TITLE

The experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study

ABSTRACT

The need for mental health clinicians to practice cultural safety is vital in ensuring meaningful care and in moving towards improving the mental health outcomes for Aboriginal people. The concept of cultural safety is particularly relevant to mental health professionals as it seeks to promote cultural integrity and the promotion of social justice, equity and respect. A substantive theory that explained the experience of providing cultural safety in mental health care to Aboriginal patients was developed using grounded theory methodology. Mental health professionals engaged in a social psychological process, called *seeking solutions by navigating the labyrinth* to overcome the experience of *being unprepared.* During this process participants moved from a state of *being unprepared* to one where they began to navigate the pathway of cultural safety. The findings of this research suggest health professionals have a limited understanding of the concept of cultural safety. The experience of providing cultural safety has not been adequately addressed by organisations, health services, governments, educational providers and policy makers. Health services, organisations and government agencies must work with Aboriginal people to progress strategies that inform and empower staff to practice cultural safety.

KEY WORDS: Aboriginal, cultural safety, Indigenous, mental health

INTRODUCTION AND BACKGROUND

Notable disparities exist in the health outcomes between Indigenous and non-Indigenous Australians and particularly in the area of mental health and wellbeing. The recent progress and priorities report of the Australia's national "Close the Gap Campaign (2008)", by the Close the Gap Campaign Steering Committee (2014) declared that there is a mental health crisis for Indigenous people that must be addressed. Indigenous people report high levels of psychological distress and associated mental health problems, (Australian Institute of Health and Welfare, 2014) and mainstream mental services are often criticised for not addressing the specific cultural needs of this group (Herring et al., 2012; Hunter et al., 2013; Wright & O'Connell, 2015, Westerman, 2010). There remains a chasm between policy and practice with many mainstream services failing to provide cultural safety. Aboriginal people report

that health services are unwelcoming and alienating, due to attitudes from staff, unfamiliar environments, lack of continuity of care, lack of information, and cultural, linguistic and educational differences (Wright & O'Connell, 2015, Johnston & Kanitsaki, 2009, Hunter et al., 2013).

Several frameworks have been proposed to address cultural diversity and health disparities in health including, cultural awareness, cultural competence, cultural security, cultural respect and cultural safety. While there are similarities between these concepts, cultural safety advocates that both professionals and institutions work to establish a safe place for patients which is sensitive and responsive to their social, political, linguistic, economic and spiritual concerns (Kirmayer, 2012). Cultural safety is more than an understanding of a patient's ethnic background (Evans, Nizette & O'Brien, 2017) as it requires the "health professional to reflect on their own cultural identity and on their relative power as a health provider" (Taylor & Guerin, 2010, p.12). Cultural safety is gaining acceptance in the Australian context and has been endorsed by The Congress of Aboriginal and Torres Strait Islander Nurses, academics and advocacy groups (Taylor & Guerin, 2010).

As mainstream services are the primary providers of health care, there is an urgent need to improve the cultural safety of these services and to improve accessibility for Indigenous people (Hunter et al., 2013). To date, the understanding of non-Indigenous health professionals' multi-dimensional experiences of providing cultural safety in mental health care within mainstream mental health services to Indigenous people is not well documented, and the substantive theory presented in this paper makes a significant contribution to this important area.

Nyoongar are the custodians of the land in south-west corner of Western Australia, ranging from Geraldton on the west coast to Esperance on the south coast, and includes the capital city Perth, where the study was completed. Nyoongar prefer to be called Aboriginal Australians (Collard and Bracknell, 2012; Harben et al., 2004) and for this reason the word "Aboriginal" is used in all Western Australian government documents and correspondence. Therefore, the word Aboriginal is used in this paper unless referring to Australia wide issues where Aboriginal and Torres Strait Islander will be used. There is no disrespect intended to Aboriginal people living in other areas of Australia or Torres Strait Islanders.

