Consultation Findings Report

“Lets Yarn Health Equity” Phase 1

February 2022

Prepared for Gold Coast Hospital and Health Service and Kalwun Development Association

LYNDA MAYBANKS OF MAYBANKS CONSULTANCY

Contents

Maybanks Consultancy acknowledges the Traditional Custodians of the Gold Coast Region, the Koombumerri and Ngarang-Wal people of the Yugembeh Language Group, and pays respect to their Elders, past, present and future.

AT A GLANCE

What was asked?

What would improve you and your family's access and experience of the health service?

Why do you think previous close the gap efforts have failed? What needs to be done to make real change?

What does racism in the system look like? Can it be removed and if so, how?

What was discussed?

- More services in community and in the home
- Better continuity of care
- Stronger partnerships
- More of our people employed at all levels
- More First Nations culture
- Better communications and engagement

- Health Equity is everyone's business
- Truth telling
- Redefining the "gap"
- Strengths based language
- More long-term support and funding

- Addressing unconscious bias
- More conversations around Identity
- More First Nations education

41 Community Members participated in consultations

BACKGROUND

From the commencement of the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021 (the Regulation) in April 2021, the Queensland Government has enacted a legislation to support Hospitals and Health Services (HHS) to partner with Aboriginal Torres Strait Islander peoples and organisations in the design, delivery, monitoring, and review of healthcare services.

As part of this reform, each HHS must develop a Health Equity Action Plan in partnership with prescribed stakeholders, including their respective Aboriginal and Torres Strait Islander Community Controlled Health Organisation(A&TSICCHO), and First Nations community.

The consultation and co-design process has been split into 3 phases:

1. Review of the South East Queensland (SEQ) Strategy
2. Development of the Action Plan
3. Ongoing co-design and feedback

This report is a summary of the first phase of consultations.

ROLE OF THE CONSULTANT

Gold Coast Health and Kalwun Development Association contracted First Nations communications and engagement consultant, Lynda Maybanks of Maybanks Consultancy, to undertake the community consultations for this work.

The consultant's role was to:

- Plan and facilitate face-to-face sessions (i.e. yarning circles, focus groups etc) with prescribed stakeholders:
    - First Nations Gold Coast Health staff members (self-nominated)
    - First Nations Staff Members – Kalwun
    - Gold Coast First Nations Health Equity working group (to be established)
    - Yugambeh Regional Aboriginal Corporation Alliance (YRACA)
    - Danggan Balun Aboriginal Corporation
    - Kurungal Corporation
    - Karulbo Partnership
- Develop a consultation findings report

LIMITATIONS

During January 2022 there was a surge of COVID-19 cases in Queensland. This included a high number of First Nations people and Gold Coast residents getting COVID-19 or being close contacts. This significantly impacted the number of sessions, and face to face consultations undertaken during the phase one period.

Although the number of sessions and number of people was not as many as first intended, there were participants from each of the prescribed stakeholder groups.

It is anticipated that more in-depth group sessions with more members of the prescribed stakeholder groups will take place during phase two consultations.

THE APPROACH

An open community consultation was held on Wednesday 16 December 2021 at the Currumbin RSL with Gold Coast Health staff, Gold Coast Aboriginal and Torres Strait Islander community members, and stakeholders.

The purpose of the 16 December session was to share information about health equity and for the community to state how they wanted to be consulted throughout this process. Over 28 community members attended this session. A summary of the discussion and suggestions are presented in **Attachment 1**.

It was advised that the consultations needed to be flexible so community could choose how they would be engaged and in what setting. An online form was developed to enable community to choose how they wanted to be engaged; if they wanted to join a small group, large group, or be alone, and where they would prefer to meet (if in person).

Ten community members requested a consultation. Of this, six requested online sessions, and three requested in person and one person requested to join a large group. Large groups were not advised due to COVID-19, so this person was invited to a smaller online session.

In addition to the requested consultations, two open online sessions were scheduled for community to join. A combination of 21 people registered and 13 joined. In the morning session (session one), 10 community members registered and seven people joined. In the evening session (session two), 11 people registered and six joined.

Each session was co-facilitated by Lynda Maybanks of Maybanks Consultancy and Paula Nihot, of Gold Coast Health.

Two smaller online sessions were requested through the online forms, however only one was held with two people.

Two in person sessions were also held. One with one person, and one with two. These smaller face-to-face sessions were held in early February, after the COVID-19 surge. It is anticipated that more face-to-face consultations will take place during the next phase.

