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for Emergency Medicine

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Submission to the Queensland Human Rights Commission on Anti-Discrimination Act 1991 Review

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Acknowledgement of Country

The Australasian College for Emergency Medicine acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands now known as Australia. We acknowledge their continuous care of land, seas and waters, and pay respects to their Elders past and present, and to emerging leaders, for they hold the memories, traditions, cultures and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to participate in the *Anti-Discrimination Act 1991* (Qld) (ADA) review process by providing this submission to the Queensland Human Rights Commission (QHRC).

1. About ACEM

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to emergency departments (EDs).

At the time of writing, ACEM has 3,344 Fellows (specialist emergency physicians) and 2,718 trainees enrolled in the FACEM Training Program. In addition, ACEM has 451 members in categories other than that of Fellow, and 654 trainees enrolled in other ACEM training programs. These Fellows, other members and trainees are based primarily in Australia and Aotearoa New Zealand; 6 Fellows and 17 trainees of the College identify as Aboriginal and/or Torres Strait Islander.

ACEM currently accredits 147 hospital EDs in Australia (29 in Queensland) for specialist emergency medicine training, and has reach to additional EDs and urgent care facilities throughout Australia, particularly in regional and rural areas, through its Emergency Medicine Education and Training (EMET) program, which operates on a hub and spoke model with 49 hub hospitals providing education and training to approximately 500 regional, rural and remote ED/urgent care facility staff who are not Fellows or trainee emergency physicians.

2. Key message

As a nation, Australia is maturing to understand the impacts of our colonial history and the ongoing legacy of inequity that Aboriginal and Torres Strait Islander peoples still suffer across many aspects of their lives, including health. ACEM believes inequities based upon culture and race impact on the health and wellbeing of ED patients and the staff that provide their care. When the very institutions designed to deliver healthcare, are in fact less accessible, and provide inequitable care to identifiable groups within our communities, then this is discrimination. These health systems that embody institutional racism perpetuate ill health and suffering.

Until there is a clear, shared definition of institutional racism, it cannot be remedied. ACEM calls upon the Queensland Government to take systems-level action and create a template for national change by defining institutional racism as a form of racism in the *Anti-Discrimination Act 1991*. Only then can it be recognised, addressed and dismantled, thus improving the health and wellbeing of all.

3. ACEM recommendation to the QHRC

ACEM strongly advocates for a definition of 'Institutional Racism' to be inserted into the *Anti-Discrimination Act 1991*.

The College notes that the amendment to the *Hospitals and Health Boards (Health Equity Strategies) Amendment Regulation* 2021[1] makes reference to 'institutional racism'[2] but does not define it. However, institutional racism is defined in the footnotes of the Explanatory notes for SL 2021 No. 34 made under the *Hospital and Health Boards Act 2011* (Qld)[3] and suggests that this definition (with minor changes boldened) would be suitable:

"Institutional racism, for the purpose of the ***Act****, refers to the ways in which beliefs, attitudes or values have arisen within, or are built into the* ***governance****, operations and/or policies of an institution in such a way that discriminates against, controls, or oppresses, directly or indirectly, a certain group of people to limit their rights, causing and/or contributing to inherited disadvantage"* (p. 8).

4. Why ACEM advocates for a definition of institutional racism to be inserted into the *Anti-Discrimination Act 1991*

ACEM embraces the concept of a shared national identity that values the rich diversity of our origins and the contribution that cultural identity makes to health and wellbeing.

We envisage a future where Aboriginal and Torres Strait Islander peoples experience culturally safe emergency care that is self-determined, free from bias and racism, and enhances opportunities for quality health outcomes. We believe achieving this will lead to flourishing health and improved wellbeing for all Australian communities.

However, in 2022, Aboriginal and Torres Strait Islander peoples continue to experience disparities and inequities with respect to both accessing health services, and their experiences of care from the health services, in turn impacting their overall health outcomes.

