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NEEDS ASSESSMENT REPORT

[VOLUME 2]

Training health providers to work with Aboriginal & Torres Strait Islander LGBTQA+ young people

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Acknowledgement of Country

We acknowledge that this research has taken place on several Aboriginal and Torres Strait nations and the research team was based on Wadjuk Noongar Boodja (Country). We pay our respects to the Elders past and present. We also acknowledge the Traditional Owners of the many lands from which our participants joined us.

Contents

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About the artist

Skye is a queer artist. They are a strong believer in equality and does their best to show this in their art. They are Yamatji and Koorie and wish to learn more about their culture from their mum and the people in their life. They do commissions and are currently studying at university. @skyangelwings

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Note: Readers should consult Volume 1 of the report for a glossary of terms, project and project team information, and the statement of data sovereignty.

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Executive Summary

Aboriginal and Torres Strait Islander LGBTQA+ young people are at markedly high risk for psychological distress and suicidal behaviour (Liddelow-Hunt et al., 2023). While emerging research suggests that ACCHOs and ACCOs feel confident in supporting their LGBTQA+ young people (Uink et al., 2022), such services have also reported a strong desire for greater information and resources to better and more comprehensively address their unique wellbeing needs (Hill et al., 2021). Specifically, ACCHOs and ACCOs have advocated for the creation of formalised professional development opportunities, such as training, to further support their inclusive care capacity for working with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families (e.g., Hill et al., 2021).

The *'Training Health Providers to work with Aboriginal and Torres Strait Islander LGBTQA+ young people'* research project was developed by Aboriginal and Aboriginal LGBTQA+ researchers to respond to this need. In Phase 1 of the project a Needs Assessment assessing definitions and experiences of inclusive practice, as well as training needs, as outlined by ACCO staff and Subject Matter Experts (SMEs), was conducted. This involved running two focus groups with staff from ACCOs in Western Australia, and nine SMEs from across Australia, who were experts in Aboriginal, LGBTQA+ or Aboriginal and LGBTQA+ health, about what they saw as primary training needs in this area.

All focus groups and interviews were recorded and then transcribed verbatim. These were subsequently sent back to participants to check for accuracy, and then deidentified. Data was analysed inductively and collaboratively by the research team, in which themes were framed by the interview questions. Findings from this analysis was split over the two volumes.

Volume 1 of this report provides a comprehensive background of how and why this project was developed, its methodology, the project timeline, and key highlights. Further, Volume 1 explores the present state of inclusive practice and an understanding of how it has developed.

Overall, Volume 1 report findings provide:

1. A detailed overview of LGBTQA+ inclusion efforts among various communities
2. Acknowledgment of the complexities working within Aboriginal and Torres Strait Islander LGBTQA+ health care
3. Support and recognition of the experiences and knowledge of ACCO staff members working directly with Aboriginal and Torres Strait Islander LGBTQA+ youth and their families, and
4. Reinforcement that any training developed for ACCO staff working with Aboriginal and Torres Strait Islander LGBTQA+ youth and their families should be tailored to the specific service.

Within this volume, the skills, knowledge, behaviours, and abilities (i.e., the competencies) necessary for providing inclusive care to Aboriginal and Torres Strait Islander LGBTQA+ young people and their families, as indicated by participants, are detailed. Further, the training content elements necessary to achieve these, as well as delivery components identified as essential to develop these within the culturally sensitive LGBTQA+ training package, were discussed. As with Volume 1, Volume 2 provides a data-driven insight, with analysis and interpretation based upon interview and focus-group responses. Furthermore, many of the themes discussed within Volume 2 mirror existing research by Aboriginal and Aboriginal LGBTQA+ scholars and/or well-established cultural knowledge.

Following review by the Data Governance Committee, three key takeaways were highlighted from this volume. Overall, the Committee found that report findings provide:

1. A comprehensive overview of the skills, behaviours, and knowledge essential to provide quality care to Aboriginal and Torres Strait Islander LGBTQA+ young people that support experiences of those working within Aboriginal and Torres Strait Islander LGBTQA+ health care,
2. Emphasis upon the power of visibility, language, and connection in inclusive, quality care, and
3. Recognition that for effective training delivery to ACCO staff to occur, focus must be placed upon participant safety, engagement, practicality, and relevance, with acknowledgment and tailoring to service context.

2

Methods

2.1. Background

Volume 2 seeks to form the basis of a competency framework and subsequent training requirements for inclusive practice with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families. The idea of 'competencies' have long been discussed in relation to improving care for Aboriginal and Torres Strait Islander peoples. Further, use of frameworks is not new to ACCOs, nor to the public health sector more broadly. Many ACCOs use frameworks to drive change, instruct policy, and act as a resource for healthcare providers (e.g., see the National Aboriginal Community Controlled Health Organisation (2018)'s National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023).

Aboriginal researchers such as Westerman (2010) have highlighted that for ongoing and effective service, organisations must define what standards of competence are required for working with their clients *by* their staff. Competency frameworks, therefore, are frameworks which outline what competencies are needed and why within an organisation; staff development and training, recruitment and selection, and performance management process may be underpinned by such frameworks.

Here, competencies are defined as a set of related behaviours, skills, abilities, knowledge, or attitudes necessary for undertaking a task successfully. When staff are recognised as competent, this highlights that they can do tasks appropriately and safely, leading to a desired outcome (Bainbridge et al., 2015). Competencies might be required by all employees by their organisation or required by staff and/or professionals undertaking specific roles (e.g., clinical frontline staff).

Furthermore, a wide variety of cultural competency frameworks have been developed by ACCHOs and healthcare organisations more broadly to help ensure healthcare professionals are appropriately supporting Aboriginal and Torres Strait Islander people (e.g., Walker et al., 2014). Past research suggests that when cultural competency frameworks are a) community-led, b) tailored to the needs and preferences of specific communities, and c) embed the framework at all levels of the organisation (e.g., staff, governance, policies), access to healthcare and health outcomes improve for Aboriginal and Torres Strait Islander people. The need for locally created and tailored initiatives continues to be championed by the National Aboriginal Community Controlled Health Organisation (NACCHO, 2022). As such, the current project took a locally based and community-informed approach to developing the competencies that are listed in this Volume.

While Continuous Quality Improvement and Cultural Competency frameworks that are Aboriginal and Torres Strait Islander-led and locally led exist, no Inclusive Practice competency framework for ACCOs working with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families does. This Volume seeks to use existing framework structures as a jumping-off point, to strive to increase ACCO practice capacity and subsequent health outcomes for Aboriginal and Torres Strait Islander LGBTQA+ young people.

2.2 Data analysis

As described in Volume 1 of the report, data analysis occurred in multiple rounds wherein the research team decided on codes, and eventual themes coming through data, working against an analysis framework.

Specific to the list of competencies reported in this Volume, focus group and interview participants were asked: *"What are the core competencies needed to work effectively with Aboriginal and Torres Strait Islander LGBTQA+ youth and their families?"*. Participants were prompted around what knowledge, skills, abilities/behaviours people needed to effectively do so, and whether these competencies were required by all staff or by people in specific roles. Participant data relating to skills, abilities, behaviours, or knowledge necessary for working with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families were labelled as relating to competencies.

Participants were also asked to highlight any gaps between competencies required for inclusive practice with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families, and any additional training needs they had. Participants responses describing desired skills, behaviour, or knowledge was referred to as 'training needs' in this Volume.

3
Findings

3.1 Competencies

Participants responses could be grouped into five core competencies: a) young person-centred care; b) effective communication; c) non-judgement; d) safety and visability; and e) connected service. It must be noted that though there is overlap between different competencies highlighted below, important distinctions and relationships between them exist. Following the discussion of each competency, and the skills, knowledge, and behaviours that comprise them, a review of these findings is presented alongside two recent studies which explored ACCO and Aboriginal and Torres Strait Islander LGBTQA+ young people's perspectives on inclusive care needs; Breaking the Silence (Hill et al., 2021) and Walkern Katatdjin (Rainbow Knowledge, Liddelow-Hunt et al., 2021).

3.1.1 Young person-centred care

In the context of supporting Aboriginal and Torres Strait Islander LGBTQA+ young people this means providing opportunities for Aboriginal and Torres Strait Islander LGBTQA+ young people to be their whole selves, and ensuring ensure personalised, empowering care.

Young person-centred care was acknowledged by several participants as a core competency for ACCO staff when working with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families. According to participants, young person-centred care encompasses a) being led by Aboriginal and Torres Strait Islander LGBTQA+ young people, b) understanding the young person as a whole, c) providing Aboriginal health prevention and promotion information, with this largely underpinned by d) relationship building.