All up 41 individuals were consulted during this phase. This includes a mixture of prescribed stakeholders from First Nations community members, First Nations health staff and representatives from other community organisations. All attendees were either residents of the Gold Coast or worked on the Gold Coast, and identified as Aboriginal and/or Torres Strait Islander, or worked with the Gold Coast Aboriginal and Torres Strait Islander community.

A draft version of this report was sent to all consultation participants for review. No suggested changes were provided.

SUMMARY OF DISCUSSIONS

Each session outline included a brief introduction about health equity, background about the consultations and then an interactive discussion, based on reviewing the three aims of the Southeast Queensland Regional Health Equity Strategy. Where the in-person discussions, were more conversational, the key points have been included under the respective headings This summary will follow the below outline:

1. **We aim to improve access to, and experience of, the healthcare system**
   What would improve you and your family's access and experience of health services?
2. **We aim to close the health gap in SEQ between Aboriginal and Torres Strait Islander people and non-Indigenous people**
   Why do you think previous close the gap efforts have failed?
   What do you think needs to be done to make real change in the health gap?
3. **We aim to remove racism from the healthcare system**
   What does racism in the health system look like to you?
   Do you think this could be "removed"? If so, how?

**The discussion points presented are summarised notations, unless in quotation marks. These discussion points are owned by session attendees and shared with Gold Coast Hospital and Health Service and Kalwun Development Corporation for the purpose of informing the development of the SEQ Health Equity Strategy and the Gold Coast Health Equity Action Plan.*

AIM 1: We aim to improve access to, and experience of, the healthcare system

Prompting question: What would improve you and your family's access and experience of health services?

More services in community and in the home

Care in the community is best practice for First Nations healthcare and has been proven in other places. There was an overwhelming response from community about the need to have more services in community and in the home. Having more services in the community means avoiding going to the hospital. Going to the hospital for appointments has several unnecessary barriers such as transport, parking and the anxiety experienced from being in a culturally unsafe and clinical setting.

More and more services in the home will improve experiences because people feel more comfortable in their own homes and often have the family support and advocacy that they may not get in the hospital setting. Community shared their bad experiences from hospital which deterred them and their family from returning. Many community members expressed that they only go to the hospital if necessary, and they do not see it as a place for treatment.

- **COMMUNITY EXPERIENCE**: "*My mother who needed to go into the hospital had a bad experience. But when the Indigenous Hospital Liaison Officer came to see her she immediately changed her mood. We need more of our people in the hospitals and clinics. Where our people can't be in community-bring community to them through the workforce".*
- **COMMUNITY EXPERIENCE:** "*Care in community is good, but it was only offered when my family had a terrible and racist experience at the hospital and refused to go back".*

Care in community can take several forms. This could look like more telehealth and virtual care, more home visits, or more services in the community-controlled clinics. In other consultations, Elders expressed that they felt more comfortable receiving care in the community-controlled sector because they felt valued and listened to, whereas in the mainstream setting they felt rushed. First Nations people are relational people, it is important that we have a relationship with the people who are providing care to us, because we need to trust them. There is also risk in the hospital setting that we won't have time or space for visitors when a family member is very sick or dying.

For community who need to be admitted into residential or long-term care, the home setting is the best option. However, some "home-like" facilities still feel clinical, it is the love and energy of the people around them that creates the home, not a painting on the wall. It was suggested that more home-like facilities run by and for community could be an option to be explored with the community-controlled housing and health sector.

More support for carers

Our culture is for our people to care for our own. Several community members shared their experiences with caring for family in the home. Many First Nations families choose to care for their loved ones in the home setting before sending them to a residential care facility. It is part of First Nations culture to care for our own, particularly our Elders. However, there are several challenges that comes with caring for a loved one. It can sometimes become a financial and emotional burden when the carer is not provided with the support they need.

SUGGESTION: More training options for families' members and the appropriate remuneration for their roles.

SUGGESTION: More support services for carers and people with mental health conditions like group therapy options, day respite services, cleaning, or gardening services etc so the burden is not always falling on family.

Better continuity of care

Continuity of care was continuously brought up throughout the consultations. First Nations people are relational people, we need to establish connection and trust with the people we interact with, especially when it comes to healthcare. Several community members expressed how important it is for them to see the same doctors and nurses, because they were tired of repeating themselves and having to re-establish a connection with new people.