METHODOLGY

Context of the study

Participants for this study were health professionals working in mainstream mental health services. Glaser and Strauss' (1967) original grounded theory method was used to develop a substantive theory to describe the experiences of mental health professionals caring for Aboriginal people in Western Australia. Grounded theory methodology engages an inductive process in understanding human behaviour rather than through hypothesis testing (Tavakol & Sandars, 2014) and involves the generation of theory from data using systematic and rigorous research methods (Glaser & Strauss, 1967). The goal is to develop a substantive theory that explains a pattern of behavior which is pertinent to those concerned (Glaser, 1978) and incorporates a basic social psychological problem and a basic social psychological process. The basic social psychological problem describes the common shared problem or experience of the participants, while the basic social psychological process explains the way people manage and seek solutions to the problem. The theory also identifies the conditions which influence these experiences and highlights social and psychological processes, including thoughts, perceptions, actions and how individuals interpret their situation. Grounded theory was chosen as it had the potential to discover original perspectives of the provision of cultural safety and it allowed the researcher to explain this unique world view shared by participants. Permission for the study was obtained from the South Metropolitan Health Service Human Research Ethics Committee and Curtin University's Human Research Ethics Committee.

Sample population

Purposeful and theoretical sampling techniques central to the grounded theory method were used to recruit 25 registered nurses and three psychologists with experience in working in public mainstream mental health services in Western Australia. Seventeen females and eleven males consented to take part in the study and 13 were aged between 46-55 years, five between 25-35 years and two participants were over the age of 61 years. Twelve participants were Australian born, 10 in the United Kingdom (UK) and six were from other overseas countries. Six participants identified as non-Anglo-Saxon. No Aboriginal participants were included in this study as the focus was specifically on the care provided by non-Aboriginal mental health practitioners.

Data collection

Data collection methods included semi-structured interviews, (ranging from 30 – 60 minutes), field observations, memo writing and reflective journaling. Each digitally recorded

interview was transcribed verbatim to ensure the richness of the data was maintained and fully captured. When data analysis was completed and categories were well established, then literature was sort to examine the findings in the context of current literature.

Data analysis

The constant comparative method of analysis central to grounded theory methodology was used to identify major and sub-categories and their relationships to one another. The method of constant comparison allows the researcher to sort data into similar categories and to build themes or concepts (Speziale & Carpenter, 2011). Consistent with the classical approach to grounded theory methodology, data analysis consisted of two key processes, open coding and selective coding. Throughout open coding, multiple codes were generated from the data which were mainly descriptive in nature (Glaser, 1978). Theoretical codes were used to clarify relationships between the categories and provide descriptions. Coding and category formation was frequently checked and verified regularly by a second researcher. If there were discrepancies, coding continued until consensus on terms was reached between the researchers.

Recruitment of participants continued until saturation was reached, where no new information was being obtained, categories were clearly defined and inter-relationships between categories were expansive and well defined. Literature was sought to ground identified categories which is consistent with grounded theory methodology. Hence the search terms were identified by emerging categories and therefore the new developed theory was grounded in not only the experience of participants, but also peer reviewed literature.

Findings

The findings revealed a basic social psychological problem that was common to all participants and a basic social psychological process that participants engaged in to manage the problem.

The Social Psychological Problem of *Being Unprepared*

The social psychological problem was called *being unprepared* and participants spoke of feeling ill-equipped and powerless to work with Aboriginal people (McGough, 2016). This experience was confronting and caused them to question their abilities as mental health clinicians: “I don’t feel confident to deal with an Aboriginal person and their cultural differences” (P26); “I don’t think I’ll ever really be prepared [to care for Aboriginal people]” (P25). The basic social psychological problem of *being unprepared* was comprised of two phases: *disruption to self-awareness* and *fluctuating emotions.*

Phase 1: Disruption to self-awareness

Participants experienced a *disruption to self-awareness* as a clinician due to their limited experience, skills and knowledge to work with Aboriginal people. Aspects of this phase included *lacking in knowledge and understanding of Aboriginal culture*; being *unprepared by the system* and *being overwhelmed*.

