Blak Butterfly Implementation

Reclaiming First Nations Health Sovereignty

Loddon Mallee Murray Regions

Moira Lake, Yorta Yorta Country

Dr Mishel McMahon
Yorta Yorta woman
Echuca Regional Health
2025

Loddon Mallee Health Network

Contents

Me Mandook Galk Grandmother Tree

Dja Dja Wurrung Country

Castlemaine, Victoria

Acknowledgement of Country

We acknowledge and celebrate Aboriginal and Torres Strait Islander peoples across Victoria. Theirs in the oldest living and continuous culture on earth. Their deep relationship with and enduring care of Country is a gift to our nation. We pay respect to the Elders past and present, their custodianship, their culture and their resilience. Sovereignty was never ceded. This was and always will be Aboriginal land. We would like to acknowledge the ongoing impacts of colonisation, acknowledging the 'othering and silencing' of our continuous knowledges and processes for health, healing and wellbeing. We also acknowledge the relational worldviews of First Nations peoples which create sovereign cultures and languages, grounded in the concepts of interconnectedness, equality, oneness, interdependence and balance between human communities, Mother Earth and our Waterways, Father Sky, other animals and the spirit world.

Loddon Mallee Region Traditional Owner Groups include Barapa Barapa, Barkindji, Bora Bora, Dja Dja Wurrung, Kureinji, Latji Latji, Mutti Mutti, Ngintait, Ngurai Illum Wurrung, Nyeri Nyeri, Tatti Tatti, Taungurung, Wadi Wadi, Wemba Wemba, Wergaia, Wurrundjeri, and Yorta Yorta.

I want to give heartfelt thanks to First Nations staff working within Loddon Mallee Region Health Services, for your input into Blak Butterfly implementation, your membership to Blak Butterfly First Nations Governance Group and your hard work and dedication for improving First Nations communities' access and experience of health care.

I also want to extend respect and gratitude to past, present and future **Aboriginal Hospital Liaison Officers** (AHLO), our front-line workers improving health outcomes for First Nations communities, for many decades.

Terms

ACCHO: Aboriginal Community Controlled Health Organisation

AHLO: Aboriginal Hospital Liaison Officer

BB: Blak Butterfly Best Practice Framework

DoH: Department of Health

ED: Emergency Department

FN: First Nations

HS: Health Service

LMHN: Loddon Mallee Health Network

LMR: Loddon Mallee Region

TOG: Traditional Owner Group

Introduction

Blak Butterfly Best Practice Framework was developed as a Department of Health (DoH) Aboriginal Health Innovation Initiative 2023-2024 throughout Victoria's Loddon Mallee Region (LMR). Initially led by the Loddon Mallee Health Network (LMHN) and Violet Vines Marshman Centre for Rural Health Research, La Trobe Rural Health School, and funded by DoH to address the high proportion (6% to 15%) of First Nations people leaving Loddon Mallee Emergency Departments (EDs) before being seen, and the lack of cultural safety reported by Aboriginal people. The objective of the Blak Butterfly (BB) implementation phase was to enable and record the implementation of the fifteen Blak Butterfly components within the different Health Services across the Loddon Mallee region, and adhere to AIATSIS Ethics approval and the Victorian Aboriginal Health, Medical and Wellbeing Research Accord requirements of tangible research benefits for First Nations communities. The implementation period was funded for five months, 1FTE Blak Butterfly Implementation Lead. In light of these limited resources I want to sincerely thank Echuca Regional Health, LMHN CEO Group, LMHN and staff from all the health services who participated through their time and innovation, enabling the implementation of Blak Butterfly to create meaningful positive change for First Nations health.

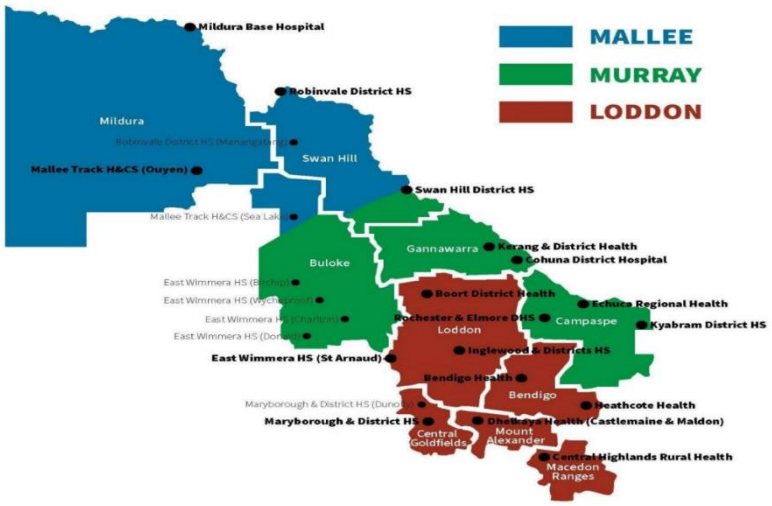

Figure 1: Loddon Mallee Region, Sub-Regions and Health Services

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Implementation Method

1. **Monthly Blak Butterfly First Nations Governance Group meetings**
   The First Nations Governance Group was convened at the beginning of Blak Butterfly implementation phase, creating this committee addressed components of Blak Butterfly Best Practice Framework such as networking and cultural support between all First Nations employees, and to position First Nations leadership and Governance. This committee meet the day before the BB Working Group, and decisions made by this committee or matters of discussion were taken to the Working Group the following day. Invited members were 27 First Nations employees at Health Services in the Loddon Mallee region.

2. **Monthly Blak Butterfly Working Group meetings**
   The Working Group was convened at the end of the Blak Butterfly project (2024), however many other members joined during implementation phase. Membership was open to Health Service staff, with the LMHN CEO Group being active members. The purpose of the Working Group was to discuss and brain storm challenges arising, celebrate initiatives being implemented in each Health Service and to listen and respond to the Blak Butterfly First Nations Governance Group.

3. **Blak Butterfly Implementation Lead Health Service Visits**
   During the five months of implementation I visited 15 Health Services to hold one on one discussions. Attendance was Health Service CEO's and Executive Management, Director's of

Aboriginal Health and AHLO's. At these meetings I discussed components of Blak Butterfly, listen to initiatives the Health Service was implementing and together we would brain storm challenges the Health Service was experiencing to improve outcomes for First Nations communities. These visits also included tours of hospital buildings and outdoor areas. Every Health Service received an email following the meeting which included support information / resources discussed during the meeting. Two visits were changed to online meetings due to my schedule.

4. **Blak Butterfly Implementation Update Forms**
   A form was created and sent out to Health Services as a way of capturing initiatives each health Service was implementing. This form also captured challenges each Health Services experienced during implementation.

This report is broken into three sections, **emerging themes** from components of Blak Butterfly being implemented, **challenges** Health Services experienced or discussed and **innovative** initiatives I learned about during Blak Butterfly implementation (2025).