3.1.1.1 Young person-led vs. making assumptions

Participants highlighted the importance of placing focus on the young person's reason for attending a service, rather than staff making assumptions for their visit, noting that making assumptions can lead to misunderstandings of the young person's reason for attending a service.

> *"I've worked in medical mainstream general practice and it's almost when they see just mob in general or, say, queer mob, they go sexual health test or they just go through health, they wanna do the health check straight away, and then they forget to ask why they presented in the first place. [They should ask] "What brought you to this practice in the first place. What do you need?" rather than going through, "I need to go through this because it's a priority."* — Focus Group 2 Participant

> *So, you don't ask those questions in a first meeting, when someone's come in to talk about a spot on their arm or something. But if someone comes in and says, "I want to start hormones, but I'm not sure about whether I should preserve fertility and do I need a sexual health test?" That's a perfect time for you to say, "Oh, well let's talk about what your situation is. What gender is your partner? Is your partner someone who could potentially carry a pregnancy?" That sort of thing. So, yeah, not making assumptions, not jumping straight to talking about bits, but being aware that at some point, it's probably an important conversation to have.* — Interview Participant 7

Further, participants emphasised that service providers should not assume that young people were made vulnerable due to their sexuality or gender.

> *I just think we have to be really careful that someone discloses their sexuality, they're not a special needs person and they don't necessarily need anything extra. Maybe we wanna normalise it, it's all okay. It's my approach that I don't go, "Oh my God, are you okay?" We wanna normalise that. It can be quite healthy – well, it is very healthy and it's not always attached to trauma, and it's something you need to be really careful about, that's my opinion. You don't always have to attach it to trauma or sexual abuse. It just is and that's fantastic and that might need to be all it is* — Focus Group 1 Participant.

3.1.1.2 Understanding the young-person as a whole person

A part of young person-centred care involved having knowledge regarding diversity within and between Aboriginal and Torres Strait Islander LGBTQA+ peoples.

> *You know, I don't have enough adequate training, like even though I might identify [as LGBTQA+], it doesn't mean I'm all over everything". So I guess when I think about even being an Aboriginal person, I think there's diversity around that, right? So I don't speak for every Aboriginal person and it's the same as LGBTIQ+. I think it's about having diversity around that as well.* — Interview Participant 3

> *We're so diverse in our Aboriginality and in our LGBTI-ness, queerness as well.* — Interview Participant 8

> *What groups are contained within that* [Aboriginal and Torres Strait Islander LGBTQA+ peoples] *and then what do they mean, how would you approach these groups, maybe even, if I'm being specific, what might be different about these groups because some people just have no idea.* — Interview Participant 4

Understanding these differences gave context for a young person's health decisions. As interview participant 8 noted (below) choices pertaining to one Aboriginal and Torres Strait Islander LGBTQA+ young person may not be appropriate for another; their context, life history, and needs will be highly diverse.

> *It's that whole thing where all decisions are hard and people make the right choice for them. They choose the hard that they can deal with, that's okay for them. I can imagine that would be a fear of people in remote communities and not wanting or being fearful for a young person's safety around coming out but it's like: what is more unhealthy for them? Are they gonna be more eating themselves up inside and suffering with their mental health from holding on to this secret, or feeling they're not being true to themselves and then to take the risk of copping all this flak from community, do you know what I mean? This whole: people have a right to choose their own hard.* — Interview Participant 8

3.1.1.3 Aboriginal and Torres Strait Islander LGBTQA+ -focused health prevention and promotion

In addition to responding to the diversity of young-people and being led by their needs, young person-centred care emphasises health promotion and prevention for young people by health and wellbeing practitioners. Understanding what Aboriginal and Torres Strait Islander LGBTQA+ young peoples' future health and wellbeing issues may be across their developmental journeys was outlined by participants as key knowledge integral to performing young-person-centred care.

> *I think awareness should be massive about that and it's not talked about, especially amphetamine use, GHB it's quite scary and it's quite common and it's quite accepted, especially when it comes to social dating apps, like Grindr stuff is absolutely insane.* — Interview Participant 4

One participant noted that understanding health risks or prevention activities for Aboriginal and Torres Strait Islander LGBTQA+ young peoples was key.

> *For GPs and sexual health nurses it's really, really important to…* [talk to a] *transgender person or to a brother boy who still has female genitalia and the importance of Pap smears.* — Interview Participant 2

3.1.1.4 Relationship focus

The final element of young person-centred care is for organisations to focus on relationships with young-people. Participants highlighted that by making relationships between young-people and services a priority, young people are more likely to return to services, especially when they feel heard, safe, and welcomed. This is supported by research, in which physically and emotionally welcoming services have been demonstrated as necessary for continued service engagement by Aboriginal and Torres Strait Islander people (e.g., Davy et al., 2016), as well as by participants.

> *I think what makes us different to other agencies as such is that we have the clientele, the staff are approachable, welcoming and obviously that first impression is going to be how the client's gonna – whether they're gonna return. And also our clients are treated with respect and our [organisation] values are making clients feel welcomed, there's no stigma, clients feeling like they are number, they're another number or another belt for the ACCO and all that, and they wanna come back and they keep coming back.* — Interview Participant 1

Such findings are unsurprising given how foundational relationality - the understanding, practice, and responsibility of connection - is for Aboriginal and Torres Strait Islander knowledge systems and culture (Dudgeon & Bray, 2019). Relationality, as outlined by the quote below, as well as within broader literature, is essential for wellbeing (Dudgeon & Bray, 2019; Tynan, 2021). While ACCO staff understand this as being essential to practice, it is something that may be lost in other services.

Indeed, participants highlight the necessity of not only building relationships with youth themselves, but also with their supportive family. Connecting with supportive family was highlighted by participants as building protective factors for young people and going the extra mile with their care.

> [I need to connect to] *whoever their supportive family member is*, [so I can] *have them present as well, so I can get an understanding of their relationship and work out how they would like to run the consultation, because sometimes – that's one of the other things I should probably mention and I'm sure you know, is that often, they're very shy, and it's very hard to get a lot of information*. — Interview Participant 7

> *So we've had youth family support groups with had transgender family support groups*. [outside organisation] *to would come here and use our facilities to have to have transgender support group for parents that because the kids said "I don't want my mom come into where I go" so we've come to an agreement where they can run that here so the parents can come here and we can provide them tea, coffee, scones, biscuits, whatever.* — Interview Participant 2

These findings regarding the importance of young people-centred care for working with Aboriginal and Torres Strait Islander LGBTQA+ young people align with broader, Aboriginal-led models of healthcare consultation such as clinical yarning (Burke et al., 2022; Lin et al., 2016), based off work by Bessarab and Ng'andu (2010). Clinical yarning follows three connected steps to engage young people in healthcare and wellbeing journeys: "social yarns", "diagnostic yarns", and "management yarns" (Burke et al., 2022; Lin et al., 2016). These steps involve relationship building between healthcare worker and young people, encouraging them to share their whole selves and health journeys, using this information to develop a health plan, and providing straight-forward but individually relatable healthcare information and management plans. This model emphasises relationality, and Aboriginal and Torres Strait Islander self-determination and autonomy (Burke et al., 2022), concepts which were evident in our discussions with participants in the Needs Assessment.

3.1.2 Effective Communication and Language

Conveying service information to and using appropriate language with Aboriginal and Torres Strait Islander LGBTQA+ young people in such a way that they are put at ease, feel included, and clearly informed.

Effective communication was identified as a second core competency for working with Aboriginal and Torres Strait Islander LGBTQA+ young people. When talking about communication as a core competency, participants differentiated between communication skills required by all staff at an ACCO, and communication skills required by clinical or practitioner staff at the ACCO. While effective communication interweaves with other competencies discussed above and below, participants highlighted it throughout as its own, unique set of characteristics.

3.1.2.1 Generalised effective communication and language

When discussing the effective communication competency with Aboriginal and Torres Strait Islander LGBTQA+ young people, participants highlighted the following characteristics as being required by all staff within an organisation, rather than specific to clinical or frontline workers:

- Actively listening
- Being authentic and approachable
- Being warm and welcoming
- Being friendly and caring
- Being interested in the young person
- Being curious versus defensive
- Using clear and easy to understand language (no jargon)
- Using gender-neutral language
- Using open and welcoming body-language

> *So if they see two staff interacting weirdly about something or being uncomfortable, right? Youth in particular can sniff that out like they could sniff out a joint. So it's so obvious, so obvious…* — Interview Participant 2

Effective communication could also involve picking up on young peoples' non-verbal gestures.