Some community members who access mainstream services access them for a particular Doctor who they have a good relationship with. Some General Practitioners (GPs) bulk bill for vulnerable populations, some are very culturally aware and safe, it is just the matter of finding them. It is important that local GPs are part of the Health Equity conversation too.

Data sharing is a barrier for continuity of care. When a patient must repeat themselves, it is frustrating, and it affects the quality of care. There is a need to improve the sharing of data between the public and private sector as well as across the acute and primary care services. Where community are unable to see the same doctor, at least the doctor they do see has all their information and has read up on it before they arrive.

It should be noted that continuity of care is not supported when a community member goes into residential care because doctors are employed by the respective aged care facility. This can be particularly stressful for our Elders who need the familiarity when transitioning from home to a facility.

- **COMMUNITY EXPERIENCE**: "*I often find that I can't ever get the same doctor or nurse. Or the lead up time to get an appointment at short notice. So, I often need to go somewhere else where I don't know the doctor or nurse, which is not ideal".*
- **SUGGESTION:** Identified Nurse Navigator positions can be used more effectively across the services and sectors. Expanding into more early intervention, and prevention services. Where patients have multiple doctors or specialists, the nurse navigator stays consistent and can advocate across the system.
- **SUGGESTION:** Health services can be more proactive. Explore more opt out models. Book appointments, then ask people to opt out, rather than expecting community to call and make their own appointments.

Stronger partnerships and pathways between the HHS and the A&TSICCHO

There is a need for the HHS and the A&TSICCHO to improve their partnership and pathways. The community want to be supported by a network of services together, not in silos. The more pathways and integrated services, the better the outcomes for community. Community wants to see more hospital services delivered through the A&TSICCHO because it is the sector that was built by our community. There has been several efforts in the past, but they have not been embedded, permanent and long term.

Community wants to know who is providing their healthcare. The communications from health services to community needs to be more regular, open, and transparent so that community know about and feel connected to the HHS that they are accessing.

Some community members do not access local A&TSICCHO due to community and family politics and fear of privacy and confidentiality breaches. While the advantage to accessing an A&TSICCHO is that service is delivered by people you know, it can also be a disadvantage for people who want to maintain privacy. How can we ensure that people who do not access A&TSICCHO for their own reasons, still have access to culturally safe and integrated care in community?

- **SUGGESTION:** More smaller clinics, more community nurses who can triage, rather than clinics with limited doctors.

More of our people in all types of roles and all levels

More First Nations staff in all levels and services will give confidence to the community that their healthcare is being delivered by people who they know, trust and who are accountable to their community.

> *"Employment targets need to include leadership positions in multiple disciplines and levels.* ***You can't be what you can't see.*** *We want to see Aboriginal and Torres Strait Islander nurses working in Emergency Department and we want to see Aboriginal and Torres Strait Islander people behind the administration desk, and we want to see our people employed across the HHS in all roles and levels, not just as a cleaner or in the kitchen".*

The current redesign of the HHS has enabled more Aboriginal and Torres Strait Islander voices into the system. But it hasn't been seen in community. There needs to be more open and transparent communications between the health services and community. This also applies to communications about staff movement. When a person leaves a role, it feels like community needs to start all over again. Just like continuity of care, community need continuity of roles, if they have established a relationship with staff in a particular role, they want to keep that relationship. Or if they do leave, let the community know and have the new person be introduced to community.

The community notices when positions are not filled. There needs to be more effort to fill identified positions and if they are not being filled, re-evaluate the criteria or ask community why they are not applying.

> *"Aboriginal health workers in the A&TSICCHO sector have the highest retention. Let's build on that".*

The adoption of First Nations Culture into the health system

Understanding time and relationships as a cultural value which improve the health experience for First Nations people. This needs to be part of the cultural capability education that health staff receive. This is one of the most important points that they need to know as health professionals working with First Nations people. As mentioned throughout this report, First Nations people need to have a connection with the people who are working with them. These connections cannot be established or maintained without mutual understanding and respect.

Traditional understanding of health also needs to be better understood in the mainstream sector. Where a First Nations person may appear sick or depressed, from a First Nations perspective this could mean that they are spiritually unwell. This is when cultural remedies and Traditional medicine are needed. There needs to be a point in the process where this can be identified, and a Traditional approach is explored. Further, health reforms need to go beyond physical health. We need to measure cultural, social, and mental health from the outset.