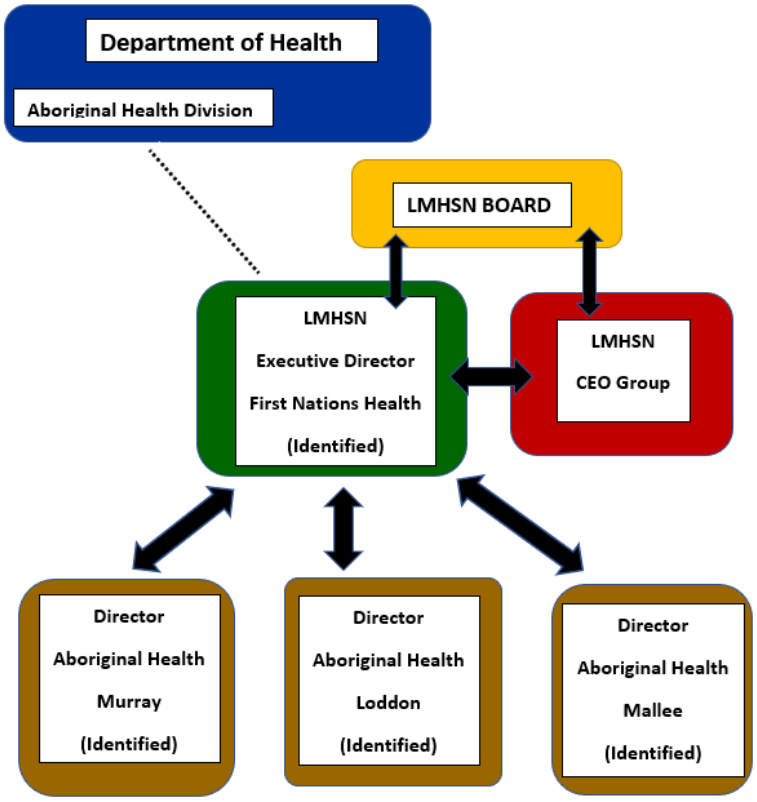
Jean & Mishel McMahon

Blak Butterfly Research Project Leads
(2024)

Blak Butterfly Implementation Emerging Themes

1. First Nations Leadership & Governance

The first component of Blak Butterfly (BB) Framework is First Nations Governance and leadership, **nothing about us, without us!** There are nearly 30 First Nations staff working across the LMR, which is capacity to hold leadership during discussions regarding First Nations health, Cultural Safety, Anti-Racism and Cultural Awareness. From this context there is the overarching necessity for cultural governance across the LMR, between First Nations employees from the Health Services and the LMHN CEO Group. To enable the continuing implementation of BB components after implementation phase has finished, First Nations leadership needs to be established throughout the LMR Health Service structure. Cultural governance embedded within Health Service Networks and hospitals recognizes and respects First Nations communities continuing sovereignty and self-determination, as framed through Victorian Governments Self-determination Reform Framework (2019), and also aligned with principles underpinning Victorian Governments Treaty process, First Peoples Assembly and Yoorrook Justice Commission. The below model was developed during Blak Butterfly project (2024). Discussions during implementation identified that First Nations leadership has begun throughout LMR. There are identified Director and Manager roles in Mildura, and identified Manager roles in Bendigo and Swan Hill, from which a First Nations leadership structure such as the model below could be developed.



To structure First Nations leadership in the Loddon Mallee region the Position Descriptions (PD) for an Executive Director First Nations Health and three Directors of First Nations Health were developed and submitted to LMHN CEO Group for review. Below are excerpts from the PD's, plus an overview of the First Nations Governance Group convened during Blak Butterfly implementation.

Executive Director First Nations Health – Loddon Mallee Health Service Network (LMHSN) (Identified)

Executive Director First Nations Health will hold high level responsibility across the Loddon Mallee region for First Nations health initiatives, First Nations HS staff, coordination of Cultural Safety and Anti-Racism training across all Health Services, localized Cultural Awareness training, communication with DoH Aboriginal Health Division, Chair LMHSN Cultural Safety Committee reporting to Ministerial Priorities, and Co-Chair LMHSN First Nations Governance Group, and in partnership with Health Service CEO's supervise LMHSN Directors First Nations Health (Loddon, Mallee, Murray). The Executive Director First Nations Health would also liaise with Loddon Mallee Aboriginal Reference Group (LMARG), Universities, VACCHO and Medical Research Institutes regarding Loddon Mallee Regions health priorities for First Nations patients within the health services.

Director First Nations Health – Loddon/ Mallee / Murray Sub Regions (Identified)

Reporting to a Health Service CEO (Mallee, Murray or Loddon) and LMHN Executive Director First Nations Health, each Director First Nations Health holds responsibility across their sub region (Mallee, Murray, Loddon) for First Nations health initiatives, First Nations health staff, delivery of Cultural Safety and Anti-Racism training, localized Cultural Awareness training and communication with LMHN Executive Director First Nations regarding celebrations and challenges within their sub-region. These positions coordinate and supervise AHLO services across their sub region, including access to AHLO virtual services. They will also develop meaningful and respectful service agreements with Traditional Owner Groups and ACCHO's in their sub-region. Each Director First Nations Health will be a member of committees such as LMHSN Cultural Safety Committee and LMHN First Nations Governance Group.

During Blak Butterfly implementation a **Blak Butterfly First Nations Governance Group** was convened and met monthly during implementation. The rationale for this committee was to

- Discuss First Nations staff experiences of burn out and isolation, dealing with racism, cultural load and or the need for role clarification and progression.
- Discuss enquiries from LMHN CEO Board Group regarding First Nations health and develop a response
- Discuss strengths, challenges, and opportunities regarding First Nations health within LMR health services.
- Discuss professional development requirements and cultural supervision of First Nations staff.
- Discuss emerging community driven health needs of First Nations communities.

Father Sky

Towards the end of Blak Butterfly implementation this committee decided to transition into an ongoing **First Nations Governance Group** for the Loddon Mallee Health Service Network (LMHSN) after July 1st 2025 Health Services Reform Plan is implemented. In light of this decision a **Terms of Reference** was developed, and submitted to all stakeholders for review. This ToR positioned a 'Cultural Governance' model taken from *Western Australia's Health Service Cultural Governance Framework (2021)* to enable a partnership relationship between LMHSN CEO Group and the LMHSN **First Nations Governance Group.**

2.2. Cultural, Corporate And Clinical Governance

As already stated, corporate and clinical governance will be ineffective if they are not integrated with cultural governance.
To summarise these three elements must come together:

- **Corporate governance** holds our service accountable for operating effectively and ethically, in line with the organisation's legislative obligations, policies, practices, code of conduct and other guidelines that apply.
  It informs and guides due diligence across all aspects of the organisation, including finance, workforce development, and models of practice, programs.
- **Clinical governance holds** our service accountable for optimising the quality of their clinical services and safeguarding high standards of care.
  It requires that employees are delivering clinical practice according to recognised best practice.
- **Cultural governance** holds our service accountable for ensuring that policies and practices are as effective for Aboriginal people as for all other clients[7].
  It requires that employees are working in ways that achieve optimum outcomes for Aboriginal people, families and communities.

To serve Aboriginal people as effectively as other Western Australians, all three governance elements need to be strong and integrated. Cultural Governance does not replace clinical or corporate governance, it is integrated into both. It will only occur if there is recognition across the organisation as essential and non-negotiable.

7. Whilst this document is about cultural governance from an Aboriginal perspective it could serve as a guide for other marginalised, and/or culturally and linguistically diverse groups and individuals.

Figure 3: Current view of Governance

Figure 4: Incorporating Cultural Governance

2. Anti-racism

Across multiple Health Services (HS) there are now Anti-Racism questions within HS People's Survey, and HS are developing their own Anti-Racism policies and processes and positioning Anti-Racism posters throughout each hospital. There was also conversation during Blak Butterfly implementation of LMHN developing a region wide Anti-Racism policy. A rapid review outlining potential frameworks to assist the development of an Anti-Racism policy was written for LMR Health Services and distributed, with a reminder this work needs to be **led or co-led** by First Nations leadership.

- AHPRA & National Boards Aboriginal and Torres Strait Islander Anti-Racism Policy
- Diversity Council Australia, RACISM AT WORK, Policy Briefing
- Department of Families, Fairness and Housing's Anti-racism Action plan, 2024–2027.
- Australian Human Rights Commission, An Anti-Racism Framework: Voices of First Nations Peoples.
- Australian Medical Association; AMA Anti-racism Statement
- Department of Health and Human Services 2017, Racism in Victoria and what it means for the health of Victorians.

