of reflexive capacity.

## 4.1 Introduction

As outlined in Chapter 1, racism is a key driver of the health inequities experienced by Aboriginal and Torres Strait Islander people (Australian Indigenous Health*InfoNet*, 2023; Australian Institute of Health and Welfare [AIHW], 2023). In the Australian healthcare system, racism manifests in practitioner attitudes and behaviours (Askew et al., 2021; Wicks et al., 2024; Wicks et al., 2023), institutional practices and policies (Elias & Paradies, 2021; Henry et al., 2004), and systemically in the racialised knowledges that inform healthcare education and practice (Gatwiri et al., 2021; Laccos-Barrett et al., 2022; Marrie & Bourke, 2020). As such, approaches to addressing racism must go beyond individual knowledge, attitude, and behaviour change to address institutional and systemic factors (Watego et al., 2021). Cultural Safety has been identified as a key approach to address racism in the healthcare system and is targeted at both individual and institutional change (Ahpra & National Boards, 2020; IAHA, 2019; Phillips, 2014).

Reflexivity is a key aspect of culturally safe practice (Castell et al., 2018; Hall et al., 2023), and central to the identification and challenging of racism, requiring a critical examination of

the self in relation to both context and to others (Denniston, 2023; Finlay, 2002b). For Australian healthcare professionals, this requires a critical examination of personal and professional cultures; biases and assumptions; power and privilege; how these are products of and work to reproduce racialised knowledges and practices; and how these shape their interactions with Aboriginal and Torres Strait Islander patients (Ahpra & National Boards, 2020; IAHA, 2019; Wilson, 2014). In this sense, reflexivity facilitates a deeper understanding of how individual practices are connected to broader knowledge systems, and how these shape everyday practices.

Despite the centrality of reflexivity to culturally safe practice, there is only limited literature examining how students engage in and express reflexivity in the context of Cultural Safety education. To date, only four studies have provided an explicit examination of student reflexive capacity (Castell et al., 2018; Franklin et al., 2014; McDowall, 2021; Min et al., 2021), one of which utilised a quantitative measure (Franklin et al., 2014) and as such, does not capture the nuance and detail of how students express and engage in reflexivity. McDowall (2021) offers a critical qualitative analysis of one student's reflexive journal entries utilising Nakata's (2007) cultural interface as a theoretical framework. This insight into student reflexivity, while limited, does highlight that development of reflexive capacity is neither linear nor consistent.

The final two studies provide comparative qualitative analyses of pre- and post-learning reflexive assessment pieces. The analysis provided by Min et al. (2021) was limited in scope, providing little detail or critical consideration of how students expressed and engaged in reflexivity, although it was identified that students' assessments generally became more complex over the course of the semester. The study by Castell et al. (2018) provided a more in-depth, critical analysis of student reflexive assessments using both Kember's (2008) four category critical reflection framework and causal layered analysis. Castell et al. (2018) found that post-learning reflexive accounts demonstrated greater nuance and criticality and suggest

that students were in the process of developing reflexive capacity. Notably, however, Kember's four category framework is designed to analyse critical reflection rather than reflexivity, where the former stops short of examining the co-determined nature of self and context. As such, there is some question as to whether the analysis provided by Castell et al. (2018) adequately captures reflexive capacity development.

Additionally, while these studies provide some insight into the process of building reflexive capacity, only Franklin et al. (2014) explicitly examined this in relation to racism. While there is a relatively robust body of reflexive theory literature exploring its potential for identifying and challenging racism (see for example: Emirbayer & Desmond, 2012; Foste, 2020; Kowal et al., 2013; McCutcheon & Kohl, 2019; Pillow, 2003b), there is little empirical research examining whether and to what extent this occurs in reflexive accounts. In the context of Cultural Safety education, where an explicit aim is to identify and challenge racialised biases, assumptions, knowledges, and practices, this represents a significant gap in the literature.

The current research seeks to critically analyse how health sciences students engage in and express reflexive accounts of learning within a tertiary unit of study. It also seeks to examine how students identify and challenge their own racialised beliefs and attitudes, as well as the racialised knowledges that inform their worldviews. Given the discursive nature of knowledge production (Hook, 2001), identity formation (Harris et al., 2013), and the production and management of racism (Augoustinos & Every, 2007), this research is informed by the following questions:

- To what extent do students demonstrate reflexivity within their accounts of learning, and how does this align with the grade received?
- How do students discursively construct their reflexive accounts of learning?

- How do students discursively express, manage, and challenge racism within their reflexive accounts of learning?

## 4.2 Methodology

### 4.2.1 Educational context

The current research focuses on a semester-long, second-year health sciences topic, *Indigenous Health for Health Sciences*, which was offered within an Australian university. Approximately 300 students enrol in the topic each year, from across a range of disciplines and programs including health sciences, allied health programs, disability and ageing studies, medical sciences, and education. The topic was mandatory for some programs and elective for others, with both first- and second-year students enrolled.

The teaching team for the topic included the lead author (JD) as topic coordinator, and four tutors. Three of the tutors identified as Aboriginal, while the topic coordinator and fourth tutor identify as white. In this iteration of the topic (delivered in 2020), several lectures and tutorials were developed and delivered by Aboriginal guest lecturers, including members of the teaching team, with support provided by the lead author where requested. The teaching team met informally throughout the semester, with formal meetings at the start and end of semester and for marking moderation.

#### *4.2.1.1 Curriculum development*

Over the prior three years, the topic had been substantially redeveloped to bring it in line with the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Department of Health, 2014); this was done by the lead author in partnership with Aboriginal colleagues as well as the university academic development team. Redevelopment included changes to content, pedagogical strategies, and assessment approaches, and aimed to address an identified

deficit narrative which had informed previous iterations of the topic, to shift towards a more strengths-based understanding and approach (Fogarty, Lovell, et al., 2018).

The 12-week topic was broken into three modules. Module 1 (*Introduction*, weeks 1-2) provided students with an overview of key concepts, including culture and identity, critical thinking and reflexivity, and equality versus equity. Module 2 (*Social and cultural determinants of Indigenous health*, weeks 3-7) explored the impact of colonisation, racism, historical and current policies, and the justice system on health and wellbeing outcomes for Aboriginal and Torres Strait Islander people, with a focus on their role in producing current health inequities. Module 2 also explored a range of cultural determinants, such as connection to Country, family and kinship, and traditional healing, as well as accounts of resistance and self-determination. Finally, Module 3 (*Cultural Safety in practice*, week 8-12) explored the concept of Cultural Safety and how to incorporate it into professional practice and health service delivery. A more detailed outline of the topic learning outcomes and content is provided in Appendix 2.1.

A key aspect of the redesign of the topic also included development of a new suite of assessment items to provide more practical, applied learning. This aligns with the current research on Aboriginal and Torres Strait Islander heath curricula, which indicates that experiential approaches to learning, such as field trips or placements, allow students to make the connection between theory and practice more effectively (Bolton & Andrews, 2018; Power et al., 2020; West et al., 2021). Field trips and placements were not feasible, so a case study project was developed as an alternative approach.

The case study project was comprised of three parts, outlined in Table 4.1. Students were instructed to choose one case study vignette at the start of semester, which would provide the basis for all responses to the case study project. These vignettes, initially developed by the topic

coordinator and reviewed by Aboriginal colleagues to ensure their appropriateness, were designed to represent a range of health conditions, ages, genders, geographical locations, and experiences.

***Table 4.1: Summary of case study project***

| Case study part | Description | Aims |
|---|---|---|
| **1: Worksheet** | Locate and report on statistical data relevant to health and social determinants impacting person in the case study.<br>Provide a short, written summary of how social determinants impact the person's health and wellbeing. | • Build knowledge and understanding of health and wellbeing relevant to the chosen case study<br>• Develop basic understanding of social determinants and their relationship to health and wellbeing<br>• Develop key research skills and ability to locate relevant data and information |
| **2: Critical essay** | Identify and discuss one social and one cultural determinant which affects the health and wellbeing of the person in the case study. | • Build on knowledge and understanding of health and wellbeing developed in part one<br>• Develop a critical and nuanced understanding of social and cultural determinants and their impact on health and wellbeing<br>• Develop critical thinking and analysis skills |

***Table 4.1 continued***

| Case study part | Description | Aims |
|---|---|---|
| **3: Video reflections** | Record two videos (one mid-semester and one at end of semester) that provide a reflexive account of learning over the semester.<br>Videos should use the questions provided to guide their reflection. | • Provides a scaffolded opportunity to develop and practice reflexivity as a core Cultural Safety skill<br>• Builds on critical thinking and analysis skills |

#### *4.2.1.2 Case study project part 3: video reflections*

The focus of the current study is Case Study Part 3: Video Reflections, where students were asked to record a pair of video reflections. In these videos, students were required to provide a reflexive account of their learning throughout the semester, including what they knew and understood prior to the topic, what new knowledge and understanding they had acquired, how they reacted to this learning, and how this was relevant to them both personally and professionally. The video format was chosen to encourage more open, spontaneous reflection, and to provide more diversity in assessment approaches in recognition of different learning and communication styles. Those uncomfortable being on camera had the option to record a slide presentation with audio only. The guiding questions for each video are provided below (Figures 4.1 and 4.2), with the more detailed assessment instructions provided in Appendix 2.2. Notably, while the development of reflexive capability was a core focus of the assignment, the number and complexity of the topic learning outcomes meant that students were also required to meet additional learning outcomes.

| **Video reflection 1** | ***Social and cultural determinants of Aboriginal health*** **Due 2pm Wednesday 7 October 2020** |
|---|---|
| Guiding questions: | • How has your learning over Module 2 (weeks 3 – 9) affected your understanding of Aboriginal and Torres Strait Islander health?<br>• How has the case study contributed to your learning about the social and cultural determinants of Aboriginal health?<br>• Which resources did you find most helpful in your learning, and why? |

***Figure 4.1: Guiding questions for Video Reflection 1***

| **Video reflection 2** | ***Cultural safety: principles and application to case study*** **Due 2pm Wednesday 21 October 2020** |
|---|---|
| Guiding questions: | • Discuss what you understand about the principles of cultural safety<br>• Discuss your personal position on the relevance of cultural safety in healthcare delivery (what and why)<br>• Identify and discuss where cultural safety could improve the outcomes and wellbeing of the person in your case study<br>• Discuss the resources that helped you develop your understanding of and personal position on the relevance of cultural safety – what were they, and why were they helpful?<br>• Identify and discuss how you might continue learning about and developing your cultural safety skills in the future |

***Figure 4.2: Guiding questions for Video Reflection 2***

Students were supported to develop their reflexive capacity throughout the semester. In the first lecture, the concept of reflexivity was introduced, drawing on the work of Wilson (2014) and Aronowitz et al. (2015). In this lecture, a broad framework for engaging in reflexivity was introduced, including the following steps:

- notice any reactions to new learning (e.g. surprise, anger, resistance, etc.)
- reflect on why they reacted that way
- consider whether new learning aligned with or challenged previous knowledge and understanding
- identify the sources of previous knowledge and understanding and critically consider their reliability
- reflection on how previous knowledge and understanding had shaped beliefs, attitudes, and behaviours

Throughout the semester, some or all of these steps were included in lecture slides to reinforce and highlight how reflexivity is a continuous process. Tutorial activities were also included to extend on lecture content and enable students to practice engaging in the reflexive process. During Module One, a series of activities were provided to build familiarity with the process of reflexivity. Throughout Modules Two and Three, activities were utilised to facilitate reflexive engagement with topic content. For example, three tutorials included art-led learning activities, where students were required to engage with visual artwork by an Aboriginal or Torres Strait Islander artist (Flinders University Museum of Art, n.d.; Salmon & Kevin, 2017). Students were asked to consider their own interpretations and impressions of the artwork and discuss these with their peers to identify similarities and differences in how the artwork was perceived and understood. This was followed by a short video of the artist discussing their motivations, meanings, and processes, after which students were encouraged to reflect on whether and how their own interpretation differed, and importantly, *why* it differed. Collectively, the intention of this activity was to demonstrate that we each interpret the world through our own cultural, social, and experiential lenses, and that this will shape our own understandings, attitudes, and actions (Aronowitz et al., 2015; Finlay, 2002b; Wilson, 2014).

Additionally, to support students in completing the video reflection assignment, the topic coordinator recorded a detailed video explaining reflexivity, including examples of reflexive practice relevant to the topic. Students were also able to attend several drop-in sessions with the topic coordinator to ask questions about the video reflection assignment.

#### *4.2.1.3 Impact of covid-19*

The *Indigenous Health for Health Sciences* topic was originally designed to be delivered in a face-to-face setting, with students attending one 1-hour live lecture and one 2-hour tutorial each week. However, with the advent of the coronavirus pandemic, the topic was moved to an entirely online format and this presented several challenges regarding the weekly tutorials. Given the technological constraints that many students faced in semester one, and being mindful that two hours in a classroom versus two hours online are very different experiences, the decision was made to split the 2-hour tutorials into one hour offline completing the required pre-tutorial activities, and one hour online engaging in discussion and modified online activities with peers and educators.

### 4.2.2 Participants

The student cohort comprised of 281 students from a range of health professional areas, including health sciences, nutrition, physiotherapy, occupational therapy, medical sciences, health promotion, health management, psychology, and education. Most students (approx. 70%) were in their second year of undergraduate study, with the remaining students in their first year of study. Student age and gender breakdown for the cohort is presented below in Table 4.2. No students identified as non-binary or transgender.

***Table 4.2: Student age and gender demographics for the topic cohort***

| Age range (years)* | Female | Male | Total *N* | Total % |
|---|---|---|---|---|
| 15 – 19 | 54 | 12 | 66 | **23.5** |
| 20 – 24 | 127 | 45 | 172 | **61.2** |
| 25 – 29 | 11 | 12 | 20 | **8.2** |
| 30 and over | 12 | 8 | 20 | **7.1** |
| Total *N* | **204** | **77** | **281** | |
| Total % | **72.6** | **27.4** | | |

* Age range brackets are sourced from the university student management system

Participants were recruited using an opt-out approach. All students were emailed with information about the research project, including a short summary of the project and a detailed participant information sheet. The email included clear instruction to reply via email if the student did not want their videos included as data, and students under the age of 18 years were instructed to withdraw from the study. A total of 11 students opted out, resulting in a data set of 270 assessments (540 video files).

### 4.2.3 Data sources

Videos were purposely selected to include examples from all grade bands (Pass, Credit, Distinction, High Distinction) to examine if and how engagement and expression of reflexivity differed across the grades. Videos were also selected for analysis to ensure representation across a spread of gender broadly aligned with the distribution in Table 4.2. One challenge in this process was that the overall spread of grades for the cohort was heavily weighted towards distinction and high distinction grade bands, with several possible explanations for this. The video format potentially made it more difficult to critically evaluate the reflexive accounts, and

this may have been exacerbated by the relative inexperience of the teaching team, most of whom were new to teaching. Of the 10 tutorial groups, two were excluded for analysis because all assignments had received either distinction or high distinction grades. Additionally, a further 16 assessments (32 video files) were excluded due to file corruption issues. Of the remaining assessments, 55 were identified across eight tutorial groups that provided an adequate gender and grade spread. Of these 55 assessments, 37 (74 video files) were included in the final analysis as data saturation had been reached.

To ensure a representative grade spread, the paired videos were assigned to an overall grade band to the lowest of the two grades received; for example, if a student received a credit grade for the first video and a distinction for the second, their assignment was counted within the credit grade band. Depending on availability, 1 – 2 video pairs were selected at each grade band, and where possible, included one video pair with a consistent grade (i.e. credit/credit) and one video pair that showed a change in grade (i.e. pass/credit or distinction/credit). Notably, of the video pairs available for analysis, none received a pass grade for the first video, so video pairs were selected where the student had received a pass grade for their second video indicating a decrease in grade from the first to second video. A summary of data selection is outlined in Table 4.3. Also of note, there were no fail grades awarded, and therefore none included for analysis.

### 4.2.4 Data analysis

Data analysis occurred over three broad phases, which are outlined in Figure 4.4, and drew on an inductive thematic analysis approach. Analysis was an iterative process, with overlap between each of phases.

*Table 4.3: Summary of data selected for analysis.*

| Assigned to grade band: | Total | Increased | No change | Decreased |
|---|---|---|---|---|
| Pass | 2 | 0* | 0 | 2 |
| Credit | 12 | 7 | 3 | 2 |
| Distinction | 11 | 3 | 7 | 1 |
| High Distinction | 12 | 0 | 12 | 0 |

* Video files were assigned to the lowest grade band achieved by the student; where Pass grades are indicated to have decreased, the grade achieved for video 1 was higher than a Pass.

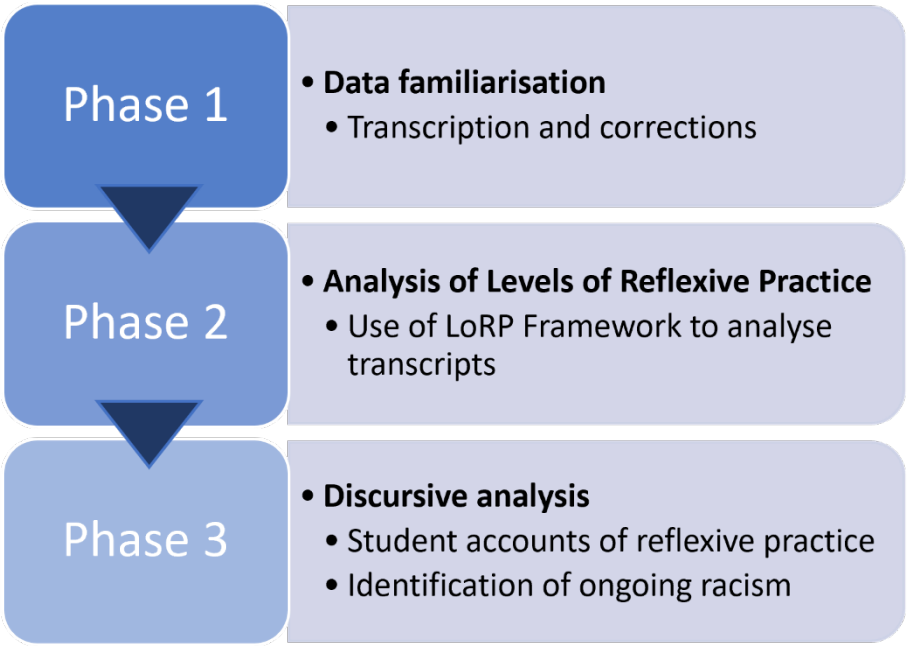


***Figure 4.3: Phases of data analysis.***

#### *4.2.4.1 Phase 1: Data familiarisation and initial coding*

All video reflections were listened to at least twice by the first author. Once during transcription, where initial thoughts, impressions, reflections, and potential codes were recorded, and the second while reviewing and making transcript corrections, where additional

notes were kept. Transcription used an adapted version of the orthographic transcription process outlined in Braun & Clarke (2013, pp. 165-166) and the simplified version of Jeffersonian transcription presented in Potter (1996, pp. 233-234). Transcription notations are included for reference in Appendix 2.3.

Following this, all transcripts were uploaded to NVivo (version 12) for analysis. Each transcript was read through again, and a set of codes were generated which built on the initial draft codes generated during transcription. The NVivo annotation function was used to record additional analytic notes, and an analytic journal was also kept.

#### *4.2.4.2 Phase 2: Analysis of Levels of Reflexive Practice*

The second phase of analysis used the Levels of Reflexive Practice (LoRP) analytic framework developed by the lead author to examine the extent to which students engaged in reflexive practice. The Levels of Reflexive Practice Framework is outlined in Table 4.4.

Development of the LoRP Framework was informed by several key theoretical perspectives. In the first instance, it was necessary to establish the context in which reflexive practice is being used, and what the intended outcomes are (Finlay, 2002a; Lumsden et al., 2019).

Given the intended purpose and outcomes of reflexive practice within Cultural Safety, the reflexive theory literature was examined to identify the most appropriate approach. Finlay (2002a) outlines five reflexive typologies, and while these are intended to be used as separate reflexive approaches, elements of each are applicable in the context of Cultural Safety . As such, relevant aspects of each typology were drawn on in the construction of the LoRP Framework. Additionally, a key aspect of developing the LoRP Framework was ensuring that reflexivity was conceptualised as an active process, where positionality and knowledge are not simply identified but critiqued and challenged (Emirbayer & Desmond, 2012; Pillow, 2003a).

***Table 4.4: The Levels of Reflexive Practice Framework (LoRP) developed to analyse student reflective videos***

| **Level of Reflexive Practice** | | **Domain** | | **Facets of reflexive practice** (***Including examples***) |
|---|---|---|---|---|
| ***1. Descriptive account*** | 1.1 | Provides an account of new information and understanding acquired. | 1.1a | Provides an account of new facts learned.<br>*"I learned that…"* |
| | | | 1.1b | Provides an account of new understanding developed because of learning.<br>*"I gained a new understanding of…"* |
| ***2. Basic Reflection***<br><br>**Descriptive account**<br>+ | 2.1 | Consideration of how the new learning has affected knowledge, understanding, and behaviours. | 2.1a | Provides an account of growth in learning, demonstrated by comparing or contrasting old knowledge and/or understanding to new knowledge and/or understanding.<br>*"I used to think X, but I have learned that…"*<br>*"I previously understood the issue in these terms, but now understand…"* |
| | | | 2.1b | Demonstrates consideration for how new knowledge or understanding will affect future actions.<br>*"Now that I know X, in the future I will…"* |
| | 2.2 | Identification and discussion of affective responses to new learning | 2.2a | Identifies and names emotional responses to new learning and understanding.<br>*"I felt very…"* |
| | | | 2.2b | Identifies the source of the emotional response.<br>*"After learning about X I felt…"* |
| | | | 2.2c | Identifies and discusses why the new learning produced an emotional response.<br>*"I felt X when I learned about Y, because…"* |

*Table 4.4 continued*

| Level of Reflexive Practice | Domain | | Facets of reflexive practice (*Including examples*) | |
|---|---|---|---|---|
| ***3. Critical Reflection***<br><br>**Basic Reflection +** | 3.1 | Identification and critique of own worldviews (beliefs, assumptions, stereotypes, and biases). | 3.1a | Identification of own worldviews (beliefs, assumptions, stereotypes, or biases).<br><br>*"I realised that I believed X…"* |
| | | | 3.1b | Critiques worldviews in the context of new learning.<br><br>*"I realised that I believed X, but my learning in this topic has demonstrated that this is problematic because…"* |
| | 3.2 | Consideration of how worldviews shape and influence attitudes and behaviours. | 3.2a | Examines how own worldviews shape and influence attitudes and behaviours.<br><br>*"I realised that my beliefs about X caused me to hold negative attitudes towards because I assumed that…"* |
| | | | 3.2b | Considers how own worldviews, attitudes, and behaviours are expressions of racism.<br><br>*"I have learned that my own attitudes were racist, and that by acting on these attitudes I have engaged in racism…"* |
| | 3.3 | Recognition of differing ways of knowing, being, and doing. | 3.3a | Recognises that there are different ways of knowing, being, and doing.<br><br>*"I realised that health can be conceptualised in different ways, depending on a person's culture…"* |
| | | | 3.3b | Specific identification of own ways of knowing, being, and doing.<br><br>*"Reflecting on what I had learned, I realised that my own idea of health includes…"* |

*Table 4.4 continued*

| Level of Reflexive Practice | Domain | | Facets of reflexive practice (*Including examples*) | |
|---|---|---|---|---|
| | | | 3.3c | Reflection on how own ways of knowing, being, and doing affect understandings of and interaction with people who engage in different ways of knowing, being, and doing.<br><br>*"Learning that there are other ways to conceptualise health made me realise that I assumed everyone thought about health the same way…"* |
| ***4. Reflexive Practice***<br><br>**Critical Reflection +** | 4.1 | Consideration of the social, historical, and political contexts in which knowledge is (re)produced. | 4.1a | Identifies the source(s) of own previous knowledge and understanding.<br><br>*"I learned about X in high school, and from the media…"* |
| | | | 4.1b | Explores the way that sources of information shaped own knowledge and understanding.<br><br>*"I learned about X in high school, but I realise now that what was presented was only part of the picture and biased my understanding…"* |
| | | | 4.1c | Consideration of dominant narratives, who controls and (re)produces them, and how these contribute to ongoing racism.<br><br>*"I realised that so much of the information available in mainstream media was racially biased, and that everything I learned was from a non-Indigenous perspective…"* |

***Table 4.4 continued***

| Level of Reflexive Practice | Domain | | Facets of reflexive practice (*Including examples*) | |
|---|---|---|---|---|
| | 4.2 | Consideration of own power, privilege, and relationship to whiteness and colonialism, and how these influenced engagement with knowledges | 4.2a | Consideration of own power, privilege, and/or relationship to whiteness and colonialism.<br>*"As a white person, I can now recognise that I have inherent levels of privilege…"* |
| | | | 4.2b | Consideration of how own power, privilege, and/or relationship to whiteness and colonialism affected prior knowledge and understanding, and/or engagement with new knowledge.<br>*"I realise that I never questioned my previously limited and racist understanding because I had the privilege of not needing to…"* |
| | 4.3 | Consideration of self as an active participant in settler colonial systems which perpetuate racism through the (re)production of dominant narratives and power imbalances | 4.3a | Locates self as a participant in settler colonial systems and institutions.<br>*"I realised that as a X person, I am a part of…"*<br>*"As a health sciences student, I will become part of the broader healthcare system…"* |
| | | | 4.3b | Consideration of own role as an active participant in settler colonial systems and institutions.<br>*"I realised that by uncritically accepting and perpetuating racist narratives, I have contributed to the upholding of social systems that produce and maintain inequity…"* |

An additional consideration in the current research is that unlike much of the available literature, which is predominantly concerned with reflexivity in the context of research, the current study is concerned with reflexivity in the context of learning. Dawson et al. (2022, p. 11) identified four common themes in how reflexivity was conceptualised within Cultural Safety education: self-identity, held beliefs, relationality, and context. These themes provided a foundation for the development of the LoRP Framework, however, there was also a need to consider how reflexive capacity might be conceptualised at beginner, intermediate, and advanced levels. The *Aboriginal and Torres Strait Islander Curriculum Framework* (Department of Health, 2014, pp. 2-11 - 12-20) provided a starting point for development, where capability development is outlined along a spectrum from *novice* to *intermediate* to *entry to practice*. University grade descriptors also informed development of the LoRP Framework to link levels of reflexive practice to established understandings of capacity development and learning, and given the educational context of the research, the LoRP Framework was developed to align with pass, credit, distinction, and high distinction grade bands. An equivalent fail grade level was not developed, however in line with the grade descriptors outlined in Appendix 2.4, this would be demonstrated by an absence of any reflection or reflexivity.

The work of both Kember et al. (2008) and Myezwa et al. (2017) provided a starting point for developing the LoRP framework. Kember et al.'s (2008, p. 372) four categories of reflection (habitual action/non-reflection, understanding, reflection, and critical reflection) provided a conceptual foundation for the LoRP framework. These levels were further developed by drawing on the work of Myezwa et al. (2017), which recognises that within each level, there is variability in the way that reflexivity is expressed (included as *domains*) and that engagement can range from simple to more complex and nuanced (included as *facets*).

Additionally, key theoretical perspectives across the reflective practice (Gibbs, 1988; Kolb, 2015), critical reflection (Fook & Askeland, 2006), and reflexivity literature (Finlay, 2002a; Gough, 2003; Lumsden et al., 2019; Pillow, 2003a) were drawn on to more clearly articulate what the four levels of reflexivity might look like. While reflection and reflexivity are not the same, reflection is arguably an important foundation for engaging in reflexivity; therefore, the reflective literature provided a basis for the beginner and intermediate levels of reflexivity. Collectively, the LoRP Framework provided a structure for identification and classification of student reflexive capacity within their accounts of learning, providing a theoretically derived framework for analysis of the data.

At the *Descriptive Account* level, students would be expected to describe the new information they have learned, as well as an articulation of the new understanding they have developed as a result. This aligns with the first stage of most reflective models such as Gibb's Reflective Cycle (Gibbs, 1988) and Kolb's Experiential Learning Model (Kolb, 2015), where identification and description of what has occurred is the starting point for further reflection. It also aligns with the second stage of Kolb's Experiential Learning Model (Kolb, 2015), which requires reflective observation and a review of the experience; in the learning context, this can be seen as the ability to identify new understandings. From an educational perspective, this level also needed to align with a *pass* grade descriptor; students have demonstrated an awareness that learning has occurred, a description of that learning, and to some extent, articulation of how this has changed their understandings. Specifically, students are required to frame this as a personal account (e.g. 'I have learned…') rather than a third-person account of concepts or information (e.g. in the form of an essay).

At the *Basic Reflection* level, it is expected that students will be able to extend beyond basic description of new learning to consider how this learning has changed their understanding, attitudes, or behaviours, including consideration of how this will inform future actions. It is

also expected that students will be able to identify affective responses to new learning, as well as reflect on what prompted these responses. This draws on elements of the Gibb's Reflective Cycle (Gibbs, 1988), specifically the ability to identify feeling responses, critically consider aspects of the learning experience, and alternative approaches in the future. It also aligns with the *credit* grade descriptor, where students have demonstrated a sound level of competencies and skills and a familiarity with relevant approaches and concepts.

At the *Critical Reflection* level, students are expected to extend their reflective capabilities and provide a more critical consideration of their learning experience. In line with both the broader critical reflection literature (Fook & Askeland, 2006; Kember et al., 2008) and the Cultural Safety literature (Department of Health, 2014; Jackson et al., 2013; McCartan et al., 2021; Power et al., 2020), this level of reflection requires students to consider their own worldviews, how these shape attitudes and behaviours, and that their own cultural practices are not the norm but one set of norms among many. In the educational context, this requires students to consider how their worldviews shaped previous knowledges and understandings and their feeling responses to new learning. Specifically, at this level there is an expectation that students will deepen their consideration of previously held beliefs to consider how these rely on racialised assumptions, and how these assumptions have influenced attitudes and behaviours towards Aboriginal and Torres Strait Islander people. Given the identified resistance to examining internalised racism demonstrated by many students (McDermott & Sjoberg, 2012; Mills et al., 2021; Thackrah & Thompson, 2013), this level of critical reflection is arguably aligned with a *distinction* grade band, where there is evidence of an advanced level of competency and skill; attainment of a more advanced level of knowledge; and proficiency in the application of methodologies and concepts. It also draws on the findings of Dawson et al. (2022, p. 11), where students begin to unpack self-identity, held beliefs, and to some extent relationality; and how

these shape their own understandings of Aboriginal and Torres Strait Islander peoples, cultures, histories, and health outcomes.

Finally, at the *Reflexive Practice* level, critical reflection is further extended to consider the context in which identity, culture, knowledge, and worldviews are formed. Here, students are required to articulate their own positionality and racial belonging, including their relationship to colonialism and whiteness and how these have shaped not only their own knowledge, but what types of knowledges are considered legitimate (Moreton-Robinson, 2004; Rix et al., 2014). This also requires an exploration of power and privilege – the student's own, and how these forces operate more broadly within systems and institutions – to produce and reproduce inequities (Kowal et al., 2013). Ultimately, it is expected that through reflexive practice, the student will begin to see themselves as participants within these systems and institutions, and that they play a role in either perpetuating or changing them. This conceptualisation builds on Finlay's (2002a) typologies of reflexivity (for a more detailed discussion see Chapter 2, pp. 81-83), as well as the findings of Dawson et al. (2022), specifically the exploration of context and how this shapes positionality, knowledges, and beliefs. The complexity of this process arguably requires a substantial level of competency, skill, and conceptual understanding, and therefore aligns most with the *high distinction* grade descriptor. While it might be argued that reflexivity should be considered the base line for capacity development, this is also arguably new to most students undertaking this type of learning. As such, the LoRP Framework is designed to recognise a scaffolded approach to learning that takes into account the varied points at which students begin this learning process.

In the initial coding, all data relating to reflexive practice were collected into one *levels of reflexive practice* code, with examples ranging from descriptive to reflexive. In Phase 2 of analysis, the levels of reflexive practice code was reviewed, and additional codes were generated to align with the LoRP Framework *domains*. Extracts were then sorted into relevant

domain codes, with some extracts assigned to more than one code where they demonstrated more than one level or domain of reflexive practice. Extracts in each domain code were analysed iteratively to generate themes and sub-themes, guided by the LoRP Framework *facets*. While the themes and sub-themes broadly aligned with the LoRP Framework domains and facets, respectively, analysis also identified where there were notable divergences or unexpected patterns in the way that students engaged in and provided an account of the reflexive process. During this phase of analysis, additional notes were taken in relation to the discursive construction of reflexive practice and the production and reproduction of racialised discourses.

#### *4.2.4.3 Phase 3: Discursive analysis of reflexive practice and ongoing racism construction*

In the final phase of data analysis, thematic discursive analysis was used to identify common patterns in student reflections regarding how reflexive practice was expressed and to what extent students were able to identify and critically engage with their own positionality and internalised racism. Analysis was informed by the tenets of social constructionism (Braun & Clarke, 2013; Potter, 1996), which posits that there is no singular, objective, and observable reality. Rather, that each person perceives, understands, and reproduces knowledge in ways that are socially, culturally, historically, and politically situated. Here, an individual's account of their knowledge or experience can be considered an attempt to convince the intended audience of the factuality of that knowledge or experience. This can include the deployment of various discourses, subject positions, and rhetorical devices which collectively work to construct an account of reality that is worked up as "true" and "factual" (O'Driscoll, 2013; Potter, 1996; van Dijk, 2006; Woolgar & Pawluch, 1985).

Analysis also drew on more recent work by Watego et al. (2021), who argue that racism is not simply an individual trait or behaviour, but the inevitable outcome of a society founded on race. From this standpoint, racism is embedded not only in social structures and systems, but in the

operation and production of knowledges (Elias et al., 2021; Moreton-Robinson, 2015). In the context of this research, there is an acknowledgement that students' perception, understanding, and reproduction of knowledges is in this racialised context, and this will influence and shape how they engage in both the learning and reflexive process. This is not to diminish the personal responsibility of students to identify, critique, and challenge their own racialised understandings of the world. Instead, it is a recognition of the ingrained nature of race as a social construct and its discursive reproduction across all systems and institutions. As such, analysis drew on an established body of work that examines the discursive reproduction of racism (Augoustinos & Every, 2007; Augoustinos et al., 2005; Augoustinos et al., 1999; Rapley, 1998; Wetherell & Potter, 1992), as well as more recent work examining racialised deficit discourses (Fforde et al., 2013; Fogarty, Bulloch, et al., 2018).

Finally, analysis also drew on literature examining the existence and operation of performative allyship (Hesford, 2021; Kutlaca & Radke, 2023) as well as the related concepts of virtue signalling (Brown et al., 2022) and moral grandstanding (Grubbs et al., 2019; Tosi & Warmke, 2016). While each of these concepts operate in distinct ways and contexts, they are all fundamentally motivated by a desire to accrue personal (moral, social, and political) benefits through positive self-presentation of the speaker (Grubbs et al., 2019; Kutlaca & Radke, 2023). In the context of a university assignment, it is possible that students will perceive the admission of racism or other morally questionable beliefs as a risk to both their academic and social standing and will therefore be more likely to engage in discursive practices that present themselves as morally acceptable (van Dijk, 1992). As Grubbs et al. (2019) note, "those who engage in insincere [moral grandstanding] may not care one way or the other about their moral stand, but want their audience to think they care deeply" (p. 4).

### 4.2.5 Ethics

This project was approved by the University of Adelaide Human Research Ethics Sub-Committee, approval number H-2019-20/79.

## 4.3 Analysis & Results

Analysis demonstrated variable levels of reflexive practice across student assessments, consistent patterns and gaps within student reflexive accounts, and variable management and discursive reproduction of racialised discourses. The following sections will explore analysis results in relation to the three research questions.

### 4.3.1 Question 1: To what extent do students demonstrate reflexivity within their accounts of learning, and how does this align with the grade received?

Analysis revealed that there were common patterns across the different grade bands in how students engaged in and expressed the varying levels of reflexive practice; these will be explored in more detail in the following sections. While each level of reflexive practice incorporates and builds on the previous level, the following sections of analysis will focus predominantly on those elements unique to each level.

#### *4.3.1.1 Descriptive accounts of learning*

Descriptive accounts of learning were found to varying degrees in all grade bands, While both facets of domain 1.1 in the LoRP were present (1.1a *provides an account of new learning*; 1.1b *provides an account of new understanding developed because of learning*) several consistent patterns emerged from the data concerning how the description was presented, the type of description provided, and what type of learning was described. These patterns presented differently across the grade bands, and there were consistent contrasts between the lower and higher-grade bands, as described below.

In the lower grade bands, descriptive accounts of learning were presented as the reflection itself, where descriptions of the new knowledges gained were offered as a complete and sufficient account of learning. An example of this can be seen in extract 4.1:

*Extract 4.1*

*one aspect I have enjoyed studying, and understanding further was self-determination (.) this was not a term I had come across before (.) however, I now understand, that self-determination gives people the right (.) to determine their own economic (.) social (.) and cultural development* (T01 P1 V1)

Here, the student identifies self-determination as a new conceptual learning but does not explore how this concept is relevant to themselves either personally or professionally. There is only a limited acknowledgement of old versus new understanding, indicated by the phrase, "not a term I had come across", with no reflection provided on why this might be the case.

In contrast, in the higher-grade bands descriptive accounts were predominantly used to provide context for their reflections. There was also a greater tendency to demonstrate critical engagement with the new information and learning, as seen in extract 4.2a:

*Extract 4.2a*

*I was not aware that um (.) Aboriginal people- Aboriginal and Torres Strait Islander people had a: um, pretty much a healthcare system set up (.) before colonisation (.) which had their own traditional medicines and (..) ah, treated (.) um their people … upon invasion, um (.) the:: Europeans just came and just (.) pretty much (..) got rid of that system* (T03 HD2 V1)

In the above extract, the student goes beyond simple identification of new understanding (colonisation) to provide a more critical discussion of how they understand the impacts of

colonisation (disruption of established systems and practices). This description also provides context for the student to further reflect on their experience of learning:

*Extract 4.2b*

*and that really just (.) hit it- it really made me stop and think that that actually happened … and that really, um (.) made me stop and think and change how I- (.) what I knew before, and really made me um (..) realise that- (.) um, the impact that colonisation had on health not just their normal life* (T03 HD2 V1)

A pattern that was evident almost exclusively in the higher grade bands was the tendency to describe the process of reflection itself. These were often presented as complete and sufficient reflexive accounts of learning, as demonstrated in the extract below:

*Extract 4.3*

*I have realised the differences in my personal attitudes, values, perspectives, knowledge, and motivations, just by broadening my understanding and learning about Aboriginal health by engaging with my case study, and applying it to the information that I receive (.) my personal values and attitudes are influenced by the world I live in, and they're constantly developing over my life time (.) with the new experiences I am having and the new information I am obtaining* (T02 DN V2)

In this extract, the student describes the elements of reflexive practice rather than providing a reflexive account of learning. For example, the student notes that they "have realised the differences in my personal attitudes, values, perspectives, knowledge and motivations"; this is a version of three-part listing (Potter, 1996), a discursive tool used to construct accounts as complete and sufficient. Here, the list functions to convey the breadth and comprehensiveness of the reflexive process, without having to provide any detail of what the differences are.