> *How to respond to people and open, whether that is how we respond to certain questions, how the body language responds, the body language is a big thing, and making the social skills acceptance is really important*. — Focus Group 1 Participant

3.1.2.2 Specialised communication and language

Unlike generalised communication, participants highlighted a range of knowledge and skills required by clinical or frontline practitioners as necessary for effective communication with Aboriginal and Torres Strait Islander LGBTQA+ young people. Much of this knowledge and many of these skills related to how practitioners might ask about pronouns or issues relating to gender-diversity.

> *I find even addressing a trans person, people aren't sure how to do it… or that's what I found the, asking certain questions [like], "How do you identify?" I just find probably the hardest bit for people who don't understand*. — Interview Participant 4

> *It's about "how do you have that conversation in a comfortable way for the client, but also for you as a clinician?" Because you know a lot of clinicians avoid these conversations and they don't even do it be 'cause they are too shame to talk about it because "I don't know how to bring it up". They don't know how to talk about, you know, "Yeah, they got ***** bit still, so we still need to screen it"*. — Interview Participant 8 [when discussing training scenarios about how to have cervical cancer screening discussions with trans young people]

However, some participants also highlighted the importance of, and how to talk about, difficult experiences that Aboriginal and Torres Strait Islander LGBTQA+ young people may have in an appropriate way. While knowledge regarding what to say in these conversations was highlighted as important, confidence in beginning difficult conversations is also a part of this specific competency.

> *Four years in for it to be voted where you know, people can even talk about marrying someone that they love and it still comes up as a really hard conversation, you know.* — Interview Participant 3

3.1.3 Safety and Visibility

Services can indicate they are a culturally safe space for Aboriginal and Torres Strait Islander LGBTQA+ young people through visibility efforts, but should follow through with organisational accountability, professionalism, and representation.

Being able to create a safe space was a third competency highlighted by participants as a requisite for working effectively with Aboriginal and Torres Strait Islander LGBTQA+ young people. Participant perceptions of what skills, attitudes, knowledge, and behaviours encompassed this were diverse although most participants noted the importance of an inclusive and intersectional cultural safety, with focus shifting towards promoting this (e.g., through representation, communication, and maintaining professionalism).

Participants were keenly aware of young people's vulnerability when accessing services, but also acknowledged that there was lack of understanding around what to do to provide a safe space for Aboriginal and Torres Strait Islander LGBTQA+ youth. Some elements of safety were being practiced by ACCOs or taught by pre-existing inclusive practice frameworks, but this was often not an intersectional form of safety.

> *I think what needs to happen is I think more services, more Aboriginal services in particular, need to be seen as a safe space. I think that's the biggest thing, that people need a safe space.* — Interview Participant 1

> *So when you talk about it* [being Rainbow Tick accredited], *I think there needs to be an extra layer, when it's an Aboriginal service, where there is that cultural safety and that's where we talk about safety. What does safety look like* [for] *that service?* — Interview Participant 3

3.1.3.1 Aboriginal and Torres Strait Islander LGBTQA+ cultural safety

Many participants discussed *cultural safety* skills, knowledge, and behaviour as a starting point for broader discussions about what is required for creating an inclusive, safe space for Aboriginal and Torres Strait Islander LGBTQA+ young people. Cultural safety has been defined by Lowitja Institute director, Tamara Mackean and colleagues (2020) as practice that "explicitly recognizes impacts of colonization and racism on Indigenous peoples and resulting inequalities in power" (p. 341) and seeks to disrupt power imbalances between service and client (Aboriginal and Torres Strait Islander LGBTQA+ young people), through understanding and subverting colonial power structures. This may be done through understanding how power imbalances and health inequalities occur and being aware of ones' own power within the systems services are situated within (Mackean et al., 2020).

Although cultural safety is an Indigenous-led service model it does not, according to participants, currently place focus on Aboriginal and Torres Strait Islander LGBTQA+ young peoples' safety. For example, a participant from the first ACCO focus group noted that their organisation had Aboriginal and Torres Strait Islander-specific policies in place, but nothing specific to Aboriginal and Torres Strait Islander LGBTQA+ peoples.

> *At the policy level though, we don't have any LGBTIQA+ specific policies. So I noticed that when I had the induction last weekend, and coming from university sector as you know, I'm more aware of that, whether or not organisations – I'm not saying that – obviously the workplace does reflect inclusion, but it would be good to have that at policy level.* — Focus Group 1 Participant

Another participant from the first ACCO focus group noted that their cultural awareness training had recently become mandatory, and that while they perceived some staff to be potentially uneasy with undergoing mandatory LGBTQA+ awareness training, adhering to their organisational values of inclusive practice was important.

> *But not everybody was gonna come along and sit down and listen to the Aboriginal cultural awareness, not everybody is gonna sit down and listen to LGBTQ and whatever. That's just who they are but we do say when you come in work, you've got to do it our way.* — Focus Group 1 Participant

3.1.3.2 Promoting inclusive cultural safety – representation and visibility

When participants discussed creating safe spaces in their organisations specifically for LGBTQA+ young people, this largely included representative behaviours through installing symbols of belonging (e.g., flags, posters, pamphlets) relevant to Aboriginal and Torres Strait Islander LGBTQA+ young people, as well as other intersectional considerations.

> *I've got heaps of art on the wall that's mostly pretty gay and pretty – or trans or both, posters about trans boys on PrEP. I've got some rainbow flags and stickers. I have gay mags, like QNews magazines sitting – and I have Indigenous art on the wall as well, like just a couple of pictures, because –, because I think that actually can make people feel more at ease when they see something and they recognise it from their culture. So, I try to make sure I've got just the visual that is both healing and welcoming. I've got a couch with a cushion that's got an ad on it for PrEP, that's got two hot guys pulling a condom out of a packet. And so what it does is it might upset some of the grandmas who come in, but for the younger LGBT people, it makes them instantly go, "I can talk to this doctor about anything, because they've got a picture of two guys who are about to have sex on their cushion, so they're probably gonna be okay to hear what I have to say".* — Interview Participant 7

> *I think also services having the pride flag, either out the front or at the reception. So it shows queer mob that, you know, they are a safe practice for them to go to. Just seeing themselves represented.* — Focus Group 2 Participant

3.1.3.3 Promoting inclusive cultural safety – accountability

While communication, representation, and service models centred on safety were identified as important, participants highlighted that to do so, ensuring all staff are aligned regarding what is acceptable, or unacceptable in regards to working with LGBTQA+ young people was vital. Confusion around policy, practice, and inclusive language within an organisation, was highlighted by one participant as a barrier to achieving safe practice.

> *'Cause there's still, not as much confusion, but there still is some confusion. Everyone's pretty OK, generally, with LGB. Because of the length of time that that's been spoken about. You know, but it's not all that long for – especially for intersex. You know, they're really only starting to speak about that now. And even with some of the trans stuff because it's so expansive. There's so many parts of the trans umbrella. When you think of non-binary people, you know, genderqueer, genderfluid, gender non-conforming, there's so many different layers.* — Interview Participant 5

While building such alignment may first require ACCO staff to be informed (and trained) in inclusive practice (i.e., having the prerequisite knowledge, skills, behaviours, and abilities discussed in this report), being able to challenge discriminatory behaviour (e.g., microaggressions) if they were to occur was noted as vital.

> *So people* [at work] *have conversations around me about homosexual people and I'm quite happy to listen to them, but there's been times where they've noticed that I'm listening and they've gone, "Oh, are you –?" and I've gone, "Absolutely, and what you're saying is not okay."* — Interview Participant 4

Indeed, many participants took a "leave your biases at the door before coming into work" perspective, highlighting the importance of organisational accountability to create safety.

> *Because I don't care when you go home, when you take your hat off and you go home, that's your personal values and your personal beliefs, your personal opinions. But when you walk through the door and you wear your uniform, or you come through the centre, you cannot display that. And if you do, you're gone, so you choose it now.* — Interview Participant 2

The above findings regarding the importance of creating safety for Aboriginal and Torres Strait Islander people has been frequently echoed by Aboriginal-lead organisations such as the Healing Foundation, noting that "a supportive environment for healing is required if change is to occur" (Healing Foundation, 2012, p. 17). The current findings expand on this work by suggesting that ACCOs could adopt inclusive cultural safety policies and practices to ensure the wellbeing of LGBTQA+ young people.

3.1.4 Non-judgement

Effective care for Aboriginal and Torres Strait Islander LGBTQA+ young people requires understanding and challenging personal biases that may threaten staff ability to provide safe or appropriate care to Aboriginal and Torres Strait Islander LGBTQA+ young people.