- RACGP, Racism in the healthcare system, Position statement – March 2025
- Victorian Equal Opportunity & Human Rights Commission; Minimum standards for preventing and responding to race discrimination.
- Victorian Equal Opportunity & Human Rights Commission; Racial literacy in the workplace, developing the knowledge and skills to recognize racism.
- Victorian Equal Opportunity & Human Rights Commission; Developing a workplace anti-racism policy
- Victorian Equal Opportunity & Human Rights Commission; Developing a workplace race discrimination prevention plan
- Lowitja Institute Policy Brief; Racism Undermines Health
- VACCHO Position Statement; Institutional Racism and Cultural Safety
- Victorian Aboriginal Legal Service (VALS) Submission on Anti-Racism Strategy
- National Aboriginal Community Controlled Health Organization (NACCHO) National Anti-Racism Framework.

3. Culturally Strong Health Spaces

Across the LMR there are multiple Health Service Re-builds during BB project and implementation. These re-builds included the development of First Nations community / family spaces and the use of biophilic design elements.

Heathcote	Re-builds have included the development of family space and outdoor areas
Mildura	Biophilic design elements throughout Health Service
Swan Hill	Kapel Telkuna Aboriginal Health Unit established and launched, an entire house across the road from emergency department filled with culturally strong services and safe spaces for community.
Dhelkaya	Discussions for First Nations strong health space for AHLO service and community for future re-build
Kyabram	Environmental cultural safety audit of HS completed by ACCO Aldara Yenara
Kerang	Commissioned Art work by local First Nations artist
Boort	Established external Healing Garden, with plans to extend.
Inglewood	UCC redevelopment included consultation with Djaara – Dumawul
Maryborough	Re-build included extensive partnership with Djaara and use of biophilic design elements
Echuca	Malka Room re-launched as a safe, culturally strong space for First Nations people

4NEWS

Waiting room next in new Kapel Telkuna space

SAM JAMES

KAPEL Telkuna's new location is expanding the capacity for healthcare services to provide access to Aboriginal patients.

Manager Charmain Anton has big plans for the new office at 44 High Street, Swan Hill, across from the emergency department.

"Things are improving and there's a lot more cultural acceptance, but we're not going to take our foot off the pedal, we'll keep improving and keep closing the gaps in Aboriginal healthcare," she said.

"Our Aboriginal staff are all local, all connected to this community, and we have the passion and the drive to provide a professional, confidential and culturally safe service."

Current plans include an after-hours Aboriginal officer, a waiting room for patients and families, hygiene packs and a full bathroom including a shower.

"The new waiting room will have utilities for patients and their families close enough to the ED that they can head straight back over when they are needed," Ms Charmain said.

"Having a place where they can have a cuppa, charge their phones and have a chat with our team will help ensure that Aboriginal patients are staying to receive the care they need.

"Patients who have travelled long distances for surgery or treatment with their families will be able to wait in comfort instead of in their cars or in hospital hallways."

The 2024 Lodden Mallee First Nations emergency care framework (the Blak Butterfly report) presented 15 recommendations for improvements to the healthcare network and has informed many of the plans Ms Anton has for Kapel Telkuna.

Charmain Anton, Deb Chaplin and Cree Clayton are spearheading the innovations in Aboriginal healthcare at Kapel Telkuna. Picture: SAM JAMES

per cent of Aboriginal patients were leaving Loddon Mallee Emergency Departments before being seen, and that those who do walk out are at increased risk of re-presentation, disease or death.

"As hospital liaisons we're helping patients understand the triage system in the ED," Ms Anton said.

"We're advocating for patients with nursing staff with a view to extending that service to 24 hours.

"The nurses are doing their best but ED numbers are large, so if we can get in and make waiting less stressful, we will do that to help Aboriginal people feel comfortable accessing emergency care."

The team is working toward hosting medical and community services in a treatment room at Kapel Telkuna.

"These will include dieticians working with elders and young families, to help plan affordable diets for patients with diabetes and heart conditions, and educate parents on healthier early years lunchbox options," Ms Anton said.

"The new space gives us the opportunity to host services such as podiatrists, physiotherapists and maternity support workers.

"In the future, we are working towards having a consultation room for specialty services, such as eye and heart specialists."

Aboriginal Hospital Liaison Officer Deb Chaplin said there had been many improvements in the Kapel Telkuna service in the past year.

"Charmain's skills and drive in this unit has pushed us all forward in the same direction," she said.

"When the service started, we were in one room with two officers, so this bigger space will help our community access care and improve Aboriginal health.

"Over the years I've had a lot of support from Swan Hill District Health (SHDH).

"We're passionate about our community and their health and are working to ensure everyone receives a professional and confidential service."

Ms Anton and the Kapel Telkuna team will continue to introduce the recommendations in the Blak Butterfly report.

"We know that there are still barriers to Aboriginal people accessing necessary healthcare," she said.

"These recommendations won't fix the issues straight away, but we're working towards that."

Kapel Telkuna invites the Aboriginal community to their reference group meetings where people can share their experiences to help shape the future of the service.

Contact the Kapel Telkuna unit on 5033 9975 for more information

Swan Hill

February 7th 2025

Swan Hill Health Service

Boab Tree

Wamba Wamba, Wadi Wadi, Barapa Barapa, Latji Latji & Tatti Tatti Peoples

ERH launches new guidelines for Malka Room

/ Ryan Bellingham

chuca Regional Health arked National nciliation Week with an rmative event and morng tea held in the health ser-e's Malka Room.

Colin Atkinson first held a noking ceremony outside e hospital main entrance, siting Elders, the executive am and staff members to rtake.

Mr Atkinson spoke about e importance of the ceremo-, which cleanses the mind, dy and spirit.

Inside, ERH interim chief ecutive Robyn Rudge dressed the crowd of about , and said the hospital was ghted to acknowledge ek's significance.

"ERH are grateful to the mmunity for sharing this ith us — the oldest living ture in the world," she said.

"Through collaboration, ditional teachings, respect d understanding, ERH rives to create shared cultur belonging, enabling everyne to have a spiritual connecon to Country so that we may k together as one."

Ms Budge said the event as a chance to acknowledge e significance of the Malka om, and launch new guidees for the space following nuse.

Uncle Des Morgan spoke bout his family's and community's battle to make e room a reality, and its eaning.

"We have this space, and it's for us to debrief, to solidify our spirit, to pay respects and remembrance to the people that we lose," he said.

"Malka is a shield. It's your shield of protection that sits over the top, and shields you at a time when you need to have your spirit not touched, and your spirit rebuilt."

Reports of ERH staff using the room for meal and rest breaks have reached the Aboriginal community, which Uncle Des said was an improper use of the room.

"I know people don't mean any disrespect for things like that. You may not know the importance of this place," he said.

Uncle John Mitchell, who helped design the room, said it needed to be inviting to the community, and told the crowd its misuse is damaging.

"We're very strong and passionate as Elders and representatives of our community, how this place should be respected 24/7 for our mob," he said.

"We've really got to work together and make sure that purpose is followed through, so our community has faith and trust."

Executive director of community services Cynthia Robins said that the Elders' concerns had been heard and valued, and were reflected in the new guidelines for the room.

"We apologise. We did lose our way, and we are on a journey of reconciliation," she said.

"Today, we're officially launching it back to the community, that this is your space."

Ms Robins also acknowledged the hospital's history of segregation, and said ERH was committed to continuing the journey of reconciliation.

Colin Atkinson preparing materials for the smoking ceremony.

Colin Atkinson, Uncle Des Morgan and Uncle Gilbert Wanganeen.