#### *4.3.1.2 Basic reflection*

All video reflections demonstrated elements of basic reflection, with three common patterns relating to the expression of domains 2.1 (*consideration of how the new learning has affected knowledge, understanding, and behaviours*) and 2.2 (*identification and discussion of affective responses to new learning*) of the LoRP Framework.

Overall, there were few examples of students providing a contrast between old and new knowledges and understandings (domain 2.1, facet 2.1, *provides an account of growth in learning, demonstrated by comparing or contrasting old knowledge and/or understanding to new knowledge and/or understanding*). In some cases, changes in knowledge and understanding were implied rather than explicitly stated. This can be seen in extract 4.4:

> *Extract 4.4*
>
> *next we progressed to racism, privilege, and health (.) I found this topic to be the most interesting for me (.) as I was previously not very not- knowledgeable in this area (..) with a dis- with the section standing out to me the mo:st (.) being the type- different types of racism (..) I was not aware of the different fo:rms of racism that can be portrayed* (T04 DN1 V1)

Here, previous understanding is characterised as being "not very … knowledgeable", with limited detail provided ("not aware of the different forms of racism"); this vagueness works to imply change without articulating how racism was previously understood.

In other instances, the contrast between old and new knowledge and understanding was more explicitly articulated. Notably, students overwhelmingly discussed what might be considered "safe" topics, where their previous knowledge or understanding would not risk the possibility of being labelled as problematic or racist. For example, in the following extract the student's choice of contrast actively constructs them as moral and just:

*Extract 4.5*

> *I did not realise before hand that this population group is often rejected from hospitals due to discrimination (.) I would've thought that every individual would receive equal treatment when it comes to health (.) so my perspective on Aboriginal health in regard to healthcare has certainly shifted* (T02 P1 V1)

In this extract, discriminative treatment is constructed as surprising to the student ("did not realise", "I would've thought"), subjectively positioning the student as non-discriminatory. The student also notes their belief in equal treatment, which positions them as holding morally just beliefs.

Some students were also able to make connections between new learning and the need for personal change (domain 2.1, facet 2.1b, *demonstrates consideration for how new knowledge or understanding will produce personal change*). The assessment instructions required students to consider the relevance of learning to future practice, and many were able to make this connection. However, consideration of change was limited to a vague "future", rather than a consideration of change they might make now, as demonstrated in Extract 4.6:

*Extract 4.6*

> *being an anti-racist involves challenging racism when it occurs and creating systemic changes to make sure it doesn't happen in the future (..) an anti-racist is someone who I want to be employed by (.) friends with (.) and who I want to be in the future* (T01 DN2 V2)

Here, an antiracist subjectivity is temporally confined to "the future", which could be an expression of the student's aspirations and an indication they intend to keep working towards this goal. However, the upshot of this construction is that it allows the student to position

themselves as morally aligned with the topic outcomes while avoiding doing the work required to be antiracist.

The articulation of an emotional response was the most common form of basic reflection that students engaged in (domain 2.2), with students expressing feelings of anger, frustration, discomfort, uncertainty, astonishment, surprise, motivation, and shock. While students displayed varying levels of all facets (2.2a, *identifies and names emotional responses to new learning and understanding*; 2.2b, *identifies the source of the emotional response*; 2.2c, *identifies and discusses why the new learning produced an emotional response*), in almost all cases, students articulated their feelings as a response to the racist or culturally unsafe actions of others, as seen in extract 4.7:

> *Extract 4.7*
>
> *when we sta:rted talking about the prevalence of racism, in today's society (.) I continued to be astonished as to how there were some people in this world (.) that cannot treat others in the same way just because of their cultural background, or the colour of their skin* (T05 CR2 V1)

There were very few instances where students articulated an emotional response to their own beliefs or actions, although some students did discuss feelings of uncertainty in relation to what their new learning means for them, and how this will be relevant for future practice.

While students were often able to identify feeling responses to new learning, including consideration of why they experienced a particular emotion, these accounts often served to deflect attention away from the student to "racist others". For example, in extract 4.7, the student subjectively positions themselves as separate from "some people", and their "astonishment" works to contrast the behaviour of "some people" to their own, non-racist and morally just behaviour. In this way, the student sidesteps any need to examine their own

potential racism. It also highlights what Watego et al. (2021) term the "pathologisation of the individual" (p. 7), where racism is seen as an aberration engaged in by "some" problematic people, rather than a foundational aspect of society.

An additional pattern that emerged from the data was students describing the contribution of Aboriginal and Torres Strait Islander perspectives to their learning, often characterising it as a "tipping point" for developing new understanding of an issue. Students noted the benefit of hearing directly from Aboriginal and Torres Strait Islander people, that having a more personal perspective made it easier to engage with the learning materials. Many students providing this type of reflection noted the role of the case study in helping to "put a human face" on their learning, as demonstrated in extract 4.8:

> *Extract 4.8*
>
> *the case study allowed me to put into perspective the content learned in lectures (.) and envision how they can be applied in a real life situation ... it definitely made me engage more deeply by thinking of him as an actual patient (.) and constantly considering the various determinants they have impact on his situation (..) in Charlie's case (.) the case study made me empathise and understand that racism and discrimination is still prevalent in society* (T03 DN2 V1)

This pattern of reflection is not unexpected, as students were required to reflect on how the case study contributed to their learning and the types of resources that they found most helpful. What is notable is how often students describe these resources as the point at which they feel like they gained a deeper understanding of both topic content and the reason why this learning is important. It is not until students are able to see the humanity of Aboriginal and Torres Strait Islander people that they begin to realise the need for personal and systematic change (Bond, 2014).

#### *4.3.1.3 Critical reflection*

Videos in the Pass and Credit grade bands demonstrated limited evidence of critical reflection, with all instances falling within facets 3.1a (*identification of own world views, including beliefs, assumptions, stereotypes, or biases*), 3.3a (*recognises that there are different ways of knowing, being, and doing*), and 3.3b (*specific identification of own ways of knowing, being, and doing*). In the higher grade bands there was a similar pattern of critical reflection, with students predominantly demonstrating facets 3.1a, 3.3a, and 3.3b, although this occurred more frequently. There were very few instances of students engaging in domain 3.2 (*consideration of how worldviews shape and influence attitudes and behaviours*).

Within domain 3.1, students were generally able to identify aspects of their own worldviews (facet 3.1a, *identification of own world views, including beliefs, assumptions, stereotypes, or biases*) but were less likely to critically engage with them (facet 3.1b, *critiques worldviews in the context of new learning*). The most common aspects of worldviews identified by students were previously held beliefs and assumptions, with less identification of or reflection on stereotypes and biases, as demonstrated in extract 4.9:

> *Extract 4.9*
>
> *I had assu:med, that the health outcomes of an individual were just determined by their personal choices (.) but I have come to understand, that while they might come into play, it is also influenced by a variety of social determinants (.) such as colonisation (.) policies, racism, communication barriers, and access to healthcare (.) as well as cultural determinants like family (.) language, connection to Country, self-determination, and person-centred healthcare* (T03 DN2 V1)

Here, the student explicitly identifies a previously held assumption about the role of individual choice in health outcomes, and this is contrasted to the new learning gained regarding social

and cultural determinants. However, there is no critical reflection on or consideration of the previous assumption, leaving its origins and impact unexamined. This was a common pattern throughout all videos, and like extract 4.9, in most cases the assumptions identified were couched in neutral terms ("health outcomes", "individual", "personal choices") to avoid language relating specifically to race or culture. In this way, students were able to demonstrate a willingness to "do the work" of identifying and unpacking assumptions while also avoiding any potential accusations of being racist.

Even where students explicitly discussed racism, this was predominantly framed as something engaged in by unidentified "others" with no consideration of personal relevance, as seen in extract 4.10:

> *Extract 4.10*
>
> *I (.) previously had the assumption that racism was no longer existent (.) or the only kind of racism in society was verbal com- ments on social media (..) however after completing this essay, I became aware that racism in different forms is still a significant issue today in Australia. I was able to learn about the different forms of racism, and how certain actions can be perceived as racist (..) therefore this new information has allowed me to change my position on the relevance of Cultural Safety, and why it is required in the healthcare system in Australia* (T01 DN1 V2)

Similar to extract 4.9, extract 4.10 identifies a previous assumption (racism as non-existent or only in certain contexts) and new learning which challenges this assumption (racism exists in many forms and is common). The student notes "…certain actions can be perceived as racist"; this point in the reflection provides an opportunity for the student to consider their own actions and whether – in the light of this new learning – any of their own beliefs or behaviours could be considered racist. Instead, however, the student connects this new learning to their changing

perception of Cultural Safety. In this way, the student is able to demonstrate reflection on their assumptions, learnings, and changing attitudes while simultaneously avoiding any reflection which might expose racist beliefs, attitudes, or actions.

While many students were able to identify their own worldviews (domain 3.1), very few were able to extend their reflections to consider how these worldviews impacted on and shaped their attitudes and behaviours (domain 3.2), with all examples found in the Distinction and High Distinction grade bands. Where this did occur, students tended to demonstrate both facets together (3.2a, *examines how worldviews shape and influence attitudes and behaviours*; 3.2b, *considers how worldviews, attitudes, and behaviours are expressions of racism*), with perhaps the most explicit example of this seen in the following extract:

> *Extract 4.11*
>
> *I do like to think of myself a:s a non-discriminative person (.) however, in all honesty: u::m, my past assumptions of Aboriginal and Torres Strait Islander health were discriminative, a:s I was ignorant (.) u::m I belie:ved i:n: ideas that were generalised, a:nd probably racist, um a:nd I had a real 'you're not helping yourself' kind of mentality and attitude towards them* (T05 HD1 V1)

Here, the student makes the link between past assumptions and beliefs which were "discriminative", "generalised", and "probably racist", and an attitude of blame and judgement towards Aboriginal and Torres Strait Islander people, characterised as "you're not helping yourself". There is an interesting contrast made between how they view themselves (non-discriminatory) and the realisations that have occurred as a result of their learning. Notably, even where the student attempts to identify the racialised nature of their worldviews and attitudes, this is couched in terminology which softens the possibility of racism and downplays the responsibility of the student. For example, the student constructs themselves as "ignorant",

holding “generalised” ideas that were “probably” racist. Also notable is the location of these discriminative and racist assumptions in the past; this allows the student to acknowledge the problematic nature of these assumptions but precludes any potential accusations of being racist in the present. A similar pattern of construction is seen in the following extract:

*Extract 4.12*

*I thought that I was really respectful towards all races, u::m, and I would never even dare to make any comments (.) but I've since reali:sed that, within myself, I held certain:: ah stereotyped biases and prejudice (.) so my previous understanding of Aboriginal heath was adequate, but in no: way did it really recognis:e the impact (.) that my own and others around me's understanding, could have upon people (..) we:: as a whole act (.) u::m (..) as a group to influenc:e othe:rs (.) behaviours, thoughts and beliefs, whereby (.) a misconception of Aboriginal health can really be passed u:m, through- (.) throughout generations (.) where this assumption ma:y be: um (.) most commonly, that we all live in equity* (T04 DN2 V1)

Here, the student begins by constructing a non-discriminatory subjectivity (“I was really respectful towards all races”, “I would never even dare to make any comments”); describes their realisation of holding racialised biases; and temporally locates these discriminatory biases in the past (“I held”). Where the student in extract 4.11 hedges their responsibility through use of terms like “probably”, the student in extract 4.12 avoids accountability by collectivising racism. There is an explicit acknowledgement that these racialised biases and prejudices have an “impact”, but this is framed as something “we” do. The limited instances of this type of critical reflection suggests that it is one of the more challenging aspects for students to engage in.

Around half of the video reflections demonstrated one or more facets of domain 3.3 (*recognition of differing ways of knowing, being, and doing*), with several examples in both the Pass and Credit grade bands but most instances occurring in the higher grade bands. Facet 3.3a (*recognises there are different ways of knowing, being, and doing*) was the most common, with students identifying differences in knowledges, perspectives, and practices, as seen in the following extract:

*Extract 4.13*

*Aboriginal peoples' connections to Country (.) was also new learning for me … I've never really: had a connection to Country beyond it being a piece of land I was born on (.) however the [concept?] of Country is mo:re than just the land and it being related to physical social (.) [historical?] spiritual (...) and being a part of sort of family (.) was illuminating* (T02 HD2 V1)

In extract 4.13, the student is able to identify new learning ('connection to Country') and extend their reflection to consider how this contrasts to their own concepts and understandings of land. Notably, this extract also represents one of the few examples of facet 3.3b (*specific identification of own ways of knowing, being, and doing*) specifically relating to sociocultural concepts and beliefs. In most other instances where students demonstrated facet 3.3b, students identified and articulated their own personal learning styles, as demonstrated in the following extract:

*Extract 4.14*

*I think I:: fou:nd overall that this topic was the hardest topic I've done due to the different style of learning (.) um, in general, the:: this topi:c asked fo:r a reflecti:ve, um process of thinking where I'm used to the:: (..) critical analysis of facts, numbers*

*and data, so the:se assignments especially have been a hard- a hard transition for me* (T05 DN1 V1)

The articulation of learning styles is perhaps not surprising, given that the assessment instructions specifically asked students to consider the resources that were most helpful and *why*; these reflections are in large part a response to this question. However, it is somewhat surprising that this was effectively the only time that students considered their own ways of knowing, being, and doing. Similar to experiential learning approaches (see for example: Dowell et al., 2001; Hart et al., 2015; Hudson & Maar, 2014), students were introduced to Aboriginal and Torres Strait Islander ways of knowing, being, and doing through the contributions of guest lecturers, and explicitly directed to reflect on how their own ways of knowing, being, and doing differed. While students were able to identify Aboriginal and Torres Strait Islander ways of knowing, being, and doing which differed from their own, in almost all cases they failed to articulate how it was different.

While facets 3.3a and 3.3b were relatively common, very few students extended their reflection to consider the implications of the identified differences (facet 3.3c, *reflection on how own ways of knowing, being, and doing affect understandings of and interactions with people who engage in different ways of knowing, being, and doing*). Where students were able to start unpacking their own cultural identity, this was predominantly in contrast to Aboriginal and Torres Strait Islander cultures and practices, as demonstrated in the following extract:

*Extract 4.15*

*I was ma:de aware of h:ow vastly different my: situation is, compa:red to the Aboriginal community (.) particularly (.) on their model of health, being a harmony betwee:n (.) an individual, others, the la:nd, and culture … I was assuming that the A- Aboriginal and Torres Strait Islanders shared the same responsibility, and*

*experiences of health as myself (.)… (..) this highlighted [importance?] for me to always acknowledge that everyone has their own challenges (.) particularly Aboriginal and Torres Strait I:slanders (.) and that the:ir health is not only determined by the responsibility of the individual (..) like what I expect of myself (.) but is influenced by a combination of history, institution (.) community and personal factors* (T06 HD1 V1)

The above reflection relies on two key insights. The first is the realisation that the student's own model and experience of health is "vastly different" to the experiences of many Aboriginal and Torres Strait Islander people. The second is identification of their own assumptions about the universality of health concepts and experiences. Collectively, these insights allow the student to understand the need to "acknowledge that everyone has their own challenges", and while not explicitly stated, implies that care cannot take a one-size-fits-all approach. This was a common realisation in all video reflections where the student acknowledged specific differences between their own and Aboriginal and Torres Strait Islander ways of knowing, being, and doing.

The inability to articulate aspects of own culture was seen consistently throughout students' videos. The following extract provides potential insight into why many students were unable to extend their reflexive practice to consider their own cultural ways of knowing, being, and doing:

*Extract 4.16*

*Cultural Safety is about a focus on my <u>own</u> cultural identities and <u>attitudes</u> (.) I noted in my: personal journal that it's (.) <u>definitely</u> easier to identify difference:s in culture, than understanding my <u>o:wn</u> culture (.) and its influence on how <u>I:</u> think, beha:ve, and feel* (T06 HD1 V2)

The student is clearly cognisant of the difficulties they are experiencing in identifying their own cultural practices, noting that it is "easier to identify differences". The research by Dawson et al. (2022) noted that the use of reflexive catalysts was one of the most common pedagogical approaches to facilitating student reflexive practice, where exposure to difference was used as a starting point for reflection. Notably, reflexive catalysts were predominantly used to facilitate student reflection on the existence of difference, or to challenge their own internalised racism and biases; catalysts were not used to examine the students' own cultural norms. Taken together with the above extract, this speaks to the need to develop ways of extending students' reflexive capabilities from acknowledgement of difference and identification of own biases to a consideration of own cultural ways of knowing, being, and doing.

#### *4.3.1.4 Reflexive Practice*

Reflexivity was most evident in the higher grade bands, with very few instances in the lower grade bands. Students in the higher grade bands demonstrated more complex and nuanced reflexivity, and while the expression of reflexive practice varied across videos, there were clear patterns in the way that students engaged in and expressed their reflexive accounts of learning.

Within domain 4.1 (*consideration of social, historical, and political contexts in which knowledge is (re)produced*), facets 4.1a (*identifies the source(s) of own previous knowledge and understanding*) and 4.2b (*explores the way that sources of information shaped own knowledge and understanding*) often occurred together. While students were able to make the link between information sources and own knowledge, how this was articulated varied from superficial descriptions to more critical discussion. The following extract exemplifies the former:

*Extract 4.17*

*my previous knowledge is acquired from news and media outlets, which often presented a disappropriate representation of Aboriginal and Torres Strait Islanders (..) I acknowledge my previous understanding was dictated by problematic (.) misinformation* (T01 CR2 V1)

While the student is able to clearly identify previous sources of information ("news and media outlets"), and acknowledges that this influenced previous knowledge and understanding, the lack of detail or critical discussion results in an account that reads more like a check list than a genuine attempt at reflexivity. In contrast, extract 4.18 (below) demonstrates a more nuanced and critical example of facets 4.1a and 4.1b:

*Extract 4.18*

*unfortunately, an assumption that I held was that colonisation does not still affect people today, which was built off problematic misinformation and as someone who is from [different country], what I learnt in school was my first point of contact in understanding Aboriginal and Torres Strait Islander peoples and culture (..) however my knowledge has been challenged, and I now acknowledge that the education I received was biased, as we are not taught about the societal structures which inequitably govern and control Aboriginal and Torres Strait Islander peoples (.) and the health injustices which originate from this* (T02 HD1 V1)

Here, the student begins with a consideration of previous assumptions ("colonisation does not still affect people") as a means of contextualising their reflexive account. This is followed by a consideration of why they held this assumption; that it was based on "problematic misinformation" and education which was "biased". In contrast to extract 4.17, the student explicitly identifies why their education was problematic, noting the lack of information

provided on “societal structures” which create social and health inequities. Extracts 4.17 and 4.18 demonstrate a consistent pattern in how facets 4.1a and 4.1b were expressed within lower and higher grade bands, respectively, and highlight the greater criticality and nuance evident in the higher grade bands.

A consideration of dominant narratives, who controls and reproduces them, and how they contribute to ongoing racism (facet 4.1c) was only evident in a small number of videos, with students able to identify why the narratives were problematic, although the ability to critique dominant narratives rarely extended to a consideration of how these narratives contribute to ongoing racism. The following extract is one of the few examples where a student demonstrated critical consideration of how mainstream media shapes broader narratives of Aboriginal and Torres Strait Islander people:

> *Extract 4.19*
>
> *watching the 'Sunrise' segment ((referring to in-class activity)) and reading the ... follow-up from the a:rticle, 'White Woman took my Baby' (.) gave me a better understanding of how the me:dia can have a (.) negative and detrimental effect on society's beliefs and in a way tricking people into believing (.) everything the media says is true and factual (.) and one hundred per cent accurate (.) however, when looking more deeply into it the fact that (.) there was no: Aboriginal (.) and Torres Strait Islander representation in questioning where (..) they got their information from* (T04 HD1 V1)

Here, the student provides an insightful reflection on their learning regarding how “the media” presents biased and problematic information to the broader public, and the role this plays in perpetuating misinformation. However, there is little consideration of who predominantly controls and distributes this media, specific consideration of how this feeds racist and racialised

narratives about Aboriginal and Torres Strait Islander people, or how these types of narratives have shaped their own worldviews, understandings, or attitudes. This reluctance or inability to specifically name and critique racism is part of a broader discursive pattern whereby racism remains un-named or is downplayed; this will be discussed in more detail in section 4.3.3 (pp. 215-225).

Within domain 4.2 (*consideration of own power, privilege, and relationship to whiteness and colonialism, and how these influenced engagement with knowledges*), facet 4.2a (*consideration of own power, privilege, and relationship to whiteness and colonialism*) was the most commonly expressed, and like domain 4.1, there was a clear difference in the reflexive accounts of students in lower versus higher grade bands. In the lower grade bands, students were cognisant of differing life experiences, and that in contrast to many Aboriginal and Torres Strait Islander people, they had not faced the same experiences or challenges. This is exemplified in extract 4.20:

*Extract 4.20*

*listening to their experiences gave me a better understanding of the challenges that they face on a daily basis (..) however, it also gave me the understa:nding (.) that I know that I will never tru:ly understand what they go through (.) as this is not something that I will experience in my daily life* (T01 P1 V1)

In contrast, students in the higher grade bands were more likely to explicitly acknowledge and critically examine their own privilege, as demonstrated in extract 4.21:

*Extract 4.21*

*without recognising this privilege that I am inherently born into, um: (.) or the privilege that I have when I walk down the street o:r um: in the shops, or applying for jobs, or seeking healthcare, and seeking education (.) um (.) without*

*recognising this, I am part of the problem, so: it's easy to say (.) 'well, not all white people, um I've never said a racist thing before in my life', but this concept of racism and the idea of whiteness runs so much deeper than that* (T01 HD2 V2)

Here, the student not only identifies their own privilege, but also demonstrates a more complex understanding of how privilege operates; that it impacts social and economic opportunities, and that its invisibility is central to its maintenance. There is also a clear connection made between privilege and the operation of whiteness and racism, that simply refraining from "saying racist things" does nothing to address racialised inequities.

While students readily identified their privilege, very few were able to identify and articulate their own positions of power. Instead, students were more likely to identify and critique social or political power imbalances. Where students did reflect on their own power, there was often a slippage between individual and structural understandings of power and privilege, as seen in extract 4.22:

*Extract 4.22*

*the reading 'The unbearable lightness of being white' allowed me to comprehend my own white privilege, where it comes from, and how it creates power imbalances (.) whiteness remains invisible to white individuals who never have to think about their race or the impact it has on their lives, and this also applied to me (.) I now understand why white people need to become more aware of their privilege (.) as it is essential to fully comprehending the unfair advantages that society has given them (..) I found this information extremely eye opening as a future health professional (.) as understanding white privilege is the first step in recognising institutional racism, which ultimately revealed to me my own biases and the*

*complexity and importance of breaking down (.) power imbalances in cross-cultural health relationships.* (T02 HD1 V1)

Here, the student reflects on how one of the topic readings facilitated insight into white privilege, including their new understanding of how white privilege "creates power imbalances" and is fundamental to the operation of institutional racism. Throughout the extract, the way the student talks about privilege shifts between individual ("my own", "also applied to me", "my own biases") and collective ("white individuals", "white people", "their privilege", "unfair advantages that society has given them"). This potentially indicates an attempt to navigate what seems to be a new realisation; that the student's own privilege and power is directly linked to systemic and institutional racism.

While considerations of privilege – and to a lesser extent power and whiteness – were relatively common, very few students extended these reflections to consider how this had influenced their own knowledge or understanding (facet 4.2b). The following extract represents one of the few examples where the student reflects on how their privilege has shaped their knowledge:

*Extract 4.23a*

*what particularly stood o:ut for me, was the sections on whi:te privilege, and the invisibility of being white … I had never given much thou:ght to the term 'white privilege' (.) other than how it disadvantages people of colour in terms of racism … reading this article really enli:ghtened the fact, that my current way of thinking is exactly what white privilege is (.) enjoying the invisible benefits of being white (.) it's as if the penny dropped … I also re:alised that being whi:te there is no appropriate terminology to descri:be us (.) which is white* (T06 DN1 V1)

Here, the student is navigating their new learning and realisations about the nature of white privilege, their own levels of privilege and identity as a white person, and how this has

influenced their thinking. While not explicitly stated, what is implied here is the realisation that their own white privilege shaped how they viewed inequity; that the very nature of white privilege renders itself invisible, therefore shifting focus to those experiencing disadvantage and racism. The student goes on to discuss how their realisation about the nature and operation of whiteness impacted their understanding of how health inequities are created, conceptualised, and framed:

*Extract 4.23b*

*my understanding was then shif:ted, from focusing on Aboriginal and Torres Strait I:slander people experiencing health inequalities (.) to why: it's even an issue in the first place (.) which determinants play a role, and why do we: as white people, have the ri:ght and power to ignore race when it benefits us? What on Earth gives us the ri:ght to be the race (.) to which all others are compared to?* (T06 DN1 V1)

While not explicitly articulated, it is evident that the student is grappling with the realisation that whiteness confers a level of power to control and shape narratives around health inequities and who is considered to be racialised. While there is a level of insight and realisation occurring here, the student still falls short of making the connection between their own identity as a white person, and the power this confers on them personally. As in extract 4.20, there is a slippage into collectivised responsibility, where power is positioned as something "we white people" have. The slippage between individual and social explanations of privilege seen in extracts 4.22, 4.23a, and 4.23b could represent an attempt to critique systems of power and privilege, where use of the collective "we" is intended to locate the student as a participant in settler colonial systems (domain 4.3). However, "we" also works to gloss over the more specific ways that the students themselves contribute to and benefit from these systems. While collectivisation was the most common way that students reflected on power, privilege, and

identity, a small number of students were able to consider this from a personal perspective, as can be seen in extract 4.24:

*Extract 4.24*

*one of the issues raised in the lecture was about white privilege and while I accept and appreciate my privilege (.) the wa:y they discussed the issue made me feel as though I was the reason why all Aboriginal people were experiencing their suffering (.) I felt guilty for feeling (.) victimised because I absolutely know this is not the case (.) and I suppose that is the point (.) to feel uncomfortable and challenged by my thinking (.) it made me realise that I do have privilege and if: (.) I use it in an in- inappropriate way (.) it could continue the suffering of Aboriginal people (.) however, I also can use- use it to improve their li:ves (.) and allo:w them to feel welcomed and equal* (T06 CR3 V1)

What is notable about the above extract is the role of emotion in the reflexive process; the student explicitly acknowledges that feelings of guilt facilitated a reflexive consideration of their own privilege. The student's emotional response aligns with the broader literature on student experiences of Cultural Safety education, where feelings of discomfort are ubiquitous (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Thackrah & Thompson, 2013). This account provides a unique insight into how feelings of discomfort can work as catalysts for deeper reflexivity and realisation, where the student is able to critically examine the reason for the discomfort. It also aligns with the theory underpinning the pedagogy of discomfort, which encourages students to "critique these emotions [and] uncover their unconscious privileges as well as their inherent acquiescence with dominant ideology" (Mills & Creedy, 2019, p. 2). Arguably, it is the ability to not just feel, but to also recognise and reflect on various feeling responses that has allowed the student to shift their understanding. For example, if the student

had remained in the feeling state of victimhood or guilt, it is possible to see how this might result in disengagement, anger, or resentment, all common responses to this type of learning (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Thackrah & Thompson, 2013).

Finally, domain 4.3 (*consideration of self as an active participant in settler colonial systems which perpetuate racism through the (re)production of dominant narratives and power imbalances*) was evident in relatively few video reflections, with facet 4.3a (*locates self as a participant in settler colonial systems and institutions*) more commonly expressed than facet 4.3b (*consideration of own role as an active participant in settler colonial systems and institutions*). Across both facets, there were two consistent patterns in the way students constructed their accounts of learning. The first and most common pattern evident in this domain was a consistent slippage from reflexive practice into critical analysis, which is exemplified in the following extract:

*Extract 4.25*

*I:: personally recognise that I'm an individual within a broade::r cultural, social, historical, and political context (.) and I understand that my interaction: ah between self (.) a:nd context has really: resulted in me gainin:g, u:m, some of the knowledges attitudes, an:d biases that are present in today's society ... we are tau:ght (.) i:n our school environment home and it is publicised right across the media (.) that the health gap betwee:n the Aboriginal and non-Aboriginal population is addressed when in fact (.) Australia as a country is the real issue (.) so I've now come to realis:e (.) u:m that the disparitie:s (.) faced (.) aren't so:lely about Aboriginal people (.) it's about the systems that, Australia as a country have built and continue to maintain which: (.) are the cause of inequity (..) I::'ve come to realise re:ally how much anger I hold towards the system* (T04 DN2 V1)

Here, the student initially locates themselves as "an individual within a broader cultural, social, historical, and political context", and reflects on how this context has shaped their "knowledges, attitudes, and biases". However, rather than examining the "interaction between self and context", the student shifts the focus of their account to "the systems", critiquing the sites of knowledge production and existence of inequities. The final line, where the student describes the "anger [they] hold towards the system" creates a separation between self and system, functioning to construct the student as morally just without further need to examine their own role within these systems, a pattern that will be discussed in more detail in section 4.3.2 (pp. 203-215).

The second consistent pattern relates to how students positioned themselves as active participants within settler colonial systems and institutions (facet 4.3b). In the few instances where this did occur, it was predominantly framed as an act of positive change, where students articulated how they might contribute to creating positive change in society, as can be seen in the following extract:

*Extract 4.26*

*simply by walking into a clinic and up to a desk, an Aboriginal person has already enga:ged in Western wa:ys (.) even before receiving any ca:re (.) which in itself is a complete embodiment of the Western conception of health (.) I can without a doubt say that I have never been required to enga:ge in another culture, which: reflects my privilege (.) because Western beliefs and values run so dee:p, critical reflection is necessary to redress the situation, and health professionals and the health sector must take responsibility: … the impact of colonisation is ongoing (.) it is o:ur issue, and we can mitigate the impact through Cultural Safety (.) as a non-Aboriginal Australian who benefits from colonisation (.) I certainly feel the*

*responsibility and obligation to endo:rse and engage in culturally safe practices* (T05 HD2 V2)

Here, the student is cognisant of how 'Western ways' shape the healthcare system and is able to reflect on their own privilege ('I have never been required to engage in another culture, which reflects my privilege'). Similar to extract 4.25 above, this potentially represents the student grappling with their own location within and contribution to colonial systems and institutions. However, their own participation in these systems and institutions and the perpetuation of racism is largely glossed over, and where responsibility is claimed by the student, it is conceptualised as creating positive change by "endorsing and engaging in" culturally safe practice.

#### *4.3.1.5 Alignment with grade bands*

Overall, there was relatively consistent correlation between grade band and level of reflexive practice. All videos demonstrated elements of descriptive and basic reflection; this was the predominant type of reflection displayed in the lower grade bands (Pass and Credit). In the higher grade bands (Distinction and High Distinction) students were more likely to utilise descriptive and basic as a basis for more critically reflective and reflexive accounts. Critical reflection and reflexivity were present across all videos, although there were limited instances in the lower grade bands; in the higher grade bands, there was more evidence of complex and nuanced reflexive practice. This pattern of results suggests a broad alignment between the levels of reflexive practice outlined in the LRP Framework and standard grade bands.

### 4.3.2 Question 2: How do students discursively construct their reflexive accounts of learning?

Analysis of the video transcripts revealed several consistent patterns in the way that reflexive accounts were discursively produced and managed by students. Two main themes – *constructing accountability* and *performative reflection* - were identified, with additional sub-themes under each. There are several parallels with the work of O'Driscoll (2013), whose thesis provided a discursive analysis of how white trainee counselling psychologists constructed accounts of learning and practice in relation to racial difference. One of the key findings relevant to the current analysis is the flexible and often contradictory ways that subject positions were constructed to manage accountability for racial prejudice. Specifically, O'Driscoll (2013) demonstrated that students drew on both "naïve/expert practitioner" and "victim of discourse" subjectivities to "constructively distance themselves from prejudice" (p. 92), with similar patterns of construction evident in the current data.

#### *4.3.2.1 Constructing accountability*

In their accounts of learning, students consistently used several discursive strategies and rhetorical devices to either avoid or take accountability for their knowledge and practices. A clear pattern was evident across the data; where there was a potential for knowledge and practices to be perceived as racist, culturally unsafe, or otherwise problematic, accounts of learning were constructed to minimise student accountability. Conversely, where there was a potential for knowledge and practices to be perceived as antiracist, culturally safe, or aligned with topic aims, students constructed themselves as agentic, emphasising their own accountability.

Minimisation of accountability was predominantly seen in accounts of previous knowledge, understanding, and learning, where students reflected on either their lack of knowledge (about colonisation, racism, or inequities) or on the racialised biases and beliefs they previously held.

The following extracts, taken from two points in the same video, illustrates what O'Driscoll (2013) terms the "naïve practitioner" (p. 68) – or in this case, the naïve learner – and the way that agency is flexibly managed to minimise student accountability:

*Extract 4.27a*

*I had minimal knowledge and understanding of the history of colonisation and the Stolen Generations, and the impact of these events for Aboriginal communities (..) while this is something that was briefly touched on in my secondary education, I:: do not believe that it was covered in nearly enu- (.) enough depth (.) um: as I was not awa:re (.) um until now, of the extent to which these events were detrimental to Aboriginal communities and how they continue to harm Aboriginal people today through intergenerational trauma* (T01 HD1 V1)

*Extract 4.27b*

*I acknowledge that I have challenged, many of my personal biases and stereotypes which I fell into the trap of believing* (T01 HD1 V1)

In the first extract (4.27a), the student describes their knowledge and understanding of colonisation and the Stolen Generations as "minimal". Responsibility for this lack of knowledge and understanding is assigned to the student's "secondary education", where these topics were "touched on briefly" but were not "covered in nearly enough depth". This is followed by an implied contrast to current knowledge and understanding ("I was not aware until now of the extent"), further emphasising the insufficiency of previous secondary education. In both cases, knowledge and understanding are constructed as driven by external agents (secondary education, university programs), with the upshot that the student's own agency and capacity to seek out information is glossed over and minimised.

In the second extract (4.27b), the student inhabits what O'Driscoll (2013) terms a "victim of discourse" subject position, where prejudice and racism are constructed as embedded in and ubiquitous throughout society and therefore unavoidable. Use of the metaphor "falling into a trap" both positions these stereotypes as external to the student and works to imply that the student was "tricked" into believing them, which functions to minimise the student's own role in knowledge production and reproduction. The collective upshot of these constructions is that the student can acknowledge that they held racist beliefs without taking any responsibility for them, thereby positioning themselves as the "unwitting racist".

Some accounts demonstrated a more nuanced management of accountability, where individual and collective subjectivity were flexibly deployed to either claim or share accountability. As in the previous extracts, which type of subjectivity was drawn on was largely dependent on whether beliefs, attitudes, or practices had the potential to be perceived as problematic (racist or culturally unsafe) or not (antiracist, culturally safe, or morally just). This is exemplified in extract 4.28:

> *Extract 4.28*
>
> *I myself am majoring in human resources a:nd so the video reiterated that I have responsibility to engage in culturally safe practice (..) the video also stated, that culturally unsafe practice (.) is a euphemism for racism, which again puts into perspective why Cultural Safety is our responsibility (.) we are the main perpetrators (.) and why: it is critical to practice* (T05 HD2 V2)

At the beginning of the extract the student utilises the singular first person when talking about their "responsibility to engage in culturally safe practice". In contrast, where the discussion shifts to "culturally unsafe practice" and the "main perpetrators" of racism, the student utilises the plural first person ("our", "we") to construct these as collective practices. This slippage

from individual to collective responsibility means that the student manages to construct a subjectivity that is both taking accountability for becoming culturally safe while diffusing accountability for any potential racism.

Where students claimed accountability for their learning, there was a notable absence of reflection on internalised racism, biases, stereotypes, or assumptions. Instead, the focus of these accounts was the absence or lack of knowledge, for example not being aware of or not understanding various concepts discussed in the topic. The upshot of these types of accounts is what van Dijk (1992) terms "positive self-presentation" (p. 88); students were able to explicitly discuss potentially sensitive topics like racism without being personally implicated. An example of this can be seen in extract 4.29:

*Extract 4.29*

*there were many terms that I hadn't heard of in this topic (.) u:m, but one of them was assimilation (.) u:m when I was researching the term, u::m, the meaning just seemed so ancient and backward to me (.) u:m I believed that society had grown away fro:m u:m this, train of thought where everybody should be like Western society (.) um I thought we had mo::ved into an a:ge of acknowledgement, u:m a:nd learnt to embrace, um other cultures, um but this is not what I found at all* (T02 DN1 V1)

Like extracts 4.27a and 4.27b, above, the student here begins by inhabiting a subject position of naïve learner, constructed initially through reference to the "many terms [they] hadn't heard of". In contrast to the previous extracts, however, there is no attribution of blame to a third party (such as "secondary education"). The vagueness of this description achieves two things. First, use of the extreme-case formulation "many" works to emphasise the extent of the gaps in the student's knowledge (Potter, 1996). Second, and relatedly, this also provides the student

with plausible deniability; any problematic beliefs, attitudes, or practices can be attributed to not knowing.

This contextual statement is followed by an account of the student's reflection on this learning, which has several key features relevant to the management of accountability and self-presentation. The first is the use of metaphors to characterise the student's response to the meaning of assimilation, which is described as "*ancient* and *backward*", and their previous beliefs about Australian society, where they thought "society had *grown* away from" assimilationist practices and that "we had *moved* into *an age* of acknowledgement and learnt to embrace other cultures" (emphases added). These metaphors invoke physical, temporal, and moral distance between the student's perception of society and assimilationism, characterising assimilation as old-fashioned and a part of distant history in contrast to an egalitarian present. The student positions themselves as aligned with the egalitarian present through use of the term "we" ("I thought we had…"), thereby implicitly distancing themselves from assimilationism and its associated ideologies ("everybody should be like Western society"). It also works to gloss over the student's own complicity in assimilationism or any deeper reflection on whether this type of thinking had shaped their own beliefs, attitudes, or behaviours.