The data on health outcomes for Aboriginal and Torres Strait Islander peoples is documented extensively and repeatedly in a range of national and state-based reports. Whilst public policies have led to improvements in some aspects of Aboriginal and Torres Strait Islander health and wellbeing, progress has been slow, and much more needs to be done by the Commonwealth and State and Territory governments to close the gap. However, The Lowitja Institute's Discussion Paper *Partnership for Justice in Health: Scoping Paper on Race, Racism and the Australian Health System*[4] argues that rather than just looking broadly at the research data linking racism and health care outcomes, there is now "an urgent mandate to better understand and intervene in the operation of race and racism in the Australian health care system."

ACEM recognises discrimination takes many forms, with the potential to cause harm to health care workers and patients alike. When health care is not culturally safe, both patients and staff experience harm due to racism and discrimination. Health staff can be directly impacted by racism, as well as indirectly, through the horizontal violence they experience as witnesses to the direct impact of racism on patients and patient care.

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[1] Subordinate Legislation 2021 No. 34 made under the *Hospital and Health Boards Act 2011*

[2] "8 Insertion of new ss 13A and 13B After section 13— insert— 13A Prescribed requirements for health equity strategies For section 40(3)(a) of the Act, a health equity strategy of a Service must— "

> (a) state the Service's key performance measures, as agreed by the Service and the chief Aboriginal and Torres Strait Islander health officer, that relate to improving health and wellbeing outcomes for Aboriginal people and Torres Strait Islander people, including—
>
> (i) actively eliminating racial discrimination and institutional racism within the Service; and..."

[3] Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021 Explanatory notes for SL 2021 No. 34 made under the Hospital and Health Boards Act 2011

[4] Watego, C., Singh, D. & Macoun, A. 2021, *Partnership for Justice in Health: Scoping Paper on Race, Racism and the Australian Health System*, https://www.lowitja.org.au/page/services/resources/Cultural-and-social-determinants/justice/partnership-for-justice-in-health-scoping-paper-on-race-racism-and-the-australian-health-system

Individuals who have the courage to speak out are often ignored, or worse still find themselves in the situation where complaint resolution places them back in harm's way through mediation with the offender. The current system of reporting can only respond to a complaint made against an individual, by an individual, so if no-one speaks up, the discrimination is able to continue.

Most contemporary organisational policies and strategies contain aspirations to eliminate racism, discrimination, and bias. However, the challenge for many employers is the translation of high-level policies into tangible 'positive action', as they wrestle with competing priorities and organisational inertia.

It is essential to move beyond the current mechanism where action is reliant on individual complaints, to one that identifies, acknowledges and can respond to the structures, policies and protocols that allow racism and discrimination to occur i.e., a process that can address ***institutional racism***. Organisations should be empowered and required to recognise the conditions that sustain racism and discrimination, and to act before an incident can occur, as well as hold themselves to account. The structural reform necessary for such a transformation needs to be underpinned by legislation to incentivise organisations into positive action and overcome the forces of inertia.

We acknowledge that institutional racism negatively impacts many other communities within Australia, and it is our intention that the legislative change we are advocating for will benefit all persons who experience institutional racism.

Our submission emphasises the intrinsic benefits of the proposed legislative amendment for Aboriginal and Torres Strait Islander peoples in recognition that historic and ongoing colonisation is entwined with institutional racism. This submission has been developed against the backdrop of national and state-based policies by governments and NGOs that position the elimination of racism in healthcare as a top priority.

The following subsections detail the many synergies which necessitate the need for ACEM to provide a submission to the ADA review, and include examples of ways in which a legislated definition of institutional racism would have a meaningful impact on the health and wellbeing of Australians / Queenslanders.

4.1 ACEM's commitment to reconciliation

A core function of the College since its establishment in 1983 is to influence public policy where necessary, by engaging in advocacy at all levels, as articulated by ACEM's constitution in object 1.1.4:
'The objects for which the College is established are to advocate on any issue which affects the ability of College members to meet their responsibilities to patients, the profession and to the community.'

ACEM's remit as a key stakeholder in the development of public policy is further reinforced in the College's 2019-2021 Strategic Plan which identifies 'Equity through Advocacy' as a key pillar of the Colleges strategic priorities[5]. This will remain as a strategic priority in the 2022-2024 Strategic Plan.