Echuca Regional Health held a National Reconciliation Week event on Thursday, May 29. Pictured are Cynthia Robins, Robyn Rudge, Uncle Des Morgan, Aunty Denise Morgan-Bulled Uncle John Mitchell, Merinda Slater and Uncle Gilbert Wanganeen. Photos: Jordan Towers

Uncle Des Morgan.

ERH interim chief executive Robyn Rudge in the Malka Room.

Uncle John Mitchell.

Echuca Riverine Herald

Monday June 2nd 2025

4. Smaller Health Services

Some Health Services have no access to First Nations staff to lead or co-led Cultural Safety, Cultural Awareness or Anti-Racism training, community led Truth Telling around past or present experiences of health for First Nations communities and or developing partnerships with local ACCHO's / TOG initiatives. This was a theme across many of the smaller Health Services in the Loddon Mallee Region. However, the 'good will and intent' within these Health Services is commendable, I experienced many positive conversations regarding how these Health Services wish to transition towards culturally strong health care for First Nations communities. These discussions collated into an idea for a **shared First Nations rural AHLO position** across multiple of these smaller Health Services. This initiative is also to address 'preventable presentations' to larger Health Services for Emergency Triage categories 3, 4 and 5. Currently First Nations families are possibly travelling further distances to present to a larger Health Service which has an Aboriginal Health Unit, and AHLO services.

Smaller rural Health Services may be about 30% Urgent Care / Acute Care services, however 70% Community and Aged Care services. So, it makes sense to extend the traditional AHLO role to align with the service delivery of these rural Health Services, especially when HS's report these are the services accessed in higher numbers by First Nations people.

Areas to be addressed through prospective **shared First Nations rural health position.**

- **Provide AHLO services across multiple smaller Health Service (HS).**
- **Provide local community education / school visits regarding Aboriginal Health Services available in the rural area**
- **Enable connection with the prospective region-wide Virtual AHLO service when needed.**
- **Participate in strategic meetings with management of the multiple HS for First Nations health matters in the rural area.**
- **Assist in HS developing effective partnerships with the local Traditional Owner Group (TOG) and ACCHO, leading to 'service agreements', for events, community groups or cultural services.**
- **Co-lead Truth Telling session and Healing events with ACCHO and TOG for HS's, in local area.**
- **Participate in NAIDOC and Reconciliation committees at HS, and discussions about First Nations art, Bush Medicine gardens and other biophilic design elements.**
- **Provide AHLO services to 'whole of health service' including Community Services, Dietitian, meals on wheels, Physio, Aged Care or domestic services.**
- **In these rural areas extend AHLO services to outreach in the home, working alongside other outreach services from the rural HS's.**
- **Smaller HS have unrecognised assets such as more space and access to nature. This role would audit the potential for community vegetable gardens, healing gardens and development of service agreements with TOG and ACCHO's to use these spaces for cultural activities.**

5. Health Services & ACCHO's / ACCO's Service Agreements / Partnerships

An emerging theme in the LMR is Health Services holding MOU, Service Agreements and partnerships with ACCHO and ACCO's. There are multiple benefits to First Nations communities from these agreements, however two way learning and effective communication between organisations are strong outcomes.

Health Service	ACCHO / ACCO	Service Agreement
Mildura	MOU ACCHO's (8) Vic & NSW	For improved continuity of care, discharge planning and care coordination
Mildura	VACCHO	AHP Trainee Project
Swan Hill	MDAS	Primary Care Medical Centre supporting MDAS Medical Clinic
Swan Hill	MDAS	Midwifery partnership for antenatal & postnatal care
Swan Hill	MDAS	Dietetics, Speech Pathology and Podiatry services

Swan Hill	Ngwala Willumbong Aboriginal Corporation	Public Intoxication Response.
Kyabram	Aldara Yenara Aboriginal Corporation	AHLO role situated at Aldara Yenara Office
Echuca	Njernda	Alcohol and Other Drugs (AOD) Pharmacotherapy Expansion Program
Echuca	Viney Morgan Medical Centre (Cummeragunja, NSW)	Discharge Summaries sent to both the nominated General Practitioner plus Viney Morgan Medical Centre to improve continuity of care
Echuca	Njernda Aboriginal Corporation.	Monthly Dietetics Service, a Student Midwifery Program and Occupational Therapy service
Echuca	Cummeragunja Health and Development Corporation (CHADAC)	Sexual Health Nursing service and shared care for people with chronic conditions through the Complex Care team.
Castlemaine	BDAC	Tarrengower Women's Prison Primary Health Care Partnership
Castlemaine	Nalderun	MOU for training such as Anti-Racism Training

6. Cultural Safety & Cultural Awareness Training

Cultural Safety and Cultural Awareness training were consistent themes in every conversation during Blak Butterfly implementation phase. Conversations begun with discussing the differences between these two types of training. As most professionals and clinicians are registered practitioners with the national agency Australian Health Practitioner Regulation Agency (AHPRA) Blak Butterfly adheres to AHPRA's definition for cultural safety from the **National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025** (pg. 9)

Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

C**ultural Safety** involves an **inward focus and examination of self**, a professional's own beliefs, body language, identity and possible personal triggers which could affect their professionality during practice. It involves recognising, understanding and responding to our own biases and racism, which may consciously or unconsciously affect our own behaviours. Patient or clients can feel accepted and safe, or rejected and unsafe from our level of Cultural Safety in the workplace. Professionals may possibly find Cultural Safety training challenging, but its vital so 'rapport' is maintained between clinician and patient, and best health outcomes are possible.

Cultural awareness helps professionals recognise and value different cultures and different ways of being, so the **focus is outwards, on others**. Cultural Awareness could be a professional learning about Traditional Owner Groups, First Nations cultures and languages, First Nations communities' experiences of colonisation, First Nations ACCHO's or ACCO's or learning about First Nations experiences of and perspectives for, health and wellbeing. Often professionals find Cultural Awareness training interesting.

Key Point 2: Cultural Awareness is not Cultural Safety retrieved [Prerequisite knowledge: Cultural safety and culturally-responsive care Archives - PCC4U]

Below is a list of training Health Services stated staff are completing during Blak Butterfly implementation. Most of these address requirements of Cultural Awareness training, however some also include aspects of Cultural Safety training.

- Lowitja Institute's Cultural Safety Audit Tool
- Kineo mandatory Cultural Awareness
- Weenthunga Health Network Cultural Safety & Critical Consciousness training
- Waaman Tour, Uncle Rick Nelson Tour
- Cultural Awareness and Safety Training Aldara-Yenara Aboriginal Corporation
- CATonline Cultural Awareness training (one-hour module)
- Djaara cultural competency training, facilitated by DUMAWUL
- Mirriyu Cultural Consulting cultural awareness training.
- GOLD Training
- Hobajing Narrative Practice & Training

To assist Health Services, learn about other training options, the below training information was also shared.

Murra Mullangari Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) training for all APHRA registered staff

AIDA Cultural Safety - Australian Indigenous Doctors' Association (training for all Doctors)

IAHA Training Indigenous Allied Health Australia (IAHA) all allied health staff (training for staff such as social workers not registered with APHRA).

Training - AIPA Australian Indigenous Psychologists Association (all psychologists).