All participants' *lacked knowledge and understanding of Aboriginal culture*: 'I would say I had almost zero knowledge" (P2); "So I know a little bit about the dreamtime and a little bit about the stolen generation … but not a lot about [Aboriginal] social culture" (P5). Many clinicians who were born overseas had not contemplated working with Aboriginal people: "I came to Australia quite naïve and I'd never, ever considered Aboriginal health." (P4); "When I first came to Australia, I knew nothing about Aboriginal culture or history. I knew nothing about the Stolen Generation" (P25). This lack of understanding resulted in challenges when engaging with Aboriginal patients: "I don't ultimately know where [they're] coming from [to understand someone's position]" (P16). This then generated questions regarding effective therapeutic interactions: "I did often wonder if a white, middle aged and middle class woman was the right person to help an Aboriginal patient" (P28).

A limited amount of information about Aboriginal culture, health and wellbeing also existed during professional training preparation: "During my undergraduate degree, there was some discussion about Aboriginal culture, but very little" (P26). Other participants had vague recollections about the lack of preparation and how it now contributed to their experience of *being unprepared*: "I just don't know; there may have been something taught [during my professional education] but it just doesn't jump out at me" (P7). Within the workplace environment, limited opportunities to attend professional development was highlighted as a factor impacting on the experience of being unprepared: "I think when you look at what the service provides in relation to [cultural] awareness and being able to engage appropriately culturally, I think that's limited" (P12): "It [has become] harder and harder to have the time to do that [professional development] because of staffing. There is never any time to do your own professional development on the wards" (P2). Subsequently, participants did not feel empowered or confident to provide cultural safety and feelings of *being overwhelmed* emerged as they were confronted by the complexities of socio-economic and health issues affecting Aboriginal people. Faced with the multi-faceted challenges, participants felt overwhelmed and experienced a range of shifting and fluctuating emotions.

Phase 2: Fluctuating emotions

Fluctuating emotions was a common experience reported by participants and included: *fear and anxiety*; *sadness, shame and guilt* and *feeling defeated. Fear and anxiety* was expressed when working with Aboriginal people: "I remember not feeling I had enough understanding and I was scared of Aboriginal people" (P25). Feelings of tension and mistrust between Aboriginal and non-Aboriginal people, existed and participants expressed how this affected therapeutic relationships: "My suspicion is that we probably don't get the full picture of what we're dealing with [when] we're dealing with Aboriginal people …because and they don't trust us enough, [and] I suspect that comes from their own past experience" (P18).

Feelings of *sadness, shame and guilt* arose when participants reflected on Australia's history and treatment of Aboriginal people and some participants reported feelings of guilt over Australia's past political policies: "Years of oppression and the treatment [of] Aboriginal people. They have lost their land, they've lost their family and they've lost their culture, it's all been sort of pulled apart" (P10). For many participants, shame resulted from the realisation that these practices and policies were part of Australia's recent history: "I now understand about the stolen generation and I understand where their trauma comes from" (P25).

Experiences of *feeling defeated* came when confronted by the severity of health issues seen in patients and the perceived limitations of the health system to provide better mental health care outcomes for Aboriginal people. The following participant felt their personal efforts were inconsequential and had limited impact: "I think we're fooling ourselves in thinking we can make a significant difference… It's like pouring a bucket of water over the towering inferno. It's not going to make a huge difference" (P4). Participants were overcome by the emotional responses to the experience of *being unprepared*, with frustration and discontent identified as the most consuming components of *feeling defeated.* Several conditions were found to influence the experience of being unprepared including, participants' prior exposure to Aboriginal people and culture; assumptions about Aboriginal people and culture; understandings of the concept of cultural safe safety; and lack of support. In an effort to address the problem of *being unprepared* participants engaged in a basic social psychological process entitled *seeking solutions by navigating the labyrinth*.