Encompassed within the Equity through Advocacy domain is the strategic commitment to *'improve equity of access and outcomes, and champion cultural safety for Aboriginal and Torres Strait Islander peoples presenting to the ED'*.

Enshrined within the ACEM Constitution is our commitment to the process of Reconciliation in Australia and the intent of the United Nations Declaration on the Rights of Indigenous peoples to build respectful relationships that promote Aboriginal and Torres Strait Islander participation in matters that concern them.

ACEM is committed to equity for Aboriginal and Torres Strait Islander patients and staff in EDs. The key pillars of ACEM's Reconciliation Action Plan (RAP) are to support and grow the Aboriginal and Torres Strait Islander emergency specialist workforce, support the delivery of culturally safe care, and engage and collaborate with communities and organisations identified through a range of initiatives.

In addition to the work undertaken by the College internally, ACEM proudly accepted an invitation to join the Closing the Gap Campaign Steering Committee in 2020 and is incredibly honoured to hold membership to this group.

[5] Australasian College for Emergency Medicine 2019, *ACEM Strategic Plan 2019-2021,* https://acem.org.au/getmedia/a52a56da-564b-4f87-99e3-872e1243105c/ACEM_Strategic-Plan_2019-2021

The 2021 State of Reconciliation in Australia Report[6] calls upon all RAP organisations to move from 'safe' to 'brave' to fulfil the promise of reconciliation. The report calls upon all RAP organisations to "be more prepared to advocate on some of the harder issues confronting First Nations Communities". ACEM is well positioned to raise concerns for inequities based upon culture and race that we see every day impacting the health and wellbeing of the patients that we care for, and the staff that provide their care. ACEM believes it is imperative to tackle institutional racism within health care organisations as an essential element to creating a health system that is free from racism and Aboriginal and Torres Strait Islander peoples are safe to participate at all levels.

4.2 Training Emergency Medicine Physicians is ACEM's core business

Most ACEM members and trainees are likely to work the majority of their career in large institutions. Therefore, it is vital that ACEM works in partnership with the health sector, and across sectors to create workplaces that are culturally safe for staff and patients and to eliminate all forms of racism in these institutions that ACEM members work.

4.2.1 Workplaces that are culturally safe

ACEM is responsible for setting standards for emergency medical care across Australia and Aotearoa New Zealand and, as such, is a key stakeholder in influencing how culturally safe care is provided.

The College considers it vital that Aboriginal and Torres Strait Islander peoples are represented throughout the ED workforce, including management, medical, nursing, allied health and support staff. A strong Aboriginal and Torres Strait Islander ED workforce is key to creating culturally safe EDs for patients and staff, and delivering health equity for Aboriginal and Torres Strait Islander peoples. Currently, the representation of Aboriginal and Torres Strait Islander workers is well below population parity in all areas of mainstream health care delivery. In ACEM's 2020 research report produced by the Lowitja Institute, titled '*Traumatology Talks – Black Wounds, White Stitches,*'[7]a major theme highlighted in the report is the importance of increasing the size and visibility of a culturally strong Aboriginal and Torres Strait Islander workforce across a variety of roles within the ED.

ACEM recognises that culturally safe workplaces are the foundation upon which to grow the Aboriginal and Torres Strait Islander workforce for EDs. For any staff to join and remain working in an ED, they must feel welcome, and believe that their contribution to the team is valued and respected. This includes the ability to raise concerns and complaints, including reporting incidences of racism. Knowing that a supervisor will hear and believe their experience, support the staff member to lodge a complaint, and act to make changes, is one way a culturally safe workplace can make the difference between an Aboriginal and Torres Strait Islander staff member choosing to continue or to leave the team.

ACEM's *Discrimination, Bullying and Sexual Harassment Action Plan*[8] is a substantive document that embodies much of the abovementioned principles, and contains a series of recommendations to drive improvements across the College. Whilst the Action Plan also contains important recommendations for employers, there are few levers available, other than through legal requirements whereby we can shift the onus of discrimination from individuals to organisations. Legislation that includes reference to institutional racism will provide a powerful lever to hold organisations accountable for improving workplaces in which our members work, by forcing the institution to examine and dismantle structures that allow racism to continue in the workplace.