Cultural Humility Framework - Murray PHN - resource

Australian Health Practitioner Regulation Agency - Aboriginal and Torres Strait Islander Health Strategy - resource

Our Work and Impact | Weenthunga Health Network Training for all staff

7. Ambulance Victoria's First Nations Initiatives

Ambulance Victoria (AV) appointed a new **Diversity and Inclusion Indigenous Lead,** who participated in Blak Butterfly project and implementation phases. Through this communication we learnt that Ambulance Victoria's Clinical mobile app which includes "Care Pathways" now holds the function to link Ambulance Victoria paramedic's and the First Nations patients being transported to AHLO service in each Health Service of Victoria. This initiative aligns strongly to Blak Butterfly's findings for best practice that early involvement of AHLO service (if consent is granted) enables more complete health assessments, in that a First Nations person is more likely to state all of their symptoms and all of their medical history if an AHLO is present. Early access to AHLO also addresses 'leave before treatment' statistics, because Cultural Safety is established at the 'front of house' during transport, triage and waiting times. The First Nations person has a Culturally Safe 'point of contact' person during this time to communicate with, if their stress levels escalate or they suddenly learn they have emergency care duties back at home.

During Blak Butterfly AV staff within the Loddon Mallee region were sent contact detail information on how to phone directly AHLOs within each Health Service. Ambulance Victoria workforce are also now asking every patient their Aboriginal and/or Torres Strait Islander status, to enable AHLO engagement early.

An AV educational video and guideline were released in February 2025 training staff AV workforce how to ask every patient their Aboriginal and/or Torres Strait Islander identity status. AV independent audits will be undertaken to include 'asking the identification question' as an ongoing Continuous Quality Improvement (CQI) process.

8. First Nations Health Staff Cultural Load Payments

During BB implementation I convened First Nations Governance Group which met monthly, invited members were all First Nations staff at Health services in the LMR, and First Nations researchers who participated in the Blak Butterfly project the year before. It was during one of these initial meetings that **Cultural Load payments** was presented as a priority to implement from Blak Butterfly Best Practice Framework.

BB Components (8 & 9) discuss a Cultural Workload Allowance an extra $8,944 per year, paid by other Australian organisations annually to First Nations staff. The Blak Butterfly First Nations Governance Group prepared a '**Recommendation Statement'** (below) for the LMHN CEO Group, which included the following information.

The **National Gari Yala Speak the Truth** report published by Diversity Council Australia (2020) interviewed over 1000 Aboriginal and Torres Strait Islander people currently employed to learn their experiences within the workplace in Australia. This report explains that over a third reported a burden of high cultural load in the workplace.
Extra work demands outside their position description (unpaid) included,

- Expectation to educate other staff regarding professional cultural safety which is actually everyone's responsibility, local cultural awareness of Traditional Owner groups, Aboriginal communities local experience of colonization and resilience, local Aboriginal organizations or groups and countless informal conversations in the corridor or after a meeting regarding any of the above topics. These areas are either outside their position description or beyond their position description.
- Expectation to represent all First Nations people, on call or impromptu to inform organizational decisions or officiate at organizational events. This situation may occur more when the organization needs to appear to external stakeholders as culturally inclusive, when an organization doesn't have First Nations leadership at the Board and Executive level, and or doesn't have a First Nations Governance structure such as a reference group made up of First Nations community members.
- 45% reported not feeling that their education level, skills, perspectives and experiences are valued in the organization.
- 37% did not feel comfortable expressing cultural beliefs within the workplace.
- Almost two thirds (63%) experienced the need to work harder, compromise their cultural identity within the workplace and tone down or be less outspoken about First Nations issues in their workplace.

Cultural Load in the workplace means First Nations employees are 2 times less likely to be satisfied with their job, 2 times less likely to recommend their workplace to other First Nations people, and 2 times more likely to intend to leave their employer during the next 12 months. Experiences of racism within the workplace may also add to the experience of cultural load, as well as level of organizational authenticity, which involves the genuine commitment of an organization to move from symbolic words to action, and visible commitment.
From these findings' recommendation six within the Gari Yala Speak the Truth report recommended: **Recognize and remunerate cultural load as part of an employee's workload.**

Cultural Load Allowance for First Nations employee's is a positive step forward in ensuring that the invaluable cultural knowledge and guidance provided by First Nations staff is recognized and remunerated in mainstream Australian organizations.
This **Statement recommends** all First Nations staff employed in health services throughout the Loddon Mallee Region be paid annually a Cultural Load allowance.

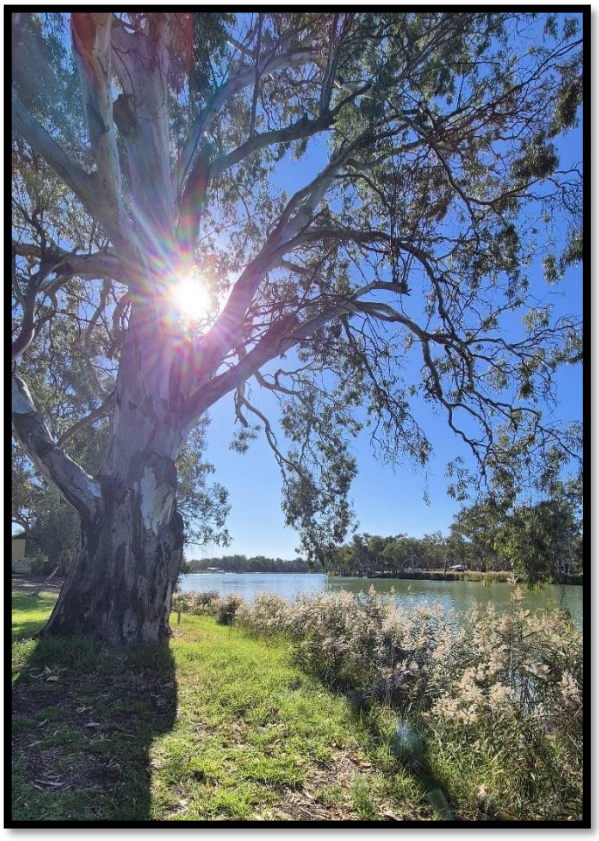
Blak Butterfly Implementation Lead
13th March 2025

This recommendation was endorsed by the LMHN CEO Group during Blak Butterfly implementation, and it was decided a First Nations Cultural Load Payment Advisory Committee to be convened, to further investigate particulars and develop a plan for going forward. Members of this 'committee' would be First Nations staff, CEO representatives and specialist Human Resources staff.

9. Aboriginal Health Practitioners

There were discussions during Blak Butterfly implementation regarding **Aboriginal Health Practitioners (AHP)**, especially since VACCHO is graduating students. Blak Butterfly positioned that AHP greatly improves Cultural Safety because of their clinical skillsets and ability to translate medical information to First Nations patients. AHP enable culturally informed assessments at Triage or 'Front of House' in emergency departments. Health Services in the LMR discussed their intention to employ AHP within these departments and other areas of a Health Service fulltime. Three matters discussed regarding the increased employment of AHP are below;

1. As AHP professionals enter Health Services their scope and duties within a hospital setting needs to be clearly identified, plus the benefits of embedding AHP staff and their clinical skills needs to be documented and communicated to all staff in Health Services so these First Nations health professionals are employed to their full clinical potential, and experience career progression within the health services sector.
2. Health Services expressed there is limited funding options for employing AHP across LMR, even though benefits have been well documented, and Health Services have evidenced they require AHP clinical skillsets due to increased First Nations presentations.
3. In different areas of the Loddon Mallee Region VACCHO's in person, Melbourne based AHP Course was discussed as a great training opportunity for First Nations students. It was requested if Loddon (Bendigo) or Murray (Swan Hill or Echuca) regional HS could also provide the AHP course similar to how in the Mallee region (Mildura) the VACCHO AHP course is delivered through a partnership between Monash University and Mildura Base Public Hospital. Enabling more AHP graduates to be employed within LMR Health Services.