The Social Psychological Process of Seeking Solutions By Navigating The Labyrinth

To manage the experience of *being unprepared*, participants engaged in the process called *seeking solutions by navigating the labyrinth*, (McGough, 2016). When participants engaged in this process, they moved from a state of *being unprepared* to one where they began to navigate a pathway to cultural safety. The process consisted of our phases: *neutralising the differences*; *taking the next step*; *seeking new solutions*; and *becoming a culturally safe practitioner.*

Phase one: Neutralising the differences

Neutralising the differences included a range of behaviours that worked to counteract or counterbalance the negative feelings and behaviours participants were experiencing as a result of *being unprepared.* Strategies included *avoidance, minimising the differences* and *denying the need to change.* In seeking ways to *neutralising the differences,* the strategy of *avoidance* allowed the participants to minimise or delay dealing with the problem and seek strategies to avoid the problem or their response to it (Littleton et al., 2007). The following participants provided examples of the use of avoidance: "The fact they're Aboriginal doesn't stand out [not prominent] because it [is] about dealing with the mental health issues. So in that regard, it was dealing as you would with everybody" (P9). This strategy assisted participants to deny cultural differences as they adopted a race-neutral approach: "Mental health is mental health" (P20); "They [Aboriginal patients] speak English, same as we do" (P4); "I've never found them [Aboriginal people] particularly any different to anybody else…. mental health is mental health at the end of the day" (P14).

The implications of providing care to Aboriginal patients was downplayed in *minimising the differences.* For some this included placing less significance on history of Aboriginal people, the impact of colonisation and the outcomes in health and wellbeing. The following participant sought to de-emphasise the impact of historical events: "I think sometimes there's a bit of over-emphasis on that [stolen generation], that's not helpful for health…I think it's important we have an understanding of it but …we've moved beyond that" (P5). For other participants, *minimising the differences* included embracing the belief that the experience of mental health and illness was the same between Aboriginal and non-Aboriginal people: "People cope, or the way they cope with their life problems is [irrespective whether] you're talking about [Aboriginal] Australians or white Australians or whatever background" (P8). This strategy allowed participants to *minimise the differences* and to seek comfort in existing practices without considering the specific mental health experience for Aboriginal people.

Denying the need to change was not seen by the participants as a passive strategy, but rather a pro-active way of managing the experience: "We treat everyone the same" (P23): "I suppose in terms of delivering clinical services, you treat everybody the same" (P1). This approach was a way of addressing differences between all cultural groups, not just for Aboriginal people, as explained by the following participants: "I don't think I treat an Aboriginal person any different than a Caucasian or any other ethnic minority" [P24]; "I've always approached people exactly the same. I don't think I've ever … approached any cultural [group] in a different way" (P11). When participants sought further strategies to manage their experience, they moved to the next phase entitled, taking the next step.

Phase two: Taking the next step

As participants sought new skills while reconsidering existing ways of working and planning for future experiences they were more in control of managing their experiences by *taking the next step.* Improvisation of care occurred when participants did not have an exact plan on how to work with Aboriginal patients: "I guess to be honest, it was a case of winging it until you got to know… a bit more about Aboriginal culture" (P14); "I just do my best" (P27). The approach *winging it* facilitated attempts to trial new ways of approaching the problem. This phase signalled a shift and progress towards in managing the problem and participants' attitudes were adjusted as a result of evaluating their knowledge, attitudes and skills as described by the following participants: "For me it was more about understanding the impact of the Stolen Generation in relation to us engaging culturally appropriately with Aboriginals" [people] (P12); "Acknowledging the pain and the journey that people in this country have gone through and acknowledging what's happened to people. It's had a massive impact on their psyche through generations" (P10). During this phase, several participants began to critically review their level of cultural awareness: "Maybe if I were more culturally aware…because I don't know very much." (P1); "Well I think I need to increase my knowledge base, because I have an old institutionalised experience I didn't like and I would really need to refresh, … and I'd love to learn more [about Aboriginal culture]" (P7). Strategies also included making adjustments to approaches to providing care and ways to modify their practice as described by the following participant: "It's doing things that are more person-centred" (P7). With confidence in managing the experience of *being unprepared,* participants began to develop new strategies and moved to the next phase entitled *seeking new solutions.*

Phase three: seeking new solutions

In seeking new solutions in managing the problem participants sought *information and education, enlisted Aboriginal liaison officers* and *reached out to peers*. The role of the Aboriginal liaison officer was highly regarded as articulated by the following participants: "Having that assistance from the Aboriginal liaison officer is great because you can then sort of find a little bit more about what's going on within the community" (P10). Aboriginal liaison officer were highly valued in not only bridging the cultural gap for Aboriginal people while in hospital, but in providing information about Aboriginal culture and history for staff. Peers and colleagues who were seen to have knowledge or skills in working with Aboriginal people were sought and this extended to reaching out to Aboriginal colleagues. Collaborating with peers added in developing new insights and understandings of how to manage *being unprepared*. In *seeking new solutions* participants gained some confidence and capacity and moved to the last phase *becoming a culturally safe practitioner*