Relatedly, students who identified themselves as international students, immigrants, or as non-white within their videos were consistently more likely to take accountability for both previous and future learning while simultaneously deploying their subjectivities to avoid examination of biases, stereotypes, or internalised racism. The following extracts, taken from the same video, demonstrate how subjectivity is deployed to manage accountability. In this video, the student identifies themselves as born in Australia to non-white immigrant parents. The first extract (extract 4.30a) demonstrates how category membership is used to construct a non-racist identity:

*Extract 4.30a*

*I was aware of the stereotypes and biases people held (.) towards Aboriginal people, and Torres Strait Islanders (.) however I can never look at a race of people and accept stereotyping [unclear] (.) I believe this is combination of two reasons (.) my parents' religious teachings, as a [religious affiliation], to look at the wo:rld (.) as one race, and one people (.) and because I'm in a very similar boat, I know the stereotypes about me are wrong, so it only made sense that that's probably the same for other people* (T02 HD2 V1)

In contrast to the previous extracts discussed, the student in extract 4.30a inhabits a subject position of "expert learner" (O'Driscoll, 2013), indicated by reference to already being "aware of the stereotypes and biases people held". As such, the student is unable to draw on ignorance as an explanation for racist or problematic beliefs, attitudes, or practices. Instead, the student draws on two types of category membership (Potter, 1996) to actively and explicitly construct themselves as non-racist. In the first, the student cites the religious teachings of their parents, which require them to "look at the world as one race and one people". This draws on commonsense notions of equality and egalitarianism; it also implies that this view of the world remains stable and consistent over time. The second category membership is constructed through the metaphor of being "in a very similar boat" to Aboriginal and Torres Strait Islander people, a metaphor which provides a colloquial shorthand for shared experiences of racism and discrimination. These categories work to reify the student's assertion that they "can never look at a race of people and accept stereotyping"; membership precludes this as a possibility. The collective upshot is that the student is able to build up a subject position which is both sensitive to the existence and impact of racism but also avoids any deeper examination of how racial ideologies, stereotypes, or biases might have influenced their own beliefs, attitudes, or practices.

Later in the same video reflection, the student reflects on their new learning in relation to colonialism:

> *Extract 4.30b*
>
> *when colonisation was talked about as being an ongoing practice, that has embedded itself as a founding pillar in our society, and how all new creations would include colonisation in our society (..) um was something I had never thought about and it took me some time to grasp what it meant (.) and how it worked (.) … I carry- carried socio-cultural views (.) from colonisation (..) which in today's time has woven itself (.) in service delivery, policy, funding, and organisation* (T02 HD2 V1)

Like extract 4.29, agency for learning is located with the student in extract 4.30b, indicated by the phrase "was something *I* had never *thought* about" (emphasis added); learning is something the student actively participates in rather than a passive process or something they are tricked into (as depicted in extract 4.27b). Perhaps more relevant, however, is the way the account of this new learning is discursively managed to minimise accountability in relation to systems of oppression. The slight pause and correction, seen where the student asserts "I *carry- carried* socio-cultural views from colonisation" (emphasis added) arguably demonstrates an awareness that the present-tense construction could be perceived negatively. The shift to past-tense construction works to create an implicit contrast between their "old self", who "carried socio-cultural views from colonisation", to their present self who does not. This is followed by a distinct shift from a first-person reflexive account of how colonialism influenced the student's "views" to an assertion that colonialism has "woven itself in service delivery, policy, funding, and organisation", thereby eliding the student's own complicity in colonialism. What is also

notable about this extract is the construction of colonialism as agentic (has "embedded itself", "woven itself"), which glosses over the role humans play in its maintenance and reproduction.

While the awareness of racism, egalitarianism, and temporal framing of extracts 4.30a and 4.30b could potentially indicate a more advanced level of understanding and reflexivity, a critical discursive analysis is concerned not just with what is said but what is achieved (Augoustinos & Every, 2007; Hook, 2001). The Cultural Safety (Ramsden, 2002; Taylor & Guerin, 2019; Williams et al., 2021), reflexivity (Finlay & Gough, 2003; Lumsden et al., 2019), and antiracism literature (Applebaum, 2010) all suggest that these are lifelong processes requiring constant vigilance and critical consciousness. However, taken together, extracts 4.30a and 4.30b construct a non-racist, socially aware, and agentic subjectivity, with the upshot that no further reflexive work is required. Ultimately, this provides an effective strategy to avoid deeper reflexive consideration of individual roles in the production and maintenance of racialised knowledges and systems of oppression.

Collectively, the above extracts demonstrate the various discursive strategies that students used to manage accountability. Accountability was consistently confined to what might be considered "safe" knowledges, attitudes, beliefs, and actions, where students were able to construct subjectivities that were morally acceptable and seen as ideologically aligned with topic aims. Conversely, students deployed a range of rhetorical devices and subject positions to avoid any accountability for knowledges, beliefs, attitudes, or actions that might be perceived as morally wrong, with a particular tendency to avoid any potential accusations of racism or discrimination.

#### *4.3.2.2 Performative reflection*

Building on the analysis provided above, the following section will examine performative reflection as another way in which positive self-presentation was constructed, where student accounts demonstrated performative allyship (Hesford, 2021; Kutlaca & Radke, 2023), virtue

signalling (Brown et al., 2022), and moral grandstanding (Grubbs et al., 2019; Tosi & Warmke, 2016). A key characteristic of performative allyship identified in the literature is an engagement in "easy, visible, and not costly actions" with little tangible associated change, including the use of symbolic imagery (Kutlaca & Radke, 2023, p. 4). An example of this in the current data is the use of metaphors as a type of symbolic imagery which were consistently used as a rhetorical shorthand to construct accounts of learning.

Two types of metaphors were commonly used throughout student accounts of learning. In the first, metaphors were used to construct the scale of learning that occurred and were generally deployed in instances where the student wanted to emphasise the contrast between previous and new understanding. For example:

> *Extract 4.31*
>
> *At the start of this topic (.) I had very limited knowledge on Aboriginal, and Torres Strait Islander health (..) this has not been something I have truly been exposed to (.) or thoroughly studied in the past (..) therefore, there has been an astronomical room for me to expand my knowledge on these subjects* (T01 P1 V1)

Here, the student uses extreme-case formulation (Potter, 1996) to emphasise their growth in learning. Their initial knowledge is described as not just limited but "*very* limited"; knowledge has not just expanded but expanded "*astronomically*" (emphasis added). As Potter (1996) notes, this type of discursive practice uses the "extreme points on relevant descriptive dimensions" (p. 187) to strengthen the persuasiveness of the account. In student accounts of learning, these types of formulations worked to persuade the marker of both the legitimacy and extent of learning that occurred. Notably absent in many of these accounts was detail of what was learned or how this learning would translate into clear actions that work towards health equity or antiracism.

Metaphors were also used to construct accounts of students' experiences of realisation during their learning. For example, idiomatic expressions like "opened my eyes", "illuminating", "dawned on me", and "light bulb moment" were used consistently throughout the reflexive accounts. These expressions draw on metaphors relating to vision and light, conveying the ability of the students to "see more clearly". Additionally, the descriptive nature of these expressions means that they are "robust … [and] not easy to challenge with specific facts or information" (Potter, 1996, p. 168). In other instances, metaphors were used to convey the students' emotional responses to the learning content, for example one student described their response to learning about racism, for example:

*Extract 4.32*

*I already had a brief understanding of what systemic racism- that occurs within the broader community however, the overwhelming statistics and supporting grey literature was quite frankly disgusting and honestly lit the spark of anger within me* (T01 DN2 V1)

The student begins the account of their reaction by describing the information they encountered as "quite frankly disgusting", where "quite frankly" is used to signal that the student is being honest in their assessment. This is followed by use of the metaphor "lit the spark", which implies the beginning of a fire or explosion, and coupled with an emotion like anger implies the potential for fury. Foregrounding anger as the primary response to learning works to position the student as passionate about injustice, with the upshot that the student inhabits a subjectivity of being morally right.

The above extracts demonstrate a consistent pattern across the data, and arguably, both types of metaphor serve a similar purpose in accounts of learning. They are shortcut statements that

allow the student to position themselves as aligned with ideologies of equity and social justice without the need for any deeper reflexive practice.

Students also demonstrated evidence of virtue signalling, evidenced by a consistent pattern of emphasising their own moral qualities. Specifically, students constructed a subjectivity that was explicitly non-racist and working towards social justice outcomes as seen in the extract below:

> *Extract 4.32*
>
> *the treatment of Aboriginal people in healthcare situations surprised me (..) I knew there were <u>some</u> injustices, but not- (.) to the extent that is experienced in reality (.) I have always been a believer in equality and tra- (.) <u>fair</u> treatment (.) growing up in the twenty first century I was <u>always</u> surrounded by people from different cultures, and inherently kn:ew that just because somebody looks different (.) or has different beliefs than me <u>does</u> <u>not</u> (.) make me <u>better</u>* (T06 CR3 V1)

Here, the student deploys several discursive strategies to construct their subjectivity as morally right. The use of extreme-case formulation ("*always* been a believer" and "*inherently* knew") works to establish social justice and equity as core, immutable aspects of the student's identity. It also establishes the student's subjectivity as beyond critique; they are already someone who embodies the core principles of Cultural Safety, therefore there is no need for a more specific examination of their beliefs about and attitudes towards Aboriginal and Torres Strait Islander people. Additionally, the student draws on the common trope of proximity to construct a non-racist subjectivity, seen in the reference to "always [being] surrounded by people from different cultures". miles-hercules and Muwwakkil (2021, p. 268) note that this type of virtue signalling is both self-validating and obfuscating, operating as complete and sufficient evidence of non-racist practices without any accountability to actually do so.

Conversely, some students engaged in a type of moral grandstanding, where their own subjectivities were constructed as morally correct and "on the right side of history" (Grubbs et al., 2019) in contrast to racist others, as seen below:

*Extract 4.33*

> *when we sta:rted talking about the prevalence of racism, in today's society (.) I continued to be astonished as to how there were some people in this world (.) that cannot treat others in the same way just because of their cultural background, or the colour of their skin* (T05 CR2 V1)

In contrast to the previous extract where injustices are constructed as existing independent of human action, in the above extract racism is perpetrated by "some people". This allows the student to situate themselves in contrast to these "racist others", whose behaviour is described as "astonishing", further reinforcing the construction of the student as non-racist. This aligns with what Rabii (2022) terms a differentiation frame, a rhetorical manoeuvre aimed at delineating themselves ("one of the good ones") from racist others (see also: Connelly, 2020). Collectively, the student manages to present a public image that aligns with the aims and objectives of the topic while neatly sidestepping the process of engaging in deeper reflexive practice.

Performative allyship, virtue signalling, and moral grandstanding allow students to engage in "safe" reflexivity, where their moral standing is not called into question. Arguably, these discursive practices can be seen as another way to avoid accountability. However, what is notable about these accounts is that through the employment of these discursive strategies, subjectivities are constructed in a way that attempts to avoid further scrutiny. If the student's own moral values and practices are aligned with those of the topic, there is no further need for deeper reflexivity and the student is able to maintain a socially desirable public image.

#### *4.3.2.3 Balancing reflexivity with the need to maintain positive self-presentation*

What is evident from the above analysis is that there is an inherent tension involved in the process of reflexivity in this context. On the one hand, student accounts of learning demonstrate an attempt to engage in reflexivity, seen in the identification and discussion of elements that align with the Levels of Reflexive Practice framework. On the other hand, what can also be seen is a consistent attempt to engage in positive self-presentation (van Dijk, 1992) through the deployment of subject positions that are constructed as either not responsible for racism (the "naïve learner" and "unwitting racist") or as factually non- or antiracist (performative allyship, virtue signalling, and moral grandstanding). Given the variation in learner knowledge and experience, these subject positions could reflect the intersection between personal agency and capacity and the embedded and normalised nature of racialised ideologies and narratives (Bonilla-Silva, 1997; van Dijk, 2006, 2012). However, discourse is not simple description but an act of construction (Augoustinos & Every, 2007; Hook, 2001; Potter, 1996); the discursive and rhetorical strategies employed in these student accounts work to construct subjectivities that protect the student from further scrutiny. The implications of these findings will be explored in more detail in the Discussion (section 4.4.2).

### 4.3.3 Question 3: Discursive management of racism: where is it challenged and where is it perpetuated?

Analysis of the data suggests that students are able to identify and challenge more overt forms of racism, such as inappropriate terminology, but consistently failed to identify or challenge the more ideological forms of racism, such as the use of deficit narratives, othering, or white paternalism.

#### *4.3.3.1 Identifying and challenging racism*

As demonstrated in the analysis of levels of reflexivity (section 4.3.1) there were very few examples of students explicitly identifying and challenging their own racialised beliefs,

assumptions, or attitudes. Where students did attempt to interrogate their own racism, a notable pattern was the absence of any reference to racism specifically; instead, students used broad or vague euphemisms, as seen in the following extract:

*Extract 4.34*

*I think this topic made me, very aware of my prejudice in general, u:m and the things that I need to be more aware of as a white person in Australian society* (T02 DN1 V1).

There are several interesting features of the above extract. The first line in particular does several things. Firstly, it establishes that the student has moved from a state of unknowing to awareness ("this topic has made me very aware"); moreover, the student is not just aware but "*very* aware" (emphasis added). Implicit here is the assertion that there is little more for the student to become aware of; they have "done the work". The object of this awareness is also interesting; use of the more general term 'prejudice' rather than the more specific (and relevant) term 'racism' works to soften the potential consequences to the student's social standing. Also notable is the lack of reference to any targets of this prejudice; instead, the student uses the vague term "in general". The upshot here is that in the context of the topic and assessment, "in general" can be inferred to mean Aboriginal and Torres Strait Islander people, but the vagueness provides the student with plausible deniability against any specific accusations of racism. In contrast, the student's own subject position is constructed through the specific category of "white person". As Potter (1996) notes, categories are often used as a type of conceptual shorthand, drawing on both social and contextually-dependant understandings to allow the reader to "fill in the blanks". In the context of this topic and assessment, "white person" works to signal an understanding that they inhabit a social position of privilege and power without the need to explicitly identify or critically examine either. Collectively, this

extract demonstrates how accounts of reflection on racism are discursively managed to construct the student as aware of racism but also do not explicitly implicate the student as *being* racist.

Another way that students discursively managed their accounts of racism was to construct racism as external and existing "out there", rather than an internalised process (O'Driscoll, 2013; Potter, 1996). An example of this can be seen in the following extract where a student is reflecting on their racist assumptions:

> *Extract 4.35*
>
> *however I thought the:se disparities were mostly a result of their own poor health choices (.) that I assumed were common in their community (..) you could say I was following th- ((does air quotes)) "but do:n't they bring it upon themselves" notion*
> (T06 HD1 V1)

The student initially locates racism as an internal process ("I thought", "I assumed"). However, this is tempered in the second half of the account, where racism is positioned as existing independently of the student. The use of air quotes plays a particular function here; they signal to the viewer/reader that the bracketed text is something said by other people. As such, they work to create distance between the claims being made in the quote and the views or beliefs of the speaker (Lampert, 2013). What is notable here is that the air-quote is not attributed to any particular source but rather worked up as a vague "notion"; this vagueness allows the student to shift blame to an unnamed other while also making it difficult to question the veracity of the account. It could be argued that this is an attempt to reflect on the embeddedness of racism within broader social structures and how this shapes and influences individual beliefs and practices, however, like many of the previously discussed extracts, what is also evident here is a minimising of accountability.

There was also consistent evidence of students attempting to actively manage their language, which potentially demonstrates what Schön (1983) terms reflection-in-action. This was evident in the pauses, word-searching, and mid-word corrections seen throughout many of the video reflections. The following extracts each demonstrate various types of this language management:

*Extract 4.36*

*I have also become aware of the difficult challenges that Aboriginal and Torres Strait Islanders (..) peoples have faced and still face* (T06 DN2 V1)

*Extract 4.37*

*as I said in the last video, I'm from Alice Springs, has a large (.) Indi- Aboriginal and Torres Strait Islander popula- ah (.) population* (T03 HD2 V2*)*

*Extract 4.38*

*so initially:: (.) ah learning the:: <u>finer</u> deta:ils regarding the British colonisation of <u>Australia</u> (..) u:m is where I really started to piece together the whole picture, an::d (.) um all of the (.) of (.) um British colonisation* (T04 CR1 V1)

In the first extract (4.36), the student fails to include personhood ("Aboriginal and Torres Strait Islanders"); there is a distinct pause (..) followed by "peoples". This pause suggests that the student realised and corrected their mistake in the moment. Similarly, in the second extract (4.37), the student begins to use the term "Indigenous" but stops themselves midway and corrects to the term "Aboriginal and Torres Strait Islander"[2]. These corrections arguably

[2] Students had been instructed to use the terms 'Aboriginal and Torres Strait Islander' or 'Aboriginal' rather than 'Indigenous', in line with the recommendations and preferences of the Aboriginal teaching staff.

indicate that students are cognisant of what constitutes appropriate terminology and were able to correct themselves in the moment (Augoustinos et al., 1999).

In the final extract (4.38), the account is punctuated by pauses (..) and fillers ('um', 'ah'). Initially, the student refers to the "finer details" and "whole picture" of British colonisation, which sets up the expectation that details of this will be discussed. Instead, this is followed by a series of pauses and fillers, and the vague description of "all of the British colonisation". Arguably, this suggests that the student is actively trying to navigate an appropriate way to discuss the British colonisation of Australia, which could potentially be considered a "delicate" or "difficult" topic to discuss in an appropriate manner (Sjoberg & McDermott, 2016).

#### *4.3.3.2 Deficit discourse, essentialism, and the centring of whiteness*

Collectively what the previous section demonstrates is a degree of willingness to challenge internalised racism under limited circumstances. For the most part, however, the more ideological aspects of racism remained unchallenged. Students consistently drew on three types of discursive formations: deficit discourse (Fforde et al., 2013; Fogarty, Bulloch, et al., 2018; Moreton-Robinson, 2015), essentialism (Moreton-Robinson, 2000/2020; Paradies, 2006b), and the centring of whiteness (Green et al., 2007; Moreton-Robinson, 2004). The extracts presented in this section variably demonstrate evidence of all three types, however, analysis of each extract will primarily focus on one type of discursive formation.

Fogarty et al. (2018) define deficit discourse as "a mode of thinking that frames and represents Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency, and failure" (p. 3). There are a range of discursive strategies that have been identified in the literature which contribute to the construction of deficit narratives (Fforde et al., 2013; Fogarty, Bulloch, et al., 2018). These overlap with findings from the critical discursive psychology literature and the strategies used to manage "race talk" (Augoustinos & Every, 2007; Augoustinos et al., 2002; Augoustinos et al., 1999), with several of these evident in the current data. For example, the

following extract demonstrates a "lifestyle fit" trope similar to that seen in Augoustinos et al. (1999):

> *Extract 4.39*
>
> *I found the continuing effects of the colonisation has on Aboriginal people (...) the taking away of their children the la::nd, and upsetting their whole li:festyles to assimilate (..) them into the European way of living and the damaging toll to their lives and health is completely shocking and devastating ... the health conditions and mortality rates of the children in these environments really hit me also (.) and it shows that putting them in a different environment and way of living is all changed (...) and fo:rced to live a certain way from their community (.) it's hard for them to understand how to live in this way and interferes with their quality of life*
> (T04 HD1 V1)

In their analysis of undergraduate psychology students' discussions of race relations in Australia, Augoustinos et al. (1999) identified a trope of "lifestyle fit", where Aboriginal and Torres Strait Islander people were positioned as responsible for contemporary inequities through a failure to adapt or "fit into" the dominant Eurocentric culture. This can also be seen in the above extract (4.39) where the student claims "it's hard for them to understand how to live in this way and interferes with their quality of life". There are three things of note here. First is the underlying assumption that the "problem" is a lack of understanding; this employs a form of *ontological gerrymandering*, which Potter (1996) defines as the process of constructing social problems by selecting "a particular range of phenomena as relevant and ignor[ing] other ones" (p. 184). In this case, "lack of understanding" is foregrounded as the relevant explanation for inequity, while other potential explanations – such as racism and oppression – are glossed over. Moreover, the assumption that "lack of understanding" is the

only explanation precludes consideration of alternative explanations, such as an active rejection of Eurocentric "ways of living".

The second thing of note is that the consistent othering ("them", "their") in conjunction with the lack of any qualifiers (for example, "some") works to construct this difficulty in understanding as an inherent trait of all Aboriginal and Torres Strait Islander people. The modalisation of this statement constructs it as a taken-for-granted fact that exists independently of the student, thereby making it difficult to undermine the claim being made (Potter, 1996). Relatedly, the final point of interest here is the way that this statement treats as unproblematic the expectation that Aboriginal and Torres Strait Islander people adapt to "European ways of living". While the student recognises the negative impacts of colonisation, the assumption that greater understanding would result in a better "quality of life" works to position whiteness as the standard to which Aboriginal and Torres Strait Islander people should aspire (Altman, 2018; Green et al., 2007; Moreton-Robinson, 2004).

Notably, deficit discourse and the problematisation of Aboriginal and Torres Strait Islander people occurred most often when students were discussing the cultural determinants of health. Despite a focus within the topic on cultural determinants as a point of strength and as a contributing factor to improved health and wellbeing, students more often framed cultural determinants as problematic and as contributing to health inequities. Further, the problematisation of cultural determinants often slipped into problematisation of Aboriginal and Torres Strait Islander people and cultures. This was most often seen in relation to family and kinship structures, as seen in the following extract:

*Extract 4.40*

*another example relevant to the determinant family and kinship (.) is that Aboriginal people generally have more complicated families, which therefore*

> *impacts negatively on the family's health (.) this made me think whether or not this statement has more to do with the fact, that they are Aboriginal, so cannot cope with their family issues due to other stresses they are under as a result of their background, rather than purely the fact that Aboriginal people have more complicated families* (T02 P1 V1)

Central to the above extract is a construction of Aboriginal and Torres Strait Islander people and family structures as causing negative health impacts. Augoustinos and Every (2007) note that the discursive management of racism often utilises a comparison between racialised groups and the dominant culture, where this difference is offered as an explanation for inequity. There are two examples of this type of comparison evident in the above extract. The first is the contrast between family structures, where the student asserts that "Aboriginal people generally have *more* complicated families" (emphasis added). This carries an unspoken comparison to non-Indigenous families who are implied to have less complicated families. The second contrast is implicitly worked up through the assertion that "they are Aboriginal so cannot cope with their family issues due to other stresses they are under as a result of their background". The term "*their* background" (emphasis added) implies that this background differs from that of an unspoken norm, and by framing this in relation to identity ("they are Aboriginal"), the implication is that Aboriginality itself is the cause of both "other stresses" and negative health outcomes (Fforde et al., 2013). Moreover, this is explicitly presented as a "fact", which constructs this assertion as "common knowledge" rather than the opinion of the student, with the upshot that this construction becomes difficult to undermine (Potter, 1996). While the extract arguably demonstrates an attempt to critically examine previous knowledges ("made me think"), it is fundamentally underpinned by deficit-based understandings of Aboriginal and Torres Strait Islander people.

Deficit discourse is directly linked to cultural and racial essentialism, which posit that cultural groups share distinct, stable traits and that these traits are the result of inherent biological (racial) differences (Harris, 2013; Paradies, 2006a), and this can be seen in both extracts above. In extract 4.39, Aboriginal and Torres Strait Islander people are worked up as unable to adapt ("putting them in a different environment and way of living … it's hard for them to understand how to live in this way"). In extract 4.40, Aboriginal and Torres Strait Islander people are worked up as having "more complicated families" and as unable to "cope … as a result of their background". In both examples, Aboriginal and Torres Strait Islander people are constructed as a homogenous group with shared, stable characteristics (inability to adapt or cope, complicated families), and these characteristics are offered as explanations for current health inequities.

In other instances, students demonstrated a form of essentialism rooted in stereotypical representations of "authentic Indigeneity" (Harris, 2013; Moreton-Robinson, 2000/2020; Paradies, 2006a). These types of accounts draw on "the 'traditional' versus 'contemporary' binary" (Moreton-Robinson, 2000/2020, p. 76), where those who look or live a certain way are perceived as more "authentically Indigenous" (Paradies, 2006a). This can be seen in the following series of extracts, taken from the same video reflection in which the student is reflecting on their decision to travel to the Northern Territory during semester. The first extract occurs near the beginning of the video:

*Extract 4.41a*

*I felt like it was re:ally important to have a- have a bit of a hands on approach to learning, um and to be honest I had never (.) really had any contact with Aboriginal and Torres Strait Islander peoples (.) um previously so I thought that it was,*

*probably a really good (.) place to um (.) get a bit of an understanding* (T02 DN1 V2)

Here, the student provides an account of their reasoning for travelling to the Northern Territory. Initially, the modalisation ("I felt") and use of extreme-case formulation ("really important") works to construct the trip as necessary while also establishing the student as committed to learning, thereby making it difficult to question or undermine their motivations or approach. This is followed by the statement "to be honest I had never really had any contact with Aboriginal and Torres Strait Islander peoples previously", where the use of "to be honest" works to frame this as a confession and underscores the facticity of the account. Taken together, these statements imply that "hands on learning" is not possible in their own location due to a lack of contact with – and by extension, opportunity to interact with – Aboriginal and Torres Strait Islander people. In contrast, the Northern Territory is positioned as "a really good place to get a bit of understanding", drawing on common stereotypes about where "real" Aboriginal and Torres Strait Islander people live (Johnston et al., 2016).

The second extract occurred approximately three quarters of the way through the video, and follows a brief description of the student's experiences in Darwin:

*Extract 4.41b*

*one beautiful thing that I did see here wa:s, generations of Aboriginal and Torres Strait Islander people sitting together on the land, u:m communicating a:nd (.) u::m (.) you- just being together, um, you know we lack a lot of that in our Western society, u:m and just, to see generation after generation sitting together on the land, was absolutely beautiful* (T02 DN1 V2)

Here, the student provides a distinct contrast between the cultural practices of Aboriginal and Torres Strait Islander people and "Western society", where the former are characterised as

"beautiful" and the latter are characterised as "lacking". Paradies (2006a) notes that constructions of "authentic Indigeneity" often draw on this type of contrast, where Aboriginal and Torres Strait Islander people are positioned as superior to non-Indigenous people in what he argues is an attempt to "mitigate their privileged position" (p. 360). Of note here is the way that the facticity of this account is constructed. The student then utilises a three-part list to describe Aboriginal and Torres Strait Islander cultural practices, which include "sitting together on the land", "communicating", and "just being together". As Potter (1996) notes, three-part lists are used to indicate "more than individual instances on their own but instances standing in for something more general" (p. 196). Additionally, the student positions themselves as both impartial witness ("I did see") and in-group expert ("*we* lack a lot of that in *our* Western society", emphasis added). Collectively, these discursive strategies work to establish the contrast between Aboriginal and Torres Strait Islander and Western societies as founded on impartial observation and insider expertise, making it difficult to undermine this account.

The above analysis also demonstrates student accounts fundamentally rely on the normalisation of whiteness as the yardstick against which Aboriginal and Torres Strait Islander people are measured. Deficit discourse by its very definition requires a standard against which deficit is measured, and this was implicitly and explicitly constructed in both the above extracts and throughout the data set. Similarly, essentialism relies on the underlying assumption of inherent and immutable group differences. Throughout the data, Aboriginal and Torres Strait Islander people and cultural practices were positioned as incompatible with Western sociocultural norms and practices. Both deficit discourse and essentialism rely on an underlying ideology of racial hierarchy, where whiteness is normalised as the standard against which Aboriginal and Torres Strait Islander people are compared.

## 4.4 Discussion

The above analysis highlights three key findings relevant to the research questions. First, that while most aspects of reflexive practice were demonstrated across the corpus of data, there were several consistent gaps and patterns in how students engaged in reflexivity. For example, very few students reflected on why they had an emotional response; no students reflected on how their beliefs, biases, or attitudes might shape their behaviour; and most were unable to consider themselves as active participants in racialised systems. Second, that there were consistent patterns in how students discursively managed their own accountability to maintain positive self-presentation. Third, that while students were able to identify and challenge more overt forms of racism, the more ideological aspects of racism such as deficit discourse and essentialism continued to underpin accounts of learning. An additional finding is that the Levels of Reflexive Practice Framework shows promise as tool for use in the assessment of student reflexive practice as a completed to existing standard grading rubrics.

### 4.4.1 Key findings

Collectively, these results suggest that in the context of a unit exploring Cultural Safety and Aboriginal and Torres Strait Islander health, there is an inherent tension for students attempting to engage in reflexivity. Students' ability to engage in deeper reflexivity – including the identification and critique of racialised knowledges, beliefs, and attitudes – is mediated by the need to maintain positive self-presentation (van Dijk, 1992). The articulation of worldviews and their influence on attitudes and practices, and the consideration of the self as an active participant in settler colonial systems and knowledge production were particularly challenging for students, and this is consistent with the findings of Castell et al. (2018). A possible explanation for these specific gaps is that both can be seen as matters of agency and choice, potentially implicating the student as actively choosing to engage in racist behaviours. Overt and intentional acts of racism are seen as socially undesirable (Applebaum, 2010; Augoustinos

& Every, 2007), and as such, would pose more risk to the student's self-presentation (van Dijk, 1992).

In contrast, students were more likely to acknowledge that their understanding and thinking had been shaped by racialised stereotypes. Arguably, acknowledgement of racist thinking and beliefs carries less risk, as responsibility for these can be assigned to external agents (such as "the education system"), allowing the student to inhabit a subjectivity of the "naïve/unwitting racist" (O'Driscoll, 2013). This was particularly evident in section 4.3.2, where a more fine-grained analysis of how student's constructed their accounts of reflexivity demonstrated a careful management of accountability. While there is a substantial body of literature examining how individuals manage explicit or implicit accusations of racism (see for example: Augoustinos & Every, 2007; Augoustinos et al., 2002; Augoustinos et al., 1999), the current research focused on how students managed reflexive accounts of their own internalised racism, and potentially highlights a new aspect of "race talk".

In addition to the management of self-presentation, another potential explanation for these results is the well-documented discomfort experienced by students when learning about Aboriginal and Torres Strait Islander peoples, cultures, and health (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Thackrah & Thompson, 2013). It is possible that the reluctance to engage in deeper reflexive work is a manifestation of student's discomfort and a resistance to learning; in this case, resistance to interrogating the way racism has shaped their own knowledges, worldviews, and attitudes. This aligns with the work of Mills and Creedy (2019), who utilised the *pedagogy of discomfort* as a framework to critically analyse student reflective essays in a First Peoples health course. The pedagogy of discomfort requires students to critically examine emotional responses to learning, to "uncover their unconscious privilege as well as their inherent acquiescence with dominant ideology" (Mills & Creedy, 2019, p. 2). The expectation is that critical engagement with these emotional responses will help students shift

from a position of *spectating*, where personal responsibility is avoided, to one of *witnessing*, where they recognise their own accountability. The analysis provided here showed a predominance of spectating, where students were able to acknowledge and discuss their learning regarding health inequities and their causes but avoided acknowledging any personal role in creating, maintaining, or addressing these inequities.

The desire to maintain positive self-presentation and avoidance of discomfort may also partially explain why students continued to organise their talk around racial ideologies and the deployment of racialised discourses. The avoidance of critical, reflexive consideration of their own role in the production and maintenance of racialised knowledges would, by extension, also mean that their own language practices remain unexamined. The attempts to use appropriate language suggest an awareness of and conscious effort to demonstrate respectful and non-racist talk. However, the prevalence of racialised discourse suggests that the more ideological aspects of racism embedded in their own thinking and practices – in this case the centring of whiteness and reliance on deficit discourse and essentialism – remain unrecognised and unchallenged.

More broadly, however, the evidence of racialised discourses may also reflect the embedded and normalised nature of racial ideology within Australian society (Watego et al., 2021). As van Dijk (2006) notes, ideologies can become so normalised that they "become part of the generally accepted attitudes of an entire community, as obvious beliefs or opinion, or common sense" (p. 117). In the Australian context, where Australian society is "structured through and upon race and racial dominance" (Watego et al., 2021, p. 7), ideologies of racial hierarchy and white hegemony inform all systems, institutions, and practices. Of note in the current analysis is that students were able to identify and critique racial ideologies and practices enacted by others or embedded in systems and institutions but were less able to examine this in their own beliefs and practices. This shares similarities with the findings of McDowall (2021), who noted that reflexivity is often non-linear and "messy" (see also: Pillow, 2003a). While McDowall's

(2021) analysis is ostensibly focused on the potential for students to be variably reflexive, the excerpts included from student journals show a similar pattern to the current findings, where the racism of others was easily recognised and critiqued, but the student's own racialised talk was not. This suggests that these ideologies may be more difficult for students to identify than more overtly racialised stereotypes and terminology, and therefore require more targeted educational strategies.

Despite the gaps in reflexive accounts and the evidence of racial ideology, the current research also demonstrated that while limited, engaging in reflexive practice assisted students to begin unpacking their own beliefs, assumptions, and practices, and to critically examine their sources of knowledge. While not a specific focus of the current study, the findings also suggest that the LoRP Framework may provide a useful tool in the development of curricula and assessments relating to reflexive Cultural Safety. As demonstrated in the current analysis, the LoRP Framework enabled the identification of consistent gaps in student reflexive accounts. Use of this Framework could enable educators to do the same, and to identify where their curriculum and teaching strategies could be strengthened to better support students in their development of reflexive capacity. Additionally, as noted previously, there is currently very little in the literature to guide educators in the development of teaching strategies for reflexive capacity development in the Cultural Safety context. As such, the LoRP Framework could provide educators with a more structured and consistent approach to developing teaching strategies in this space.

### 4.4.2 Considerations for teaching reflexive practice and directions for future research

Given the findings of the current study, there are several considerations for the design and delivery of curriculum relating to reflexivity in the context of Cultural Safety.

#### *4.4.2.1 Educational strategies to help students navigate the tension between reflexivity and positive self-presentation*

Perhaps the most pertinent question is how educators can more effectively support students to navigate the tension between assessment requirements to examine internalised racism and the need to engage in positive self-presentation, demonstrated in the above analysis. What is required, then, is the identification or development of teaching strategies that more effectively facilitate the navigation of these tensions.

The antiracism education literature provides a useful starting point, with several approaches that offer potential. For example, an emerging trend in antiracism literature in the United States is the use of art to facilitate deeper reflection and engagement with learning. In their commentary on the role of art in antiracism education and praxis, Griffith and Semlow (2020) argue that art can "disrupt mental models and worldviews" (p. 377), enabling people to critically analyse social systems and their own complicity within them. Likewise, Balhara Philip et al. (2023) argue that art can moderate the tension between learning which challenges long-held worldviews and the discomfort that can accompany critical reflection, operating as a "third thing" (p. 623). In a pilot study aimed at developing a digital image collection for health professions educators engaged in antiracism education, participant accounts demonstrate that engaging with visual art enabled a consideration of both positionality and broader social systems (Balhara Philip et al., 2023).

In the Australian context, Salmon and Kevin (2017) outline a series of case studies on art-based learning approaches. While not explicitly framed as antiracism education, one case study provided an account of how art was used as a focal point for learning about early relations between Aboriginal and Torres Strait Islander people and early colonialists. Analysis of student reflective assessments demonstrated that use of visual art as a pedagogical strategy increased learner empathy and facilitated explicit consideration of positionality and the self as a

participant within settler-colonial systems (Salmon & Kevin, 2017). A similar art-led learning approach was utilised within the topic in this research, although like Salmon and Kevin (Salmon & Kevin, 2017), was not explicitly used as an antiracism learning strategy. Future research could explore the potential of art-led approaches to facilitate more effective antiracism learning.

Alternatively, Applebaum (2010) suggests a *white complicity pedagogy*, which requires students to develop an understanding of "how even their best moral intentions must be scrutinized for their potential to reproduce racist systems" (p. 183). In this approach, students are encouraged to "cultivate a vigilantly vulnerable informed humility" (Applebaum, 2010, p. 329), to understand that while they cannot change their whiteness, they can be cognisant of how they benefit from, embody, and reinscribe whiteness. While this approach offers a clear theoretical foundation, as yet there are no directives regarding how to develop or deliver Applebaum's (2010) white complicity pedagogy. Additionally, this approach is developed in the context of the United States and is explicitly concerned with whiteness; how this might be adapted to the Australian context and be relevant to students who do not identify as 'white' requires further research.

The approach outlined by Pope and Shelton (2023), while not explicitly targeted towards unpacking racism or whiteness, also offers potential. Pope and Shelton (2023) used a modified version of Peshkin's *Subjective I's* model to facilitate student development of reflexive capacity. Here, students are required to consider their various subjectivities and how these might intersect with and shape their future practice. In the context of Cultural Safety education, this offers a potential opportunity for students to connect their own subjectivities with their future practice as health professionals. Likewise, Kowal et al. (2013) suggest a *reflexive antiracism*, which has a central focus on the concepts of racialisation and identity formation, and how these are linked to the production and maintenance of racialised social systems and

power imbalances. In an evaluation of a reflexive antiracism training program aimed at professionals working in the Aboriginal and Torres Strait Islander health context, Franklin et al. (2014) used the Reflexive Antiracism Scale – Indigenous (RAS-I: Paradies et al., 2013) to measure pre- and post-training levels of reflexive antiracism. While the results indicate significant changes in some areas and indicate at least a moderate increase in reflexive antiracism, the quantitative nature of the evaluation arguably does not capture much of the nuance and complexity of engaging in reflexivity. Further research into the potential of these approaches is required to explore their utility in negotiating the inherent tensions of being reflexive within the context of Cultural Safety education.

Relatedly, there is a need to identify effective strategies to facilitate student understanding of and ability to identify more ideological and discursive forms of racism. In the Australian context, Bargallie et al. (2024) argue that greater racial literacy is required for antiracism to be effective. Likewise, in a review of the Canadian nursing education literature, Bell (2021) suggests that for nurse educators to effectively train nursing students, greater racial literacy in order to effectively interrogate curricula, transform educational practices, and foster antiracist nursing students. To date, very few studies have explored strategies to develop students' capacity to critically identify or critique racialised narratives and discourses. One potential option is the *deconstruction exercise* outlined by Sjoberg and McDermott (2016), an essay-style assessment piece which requires students to critically analyse and deconstruct the racialised assumptions underpinning anonymously submitted questions. While it has not been empirically evaluated, the deconstruction exercise has shown promise as an approach to facilitate student criticality and identification of discursive racism (Sjoberg & McDermott, 2016). Notably, the deconstruction exercise was developed in the context of a postgraduate program, so its utility in undergraduate programs is yet to be determined.

#### *4.4.2.2 What counts as enough? Developing a scaffolded understanding of reflexive capacity development*

The approaches outlined in the previous section provide possibilities for future curriculum development, however, Kowal et al.'s (2013) approach is targeted towards adult professionals and Pope and Shelton's (2023) approach is intended for use with postgraduate students. While Applebaum's (2010) pedagogy does not specify a level of study, the complexity of the underpinning theory suggests it would be better suited to a postgraduate level of learning. Given that most Cultural Safety training occurs at the undergraduate level, it is questionable whether any of the three approaches would be suitable in this context.