Mildura Red Gum

Latji Latji, Nyeri Nyeri, Wergaia, Ngintait & Barkindji Country

10. Cultural Healing Services

University of Sydney (2016). How Traditional Aboriginal medicine can help close the health gap. (Article picture)

Various Health Services discussed their intentions to progress cultural healing services as outlined in Blak Butterfly. These discussions included increasing healing spaces inside or outside the Health Service, underpinned by biophilic design principles, for patient healing and stress regulation.

They also included discussions regarding bringing in community based 'Cultural Healers' to provide services similar to how Allied Health services hold offices within a Health Service.

Cultural healing modalities can be placed on a spectrum, at one end it may be Traditional Healers such as South Australian Ngangkari Healers, along the spectrum it may be a local First Nations meditation, breathwork or grounding practitioner or it may be ACCHO's or Traditional Owner Groups facilitating smoking ceremonies or men's / women's business healing group work. These modalities of cultural healing are different; however, all have documented health benefits.

Whichever cultural healing modality a Health Service intends to provide space for, it was discussed these initiatives are progressed with **First Nations leadership**; First Nations leadership from within the Health Service, local ACCHO's and TOG's. Further information provided.

Community benefits from Ngangkari healing | Sydney Local Health District (article)

Best-of-Both-Worlds-Approach-to-Mental-Health-Care-Importance-of-Traditional-Healers.pdf (pdf)

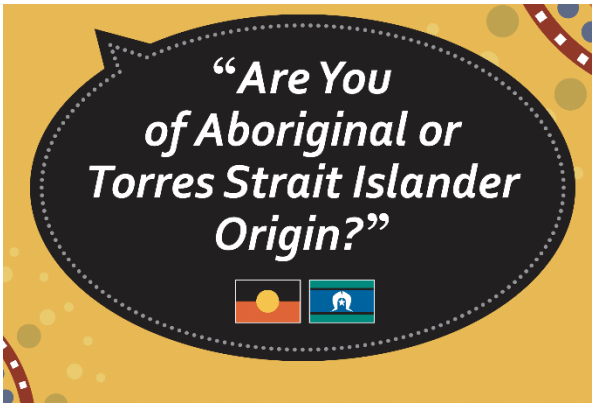
The Healing Touch: Indigenous healers getting results (YouTube video)

The other area of cultural healing discussed was **Bush Medicine gardens,** to be developed within Health Service grounds. Encouraging Bush Medicine ingredients to be used within Health Service **catering** so all patients enjoy the medicinal benefits of Australia's Indigenous plants.

There are First Nations organisations providing Bush Tucker plants and produce throughout Victoria, however Nalderun Me Mandook Galk Bushtucker Place information was given to Health Services in the Greater Bendigo region.

Nalderun | BUSH TUCKER / bushtucker@nalderun.net.au

11. Asking the Identity Question



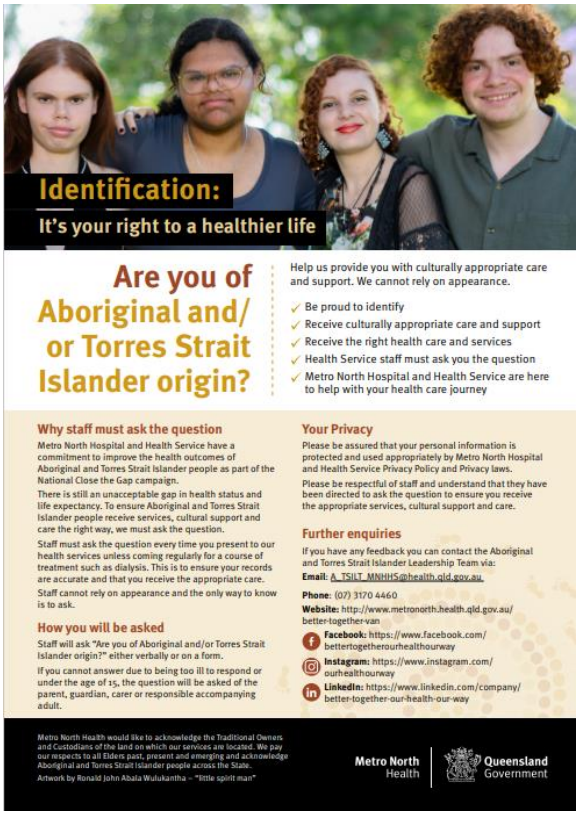
There were ongoing conversations regarding asking the 'identity question', when a person first presents to emergency and clinical or clerical staff ask '**Do you identify as Aboriginal or Torres Strait Islander?'**

Open conversations during BB implementation revealed that even though Health Services requested all patients are asked the identity question, non-Aboriginal staff have requested deeper understanding and resources to assist them ask the 'Identity Questions' successfully.

Patients will say to staff…Why are you asking this question?

Staff don't feel prepared to effectively provide answers, especially in the busy environments of emergency care. Loddon Mallee Health Services need resources to develop posters which explain why the identity question is being asked.

Poster example from Metro North Health, Queensland Government.



Patients may also ask…What happens if I answer yes?

The next question, what happens if I say yes? Is the Identity question only asked for gathering data / statistics? If I answer 'yes' will I receive preferential medical treatment? Or if I answer 'yes' is there increased chances of security or child protection becoming involved? These are a few of the challenging questions staff navigate with little training.

The resource also needs to explain what happens next when someone identifies so challenging conversations are clarified for Health Service staff, and consumers know what will and won't occur if they proudly identify as Aboriginal or Torres Strait Islander.

If you identify we will next ask… do you consent to be connected to an AHLO, do you wish to be connected immediately, and is your GP located at an ACCHO so we can offer you culturally strong referrals at discharge, if applicable.

12. Triage & Discharge for First Nations Patients

During implementation of Blak Butterfly there was a focus on how presenting to emergency care could become more Culturally Safe, elements of Cultural Safety are presented in the story below.

Rose is a proud Aboriginal woman, in her early forties, who works at her local ACCHO and is now also studying. She needs to go to emergency for a horrible cough and also terrible sinus pain which has recently become intense pain down one side of her face. The pain had become unbearable through the day, Rose is really scared of it getting worse through the night. It is late in the afternoon, she has her own children home and for a few days her sister's child. Afraid to go to hospital with four kids especially after what happened to her sister at work, Rose asks her ex partner to watch the kids. Rose promises to be no longer than two hours, saying… if it takes longer than two hours she'll walk out…. She pleads to her ex, just don't leave until I return.

Rose gets out of her neighbours' car and as she walks into emergency a sudden feeling of fear makes her feel nauseous. She notices the Aboriginal flags and large painting on the wall. The artist is an Aunty from work, she pauses for a moment, remembering the Aunties big beautiful laugh. Standing in the Triage line there is a poster explaining the 'Identity Question', and information about the AHLO workers at the hospital. The fear begins to subside a little, she scans the room to see if there is somewhere safe to sit and she thinks…. maybe everything will be okay this time. At Triage Rose states she is Aboriginal, and consents to seeing an AHLO. To her surprise the nurse asks do you want to be connected to an AHLO immediately and is your GP from the local ACCHO. She nods, agreeing to see an AHLO now, and 'yes' her GP is from her ACCHO Medical Clinic.

After 30 minutes of waiting, texting and checking her ex is still at the house, the AHLO arrives. Rose says her symptoms but explains her actual main concern is that her ex might need to leave, and the kids will be home alone. A situation she would never tell the nurses. The AHLO promises to check her every 20 minutes, and gives her their work number so she can message if she does need to leave quickly. The AHLO explains they will ask the nurse to talk to her about pain relief, and if she does need to walk out early they'll write up a Rapid Discharge Plan, so she can re-present the next day and pick up where she got to in her treatment. She relaxes thinking…wow there is a back-up plan.