Phase four: Becoming a culturally safe practitioner

In this final stage, participants considered cultural differences; accepted the historical impact of colonisation on the social, cultural and health outcomes for Aboriginal people; and engaged in critical reflection of their own experiences, values and practices.

As they moved through the previous phases of the core process, participants' experiences of *being unprepared* had diminished due to the strategies implemented in the previous phases as they gained capacity and began to navigate the complexities of cultural safety. Engagement in this phase was not determined by the length of experience as a mental health professional, but by the experience of the core process and conditions influencing that experience. Only eight participants had moved to final phase of *becoming a culturally safe practitioner* at the time of being interviewed for this study. However the level of emersion in this final phase varied, with some just starting and with others more further along the continuum of *becoming a culturally safe practitioner*. The majority of participants in this study were in the previous phase, with three participants in the first phase managing the core process at the time of interview.

In reaching this phase, participants felt more self-assured in managing the problem and moving through the labyrinth to *becoming a culturally safe practitioner* with the following participant providing this reflection:

> They [health professionals] need to get to the foundation of what it means [to provide be cultural safety] and it's not about the dos and don'ts. It's actually understanding who you are and respecting people and recognising difference and growing in yourself and acknowledging the pain and the journey that people in this country have gone through, and acknowledging what's happened to [Aboriginal] people (P10).

Several conditions influenced participants' movement through the four phases of this process including, *participants' experience of racism and discrimination*; *participants' level of social support;* and *feeling part of the solution.* Many participants reported examples of racism occurring within society or the work setting: "People get defensive around the idea of racism as nobody wants to think of themselves as being racist, but we're still a pretty racist society" (P28); "Institutional racism [exists including] the exclusion [of] people [on] so many levels [for example] when they're not acknowledged in the community (P10). However, others were unaware of the forms of racism occurring and were oblivious of the impact that racism and discrimination had on Aboriginal people or how it contributed to health outcomes. Dovidio and Fiske (2012) propose the lack of awareness of existing racism and discrimination can unconsciously influence decisions for care and interactions between Aboriginal and non-Aboriginal people, thus perpetuating discriminatory practices and ultimately contributing to disparities in mental health care outcomes.

Support was received from several avenues, including peers, colleagues, leaders and managers and the organisation. Participants' relationships with colleagues and peers were also important in their ability to move through the phases. Finally, feeling empowered and in control was an important element towards *becoming a culturally safe practitioner* and was attributed to the opportunities arising in the context of the workplace and society in general.

SUMMARY OF THEORY

The substantive theory of *seeking solutions by navigating the labyrinth* saw participants move from *being unprepared* to a state where they sought solutions to move towards counteracting their experience and allowed them to consider their position and negotiate a complex and multidimensional experience. Participants made adjustments to their attitudes, thoughts and behaviour that influenced their ability to provide cultural safety. As participants negotiated these changes, they developed capacity to provide cultural safety to Aboriginal patients. Conditions identified as influencing the experience of *seeking solutions by navigating the labyrinth* were *participants' experiences with racism and discrimination*; *level of social support*; and *feeling part of the solution*.

[Insert figure 1]

DISCUSSION

The substantive theory described here highlights the complex social, psychological interactions that mental health clinicians experience in striving to provide cultural safety in mental health care. Further, despite national frameworks outlining cultural care requirements for health services, participants still felt unprepared. Attempts to address this experience were influenced by social and organisational support and feelings of empowerment. Johnstone and Kanitsaki, (2009) suggest that cultural safety depends on operationalising the concept as an outcome to cultural competence at both an individual and organisational level.