More broadly, this raises questions about what a suitable curriculum looks like for undergraduate students, and what level of reflexive capacity development can be expected at first, second, third year, and beyond. A consideration of the revised Bloom's Taxonomy of learning (Krathwohl, 2002), which underpins the development of most learning and assessment objectives throughout tertiary education, shows that the development of reflexive capacity involves all aspects of the knowledge dimension and most of the cognitive process dimensions. At what point in their studies would it be reasonable to expect a student to demonstrate reflexive practice? The *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Department of Health, 2014) provides a potential starting point, with learning outcomes for the capability *reflection* mapped across three key descriptors (cultural self and healthcare, racism, and white privilege) and three levels of learning (novice, intermediate, and entry to practice). While one of the learning outcomes explicitly calls for reflexivity (11.3 Design practical strategies to enable ongoing self-reflexivity in a professional context; Department of Health, 2014, pp. 2-13), what it means to be reflexive is not clearly articulated. Alternatively, the levels of reflexivity outlined in the LoRP Framework could be utilised to build a scaffolded

framework for conceptualising beginner, intermediate, and advanced levels of reflexive capacity. Further research is required to explore the appropriateness and utility of this approach.

#### *4.4.2.3 The practicalities of teaching and assessing reflexive capacity development*

Arguably, the complexity of reflexivity and the need to scaffold capacity development requires that this content and learning is embedded across programs of study. However, in most cases Cultural Safety curricula is taught in conjunction with Aboriginal and Torres Strait Islander health curricula in standalone compulsory units of study, often in the first or second year of a program (Dawson et al., 2022). It is questionable, then, what level of reflexive capacity development is achievable in a one-semester unit of study. There are two potential ways to address this. The first is to embed reflexive capacity development throughout programs of study, beginning with an introduction and basic reflection in first year and progressing to more complex and critical reflexivity in the final year of study. In many health programs, reflective practice is included in units on communication, often in the first year of study. Effective scaffolding could build on this in subsequent years and would be well suited to units which aim to develop student's critical evaluation of the healthcare system.

The second option would be to ensure that Cultural Safety – and therefore reflexive practice – is not consigned to one standalone unit but is scaffolded and embedded across programs of study. This would more closely align with the original conceptualisation of Cultural Safety curricula for nursing and midwifery degrees in Aotearoa (New Zealand), where learning was scaffolded and embedded across all three years of these programs (Joyce, 1996; Wepa, 2003). It would also align more closely with the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Department of Health, 2014), where the novice, intermediate, and entry to practice level learning outcomes are intended to map onto the first, second, and third years of health programs. More broadly, a scaffolded curriculum is supported by the literature. In their review of Cultural Safety training evaluation literature, Mohamed et al. (2024) note

that longer training programs were recommended to facilitate a deeper engagement with the material and more transformative learning experiences, including greater awareness of identity, whiteness, privilege, and power (see also: Fleming et al., 2020; Gray et al., 2020; Mills & Creedy, 2019; Mills et al., 2022; Paul & McKivett, 2022). To date, there are very few examples in the literature of integrated Cultural Safety curricula (McCartan et al., 2021; Nash et al., 2006; Paul et al., 2019), and none have specifically explored the impact of this types of curricula on the development of reflexive capacity.

What is also evident from the current analysis is the complexity of student reflexive accounts, and this raises questions about the ability of educators to effectively assess the development and growth of reflexive capacity. Identification of the gaps in reflexive accounts, the discursive management of self-presentation, and the utilisation of racialised discourses required intensive, fine-grained analysis. Is it possible, then, for educators – who are increasingly under pressure to reduce marking hours – to effectively assess the complex, messy, and variable ways that students express and engage in reflexivity? (McDowall, 2021; Pillow, 2003a). Additionally, within the context of Cultural Safety and Aboriginal and Torres Strait Islander health content, several studies have highlighted both the variability in student preparedness to undertake and engage with this content (Bullen et al., 2017; Gray et al., 2020; Paul et al., 2006), as well as the spectrum of responses to this type of learning (McDermott, 2020). Indeed, if taken at face value, the reflections offered by students in the current study indicate a wide variation in prior knowledge and understanding. Add to this the inherent messiness of engaging in reflexivity, and it is questionable whether and to what extent growth in reflexive capacity is able to be captured.

Kember's (2008) four-level framework for assessing reflection has been used in several studies to evaluate levels of reflexive practice (Bruno et al., 2011; Castell et al., 2018; Glass, 2015). Similar to the current analysis, in each of these studies, Kember's (2008) framework was used

in conjunction with thematic analysis, and identified varying levels of reflective and reflexive practice. Arguably, the LoRP Framework offers a similar potential for use in the assessment of reflexive capacity development, with a more tailored and contextualised approach relevant to the context of Cultural Safety in Australia.

#### *4.4.2.4 The ethics of grading student reflexive accounts*

Finally, the broader ethics of grading student reflexive accounts must be considered. In the context of Cultural Safety, students are required to examine their own positionality, privilege, racialised knowledges, and participation in colonial systems of oppression. For many students this may be their first encounter with these concepts, challenging their understanding of their place in society and their very identity and sense of self. The argument here is not that this should be avoided; on the contrary, the critical and reflexive consideration of self (and all that entails) is essential to becoming a culturally safe practitioner (McDermott, 2020; Mohamed et al., 2024; Ramsden, 2002). What is worth considering are the ethical implications of assigning a grade to what might be an incredibly vulnerable moment of insight for a student. As Ryder et al. (2017) note, "for some it could be the first time they realise they may be a part of the problem rather than the solution" (p. 26).

In recognition of these concerns, some educators have opted to use non-graded assessments within their Cultural Safety curricula to encourage more honest and genuine reflexivity. For example, Bernhardt et al. (2011) discuss the inclusion of a reflection journal in a Cultural Safety unit of study, in which students were required to reflect on three cultural experiences. Journal entries were verified but not read, with the justification that "each individual's journey is her or his own, and the material diary-like, hence, private" (Bernhardt et al., 2011, p. 183). While a non-graded approach may facilitate a more uninhibited account, there is also the risk that students will not make a genuine attempt at reflexivity (Tsingos et al., 2015), and this risk has arguably increased in the wake of artificial intelligence programs like ChatGPT becoming

freely available and difficult to detect within written work. Even where students do make a genuine attempt to reflexively engage with their learning, in the absence of feedback, it is uncertain whether or how students would further develop their reflexive capacity.

A potential way to address these dilemmas is to develop assessment approaches which focus on the process of reflexivity rather than outcome. This type of approach is common in reflective assessments, which draw on well-established models of reflective practice such as Mezirow, Boud, Kember, and Schön (Tsingos et al., 2015). As Tsingos et al. (2015) note, while reflection often involves subjective elements such as emotions, it can be objectively assessed because "reflection on a critical incident is a *learning process* concerned not only with content of an experience but also with *how* one processes and learns from that experience" (p. 4, emphasis added). To date, there has been no comparable work undertaken in the field of reflexivity, perhaps because as Pillow (2003a) argues, to attempt to standardise reflexivity risks reducing it to a check box approach. Perhaps more pertinent, it is worth questioning whether the separation of content and process is possible, given that reflexivity is deeply entwined with the context in which it occurs. The LoRP Framework represents an attempt to identify stages or steps in the development of reflexive capacity, however, additional work is required to determine whether the current conceptualisation of the levels adequately capture what it means to engage in reflexivity.

### 4.4.3 Strengths and Limitations

#### *4.4.3.1 Strengths*

A key strength of the current study is the depth and richness of the data analysed. On average, videos were approximately 10 minutes long (ranging from 5 minutes to 15 minutes in length), equating to around 12 hours of data. While the videos were relatively short, this also allowed for the inclusion of more participants, thereby facilitating a much broader picture of students' engagement with and expression of reflexivity.

Another major strength was the novelty of the analytic approach taken. Much of the current reflective practice literature uses thematic analysis in conjunction with established reflective practice frameworks such as Kember et al.'s (2008) four-category scheme (Bruno et al., 2011; Castell et al., 2018; Glass, 2015). A similar approach was utilised here, with the LoRP Framework developed specifically for this project, providing a theoretically grounded framework to guide the thematic analysis of student reflexive videos. Given the discursive nature of reflexive practice, knowledge production, identity formation, and racism, the use of critical discourse analysis provides a unique approach to data analysis not seen elsewhere in the literature. As Wigginton and Lee (2014) demonstrate, thematic analysis and critical discursive analysis of the same data will highlight different – but equally relevant – aspects of the data. The two distinct approaches to analysis reinforce and support the findings of each other, and arguably lend weight to the validity of the findings overall.

Additionally, the use of the LoRP Framework provided a level of consistency in the analysis and draws on the work of experts across reflexive practice, Cultural Safety, and Australian race scholarship (Emirbayer & Desmond, 2012; Finlay, 2002b; Kowal et al., 2013; Lumsden et al., 2019; Mills et al., 2021; Moreton-Robinson, 2015; Pillow, 2003a; Sjoberg & McDermott, 2016; Watego et al., 2021). It was also developed in consultation with an Aboriginal colleague with expertise in both race scholarship and Cultural Safety education. As such, the LoRP provided a contextually relevant analytic framework to better understand reflexive practice in the context of colonial Australia.

#### *4.4.3.2 Limitations*

There are several limitations of the current research. As with most qualitative research (Braun & Clarke, 2013), the findings in this study are specific to the context in which the data was generated, and as such are not generalisable to the broader population. Notably, there are several contextual factors that may have impacted the results. While a video format was chosen

to encourage a more naturalistic approach to reflexivity, this may have unintentionally inflated the extent to which students engaged in positive self-presentation due to the increased visibility of the students. Another factor that may have impacted the results is the complexity of the topic learning outcomes. While reflexive capacity was the primary focus of the assessment, students were also required to demonstrate several other learning outcomes and this may have influenced the way students expressed their reflexive accounts. Arguably, however, these findings provide a foundation for understanding how students engage in and express reflexivity in the context of Cultural Safety education, and highlight some of the challenges in this space.

While the LoRP Framework provided a level of consistency in the analysis, it is also possible that the Frameworks does not adequately capture the nuance or complexity of reflexivity in the context of Cultural Safety education in Australia. As such, it may have skewed the results. However, as noted above, development of the LoRP Framework was informed by expertise in relevant fields of reflexivity, Cultural Safety, and racism, and as such represents the first step in establishing a more comprehensive understanding of reflexivity in this context. Relatedly, the LoRP framework is constructed to capture a progressive development of reflexive capacity, however as noted previously, reflexivity is an often messy process (McDowall; Pillow; others). What this development process looks like, and whether the levels, domains, and facets accurately articulate this process is an under-researched area. Additional research is now required to determine the appropriateness and utility of the LoRP Framework for use in Cultural Safety education across a variety of teaching institutions and programs.

Another limitation is the lack of analysis on gender and age differences in reflexive accounts. While age and gender identity information were available on the topic management site, individual age and gender information for each participant was not available. An attempt was made to select videos that approximated the gender distribution of the topic, but this was predominantly based on visual assessment of the student videos and familiarity with the student

cohort. Therefore, an analysis based on age and gender differences was not appropriate for this reason. Likewise, student status (domestic or international), ethnicity, and course enrolment data were not available at the individual student level unless explicitly disclosed by the student during their video. There is some evidence that domestic and international students hold significantly different attitudes towards Aboriginal and Torres Strait Islander people (Ramjan et al., 2016), and it is possible that other demographic differences may also impact both attitude and ability to engage in reflexivity. As such, an exploration of whether and how reflexive capacity development varies across demographic groups is an area for further research. Further, no analysis has been provided on the differences in reflexivity between the first and second videos. Given the complexity of the learning outcomes underpinning the assessment, the relative inexperience of most of the teaching team, and the potential impact of these on the student grades, it was felt that in this instance, this type of analysis would not have been appropriate. However, this is an important avenue for future research.

Finally, but perhaps most importantly, my own whiteness must be considered as a potential limiting factor in this research. I do not come to this research as a neutral observer, but as someone with inherent biases, assumptions and ideologies which influence both the type of work I undertake and the way in which I conduct my research. Notably, as the topic coordinator, I was primarily responsible for development and delivery of the curriculum outlined in this study; as such, I could be viewed as having a vested interest in demonstrating the efficacy of the curriculum in facilitating student reflexivity. To account for both my own whiteness and potential vested interest, I have engaged in reflexive thematic analysis throughout this research and employed several strategies to better understand and account for my own relationality to the project. A key strategy has been to engage in analytical journaling. At various stages throughout the research project, I have done a personal check-in to ask myself, '*What assumptions underpin my arguments or analysis?*' and '*Are there other ways that I might*

*interpret this data?*'. While I cannot claim this is a perfect solution, the process of pausing and reflecting did help me to work through several assumptions and their potential implications.

## 4.5 Conclusion

The current research suggests that the provision of structured guidance contributes to student development of reflexive capacity, with varying levels of reflexivity demonstrated across the data. Findings also demonstrate that students in higher grade bands demonstrated increasingly complex and nuanced reflexivity, suggesting that the LoRP Framework has some utility in the development of curricula and assessments relating to reflexivity. However, there were several consistent gaps in students' reflexive accounts, for example, students were able to identify emotional responses to learning but predominantly did not consider why they had responded that way; did not consider how their beliefs, biases, or attitudes might affect their behaviour; and most were unable to locate themselves as active participants within racialised systems. This was coupled with an overall tendency to engage in positive self-presentation and an inability to identify or challenge ideological forms of racism.

While students showed limited ability to consider the racialised nature of their own worldviews, values, and attitudes, they were able to consider the racialised nature of knowledge production more broadly and to an extent, how this shaped their own knowledge and understanding. Students also demonstrated attempts to challenge more superficial aspects of racism, such as appropriate language use. Collectively, these results suggest that more research is required to identify pedagogical strategies which more effectively facilitate students' development of reflexive capacity, including strategies to identify and challenge ideological forms of racism.

# Chapter 5: Closing the Gap: Examining how the problem of Aboriginal and Torres Strait Islander disadvantage is represented in policy

# Statement of Authorship

| | |
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| Name of Principal Author (Candidate) | Jessica Dawson | | |
| Contribution to the Paper | Conceptualisation; data collection and analysis; drafting and final write-up of manuscript for publication. | | |
| Overall percentage (%) | 70% | | |
| Certification: | This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper. | | |
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By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

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## Chapter overview

As noted in the Preface, the research that informs this chapter was undertaken early in the candidature and reflects a less developed understanding of racism. As such, the more structural and discursive forms of racism – which inform and shape the *Closing the Gap* policy (DFHCSIA, 2009) – are not explicitly identified or articulated. Rather, what is presented here is an approach to policy analysis which shares a number of similarities with reflexivity and represents a potential approach to expand reflexivity from an individual to a structural process.

Bacchi's (2009) *What's the Problem Represented to Be?* (WPR) analytic framework provides six questions to guide policy analysis. Used together, these questions facilitate a critical examination of the underlying assumptions and ideologies that inform policy development; a consideration of how particular representations of 'problems' have come about; identification of the silences and alternative problematisations; and what real world impact particular problematisation have (Bacchi, 2009; Bacchi & Goodwin, 2016). Reflexivity, as outlined in chapters 2, 3, and 4, is also concerned with identifying underlying beliefs and assumptions and where they came from; consideration that individual norms and practices are not universal; understanding the co-constitutive relationship between self and context (Causadias, 2020); and the potential and actual impact that assumptions and practices can have. Additionally, WPR and reflexivity share similar theoretical underpinnings, given that both are grounded in poststructuralism and the recognition that discourse, power, and knowledge intersect to construct some knowledges as 'objective' and 'commonsense' and others as 'subjective' and open to question (Bacchi, 2009; Bacchi & Goodwin, 2016; Finlay, 2002a; Lumsden et al., 2019; Pillow, 2003a). As such, the following analysis demonstrates the potential use of WPR as a form of structural reflexivity.

## Abstract

Policymaking is increasingly being recognised as a value-laden process in which social problems are not simply identified and measured but discursively produced. The current study examined how the problem of Indigenous disadvantage is produced within the original Closing the Gap policy framework, to identify underlying assumptions and problem representations. Bacchi's "What's the Problem Represented to be?" approach was used as the analytic framework, with critical discursive analysis used for a fine-grained discourse analysis. Findings indicate that the problem of Indigenous disadvantage is produced in culturally limited terms, demonstrates lifestyle drift and relies on deficit-based narratives of Aboriginal and Torres Strait Islander Australians, which collectively work to produce disadvantage as a product of individual behaviours, and problematises Aboriginal and Torres Strait Islander people as inherently dysfunctional. Potential lived effects of these discourses are discussed, and future areas of research are identified.

## 5.1 Introduction

Closing the Gap, the national policy framework for addressing Aboriginal and Torres Strait Islander disadvantage, is currently undergoing a significant refresh considering the limited progress made against the policy targets between 2008 and 2020. In the 2020 Prime Minister's annual report on Closing the Gap, only two of the seven targets were on track to being met within the policy timeframe (Department of the Prime Minister and Cabinet, 2020). Underpinning the refresh process is the new Partnership Agreement on Closing the Gap 2019–2029 (Council of Australian Governments, 2019), which recognises the need to move from a problem- and deficit-based approach to one that recognises strengths and capacities and ensures that policy targets and approaches are community driven. Much like the initial development

and implementation of Closing the Gap, the refresh process represents an important opportunity for achieving substantial improvement in Aboriginal and Torres Strait Islander health and socioeconomic outcomes and addressing some of the more problematic aspects of the original policy framework. A critical analysis of problem representations within the Closing the Gap framework will highlight the dominance of particular discourses, the way these shape policy approaches and lessons to be learned going forward. The following sections will provide a brief background to the Closing the Gap policy framework and our rationale for taking a policy-as-discourse approach to analysis.

### 5.1.1 Background

Health disparities experienced by Aboriginal and Torres Strait Islander people are well documented (2019a; Australian Bureau of Statistics [ABS], 2019b; Australian Institute of Health and Welfare [AIHW], 2015) and have been a source of national discussion and debate for over 50 years. Chronic and communicable diseases, mental health issues, injury and avoidable hospitalisations all occur at unacceptably higher rates for Aboriginal and Torres Strait Islander Australians than for non-Indigenous Australians (AIHW, 2015), with a current infant and child mortality rate two times greater than for non-Indigenous children (Department of the Prime Minister and Cabinet [DPMC], 2020). Additionally, the all-cause mortality has a rate ratio of 1.7 times higher for Aboriginal and Torres Strait Islander Australians in comparison with the non-Indigenous population (ABS, 2019a). Higher mortality rates are reflected in the enduring gap in life expectancy, where estimates indicate that Aboriginal and Torres Strait Islander Australians will live approximately 10 years less than their non-Indigenous counterparts (ABS, 2019b; AIHW, 2015).

In 2005, the Social Justice Report (Calma, 2005) highlighted the enormity of the health inequities experienced by Aboriginal and Torres Strait Islander Australians, most demonstrably through the then 17-year gap in life expectancy. Crucially, it also highlighted the structural fac-

tors contributing to health inequity, including the issues of healthcare and health infrastructure accessibility, education, and employment (Calma, 2005). The following year, "Close the Gap" became the public catch cry of the Campaign for Indigenous Health Equality, with the grassroots movement gaining widespread public support. In February 2008, the newly elected Labor government offered a landmark National Apology to the Stolen Generations (AIATSIS, n.d.). This was followed by the National Indigenous Health Equality Summit, where a Statement of Intent was signed by representatives from both the government and a range of Aboriginal and main- stream health organisations (Human Rights and Equal Opportunities Commission [HREOC], 2008). The Statement of Intent outlined a series of commitments made by the government to achieve health equality for Aboriginal and Torres Strait Islander Australians by 2030, including to work "collectively to systematically address the social determinants" that impact health (HREOC, 2008, p. 17). It also formed the basis for the development of Closing the Gap, the government's policy framework for addressing Indigenous health and socioeconomic disadvantage.

The government's bipartisan approach to Indigenous policy, coupled with the commitment to work in partnership with Aboriginal and Torres Strait Islander Australians to address a range of health and socioeconomic indicators, meant that Closing the Gap was viewed by many as a watershed moment in Australian policy (HREOC, 2008; Mackean et al., 2008; Mooney, 2008). The Council of Australian Governments (COAG) outlined a set of key targets with specific timelines, as well as a range of funding agreements with measures to address what were deemed to be the "building blocks" necessary to successfully meet the policy targets, which included early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership (DFHCSIA, 2009, p. 20). The specificity of target timelines, the bipartisan commitment and the substantial investment in funding and resources set Closing the Gap apart from previous policy efforts.

Despite its outward appearances, it has been argued that Closing the Gap is fundamentally no different from previous policy approaches (Altman et al., 2009; Marks, 2008; Pholi et al., 2009). Altman et al. (2009, p. 226) argue that the current focus on Closing the Gap is almost identical to previous governments' efforts to achieve "statistical parity" and that ostensibly, the only real difference is the specificity of timelines. Donato and Segal (2013) note that there were no changes to funding structures, and thus, current funding siloes continue to prevent a truly whole-of-government response. Altman et al. (2009) and Hoy (2009) have also questioned the likelihood of achieving policy targets in the stated timeframe, based on previous trends in the data and the complexity of intergeneration health issues.

Other critiques of Closing the Gap indicate more deep-seated issues within the policy framework. It has been noted that while the policy acknowledges and, to some extent, addresses broader social determinants of health, specific measures are predominantly aimed at individual and community behaviour change (Holland, 2018; Pholi et al., 2009). Others have noted a reliance on deficit discourse throughout the policy, which emphasises disadvantage and problems with little recognition of strength and capacity (Fogarty, Bulloch, et al., 2018; Pholi et al., 2009). Fogarty, Bulloch et al. (2018) note that a reliance on deficit discourse works to focus attention on the symptoms of disadvantage, such as individual and community behaviours, rather than the underlying structural causes. This discourse also carries the potential to further entrench negative stereotypes of Aboriginal and Torres Strait Islander Australians, as well as shifting blame to Aboriginal and Torres Strait Islander people for both their own disadvantage and the lack of policy success (Fogarty, Bulloch, et al., 2018; Pholi et al., 2009). Additionally, research by Howard-Wagner (2019) has demonstrated that the way disadvantage is conceptualised in the policy is fundamentally at odds with Aboriginal and Torres Strait Islander conceptualisations of disadvantage, where the former relies on neoliberal notions of individual socioeconomic success and the latter acknowledges the centrality of

racism, social exclusion and Aboriginality to current disadvantage (for a more detailed discussion of the concept of Aboriginality, please refer to Walter, 2009).

### 5.1.2 Defining the 'problem' of Indigenous disadvantage

While few would dispute the existence of widespread disadvantage for Aboriginal and Torres Strait Islander Australians, what constitutes and causes disadvantage is highly contested. A wealth of statistical data currently exist enumerating the gap in health and socioeconomic outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians (ABS, 2016; 2019a; AIHW, 2015). These data predominantly inform political and media discussions of disadvantage and have been used to inform policy development and funding priorities (see for example: DFHCSIA, 2009, pp. 10-17).

The rise of neoliberalism in recent decades has seen an emphasis on economic participation, where the engagement of Aboriginal and Torres Strait Islander people in the mainstream economy and education system is seen as key to addressing disadvantage more broadly (Marks, 2008; Mundine, 2018). This has been particularly evident since the late 1990s and the introduction of the Practical Reconciliation era of policy, where the Howard-led government rejected the so-called "symbolic" reconciliation in favour of measures that targeted employment, housing, education and health outcomes (Gunstone, 2008, p. 3). This has been "given moral authority" through the opinions of prominent Aboriginal and Torres Strait Islander leaders and commentators such as Noel Pearson and Warren Mundine (Altman, 2018, p. 181; Mundine, 2018), legitimising this viewpoint to the wider Australian public.

The focus on improving socioeconomic outcomes arguably reflects a specific understanding of the good life, where economic independence and participation in the mainstream economy are considered the hallmarks of success. Yet, this is at odds with how many Aboriginal people conceptualise the good life, where connection to country, family, community and language, as

well as the freedom to pursue culturally relevant livelihoods, are viewed as equally important (Altman, 2018; Bulloch & Fogarty, 2016; Dodson, 2007). It is also at odds with the findings of Howard-Wagner (2019), which suggest that simply improving socioeconomic outcomes does little to address other aspects of disadvantage such as racism, dispossession, family dislocation and social exclusion. Authors such as Dodson (2007), Marks (2008), Bulloch and Fogarty (2016) and Altman (2018) have argued that the focus on socioeconomic indicators is nothing more than thinly veiled assimilation, given that participation in the mainstream economy is premised on individual wealth building, which is fundamentally at odds with collectivist approaches.

Also evident in political and media discussions of Aboriginal and Torres Strait Islander disadvantage is a tendency to problematise Aboriginal and Torres Strait Islander people and cultures. This is particularly evident in critical analyses of the Northern Territory Emergency Response (NTER), a suite of policy and legislative changes introduced in 2007 in response to reports of child sexual abuse in remote Northern Territory Aboriginal communities. Analysis of the policy itself (Dodson, 2007; Mansell, 2007), as well as mainstream media accounts of the NTER (McCallum, 2013; Proudfoot & Habibis, 2015), demonstrates a rhetoric of inherent dysfunction, where Aboriginal individuals and communities are produced as incapable of self-management, prone to violence and antisocial behaviours, and ultimately responsible for their own disadvantage. This reflects a broader deficit discourse ubiquitous across political and media discussions of Aboriginal and Torres Strait Islander disadvantage, where Aboriginality is discursively produced in terms of deficiency and failure (Fogarty, Bulloch, et al., 2018; McCallum, 2013).

An emerging trend in policy analysis challenges the assumption that problems exist independently of policymakers, instead recognising that policymaking is an inherently constructivist activity; that is, problems are not simply described but are discursively produced

(Bacchi, 2009; Russell et al., 2008; Shaw, 2010). The juxtaposition between mainstream neoliberal and Aboriginal and Torres Strait Islander understandings of disadvantage clearly demonstrates that multiple understandings of disadvantage and its causes exist. We would argue, therefore, that a closer examination of the policy framework is warranted; specifically, how the problem of Indigenous disadvantage is produced, and the potential effects of this type of problematisation.

## 5.2 Methods

### 5.2.1 Approach

The current study used 'What's the Problem Represented to be?' (WPR: Bacchi, 2009; Bacchi & Goodwin, 2016) as the overarching framework for data analysis. Bacchi (2009) outlines six questions that can be used to guide the analysis of policy and other related documents. The questions are as follows (Bacchi, 2009, p. xii):

1. What's the "problem" ... represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the "problem"?
3. How has this representation of the "problem" come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be thought about differently?
5. What effects are produced by this representation of the "problem"?
6. How/where has this representation of the "problem" been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

The WPR approach takes as its starting point the recommendations for actions made in policy; the solutions to the problem being addressed. Through an examination of these proposed

solutions, the underlying assumption about the nature of the problem – that is, how the problem is represented – can be discerned. Bacchi and Goodwin (2016, p. 24) note that the WPR questions can be drawn on selectively as appropriate and that analysis is often an iterative process to unpack multiple layers of problematisation. The current study presents an iterative, integrated analysis focussing primarily on questions 1, 2, 4 and 5 (Bacchi, 2009). A full genealogy of the problem (question 3) is beyond the scope of the current analysis; however, questions 3 and 6 are addressed briefly in the previous section (5.1.2 "Defining the problem of Indigenous disadvantage").

Fine-grained analysis of how policy problems are discursively produced was informed by critical discursive analysis (CDA) and drew on the work of several authors in the field (Fairclough, 1985; Potter, 1996; Woolgar & Pawluch, 1985). Of interest in the current analysis is how knowledge about the problem is constructed through the normalisation of some discourses and the marginalisation and silencing of others, and who is positioned as having the right to define and enumerate the problem of Indigenous disadvantage. Rhetorical devices employed throughout the policy document were critically examined, to provide a more nuanced understanding of how some discourses are normalised and produced as real, which allowed for alternative explanations of problems to be identified (Bacchi, 2009; Fairclough, 1985; Potter, 1996; Woolgar & Pawluch, 1985).

The bulk of the analysis was carried out by the lead author. Problem representations were systematically identified and collated into themes; CDA was then used to provide a more nuanced understanding of how problems were produced. Results of analysis were discussed as a team, to provide a cross-check of findings and ensure a level of analytic consistency. Ethics approval was not required for this research, given that all data were publicly available.

### 5.2.2 Data sources

The current study takes as its focus the first of the annual Prime Minister's reports on policy progress, titled Closing the Gap on Indigenous disadvantage: The Challenge for Australia (DFHCSIA, 2009). In its entirety, the policy framework is comprised of the National Indigenous Reform Agreement (NIRA), which outlines in detail the targets, areas for policy action, benchmarks and measures of progress, as well as a suite of National Partnership Agreements. In addition, the Prime Minister's annual report on Closing the Gap provides a level of public accountability, where progress against the targets is outlined.

Here, we analyse the first of the annual Prime Minister's reports for the following reasons. First, the report represents the first policy document aimed at the general public and therefore represents an important opportunity to explore how the problem of Indigenous disadvantage is conceptualised and sold to a largely non-Indigenous public (Russell et al., 2008). As Russell et al. (2008) argue, policymaking does not occur in a vacuum. Governments must be able to convince the wider public of both the legitimacy and the necessity of their particular approach to policy. In Australia, where Aboriginal and Torres Strait Islander people make up around three per cent of the total population (AIHW, 2015), policy must appeal to a largely non- Indigenous audience.

Second, after a thorough examination of other potential data sources, including the NIRA and the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, significant similarities were noted across all three documents. Therefore, the decision was made to focus specifically on the first annual Prime Minister's report, as it was viewed as representative of the corpus of policy documents regarding how problems were discursively produced.

## 5.3 Analysis

Analysis of the data revealed three key aspects of problem representation within the policy document. First, that disadvantage is conceptualised according to neoliberal understandings of the good life, resulting in the silencing and marginalisation of Aboriginal and Torres Strait Islander voices and aspirations. Second, there is evidence of *lifestyle drift* (Hunter et al., 2010), where explicit descriptions of problems acknowledge structural factors, but solutions offered are reliant on individual behaviour change. Finally, that Aboriginal and Torres Strait Islander individuals and communities are problematised as inherently dysfunctional and resistant to change.

### 5.3.1 Constructions of the good life

Central to the Closing the Gap policy framework is a stated aim to achieve statistical parity between Aboriginal and Torres Strait Islander and non-Indigenous Australians, across six specific targets (expanded to seven revised targets in 2014: DFHCSIA, 2009; DMPC, 2015). The original targets highlight the underlying assumptions being made about the causes of disadvantage, and the dominance of neoliberal discourses of the good life (Altman, 2018). The original targets, outlined below in Extract 5.1, are found at the beginning of the first main section of the report:

*Extract 5.1 (p. 5, para. 1)*

**Setting clear, measurable targets**

For the first time, the Australian Government, together with the states and territories through COAG, has set specific and ambitious targets to address Indigenous disadvantage. The six key targets that form the Closing the Gap objective are to:

1. Close the life expectancy gap within a generation
2. Halve the gap in mortality rates for Indigenous children under five within a decade

3. Ensure access to early childhood education for all Indigenous four year olds in remote communities within five years
4. Halve the gap in reading, writing and numeracy achievements for children within a decade
5. Halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020, and
6. Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

The targets listed are those deemed necessary to 'address Indigenous disadvantage' (l. 3), where the underlying assumption is that disadvantage is characterised by statistical inequality across life expectancy, child mortality, early childhood education, schooling, and employment. Of note is the use of the key metaphor (l. 4) to describe these target areas, which implies that the only way to address the disadvantage experienced by Aboriginal and Torres Strait Islander Australians is via these particular areas. This is further emphasised in the second main section of the policy report, titled *The challenge facing Australia: The evidence* (DFHCSIA, 2009, pp. 9-17), where a range of statistical information is presented detailing the size and nature of the statistical gap between Aboriginal and Torres Strait Islander and non-Indigenous outcomes, grouped under sub-headings that align with the policy targets listed. The upshot is that these targets are presented as both a sufficient and complete explanation of Indigenous disadvantage, while other potential explanations for disadvantage are silenced.

The assumption that disadvantage will be addressed by improving health and socioeconomic outcomes alone relies on neoliberal understandings of what constitutes the good life (Altman, 2018; Bulloch & Fogarty, 2016). The targets themselves are essentially no different to those outlined under previous Practical Reconciliation approaches (Altman et al., 2009; Gunstone, 2008). Arguably this is reflective of the way that discourses shape and constrain the policy

making process, given that “practical reconciliation” had dominated political and media discussions of Indigenous disadvantage for 11 years prior to the introduction of Closing the Gap (Gunstone, 2008; Marks, 2008). Indeed, this rhetoric of health and socioeconomic disadvantage was evident in both the 2005 Social Justice Report (Calma, 2005) and the Close the Gap Campaign (Australian Human Rights Commission [AHRC], 2008), and underpinned the development of the National Indigenous Health Equality Targets (HREOC, 2008).

The literature highlights several potential issues that would be equally important in addressing the disadvantage experienced by Aboriginal and Torres Strait Islander Australians, which are not seen in the policy targets. These include issues of sovereignty, land rights and a voice in Parliament (Aboriginal and Torres Strait Islander Referendum Council, 2017; Mansell, 2007), self-determination, racism and social exclusion, and culturally appropriate and accessible health and social services (Holland, 2018; Howard-Wagner, 2019; Osborne et al., 2013). Arguably, one of the most significant absences from the listed tar- gets is the need to address racism and discrimination experienced by Aboriginal and Torres Strait Islander Australians. Evidence indicates that both can significantly impact physical and mental health and are key drivers of social and economic inequity, as racism and discrimination can limit a person’s ability to access health care, education and employment (DPMC, 2017; Ferdinand et al., 2013; Howard-Wagner, 2019; Paradies, 2006b).

It could be argued that the targets included in the policy framework are those that are practical and measurable, have a significant evidence-base to support their implementation, and would be viewed by both stakeholders and the general (largely non-Indigenous) public as a logical and appropriate investment (Russell et al., 2008). However, there are three key issues worth considering. First, the unreliable nature of statistical data pertaining to Aboriginal and Torres Strait Islander Australians due to identification issues (Altman et al., 2009). Second, the argument that evidence production is an inherently value-laden process that in Australia is

predominantly carried out by non-Indigenous institutions (such as the ABS), and arguably serves to normalise particular understandings of disadvantage and inequity (Bacchi & Goodwin, 2016). And third, the gerrymandering of the evidence presented; only some evidence is included as relevant, effectively silencing other forms of knowledge (Woolgar & Pawluch, 1985).

### 5.3.2 Lifestyle drift

Also evident throughout the policy is a consistent slippage from structural to individual explanations of disadvantage. The following two extracts provide an exemplar of this lifestyle drift (Hunter et al., 2010), focussing on the problem of life expectancy. Extract 5.2 (below) is taken from the section detailing the statistical gap in outcomes (DFHCSIA, 2009, pp. 9-17), and follows on from a numerical description of the difference in life expectancy:

*Extract 5.2 (p. 11, para. 4–5)*

1 Life expectancy is affected by many factors, including socio-economic status, quality and
2 accessibility of the health system, risk factor behaviour (tobacco, alcohol, nutrition, exercise),
3 social factors and environmental factors (e.g. over-crowded housing, poor drinking water and
4 sanitation).

5 Improvements to health outcomes will directly contribute to Indigenous life expectancy, and
6 are a priority for this Government. Chronic and preventable diseases are the areas requiring the
7 greatest action.

The first paragraph (ll. 1–4) in the above extract provides an explicit description of the problem of life expectancy. Specifically, it provides a list of identified "factors" that affect life expectancy, which collectively provide an explanation for the cause of lower Aboriginal and Torres Strait Islander life expectancy. The specific factors listed draw on both biomedical ("risk factor behaviour", l. 2) and social determinants ("socio-economic status...quality and

accessibility of the health system… social factors and environmental factors", ll. 1–3) models of health. It is notable that while the list provided represents a significant shift away from individualist explanations of health and life expectancy, it is still largely rooted in a Western health paradigm. Aspects such as connection to family and Country are absent from this list, despite evidence that they are significant contributors to Aboriginal and Torres Strait Islander health and wellbeing (Bulloch & Fogarty, 2016; Osborne et al., 2013). Arguably, then, the list provided here presents a somewhat culturally limited explanation of the life expectancy gap.

The second paragraph (ll. 5–7) begins to outline a proposed solution to the problem of Aboriginal and Torres Strait Islander life expectancy, and it is here that we begin to see the lifestyle drift. There is an initial suggestion that "improvements to health outcomes will directly contribute to Indigenous life expectancy" (l. 5); already, there is a shift from understanding life expectancy as the product of both individual and structural factors, to a focus on the individual experience of "health outcomes". This is further emphasised by presenting "health outcomes" as an issue of "chronic and preventable diseases" (l. 6), highlighting the dominance and privileging of biomedical understandings of health, while glossing over structural and Aboriginal understandings of health.

It might be argued that the structural factors listed in the first paragraph would be addressed elsewhere in the policy framework, given the recognition in Closing the Gap that "outcomes in one area [will support] outcomes in others" (DFHCSIA, 2009, p. 17). Yet the lifestyle drift demonstrated in the above extract (and explored in more depth in the following extract) is evident throughout the policy, reducing socioeconomic and educational inequity to issues of individual behaviour and responsibility. The following extract, taken from the section outlining the various National Partnership Agreements, provides a summary of the various measures included under the National Partnership on Indigenous Health Outcomes:

*Extract 5.3 (p. 20, para. 8–9)*

**National Partnership on Indigenous Health Outcomes**

Governments have committed $1.57 billion over four years through COAG to reduce the biggest risk factors, such as smoking, to improve chronic disease management and follow-up, and to expand the capacity of the health workforce to tackle chronic disease in the Indigenous population.

Over the next four years, this investment will result in more than 133,000 additional health checks and 400,000 additional chronic disease management programs for Indigenous people with a chronic condition, support for more than 160 new Indigenous outreach working positions, 75 extra health professionals and practice managers in Indigenous healthcare services, 38 new GP registrar training posts in Indigenous health services and expanded nurse scholarship and clinical placements.

Extract 5.3 provides a detailed account of how the "chronic and preventable diseases" (Extract 5.2, l. 6) will be addressed. Measures include: reducing "the biggest risk factors, such as smoking" (ll. 2–3); improving "chronic disease management and follow-up" (l. 3); and expanding the "capacity of the health workforce" (l. 4). Collectively, then, the problem of life expectancy and poor health outcomes is produced as a product of engaging in risk factor behaviours, poorly managed chronic disease, and limited health workforce capacity.

Individual risk factor behaviours "such as smoking" (l. 3) and chronic disease are positioned here as key drivers of poor health outcomes, and by extension lower life expectancy, and this is supported by the current data (AIHW, 2015). While these are important health factors to address, we would argue that this limited version of the problem both draws on and reinforces dominant lifestyle discourses (Baum & Fisher, 2014). Health outcomes are produced as an issue of individual choice and therefore individual responsibility. This sits in stark contrast to the social determinants of health outlined in Extract 5.2 (ll. 1–4).