- **SUGGESTION**: Better than Condom man - maybe have a health man / woman that strives to share the benefits of being healthy, spiritually, culturally, mentally and physically. A way to present holistic health and teach our community about what it looks like to be holistically healthy.

We are the oldest living culture in the world. There is something about our sustainability that everyone else hasn't got. We have so much to contribute back into the health system. Traditional medicine, cultural knowledge and holistic health are strengths of First Nations people that is not tapped into. This type of knowledge can be integrated into the mainstream system as well. Services can be designed with First Nations people who hold that knowledge if it is appropriate. This could be another way to bring non-Indigenous people along on the journey.

All Traditional Custodian groups should be acknowledged and recognised. The wrong cultural narrative can deter community from accessing services. When embedding First Nations culture, this must be done in partnership with Traditional Custodians. The health services need to have formalised processes and protocols for seeking cultural knowledge. It is culturally appropriate for any type of Traditional Medicine or knowledge to be either from the Traditional Custodians or endorsed by them.

Better communication and community engagement

It became evident throughout these consultations that a communications and community engagement framework is needed for the Gold Coast Community. The framework would stipulate things like remuneration and reimbursement for travel etc. Community expressed that they are tired of being consulted for free and feeling like nothing is coming of it. They feel undervalued and used.

Further there has been some incidents during community consultations, where consumers were put into culturally unsafe situations. A community consultation protocol should be co-developed with community to understand what a culturally safe consultation looks like and doesn't look like. E.g., ensuring there is a balance of male and female attendees, Traditional Custodian representation, etc.

"The national partnership agreement in Closing the Gap will go a long way in bringing forward and privileging our voices. If we are part of the conversation. If the grassroot people are not having the say, then it is not going to go anywhere. All that's going to do is tick boxes and the grass roots people will not have their needs met. These types of conversations are fantastic in bringing forward what we need to say, and we need more opportunities to do this". More investment into community

engagement roles is essential. Historically it has fallen on the shoulders of First Nations staff who are not provided with the support needed. It seems that engagement has always been an additional task, rather than someone's full-time role. Engagement roles can ensure that there are formalised feedback processes and more community events and opportunities for networking. This will be particularly important throughout the delivery of the Health Equity Action Plan.

"CO – Co-design, Collaborate, Connection"

We want to be consulted about service delivery and improving services – not always about artwork. The community is very diverse and different community members want to be engaged in different ways and on different things. There was a suggestion to develop community profiles, which can outline a community members expertise, experience and how they prefer to be engaged. This could help the engagement be more meaningful because it is not one approach. You are more likely to get good outcomes when people feel comfortable in the way they are being engaged.

Karalbo was a good model for sharing information, but it should not be the only source of information as not everyone is good in group settings. Community expressed the need to have flexible engagement and communication channels that can reach everyone. Health promotion events were highly regarded, as it provided an opportunity to interact with health staff outside of the clinical setting. It also brought the services into community rather than the other way around. Other suggestions for more flexible communication, was to provide more postal information to the older populations, and online content for the younger and tech savvy community members. A webpage with all information about Health Equity, upcoming events, stories etc would be great for community to keep up to date, especially any people who can't leave the house or make it to a consultation session.

AIM 2: We aim to close the health gap in SEQ between Aboriginal and Torres Strait Islander people and non-Indigenous people

Prompting questions:
Why do you think previous close the gap efforts have failed?
What do you think needs to be done to make real change in the health gap?

Health Equity needs to be everyone's business

The problem does not just sit with us. Community expressed their frustration with feeling that they are alone on the journey, and that they are the only people who care about the health gap. Staff working with in identified roles, feel as though these reforms are their responsibility and no one else's, even though most of the time it is not actually part of their role.

> *"We can't be everywhere all the time as Aboriginal and Torres Strait Islander people and 3% of the population. We need management level people and champions across the sector who can lead and advocate for these types of reforms. How do we clarify, how we can move forward together? It is a two-way street. We all need to have a say and ownership over close the gap – we can do it all together".*

The lack of shared accountability between First Nations people, staff and non-Indigenous people, is a significant barrier to previous closing the gap efforts. This is also influenced by the lack of First Nations leadership within these reforms.

"We need better accountability – people who are working on these reforms need to have training about what closing the gap really is. A lot of the time Close the Gap reforms are rolled out by people who want to be an ally but have no idea how". It was suggested that for the Health Equity reform to work, non-Indigenous community members and non-Indigenous staff across all sectors and levels, need to be brought along on the journey from the outset. There is still a lot of misunderstanding about what the health gap is, and why First Nations people have different health needs.