A fourth competency was practising without judgement. Many participants spoke about the critical importance of being non-judgemental. Often, when this initially arose in discussion, participants highlighted non-judgement as an inherent quality, rather than a multi-faceted competency.

> *I think the non-judgmental is an interesting one because it's something that we expect people to bring along naturally and not everyone does.* — Focus Group 1 Participant

However, when spoken about more deeply, it was clear that different skills, values, behaviours, and knowledge encompassed 'being non-judgemental': a) being aware of and challenging one's biases by engaging in critical self-reflection; and b) practicing empathy.

3.1.4.1 Critical self-reflection

Participants highlighted that some ACCO staff may not be aware of how bias against LGBTQA+ young people forms and the impact it can have. In addition to recognising bias exists, and what it may lead to behaviourally, participants stressed that critical self-reflection skills encompass people being able to think about why their biases exist, engaging in reflections on privilege and power, and actively being able to challenge them.

> *Recognise that everybody makes judgments all the time, and we all actually are biased. But if you can reflect on those, and like [participant] says, put aside and do your job, that's still okay, to be honest, if somebody is able to do that.* — Focus Group 1 Participant

> *I mean self-reflection is key. If people can keep on going and keep saying* [incorrect terminology] *and not self-reflect, then that's becoming a problem.* — Focus Group 2 Participant

3.1.4.2 Practicing empathy

The second element of non-judgement incorporated practicing empathy – the ability to place oneself in another's position, to understand what they have gone through, and what that may mean for their health and wellbeing.

> *Empathy, that's it. Yeah, maybe that's part of what we're trying to build.* — Interview Participant 6

Some participants recognised the importance of empathy, but felt frustrated at how to facilitate this skill amongst staff:

> *You know because it's a really hard thing this, it's hard and I understand. It's hard like "how do you teach someone to empathise".* — Interview Participant 6

Other participants highlighted that empathy could be developed by reflecting upon similar histories, highlighting similar struggles:

> *Understanding what queer mob have gone through their entire lives and understanding that certain cases, if there was training and there was certain stories, understanding what particular situations queer mob have gone through as well.* — Focus Group 2 Participant

> *So looking at history and what queer people in general, not just queer mob, have had to go to over the years, it might be easier to understand as Aboriginal people because that's already how like non-Indigenous mob I guess gain that understanding.* — Focus Group 2 Participant

The skills identified by participants such as empathy, awareness and critical self-reflection are routinely used in cultural competency programs addressing racism or heterosexism (e.g., Downing et al., 2011). However, Aboriginal researchers warn that taking a purely individualistic approach to developing such skills disregard the role of systems of power, and consequently, the organisational or systemic changes needed (Hill et al., 2021; Watego et al., 2021). Therefore, it is suggested that non-judgement, alongside the other competencies, are undertaken not just by individual staff, but by leaders within the organisation, for the organisation itself.

3.1.5 Connected service

Building and maintaining professional, peer, and referral networks for sustainable, up-to-date inclusive practice for working with Aboriginal and Torres Strait Islander LGBTQA+ young people.

The fifth and final competency participants discussed as critical when working with Aboriginal and Torres Strait Islander LGBTQA+ young people was for ACCO staff to promote connectedness within and between ACCO services. This meant a) building individual professional networks for ongoing professional development and b) service relationships for developing safe referral pathways.

3.1.5.1 Building networks and continued development

Professional relationship development was highlighted as a key skill for working with Aboriginal and Torres Strait Islander LGBTQA+ young people. This was often discussed in relation to clinical staff or front-line practitioners.

> [Practitioners] *need the ability to get together with their peers and learn about new ways of doing things and best practice in trans health. So, networking's really important for them as well.* — Interview Participant 7

Developing peer and service networks were useful for ongoing development of staff, for locating resources and referrals that were safe for young people. Understanding which services were safe or appropriate for referral was done through relationship building.

> *The young person contacted us to link in with us and to link them in with some of the national online networks and people that I've met through sexual health, 'cause we had people like* [famous transwoman] *come over and do presentations at conferences with us and a young fella and* [famous Sistergirl advocate]*, so had a bit of a network through sexual health.* — Interview Participant 8

3.1.6 Alignment with prior research

The distinct competencies for working with Aboriginal and Torres Strait Islander LGBTQA+ young people outlined in this report are consistent with previous research. Indeed, the Walkern Katatdjin Phase 1 focus groups explored the experiences and opinions of fourteen young Western Australian Aboriginal and Torres Strait Islander LGBTQA+ people on their wellbeing service use experiences and needs (Liddelow-Hunt et al., 2021). Further, the Breaking the Silence study (Hill et al., 2021) explored ACCO/ACCHO, LGBTIQ+, and mainstream health, social, emotional, and community wellbeing services' opinions on how effectively they are working with LGBTIQ+ Aboriginal and Torres Strait Islander people in Western Australia.

Results from both studies provide support for the competencies highlighted above. For example, 81% of Breaking the Silence (Hill et al., 2021, p. 32) respondents who worked at Aboriginal-led services reported the need for *connected service*; that is, knowledge, development, and maintenance of referral networks and pathways – particularly those relating to transition services. Connection and networks between services was also reported as highly desirable by Aboriginal and Torres Strait Islander LGBTQA+ young people in the Walkern Katatdjin study; many young people "spoke about the need for greater connection between services" to increase capacity (Liddelow-Hunt et al., 2021, p. 41).

Non-judgement and its components were also routinely emphasised within Breaking the Silence – 57% of survey respondents who worked for ACCO/ACCHOs highlighted the need for more empathy and awareness regarding Aboriginal and Torres Strait Islander LGBTQA+ people. Moreover, these survey respondents noted that critical self-reflection was "important" in providing appropriate care (Hill et al., 2021, p.33).

Safety and visibility, particularly cultural safety, was repeatedly outlined by both studies as a primary concern for ACCO/ACCHO staff in delivering effective service. In both studies, this included appropriate, responsive, and safe service for Aboriginal and Torres Strait Islander LGBTQA+ people. However, policies relating to LGBTIQ+ issues could be "ad-hoc and/ or intermittent and not necessarily adhered to consistently by all staff" (Hill et al., 2021, p. 25). As highlighted above, this may be due to a lack of policies *specifically referring* to LGBTQA+ issues, rather than those grouped under standard anti-discrimination policies. Alternatively, it may be due to a lack of buy-in by ACCO/ACCHO CEOs or managers (Hill et al., 2021).

Effective communication and language was highlighted as another way of ensuring safety, but also to ensure Aboriginal and Torres Strait Islander LGBTQA+ young people were appropriately cared for by their frontline staff. For example, Walkern Katatdjin participants highlighted that all staff using welcoming body language and expressions, smiling, warm greetings, and respectful speech led were viewed as "green flags" and indicated services were allies (Liddelow-Hunt et al., 2021, p. 34). Furthermore, that transparent and clear communication around policies (specifically around confidentiality) would increase perceptions of safety (Liddelow-Hunt et al., 2021). Regarding frontline or clinical workers' communication, Breaking the Silence emphasised the importance of understanding and using the correct language and terminology and knowing when and how to ask about Aboriginal and Torres Strait Islander LGBTQA+ identities and issues as "key education and information needs" (Hill et al., 2021, p. 31). Furthermore, Walkern Katatdjin stressed the importance of ensuring that services are informed about and provide information that is appropriate, up-to-date, and credible, on topics relevant to Aboriginal and Torres Strait Islander LGBTQA+ young people (e.g., sexual health education).

Finally, *young person-centred care* elements echoed throughout both studies. Walkern Katatdjin findings particularly emphasised the need of services to treat Aboriginal and Torres Strait Islander LGBTQA+ young people as whole persons, to help them avoid having to suppress or hide parts of themselves (Liddelow-Hunt et al., 2021). Breaking the Silence, meanwhile, focused heavily on building relationships between services and Aboriginal and Torres Strait Islander LGBTQA+ people – highlighting this as "crucial" (Hill et al., 2021, p. 31), desiring person-led changes to be worked into wider organisational systems.

3.2 What should an LGBTQA+ inclusivity training package for ACCOs look like?

The remaining part of this report outlines participants' responses when they were asked to identify approaches and content areas that should be included in a culturally sensitive inclusive care training package for working with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families. Approaches included a) being trauma-informed, b) connecting trainees with peers, c) tailoring content to specific roles, d) acknowledging Country and context, e) using stories and case studies, and f) using a hybrid delivery mode with inbuilt assessment.