A bit over an hour later Rose is ready to leave. The AHLO has checked in on her a few times, a doctor saw her, she has a prescription for antibiotics she will pick up tomorrow, and information from a nurse that her ACCHO currently has walk in appointments for flu shots. The AHLO makes sure she has enough pain relief to get through the night, wishes her all the best, and organises a taxi so she can return to the kids. As Rose is walking out the AHLO hands her a flyer…exciting news Sis, in a few days were opening our new Aboriginal community room, bring the kids next time hey! It's become dark now, but she feels relief walking to the taxi… everything went okay.

Different reasons were discussed during Blak Butterfly implementation why a First Nations person might leave before treatment is complete.

- **Lack of Culturally Safety**, example - clinician is visually iritated when a First Nations male is reluctant to discuss all symptoms or health history to female nurse, or when First Nations person wants family with them during treatment.

- **Experience of racism**, example – First Nations person has their identity questioned in public, or denied pain relief because clinicians believe they are intoxicated.

- **Frightened** – First Nations person has either personal experience or knowledge from family of tragic outcomes for First Nations people when presenting to hospital.

- **Loss of transport** if they remain longer – Public transport was an option but its later in the day now so its no longer available, AHLO is not available so patient is unsure if taxi is an option, patient was dropped off by friend but just received text the friend can no longer picking them up.

- **Urgent caring responsibilities**, the care of children or Elders is highest priority, even over a First Nations persons own health status. If a First Nations person receives communication about caring duties and there is no other option available, they may walk out of hospital.

If a First Nations person needs to **exit quickly**, it is optimal for the patient and for the Health Service if continuity of care is maintained. Information regarding St Vincent's Hospital, Sydney Flex Clinic for First Nations patients and an example of a Rapid Discharge Plan was distributed.

https://issuu.com/aushealthcare/docs/the_health_advocate_february_2022/s/14926716

In the three months following the introduction of the Flexi Clinic system, the rate of incomplete treatment among First Nations patients fell from 19.5% to 5.2% of presentations - a five-fold decrease.

Rapid Discharge Plan - A card is presented to First Nations patient

Name of treating team AHLO, nursing or medical staff

Where patient got to in their treatment, next steps to complete.

Patients intended time / day to re-present

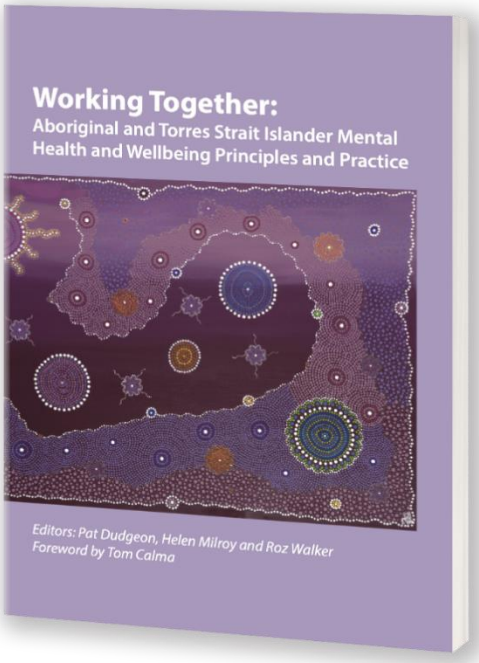
Patient understands they have **not been** fully medically discharged. (signed)

Patient knows to presents this card on return to the health service

However, if First Nations patient is **fully discharged**, possible questions for best practice.

1. Are you okay getting home safely?
2. Is there anything regarding your treatment you didn't understand?
3. Were you able to connect with AHLO services as much as you needed during your stay?
4. Are your discharge / referrals going to the right people, can we send a copy to your ACCHO medical Clinic (if applicable).

13. Culturally informed mental health assessments for First Nations patients



During the visits to Health Services conversations occurred regarding the component of Blak Butterfly which described **culturally informed mentally health assessments**. The Australian Government Department of the Prime Minister and Cabinet, The Kids Research Institute Australia / Kulunga Aboriginal Research Development Unit, University of Western Australia and the great work of First Nations leaders Professor Pat Dudgeon, Professor Helen Milroy, and Professor Roz Walker developed the publication **Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice** (2nd Edition, 2014).

Access found [Working Together - Transforming Indigenous Mental Health and Wellbeing https://timhwb.org.au/working-together-book/](https://timhwb.org.au/working-together-book/) download for free whole book, or chapters.

During Health Service visits I shared a diagram (below, Chapter 16, pg. 281) from the text as a resource. Blak Butterfly recommends clinicians practicing in the First Nations mental health field use the text as a resource for assessments and treatment plans. It is commendable that there is increased Mental Health AHLO roles in the LMR. However, access to or employment of a **First Nations psychologist** experienced in Aboriginal psychology for the LMR would also be advantageous in mitigating possible harm created when only mainstream psychology is applied to First Nations populations.

Appearance	Understand the person's 'usual' standard of self-care and appearance. Identify any changes that may indicate a mental health issue. Consider cultural influences and manifestations such as grief.
Behaviour	Have a good understanding of Aboriginal culture as it relates to a person's behaviour. Behaviours can be culture-specific.
Affect	Affect can take on cultural forms as not all human emotions are universal. Anxiety and depression for example, may be difficult to diagnose as the manifestation of these conditions could be vastly different to that of other people.
Mood	An Aboriginal person's mood may not be expressed in the same way as a non-Aboriginal person. Language may not have meaning for Aboriginal people and may need to be translated into meaningful terms.
Speech and thought form	Thought disorders may be difficult to detect if the client does not have good English. The clinician would then need to rely on the services of an AMHW.
Thought Content	Aboriginal spirituality may display as delusional or otherwise cultural. The clinician needs to ascertain whether the primary symptoms pre-date the culturally based retrospective attributions.
Perception	These may be pathologically or culturally based. It is advisable to seek advice from the AMHW. Auditory hallucinations are less commonly sited and may be indicative of a mental disorder.
Cognition	Assessing cognition is difficult due to the lack of culturally appropriate assessment tools— assessments of function and activities of daily living are not appropriate in remote communities where living in collective in nature. It is not uncommon for families to seek help as a last resort.

Challenges

Throughout the implementation phase of Blak Butterfly, health services also raised challenges they experienced, either in implementing components of Blak Butterfly or challenges in general for their Health Service regarding First Nations health.

1. Recognition within Health Services (HS) of local Traditional Owner Groups (TOG). HS explained they needed help navigating these discussions. In some areas a HS was located in multiple TOG areas, some formally recognized, some that are not. HS also need assistance establishing relationships with TOG organisations, understanding appropriate processes to follow. Generic 'Acknowledgment of Country' are sometimes used however HS held preference for localized recognition of TOG

2. No AHLO service available within a HS, even virtually but then finding 'housing' for AHLO staff is an issue. Enough to prevent advertised positions being filled. Also, some HS required AHLO services but are not part of regional AHLO conversations, and HS needing AHLO services say it needs to be a 'whole of health service' role, not just our Urgent Care Centers or Acute ward.

3. First Nations staff at a HS require 'cultural supervision' from First Nations health professionals. Understanding they may still have direct line management supervision from a non-Aboriginal person but still require periodic cultural supervision from a First Nations person for culturally strong professional development.

4. Aboriginal Health Unit (AHU) needs improved process to be notified when First Nations person initially presents, knowing that early AHLO involvement can address 'leave before seen' statistics and improve cultural safety experience. There also needs to be process so First Nations people can 'wait' at Aboriginal Health Unit if it is safe to do so, and not lose their place in the triage queue, then return when it's their turn to be seen.

5. There is a need in the LMR for a culturally strong Murray – Mallee Elders facility similar to Rumbalara Elders facility. Also, nearly all HS, some of which have large Aged Care facilities explained they need more information regarding what does culturally strong Elder Care / Palliative Care best practice include? Asking can the AHLO role be positioned in these services?