More specifically, here follows an example of institutional racism that is current and affecting the health and wellbeing of our members in the area of education and training. Members of ACEM's Indigenous Health Committee (IHC) and Reconciliation Action Plan (RAP) Steering Group have highlighted that flexibility in study time for those with family and cultural commitments is important both at higher education (medical school) and junior doctor levels. They have seen Aboriginal and Torres Strait Islander medical students and junior doctors pull out of education and employment because they needed more flexible study and working conditions that were not available or were discouraged from pursuing flexible study or work conditions by

[6] Reconciliation Australia, *2021 State of Reconciliation in Australia, https://www.reconciliation.org.au/wp-content/uploads/2021/02/State-of-Reconciliation-2021-Full-Report_web.pdf*

[7] Australasian College for Emergency Medicine 2020, *Traumatology Talks – Black Wounds, White Stitches, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-safety/Traumatology-Talks-Black-Wounds,-White-Stitches*

[8] Australasian College for Emergency Medicine 2018, *Discrimination, Bullying and Sexual Harassment Action Plan, https://acem.org.au/getmedia/533f9238-b12f-44ca-aa2a-38582002591c/ACEM_DBSH_Action_Plan.aspx*

their employer or education provider. Our members have noted that even working part-time is seen by many hospitals as unfavourable and has historically been difficult to arrange.

In summary, we need legislative safeguards to increase the accountability of organisations to provide culturally safe workplaces. Legislation that forces organisations to review and dismantle the structures that create institutional barriers, such as the abovementioned scenario, will effectively aid the supply of Aboriginal and Torres Strait Islander healthcare workforce by recognising the importance of, and fostering training and employment pathways that are responsive to the cultural needs of those traversing those pathways.

4.2.2 Culturally safe care and service delivery

ACEM acknowledges the Australian Health Practitioner Regulation Agency's (AHPRA) definition of Cultural Safety,[9] and considers that this understanding of cultural safety should be embodied across all levels of the health care system, from policy-makers, health and hospital service executives and management, through to individual practitioners:

"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."

Emergency Departments increasingly stand as the front door to the mainstream hospital service for patients. For many Aboriginal and Torres Strait Islander peoples, the ED can also be the first, or only, point of contact for health care. Often, hospital systems designed to cater for everyone take a "one size fits all" approach to health care delivery that is not culturally safe and tone deaf to diversity and cultural identity. The care provided is the "same" for all patients, rather than recognising that the needs of all patients are not the same. Unfortunately, this approach is substantiated by the belief that equality is about equal delivery of care, not equity in outcomes. This exemplifies institutional racism embedded within our current healthcare system approach.

Health care staff need explicit and rigorous training in anti-racism to develop the tools to provide culturally safe care, and to ensure equity of access to care for Aboriginal and Torres Strait Islander peoples. ACEM has mandated Cultural Competency and Safety Training for all Fellows as part of their Continuing Professional Development (CPD), and recently introduced mandatory ACEM Indigenous Health and Cultural Competency (IHCC) Program[10] for first year ACEM trainees. While Queensland Health's mandatory staff training includes the Cultural Practice Program, there is not universal enforcement of completion across each Hospital and Health Service (HHS) in Queensland. In addition, this single workshop should be considered an introduction to essential skills and knowledge in health care delivery, and is yet to be supplemented by further cultural safety and anti-racism training necessary for staff to put their learnings into practice.

Health care cannot be clinically safe, unless it is also culturally safe. The AHPRA definition is an important first step towards embedding cultural safety as a core skill for registered health care professionals. The Australian Charter of Healthcare Rights[11] states more broadly that "*the care provided shows respect to me and my culture, beliefs, values and personal characteristics.*" Healthcare organisations must have the systems in place to ensure cultural safety reaches into every aspect of the health system. However, there are currently limited, if any, processes to enforce appropriate training of staff, including those not registered with AHPRA, in cultural safety and anti-racism. Defining institutional racism in legislation will articulate the importance of investment into staff capability. It will facilitate organisational ability to remediate non-compliance with training. Reports of culturally unsafe care and racism may trigger not just individual sanctions, but also organisational actions to prevent future occurrences.