Participants identified two broad content areas: knowledge content and skill development content. Regarding knowledge, participants noted wanting to learn a) introductory knowledge, b) knowledge specific to Aboriginal and Torres Strait Islander LGBTQA+ young people's needs, c) local history and legitimised content, d) the impacts of stress and discrimination, e) relevant legislation, organisational policies, and processes, and f) potential referral pathways and resources.

Regarding skill development, participants primarily wanted to learn and practice a) communication skills, b) skills surrounding inclusive language, and c) critical self-reflection skills.

Finally, participants discussed what kind of facilitator/s the training should have. Here, discussions of a) the number and personal characteristics of the ideal facilitators are discussed, as are b) key skills that facilitators should have.

3.2.1 Training approaches

3.2.1.1 Trauma-informed

Several participants commented that the training package should consider that discussions around sexuality and gender could be triggering for some people who attended the training. Adopting a trauma-informed care approach to the training was therefore recommend.

> *Definitely having that trauma informed healing aware approach and strength-based approach when you're training your trainer, having that as part of the training*. — Interview Participant 2

> *TICP* [trauma informed care principles] *and you look at their principles, I think it just totally is respectful to…us look at inclusivity and supporting communities. You know, if we were to actually put some of those principles against what we're trying to do, it would be 100% perfect match*. — Interview Participant 3

Participants offered several recommendations on how a future training package could be trauma-informed, including:

- Setting a group agreement at the start of training which outlines rules and expectations for the attendees
- Including content warnings in training materials
- Asking attendees to be careful of their language to ensure safety of LGBTQA+ peoples in the room
- Not allowing attendees to ask questions of participants from lived experience panels (or vetting questions before hand to ensure panel member safety)
- Stating that there are no “stupid questions”
- Acknowledge Country and LGBTQA+ people in our history
- Allowing attendees to introduce themselves, their Country and connections (if they feel comfortable doing so)
- Be upfront about what is going to be discussed in the training
- Ensure confidentiality and privacy of training discussions
- Encourage curiosity and flexibility
- Not shaming or ‘shouting down’ attendees who do not understand LGBTQA+ identities or those who have a differing view.
- Playing familiar music to help attendees relax
- Staff and participant debrief at the end of each day (if it is a multiple-day training)

3.2.1.2 Connect trainees with peers

Several participants recommended that the training package should ideally connect attendees with supportive networks and communities of practice.

> *I think it definitely means maybe peer support, opening the doors, and more expression about culture and identity, like a coming togetherness.* — Focus Group 1 Participant

> *Networking’s really important for them as well. So, I’m talking mainly about mental health social workers and psychologists and counsellors they need the ability to get together with their peers and learn about new ways of doing things and best practice.* — Interview Participant 7

3.2.1.3 Tailored to specific roles

Although most participants agreed that all members of an ACCO should receive inclusivity training, there was some discussion around whether the training should be tailored for specific roles within organisations. Participants felt that some staff should receive training that is specific to their role.

> *I think there should be tailored training depending on what role you have because some people might be overwhelmed by content and would think this doesn’t apply to them and then may accidently think that a particular thing doesn’t apply to them because it seems complicated but actually it does. So, GP versus nurse versus Aboriginal health worker versus admin worker versus all, so all the levels of healthcare make sense.* — Focus Group 2 Participant

> *... yeah, having a front desk staff who are switched on and understand about asking people about pronouns and making sure that they get that right, and we have a medical software system that allows people to have a preferred name that always comes up as the name you should call.* — Interview Participant 7

> *I only feel there is a need for a basic training that everyone should be doing. Because even, yes, the clinical staff probably needs extra knowledge and support around working with clients, long-term, but reception staff, for example, are usually the first point of contact and are crucial in making people feel welcome. And anyone else within the organisation, are co-workers of people from the LGBTQI community, so that is crucial too. It’s not just about the client, it’s about the whole community and therefore, everyone should have some basic knowledge.* — Focus Group 1 Participant

3.2.1.4 Acknowledging Country and context

Participants stressed that it was essential that any culturally sensitive inclusivity training for LGBTQA+ young people must consider the Country on which training is delivered. This consideration would ensure that the training was respectful to local traditions, customs and community needs as well as ensure the safety of LGBTQA+ young people in the area. As interview participant 3 pointed out, inclusive practice is most effective when it is a part of community-led change. Further, that acknowledging Country and context meant trainers might have to delay training if the community was not reading to receive it.

> *Having knowledge of local context, which also included an assessment of whether a service/community was ready for training and being willing to walk away if not... Then you’d actually have maybe someone in the community going “Actually, it’s not right for our community right now” and we just go “Absolutely. That’s OK.” You know?* — Interview Participant 3

Acknowledging the Country of the training well as the Country of the training attendees could also help identify potential barriers to implementing the training in practice.

> *But just even maybe acknowledging which Aboriginal people are from where they are, because I find I’d like to be welcome to Noongar country, it’s fantastic, but for me it feels odd for me ‘cause it’s not my country. So, I’m expected at work sometimes to do it but I always refuse because it’s not my country to welcome people onto, but maybe just an acknowledgement of who else is there.* — Interview Participant 4

> *Ensuring that people are at the heart of end of service, design and delivery. And recognizing that, you know, those might – and there’s a reason for that, why it has to happen at the local level, because it has to attend to local needs and expectations.* — Interview Participant 6

Participants also noted that it was essential that the training be tailored to the needs of the specific ACCO.

> *And another suggestion, I suppose if we want to get a picture on how our staff are and their responses if may be do a SurveyMonkey, survey on around their knowledge and any concerns or challenges and use that as a starting point I suppose to measure where staff are at with it.* — Focus Group 1 Participant

3.2.1.5 Using stories and case studies

Participants acknowledged the power of using case studies and personal stories of LGBTQA+ young people in helping training attendees understand the lived experience of being Aboriginal, LGBTQA+ and young.

> *I just love anything that really helps people put themselves into other people's shoes.* — Interview Participant 8

> *I use a few videos. Lived experience videos. Because then they get to see what it's like. It's not, you know, us. We might have a discussion with the participants about a certain issue, but if they see what people are going through from their own perspective, I think that sort of rings a few bells and makes them think and reflect and that's how they can change their practice.* — Interview Participant 8

> *And I guess by doing that is showing more videos and having the lived experience, like what we've done in the training is shown videos of Aboriginal mob speaking.* — Interview Participant 9

> *I love hearing people's stories about their lives and their journeys, and I think that's always – for me, personally, that's where I learn, that's where I feel I grow more when I hear people's stories, and I know everybody's stories are different.* — Focus Group 2 Participant

3.2.1.6 Hybrid delivery

The question of whether training should be delivered in-person or if it could be hosted online lead to suggestions from participants for a hybrid approach to delivery, that is, a training package that included both in-person and online components. The decision for different training formats depended on the specific training need being targeted. For example, online training was viewed as good for sharing knowledge whereas in-person training was considered better for skill building.

> *... both is probably the way to go in this day and age... if you wanted to just impart knowledge, and awareness, particularly around language and stuff, that is definitely maybe something you could do online. But if you want that deeper maybe even towards some behavioural type change, then perhaps having that face-to-face opportunity for to open up yarn to maybe have some – I know people don't like the word roleplay, but, that maybe in inviting people guest speakers in and listening to stories, that deeper stuff where you might have some more, maybe, behavioural change for people to take back.* — Focus Group 2 Participant

> *There should be the flexibility for both [in person training and online] in case there is another pandemic outbreak, and I feel everything should be made in multiple modes now until whatever next virus comes along.* — Focus Group 2 Participant

> *I think having an LGBT training module within your organisation that you can refresh yourself with once a year that you have to do for other stuff, in all honesty, nowadays it should be a thing.* — Interview Participant 9

3.2.1.7 Length of training

Participants commented that the training package should last two days maximum and could be broken up into smaller components. This length was considered ideal for attendees as well as the facilitators.

> *So, three hours, that's probably where I would get to at the end of an LGBTIQ 101. If it was a one-day session, I'd go a bit further than that, obviously, and I'd start talking through some of these core principles. There's kind of five or six core principles outlined in the Rainbow Tick to help people understand "These are the things that you need to be working towards," and you could not cover all of those in a one-day session, I don't think, but you could at least point people to the kinds of things that they need to be holding in their mind.* — Interview Participant 6

> *It's a whole day training. And we can run them in half day trainings, but generally we get the most out of people when it's a full day training.* — Interview Participant 3

> *I feel max two-day training, max definitely.* — Focus Group 2 Participant

3.2.1.8 Assessing training efficacy

Most participants noted that the efficacy of the training should be measured and offered several suggestions for assessment methods.