6. HS's need a Culturally Safety Training implementation strategy, there is limited staff exposure, knowledge and capacity for implementing and tracking Cultural Safety and Cultural Awareness initiatives. However, 98% to 99% of HS staff are motivated and supportive of training. The 1% to 2% that are not ready makes Cultural Safety training challenging, needs experienced facilitators.

7. HS's need increased efficiency regarding consent, if someone identifies as First Nations and consents to receiving AHLO services then this consent needs to be recorded and communicated to all other departments and services.

8. Not enough resources or capacity for HS to deliver ‘slow track’ care even though HS’s discussed they understood the benefits. Slow track involves multidisciplinary teams, including allied health when a patient presents with complex needs such as isolation, homeless, substance use or mental health challenges.

9. The absence of an Electronic Medical Record (EMR) systems in many LMR Health Services, creates challenges in ensuring accurate data collection, reporting, standardised processes and language or introducing many innovative solutions. The absence of automated alerts hinders the provision of both clinical and culturally responsive care.

10. HS need improved Cultural Awareness training to support health service staff understand the Aboriginal Health Sector; who are NACCHO, VACCHO and local ACCHO’s, or who are the national First Nations organisations who produce useful resources for clinicians such as Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australia (IAHA) etc.

11. HS’s need clarification for different AHLO Award rates, understanding that this role is now being required to fill leadership duties across a whole HS, and for local rural communities. There also needs to be AHLO career progression discussions and opportunities.

12. LMR needs after hours and weekend AHLO services established, either in person or a Loddon Mallee region virtual AHLO service.

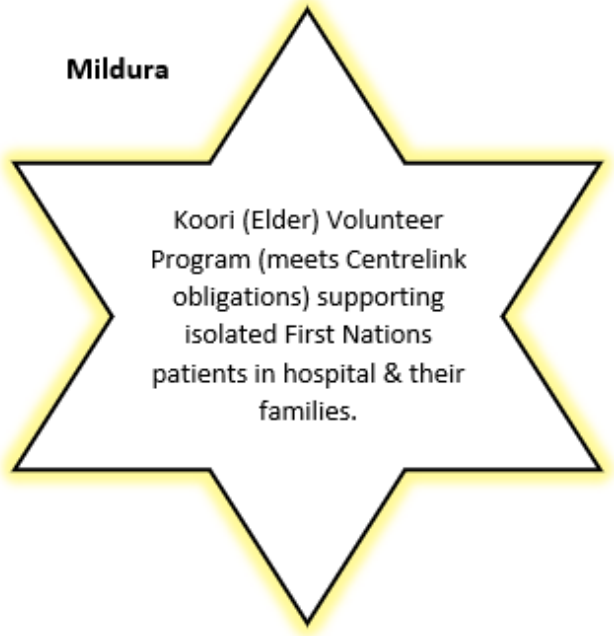
East Wimmera Health Services

St Arnaud Big Tree

Dja Dja Wurrung, Wotjobaluk, Jaadwa, Jadawadjali, Wergaia and Jupagalk Peoples

Innovation

Throughout the Loddon Mallee Region some truly innovative projects for improving First Nations health were either discussed or implemented. I hope highlighting these initiatives we can celebrate these collaboratively, understanding from conversations there is intent to be innovative region wide, however some Health Services are very limited by resources and capacity.



Swan Hill

Cultural Supervision (Hobajing Narrative Practice Supervision) for Kapel Telkuna First Nations staff. and other First Nations staff.

Rochester

REDHS investigating re-establishment of a Detox Unit, previously pivotal service for local ACCHO's.

Heathcote

Dan Douglas thank you for your commitment, and support

Kyneton & Castlemaine

Anti-Racism posters throughout Health Service, RACISM IT STOPS WITH ME

Kyabram

Aldara Yenara ACCO permanent Offices on Health Service grounds, resulting in ongoing joint projects & opportunities

Bendigo

AHLO Mental Health enabling culturally informed assessment for First Nations patients, Australian Indigenous Psychologists Association recommendation.

Echuca

Monthly Njernda & Viney Morgan meetings w/ ERH, & share Cultural Advisor role shared between ERH & Njernda Aboriginal Corporation.

Mildura

VACCHO Aboriginal Health Practitioner Course delivered a Mildura site, through partnership b/w Monash, VACCHO & Mildura Hospital.

Maryborough

BDAC (ACCHO) to have permanent space within HS providing cultural services, space for both AHLO and BDAC together, culturally strong health hub within the hospital.

Swan Hill

Kapel Telkuna ED Protocol, once a FN patient is assessed at Triage (if safe), 'waiting time' can be in Kapel Telkuna Unit, returning to ED when called.

Swan Hill

Intentions to include First Nations 'Bush Food' ingredients through HS's catering services for all patients.

Echuca

Partnership w/ Njernda (ACCHO), develop AHLO education video screened in ED for visual celebration of health supports for First Nations people.

Concluding Comments

Yakoa River

Dja Dja Wurrung (side)

Travelling to Loddon Mallee Health Services during implementation of Blak Butterfly Best Practice Framework was indeed rewarding. Driving along, I was thinking 'isn't this a great gig'. An overarching theme is rural Victoria itself, the beautiful Country, waterways and communities. For small and big towns, Health Services are the central hubs of each community. I was met by CEO's at the front door, taken to view healing gardens for patients, taken to say hello to big trees, inspected many new builds, visited a Kindergarten and Lake, got to view many beautiful pieces of First Nations artwork, spent time with Community Services and Aged Care staff, felt strong in LMR Aboriginal Health Units, learnt so much from AHLO's, experienced tours of the Health Service 'outside grounds' listening to the 'future vision' for expansion, and of course drank coffee at the best local café's.

Biophilic design elements in Health Services is growing. Walking into Kerang District Health you will see colour everywhere, the new build for Maryborough & District Hospital is a special experience with Djaara artwork throughout, warm sandstone walls and multiple indoor garden areas, and the soothing large nature wall-art in Mildura Base Public Hospital, are just some examples.

The framing of rural Health Services is changing, from my perspective, instead of being smaller versions of metropolitan hospitals, they are becoming community-based health and healing centers, inclusive of their natural environment. This shift is aligned with First Nations cultural ways of being for health, especially as each Health Service develops partnerships and service agreements with local ACCHO's and Traditional Owner Groups. I have been thinking, **what is First Nations health**? Is it Closing the Gap in health disparities between Aboriginal and non-Aboriginal people, is it Truth Telling addressing the continuing impact of colonization and racism, or is it about human rights, self-determination and reclaiming First Nations health sovereignty, through experiencing a small measure of pre-colonial Ancestral health and wellbeing? I think it is all of them.

However, First Nations health is something more, it is possibly a **litmus test of health for everyone, including nature**. During Blak Butterfly, the project and implementation, I received input from non-Aboriginal health service staff from different overseas cultures, explaining their high personal resonance with First Nations health perspectives. First Nations health is also strong in caring for Country as Country cares for us, it results in increased environmental sustainability and inclusion of ecological modalities of healing such as grounding. First Nations populations may be around 3% of the population, however we are young, median age being 24 years old (ABS). I suspect, if First Nations communities convey, they are not experiencing optimal health outcomes from mainstream health services, there may be, another larger cohort of Australians nodding their heads agreeing, for themselves. First Nations health is not only an endeavor for improving Aboriginal and Torres Strait Islander people's health outcomes, it is about re-establishing relationships to the natural world and about improving our understanding of health and welling for everyone. Blak Butterfly is **system reform**, which can be uncomfortable. However, I hope the discussions and resources created during this project have been beneficial.