An exception to this is the stated need to "improve chronic disease management and follow-up" (l. 3) and "expand the capacity of the health workforce" (l. 4). A list of measures aimed at achieving these outcomes is provided in lines 6–11, yet what is notable here is that *capacity* is imagined in terms of quantity rather than quality, by increasing numbers of programs and staff. Additionally, it is worth noting where this expansion is occurring; with the exception of the health checks and chronic disease management programs, the increases in staff numbers are in Aboriginal-specific health services. The problem of limited capacity, then, is located in the Aboriginal and Torres Strait Islander health sector, rather than the health workforce as a whole. There is certainly support in the literature for expanding the number and workforce of Aboriginal-specific services (Holland, 2018; Osborne et al., 2013), however there is also extensive literature arguing for the need to improve the accessibility and acceptability of mainstream health services as well (DPMC, 2017; Holland, 2018). Yet this is largely glossed over in the solutions listed here, effectively absolving the broader mainstream health system of responsibility and the need to change.

### 5.3.3 Constructions of responsibility

Together, Extracts 5.2 and 5.3 demonstrate the lifestyle drift that is evident throughout the policy, where Aboriginal and Torres Strait Islander people (individuals and communities) are positioned as primarily responsible for both the problem and the solution. This lifestyle drift is underpinned by a deficit-based narrative, where Aboriginal and Torres Strait Islander peoples themselves are problematized as lacking in a range of skills and abilities. In contrast to most of the document, where this narrative is more subtle, the following analysis examines a more explicit use of the deficit discourse narrative.

Extract 5.4 (below) is taken from a sub-section of the document, titled *Re-setting the relationship with Indigenous Australians* (DFHCSIA, 2009, p. 5). The first four paragraphs of the sub-section (omitted here) provide an overview of the Government's vision for how a new

relationship between Governments and Aboriginal and Torres Strait Islander Australians should look.

*Extract 5.4 (p. 5, para. 2–7)*

To achieve lasting progress, the Government will work in partnership with Indigenous Australians to address patterns of individual and community behaviour that may contribute to entrenched disadvantage. The Government is committed to finding ways to foster healthy relationships within and across families, peer groups, communities and organisations, and to support Indigenous communities in their efforts to deal with destructive behaviours, establish higher expectations and manage conflict.

In doing so, governments must nevertheless be prepared to respond when manifest failures on the part of individuals or communities places others at risk of harm. Governments have a responsibility to act quickly to provide immediate protection to those in need, but in doing so they must work closely with Indigenous Australians to develop communities and build responsibility and capacity over time.

The explicitly stated problem in the above extract is that Aboriginal and Torres Strait Islander individuals and communities are engaging in "behaviour[s] that may contribute to entrenched disadvantage" (ll. 2–3). A number of solutions are put forward to address this, which highlight the underlying assumptions being made about the nature and extent of the problem in Aboriginal and Torres Strait Islander communities: unhealthy relationships (ll. 3–4); "destructive behaviours" (l. 5); low expectations and an inability to manage conflict (l. 6); potential violence ("risk of harm", l. 8); and a lack of "responsibility and capacity" (l. 11). Collectively, Aboriginal and Torres Strait Islander communities are constructed as inherently dysfunctional, and Aboriginal and Torres Strait Islander individuals as lacking the responsibility and capacity to manage relationships or problematic behaviours.

Additionally, Aboriginal and Torres Strait Islander individuals and communities are positioned as not only incapable of self-management, but as reliant on significant levels of Government intervention to affect any kind of "lasting progress" (l. 1). Government involvement is softened through the use of language such as "work in partnership" (l. 1), "committed" (l. 3), and "support" (l. 5), yet what is alluded to is a significant level of Government surveillance of the community and individuals. It is worth asking, under what circumstances would non-Indigenous communities be subject to potential Government intervention due to the actions of individual citizens? This type of problematisation would suggest that the discourses of dysfunction and irresponsibility found within the preceding NTER policy (Dodson, 2007; Mansell, 2007) significantly shaped the way that the problem of Indigenous disadvantage was conceptualised in the Closing the Gap policy.

Potential accusations of victim-blaming and racism are carefully managed throughout the policy, an example of which is the use of the "pattern" metaphor (l. 2). By describing these behaviours as a pattern, the implication is that they occur with regularity and frequency; the Government is simply reporting what is there for all to see (Potter, 1996). The description of these behaviours is sufficiently vague, implying violence through terms such as "destructive behaviours" and "conflict" (ll. 5–6), and by intimating that people will be "at risk of harm" and in need of "protection" (ll. 8–9). This allows readers to draw their own conclusions about these behaviours, while avoiding the more explicit descriptions of community violence seen in the NTER, descriptions which drew substantial criticism (Dodson, 2007; Mansell, 2007; McCallum, 2013; Proudfoot & Habibis, 2015). While violence is an issue in some Aboriginal and Torres Strait Islander communities, arguably this violence is a result of disadvantage rather than the cause (DMPC, 2017). Yet here these behaviours are produced as causative factors, with the potential upshot being that Aboriginal and Torres Strait Islander people are positioned as responsible for their own disadvantage. However, the explicit link made between behaviours

and disadvantage are downplayed by the qualifier "may" (l. 2), constructing the link as possible rather than absolute, which in turn inoculates the Government against potential accusations of victim-blaming.

In contrast, the lack of qualifiers elsewhere in the extract, or indeed throughout the document, is noteworthy. There are no numerical qualifications to indicate that only some individuals and communities are experiencing these issues, thereby implying that the behaviours and dysfunction are endemic in all Aboriginal and Torres Strait Islander communities. Unhealthy relationships, "destructive behaviours", conflict, threat of harm, and a lack of responsibility and capacity are produced here as pervasive "patterns", and as normalised, everyday aspects of Aboriginal and Torres Strait Islander life. The construction of Aboriginal and Torres Strait Islander individuals and communities, and indeed Aboriginality itself, as inherently problematic and dysfunctional has been noted elsewhere (Fogarty, Bulloch, et al., 2018; McCallum, 2013; Proudfoot & Habibis, 2015). The consequence, then, is that not only is a significant level of responsibility for disadvantage apportioned to Aboriginal and Torres Strait Islander peoples themselves, but this construction also works to protect the Government against potential future accusations of failure; they have made significant financial investments, and have been "committed" (l. 3) to "supporting" (l. 5) and "working with" (l. 10) Aboriginal and Torres Strait Islander communities, but Aboriginal and Torres Strait Islander people must "do their part" and address their own dysfunction.

## 5.4 Discussion

The above analysis demonstrates three key intersecting aspects of the Closing the Gap policy: first, the limited way in which disadvantage is conceptualised, and reliance on neoliberalist assumptions about what counts as a good life (Bulloch & Fogarty, 2016); second, evidence of

life-style drift, where the problem of disadvantage is explicitly described in structural terms, yet proposed measures predominantly target individual behaviours; and third, that deficit discourse significantly influences both the subjectification of Aboriginal and Torres Strait Islander people, and the way that the problem of Indigenous disadvantage is understood. As noted by Holland (2018), the intentions to base the policy framework on partnerships between Aboriginal and Torres Strait Islander people and the Government were not borne out in practice, and this is reflected in the limited understandings outlined above; the culturally meaningful aspirations are conspicuously absent.

This is particularly important when we take into consideration an Aboriginal and Torres Strait Islander perspective on health and well-being. While there are multiple Aboriginal and Torres Strait Islander understandings of health, NACCHO (n.d.) provides a broad definition, which captures central aspects of many of the various models: "...the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community." The behavioural model of health seen in Extracts 5.2 and 5.3 does not reflect the above definition. While the focus on educational and economic outcomes (Extract 5.1) might to some extent contribute to social and emotional well-being, arguably they do not go far enough to address other structural issues like marginalisation, discrimination and the impact of intergenerational trauma. Cultural aspects of well-being are largely absent from the policy, with two exceptions. There is a reference to the government drawing on the "strengths of Indigenous cultures" and "working to improve the native title system" (DFHCSIA, 2009, p. 5 & 31, respectively). Yet in both instances, these are positioned primarily as a way to increase economic growth; their social, emotional and cultural benefits are only nominally recognised. Arguably, then, neoliberal understandings of health and the good life inform the way that the problem of Indigenous disadvantage is addressed.

The current findings highlight that one of the most important aspects of the policymaking process is the very act of identifying and describing the problem to be addressed. Our analysis suggests that the assumptions underpinning the policy may work to limit the appropriateness and efficacy of the measures, as they are neither culturally meaningful nor sufficient to address the structural barriers to health and socioeconomic equity. We would argue that adopting a strengths-based narrative and approach to policy has the potential to ensure culturally meaningful approaches, challenge pervasive stereotypes such as those seen in Extract 5.4 and ensure greater funding and resource efficiency (Brough et al., 2004; Fogarty, Lovell, et al., 2018; McPhail-Bell et al., 2018). Strengths-based community programmes have demonstrated health benefits for participants but go beyond an individual level of benefit to whole-of-community empowerment and have the potential to address broader social determinants (Brough et al., 2004; McPhail-Bell et al., 2018). This also provides the possibility of countering lifestyle drift, by shifting focus from individual problems to community strengths and capacities, although as yet there is little research specifically exploring this. Baum (2011) suggests that Closing the Gap provides a useful template for future policymaking efforts, yet the above analysis demonstrates that even within a seemingly robust social determinants-based policy, there is still evidence of lifestyle drift. Building the evidence base for effective policy measures against lifestyle drift should be a priority of future research.

Several of the above suggestions are included as part of the Closing the Gap Refresh Strategy (Council of Australian Governments, 2019). Recommendations include ‘genuine, formal partnership with Aboriginal and Torres Strait Islander people’, the need to incorporate strengths-based approaches and recognising the centrality of culture to health and well-being (Council of Australian Governments, 2019, p. 2). Arguably, then, the Refresh Strategy represents an important opportunity to address some of the issues identified in the current Closing the Gap framework. Worth noting, however, is that Closing the Gap, the NTER and

Practical Reconciliation were all greeted with a level of cautious hope because all promised either a revitalised way of addressing a long-standing disadvantage through whole-of-government approaches or indicated a serious commitment to making genuine change (Gunstone, 2008; Marks, 2008). Yet with each promise of a new and committed approach, the dominant neoliberal rhetoric of disadvantage, and the problematisation of Aboriginal and Torres Strait Islander people more broadly, has resulted in policies with limited reach and efficacy. Although there is much to be hopeful for with the Closing the Gap Refresh Strategy, it is also necessary to continue to critically examine the way that Indigenous disadvantage is problematised, and how this either enables or constrains policy approaches.

### 5.4.1 Limitations

Two limitations of the current study should be noted. Our decision to focus on the first Prime Minister's report, to provide a more focused analysis, may have limited our understanding of how the problem of Indigenous disadvantage was more broadly represented throughout the policy suite. Further, our analyses were undoubtedly influenced by our own personal world views, which predominantly reflect a Western viewpoint. To overcome this as a potential source of bias, we engaged in a constant process of critical reflection, with Aboriginal and Torres Strait Islander co-authors (KC, KH) and colleagues, and by referring back to the writings of Aboriginal and Torres Strait Islander scholars throughout the analysis.

## 5.5 Conclusion

Closing the Gap was lauded by many as a new approach to Aboriginal and Torres Strait Islander policy, given the broader focus on the social determinants of health (AHRC, 2008; Mackean et al., 2008; Mooney, 2008). Despite initial optimism, progress on Closing the Gap has been limited, with most targets still not on track (DPMC, 2020). The analysis presented here offers

potential insight into why so little progress has been made. Put simply, the way that a problem is understood and defined will determine the types of solutions available. The problem of Indigenous disadvantage is produced in culturally limited terms, demonstrates lifestyle drift and relies on deficit-based narratives of Aboriginal and Torres Strait Islander Australians. We argue that it is not just the effectiveness of policy measures that need to be refreshed, but the way in which the problem is understood needs to be critically examined. Strengths-based approaches and a genuine engagement with Aboriginal and Torres Strait Islander people may offer ways forward, to provide policy measures that are based on Aboriginal and Torres Strait Islander cultures and aspirations; how this will influence the future of Closing the Gap is yet to be seen.

# Chapter 6: Discussion

## 6.1 Overview

The specific findings of each study are detailed in the previous chapters; what will be provided in this final chapter is a consideration of commonalities across each study and their implications. The following sections will consider three overarching themes: the pervasiveness of racism; reflexivity and Cultural Safety as a starting point for addressing racism; and the need for additional clarification of reflexivity in the context of Cultural Safety.

## 6.2. The pervasiveness of racism

Given the discussion provided in Chapter 1, it is not surprising that racism was evident in the findings of all three studies. What is notable, however, is that across this body of research, racism was evident even where the aim was to reduce racialised inequities and address the occurrence and impact of racism. In other words, even where people – either individually or as part of institutional efforts – were trying to be non-racist or actively address racism, racialised discourses and ideologies were still evident. These findings arguably indicate that racism is pervasive; they also suggest that racism can manifest in ways that may be invisible to the individual and institutional perpetrators.

This was most evident in the analysis of the Closing the Gap policy (Chapter 5), where the overtly stated aims of addressing the social determinants of health and reducing racialised inequity were underpinned by assumptions of individual responsibility and deficit-based narratives (Dawson et al., 2021; Fforde et al., 2013; Fogarty, Bulloch, et al., 2018). Similarly, it was also evident in the analysis of student reflexive accounts (Chapter 4), where students

constructed subjectivities variously as non-/anti-racist, culturally safe, and social justice oriented (Kutlaca & Radke, 2023; O'Driscoll, 2013; van Dijk, 1992), yet consistently drew on racialised discourses and understandings of inequities that were founded on an ideology of racial hierarchy (Elias et al., 2021; Moreton-Robinson, 2015). Racialised discourses were less overt in the critical synthesis of the Cultural Safety literature (Chapter 3), yet were evident in the curricula design which positioned Indigenous peoples as the "object of study", either through curricula which took a focus on learning about Indigenous people or through the utilisation of Indigenous community members and educators as reflexive catalysts (Bond, 2014; Dawson et al., 2022). Collectively, what these studies have demonstrated is that even where the policy, curricula, or learning is well-intentioned, racial ideologies remain embedded within discourses and practices.

These findings align with the broader literature on racism, and particularly the work of Watego et al. (2021) and Elias et al. (2021), who argue that racism – both individual and institutional – is the logical outcome of a society founded on racialised power hierarchies and ideologies. As van Dijk (2006) argues, ideologies can become so pervasive that over time they become seen as "common knowledge", and the current body of critical discursive work in Australia examining the construction and management of "race talk" suggests that ideologies of racial hierarchies have attained this status (Augoustinos & Every, 2007; Augoustinos et al., 2005; Augoustinos et al., 1999). These findings also support the arguments made by Applebaum (2010) and Connelly (2020), who both point to the dangers of assuming that a lack of overt racism equates to being non- or anti-racist. While none of the data analysed in this thesis used any overtly racist language – the types of racial slurs that are commonly understood to constitute racism (Augoustinos & Every, 2007; Garner, 2010) – all data demonstrated evidence of racialised ideology and discourse.

Garner (2010) asserts that racism is not well understood by the general population, and there is literature in the Australian context to support this. In some research, there is an identified lack of understanding regarding key concepts relevant to the operation of racism. For example, Sonn (2008) provides an anecdotal account of teaching an intercultural psychology class, and notes that while students were often engaged and receptive to learning about racism, there were notable blind spots in relation to the operation of whiteness and white hegemony. Similarly, in a qualitative study of allied health professional's understandings of and feelings about antiracism, Prince (2024) found that there were limited understandings of whiteness and white privilege. Additionally, while nearly all participants understood racism as an individual practice, just over half of participants understood it as institutional or structural.

More broadly, several studies have found that participants demonstrated variable and often limited understandings of where and how racism operates. Qualitative interviews with 31 South Australian healthcare providers by Grant and Guerin (2018) conducted focus groups with 31 South Australian Child and Family Health Nurses (CaFHNs) to understand how their perceptions, definitions, and experiences of racism in the workplace. Similarly, D'Costa et al. (2023) conducted interviews with 49 Australian hospital staff to understand how they define racism and its impacts on healthcare provision. In both the Grant and Guerin (2018) and D'Costa et al. (2023) studies, participants' understandings of racism were predominantly as an individual set of beliefs, attitudes, or practices, with limited understanding of how it operates at institutional or structural levels, or how power and privilege are central to its operation. As Applebaum (2010) argues, the normalisation of racialised systems, knowledges, and practices requires a constant vigilance and a willingness to sit with discomfort. However, what the current body of research suggests is that in order to *be* vigilant, a more comprehensive and nuanced understanding of racism is required. As such, there must be a greater focus on all forms of racism within Cultural Safety education (Rashid et al., 2021) in order to achieve the stated

aim of providing care that "is holistic, free of bias and racism" (Ahpra & National Boards, 2020, p. 9).

## 6.3 The potential of reflexivity as a critical strategy to address racism

Despite the pervasiveness of racism, the findings of each study also indicated the possibilities of reflexivity as a strategy to identify and challenge racism, at both the individual and systemic level. At the individual level, students demonstrated a willingness and capacity to identify and critique racism (Chapter 4), and while in most instances this was directed externally to consider racist others and systems, there was also some evidence of students examining their own thinking and attitudes, as well as limited ability to connect their own understandings to racialised knowledge systems (Watego et al., 2021; Williams et al., 2021). More broadly, while most accounts demonstrated discursive management of subjectivity and attempts to construct a positive self-presentation, arguably this also suggests that to at least some extent, students understood and valued a non-racist identity.

As noted in Chapter 4 (pp. 204-205), this must be considered in context; these reflexive accounts were part of an assessment piece, and as such, this performance of non-racist identity may simply be a way to meet assessment criteria. Given the potential influence of the educational and assessment context on how students engage in the reflexive process, there is some debate in the literature as to whether it is appropriate to assess student reflexive accounts. For example Bernhardt et al. (2011) included a non-graded reflexive journal, with the reasoning that it would provide students with a level of privacy and freedom to express their thinking and reflections, resulting in more honest reflections. However, given that reflexivity is a core capacity of culturally safe practice (Hall et al., 2023; McDermott, 2020; Mohamed et al., 2024; Wilson, 2014), and the fact that Cultural Safety is now an accreditation and registration

requirement for many health professions in Australia (Ahpra & National Boards, 2020, 2022), there is arguably a need to assess students' reflexive capacity development.

The literature included for analysis in Chapter 3, however, demonstrates that there is very little known about best practice approaches to assessing the development of reflexive practice (Dawson et al., 2022). Of those studies which outlined an assessment approach, most utilised reflexive journals or portfolios, however, there was little consistency in how the content was assessed. The Levels of Reflexive Practice (LoRP) Framework developed for this thesis and outlined in Chapter 4 provides a potential starting point for developing more a more consistent and structured approach to assessing reflexive capacity development, given that it draws on both reflexive theory as well as the Cultural Safety literature to establish purpose. However, the LoRP Framework was developed specifically to evaluate reflexive capacity development in a learning and teaching context, so there is some question as to whether it articulates all relevant aspects of reflexivity. For example, there is a substantial emphasis on knowledge production with consideration of how this knowledge shapes beliefs, attitudes, and behaviours; however, there is very little consideration of how whiteness is an embodied set of practices which reinscribe and reinforce racialised power dynamics (Applebaum, 2010), or the role and impact of disciplinary knowledges and practices (Walsh, 2003; Wilkinson, 1988). This could be incorporated through a reflexive consideration of how students behave and operate within different contexts, such as in-class discussions (Sonn, 2008), experiential learning activities (Bolton & Andrews, 2018; Duthie et al., 2013; Fleming et al., 2017), or practice placements (Hart et al., 2015; Power et al., 2020). Additional research is required to further build on the LoRP Framework to more effectively capture what it means to engage in reflexivity as part of culturally safe practice, both within the health sciences and within other fields in which Cultural Safety is being utilised, such as social work (Duthie et al., 2013) and education (Thorpe & Burgess, 2012).

At the systemic level, Chapter 5 demonstrated the potential utility of the *What's the Problem Represented to Be?* (WPR: Bacchi, 2009) approach as a method of engaging in reflexivity at the systemic level, one which could be incorporated into the policy making process itself. WPR parallels the reflexive process in several key ways, and these are outlined in Table 6.1.

***Table 6.1: Parallels between the WPR Questions and the reflexive process.***

| **WPR Questions (Bacchi, 2009, p. xii)** | **Reflexivity** |
|---|---|
| What's the "problem" . . . represented to be in a specific policy? | Identification and articulation of knowledges and beliefs. |
| What presuppositions or assumptions underlie this representation of the "problem"? | Identification and critical consideration of assumptions and biases, and how these shape attitudes. |
| How has this representation of the "problem" come about? | Reflection on where knowledges, understandings, and biases originated; understanding connection between context and personal understandings. |
| What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be thought about differently? | Understanding and recognition of differing ways of knowing, being, and doing; own cultural norms are not universal. |
| What effects are produced by this representation of the "problem"? | Reflection on how beliefs, biases, and attitudes shape behaviour; consideration of own racialised practices. |
| How/where has this representation of the "problem" been produced, disseminated and defended? How could it be questioned, disrupted and replaced? | Reflection on complicity; reproduction and normalisation of racialised discourses and practices. |

Arguably, some may question how comparable the WPR approach and reflexivity are, given that emotion – and the working through of emotional responses – is a key aspect of reflexive, transformative learning (McDermott & Sjoberg, 2012; Mills & Creedy, 2019; Mills et al., 2021). However, given that policy cannot reflexively analyse itself, this represents a potential way to extend reflexivity from the self to the system. Indeed, in the last 5 years, a growing body of research has utilised the WPR framework to critically examine the ways in which "problems" are represented within Aboriginal and Torres Strait Islander policy (Burgess & Lowe, 2022; Burgess et al., 2023; Gordon, 2022; Guenther et al., 2020; Lowe et al., 2024; Street et al., 2020), as well as in government reports (Shay & Lampert, 2022) and media narratives (van Burgel et al., 2023). Collectively, what is evidenced in these analyses is a reliance on deficit narratives, problematisation of Aboriginal and Torres Strait Islander peoples and cultures, and a silencing of Aboriginal and Torres Strait Islander voices, aspirations, and needs. As such, the WPR approach arguably offers a useful framework for examining the racialised assumptions, discourses, and ideologies which inform Aboriginal and Torres Strait Islander policy.

Notably, however, each of the above analyses – including the analysis of Closing the Gap offered in the current research – have been conducted on existing policies. As such, while these analyses provide useful insights, it is questionable whether and to what extent they can influence current policy outcomes or future policy making, given the complexity of the policy making process and the identified gap between release of research findings and incorporation into policy measures (Althaus et al., 2020). Arguably, then, it would be useful to incorporate WPR analysis into the policy making process, for example as part of the policy drafting stage.

Given the demonstrated silencing of Aboriginal and Torres Strait Islander voices, aspirations, and needs within policy (Burgess & Lowe, 2022; Lowe et al., 2024; Shay & Lampert, 2022; van Burgel et al., 2023) it is imperative that any attempt to incorporate the WPR approach into

the policy making process be led by Aboriginal and Torres Strait Islander people. Several studies (Maxwell et al., 2018; Patrick & Moodie, 2016; Street et al., 2020) have utilised the WPR approach in conjunction with Critical Race Theory, in recognition of the need to more explicitly examine issues of racialisation and power within policy. In their comparative analysis of the Uluru Statement from the Heart and contemporary government policy, Lowe et al. (2024) found that while the WPR approach provided a useful foundation for analysis, it did not adequately "foreground Indigenous standpoint, sovereignty and aspirations", and required that "deep-seated colonial assumptions … be much more explicitly problematised in policy analysis" (p. 66). Lowe et al. (2024, p. 66) offered an additional set of five questions which foreground sovereignty, relationality, self-determination, and power; applied to contemporary government education policy, these five questions identified a significant silence in regard to acknowledging sovereignty, colonialism, and self-determination. As Watego et al. (2021, p. 7) assert, racism cannot be adequately addressed until the racialisation and racial dominance which underpins Australian society is overcome. Incorporation of an adapted WPR approach utilising the additional questions developed by Lowe et al. (2024) may provide a more targeted, appropriate, and useful method for challenging the racialisation underpinning contemporary and future policy.

### 6.3.1 Pedagogical approaches which facilitate a more authentic reflexive process are needed

Adaptation of the WPR approach and Lowe et al.'s (2024) questions could also be explored as a potential pedagogical strategy to encourage individual reflexive practice. As noted above, students struggled to identify their own racialised thinking and beliefs; potentially, students could utilise an adapted version of the WPR questions and Lowe et al.'s (2024) questions to examine the assumptions that underpin their own thinking, the origins of these assumptions, and the impact they have on their attitudes and practices. While Lumsden (2019) argues that

the provision of structured guidance may encourage a more "check box" approach to reflexivity, arguably there is also a need to start somewhere, and that perhaps a "checkbox" approach may assist in the development of a baseline level of understanding and capacity. The WPR analytic framework takes a similar approach to that used by Sjöberg and McDermott (2016) in their *deconstruction exercise*, where students were supported to unpack rather than answer their chosen essay question and identify underlying racialised discourses and assumptions through a structured learning process. In their analysis of a corpus of deconstruction assessments, Sjöberg and McDermott (2016) noted that students were able to identify and critically examine the racialised discourses underpinning the essay questions and were also able to reflexively connect these to their own thinking, assumptions, and experiences. What Sjöberg and McDermott (2016) argue is that a more objective approach works to "diffuse sometimes emotive and/or difficult teaching and learning spaces" (p. 30), which may make it less likely for students to disengage from the analytic and reflexive process.

What Chapters 3 and 4 also indicate is that there is a need to develop more targeted pedagogical strategies and assessment processes to build and assess reflexive capacity development. The available research on reflexive pedagogy and assessment is predominantly found in the research training (Hsiung, 2008; Orange, 2016) and pre-service teacher fields (Feucht et al., 2017), and very little provides any specific consideration of the racialised nature of these disciplines.

While there is a dearth of research on reflexivity in relation to Cultural Safety education or practice, there are insights that can be gleaned from the Indigenous Studies, antiracism, and reflexivity literature. Mills and Creedy (2019) examine the potential of using a *pedagogy of discomfort*, where students are encouraged to critically analyse the uncomfortable emotional responses experienced during their learning and critical examination of ideological assumptions. This approach recognises that discomfort, resistance, anger, guilt, and denial are

all commonly experienced by students when confronted by the realities of colonialism and racism (McDermott & Sjoberg, 2012; Mills et al., 2021; Thackrah & Thompson, 2013). Rather than avoiding these emotions, acknowledging and critically analysing them can facilitate deeper insights and "students may uncover their unconscious privileges as well as their inherent acquiescence with dominant ideology" (Mills & Creedy, 2019, p. 2). Ultimately, this approach seeks to produce transformative learning experiences (Mezirow, 1997), with the assumption that these will result in changes to knowledges, beliefs, attitudes, and practices.

While a pedagogy of discomfort may facilitate a more productive engagement with feelings of discomfort, McDowall (2021) argues that the underlying premise of transformative education ignores the messy reality of reflexivity (Pillow, 2003a). Rather than a linear progression from 'untransformed' to 'transformed', McDowall (2021) suggests that an *uncomfortable reflexivity* is required, which recognises the complexity of identity, positionality, and relationality. By drawing on Nakata's (2007) *cultural interface*, McDowall (2021) seeks to avoid dichotomising identity, and in this way shares some similarity with the notion of *reflexive antiracism* put forward by Kowal et al. (2013). Kowal et al. (2013) argue that much "diversity" training relies on the essentialisation of identity and the positioning of all white people as inherently "bad". Instead, what is required is a more nuanced unpacking of how white people "benefit from privilege without becoming mired in guilt and anxiety. Although they can and should try to be ever cognisant of their privilege, they need to accept that they cannot erase their whiteness" (Kowal et al., 2013, p. 325).

What the above discussion highlights is the ongoing debate within the Cultural Safety and reflexivity literature regarding whether and how to manage the discomfort experienced by students. Equally, what is also clear is that whether this discomfort is managed through more objective methods (Sjoberg & McDermott, 2016) or by directly engaging with and examining the discomfort (McDowall, 2021; Mills & Creedy, 2019), emotions are a key aspect of

developing reflexive capacity. While the work of Kowal et al. (2013) provides guidance in relation to the management of "white guilt", more consideration is required regarding the emotional responses of non-white non-Indigenous people as well as Aboriginal and Torres Strait Islander people, groups who often have complex relationships to whiteness. Future research could look at whether the above approaches could be utilised or adapted within the Cultural Safety context.

## 6.4 Reflexivity is a central but not well-understood aspect of Cultural Safety

While the results of the three studies show support for reflexivity as a starting point for addressing racism, they also indicate that there is substantial work to be done to clarify the purpose and approach to reflexivity in the context of Cultural Safety.

As demonstrated in Chapter 3, while reflexivity is considered a core aspect of culturally safe practice, there is little consensus or consistency in how reflexivity is defined, conceptualised, or included in Cultural Safety education (Dawson et al., 2022). Some variation is expected given the variability in how reflexivity is defined and conceptualised in the broader literature (Finlay, 2002a; Lumsden et al., 2019; Walsh, 2003). However, the variability demonstrated in the Cultural Safety education literature is arguably more than would be accounted for by geographical or disciplinary differences. Rather, students were required to engage in everything from basic self-awareness (for example: Duthie et al., 2013; Lucas et al., 2021) to more complex critical reflexivity (for example: Bolton & Andrews, 2018; Mills et al., 2022), with the majority falling short of what would be considered reflexivity. In most cases, students were required to reflect on their cultural identity and privilege; identify their own beliefs, biases, and

assumptions; and in some cases reflect on how these influence attitudes and behaviours towards Indigenous people.

Given this limited scope, it is questionable whether this would provide students with the skills or capacity to identify their own racialised thinking, or how this is a product of and contributor to broader racialised systems and structures. Indeed, it raises concerns about the potential of current approaches to reinforce the racialised power dynamics and inequities they seek to challenge. The emphasis on identity, privilege, and attitudes is akin to the more performative aspects of positionality statements outlined by Gani and Khan (2024), which function to centre whiteness and the feelings, benevolence, and agency of the individual. Arguably, any approach to reflexivity in the context of Cultural Safety must encourage the examination of the co-constitutive relationship between self and society; that as individuals, we are both the product of and (re)producers of social systems, norms, and practices. As noted in previous chapters (Chapters 2 and 3), there is a substantial body of critical work examining the conceptualisation and practice of reflexivity across a range of disciplines and contexts. However, there is comparatively little examining this in the context of Cultural Safety, resulting in a lack of conceptual clarity and substantial inconsistency in teaching approaches. What is required, then, is the development of a definition and conceptualisation of reflexivity relevant to the context of Cultural Safety.

More broadly, any conceptualisation of reflexivity in the context of Cultural Safety would need to foster an authentic examination of the self in relation to systems of colonialism, racism, and whiteness. As the results of Chapter 4 demonstrate, students were able to critique racism external to themselves, but continued to draw on racialised discourses and ideologies in their own talk while engaging in positive self-presentation (van Dijk, 1992). This is what Connelly (2020) refers to as the "good white racist"; those who see themselves as inherently "good people" who do not use overtly racist language or hold explicitly racist beliefs, but who

nonetheless perpetuate racism through embodied racialised practices. Applebaum (2010) proposes a *white complicity pedagogy*, which asks,

> *How do white people reproduce and maintain racist practices even when, and especially when, they believe themselves morally good?*
>
> *How do these practices function to protect their white moral innocence?*
>
> *What allows white people to see themselves as part of the solution and to deny that they are part of the problem?* (p. 180)

Applebaum's (2010) work, like that of Connelly (2020) highlights the need for constant vigilance, and the relative ease with which reflexivity and awareness of own positionality and privilege can slip into a perception of having "done the work". The above research (Applebaum, 2010; Connelly, 2020; Kowal et al., 2013; McDowall, 2021; Mills & Creedy, 2019) contains threads of possibility for what reflexive Cultural Safety might look like; further work is required to weave them together.

## 6.5 Recommendations for future research

Given the findings outlined in chapters 4, 5, and 6, and the discussion provided above, the following sections will outline several key recommendations for future actions and research.

### 6.5.1 Defining and conceptualising reflexivity in the context of Cultural Safety

Perhaps the most significant finding is that there is very little consistency in how reflexivity is defined and conceptualised in relation to Cultural Safety. Further, in some cases, reflexivity was not included as part of Cultural Safety education, leaving questions as to the efficacy of such training. Therefore, the following recommendations are proposed:

***Recommendation 1:*** *Develop a consistent definition and conceptualisation of reflexivity in relation to Cultural Safety in the Australian colonial context.*

***Recommendation 2:*** *Include reflexive capacity development as a core Cultural Safety capability and learning outcome within Cultural Safety education.*

### 6.5.2 Teaching and learning considerations: pedagogical approaches and assessment approaches

The inconsistency in definitions and conceptualisations of reflexivity also meant that there was a lack of consistency in teaching and assessment approaches. Additionally, given the limited scope of most reflexivity within Cultural Safety education (Chapter 3), and the predominantly external focus of student reflexive accounts (Chapter 6), there is a need for more targeted pedagogical approaches to support student reflexive capacity development. There are several potential approaches outlined in the existing literature, such as reflexive antiracism (Kowal et al., 2013), pedagogy of discomfort (Mills & Creedy, 2019), uncomfortable reflexivity (McDowall, 2021), critical consciousness (Hall et al., 2023), and white complicity pedagogy (Applebaum, 2010). However, with the exception of Mills and Creedy (2019; Mills et al., 2021) it is largely unknown whether and to what extent these approaches facilitate student development of reflexive capacity.

Relatedly, there is a need to ensure that education supports the development of a comprehensive understanding of racism, as well as their own complicity in or relation to systems of whiteness and racialised power structures. While the Cultural Safety literature ubiquitously recognises that addressing racism is a priority, to date there has been no examination of how racism is conceptualised and taught within Cultural Safety education.

There is also very little literature exploring appropriate methods to assess reflexive capacity development and given that Cultural Safety is now an accreditation and registration requirement in Australia (Ahpra & National Boards, 2020, 2022), further research is required in this area to adequately measure student learning. As such, the following recommendations are proposed:

***Recommendation 3:*** *Identify and/or develop targeted pedagogical approaches to facilitate authentic reflexive practice.*

***Recommendation 4:*** *Review and refine the racism-related content included in Cultural Safety education and identification of strategies to ensure it moves beyond 'individual pathologisation' to a broader consideration of systemic and structural racism.*

***Recommendation 5:*** *Undertake research to explore the potential of the Levels of Reflexive Practice framework as a tool for the assessment of reflexive capacity development.*

### 6.5.3 Structural and institutional considerations: reflexive policymaking

Finally, despite calls for Cultural Safety to be extended beyond individual practice to consider systemic and institutional applications, very little consideration has been given to whether and how this might include reflexivity. Chapter 5 demonstrated that the WPR analytic approach shows some promise in the policy space, however more work is required to explore how it might be applied more broadly to systems and institutions:

***Recommendation 6:*** *Explore the potential utilisation of What's the Problem Represented to Be? (WPR) analysis as a means of reflexively developing and evaluating policy to ensure it meets the priorities, needs, and aspirations of Aboriginal and Torres Strait Islander peoples.*

### 6.5.4 Additional areas for research

While not the specific focus of the current research, as highlighted in Chapter 2 (section 2.2.5, p. 86), there is currently little research examining healthcare provider and public understandings of Cultural Safety (Johnstone & Kanitsaki, 2007). Likewise, there is currently little research examining educator understandings of Cultural Safety, although given the findings outlined in Chapter 3 as well as those of Kurtz et al. (2018), there is considerable variation in both educator understanding of and approaches to teaching Cultural Safety. Arguably, this variability could account for the lack of consistency in whether and how reflexivity was included in curricula, and this is an area for further research.

The current lack of research on patient experiences of culturally safe care, and the impact this has on both patient experiences and outcomes is also an area that requires further research. Specifically, in relation to the current research, there is a need to examine whether a healthcare workforce trained in Cultural Safety results in reduced levels of racism at the individual and institutional level. As such, the following recommendations for further research are proposed:

***Recommendation 7:*** *Evaluate current levels of healthcare professional and healthcare educator understandings of Cultural Safety to determine workforce training requirements in Cultural Safety practice and education, respectively.*

***Recommendation 8**: Conduct large-scale evaluations of patient experiences and outcomes of culturally safe care provision to determine efficacy and impact of Cultural Safety education and practice.*

## 6.6 Strengths

This thesis represents the first comprehensive exploration of reflexivity as a core Cultural Safety capability, and as such makes several original contributions to the Cultural Safety literature. Specifically, this thesis provides new insights into systemic, institutional, and individual aspects of reflexivity which have not previously been explored, as well as the potential and limits of reflexivity as a starting point for addressing racism. Additionally, this thesis identifies several key areas for future research, discussed above. As such, this thesis provides a foundation for further critical exploration of reflexivity in the context of Cultural Safety.

***First critical examination of how reflexivity is conceptualised and taught within Cultural Safety education***

To date, there has been little critical consideration of how reflexivity is conceptualised and taught within Cultural Safety education. The research presented in this thesis provides a unique insight into current approaches to Cultural Safety education; importantly, this research has highlighted that current approaches have the potential to reinforce the privilege, power dynamics, and racism that reflexivity seeks to challenge. As such, it also highlights that more research is required to ensure a more consistent definition and conceptualisation of reflexivity which encourages critical consideration of racialised systems of power, knowledge, and practice.

### *Development of the Levels of Reflexive Practice Framework*

As identified previously, there is little guidance in the literature regarding how to assess the development of reflexive capacity within Cultural Safety education. The Levels of Reflexive Practice (LoRP) Framework developed and outlined in Chapter 4 provides an innovative approach to identifying and assessing student reflexive capacity and has the potential to be adapted for use within Cultural Safety learning and teaching contexts. While there are similar frameworks found in the critical reflection literature (for example: Kember et al., 2008; Myezwa et al., 2017), this is the first framework developed specifically to capture reflexivity. There is potential for the LoRP Framework to be further developed; to be used as a foundation for teaching reflexivity; and in the development of materials to assess reflexive capacity development, such as marking rubrics.

### *Methodological approaches*

The use of discursive analysis methodologies was a strength of the current research. Given the discursive and ideological foundations of racism, critical discursive analysis and pattern-based thematic analysis present the most appropriate approach to examine the way both racism and subjectivity are managed (Augoustinos & Every, 2007; van Dijk, 1992) across a range of media and types of data. In each of the three studies, thematic and critical discursive analysis were adapted to suit the nature of the data and provided insights into both broader patterns of language and construction, as well as more fine-grained analysis of how these patterns are legitimised and normalised.

## 6.7 Limitations

Individual limitations of each study are covered in the Discussion sections of the previous chapters. The following sections identify and discuss limitations of the overall thesis.