> *... when I was part of another training program, they used to assess their participants at the end of it. And it was like "I'm not sure that's really, whether that really achieves anything".* — Interview Participant 5

> *You just wanna have a good balance of content of practical activities. I hate quizzes, don't do quizzes, just no quizzes. A practical reflection of what you've learned. That's actually more useful than a quiz.* — Focus Group 2 Participant

> *I like the way at the end of this training, we do a roleplay activity, and you get these cards, and it kinda tests – but it's not really testing. It's just like give the name of the person ... in a scenario of "This person came in, they're pregnant –" That's a fun way.* — Focus Group 2 Participant

3.2.2 Training Content

3.2.2.1 Introductory knowledge

An explanation of the LGBTQA+ acronym and information on some of the unique health issues that LGBTQA+ young people face was considered important parts of knowledge to include in training.

> *Probably first having an understanding of what the community is. So, what are the definitions of LGBTQA+, how do you recognise people and how do people identify themselves, just that baseline kind of stuff.* — Focus Group 1 Participant

> *... and a lot of participants never even think about this. Um, so, for a trans person, a trans woman, having to think about prostate cancer.* — Interview Participant 5

There were also suggestions to tap into data sources that detailed the health needs of Aboriginal and Torres Strait Islander LGBTQA+ young people.

> *And I guess I used the GOANNA data[1]... Like one in five people were LGBTI young people. They haven't analysed it for LGBTI, like stratified it or anything, but it's a good data thing to show. I try to use that just to make a point that one in five of young people across remote, regional, and urban were part of the LGBTIQ community.* — Interview Participant 9

> *I bring it back to the World Health* [Organisation] *a lot. So, lot of the training does come back to "this comes from here, this comes from there and the reason why we need to do this is because of these reasons in not, not because that's what the World Health [Organisation] said, but" just making it tangible 'cause I want – people need tangible facts and understanding like "Oh this," so "Oh really?" I had a so many people say "I didn't realize the World Health* [Organisation] *had a stance on this".* — Interview Participant 2

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[1] An Australia-wide sexual health survey of young Aboriginal and Torres Strait Islander people (Ward et al., 2020).

3.2.2.2 Embedded within Aboriginal and Torres Strait Islander and LGBTQA+ history

Regarding the specific content of training, several participants iterated that it was important to ground the training content within the context of Aboriginal and Torres Strait Islander peoples, especially history since colonisation. Importantly, queer history within Aboriginal and Torres Strait Islander communities should be included.

> *One of the big things that we wanted to focus on, when I was presenting about* [local remote Aboriginal and Torres Strait Islander LGBTQA+] *project was demystifying the whole concept of it not being an appropriate thing to talk about, and also the whole diverse range of experiences that people have because I feel like at that time too when we were doing* [local remote Aboriginal and Torres Strait Islander LGBTQA+] *project, we were pushing back from a lot of stuff in the media in that certain individuals are going around saying around how Aboriginal communities are not inclusive and that it's all negative experiences, and nobody has positive experiences in this space and we really wanted to push back against that and say "not all communities are like that, not all young people have had all entirely negative experiences, this is what it is actually liked being black and queer".* — Interview Participant 8

> *And they talk about they/them pronouns and very critical of gender as the colonial project. So, I do wonder if that should be part of it if you're talking about historical training, what might it have been like for Aboriginal people before colonisation in terms of understanding what we today called sexuality and gender but that would've been conceived differently, if at all.* — Focus Group 1 Participant

As interview participant 3 stated, training also need to reference LGBTQA+ identities (e.g., homosexuality) having been categorised as mental disorders and that older generations of Aboriginal and Torres Strait Islander LGBTQA+ peoples had survived through this.

> *I would like it to see... Yeah, the historical elements still put into there as well as the people that have actually come before us that, you know, they weren't able to celebrate, you know, or able to even acknowledge their own sexuality around how hard it was for them... And having the historical values that, what was it? The DSM5 that you know it was only just taken away from being an actual mental illness.* — Interview Participant 3

> *... if could be more educational and historical and this is what people have experienced over several decades maybe and leading up to – and this how we get to where we are today, and then this is where we are today, and then from there that's a baseline for people that don't have – have never explored that.* — Focus Group 1 Participant

3.2.2.3 Content with local legitimacy

Some participants stressed the importance of the training and its content having legitimacy within the local community. This could be achieved through including local examples (e.g., stories from local Aboriginal and Torres Strait Islander LGBTQA+ peoples) in training content or having local cultural authorities sit in on the training.

> *Who in the community do you work with where you know that perhaps they work with young Aboriginal people and where they would also find that the training would be helpful?... you'll have headspace, you might have alcohol and other drug services coming on board. So, they're partner services, they say, you know, "Would you to come along, [organisation] are coming to deliver this training, we'd love you to be a part of it," so they're inviting their community partners to come along to the training.* — Focus Group 2 Participant

> *'Cause right or wrong, I feel like there would probably be a level of fear of that and there certainly was in sexual health generally around knowing how to have these conversations and the perceptions of community. So having community members there which I know is much easier –And that you've got some key people to help facilitate or to be present and reinforce that messaging I think would be really important actually, that makes a huge difference.* — Interview Participant 8

> *Victorian mob are pretty staunch and strong about being from Victoria, and in the past when we've had to do resources that suit Victorian communities and feature people from down here and stuff like that, it's really important.* — Interview Participant 9

Importantly, when we probed participants in the second ACCO focus group about the role of Elders in providing legitimacy for the training package, participants explained that the training did not necessarily have to be Elder-endorsed. This was because the training was to focus on supporting young people and Elders were not seen as the most appropriate people to speak for young community members.

> *I don't think it's extremely important. That's just my personal opinion. Because it's not an Elder-specific thing. And also, if I'm gonna be blunt, I think Elders, a lot of them are still a part of a generation that don't understand... I think if you can get an Elder who was really switched on, then yes, but I don't think it needs to be a necessary thing, because it's not extreme – it's not cultural, it's Aboriginal-specific, but it's for young people, and also young people need to be making the content for young people, not Elders making the content for young people, because then it gets lost in translation.* — Focus Group 2 Participant

> *I think in some cases, maybe for that credibility, because you're gonna have different ages working with different age people in the AMSs that are working with young people or queer mob in general. So, any other time, I would say no. But I feel like to get the older people to think it's credible...* — Focus Group 2 Participant

3.2.2.4 Include the impacts of stress and discrimination

Participants stated that the training package should include research findings that demonstrate the impacts of stress and discrimination on Aboriginal and Torres Strait Islander LGBTQA+ young people.

> *I think some really practical things around what you can say... see the broad stuff around the impacts of us not doing this on people's mental health and general well-being and the community.* — Interview Participant 8

> *Understanding some of those generational impacts and how that can affect such things as mental health. You know, we're finding, especially with older LGBTI people now who lived through that era of or knew someone from a previous era that lived through, you know, conversion therapies and having to hide their identity and stuff like that, going into aged care facilities now and still not being able to express their identity because they don't know how they're going to be treated. Or having people come into your home and having to hide all your photos, you know, because they've got home care. And you know, they go around their home hiding their identities so that people who are coming to care for them, whether a nurse or whatever, doesn't see who they are. That's common, unfortunately. So that's the sort of things that we need – I want clinicians to understand, about what it's like to be an LGBTI person.* — Interview Participant 5

As illustrated by the excerpt (below) from one of the subject matter experts, long-term experiences of violence and stigma associated with being LGBTQA+ could prevent people from engaging with ACCOs and so the training should acknowledge this possibility.

> *There's also a sense that many LGBTIQ people unfortunately are so used to being stigmatized and discriminated against, they're so used to being verbally abused and even physically harassed, that that's another reason why they might struggle to recognize their experience as one of violence within a relationship, because it's just a part – violence and abuse is a part of their broader everyday life, on an everyday basis anyway. And they and then kind of have a hard time reconciling it and kind of psychologically adapting to it even at the point at which they enter into services. So, there's some kind of like further repair work in in helping people kind of think through those processes so that staff – I guess I'm saying staff in training need to be aware of some of those concerns, and some of those machinations that people are having to try to kind of reconcile, correct, recognize and reconcile.* — Interview Participant 5

3.2.2.5 Education on the role of legislation, organisational policy, and data management systems in inclusive practice

Some participants suggested that the inclusive practice training package could be a useful vehicle to update attendees on state and federal legislation that protected the rights of LGBTQA+ community members.

> *... always include a section on any relevant guidelines or legislation that would be relevant for your jurisdiction..., I always choose the Sex Discrimination Act Amendment 2013. There'll be some type of state or territory government legislation that can be dragged in. You might even have policies that some organisations use to frame what happens.* — Interview Participant 5

Some participants also noted that the training package could provide examples of how to structure organisation-level policies and data management systems to better support inclusive practice.