- **SUGGESTION:** "Bring a friend" building our champion base. Closing the gap is everyone's responsibility. Too much of us VS them. Let's bring non-indigenous people into the journey so they also have ownership.
- **SUGGESTION:** All staff who work for health must have access to learning about Aboriginal and Torres Strait Islander people with a cultural awareness program that is based on First Nation research done by Aboriginal and Torres Strait Islander people. Schools from kindergarten through to year 12 must have this in their curriculum.

Truth telling and education about history and trauma

"There is not a lot of recognition of trauma in the government. The government does not acknowledge trauma and they don't want to talk about it and certainly don't want it reported". Trauma and its' effects on the health gap is not as recognised or understood as it should be. It was stated that in other closing the gap reforms, trauma was overlooked and not addressed, because it made people uncomfortable. We really need to understand trauma and have ways of dealing with it. We cannot move forward without addressing the past and its' effects on First Nations people's lives today. We cannot heal when the wound is ignored.

"When we do co-design, we need to acknowledge that trauma comes up, but it is not allowed to be put into reports. The word trauma creates issues. But we need to understand intergenerational trauma and how it impacts every aspect of our lives spiritually and culturally, around how things have been passed down through generations what we have experienced over the last 332 years and how it impacts us today".

Reconsider how the "gap" is measured

"How do we measure closing the gap and who is doing the measuring? We are happy we are healthy we are on community – our kids are going to school but are being measured as below par. However, our kids speak four languages and hunt on country, they go to ceremony, and they do rituals. They still have women's business and men's business and yet our kids are being classed below average – how can that be?".

Closing the gap reforms, don't mention the strength and resilience of First Nations people. How do we report on strengths so that we can continue building on those rather than only working from a deficit? Consumers talked about how previous closing the gap efforts focus on comparing First Nations people with non-Indigenous people with deficit thinking. Further, trauma has been experienced differently for all First Nations people. Therefore, the health gap is not representative of one trauma experience, but many. There is a need to redefine what the gap is on a smaller scale too, what does trauma look like for each person? How has that effected their own health outcomes? Personalised and localised health data and strategies are needed to address health outcomes rather than regional, state-wide, and national plans which are "Once size fits all approaches".

Using strengths-based language

"Closing the gap uses a deficit language. We are always being told we are not as good. E.g., Not good enough at English but can speak four languages. That is deficit rather than strengths based. Let's look at the cultural determinants of health, push those and leading with that".

Community discussed how all closing the gap efforts to date have used a deficit-based language. *"Although deficit language is used to gain funding, it does not inspire community, it puts us down".* First Nations people don't want to be represented from a deficit all the time, we want to hear about our strengths, we want to know what we are doing right and how we can do it better, rather than feeling blamed.

When developing the Action Plan, the community want to be conscious of the language being used, they want to language to inspire. The Action Plan should build on the great things already happening in community. Further, we need to flip the narrative about the health gap. The health gap exists because of colonisation and a colonial system and the blame does not lie with First Nations people.

Language around race was also discussed.: "*Talking about race can limit the conversation. It makes the conversation binary, us vs them and does not recognise the complexity around race issues".* When talking about diversity and identity, it should be on a personal level. It should provide a platform for the person because it is a personal topic and is "for the health of the heart". A community member shared that in his culture they talk about heart and soul and looking after the heart is important because you can literally die from heartbreak and a heart attack. This is why discussions around trauma are necessary but need to be done in a sensitive and safe way.

> *"The word trauma has so much negativity associated with it. There is value in changing how we use words".*

More long term support and funding

> *"It all boils down to funding. There are positive services and programs positive but had limited timeframes and limited funding to achieve the whole of community perspectives and outcomes. Programs need to be better based on the needs of the community".*

AIM 3: We aim to remove racism from the healthcare system

Prompting questions:
What does racism in the health system look like to you?
Do you think this could be "removed"? If so, how?