***My own complicity in whiteness and racialised systems of knowledge and practice***

Throughout most of the time spent completing this thesis I have attempted to engage in reflexivity, to critically examine and challenge the impact of my own positionality, complicity, worldviews, and biases on this research. While this process has generated many insights and learnings, as several have noted (for example: Applebaum, 2010; Savolainen et al., 2023) there are limits to how well we can ever know ourselves given that our sense of self is constructed in relation to others. There is also the oft-used metaphor of the fish in water, and that as a white person, trying to identify and critique all the ways that whiteness shapes my own ontologies, epistemologies, knowledges, perceptions, and practices is akin to a fish trying to become aware of the water that surrounds it. Applebaum (2010) calls for a more critical engagement with how we, as white people, embody and practice whiteness, yet even these are largely invisible until challenged by new and contrasting ways of knowing being, and doing.

Over the course of this thesis I have sought out the knowledges, perspectives, and expertise of Aboriginal and Torres Strait Islander leaders and scholars as a means of countering the hegemonic nature of my own thinking and practices. The work of Professor Chelsea Watego (Bond & Singh, 2020; Bond et al., 2020; Watego et al., 2021), Professor Yin Paradies (Elias et al., 2021; Paradies, 2016; Paradies et al., 2015), Professor Aileen Moreton-Robinson (Moreton-Robinson, 2000/2020, 2004, 2015), the late Professor Dennis McDermott (McDermott, 2012, 2020; McDermott & Sjoberg, 2012), as well as Dr Irihapeti Ramsden (Ramsden, 1992, 2002) have been particularly influential in shaping my thinking. By engaging with the broader literature as well as following various social media accounts where opinions and perspectives

are not filtered through academic processes, I have been able to gain greater understanding and reflexively challenge my own thinking and practices without placing additional burden on Aboriginal and Torres Strait Islander friends and colleagues (Sivertsen et al., 2023).

While the broader literature has been invaluable in developing my knowledge, the relationships I have developed and the conversations I have had with Aboriginal and Torres Strait Islander friends and colleagues – and the knowledges and perspectives they have generously shared – have been equally valuable. This includes the co-authors who have provided such critical input on each of my published papers: Dr Kootsy Canuto and Karen Glover, who reviewed my policy analysis and provided alternative perspectives on the findings; Keera Laccos-Barrett, who spent many hours discussing both the findings of the Cultural Safety education literature analysis and the LoRP framework; and Courtney Hammond, whose efforts in collating and reviewing the Cultural Safety education literature were invaluable. The conversations I have had with friends and colleagues, and the critical feedback provided by co-authors have provided opportunities for me to engage in relational reflexivity, and created a space in which knowledge and understanding were co-created through dialogue (Finlay, 2002a; McCutcheon & Kohl, 2019).

***Addressing the emergent scholarship***

Over the course of this thesis completion there have been developments in how racism and Cultural Safety are defined, conceptualised, and understood (see for example: Elias et al., 2021; Mohamed et al., 2024; Watego et al., 2021). Additionally, the *Closing the Gap* policy framework has undergone a substantial review (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2020), driven by Aboriginal and Torres Strait Islander peak bodies and experts. Given these developments, it is worth considering the relevance of the current findings.

Racism remains a driving cause of inequity in Australia (Elias et al., 2021), and in the last decade there has been increased media attention on the existence and impact of racism (Chang, 2024; Murphy, 2023; Pillarisetty, 2024), protests against Aboriginal and Torres Strait Islander deaths in custody (Schubert, 2021; Torre, 2023), and the defeat of the Voice to Parliament Referendum (Brennan, 2023; Maguire, 2023). The world, too, has seen much change in this time, with global events such as the death of George Floyd and the resulting Black Lives Matter movement (Gottbrath, 2020), and the current genocide occurring in Palestine (United Nations, 2024) putting a spotlight on the intersection of racism and colonialism as well as the role of discourse in shaping narratives. Arguably, then, the identification of ways to identify and challenge racism remain a high priority.

There have also been several key developments in the field of Cultural Safety, two of which are particularly relevant to this thesis. In 2020, the Australian Health Practitioner Regulation Agency released their *Cultural Safety Strategy 2020-2025* (Ahpra & National Boards, 2020), which included a definition of Cultural Safety developed in and for the Australian context. Ahpra also formally included Cultural Safety as an accreditation and registration requirement for all registered health professions (Ahpra & National Boards, 2022; Australian Medical Council, 2024; Nursing and Midwifery Board Ahpra, 2022a, 2022b). As a result of these changes, Cultural Safety education is now a mandatory requirement in all registered health professions programs; arguably, then, it is imperative that curricula and pedagogical approaches effectively support the development of relevant capabilities, including reflexivity.

More recently, Mohamed et al (2024) released a discussion paper outlining a revised set of National Cultural Safety Training Standards, including a framework to guide development and evaluation of educational programs. While this framework represents an important step forward in ensuring high quality, evidence-based, and consistent approaches to the development and delivery of Cultural Safety training, it is notable that like much of the

literature analysed in chapter 3, critical self-reflection is included as an assumed skill that learners already possess, rather than a capacity to be developed.

Finally, the Closing the Gap policy framework analysed in chapter 5 has undergone several revisions, with the most recent revision, the *National Agreement on Closing the Gap* (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2020) developed in partnership between the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and the Australian Government. While the new National Agreement represents a significant shift in the policy making space and aligns with the recommendations made in chapter 5, there are two key reasons why the current research remains relevant. The first is that decision-making remains a shared process between the Coalition of Peaks and the government; there is a very real risk that policy decisions and approaches will be filtered through the ideological lens of the sitting government or those involved in the policy making process. The second is that Priority Reform 3 calls for improvements to mainstream government institutions and organisations, with an explicit call to "identify and eliminate racism" and to "embed and practice meaningful Cultural Safety" (Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2020, p. 19). Arguably, then, there is a need to further examine how Cultural Safety can be meaningfully embedded into government practice, including policy development.

***Reliance on use of English language literature***

As Bonnet (2000) notes, there is a wealth of antiracism theory and literature developed globally, not just in Western, English-speaking countries, and this is also true of related literature on race, racism, Cultural Safety, and reflexivity. As such, there is a diversity of theory and practice that is not captured in the current research due to a reliance on English language literature. Given that much of the English language literature is produced in the Global North and heavily

influenced by Western ontologies and epistemologies, there is also a question about the appropriateness of the theory, approaches, and findings outlined in this thesis. However, as noted above, the work of Aboriginal and Torres Strait Islander scholars and experts provided a foundational understanding for many of the concepts discussed in this thesis and worked to ground it in a contextually relevant body of literature (McDermott, 2012; Mohamed et al., 2024; Moreton-Robinson, 2015; Paradies, 2016; Ramsden, 2002; Wategо et al., 2021).

***Conceptual underpinnings: are Cultural Safety and reflexivity enough?***

Finally, there is a question as to whether the central theories explored in this thesis – Cultural Safety and reflexivity – are adequate to the task of addressing racism. Both have been critiqued for similar reasons; that superficial engagement in either culturally safe learning and practice or reflexivity can reinforce the racialised thinking and practices they seek to challenge (Curtis et al., 2019; Gani & Khan, 2024; Williams et al., 2021). Arguably this emphasises rather than undermines the relevance of this thesis; that there is a need to better understand how to engage in meaningful reflexivity which actively challenges and begins to dismantle the racialised power structures that create and maintain inequities. There are several potential alternatives that could be explored, such as antiracism (Bonnett, 2000) or white complicity pedagogy (Applebaum, 2010). However, the requirements for Cultural Safety to be included as mandatory content in health professions programs, its increasing inclusion in policy recommendations (Australian Government Department of Health, 2021; Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Australian Governments, 2020), and its endorsement by Aboriginal and Torres Strait Islander organisations (IAHA, 2019; Mohamed et al., 2024; NATSIHWA, 2016) means that Cultural Safety remains the most appropriate approach.

## 6.8 Implications for practice

The findings outlined in the current research provide an important baseline understanding of reflexivity in relation to Cultural Safety, with systemic, institutional, and individual considerations outlined.

For those in the Cultural Safety education space, this thesis highlights several key considerations for future development of pedagogical strategies, content, and assessment approaches. Firstly, it demonstrates the need to clearly define and conceptualise reflexivity in this context. Educators must clearly understand what they want students to achieve when engaging in reflexivity, as this will provide a clear foundation for the development of pedagogical strategies to support students in this process. Second, educators need to move away from the assumption that students possess the knowledge and capacity to engage in reflexivity and instead recognise that students require explicit instruction and support in the early stages. The findings of Chapters 3 and 4 provide a substantial basis for developing contextually relevant and scaffolded learning and teaching materials to support both students and educators. Finally, educators must critically consider their approach to teaching and learning, to critically and reflexively consider whether and how whiteness shapes curricula and works to reinforce racialised power dynamics.

For those in the public service and policy making space, the results presented in chapter 5 demonstrate that even – or especially – where policy measures are well-intentioned, there is a need to critically examine the assumptions that underpin them to identify potential unintended consequences. The analytic approach taken in this thesis demonstrates a systematic method of critically analysing policy measures, and future research could explore the potential of incorporating a modified WPR analysis approach into the policy-making process.

## 6.9 Conclusion

This thesis sought to provide a critical examination of reflexivity in relation to Cultural Safety and explore the potential of reflexivity as a critical strategy to identify and challenge racism. The findings presented here demonstrate that while reflexivity shows strong potential to achieve this, the current variability in how reflexivity is defined, conceptualised, and taught means that its efficacy as a means of identifying and challenging racism is undetermined. The findings of the three studies all provide starting points for developing a more consistent and theoretically robust conceptualisation of reflexivity relevant to Cultural Safety education and practice, although more work is required to fully realise its potential as an antiracism strategy.

# Appendices

# Appendix 1

*Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature*

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*Article*

# Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature

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**Abstract:** Cultural safety is increasingly being taught in tertiary programmes of study for health professionals. Reflexivity is a key skill required to engage in culturally safe practice, however, there is currently limited literature examining how reflexivity is taught or assessed within cultural safety curricula. A systematic review of the literature up until November 2021 was conducted, examining educational interventions which aimed to produce culturally safe learners. Studies were limited to those with a focus on Indigenous health and delivered in Australia, Aotearoa New Zealand, Canada, and the United States. A total of 46 documents describing 43 different educational interventions were identified. We found that definitions and conceptualisations of reflexivity varied considerably, resulting in a lack of conceptual clarity. Reflexive catalysts were the primary pedagogical approaches used, where objects, people, or Indigenous pedagogies provided a counterpoint to learners' knowledges and experiences. Information regarding assessment methods was limited but indicates that the focus of existing programmes has been on changes in learner knowledge and attitudes rather than the ability to engage in reflexivity. The results demonstrate a need for greater conceptual clarity regarding reflexivity as it relates to cultural safety, and to develop methods of assessment that focus on process rather than outcomes.

**Keywords:** Indigenous; education; cultural safety; reflexivity; curriculum; pedagogy; assessment

## 1. Introduction

The beliefs, attitudes, and biases that healthcare professionals hold can substantially influence the way they interact with and provide care to people. This is particularly relevant to the health and well-being of Aboriginal and Torres Strait Islander Australians, where healthcare professional attitudes are seen as a major factor in whether care is considered safe, adequate, and acceptable [1–3]. Dismissive, rude, and outright racist behaviours have been reported by Aboriginal and Torres Strait Islander people in their encounters with non-Indigenous healthcare professionals. These experiences can result in inadequate or negligent care provision and deter recipients of care from further engaging with a healthcare system that is perceived as culturally unsafe [4–6]. In turn, this can have significant flow-on effects for healthcare access and outcomes and contributes

to the health inequities experienced by Aboriginal and Torres Strait Islander people. Parallels can be seen in Aotearoa New Zealand, Canada, and the United States, where racial discrimination and culturally unsafe care contribute to inequities in healthcare access and outcomes for Indigenous peoples [7–9].

Cultural safety is recognised as an approach to healthcare with the potential to improve the experience of care for Indigenous peoples in Australia, Aotearoa New Zealand, Canada, and the United States. The concept of cultural safety was originally developed in Aotearoa New Zealand by Māori nurses and midwives, to address the racism experienced by Māori patients being cared for by a largely non-Indigenous health workforce [10,11]. Cultural safety in healthcare delivery recognises the centrality of culture to health and well-being and seeks to ensure that healthcare is respectful and non-discriminatory. To provide culturally safe care, healthcare professionals need to engage in critical reflexivity, whereby they examine their own cultural identity, positioning and power, the values, attitudes, and biases they carry, and the potential consequences of these for the people they provide care to [12–15].

The importance of cultural safety as an approach to healthcare provision is now well established, with a substantial body of literature exploring the application of cultural safety across a range of health professions, including nursing and midwifery [16–23], medicine [24–28], psychology [29], physiotherapy [30], occupational therapy [31,32], and nutrition [33]. As such it is increasingly being included in health sciences curricula at the tertiary level in Australia, Aotearoa New Zealand, Canada, and the United States [34] and developed as short continuing professional education courses (for example, [35–37]). While there is a growing body of literature exploring best practice approaches to the development and delivery of cultural safety education, this predominantly focuses on overall curriculum structure and content (for example [20,31,38]). Currently, however, there is little guidance on the most appropriate pedagogical approaches to teach students how to be reflexive, or on how educators should assess student learning outcomes concerning reflexivity. Given the centrality of reflexivity to culturally safe practice, we argue that there is a need to develop best practice approaches to the teaching and assessment of reflexivity within cultural safety education.

*Reflexivity and Cultural Safety*

The way reflexivity is defined, conceptualised, and operationalised varies both across and within fields and disciplines, depending on the purpose to which it is being put [39,40]. At its core, reflexivity involves an awareness and examination of the ontological and epistemological foundations that inform our existence and shape our thoughts and behaviours [39,41]. Notably, reflexivity is concerned with the self in relation to others; that is, how our ways of knowing, being, and doing shape our interpretation of and behaviour towards people [40,42]. Despite its centrality to culturally safe practice, reflexivity has not been specifically defined or conceptualised in this context. In her account of reflexive, culturally safe research, Wilson draws on the broader research literature to define reflexivity as a tool "to gain greater understanding of the self/other positionalities and the experience of research" [42] (p. 219). How this might be adapted into healthcare contexts and included in cultural safety education is yet to be determined.

In the context of cultural safety, reflexivity serves several purposes, and each presents challenges for educators and students alike. Perhaps the most cited purpose of reflexivity is the examination of own cultural worldviews and values and how these might influence delivery of care to people from different cultural backgrounds [43,44]. Notably, there is an acknowledgement that 'culture' is a complex intersection of factors such as race, ethnicity, gender, age, socioeconomic status, disability status, geographical location, and sexual orientation, among others [34,43,44]. Arguably, this complexity presents students with a significant challenge of understanding their own intersectional nature. Given the tendency of cultural safety education to focus on Indigenous health, there is a risk that this type of curricula reinforces a false dichotomy of Indigenous and

non-Indigenous identity, resulting in a curriculum more akin to cultural competency training [13,45]. It also risks diminishing the complexity of Indigenous identity, which encompasses more than ethnicity on its own [46,47]. Further, as Lumsden [39] (p. 3) notes, there is an inherent risk that reflexivity can easily become entangled in notions of individual identity, "while failing to recognize the wider disciplinary, institutional, and political context(s) in which reflexivity…takes place, and in which knowledge is constructed, situated, and (re)negotiated". In cultural safety education, and specifically in the context of Indigenous health, considerations of these broader contexts and the sites and methods of knowledge (re)production are essential.

The development of reflexive skills and the exploration of own cultural identity most often occurs in conjunction with learning about the social determinants of Indigenous health. In colonised countries like Australia, Aotearoa New Zealand, Canada, and the United States, this includes developing an understanding of historical and ongoing processes of colonisation, and the resulting interpersonal and institutional racism, whiteness, and power differentials. Students also need to develop an understanding of how these factors intersect with other social determinants such as education, employment, housing, and food security to produce the health inequities that Indigenous people experience [13,43,48]. In part, this learning is intended to help students understand that health is the product of social, economic, political, and historical forces [44]. It is also an opportunity for students to become aware of and challenge their own internalised stereotypes, assumptions, and biases through exposure to new learning. Yet this can be a challenging process for students, one which has been consistently shown to produce feelings of discomfort for students [48–50]. These feelings of discomfort can range from disengagement in class to outright hostility towards content, learning, and educators. This discomfort, if carefully managed, can produce transformative learning experiences for students. Conversely, poorly managed discomfort may serve to reinforce negative attitudes towards learning, content, and Indigenous people themselves [48–50].

Additionally, students are expected to engage in this complex, deeply personal, and potentially uncomfortable learning process in the context of a tertiary educational institution. While educators might strive to provide genuinely transformative learning experiences, the reality for students is that they need to pass their studies. Faced with the task of engaging reflexively, there is a risk that students will simply provide the responses they think educators want. This has been acknowledged as a potential issue in the literature [39,49,51–53] but has not been explored in-depth regarding whether and to what extent this occurs within cultural safety education.

While there is a growing body of literature on cultural safety education, at present, there is little guidance on the best approach to teach or assess reflexivity in the context of cultural safety. Currently, most cultural safety education literature falls into three broad categories: qualitative explorations of student learning experiences [18,22,30,54–58], evaluations of student learning outcomes [17,19,23,26,29,32,33,50,59–66], and descriptions of curricula development and delivery [16,20,21,25,28,31,38,67–73]. In evaluations of curricula and learning outcomes, student reflective journals are a common source of data. However, these articles tend to focus on whether and how the curricula have produced transformative learning, with little information provided on the specific pedagogical approaches used to teach students reflexivity, nor how assessments are structured to capture the reflexive process.

The dearth of literature on teaching and assessment of reflexivity may be reflective of the diversity of definitions, conceptualisations, and ways of operationalising it as a concept. Lumsden [39] warns against using standardised instructions for learning how to engage in reflexivity, as this implies a 'correct' and 'incorrect' way of going about the process, and risks reducing it to a checklist approach. In the absence of such instruction, how do educators help students develop the skill of reflexivity? Further, in the tertiary education system, where educators are required to assess the learning outcomes of students in a standardised manner, how do they assess whether students have effectively

demonstrated these skills? The current research aims to address these questions through a systematic synthesis and exploration of the Indigenous cultural safety literature, with a specific focus on reflexivity, and aims to address the following questions:

1. How is reflexivity conceptualised within cultural safety educational interventions?
2. Where and how is reflexivity included as part of learning outcomes in educational interventions?
3. What types of pedagogical approaches are used in cultural safety educational interventions to help students develop reflexive skills?
4. How is the development of reflexivity as a skill assessed?

## 2. Materials and Methods

### *2.1. Data Sources and Search Strategies*

An initial systematic search of the following databases was conducted: CINAHL, PubMed, Scopus, Informit, PsycINFO, and Embase. Consultation with a research librarian determined that, due to the specificity of the search parameters and the limitations this placed on using indexing terms, a simplified set of search terms was most appropriate. Therefore, all searches across the databases used the following search terms: "cultural safety" and "culturally safe". Where the databases provided the option, searches were limited geographically to Australia, Aotearoa New Zealand, Canada, and the United States of America, and to articles in English.

Additionally, a targeted internet search was also conducted, specifically to capture data produced by Indigenous and other non-government organisations (NGOs) as well as any available information on CPE. These data sources represent an important but often overlooked source of information not captured in other literature reviews, as they are often direct accounts of the educational process and often centre Indigenous experiences, knowledges, and aspirations.

### *2.2. Eligibility Criteria*

Data sources were included if they described an educational programme or intervention that fitted the following inclusion criteria: (1) aimed to develop culturally safe learners; (2) was delivered as either part of an undergraduate or postgraduate degree or as continuing professional education (CPE); (3) had a focus on Indigenous health outcomes; and (4) was delivered in Australia, Aotearoa New Zealand, Canada, or the United States of America. The latter criteria were employed as these countries share similar historical and ongoing colonial processes, with resulting similarities in health inequities experienced by Indigenous peoples. The inclusion criteria were designed to allow for the inclusion of all cultural safety education literature and the identification of variations in how and where reflexivity was included or excluded.

Data sources were excluded if they were published in a language other than English, described an educational approach other than cultural safety, or a full-text article was not available.

### *2.3. Article Review*

The initial search of the databases returned a total of 2860 results, which were exported into Endnote [74]. Duplicates were removed ($n = 1125$), leaving 1735 results. Initial screening of titles was carried out by the lead author (JD), and identified a further 852 for removal, due to either irrelevance (for example, most of those excluded discussed a "culture of safety" rather than cultural safety), or duplicates missed by the Endnote sorting function.

Titles and abstracts of the remaining articles ($n = 883$) were reviewed by JD and CH according to the inclusion/exclusion criteria; 738 articles were excluded, leaving 145 articles for full-text review. Full-text review resulted in the identification of another two articles, bringing the total number of articles reviewed to 147. JD conducted all full-text re-

views, with a 10% cross-check provided by CH. Where agreement could not be reached on an article, it was discussed with AR until a decision could be made. An additional 29 articles were identified in the grey literature. An updated search conducted in 2021 identified an additional 17 articles for inclusion.

It should be noted that the targeted internet search identified a wide range of cultural safety training modules available via organisational websites, such as Australian Indigenous Doctors' Association (Australia) and San'yas (Canada). Most of these organisational websites contained publicly available information about the expected learning outcomes of the training module but were excluded from analysis due to insufficient information on other aspects of learning.

### 2.4. Data Extraction

Data in the current research are descriptive and primarily sourced from the introduction and background sections of articles where information about the educational intervention is provided as a preface to evaluation or measurement of student learning and outcomes. Data were analysed using a two-stage thematic analysis process. In the first stage, data were coded under four major themes drawn from the research questions: definition and conceptualisation of reflexivity; where and how reflexivity is included in learning outcomes; pedagogical approaches used to develop reflexivity; and assessment methods used to measure reflexivity development. The second stage of analysis used inductive thematic analysis, where learning is generated from the data itself rather than guided by existing theoretical frameworks [75]. Data in each of the major themes were iteratively analysed and coded according to the sub-themes that emerged.

Additionally, discursive analysis [75] was used to provide a more nuanced understanding of how language practices shape the definition, conceptualisation, and practice of reflexivity within cultural safety education. Analysis of how reflexivity is defined drew on constructivist theory [76] to examine how language shapes our understanding of both the nature and purpose of reflexivity. Analysis of how reflexivity is conceptualised primarily drew on existing cultural safety and reflexivity literature (for example, [13,38,39,43]), and analysis of the pedagogical approaches drew on the object-based learning literature [77,78]. Throughout the analysis, we also drew on the work of Indigenous educators who operate at the cultural interface [79] and whose writings and approach to teaching are informed by Indigenous ways of knowing, being, and doing [53,55,80,81].

Data and analysis were managed using NVivo12 software [82].

## 3. Results

### 3.1. Summary of Educational Interventions

A total of 46 documents were analysed, describing 43 different educational interventions. The majority ($n$ = 35) of documents described university-based educational interventions [16,18,21–33,38,54–60,62–64,66,68–70,73,80,81,83,84], with one set of documents describing a short vocational training course [85–87], and the remainder ($n$ = 8) describing continuing professional education (CPE) courses for practicing health professionals [17,19,20,36,69,73,88,89]. Just over half of the documents analysed ($n$ = 28) were from Australia [17,18,20,22–24,27–30,33,36,38,54–57,62,64,66,67,73,81,84–87,90], with the rest from Aotearoa New Zealand ($n$ = 5) [25,61,71,72,89], and Canada ($n$ = 13) [16,19,21,26,31,32,59,60,64,70,73,85,86]; there were no documents from the United States. Table 1 provides a summary of key characteristics of the documents included for analysis.

**Table 1.** Summary of key characteristics of the educational interventions included.

| Reference Country | Learner Level and Field of Study | Site and Type of Educational Intervention | Duration. Delivery Method | Level of Indigenous Involvement |
|---|---|---|---|---|
| Arnold et al. (2008) [16] Canada | Undergraduate nursing students. | University. Reciprocal partnership, including community placements. | Not specified. Face-to-face. | Initiated, co-designed, and co-delivered. |
| Bernhardt et al. (2011) [59] Canada | Undergraduate speech-language pathology and audiology students. | University. Unit of study, including community placement. | 8-month teaching period. 26 h in-class teaching time. 26 h out of class time. Face-to-face with some online components. | Advisory Group established. Co-designed and co-delivered. |
| Bolton and Andrews (2018) [30] Australia | Doctor of physiotherapy students. | University. Field trip within a unit of study. | Not specified. Face-to-face. | Co-designed and co-delivered. |
| Carriage et al. (2017) [24] Australia | Fifth-year medical students. | University. Rural and remote placements. | Half-day lecture followed by 5-week placement. Face-to-face. | Aboriginal Medical Service host organisations, including cultural mentoring. |
| Chiodo et al. (2014) [29] Australia | Undergraduate psychology students. | University. Unit of study. | 6-week teaching period. 2 h weekly lectures. 1 h weekly tutorials. Face-to-face. | Includes a 'diverse teaching group' and involvement of 'Indigenous guest speakers.' |
| Crampton et al. (2003) [25] Aotearoa New Zealand | Third-year medical students. | University. Cultural immersion placement. | 1 week Face-to-face. | Consultation and collaboration with local community. |
| Delbridge et al. (2021) [38] Australia | Undergraduate and postgraduate health professions students. | University. 2 discipline specific PBL modules. 1 inter-professional simulation session. | PBL modules: Pre-workshop online learning, 1 h seminar, and 3 h workshop. Simulation: Pre-session online learning, length of session not specified. Face-to-face with some online components | Co-designed involving expert knowledge holders. |
| Demers et al. (2021) [31] Canada | Undergraduate occupational therapy students. | University. Fieldwork placement. | Pre-placement self-paced learning. 8-week placement. Face-to-face with | Partnership was initiated by a community-based Indigenous OT. |

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| | | | some online components. | |
| Dowell et al. (2001) [60]<br>Aotearoa New Zealand | Third-year medical students. | University.<br>Cultural immersion placement; part of a unit of study. | 1 week<br>Face-to-face. | Consultation and collaboration with local community. |
| Durey et al. (2017) [90]<br>Australia | Health professionals (radiation oncology). | CPE.<br>Workshop. | 2 h workshop.<br>Face-to-face. | Co-presentation. |
| Duthie et al. (2013) [54]<br>Australia | Master of social work students. | University.<br>Field experience; part of a unit of study. | 1 day.<br>Face-to-face. | Co-designed and co-delivered. |
| Fleming et al. (2017) [17]<br>Australia | Midwifery academic educators. | CPE.<br>Workshops and yarning circles. | 2 half-day workshops and 5 yarning circles; held over a 12-week semester.<br>Face-to-face. | Co-designed and co-delivered. |
| Gray et al. (2020) [62]<br>Australia | Undergraduate allied health students. | University.<br>Workshop. | 1 day.<br>Face-to-face. | Co-designed and co-delivered. |
| Hardcastle and Bradford (2007) [67]<br>Australia | Nurses and other health professionals. | CPE.<br>Online module. | 6 self-paced learning modules.<br>Online (web-based training programme). | Initiated, co-designed, and co-delivered. |
| Hart et al. (2015) [18]<br>Australia | Undergraduate nursing students. | University.<br>Pre-placement unit.<br>Placement (urban, rural, and remote locations). | Pre-placement semester unit of study.<br>Placement (5 weeks).<br>Face-to-face. | Collaboration and consultation with Aboriginal Medical Services to set up placements. |
| Herzog (2017) [83]<br>Canada | Fourth-year medical students. | University.<br>Elective unit of study. | 4 weeks.<br>Face-to-face. | Development and delivery of learning. |
| Herzog et al. (2021) [68]<br>Canada | Second-year medical students. | University.<br>Class activity. | Not specified.<br>Face-to-face | Not specified. |
| Hudson and Maar (2014) [26]<br>Canada | First-year medical students. | University.<br>Pre-placement preparation.<br>Placement in community. | 4 weeks (total)<br>2-week placement in Aboriginal community.<br>2-week follow-up on campus.<br>Face-to-face with some online components. | Co-designed, co-delivered, and co-evaluation. |
| Hulko et al. (2021) [19]<br>Canada | Health professionals (nurses working with dementia patients). | CPE.<br>Module. | Self-paced, equivalent to 8–10 h completed over 8 weeks.<br>Online and face-to-face components. | Co-designed and co-delivered. |

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|---|---|---|---|---|
| Jackson et al. (2013) [55] Australia | Masters-level post-graduate health professions students. | University. Workshop within a compulsory subject. | 1 day; 7 discrete sessions. Face-to-face. | Co-designed and co-delivered. |
| Jamieson et al. (2017) [32] Canada | First-year occupational therapy students. | University. Modules included in a first year OT course. | 3 x 1 h modules. Face-to-face. | Co-designed and co-delivered. |
| Joyce (1996) [69] Aotearoa New Zealand | Undergraduate nursing students. | University. Scaffolded and integrated curriculum across undergraduate programme. | 3-year curriculum. Approximately 252 h total across 3600 h of teaching. Face-to-face. | Co-delivery of teaching. |
| Kelly et al. (2016) [20] Australia | Renal health training for new and current nursing staff. | CPE. Workshop (pilot and evaluation). | Aim is to offer a 1-day workshop. Face-to-face. | Not specified. |
| Kickett et al. (2014) [56] Australia | First-year health sciences students. | University. Integrated curricula. | 12-week semester. 2 h weekly tutorials. Offered in two formats: fully online; and face-to-face with some online components. | Co-coordination. Delivery of teaching. |
| Lucas et al. (2021) [57] Australia | Master of pharmacy students. | University. Immersive workshop. | 8 h. Face-to-face. | Co-designed and co-delivered. |
| Maar et al. (2020) [80] Canada | Pre-clerkship medical students. | University. Simulated clinical scenarios. | 15-min interview and 20-min debrief interview. Face-to-face. | Co-designed and co-delivered. |
| Mahara et al. (2011) [21] Canada | Baccalaureate nursing students. | University. Proposed curriculum. Scaffolded and integrated curriculum across the programme; includes a community placement. | 4-year curriculum. Total amount of time not specified. Proposed activities would be face-to-face. | Conceptualisation, planning, and development. |
| McCartan et al. (2021) [33] Australia | First-year nutrition science students. | University. Integrated curriculum across first year. | Integrated across 4 semester-long first-year subjects. Face-to-face. | Co-designed. |
| Mills et al. (2022) [84] Australia | Undergraduate health sciences students. | University. Semester-long unit of study. | Four 3 h workshops across a 12-week unit. 1 face-to-face workshop; 3 online workshops (due to covid-19). | Co-designed and co-delivered. |
| Min et al. (2020) [63] Canada | Third- and fourth-year pharmacy students. | University. One-semester unit of | 3 h per week; 36 h total. | Co-designed and co-delivered. |

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| | | study; includes experiential learning activities. | Face-to-face. | |
| Nash et al. (2006) [64]<br>Australia | Undergraduate nursing students. | University.<br>Scaffolded and integrated curricula across the programme of study. | Seven units across the programme had content embedded; five were practical placements.<br>Face-to-face with online components. | Consultation and collaboration in the development. |
| NSW Government Family and Community Services (2007) [85–87]<br>Australia | Not specified. | Vocational training.<br>Units of study within a Certificate III in Aged Care. | 5-day workshop.<br>Face-to-face. | Contributed to resource development.<br>Required as assessor(s). |
| Oosman et al. (2019) [58]<br>Canada | Master of physical therapy students. | University.<br>Pre-placement orientation session.<br>Placement in community. | Varied length, 2–4-week placements.<br>2 days per week in a health facility, 3 days per week in community.<br>Face-to-face. | Design and delivery of community practicum. |
| Paul et al. (2019) [27]<br>Australia | Medical students, first to fourth year. | University.<br>Vertically and horizontally integrated curriculum. | Activities included in the curriculum vary between 1 h (smoking ceremony and welcome to country) and 8-weeks (rural GP and psychiatry rotation).<br>Face-to-face. | Aboriginal health team responsible for coordination, development, implementation, and evaluation. |
| Power et al. (2020) [22]<br>Australia | Third-year nursing students. | University.<br>Elective clinical placement. | Not specified.<br>Face-to-face. | Written and facilitated. |
| Ramsden (1992) [70]<br>Aotearoa New Zealand | Undergraduate nursing and midwifery students. | University.<br>Proposed curriculum framework. | Not specified, but curricula to be scaffolded and embedded throughout the programmes.<br>Not specified. | Conceptualisation of framework. |
| Richardson et al. (2017) [71]<br>Canada | Child and youth mental health workers. | CPE.<br>Short course. | 5-day training programme.<br>Face-to-face. | Co-designed and co-delivered. |
| Royal Australian College of General Practitioners (2011) [36]<br>Australia | Medical practitioners. | CPE.<br>Framework for delivery; to be developed and delivered on a | Minimum 6 h, up to 10 h of structured learning.<br>Must also include | Planning, delivery, and evaluation of the programme. |

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| | | case-by-case basis by accredited trainers. | preparatory activities. Mandatory 6 h face-to-face; can also include online components. | |
| Ryder et al. (2013) [28] Australia | Second- and third-year medical students. | University. Structured clinical simulations. | 3 h session. Face-to-face. | Co-designed and co-delivered. |
| Sjoberg and McDermott (2016) [73] Australia | Health professions students (undergraduate and postgraduate). | University. Assessment included within a semester-long unit of study. | Not specified. Face-to-face. | Development. |
| Thackrah and Thomson (2013) [23] Australia | First-year midwifery students. | University. Semester-long unit of study. | 12-week semester. 2 contact hours per week. Face-to-face. | Co-designed and co-delivered. |
| The Royal New Zealand College of General Practitioners (n.d.) [91] Aotearoa New Zealand | Practicing general practitioners. | CPE. Online training module. | Self-paced training module. Online. | Development and presentation. |
| Thorpe and Burgess (2012) [66] Australia | Undergraduate preservice teachers. | University. Semester-long unit of study. | 12-week semester. Weekly contact time not specified. Face-to-face. | Co-designed and co-delivered. |
| West et al. (2021) [81] Australia | Final year undergraduate podiatry students. | University. Immersive clinical placement. | Minimum of four 1-day placements over the final year of study. Face-to-face | Clinic is staffed by Aboriginal health professionals. |

### 3.2. *Definitions of Cultural Safety*

While an exploration of cultural safety definitions was not a central aim of this study, it was notable that several definitions included did not contain any reference to reflexivity or similar processes, such as critical reflection or self-awareness. Six of the documents included for analysis made no reference to reflexivity or similar in either the definition of cultural safety or in the educational intervention [19,24,27,28,73,88]. One of these documents referred to practicing cultural safety skills learned in a previous topic via structured simulation workshops [28], but the cultural safety skills are not outlined so it is unclear whether this includes reflexivity. An additional eight documents included in the analysis did not include reflexivity in the definition or conceptualisation of cultural safety but did include reflexivity as part of the educational intervention described [23,32,33,56,57,64,67,68].

### 3.3. *Definition of Reflexivity*

Inductive thematic analysis of the data found a lack of consistency in the terminology used to name and describe the reflexive process within cultural safety educational interventions. Of the 46 documents analysed, 40 described some form of reflexive process. Ten documents specifically referred to a process of 'reflexivity', either as part of the cultural safety definition [17,18,25,26,29–31,84] or as part of the educational intervention

[23,38]. The remaining 30 documents used variations of the following terms: (self) awareness [20,54,57–59,63,64,69,80,91]; (critical and/or self) reflection [21,22,32,33,36,55–58,63,64,66–68,73,80,81,83–87,91]; (self) examination [16,61,65,71,72,75]. None of the documents analysed used the term reflexivity as a standalone concept; the ten documents that used the term reflexivity did so interchangeably with the other terms listed above.

Where documents described the process of reflexivity, a variety of terms was used. The most common descriptors included 'reflect on' [21–23,27,30–33,36,56,64,66–68,73,80,90]; 'examine' [16,17,25,61,71,72]; 'become aware of' [17,18,36,63,68,75,88]; 'explore' [17,18,36,63,68,75,88]; 'consider' [29,56,67,68]; 'understanding' [36,58,87]; and 'identify' [21,64,67,72,89]. What is notable about these descriptors is that most—including all the most commonly used—describe a passive process of identification, observation, and awareness. In contrast, some descriptors contain a call to action, for example, the requirement to use this new knowledge and understanding of self to enact attitude change [23,36,56,71,72], and to contest and deconstruct previous understandings [29,73].

### 3.4. Conceptualisations of Reflexivity

Four sub-themes emerged relating to how the purpose and focus of reflexivity was conceptualised. These sub-themes included self-identity; held beliefs; relationality; and context, with each sub-theme encompassing a suite of factors that learners were expected to reflect on. These factors are outlined in Table 2, below, although it should be noted that conceptualisations of reflexivity varied considerably across the data and inclusion of a sub-theme did not guarantee inclusion of all factors. All documents included for analysis conceptualised reflexivity using at least one sub-theme, but usually two or more sub-themes were present.

**Table 2.** How the purpose and focus of reflexivity is conceptualised: sub-themes identified in the data.

| Self-Identity | Held Beliefs | Relationality | Context |
|---|---|---|---|
| Identity<br>Culture and ethnicity<br>Worldview<br>Values | Assumptions<br>Biases and stereotypes<br>Internalised racism<br>Power and privilege | Impact of self-identity and held beliefs on relationships with others | Impact of context on self-identity, held beliefs, and relationality |

#### 3.4.1. Sub-Theme 1: Self-Identity

The sub-theme of self-identity was primarily concerned with students reflecting on their own identity, culture, worldviews, and values, and was seen in 30 of the documents analysed [16–18,20–23,26,28–33,36,57–60,62–64,66,67,69–71,73,83,87]. The primary purpose of reflecting on self-identity was broadly described as developing an understanding that identity, culture, worldviews, and values are not universal, exemplified in the following extracts:

> *"Participants were therefore encouraged to…explore their own culture, values, and beliefs [and] acknowledge difference"* [17] (p. 248)

> *"[Cultural safety] requires registered nurses to reflect on their own cultural identity and practice in a way that affirms the culture of clients and co-workers"* [21] (p. 3)

Further, learners were required to develop an understanding that their own self-identity shapes and influences understanding, attitudes, and behaviours, as demonstrated in the following extracts:

> *"This includes understanding your own worldview and how your values and beliefs influence the way you perceive other people"* [57] (p. 88)

> *"[Students will] reflect on their own cultural background and their life experiences including the development of values and attitudes that have shaped their thinking and behaviours"* [23] (p. 120)

#### 3.4.2. Sub-Theme 2: Held Beliefs

Thirty-five of the documents analysed described the sub-theme of held beliefs, where learners were required to identify and articulate their current knowledge, attitudes, biases, power, and privilege specifically in relation to Indigenous peoples [16,17,19–23,25,26,29–31,33,36,38,54,55,57–60,62–64,66,67,69,70,73,80,81,83,87,90,91]. In most of these educational interventions, learners were required to reflect on both self-identity and held beliefs, and these were conceptualised as related. However, eight of the educational interventions only included a requirement to identify, reflect on, and in some cases actively critique held beliefs [19,25,55,56,68,86,88,89].