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[9] AHPRA, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025,* *file:///C:/Users/hamish.bourne/Downloads/National-Scheme-s-Aboriginal-and-Torres-Strait-Islander-Health-and-Cultural-Safety-Strategy-2020-2025%20(1).PDF*

[10] Australasian College for Emergency Medicine, *Indigenous Health and Cultural Competency Program*, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Indigenous-Health-and-Cultural-Competency.aspx

[11] Australian Commission on Safety and Quality in Healthcare 2008, *Australian Charter of Healthcare Rights,* *https://www.safetyandquality.gov.au/sites/default/files/2019-05/charter-pdf.pdf*

If meaningful change is to occur then it is critical to establish parameters for what constitutes institutional racism under law, and it is the College's view that a legislated definition is the only means by which organisations can genuinely be made accountable, and embed cultural safety as the norm.

4.3 Public policy linkages

Aboriginal and Torres Strait Islander health policy at the Federal and State levels is entering a new era, with many new long-term strategies that provide the overarching framework to achieve the policy objectives of the next decade. This section summarises the current policy context at the Federal and State levels, demonstrating the connection between key policies and our proposal for the inclusion of a definition of institutional racism in the *Anti-Discrimination Act 1991*.

The 2016 audit of all 16 of Queensland's health and hospital services (HHS) using the *Marrie Institutional Racism Matrix (MRIM) Tool*[12] and the subsequent report titled *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander Peoples in Queensland's Public Hospital and Health Service* (also referred to as the Health Equity Report) laid bare the extent to which institutional racism is present across all 16 HHSs.[13]

The College commends the Queensland Government, particularly Queensland Health's (QH) response to the confronting findings contained in the Health Equity Report. ACEM welcomes the amendment to the *Hospital and Health Boards Act 2011* (Qld) that now requires each HHS to develop and implement a health equity strategy. Most notable is the partnership between QH and the Queensland Aboriginal and Islander Health Council (QAIHC) in the *Making Tracks* discussion paper. [14]

The Making Tracks discussion paper and accompanying Health Equity Framework[15] are comprehensive strategic documents that have the potential to serve as the template for national change, and will assist in achieving many of the 16 targets detailed in the 2020 Council of Australian Governments (COAG) National Agreement on Closing the Gap. The COAG National Agreement is also referred to in the above Regulation.[16]

The four priority areas set in the COAG National Agreement are: Formal Partnerships and Shared Decision making; Building the Community Controlled Sector; Transforming Government Organisations; Shared Access to Data and Information at a Regional Level.

Priority three: Transforming Government Organisations is particularly relevant to this submission. The first transformation element contained in the Agreement is:

a. *Identify and eliminate racism – Identify and call out institutional racism, discrimination and unconscious bias in order to address these experiences. Undertake system-focused effort to address disproportionate outcomes and overrepresentation of Aboriginal and Torres Strait Islander peoples by addressing features of systems that cultivate institutional racism. (p. 11)*

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[12] Marrie, A & Marrie, H. (2014). A matrix for identifying, measuring and monitoring institutional racism within public hospitals and health services. Gordonvale: Bukal Consultancy Services

[13] Marrie, A. (2017). Addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland's public hospital and health services

[14] Queensland Aboriginal and Islander Health Council & Queensland Health 2021, *Making Tracks: towards health equity with Aboriginal and Torres Strait Islander peoples – working together to achieve life expectancy parity by 2031,* https://www.health.qld.gov.au/__data/assets/pdf_file/0035/1028879/health-equity-discussion-paper.pdf

[15] Queensland Aboriginal and Islander Health Council & Queensland Health 2021, *Making Tracks Together – Queensland's Aboriginal and Torres Strait Islander Health Equity Framework,* https://www.health.qld.gov.au/__data/assets/pdf_file/0019/1121383/health-equity-framework.pdf

[16] "8 Insertion of new ss 13A and 13B After section 13— insert— 13A Prescribed requirements for health equity strategies For section 40(3)(a) of the Act, a health equity strategy of a Service must—

(c) state how the strategy aligns with—

.....