> *"I don't think it can be removed but we can be aware of the problem and the reaction".*

> *The system was built on racism so it cannot be removed. The system was not built for our people, which is why it does not work for us. We should be focusing our efforts on building up the Community Controlled sector, which was developed by and for our community. This will provide better outcomes than trying to remove racism from a racist colonial system.*

Unconscious Bias

"Racism in the health system looks like creating identified jobs to do a job that others also do but not being paid for your knowledge & skills when others are paid for their additional study. It seems that cultural knowledge and skills is not equal". The issue with First Nations staff not being valued for their cultural knowledge was a frequent topic discussed throughout the consultations. It is not just First Nations staff in the health sector, but in all sectors that experience this. First Nations staff are often expected to educate other staff, plan cultural events or work on First Nations projects, in addition to their roles.

"Stereotypes are an issue. We are diverse people with diverse health problems – our health issues are not always the same and therefore the strategies shouldn't be either". Several community members shared their experiences of stereotypes and racism perpetrated by health staff. These types of experiences can be mitigated through better education for staff on Australian history, particularly the stolen generation and intergenerational trauma. There also needs to be more clear processes for reporting racism, and it needs to be taken seriously. It was suggested that community explore how they can use the Human Rights Declaration for Indigenous Peoples to hold health services accountable for discrimination.

- **CONSUMER EXPERIENCE:** *"My child is skinny, and the first response from health staff was "is everything alright at home". Unconscious bias – I don't think it is malicious, but people need to look at their own unconscious bias".*
- **CONSUMER EXPERIENCE:** *"When you identify as Aboriginal, I have always get a different look from medical staff and its make you feel like you should not say you are and then I feel you get treated different to other patients around you".*
- **CONSUMER EXPERIENCE:** A local family waited three hours to be told that there was nothing that could be done for their father, then up to eight months for a diagnosis. But a family friend referred him to a private hospital, where a diagnosis took one day. It made the family feel like they were not valued in the public system and it took money to get a diagnosis quickly.
- **CONSUMER EXPERIENCE:** This family' father was also admitted to the Emergency Department with a degenerate disease, the nurses assumed that he was a drunk and left him in the hall. Family vowed to never return to that hospital due to the mistreatment. Bad experiences will stop community from accessing a certain service.

More conversations about identity

Identity is a very sensitive topic for some First Nations people, due to the stolen generation and racism. Some First Nations people with fair skin, choose not to identify because they are tired of having to explain themselves to people. This can be very draining and even traumatic. A lot of young First Nations people struggle with their own identities and need guidance about what it means to identify and why they should. It was suggested that there be more safe spaces for First Nations people struggling with identity to talk to Elders or other community members about identity. A lack of cultural identity contributes to negative health outcomes, so it is important that these conversations are part of the Health Equity reform.

More First Nations education in the education sector and the workplace

> *"All staff who work for health must have access to learning about Aboriginal and Torres Strait Islander people with a cultural awareness program that is based on First Nation research done by Aboriginal and Torres Strait Islander people. Schools from kindergarten through to year 12, TAFE, University and in the workplace".*

It was discussed that the lack of education about First Nations people, culture and history has a significant impact on unconscious bias and racism in the health system. It was suggested that more First Nations education needs to be embedded from school, tertiary education and in the workplace. It is important that these education packages are developed by First Nations people, includes experiences, and is localised.

> *"TAFE & Universities also should have all courses covering Aboriginal and Torres Strait Islander people and including South Sea Islander history as well. We have always been here, we will always be here, everyone else needs to step up and learn. Health & Education can have the biggest impact".*

A Traditional Custodian shared that they have provided localised Koombumerri training in the Emergency Ward at Robina hospital, which was a great experience, however this type of education should be across the whole hospital and health service not just one service. Education about the local people is important because knowing about the different groups, countries and cultures will help people understand the diversity among First Nations people and the importance of person-centred care.

> Education should be inclusive of the individual and their own backgrounds. Not a general education that continues the racism covertly, objectively or subjectively.

It is important that there is education about colonisation and the stolen generation because this will help staff understand why First Nations people have diverse looks, skin tones, and may not always be confident to identify. Identity is a sensitive topic for First Nations people and when it is challenged, it can be very traumatic.

NEXT STEPS

This report provides a summary of discussion and findings from the consultations held with Gold Coast Health Equity Prescribed Stakeholders from December 2021- February 2022.

The findings and suggestions will help guide the planning for the second phase of consultations from February 2022 – June 2022. The second phase of consultations will be more widespread and more interactive, as these conversations will be developed into the Gold Coast Health Equity Action Plan.

Maybanks Consultancy will continue facilitating consultations for the second phase.

CONTACT

To discuss anything in this report further please contact Lynda Maybanks of Maybanks Consultancy at maybanksconsultancy@gmail.com