A closer examination of the language used to describe the sub-theme of held beliefs found that the process and focus of reflexivity was often couched in neutral terms that glossed over the inherent racism underpinning beliefs and attitudes, as seen in the following extracts:

> *"…highlighted the importance of health providers reflecting on and questioning their own assumptions about Aboriginal people that can impact on the care they provide."* [90] (p. 3, emphasis added)

> *"…learners were encouraged to reflect on their own cultural values or emotional responses to diverse histories, cultures, worldviews, values, and contemporary events related to Indigenous people"* [32] (p. e2, emphasis added)

Notably, across the educational interventions, there was minimal expectation that learners would reflect on their future or current professional culture, and the norms, beliefs, and values that would inform their practice. Three exceptions to this are Demers et al. [31], Kelly et al. [20], and Ramsden [70]. Demers et al. note that cultural safety "requires exploration of cultures and identities, on both a personal and professional level" [31] (p. 184). Similarly, Kelly et al. argue that culturally safe nurses are "aware of their own culture and that of the hospital" [20] (p. 110), and Ramsden states that nurses and midwives must become aware of "the cultural boundaries which surround [the] traditional nursing and midwifery role" [70] (p. 23).

#### 3.4.3. Sub-Theme 3: Relationality

Half of the educational interventions ($n$ = 23) described the sub-theme of relationality [16–18,20–22,25,29,31,36,54,57–60,64,66,67,69,70,73,87,91]. In this sub-theme, learners were required to reflect on how self-identity and held beliefs impact on engagement with and care for others, and how this contributes to poor health and social outcomes, as exemplified by the following extracts:

> *"…students reflected on their own place-based identity (i.e., who they were, where they came from) and recognized how their own personal biases were unintentionally but significantly brought into practice and how those biases influenced their work and social interactions"* [31] (p. 187)

> *"…notice our own cultural practices and individual behaviours and the impact these may have on Aboriginal and Torres Strait Islander people"* [87] (p. 23)

#### 3.4.4. Sub-Theme 4: Context

The fourth sub-theme identified in the data was context and was included in 10 of the educational interventions analysed [16,22,23,29,31,55,59,60,67,75]. Context was described as a process of reflecting on how self-identity, held beliefs, and relationality have been shaped by historical, social, political, and economic forces. Like relationality, reflection on context takes the process of reflexivity beyond introspection and allows a more

critical analysis of the self as socially located. In some cases, this was a passive analysis, as in the following extract:

> *"Become aware of their own social conditioning, their (often privileged) status, and how their conditioning and status can affect their interactions with clients"* [59] (p.179)

In contrast, other conceptualisations of reflexivity recognised the opportunity to actively challenge and deconstruct [29] this social conditioning, a process that Sjoberg and McDermott refer to as "disassembling planks of belief" [73] (p. 30).

All educational interventions included content on contextual factors such as colonisation, racism, and sociopolitical processes, and their impact on the health and well-being of Indigenous peoples. It is notable that while there is ubiquitous recognition of how colonialism and racism have impacted on Indigenous health and well-being, there is comparatively less recognition of how these factors have shaped non-Indigenous self-identity, held beliefs, and relationality.

The varying conceptualisations of reflexivity can be seen as existing on a spectrum, ranging from basic reflection on self-identity at one end, to more critical reflection on self-beliefs and relationality in the middle, and reflexive analysis of the self as contextually situated at the other end. This can be seen in Figure 1, below:

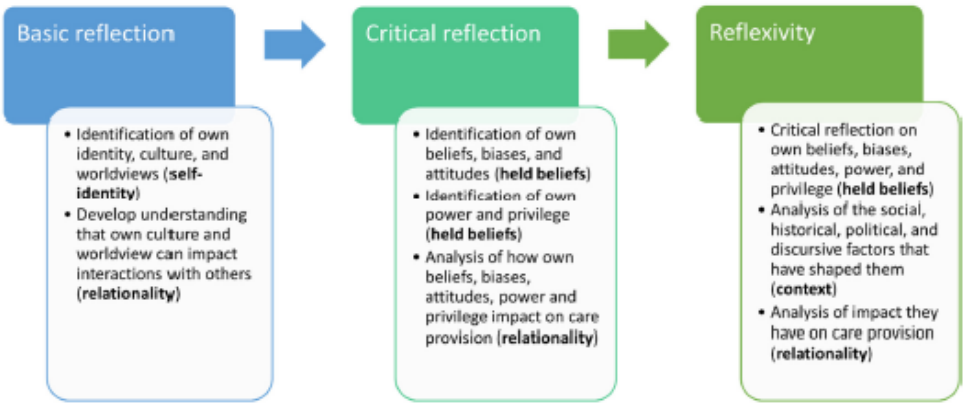


**Figure 1.** Spectrum of reflexive practice.

### 3.5. *Where and How Reflexivity Is Included as a Learning Outcome*

None of the educational interventions included learning outcomes that explicitly required students to develop knowledge of or ability to engage in reflexivity. Instead, reflexivity was operationalised as a method for achieving other learning outcomes, such as developing awareness and knowledge of self-identity, held beliefs, relationality, and/or context. Of the documents included for analysis, only 15 explicitly stated the learning outcomes of the educational intervention, and of these, 10 included learning outcomes relating to reflexivity [17,29,54–56,59,64,70,85,91]. An example of this can be seen in the following extract, which outlines two of the learning aims of a one-day workshop for Australian postgraduate health sciences students:

> *Specific aims of the day were to facilitate students in:*
> *"Recognising and acknowledging their own views and frames of reference in relation to Indigenous Australians";*
> *"Critically reflecting on the impact of ongoing colonisation and its pervasive discourse on the health and well-being of Indigenous Australians."* [55] (p. 106)

In most of the other documents included for analysis ($n$ = 31), expected learning outcomes could be inferred from the description of the educational intervention. For example, the extract below describes the intended learning outcomes of a community placement for master of physical therapy students in Canada:

> *"Our goal was to study whether expanding the clinic beyond the classroom and into a Métis community would make the students more aware of their own identity and worldviews, how they may be different from those in that community, and how they shape their stereotypes and misperceptions of peoples from other cultures."* [58] (p. 147)

The conceptualisation of reflexivity as an approach to learning can be traced back to Ramsden's early work on cultural safety education. The learning objectives outlined by Ramsden specifically require students to "examine their own reality and…attitudes", "be open minded and flexible in their attitudes toward people", and to become "self-aware" [70] (p. 22), learning requirements that are reflected throughout the cultural safety education literature. While there were a range of pedagogical approaches used to facilitate reflexivity, there is no mention of whether students were explicitly taught about the concept and purpose of reflexivity, or how to go about being reflexive. It may be that some of the facilitated activities included instruction on the concept and process, but this is not outlined in any of the literature included for analysis.

### 3.6. *Pedagogical Approaches to Facilitate Reflexivity*

The analysis revealed that reflexivity was facilitated through a range of pedagogical approaches, all of which involved some type of reflexive catalyst [78]. These catalysts were used as a counterpoint to the learner's own lived experiences and worldviews, with the intention that exposure to difference would result in some level of reflexivity. Pedagogical approaches can be seen as grouped into three broad categories, depending on the type of catalyst used: objects, people, and Indigenous pedagogical practices.

#### 3.6.1. Objects

Object catalysts were described in 27 of the educational interventions analysed, and included things like readings, case studies, stories, visual art, and films [17,20,23,24,29–33,36,38,56,59,62–64,66–69,71,73,84,85,87,90,91]. Reflexive engagement with object catalysts was most often depicted as small or large group discussions, where new knowledge and understanding was co-produced through the sharing of beliefs, experiences, and interpretations. Examples of this can be seen in the following extracts:

> *"… the session includes a semi-formal lecture in a quieter space of the gallery … student literature reviews, gallery exploration, and a group reflective discussion."* [30] (p. 37)

> *"The tutorial format was tightly structured and included the viewing of a vodcast (prepared specifically for the unit and featuring Aboriginal speakers), discussion of issues arising, case studies, and periodic presentations by students. … Guidelines [were] developed by students [to facilitate classroom discussions, to ensure] that consideration be given to experiences and background that may influence attitudes expressed."* [23] (pp. 115–116)

#### 3.6.2. People

Twenty-six educational interventions analysed included people as a reflexive catalyst [16–19,21,22,24–28,31,36,38,54–60,62,63,69,80,81,83,84]. Immersive, community-based placements or field trips were the most common ($n$ = 16), where predominantly non-Indigenous students visited (and sometimes stayed in) Indigenous communities or health services [16,18,22,24–27,31,54,57–60,63,81,83]. The educational interventions that took this approach shared similar theoretical underpinnings, where exposure to differ-

ence was described as an opportunity for reflection and growth. The extract below is exemplary of this theory:

> *"Cultural immersion is an experiential approach to learning about culture and social situations. In medical education this type of approach is beginning to be recognized for its potential to raise consciousness among students; expose tacit inappropriate biases, including racism; help students learn about themselves and other cultures; and assist students in their preparation for work in culturally diverse settings."* [26] (p. 3)

In 13 of the educational interventions analysed, Indigenous educators were positioned as the reflexive catalysts, either as core teaching staff [17,36,56,57,68,71,90] or in ad hoc roles such as guest speakers [19,21,60,64] or patient simulation actors [28,63,86]. Indigenous educators were frequently described as providing learners with an opportunity to challenge their own stereotypes and beliefs about Indigenous peoples, as exemplified in the following extract:

> *"Having the opportunity to be taught by and interact with an Indigenous academic is thought to have a major role in reducing stereotypes and negative attitudes about Indigenous Australians … Our objective was to present an Indigenous informed perspective filling in the gaps of knowledge that have resulted from silencing Indigenous peoples, their stories and experiences. We wanted to provide students with some positive and affirming images of the strength and resilience of Australian Indigenous peoples."* [55] (pp. 105–107)

Simulated patient scenarios involving Indigenous people as 'patients' were all described as an opportunity for learners to practice and refine communication skills and develop their cultural safety skills. This was seen as providing a safe, controlled environment for both learners and 'patients' where feedback could be provided to facilitate learner reflection [28,63,86].

#### 3.6.3. Indigenous Pedagogical Practices

Eighteen of the educational interventions analysed described the inclusion of Indigenous pedagogies as a method of facilitating learner reflexivity [16–19,27,30,32,38,54,56,60,64,68,71,73,81,83,84]. In some educational interventions this was an integral aspect of immersive community placements, where learners engaged in a variety of cultural and community events [16,18,27,55,61,85]. In other educational interventions, this was described as a process of engaging with Indigenous ways of knowing, being, and doing through activities such as talking (or yarning) circles [17,57,70,73], storytelling [19,30,32,68,90], and 'Indigenised spaces' [30,65,87]. In these educational interventions, Indigenous pedagogies were described as providing a counterpoint to deficit-based understandings that may be held by learners, or to legitimate Indigenous knowledges, as demonstrated in the following extracts:

> *"field experiences can provide students with a first-hand account of the 'ways of knowing, being, and doing' …that is, communicating with and listening to Aboriginal Elders, practitioners and community members provides a deeper analysis of social work practice through assessing the cultural context, yarning and storying"* [54] (p. 199)

> *"A yarning circle approach was used to privilege First Peoples' culture and voice. First Peoples have recognised yarning as a method of sharing stories, information and knowledge for generations."* [17] (pp. 247–248)

### 3.7. Assessment of Reflexivity

Of the 46 educational interventions analysed, only 22 provided information on the assessment of reflexivity, and in most instances only a brief description of the assessment task(s) was provided [18,22–24,26,27,29,33,38,54–56,58,59,63,66,69,73,81,84,85,91]. The most common forms of assessment were written reflections in the form of journals

[23,24,29,57,60,87], essays [22,59,67,68,75], and portfolios [26,27,33]. Other forms of assessment included structured reflective questions [54,85], oral presentations [18], and arts-based reflection activities [59,63].

A common theme throughout assessments is the requirement for students to reflect on their learning, and how this applies to them personally and professionally, as demonstrated by the following extracts:

> *"Students subsequently submitted a critical self-reflection exploring their personal learnings, including reflections on assumptions, discomfort and realisations."* [38] (p. 6)

> *"The idea that students would be given a 'real world' experience, be required to reflect on what they had observed and what they had learnt, with supporting literature, was vital to identifying elements of changing attitudes and effectiveness of learning. Furthermore, students then had to plan how they would use their new knowledge in future practice contexts."* [54] (p. 201)

The above extracts demonstrate the two different ways that learners were required to reflect on their learning. In the first extract [38], the purpose of the assessment is described as assessing what students have learned about themselves, demonstrating an inward focus on self-identity and held beliefs. In the second extract [54], assessment is described as having a more applied focus; students must reflect on what they have learned and consider the implications for practice.

Two documents included for analysis focused specifically on the assessment of reflexivity in their respective educational interventions, with descriptions of how these assessments connect to learning outcomes and are supported via learning activities. Sjoberg and McDermott [73] discuss what they call the 'deconstruction exercise', where students are required to critically examine and 'deconstruct' their chosen question rather than answer it directly. The aim is to expose the racialised assumptions and stereotypes that inform the question and how this links to broader social, historical, and political contexts. By externalising this critique, Sjoberg and McDermott argue that the deconstruction exercise provides learners with an "opportunity to reflect on the everyday language in which they may be immersed, to see behind the dominant Australian lexicon to the colonial, discursive position from which it has been constructed" [73] (p. 31).

Power et al. [22] describe a reflective essay assignment in which students were required to complete three online reflections before, during, and after their 3-week placement. Students were provided with 'trigger questions' to prompt their online reflections, and these reflections formed the basis of their submitted reflective essay. The trigger questions step students through the reflective process, prompting them to think about their current knowledge and expectations (pre-placement), new learnings about themselves (mid-placement), and how this applies to future practice (post-placement).

What is notable about the educational interventions described by Sjoberg and McDermott [73] and Power et al. [22] is that learners are supported to complete these assessments in several ways, including clear links made to topic content, scaffolded activities to support reflexive skill development, and prompting questions to guide the reflexive process. Several other educational interventions described similar approaches to support learner reflexivity, although only limited information was provided. For example, Chiodo et al. note that learners were required to keep a reflective journal in which they "reflect upon the topics covered in class and in the set reading material … to think about what the issues/concepts/theories…meant for them both in their personal and professional lives" [29](p. 184). Here, assessment requirements are clearly tied to learning content and instructions regarding the focus of reflexivity; this was described in eight documents analysed [22,26,29,55,64,67,68,75].

## 4. Discussion

The current study analysed a total of 46 documents, which described 43 different educational interventions. Definitions and conceptualisations of reflexivity varied; in many definitions, reflexivity was conceptualised as a passive process of observation rather than an active process of analysis, critique, and change. Four sub-themes were identified: self-identity, held beliefs, relationality, and context, with conceptualisations of reflexivity drawing on varying combinations of these sub-themes.

In all educational interventions analysed, reflexivity was considered an approach to learning rather than a learning outcome itself. Only 15 of the documents included for analysis specifically outlined syllabus learning outcomes, so it is possible that the other educational interventions include learning outcomes related to the development of reflexivity as a skill. Pedagogical approaches relied on three types of reflexive catalysts: objects, people, and Indigenous pedagogies. The use of reflexive catalysts was premised on the assumption that exposure to difference would engender understanding and respect for perspectives, beliefs, and experiences different to those of the learners. There was limited information available on the assessment of reflexivity, although most assessments focused on new knowledges and understandings gained through the educational intervention, including knowledge of self, and how these apply to students' personal and professional lives.

It is noteworthy that 14 of the documents analysed included a definition of cultural safety that did not include reflexivity as a core aspect of culturally safe practice, with eight of those documents positioning reflexivity as additional to cultural safety, and six documents making no reference to reflexivity at all. Definitions that lack reference to reflexivity tend to align more with cultural competency models, which emphasises learning about other cultures and has been criticised as taking a more tick-box approach that risks essentialising culture and reinforcing stereotypes [13,45]. Cultural safety specifically moves away from this model of learning, with the emphasis placed on students learning about themselves and their own culture, and how power imbalances impact healthcare provision. Notably, there were several documents included in the analysis that used the terms 'cultural safety', 'cultural awareness', and 'cultural competency' interchangeably (for example, [21,23]) or conceptualised them as aspects or stages of the same process (for example, [17,36,86]). This potentially highlights a lack of understanding of core cultural safety concepts, and arguably, results in less effective teaching.

Variations in how cultural safety is conceptualised may provide some explanation for the variations in how reflexivity was defined and conceptualised. As noted by Lumsden [39], definitions of reflexivity differ according to context and purpose. The analysis showed that where the purpose of the educational intervention was to increase recognition and respect for diversity, reflexivity tended to be conceptualised as a process of understanding self-identity, held beliefs, and in some cases, relationality [16–20,22,23,25,26,28–33,36,38,54,55,57–60,62–64,66,67,69,70,73,80,81,83,87,90,91]. Where educational interventions were conceptualised as a way to address colonialism, privilege, and power imbalances, reflexivity was defined as a process of identifying and critiquing self-beliefs and the structural, institutional, and discursive factors that contribute to them [16,22,23,29,31,55,59,60,67,75].

As outlined in Figure 1, reflexivity could be conceptualised as existing on a spectrum. At one end, reflexivity was concerned with acknowledging and exploring self-identity and held beliefs, while at the other end, reflexivity was concerned with contextualising the self as socially located. Most of the documents analysed fell into the 'basic' or 'critical' reflection portions of the spectrum, with a greater focus on identification and understanding of self-identity and held beliefs, and to a lesser extent relationality. Expectations that students will identify and critique their self-identity and held beliefs would arguably be a contributing factor to student feelings of discomfort and resistance [48–50]. While discomfort is a necessary part of transformative learning, this discomfort needs to be carefully managed [49,50,54]. We would argue that a greater focus

on the social, historical, political, and discursive forces which inform and shape students' self-identity and held beliefs are an important part of the reflexive process. This would provide students the opportunity to understand that these are not immutable aspects of their own identity, but rather changeable aspects that have been shaped by problematic, inequitable, and racist systems [73]. If adequately managed, students may feel empowered to change problematic beliefs and attitudes while critiquing the systems that produced them.

All educational interventions analysed included information about the social determinants of health, so it is possible that learners were assisted to reflect on the connections between their own worldviews and broader contextual factors during learning. This is common throughout the cultural safety education literature, where learning about social determinants is positioned as a method for challenging and critiquing racialised beliefs, assumptions, and stereotypes that may negatively impact on care provision [20,33,42,43,56,57,68,71,72]. However, this was not evident from the available data, where discussion of the social determinants was explicitly described as developing an understanding of their impact on health outcomes for Indigenous peoples. Arguably this works to construct social processes as unidirectional, only impacting on Indigenous peoples' health, without acknowledgement of how learners themselves are embedded within and shaped by these processes. This potentially limits the extent to which learners can engage in reflexivity, directing greater attention to self-identity and held beliefs and how they impact on behaviours and attitudes towards others.

The pedagogical methods used to facilitate reflexivity are also worth greater examination. More than half ($n = 26$) of the documents analysed used people as the catalyst for reflexivity, where exposure to people with different cultures and life experiences provided learners with a counterpoint to their own culture, beliefs, assumptions, and stereotypes. Cultural immersion theory aligns with a pedagogy of discomfort [49], in that learners are taken out of their comfort zones and confronted with new knowledges and experiences that may challenge their preconceptions. What is notable here is that, while many of the immersion-based curricula were designed and delivered by Indigenous community members, there was little consideration given to the cultural safety of this experience for the community itself. In contrast, learner needs were paramount in discussions, with a range of strategies employed to manage student discomfort and create culturally safe learning experiences. For example, Gray et al. [62] describe an Indigenous health workshop for fourth-year allied health students, in which students interviewed local Aboriginal Elders and other community members to develop culturally safe communication skills. Gray et al. note that "this process provided a 'safe space' for students to interact with an Indigenous Australian person" [62] (p. 3). Arguably, however, there is at least as much risk for elders and other community members in the potential exposure to the racism, dismissive attitudes, and resistance to learning that often accompanies student feelings of discomfort [23,49,50]. Gray et al. indirectly acknowledge the potential for this to occur, noting that educators are taught how to de-escalate situations, and "post-workshop debrief sessions were held for teaching staff, to allow for the 'venting' of concerns" [62] (p. 3).

In other immersive-based curricula, efforts were made to ensure that reciprocity was an underpinning principle, where communities received as much benefit as students did. This is exemplified by Hudson and Maar, who note that their placement experience was informed by a social accountability model, where "the obligation of medical schools is to direct education, research and service activities towards addressing priority health concerns in the community" [26] (p. 2). While laudable, it does not explicitly address the potential risks for the community members hosting students; there is an expectation that the risk to educators and other community members is worth the educational gains for students. Only two educational interventions explicitly addressed the issue of safety for Indigenous educators and community members [55,80], acknowledging the potential for Indigenous people to be exposed to racism. The culturally unsafe nature of the classroom

for Indigenous educators is well recognised (see for example, [53,80,81]) yet there are currently limited strategies put in place to address this risk. Most educational interventions analysed had some level of Indigenous involvement in development and/or delivery (see Table 1), yet on its own this does not guarantee the safety of Indigenous educators or community members. There is a need for more research to develop strategies that minimise the risk for Indigenous people working in this space [92].

Finally, the lack of information on the assessment of reflexivity within cultural safety curricula highlights a significant gap in the literature. Reflexivity is a fundamental aspect of being culturally safe; presumably, then, it is important to determine whether learners have developed the necessary reflexive skills to become culturally safe. Yet assessment is often glossed over in curricula descriptions, with only brief summaries provided of what is being assessed. In all instances where information on assessments was provided, learners were expected to demonstrate reflection on learning and how this applied to them personally and professionally. There were no examples that required students to explicitly demonstrate reflexive skills; in other words, assessment was of content rather than process. Arguably there are issues with this approach; as noted previously, focusing on what students have learned about themselves is potentially problematic and could be a causative factor in student feelings of discomfort, disengagement, and resistance [50,75,80]. Additionally, the potential for students to game their reflections also calls into question the efficacy of these types of assessments. A possible solution is to shift the focus of assessment from content to process, where learners' ability to demonstrate reflexivity is assessed, although currently there is very little research to indicate what this might look like (for example, [93]), and none within cultural safety education. Arguably then, there is a need for more research to determine how best to assess reflexive skills within cultural safety education without reducing it to either a checklist approach or a navel-gazing exercise [40].

While the results of this study are specifically concerned with reflexivity in the context of Indigenous cultural safety, cultural safety is increasingly being adopted in other discipline and population contexts. In particular, there is growing interest in how cultural safety might improve care provision and health outcomes for marginalised and disadvantaged populations, for example the LGBTIQA+ community [88,89], racial and cultural minority groups [94,95], and Indigenous populations globally [96]. In an increasingly globalized and multicultural society, the importance of cultural safety and the ability to engage reflexively is fundamental to the provision of equitable, non-discriminatory care.

*Limitations*

A potential limitation of the current study is the type of literature that has been included. Most articles included in the analysis were evaluations of all or part of a cultural safety curriculum, with information on the learning outcomes, pedagogical approaches, and assessment options provided in the introduction or methodology sections. Articles were included where they provided sufficient information on at least three of the four key areas of analysis. The reliance on this type of data may explain the paucity of information on assessment approaches, as this was not a key feature of curriculum evaluations, where most of the focus was on changes in learner attitudes and knowledges, or learner experiences. However, the inclusion of this literature also means that a much broader picture of cultural safety education can be gleaned, compared to only including articles that focus on curriculum description.

Another possible limitation is that literature was only sourced from Australia, Aotearoa New Zealand, Canada, and the United States. It is possible that additional insights and perspectives might have been gained from other countries, broadening our current understanding of cultural safety curricula. Given the similarities in colonial history and Indigenous experiences of health and social inequity, it was felt that the cultural safety

curricula literature would be comparable across these four countries, whereas this may not be the case for other countries.

## 5. Conclusions

While there is a substantial body of research exploring pedagogical approaches to teaching cultural safety in the context of Indigenous health, relatively little work has been done to determine best practice approaches to teaching and assessing reflexivity as a core cultural safety skill. Indeed, the above analysis demonstrates that even within the cultural safety education literature, there is substantial variation in whether and how reflexivity is included within definitions of cultural safety, and how reflexivity itself is conceptualised. This lack of conceptual clarity presents issues for educators when trying to develop cultural safety curricula and suggests that more work is required to develop a more cohesive model of reflexivity specifically aligned with the aims of cultural safety curricula and practice. Additionally, more thought must be given to the pedagogical and assessment approaches utilised within cultural safety education. A range of strategies were utilised during learning to manage student discomfort, yet almost no attention was given to how that discomfort might manifest in the context of assessments. Likewise, while there was a substantial focus on student safety within the educational interventions, relatively few educational interventions considered the cultural safety of Indigenous educators and community members involved in the development of delivery of these programmes. Further research is required to provide greater conceptual clarity, consistency in skills development, and safety of learners and educators alike.

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# Appendix 2

## Appendix 2.1: Detailed outline of topic learning outcomes and content

**HLTH2102 Topic: Expected Learning Outcomes**

| | |
|---|---|
| **LO1** | Use appropriate language and accurately describe the diversity of the Indigenous Australian population and cultures. |
| **LO2** | Understand the major health issues relevant to Indigenous health status. |
| **LO3** | Identify and develop an understanding of the social determinants of Indigenous health. |
| **LO4** | Appreciate and reflect on Topic material in relation to one's own cultural background and identify impacts on Health Sciences practice. Describe the personal, professional, and structural elements of Cultural Safety and apply to Health Sciences practice. |
| **LO5** | Recognise and explain how the colonisation of Australia continues to impact on Indigenous health. |
| **LO6** | Critically analyse and reflect on how racism and discrimination impact on Indigenous health outcomes. |
| **LO7** | Develop reflective communication skills for Health Sciences practice that are commensurate with the principles of Cultural Safety. |
| **LO8** | Understand the role of practitioners working with Indigenous Australians in a range of health care settings and communities, through examples of best practice in primary health care. |

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| **LO9** | Become familiar with Indigenous holistic and traditional health practices and appreciate their incorporation into a western framework of Health Sciences practice. |
| **LO10** | Articulate the importance of family, country, and sovereignty to the development of Indigenous identity and health and wellbeing. |
| **LO11** | Describe differences in public health infrastructure between metropolitan, rural, and remote areas. |

**HLTH2102 Topic: Structure and content**

| Week | Lecture content | Tutorial content |
|---|---|---|
| ***Module 1: Topic introduction*** | | |
| **1** | **Topic overview**<br>Key concepts:<br>• Culture and identity<br>• Respectful terminology<br>• Self-reflexivity<br>• Critical thinking | Pre-tutorial activities:<br>• Introducing yourself on the Discussion Forum<br>• Introduction to the 'cultural backpack'<br>In-class activities:<br>• Using the 'Cultural Iceberg' to unpack cultural identity<br>• Critical examination of the contents of our 'cultural backpacks' |
| **2** | **Health inequities and the Social Determinants of Health**<br>Key concepts:<br>• Statistical data considerations<br>• Inequality versus inequity<br>• Current health inequities<br>• Evaluating data sources<br>• How to use the grey literature | Pre-tutorial activities:<br>• Grey literature evaluation<br>• Identify and consider how social determinants of health have impacted own health<br>• Choosing a case study: part I<br>In-class activities:<br>• Whose Traditional Lands are you on? Facilitated reflection<br>• Navigating the statistical data<br>• Small group discussions |
| ***Module 2: Social & Cultural Determinants of Indigenous Health*** | | |
| **3** | **Our shared histories: Colonisation and its aftermath (guest lecturer)**<br>Key concepts:<br>• Pre-colonisation<br>• Early colonisation<br>• Colonisation as an ongoing process | Pre-tutorial activities:<br>• Art-Led Learning activity sheet: Ali Gumillya Baker art collection<br>In-class activities:<br>• Art-Led Learning activities: small and large group discussions<br>• Facilitated reflection |

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| **4** | **Racism, privilege, and health (guest lecturer)**<br>Key concepts:<br>• Theoretical foundations of racism<br>• Experiences and effects of racism<br>• Resistance and decolonisation | Pre-tutorial activities:<br>• Structured reflection questions on the weekly reading<br>• Case study part II: applying learning from the lecture<br>In-class activities:<br>• Response to the weekly reading: Facilitated reflection<br>• Critiquing racialised media: group activity |
| **5** | **Policies past and present**<br>Key concepts:<br>• Historical policies and their impact<br>• Contemporary policies and their impact<br>• Critical perspectives on policy | Pre-tutorial activities:<br>• Art-Led Learning activity sheet: Sandra Saunders art collection<br>In-class activities:<br>• Art-Led Learning activities: small and large group discussions<br>• Facilitated reflection |
| **6** | **Health systems and communication (guest lecturer)**<br>Key concepts:<br>• Family and kinship structures<br>• Barriers to access mainstream healthcare services<br>• Communication in healthcare | Pre-tutorial activities:<br>• Case study part III: applying learning from the lecture<br>In-class activities:<br>• Critiquing communication in healthcare: Byalawa video activity<br>• Critical analysis of mainstream and Aboriginal Community Controlled Health Service accessibility |
| **7** | **Country, Land Rights, and the Justice System (guest lecturer)**<br>Key concepts:<br>• Connection to Country<br>• Land Rights and self-determination<br>• The (in)justice system and impact on health and wellbeing | Pre-tutorial activities:<br>• Art-Led Learning activity sheet: Darren Siwes art collection<br>In-class activities:<br>• Art-Led Learning activities: small and large group discussions<br>• Facilitated reflection |

| *Module 3: Cultural Safety in Practice* | | |
|---|---|---|
| **8** | **Introduction to Cultural Safety**<br>Key concepts:<br>• Person-centred care<br>• Cultural Safety<br>• Cultural Responsiveness | Pre-tutorial activities:<br>• Structured analysis of the weekly reading<br>In-class activities:<br>• Facilitated reflection on learning<br>• Group discussion<br>• Applying learning to the case study |
| **9** | **Being a culturally safe health professional (guest lecturer)**<br>Key concepts:<br>• Review of Cultural Safety principles<br>• Professional requirements<br>• Practical strategies<br>• Applying our learning: example | Pre-tutorial activities:<br>• Applying our learning to the case study<br>In-class activities:<br>• Facilitated reflection on the pre-tutorial activity<br>• Small and large group discussions |
| **10** | **Creating a culturally safe health service**<br>Key concepts:<br>• Aboriginal Community Controlled Health Services (ACCHS)<br>• What we can learn from ACCHS<br>• How can you create a culturally safe healthcare service? | Pre-tutorial activities:<br>• Comparative analysis of mainstream healthcare service and ACCHS<br>In-class activities:<br>• Facilitated reflection<br>• Small and large group discussions |
| **11** | **Indigenous health in a global context (topic coordinator & guest lecturer)**<br>Key concepts:<br>• Aotearoa<br>• Canada<br>• United States<br>• Comparing the statistics | Pre-tutorial activities:<br>• Weekly readings<br>In-class activities:<br>• Video and structured analysis of colonial narratives<br>• Small group discussion to identify and critique colonial narratives in media |

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|---|---|---|
| **12** | **Where to from here?**<br>Key concepts:<br>• Being an ally: tokenism versus active allyship<br>• Anti-racism<br>• Future learning and suggested resources | Pre-tutorial activities:<br>• Weekly readings<br>In-class activities:<br>• Facilitated reflection on learning<br>• Video and small group discussions |

Appendix 2.2: Assessment instructions provided to students completing the *Indigenous Health for Health Sciences* topic assessment 3, Video Reflection

# AE3: Case Study Video Reflections

# INSTRUCTIONS

***Scope***

The purpose of this assessment is to provide you with an opportunity to:

- practice your critical reflection/reflexive skills
- discuss your understanding of Cultural Safety principles and why they are important to health care practice and delivery
- critically reflect on and discuss the case study, with the aim of identifying culturally unsafe practice, and opportunities for the provision of culturally safe care

***Task***

You are required to record and upload three video reflections, with each providing a discussion of your learning in the topic. Each video reflection should be approximately 5 minutes in length (maximum 7 minutes) and should address the guiding questions outlined below.

| **Video reflection 1** | ***Social and cultural determinants of Aboriginal health*** **Due 2pm Wednesday 7 October 2020** |
|---|---|
| Guiding questions: | • How has your learning over Module 2 (weeks 3 – 9) affected your understanding of Aboriginal and Torres Strait Islander health?<br>• How has the case study contributed to your learning about the social and cultural determinants of Aboriginal health?<br>• Which resources did you find most helpful in your learning, and why? |

| **Video reflection 2** | ***Cultural Safety principles*** **Due 2pm Wednesday 21 October 2020** |
|---|---|
| Guiding questions: | • Discuss what you understand about the principles of Cultural Safety<br>• Discuss your personal position on the relevance of Cultural Safety in healthcare delivery (what and why)<br>• Discuss the resources that helped you develop your understanding of and personal position on the relevance of Cultural Safety – what were they, and why were they helpful? |
| **Video reflection 3** | ***Application of Cultural Safety to the case study*** **Due 2pm Wednesday 4 November 2020** |
| Guiding Questions: | • Identify and discuss where Cultural Safety could improve the outcomes and wellbeing of the person in your case study<br>• Discuss the resources that helped develop your understanding of culturally safe practice – what were they, and why were they helpful<br>• Identify and discuss how you might continue learning about and developing your Cultural Safety skills in the future |

Please see below for instruction on how to record and upload your videos, and the requirements for submission.

| ***AE3 relates to the following topic Learning Outcomes:*** | |
|---|---|
| **LO1** | Use appropriate language and accurately describe the diversity of the Indigenous Australian population and cultures. |
| **LO3** | Identify and develop an understanding of the social determinants of Indigenous health. |
| **LO4** | Appreciate and reflect on Topic material in relation to one's own cultural background and identify impacts on Health Sciences practice.<br>Describe the personal, professional, and structural elements of Cultural Safety and apply to Health Sciences practice. |
| **LO7** | Develop reflective communication skills for Health Sciences practice that are commensurate with the principles of Cultural Safety. |

| | |
|---|---|
| **LO8** | Understand the role of practitioners working with Indigenous Australians in a range of health care settings and communities, through examples of best practice in primary health care. |

***Please note:*** *These Learning Outcomes are included to help guide your thinking and demonstrate the links between topic content and assessment exercises. They should be drawn on as appropriate to your assigned case study.*

| **Submission requirements** | |
|---|---|
| ***Recording your videos*** | • Videos should be between 5 – 7 minutes in length<br>• Videos can be recorded on a range of devices (e.g. tablet, mobile phone)<br>• Your videos can be as creative as you like, e.g. you can include pictures, music, backgrounds, etc., as long as you address the assignment criteria adequately<br>• Videos can be edited using online editing software if you require<br>For more information on recording and editing videos, please visit the FLO Student Support 'More on Video Assignments' link. |
| ***Submission*** | • Video files need to be clearly labelled with your name, the assessment number and case study name, e.g.<br>J_Dawson_AE3_VR1_Benny<br>• Videos can be submitted using either My Media or as a drag-and-drop file directly into the assignment submission drop box.<br>Please note: We strongly recommend using My Media to manage and submit your videos, as this will automatically compress video files.<br>For more information on submitting video assignment files, please visit the FLO Student Support 'Video Assignments' link. |

# AE3: Case Study Video Reflections

## INSTRUCTIONS

## ***REVISED***

**Please note:** these instructions have been revised to incorporate video reflection 2 and 3 into one single video submission.

If you have already recorded your video reflection 2, you will be able to submit 2 shorter videos if you ensure that all assignment criteria are addressed.

### *Scope*

The purpose of this assessment is to provide you with an opportunity to:

- practice your critical reflection/reflexive skills
- discuss your understanding of Cultural Safety principles and why they are important to health care practice and delivery
- critically reflect on and discuss the case study, with the aim of identifying culturally unsafe practice, and opportunities for the provision of culturally safe care

### *Task*

You are required to record and upload three video reflections, with each providing a discussion of your learning in the topic. Each video reflection should be approximately 5 minutes in length (maximum 7 minutes) and should address the guiding questions outlined below.

| | |
|---|---|
| **Video reflection 2** | ***Cultural Safety: principles and application to case study***<br>**Due 2pm Wednesday 21 October 2020** |

| | |
|---|---|
| Guiding questions: | • Discuss what you understand about the principles of Cultural Safety<br>• Discuss your personal position on the relevance of Cultural Safety in healthcare delivery (what and why)<br>• Identify and discuss where Cultural Safety could improve the outcomes and wellbeing of the person in your case study<br>• Discuss the resources that helped you develop your understanding of and personal position on the relevance of Cultural Safety – what were they, and why were they helpful?<br>• Identify and discuss how you might continue learning about and developing your Cultural Safety skills in the future |

Please see below for instruction on how to record and upload your videos, and the requirements for submission.

| ***AE3 relates to the following topic Learning Outcomes:*** | |
|---|---|
| **LO1** | Use appropriate language and accurately describe the diversity of the Indigenous Australian population and cultures. |
| **LO3** | Identify and develop an understanding of the social determinants of Indigenous health. |
| **LO4** | Appreciate and reflect on Topic material in relation to one's own cultural background and identify impacts on Health Sciences practice.<br>Describe the personal, professional, and structural elements of Cultural Safety and apply to Health Sciences practice. |
| **LO7** | Develop reflective communication skills for Health Sciences practice that are commensurate with the principles of Cultural Safety. |
| **LO8** | Understand the role of practitioners working with Indigenous Australians in a range of health care settings and communities, through examples of best practice in primary health care. |

***Please note:*** *These Learning Outcomes are included to help guide your thinking and demonstrate the links between topic content and assessment exercises. They should be drawn on as appropriate to your assigned case study.*

| **Submission requirements** | |
|---|---|
| ***Recording your videos*** | • You video should be between 10 – 14 minutes in length<br>• Videos can be recorded on a range of devices (e.g. tablet, mobile phone)<br>• Your videos can be as creative as you like, e.g. you can include pictures, music, backgrounds, etc., as long as you address the assignment criteria adequately<br>• Videos can be edited using online editing software if you require |

| | |
|---|---|
| | For more information on recording and editing videos, please visit the<br>FLO Student Support 'More on Video Assignments' link. |
| ***Submission*** | • Video files need to be clearly labelled with your name, the assessment number and case study name, e.g.<br>J_Dawson_AE3_VR2_Benny<br>• Videos can be submitted using either My Media or as a drag-and-drop file directly into the assignment submission drop box.<br>**Please note:** We strongly recommend using My Media to manage and submit your videos, as this will automatically compress video files.<br>For more information on submitting video assignment files, please visit the FLO Student Support 'Video Assignments' link. |

*The original version of the assessment included three video reflections. In response to both tutor and student feedback, the second and third video reflection videos were revised and combined into one video reflection, to be submitted later in the semester.