> *Intake forms: diverse gender options, blank space for gender and pronouns, chance to disclose, can be completed online. So, I think any of that sort of stuff that can be built into the actual systems of the clinics you used it in and their forms and questions that they have to ask when young people check in or whatever are really good...* — Interview Participant 8

3.2.2.6 Resource lists and referral pathways

Across all participants, there were requests for knowledge of referral pathways and helpful resources for Aboriginal and Torres Strait Islander LGBTQA+ young people and those who care for them to be provided in the training package. This information was already being included in some local trainings.

> *... in the inclusive practice, I just include a little bit about services that are provided in your area that may be useful. If someone comes into your organisation and says, "Oh, do you know where this place* [in Australia] *is?" That's always handy... At least they know where they could send them.* — Interview Participant 5

> *The referral pathways, the emotional supports as well as, you know, the doctors that you need to see and the psychologists that you need to see that are safe for our mob.* — Interview Participant 2

> *It's also having access to resources and stuff that can focus on the individual but also for families of those individuals as well and their different views that they may have.* — Focus Group 1 Participant

3.2.3 Skills development

3.2.3.1 Communication skills

Throughout conversations with participants, it become clear that any training package should aim to build certain skills within attendees. Participants commonly spoke about the need for building ACCO staff general conversational skills and ability to form a therapeutic report with LGBTQA+ young people, acknowledging that some staff may not be automatically comfortable talking about sexuality and gender.

> *So, I think stuff just generally about how to – this is similar stuff to sexual health generally to be honest, people are either comfortable with it or they're not comfortable with it so it's really basic level sh*t how to start that conversation. What you could say to make young person or anybody know that they're able to talk about these things with you or to mention that they're having sex with people of the same sex or I think some really practical things around what you can say, how that conversation might look...* — Interview Participant 8

> *I think how to approach people, just generally being sensitive in your questioning because it's a hard topic. And I think for the people who aren't comfortable with it, offering them an opportunity to be a part of it.* — Interview Participant 4

Training could also cover how to have difficult conversations between caregivers and young people and between young people and their health provider.

> *If I'm working with an Aboriginal young person who's identifying as transgender but then their family is not supportive of them for different cultural practices and that person is being rejected by their family, how am I supposed to make that person feel safe?* — Focus Group 1 Participant

> *It's really, really important to role play language in conversations and giving a voice to a transgender man or to a Brotherboy who still has female genitalia and the importance of Pap smears...* — Interview Participant 2

3.2.3.2 Using inclusive language

Knowing how to use inclusive language correctly was also noted as another skill that could be built through the training package.

> *Have yarns about diversity and people making assumptions and pronouns and assume gender neutral terms like partner and not assuming things of people and – yeah.* — Interview Participant 9

> *I think, as general, everyone should know how to introduce themselves in an inclusive manner and should know the basics of pronouns, and gender assignment at birth, and how queer mob can identify themselves, so I think that's an important part of training in general.* — Focus Group 2 Participant

3.2.3.3 Critical self-reflection

Overwhelmingly, the ability for staff to engage in critical self-reflection was noted as an essential skill to be targeted in the training.

> *There's a certain degree of people needing to seriously reflect on whether they are the right person and a safe person for young people to talk to…And that whole thing of how to respectfully say to somebody if they're gonna do more damage than good, being able to hand the client over to somebody else who's actually gonna be able to provide them with the care that they deserve.* — Interview Participant 8

> *... dealing with your own discomfort and where that discomfort comes from, and how you can work on that.* — Focus Group 1 Participant

> *... therefore, whoever's thinking that way, in a discriminatory way, needs to do some self-reflection and reflect on why they feel that way, because end of the day, that has the potential to harm people that they work with. So, it's the responsibility of individuals to do that but if that could be built into training, to give people the skills and tools to do that, 'cause it's quite difficult thing to do.* — Focus Group 1 Participant

3.2.4 Facilitator characteristics

3.2.4.1 Number and characteristics of facilitators

Last, participants were asked to comment on the characteristics of the facilitators of the training should have. It was important to some participants that the training facilitator(s) had a solid understanding of the topic material.

> *... someone that is really kind but is really good at training and understands all the subjects.* — Focus Group 2 Participant

> *Needs someone with energy. I've had trainers before who are literally reading their slides and they're like, "All right guys on to this next bit".* — Focus Group 2 Participant

Facilitators also needed to be skilled in holding space for polarised discussions while protecting themself and training attendees. This was in acknowledgement that LGBTQA+ inclusion could be a polarising topic and that facilitators could encounter defensiveness and fear.

> *Someone that knows how to defuse conflict and tension and just get everyone back to a calm level.* — Focus Group 2 Participant

Participants preferred training sessions to be run by two or more facilitators. There was also discussion across participants as to whether facilitators needed to be Aboriginal or Torres Strait Islander and LGBTQA+. Generally, this was not seen as vital, with some fear that an LGBTQA+ Aboriginal or Torres Strait Islander facilitator may be in danger of harm, if faced with backlash during training.

> *People would think it'd be the token queer person, but it's not, definitely not, because they could be real crap of facilitating as well, and also you're opening yourself up to like, micro-aggressions and trauma.* — Focus Group 2 Participant

> *...a couple of people and sometimes I think there's even a third person there delivering the training. I think that works really well because they bounce off each other as trainers. Definitely, if we're talking about training for mob it needs to come from mob.* — Focus Group 2 Participant

> *I would say an expert in sexual health, for starters, and then someone who has a good knowledge of Aboriginal culture, especially because if you're an Aboriginal person or if you had good understanding of Aboriginal people you know it's quite separated, men and women. It's quite private and there's a lot of shame associated with it. So, I would have a male and female representative if I could, if there was a magic wand, definitely people who can be approached and are experts in the matter.* — Interview Participant 4

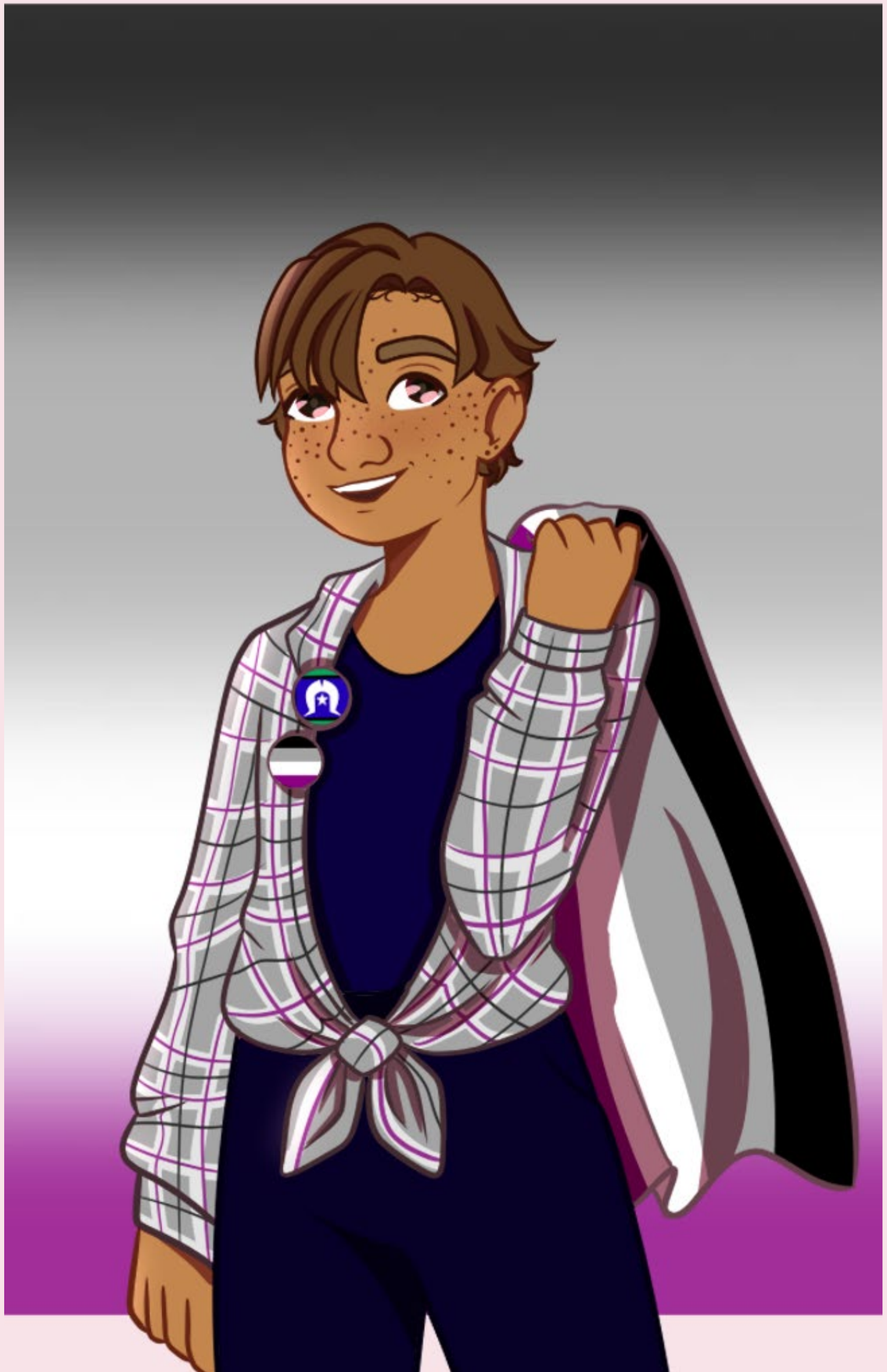
3.2.4.2 Not starting conversations that you cannot finish