(iv) other national, state and local government strategies, policies, agreements and standards relevant to promoting shared decision-making, shared ownership and working in partnership with Aboriginal people and Torres Strait Islander people.

Examples— • the National Agreement on Closing the Gap (2020)....

The Vision Statement contained in the National Aboriginal and Torres Strait Islander Health Plan 2021-2031[17] is that "*Aboriginal and Torres Strait Islander peoples enjoy long, healthy lives that are centred in culture, with access to services that are prevention-focused, culturally safe and responsive, equitable and free of racism*". Priority 8 of the National Plan is to identify and eliminate racism, with the stated desired outcome that "*individual and institutional racism across health, disability and aged care systems is identified, measured and addressed under a human rights-based approach*".

The National Health Reform Agreement (NHRA)[18] has a long-term vision for public health reform and has committed to Aboriginal and Torres Strait Islander leadership, design, community control, and cultural safety across the whole health system. The NHRA is also identified in the National Plan as one of the key overarching policies that the National Plan is closely aligned with.

The Close the Gap Campaign Report 2021[19] recognised the new National Agreement on Closing the Gap as a game changer in setting a new standard in the way governments work with Aboriginal and Torres Strait Islander organisations and communities – with the caveat being that Governments must be guided by, and invest in, Aboriginal and Torres Strait Islander led solutions and the priority reforms in the National Agreement.

This section has highlighted a range of the key strategic documents that will underpin the next decade of public policies that intersect with Aboriginal and Torres Strait Islander health. Whilst they read as great aspirational documents, their aims and objectives cannot be met without those responsible for the stewardship of the health care system taking significant action. We strongly urge the Queensland government to take an historically significant step, by being the first jurisdiction in Australia to insert a definition of institutional racism into legislation.

5. Conclusion

ACEM is calling upon the Queensland Government to lead the way, as it has in recent years, to address inequitable health outcomes for Aboriginal and Torres Strait Islander peoples. The Close the Gap *Progress and Priorities Report 2016*[20] signalled its hopes that the Marrie Institutional Racism Matrix will make a significant contribution to understanding institutional racism in health services over the next decade. We believe this to be the case. There is an opportunity now for the Queensland Government to take further systems-level action and provide the other States and Territories with the template for national change.

As a nation, Australia is maturing to understand the impacts of our colonial history and the ongoing legacy of inequity that Aboriginal and Torres Strait Islander peoples still suffer across many aspects of their lives, including health. When the very health services designed to deliver care, are in fact less accessible, and provide inequitable care to identifiable groups within our communities, then this is discrimination. This is institutional racism that is perpetuating ill health and suffering.

Until there is a clear, shared definition of institutional racism, it cannot be recognised, nor can it be rectified. ACEM calls upon the Queensland Government to take systems-level action and create a template for national change by defining and recognising institutional racism as a form of racism in the *Anti-Discrimination Act 1991*. Only then can it be named, addressed and dismantled, thus improving the health and wellbeing of all.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement (jesse.dean@acem.org.au; +61 423 251 383).

[17] Department of Health 2021, *National Aboriginal and Torres Strait Islander Health Plan 2021-2031,* https://www.health.gov.au/sites/default/files/documents/2021/12/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031_2.pdf

[18] National Health Ministers 2021, *The National Health Reform Agreement Long Term Reforms Roadmap,* https://www.health.gov.au/sites/default/files/documents/2021/10/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap_0.pdf

[19] Close the Gap Campaign Steering Committee 2021, *Leadership and Legacy Through Crises: Keeping our Mob Safe – Close the Gap Campaign Report 2021,* https://apo.org.au/sites/default/files/resource-files//apo-nid311463.pdf

[20] Close the Gap Campaign Steering Committee 2016, *Progress and priorities report 2016,* https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/publications/close-gap-progress