## Appendix 2.3: Transcription notations used during qualitative analysis of student reflective videos

**Transcription notations**

| | |
|---|---|
| Slight pause (<0.5 seconds) | , |
| Short pause (approx. 0.5 seconds) | (.) |
| Long pause (approx. 1 second) | (..) |
| Very long pause (> 1 second) | (…) |
| Laughing, coughing, etc. | ((laugh)), ((cough)) |
| Emphasis on word | Underline word or section |
| Questioning intonation | ? |
| Prolonged sound | :: |
| Abrupt termination of word | - |
| Inaudible word | [unclear] or [best guess?] |

Transcription notations used in this study are an adapted version of the orthographic transcription process provided in Braun & Clarke (2010, pp. 165-166) and the simplified version of Jeffersonian transcription presented in Potter (1996, pp. 233-234).

## Appendix 2.4: Standard grade descriptors provided by the university

| Grade | Description |
|---|---|
| ***Pass (P)*** | The grade will be awarded where there is evidence that a student has demonstrated at least an adequate level of knowledge/ understanding/ competencies/ skills required for meeting topic outcomes and satisfactorily completing essential assessment exercises. |
| ***Credit (CR)*** | The grade will be awarded where there is evidence that a student has demonstrated a sound level of knowledge/ understanding/ competencies/ skills required for meeting topic outcomes at a proficient standard.<br>The student would normally have attained a sound knowledge of matter contained in set texts or reading materials and have done wider reading and demonstrated familiarity with and the ability to apply a range of major academic debates, approaches, methodologies and conceptual tools.<br>Students should have a reasonable opportunity of reaching this grade provided they have completed all course requirements, demonstrated proficiency in the full range of course outcomes and shown considerable evidence of a sound capacity to work with the range of relevant subject matter. |
| ***Distinction (DN)*** | The grade will be awarded where there is evidence that a student has demonstrated advanced knowledge/ understanding/ competencies/ skills required for meeting topic outcomes and completing assessment exercises at a high standard.<br>The student would normally have attained an advanced and have demonstrated a broad familiarity with and facility at applying a range of major academic debates, approaches, methodologies and conceptual tools.<br>The grade should reflect very high quality work which shows the student generally works at a level which is beyond the requirements of the topic outcomes and is developing a capacity for original and creative thinking. |

| | |
|---|---|
| ***High Distinction (HD)*** | The grade will be awarded where there is evidence that a student demonstrated the acquisition of an advanced level of knowledge/understanding/competencies/skills required for meeting topic outcomes and passing the range of topic elements at the highest level.<br>The student would normally have attained an in-depth knowledge of and have consistently demonstrated a high level of proficiency at applying a range of major academic debates, approaches, methodologies and conceptual tools and combining knowledge of the subject matter of the topic with original and creative thinking.<br>The grade will be awarded in recognition of the highest level of academic achievement expected of a student at a given topic level. |
| ***Fail (F)*** | The grade will be awarded if a student is unable to demonstrate satisfactory academic performance in the topic or has failed to complete essential topic elements or required assessment exercises at an acceptable level, in accordance with topic outcomes. |

# Appendix 3

*Closing the Gap: Examining how the problem of Aboriginal and Torres Strait Islander disadvantage is represented in policy*

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WILEY

ORIGINAL ARTICLE

# Closing the Gap: Examining how the problem of Aboriginal and Torres Strait Islander disadvantage is represented in policy

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**Abstract**

Policymaking is increasingly being recognised as a value-laden process in which social problems are not simply identified and measured, but discursively produced. The current study examined how the problem of Indigenous disadvantage is produced within the original Closing the Gap policy framework, to identify underlying assumptions and problem representations. Bacchi's "What's the Problem Represented to be?" approach was used as the analytic framework, with critical discursive analysis used for a fine-grained discourse analysis. Findings indicate that the problem of Indigenous disadvantage is produced in culturally limited terms, demonstrates lifestyle drift and relies on deficit-based narratives of Aboriginal and Torres Strait Islander Australians, which collectively work to produce disadvantage as a product of individual behaviours, and problematises Aboriginal and Torres Strait Islander people as inherently dysfunctional. Potential lived effects of these discourses are discussed, and future areas of research are identified.

**KEYWORDS**

Aboriginal, deficit discourse, Indigenous policy, lifestyle drift, problem representation



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# 1 | INTRODUCTION

Closing the Gap, the national policy framework for addressing Aboriginal and Torres Strait Islander[1] disadvantage, is currently undergoing a significant refresh considering the limited progress made against the policy targets between 2008 and 2020. In the 2020 Prime Minister's annual report on Closing the Gap, only two of the seven targets were on track to being met within the policy timeframe (DPMC 2020). Underpinning the refresh process is the new Partnership Agreement on Closing the Gap 2019–2029 (COAG 2019), which recognises the need to move from a problem- and deficit-based approach to one that recognises strengths and capacities and ensures that policy targets and approaches are community driven. Much like the initial development and implementation of Closing the Gap, the refresh process represents an important opportunity for achieving substantial improvement in Aboriginal and Torres Strait Islander health and socioeconomic outcomes and addressing some of the more problematic aspects of the original policy framework. A critical analysis of problem representations within the Closing the Gap framework will highlight the dominance of particular discourses, the way these shape policy approaches and lessons to be learned going forward. The following sections will provide a brief background to the Closing the Gap policy framework and our rationale for taking a policy-as-discourse approach to analysis.

## 1.1 | Background

Health disparities experienced by Aboriginal and Torres Strait Islander people are well documented (AIHW 2015; ABS 2019a; ABS 2019b) and have been a source of national discussion and debate for over 50 years. Chronic and communicable diseases, mental health issues, injury and avoidable hospitalisations all occur at unacceptably higher rates for Aboriginal and Torres Strait Islander Australians than for non-Indigenous Australians (AIHW 2015), with a current infant and child mortality rate two times greater than for non-Indigenous children (DPMC 2020). Additionally, the all-cause mortality has a rate ratio of 1.7 times higher for Aboriginal and Torres Strait Islander Australians in comparison with the non-Indigenous population (ABS 2019b). Higher mortality rates are reflected in the enduring gap in life expectancy, where estimates indicate that Aboriginal and Torres Strait Islander Australians will live approximately 10 years less than their non-Indigenous counterparts (AIHW 2015; ABS 2019a).

In 2005, the Social Justice Report (Calma 2005) highlighted the enormity of the health inequities experienced by Aboriginal and Torres Strait Islander Australians, most demonstrably through the then 17-year gap in life expectancy. Crucially, it also highlighted the structural factors contributing to health inequity, including the issues of healthcare and health infrastructure accessibility, education, and employment (Calma 2005). The following year, 'Close the Gap' became the public catch cry of the Campaign for Indigenous Health Equality, with the grassroots movement gaining widespread public support. In February 2008, the newly elected Labor government offered a landmark National Apology to the Stolen Generations (AIATSIS n.d.). This was followed by the National Indigenous Health Equality Summit, where a Statement of Intent was signed by representatives from both the government and a range of Aboriginal and mainstream health organisations (HREOC 2008). The Statement of Intent outlined a series of commitments made by the government to achieve health equality for Aboriginal and Torres Strait Islander Australians by 2030, including to work 'collectively to systematically address the social determinants' that impact health (HREOC 2008:17). It also formed the basis for the development

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of Closing the Gap, the government's policy framework for addressing Indigenous health and socioeconomic disadvantage.

The government's bipartisan approach to Indigenous policy, coupled with the commitment to work in partnership with Aboriginal and Torres Strait Islander Australians to address a range of health and socioeconomic indicators, meant that Closing the Gap was viewed by many as a watershed moment in Australian policy (HREOC 2008; Mackean et al. 2008; Mooney 2008). The Council of Australian Governments (COAG) outlined a set of key targets with specific timelines, as well as a range of funding agreements with measures to address what were deemed to be the 'building blocks' necessary to successfully meet the policy targets, which included early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership (DoFHCSIA 2009:20). The specificity of target timelines, the bipartisan commitment and the substantial investment in funding and resources set Closing the Gap apart from previous policy efforts.

Despite its outward appearances, it has been argued that Closing the Gap is fundamentally no different from previous policy approaches (Marks 2008; Altman et al. 2009; Pholi et al. 2009). Altman et al. (2009:226) argue that the current focus on Closing the Gap is almost identical to previous governments' efforts to achieve 'statistical parity' and that ostensibly, the only real difference is the specificity of timelines. Donato and Segal (2013) note that there were no changes to funding structures, and thus, current funding siloes continue to prevent a truly whole-of-government response. Altman et al. (2009) and Hoy (2009) have also questioned the likelihood of achieving policy targets in the stated timeframe, based on previous trends in the data and the complexity of intergeneration health issues.

Other critiques of Closing the Gap indicate more deep-seated issues within the policy framework. It has been noted that while the policy acknowledges and, to some extent, addresses broader social determinants of health, specific measures are predominantly aimed at individual and community behaviour change (Pholi et al. 2009; Holland 2018). Others have noted a reliance on *deficit discourse* throughout the policy, which emphasises disadvantage and problems with little recognition of strength and capacity (Pholi et al. 2009; Fogarty, Bulloch et al. 2018). Fogarty, Bulloch et al. (2018) note that a reliance on deficit discourse works to focus attention on the symptoms of disadvantage, such as individual and community behaviours, rather than the underlying structural causes. This discourse also carries the potential to further entrench negative stereotypes of Aboriginal and Torres Strait Islander Australians, as well as shifting blame to Aboriginal and Torres Strait Islander people for both their own disadvantage and the lack of policy success (Pholi et al. 2009; Fogarty, Bulloch et al. 2018). Additionally, research by Howard-Wagner (2019) has demonstrated that the way *disadvantage* is conceptualised in the policy is fundamentally at odds with Aboriginal and Torres Strait Islander conceptualisations of disadvantage, where the former relies on neoliberal notions of individual socioeconomic success and the latter acknowledges the centrality of racism, social exclusion and Aboriginality to current disadvantage (for a more detailed discussion of the concept of Aboriginality, please refer to Walters 2009).

## 1.2 | Defining the problem of Indigenous disadvantage

While few would dispute the existence of widespread disadvantage for Aboriginal and Torres Strait Islander Australians, what constitutes and causes disadvantage is highly contested. A wealth of statistical data currently exist enumerating the gap in health and socioeconomic outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians (AIHW

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2015; ABS 2016; ABS 2019b). These data predominantly inform political and media discussions of disadvantage and have been used to inform policy development and funding priorities (See for example: DoFHCSIA 2009:10–17).

The rise of neoliberalism in recent decades has seen an emphasis on economic participation, where the engagement of Aboriginal and Torres Strait Islander people in the mainstream economy and education system is seen as key to addressing disadvantage more broadly (Marks 2008; Mundine 2018). This has been particularly evident since the late 1990s and the introduction of the Practical Reconciliation era of policy, where the Howard-led government rejected the so-called 'symbolic' reconciliation in favour of measures that targeted employment, housing, education and health outcomes (Gunstone 2008:3). This has been 'given moral authority' through the opinions of prominent Aboriginal and Torres Strait Islander leaders and commentators such as Noel Pearson and Warren Mundine (Altman 2018:181; Mundine 2018), legitimising this viewpoint to the wider Australian public.

The focus on improving socioeconomic outcomes arguably reflects a specific understanding of the *good life*, where economic independence and participation in the mainstream economy are considered the hallmarks of success. Yet, this is at odds with how many Aboriginal people conceptualise the good life, where connection to country, family, community and language, as well as the freedom to pursue culturally relevant livelihoods, are viewed as equally important (Dodson 2007; Bulloch & Fogarty 2016; Altman 2018). It is also at odds with the findings of Howard-Wagner (2019), which suggest that simply improving socioeconomic outcomes does little to address other aspects of disadvantage such as racism, dispossession, family dislocation and social exclusion. Authors such as Dodson (2007), Marks (2008), Bulloch and Fogarty (2016) and Altman (2018) have argued that the focus on socioeconomic indicators is nothing more than thinly veiled assimilation, given that participation in the mainstream economy is premised on individual wealth building, which is fundamentally at odds with collectivist approaches.

Also evident in political and media discussions of Aboriginal and Torres Strait Islander disadvantage is a tendency to problematise Aboriginal and Torres Strait Islander people and cultures. This is particularly evident in critical analyses of the Northern Territory Emergency Response (NTER), a suite of policy and legislative changes introduced in 2007 in response to reports of child sexual abuse in remote Northern Territory Aboriginal communities. Analysis of the policy itself (Dodson 2007; Mansell 2007), as well as mainstream media accounts of the NTER (McCallum 2013; Proudfoot & Habibis 2015), demonstrates a rhetoric of inherent dysfunction, where Aboriginal individuals and communities are produced as incapable of self-management, prone to violence and antisocial behaviours, and ultimately responsible for their own disadvantage. This reflects a broader deficit discourse ubiquitous across political and media discussions of Aboriginal and Torres Strait Islander disadvantage, where Aboriginality is discursively produced in terms of deficiency and failure (McCallum 2013; Fogarty, Bulloch et al. 2018).

An emerging trend in policy analysis challenges the assumption that *problems* exist independently of policymakers, instead recognising that policymaking is an inherently constructivist activity; that is, problems are not simply described but are discursively produced (Russell et al. 2008; Bacchi 2009; Shaw 2010). The juxtaposition between mainstream neoliberal and Aboriginal and Torres Strait Islander understandings of disadvantage clearly demonstrates that multiple understandings of disadvantage and its causes exist. We would argue, therefore, that a closer examination of the policy framework is warranted; specifically, how

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the problem of *Indigenous disadvantage* is produced, and the potential effects of this type of problematisation.

## 2 | METHODS

### 2.1 | Approach

The current study used 'What's the Problem Represented to be?' (WPR: Bacchi 2009; Bacchi & Goodwin 2016) as the overarching framework for data analysis. Bacchi (2009) outlines six questions that can be used to guide the analysis of policy and other related documents. The questions are as follows (Bacchi 2009:xii):

1. What's the "problem" ... represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the "problem"?
3. How has this representation of the "problem" come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be thought about differently?
5. What effects are produced by this representation of the "problem"?
6. How/where has this representation of the "problem" been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

The WPR approach takes as its starting point the recommendations for actions made in policy; the solutions to the problem being addressed. Through an examination of these proposed solutions, the underlying assumption about the nature of the problem – that is, how the problem is represented – can be discerned. Bacchi and Goodwin (2016:24) note that the WPR questions can be drawn on selectively as appropriate and that analysis is often an iterative process to unpack multiple layers of problematisation. The current study presents an iterative, integrated analysis focussing primarily on questions 1, 2, 4 and 5 (Bacchi 2009). A full genealogy of the problem (question 3) is beyond the scope of the current analysis; however, questions 3 and 6 are addressed briefly in the previous section ('Defining the problem of Indigenous disadvantage').

Fine-grained analysis of how policy problems are discursively produced was informed by critical discursive analysis (CDA) and drew on the work of several authors in the field (Fairclough 1985; Woolgar & Pawluch 1985; Potter 1996). Of interest in the current analysis is how knowledge about the problem is constructed through the normalisation of some discourses and the marginalisation and silencing of others, and who is positioned as having the right to define and enumerate the problem of Indigenous disadvantage. Rhetorical devices employed throughout the policy document were critically examined, to provide a more nuanced understanding of how some discourses are normalised and produced as real, which allowed for alternative explanations of problems to be identified (Fairclough 1985; Woolgar & Pawluch 1985; Potter 1996; Bacchi 2009).

The bulk of the analysis was carried out by the lead author. Problem representations were systematically identified and collated into themes; CDA was then used to provide a more nuanced understanding of how problems were produced. Results of analysis were discussed as a team, to provide a cross-check of findings and ensure a level of analytic consistency. Ethics approval was not required for this research, given that all data were publicly available.

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### 2.2 | Data sources

The current study takes as its focus the first of the annual Prime Minister's reports on policy progress, titled *Closing the Gap on Indigenous disadvantage: The Challenge for Australia* (DoFHCSIA 2009). In its entirety, the policy framework is comprised of the *National Indigenous Reform Agreement* (NIRA), which outlines in detail the targets, areas for policy action, benchmarks and measures of progress, as well as a suite of National Partnership Agreements. In addition, the Prime Minister's annual report on Closing the Gap provides a level of public accountability, where progress against the targets is outlined.

Here, we analyse the first of the annual Prime Minister's reports for the following reasons. First, the report represents the first policy document aimed at the general public and therefore represents an important opportunity to explore how the problem of Indigenous disadvantage is conceptualised and sold to a largely non-Indigenous public (Russell et al. 2008). As Russell et al. (2008) argue, policymaking does not occur in a vacuum. Governments must be able to convince the wider public of both the legitimacy and the necessity of their particular approach to policy. In Australia, where Aboriginal and Torres Strait Islander people make up around three per cent of the total population (AIHW 2015), policy must appeal to a largely non-Indigenous audience.

Second, after a thorough examination of other potential data sources, including the NIRA and the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, significant similarities were noted across all three documents. Therefore, the decision was made to focus specifically on the first annual Prime Minister's report, as it was viewed as representative of the corpus of policy documents regarding how problems were discursively produced.

## 3 | ANALYSIS

Analysis of the data revealed three key aspects of problem representation within the policy document. First, that disadvantage is conceptualised according to neoliberal understandings of the good life, resulting in the silencing and marginalisation of Aboriginal and Torres Strait Islander voices and aspirations. Second, there is evidence of *lifestyle drift* (Hunter et al. 2010), where explicit descriptions of problems acknowledge structural factors, but solutions offered are reliant on individual behaviour change. Finally, that Aboriginal and Torres Strait Islander individuals and communities are problematised as inherently dysfunctional and resistant to change.

### 3.1 | Constructions of the good life

Central to the Closing the Gap policy framework is a stated aim to achieve statistical parity between Aboriginal and Torres Strait Islander and non-Indigenous Australians, across six specific targets (expanded to seven revised targets in 2014: DoFHCSIA 2009; DPMC 2015). The original targets highlight the underlying assumptions being made about the causes of disadvantage, and the dominance of neoliberal discourses of the good life (Altman 2018). The original targets, outlined below in Extract 1, are found at the beginning of the first main section of the report:

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**Extract 1 (p. 5, para. 1)**

**Setting clear, measurable targets**

For the first time, the Australian Government, together with the states and territories through COAG, has set specific and ambitious targets to address Indigenous disadvantage. The six key targets that form the Closing the Gap objective are to:

1. Close the life expectancy gap within a generation
2. Halve the gap in mortality rates for Indigenous children under five within a decade
3. Ensure access to early childhood education for all Indigenous four year olds in remote communities within five years
4. Halve the gap in reading, writing and numeracy achievements for children within a decade
5. Halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020, and
6. Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

The targets listed are those deemed necessary to 'address Indigenous disadvantage' (l. 3), where the underlying assumption is that disadvantage is characterised by statistical inequality across life expectancy, child mortality, early childhood education, schooling, and employment. Of note is the use of the key metaphor (l. 3) to describe these target areas, which implies that the only way to address the disadvantage experienced by Aboriginal and Torres Strait Islander Australians is via these particular areas. This is further emphasised in the second main section of the policy report, titled *The challenge facing Australia: The evidence* (DoFHCSIA 2009:9–17), where a range of statistical information is presented detailing the size and nature of the statistical gap between Aboriginal and Torres Strait Islander and non-Indigenous outcomes, grouped under sub-headings that align with the policy targets listed. The upshot is that these targets are presented as both a sufficient and complete explanation of Indigenous disadvantage, while other potential explanations for disadvantage are silenced.

The assumption that disadvantage will be addressed by improving health and socioeconomic outcomes alone relies on neoliberal understandings of what constitutes the good life (Bulloch & Fogarty 2016; Altman 2018). The targets themselves are essentially no different to those outlined under previous Practical Reconciliation approaches (Gunstone 2008; Altman et al. 2009). Arguably this is reflective of the way that discourses shape and constrain the policy making process, given that 'practical reconciliation' had dominated political and media discussions of Indigenous disadvantage for 11 years prior to the introduction of Closing the Gap (Gunstone 2008; Marks 2008). Indeed, this rhetoric of health and socioeconomic disadvantage was evident in both the 2005 Social Justice Report (Calma 2005) and the Close the Gap Campaign (AHRC 2008), and underpinned the development of the National Indigenous Health Equality Targets (HREOC 2008).

The literature highlights several potential issues that would be equally important in addressing the disadvantage experienced by Aboriginal and Torres Strait Islander Australians, which are not seen in the policy targets. These include issues of sovereignty, land rights and a voice in Parliament (Mansell 2007; ATSIRC 2017), self-determination, racism and social exclusion, and

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culturally appropriate and accessible health and social services (Osborne et al. 2013; Holland 2018; Howard-Wagner 2019). Arguably, one of the most significant absences from the listed targets is the need to address racism and discrimination experienced by Aboriginal and Torres Strait Islander Australians. Evidence indicates that both can significantly impact physical and mental health and are key drivers of social and economic inequity, as racism and discrimination can limit a person's ability to access health care, education and employment (Paradies 2006; Ferdinand et al. 2012; DPMC 2017; Howard-Wagner 2019).

It could be argued that the targets included in the policy framework are those that are practical and measurable, have a significant evidence-base to support their implementation, and would be viewed by both stakeholders and the general (largely non-Indigenous) public as a logical and appropriate investment (Russell et al. 2008). However, there are three key issues worth considering. First, the unreliable nature of statistical data pertaining to Aboriginal and Torres Strait Islander Australians due to identification issues (Altman et al. 2009). Second, the argument that evidence production is an inherently value-laden process that in Australia is predominantly carried out by non-Indigenous institutions (such as the ABS), and arguably serves to normalise particular understandings of disadvantage and inequity (Bacchi 2016). And third, the gerrymandering of the evidence presented; only some evidence is included as relevant, effectively silencing other forms of knowledge (Woolgar & Pawluch 1985).

## 3.2 | Lifestyle drift

Also evident throughout the policy is a consistent slippage from structural to individual explanations of disadvantage. The following two extracts provide an exemplar of this lifestyle drift (Hunter et al. 2010), focussing on the problem of life expectancy. Extract 2 (below) is taken from the section detailing the statistical gap in outcomes (DoFHCSIA 2009:9–17), and follows on from a numerical description of the difference in life expectancy:

**Extract 2 (p. 11, para. 4–5)**

1 Life expectancy is affected by many factors, including socio-economic status, quality and accessibility
2 of the health system, risk factor behaviour (tobacco, alcohol, nutrition, exercise), social factors and
3 environmental factors (e.g. over-crowded housing, poor drinking water and sanitation).

4 Improvements to health outcomes will directly contribute to Indigenous life expectancy, and are a
5 priority for this Government. Chronic and preventable diseases are the areas requiring the greatest
6 action.

The first paragraph (ll. 1–3) in the above extract provides an explicit description of the problem of life expectancy. Specifically, it provides a list of identified 'factors' that affect life expectancy, which collectively provide an explanation for the cause of lower Aboriginal and Torres Strait Islander life expectancy. The specific factors listed draw on both biomedical ('risk factor behaviour', l. 2) and social determinants ('socio-economic status. . .quality and accessibility of the health system. . .social factors and environmental factors', ll. 1–3) models of health. It is notable that while the list provided represents a significant shift away from individualist explanations of health and life expectancy, it is still largely rooted in a Western health paradigm. Aspects such as connection to family and Country are absent from this list, despite evidence that they are significant contributors to Aboriginal and Torres Strait Islander health and wellbeing (Osborne

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et al. 2013; Bulloch & Fogarty 2016). Arguably, then, the list provided here presents a somewhat culturally limited explanation of the life expectancy gap.

The second paragraph (ll. 4–6) begins to outline a proposed solution to the problem of Aboriginal and Torres Strait Islander life expectancy, and it is here that we begin to see the lifestyle drift. There is an initial suggestion that 'improvements to health outcomes will directly contribute to Indigenous life expectancy' (l. 4); already, there is a shift from understanding life expectancy as the product of both individual and structural factors, to a focus on the individual experience of 'health outcomes'. This is further emphasised by presenting 'health outcomes' as an issue of 'chronic and preventable diseases' (l. 5), highlighting the dominance and privileging of biomedical understandings of health, while glossing over structural and Aboriginal understandings of health.

It might be argued that the structural factors listed in the first paragraph would be addressed elsewhere in the policy framework, given the recognition in Closing the Gap that 'outcomes in one area [will support] outcomes in others' (DoFHCSIA 2009:17). Yet the lifestyle drift demonstrated in the above extract (and explored in more depth in the following extract) is evident throughout the policy, reducing socioeconomic and educational inequity to issues of individual behaviour and responsibility. The following extract, taken from the section outlining the various National Partnership Agreements, provides a summary of the various measures included under the National Partnership on Indigenous Health Outcomes:

**Extract 3 (p. 20, para. 8–9)**

**National Partnership on Indigenous Health Outcomes**

Governments have committed $1.57 billion over four years through COAG to reduce the biggest risk factors, such as smoking, to improve chronic disease management and follow-up, and to expand the capacity of the health workforce to tackle chronic disease in the Indigenous population.

Over the next four years, this investment will result in more than 133,000 additional health checks and 400,000 additional chronic disease management programs for Indigenous people with a chronic condition, support for more than 160 new Indigenous outreach working positions, 75 extra health professionals and practice managers in Indigenous healthcare services, 38 new GP registrar training posts in Indigenous health services and expanded nurse scholarship and clinical placements.

Extract 3 provides a detailed account of how the 'chronic and preventable diseases' (Extract 2, l. 5) will be addressed. Measures include: reducing 'the biggest risk factors, such as smoking' (ll. 2–3); improving 'chronic disease management and follow-up' (l. 3); and expanding the 'capacity of the health workforce' (l. 4). Collectively, then, the problem of life expectancy and poor health outcomes is produced as a product of engaging in risk factor behaviours, poorly managed chronic disease, and limited health workforce capacity.

Individual risk factor behaviours 'such as smoking' (l. 3) and chronic disease are positioned here as key drivers of poor health outcomes, and by extension lower life expectancy, and this is supported by the current data (AIHW 2015). While these are important health factors to address, we would argue that this limited version of the problem both draws on and reinforces dominant lifestyle discourses (Baum & Fisher 2014). Health outcomes are produced as an issue of individual choice and therefore individual responsibility. This sits in stark contrast to the social determinants of health outlined in Extract 2 (ll. 1–3).

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An exception to this is the stated need to 'improve chronic disease management and follow-up' (l. 3) and 'expand the capacity of the health workforce' (ll. 3–4). A list of measures aimed at achieving these outcomes is provided in lines 5–9, yet what is notable here is that *capacity* is imagined in terms of quantity rather than quality, by increasing numbers of programs and staff. Additionally, it is worth noting where this expansion is occurring; with the exception of the health checks and chronic disease management programs, the increases in staff numbers are in Aboriginal-specific health services. The problem of limited capacity, then, is located in the Aboriginal and Torres Strait Islander health sector, rather than the health workforce as a whole. There is certainly support in the literature for expanding the number and workforce of Aboriginal-specific services (Osborne et al. 2013; Holland 2018), however there is also extensive literature arguing for the need to improve the accessibility and acceptability of mainstream health services as well (DPMC 2017; Holland 2018). Yet this is largely glossed over in the solutions listed here, effectively absolving the broader mainstream health system of responsibility and the need to change.

## 3.3 | Constructions of responsibility

Together, Extracts 2 and 3 demonstrate the lifestyle drift that is evident throughout the policy, where Aboriginal and Torres Strait Islander people (individuals and communities) are positioned as primarily responsible for both the problem and the solution. This lifestyle drift is underpinned by a deficit-based narrative, where Aboriginal and Torres Strait Islander peoples themselves are problematized as lacking in a range of skills and abilities. In contrast to most of the document, where this narrative is more subtle, the following analysis examines a more explicit use of the deficit discourse narrative.

Extract 4 (below) is taken from a sub-section of the document, titled *Re-setting the relationship with Indigenous Australians* (DoFHCSIA 2009:5). The first four paragraphs of the sub-section (omitted here) provide an overview of the Government's vision for how a new relationship between Governments and Aboriginal and Torres Strait Islander Australians should look.

**Extract 4 (p. 5, para. 2–7)**

To achieve lasting progress, the Government will work in partnership with Indigenous Australians to address patterns of individual and community behaviour that may contribute to entrenched disadvantage. The Government is committed to finding ways to foster healthy relationships within and across families, peer groups, communities and organisations, and to support Indigenous communities in their efforts to deal with destructive behaviours, establish higher expectations and manage conflict.

In doing so, governments must nevertheless be prepared to respond when manifest failures on the part of individuals or communities places others at risk of harm. Governments have a responsibility to act quickly to provide immediate protection to those in need, but in doing so they must work closely with Indigenous Australians to develop communities and build responsibility and capacity over time.

The explicitly stated problem in the above extract is that Aboriginal and Torres Strait Islander individuals and communities are engaging in 'behaviour[s] that may contribute to entrenched disadvantage' (ll. 2–3). A number of solutions are put forward to address this, which highlight the underlying assumptions being made about the nature and extent of the problem in Aboriginal

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and Torres Strait Islander communities: unhealthy relationships (ll. 3–4); 'destructive behaviours' (l. 5); low expectations and an inability to manage conflict (l. 5); potential violence ('risk of harm', l. 7); and a lack of 'responsibility and capacity' (l. 9). Collectively, Aboriginal and Torres Strait Islander communities are constructed as inherently dysfunctional, and Aboriginal and Torres Strait Islander individuals as lacking the responsibility and capacity to manage relationships or problematic behaviours.

Additionally, Aboriginal and Torres Strait Islander individuals and communities are positioned as not only incapable of self-management, but as reliant on significant levels of Government intervention to affect any kind of 'lasting progress' (l. 1). Government involvement is softened through the use of language such as 'work in partnership' (l. 1), 'committed' (l. 3), and 'support' (l. 4), yet what is alluded to is a significant level of Government surveillance of the community and individuals. It is worth asking, under what circumstances would non-Indigenous communities be subject to potential Government intervention due to the actions of individual citizens? This type of problematisation would suggest that the discourses of dysfunction and irresponsibility found within the preceding NTER policy (Dodson 2007; Mansell 2007) significantly shaped the way that the problem of Indigenous disadvantage was conceptualised in the Closing the Gap policy.

Potential accusations of victim-blaming and racism are carefully managed throughout the policy, an example of which is the use of the 'pattern' metaphor (l. 2). By describing these behaviours as a pattern, the implication is that they occur with regularity and frequency; the Government is simply reporting what is there for all to see (Potter 1996). The description of these behaviours is sufficiently vague, implying violence through terms such as 'destructive behaviours' and 'conflict' (l. 5), and by intimating that people will be 'at risk of harm' and in need of 'protection' (ll. 7–8). This allows readers to draw their own conclusions about these behaviours, while avoiding the more explicit descriptions of community violence seen in the NTER, descriptions which drew substantial criticism (Dodson 2007; Mansell 2007; McCallum 2013; Proudfoot & Habibis 2015). While violence is an issue in some Aboriginal and Torres Strait Islander communities, arguably this violence is a result of disadvantage rather than the cause (DPMC 2017). Yet here these behaviours are produced as causative factors, with the potential upshot being that Aboriginal and Torres Strait Islander people are positioned as responsible for their own disadvantage. However, the explicit link made between behaviours and disadvantage are downplayed by the qualifier 'may' (l. 2), constructing, constructing the link as possible rather than absolute, which in turn inoculates the Government against potential accusations of victim-blaming.

In contrast, the lack of qualifiers elsewhere in the extract, or indeed throughout the document, is noteworthy. There are no numerical qualifications to indicate that only some individuals and communities are experiencing these issues, thereby implying that the behaviours and dysfunction are endemic in all Aboriginal and Torres Strait Islander communities. Unhealthy relationships, 'destructive behaviours', conflict, threat of harm, and a lack of responsibility and capacity are produced here as pervasive 'patterns', and as normalised, everyday aspects of Aboriginal and Torres Strait Islander life. The construction of Aboriginal and Torres Strait Islander individuals and communities, and indeed Aboriginality itself, as inherently problematic and dysfunctional has been noted elsewhere (Fogarty, Bulloch, et al. 2018; McCallum 2013; Proudfoot & Habibis 2015 ). The consequence, then, is that not only is a significant level of responsibility for disadvantage apportioned to Aboriginal and Torres Strait Islander peoples themselves, but this construction also works to protect the Government against potential future accusations of failure; they have made significant financial investments, and have been 'committed' (l. 3) to 'supporting' (l. 4) and

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'working with' (l. 8) Aboriginal and Torres Strait Islander communities, but Aboriginal and Torres Strait Islander people must 'do their part' and address their own dysfunction.

## 4 | DISCUSSION

The above analysis demonstrates three key intersecting aspects of the Closing the Gap policy: first, the limited way in which disadvantage is conceptualised, and reliance on neoliberalist assumptions about what counts as a good life (Bulloch & Fogarty 2016); second, evidence of lifestyle drift, where the problem of disadvantage is explicitly described in structural terms, yet proposed measures predominantly target individual behaviours; and third, that deficit discourse significantly influences both the subjectification of Aboriginal and Torres Strait Islander people, and the way that the problem of Indigenous disadvantage is understood. As noted by Holland (2018), the intentions to base the policy framework on partnerships between Aboriginal and Torres Strait Islander people and the Government were not borne out in practice, and this is reflected in the limited understandings outlined above; the culturally meaningful aspirations are conspicuously absent.

This is particularly important when we take into consideration an Aboriginal and Torres Strait Islander perspective on health and well-being. While there are multiple Aboriginal and Torres Strait Islander understandings of health, NACCHO (2018) provides a broad definition, which captures central aspects of many of the various models: '…the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.' The behavioural model of health seen in Extracts 2 and 3 does not reflect the above definition. While the focus on educational and economic outcomes (Extract 1) might to some extent contribute to social and emotional well-being, arguably they do not go far enough to address other structural issues like marginalisation, discrimination and the impact of intergenerational trauma. Cultural aspects of well-being are largely absent from the policy, with two exceptions. There is a reference to the government drawing on the 'strengths of Indigenous cultures' and 'working to improve the native title system' (DoFHCSIA 2009:5 & 31, respectively). Yet in both instances, these are positioned primarily as a way to increase economic growth; their social, emotional and cultural benefits are only nominally recognised. Arguably, then, neoliberal understandings of health and the good life inform the way that the problem of Indigenous disadvantage is addressed.

The current findings highlight that one of the most important aspects of the policymaking process is the very act of identifying and describing the problem to be addressed. Our analysis suggests that the assumptions underpinning the policy may work to limit the appropriateness and efficacy of the measures, as they are neither culturally meaningful nor sufficient to address the structural barriers to health and socioeconomic equity. We would argue that adopting a strengths-based narrative and approach to policy has the potential to ensure culturally meaningful approaches, challenge pervasive stereotypes such as those seen in Extract 4 and ensure greater funding and resource efficiency (Brough et al. 2004; Fogarty, Lovell, et al. 2018; McPhail-Bell et al. 2018). Strengths-based community programmes have demonstrated health benefits for participants but go beyond an individual level of benefit to whole-of-community empowerment and have the potential to address broader social determinants (Brough et al. 2004; McPhail-Bell et al. 2018). This also provides the possibility of countering lifestyle drift, by shifting focus from individual problems to community strengths and capacities, although as yet there is little research specifically exploring this. Baum (2011) suggests that Closing the Gap provides

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a useful template for future policymaking efforts, yet the above analysis demonstrates that even within a seemingly robust social determinants-based policy, there is still evidence of lifestyle drift. Building the evidence base for effective policy measures against lifestyle drift should be a priority of future research.

Several of the above suggestions are included as part of the Closing the Gap Refresh Strategy (COAG 2019). Recommendations include 'genuine, formal partnership with Aboriginal and Torres Strait Islander people', the need to incorporate strengths-based approaches and recognising the centrality of culture to health and well-being (COAG 2019:2). Arguably, then, the Refresh Strategy represents an important opportunity to address some of the issues identified in the current Closing the Gap framework. Worth noting, however, is that Closing the Gap, the NTER and Practical Reconciliation were all greeted with a level of cautious hope because all promised either a revitalised way of addressing a long-standing disadvantage through whole-of-government approaches or indicated a serious commitment to making genuine change (Gunstone 2008; Marks 2008). Yet with each promise of a new and committed approach, the dominant neoliberal rhetoric of disadvantage, and the problematisation of Aboriginal and Torres Strait Islander people more broadly, has resulted in policies with limited reach and efficacy. Although there is much to be hopeful for with the Closing the Gap Refresh Strategy, it is also necessary to continue to critically examine the way that Indigenous disadvantage is problematised, and how this either enables or constrains policy approaches.

### 4.1 | Limitations

Two limitations of the current study should be noted. Our decision to focus on the first Prime Minister's report, to provide a more focused analysis, may have limited our understanding of how the problem of Indigenous disadvantage was more broadly represented throughout the policy suite. Further, our analyses were undoubtedly influenced by our own personal world views, which predominantly reflect a Western viewpoint. To overcome this as a potential source of bias, we engaged in a constant process of critical reflection, with Aboriginal and Torres Strait Islander co-authors (KC, KH) and colleagues, and by referring back to the writings of Aboriginal and Torres Strait Islander scholars throughout the analysis.

## 5 | CONCLUSION

Closing the Gap was lauded by many as a new approach to Aboriginal and Torres Strait Islander policy, given the broader focus on the social determinants of health (AHRC 2008; Mackean et al. 2008; Mooney 2008). Despite initial optimism, progress on Closing the Gap has been limited, with most targets still not on track (DPMC 2020). The analysis presented here offers potential insight into why so little progress has been made. Put simply, the way that a problem is understood and defined will determine the types of solutions available. The problem of Indigenous disadvantage is produced in culturally limited terms, demonstrates lifestyle drift and relies on deficit-based narratives of Aboriginal and Torres Strait Islander Australians. We argue that it is not just the effectiveness of policy measures that need to be refreshed, but the way in which the problem is understood needs to be critically examined. Strengths-based approaches and a genuine engagement with Aboriginal and Torres Strait Islander people may offer ways forward, to provide policy measures that are based on Aboriginal and Torres Strait Islander cultures and aspirations; how this will influence the future of Closing the Gap is yet to be seen.

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## CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

## NOTE

[1] 'Aboriginal and Torres Strait Islander Australians' has been used to acknowledge the diversity of cultures that comprise the Aboriginal and Torres Strait Islander population. The term 'Indigenous' is used for direct quotes and as a conceptual tool (e.g. 'Indigenous disadvantage'), to reflect the language used in the data. 'Aboriginal and Torres Strait Islander Australians' has been used to acknowledge the diversity of cultures that comprise the Aboriginal and Torres Strait Islander population. The term 'Indigenous' is used for direct quotes and as a conceptual tool (e.g. 'Indigenous disadvantage'), to reflect the language used in the data.

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