Last, participants were cognizant of the fact that training facilitators should not bring up topics which they were not prepared to fully discuss. Some participants drew on their own experiences in delivering training such as cultural awareness training.

> *I'm hesitant asking any question on paper and getting people who write things down if we're not clear what we're gonna do with the answer. If the answer is informing, training that we wanna provide then great, then we know where we need to start and how to pitch the training. But it also can lead to answers that left alone are not helpful at all because it's tolerating some statements that we maybe not agree with as well.* — Focus Group 1 Participant

> *I've done a few online things where I didn't want racism to show its ugly head or the phobias, so – yeah.* — Interview Participant 8

> *... It's opening a can of worms, and then going "Okay, it's out in the open now. Great. You've all had a chat about it. Let's move on," and this person has got all this stuff.* — Focus Group 2 Participant



Summary

The *'Training Health Providers to work with Aboriginal and Torres Strait Islander LGBTQA+ young people'* research project Phase 1 Needs Assessment Reports builds towards understanding how to strengthen capacity of staff working in ACCOs to practice service provision inclusively. That is, to effectively support young Aboriginal and Torres Strait Islander young people who are sexually and/or gender diverse. Volume 2 (this report) assessed what competencies participants thought were required of ACCOs to provide care to Aboriginal and Torres Strait Islander LGBTQA+ young people. These competencies matched with previous research about what Aboriginal and Torres Strait Islander LGBTQA+ young people would like to see in Aboriginal health services (e.g., Hill et al., 2021; Liddelow-Hunt et al., 2021). Second, the ideal training content, and structure to build these competencies and inclusive practice capacity was outlined.

Five core competencies were highlighted as necessary for providing effective support: 1) young person-centred care, 2) effective communication and language, 3) safety and visibility, 4) non-judgement, and 5) connected service. Young person-centred care described an approach to wellbeing support whereby ACCO staff understand the young person's background and potential health needs, actively work towards building rapport with them and their families and let Aboriginal and Torres Strait Islander LGBTQA+ young people direct their own care pathways, versus making assumptions. Much of this competency describes and reemphasises the importance of relationality, a core part of Aboriginal and Torres Strait Islander cultural practice.

Effective communication and language was divided into two broad areas: general communication and language, and specialised communication and language knowledge, behaviours and skills. Participants thought that being warm, friendly, and being able to actively listen, among other skills, were vital for anyone working at an ACCO and working with Aboriginal and Torres Strait Islander LGBTQA+ young people and their families. However, they also noted that for clinicians and frontline staff specifically, specialised communication skills – such as being able to discuss coming out, asking about sexuality or gender identities, or having difficult conversations about these identities were important.

These skills also reflected a need for ACCO staff to develop a safe service, where Aboriginal and Torres Strait Islander LGBTQA+ young people felt comfortable and confident to be themselves and share their needs and stories. These ideas are not new, being identified as core healing principles by wellbeing services such as the Healing Foundation; their reiteration reemphasises their importance. Additionally, participants routinely stressed elements of inclusive language, using correct terminology such as pronouns, visual signs, and symbols (e.g., flags, health resources), and being aligned as an organisation around what safety is, with accountability measures in place.

Non-judgment was frequently mentioned by participants as crucial to developing inclusive care. When asked what this incorporated, participants highlighted critical self-reflection and empathy, as vital to this skill. That is, being able to understand what their beliefs, biases, and opinions may mean for their behaviours, how to manage these internal feelings, and how to reflect upon and understand another's situation. Again, as emphasised by Aboriginal scholars (e.g., Watego, 2021), it is important that this does not stop with individual staff but is engaged by ACCOs' governance.

The final competency discussed by participants was that of service connection. Specifically, ACCOs seeking out and building peer and professional networks, as well as referral pathway relationships with other services. This was viewed as vital not only for continual growth of their frontline or clinical staff, but also for being able to better connect young people with safe support beyond what they could offer if necessary.

The competencies discussed above, are multi-faceted, comprised of wide arrays of knowledge, skills, and behaviours. To develop these competencies within ACCO staff, participants outlined ideal content for the training drawing upon these elements.

Ideal content for training included the need for Acknowledgment of Country and context and for training discussions to be grounded in historical contexts of LGBTQA+ Aboriginal and Torres Strait Islander histories, exploring the impact of colonisation. Loosely, the knowledge desired by participants could be grouped into three types: introductory knowledge, locally specific knowledge, and knowledge about the systems in place in which LGBTQA+ Aboriginal and Torres Strait Islander young people engage with.

In addition to knowledge-based content, several skills were identified as essential for the training package. Participants emphasised wanting to build their communication skills, particularly around how to have difficult conversations with LGBTQA+ Aboriginal and Torres Strait Islander young people and their families, and how to ask about sexuality or gender diversity. Further, participants highlighted the importance of training to use inclusive language (e.g., getting pronouns correct, how to avoid enacting microaggressions). Finally, participants acknowledged the need to develop critical self-reflection (e.g., how to be aware of biases and manage them appropriately).

Participants also noted the need for resource lists and referral pathways across a range of local, state-wide, and national services catering (safely) to LGBTQA+ Aboriginal and Torres Strait Islander young people. Further, participants discussed desiring being connected with supportive networks and communities of practice they themselves could draw upon.

When asked how training should be provided, participants noted key factors that must be considered to ensure training is provided safely and effectively. For example, participants emphasised the importance of acknowledging Country (of training and of the participants themselves) and the local context of the attendees, and that training needed to be trauma informed. Trauma informed training, according to participants, involved creating participant and trainer safety throughout by being transparent, flexible, and non-judgemental, encouraging curiosity, and practicing confidentiality. Participants also noted that training should be role-specific, especially for content that may be more appropriate for clinical staff versus administration staff (e.g., having difficult conversations).

Finally, participants gave suggestions for training structural elements such as ideal activities, delivery methods, training lengths, and facilitator characteristics. For training activities, participants suggested stories and case studies to help cement understanding of lived experience. Further, participants wanted skill role-play to cement difficult behaviours (e.g., starting conversations around sexuality). Finally, participants acknowledged the need for assessment activities but noted the ineffectual nature of quizzes or satisfaction questionnaires, instead opting for scenario-based role-play assessments or self-reflection assessments.

Most participants agreed that training should have both online and in-person elements to improve flexibility and accessibility, and, for similar reasons, that training should not exceed more than two-days' worth of content. When asked about facilitator characteristics, participants noted that having at least two facilitators would be useful, but that facilitators must have thorough understanding of the material and be skilled at safely negotiating polarising discussions. To this end, participants emphasised that facilitators need to ensure they do not start conversations out of their depth, given the potential for distress such training may have.

Overall, participants gave thorough direction regarding the content, structure, and outcome competencies they desired from the end-product training package. There is much to include in the training design which could potentially lead to strengthened capacity of ACCO staff to work with LGBTQA+ Aboriginal and Torres Strait Islander young and their families in a meaningful way. The goal of building capacity to deliver care that recognises and celebrates diversity, provides safe and effective care outcomes, is ongoing. The next step of the project (Phase 2) will co-design the culturally sensitive inclusive care package with ACCO staff and Aboriginal and Torres Strait Islander LGBTQA+ young people from across Australia, that can be tailored to services. The findings of this Needs Assessment (Volume 1 & 2) provide a clear direction looking forward.

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