Health care organisations have a responsibility to meet the needs of clinicians who do not feel prepared to provide cultural safety. The level of competency and cultural awareness of non-Aboriginal health professionals remains problematic (O'Brien, Boddy, & Hardy, 2007) and quality care is compromised when discriminating against others, however unintentionally, based on race or culture (Henry, et al, 2004). Many participants were unaware of the forms of racism occurring within the clinical setting and were oblivious of the impact that racism and discrimination had on Aboriginal people. It is imperative that health professionals critically reflect and examine their own beliefs and values which form the foundations of their cultural positioning influencing health interactions and the delivery of care to [Aboriginal] patients (Durey, et al., 2014, p. 296). As white health professionals gain insights into racism, their own racial identity and white privilege, they will develop empathy and skills in providing culturally appropriate care (Ancis & Szymanski, 2001; Utsey, et al., 2005). Without insight and changes into behaviour towards Aboriginal people, initiatives to improve health services may have limited impact on health inequalities (Larson et al., 2007).

Health care organisations need to demonstrate explicit strategies to challenge organisational racism and discrimination. Strategies targeting racism and discrimination at an organisational level will contribute to supporting the mental health professional in being prepared to provide cultural safety. Durey, et al., (2014), discuss the need for better education and training in cultural safety; embedding Aboriginal health workers and support staff in the health service and improving relationships with Aboriginal people. There needs to be a committment to Aboriginal representation on committees responsible for planning, monitoring and evaluating health care and consultation with Aboriginal patients and families to provide insight into

barriers and enablers of cultural safety care and as part of a recovery-based and collaborative approach with Aboriginal people.

Clinical leaders are key agents in identifying areas of care which are exemplary and requiring additional resources. Changes are more likely to be effective when clinical leaders and senior staff promote and foster these changes (Hoffmann, et al., 2013). Clear, unambiguous and explicit role modelling and direction from these leaders may encourage and promote changes to practice. Further, a team of role models and mentors system-wide is vital to the implementation of strategies and sustainability in the organisation (Melnyk et al., 2011).

There is a need to develop outcome measures of quality and best practice in providing cultural safety. Walker (2011) addresses several areas to consider in assessing cultural safety in the workplace. These include leading and managing organisational change and continuous quality improvement; creating culturally welcoming environments for Aboriginal people and their families; developing the cultural competency all staff; providing culturally responsive care to improve Aboriginal access to services; facilitating culturally inclusive policies and practices; effective communication with Aboriginal people; building collaborative partnerships and relationships with Aboriginal communities and organisations; improved service delivery in cultural competence; and monitoring and evaluation of the effectiveness of implemented strategies.

Work needs to continue in strengthening the contribution of Aboriginal leaders and Elders in the development of policy and practice affecting Indigenous people (Wright et al, 2016). The recognition and acceptance of Aboriginal culture and perspectives of health and wellbeing must remain high on the agenda of mental health reform (Dudgeon et al, 2014). Governments must continue to strive to work with Indigenous leaders, Elders and communities, in collaborative partnerships in providing culturally appropriate care (Wright & O'Connell, 2015).

Further research is needed to evaluate the effectiveness of cultural training in preparing staff to work with Aboriginal patients. More research is needed to understand the expectations of Aboriginal patients in mental health settings and the experience cultural safety.

CONCLUSION

This paper provides unique insights into the experiences of how mental health professionals provide cultural safety in the care of Aboriginal patients in a mental health setting. This area

has not been fully explored within the Australian context and therefore highlights multifaceted issues encompassed in this experience.

RELEVANCE FOR CLINICAL PRACTICE

Many mental health professionals felt unprepared to provide cultural safety to Aboriginal patients and this is largely influenced by lack of understanding about Aboriginal people and history and support in providing this care. The experiences of feeling unprepared occurred despite national agendas to reduce the gap in poor health outcomes for Aboriginal people and the national frameworks outlining cultural care requirements. The issue of racism and discrimination that exists within society and that permeates the health care setting cannot be ignored. While participants acknowledged underlying racism in the broader community, few realised the levels of racism occurring within the health environment or the impact this had on Aboriginal people. The relationship between historical events, generational trauma, racism and current health care outcomes for Aboriginal people was not well recognised by participants. Recognising the level of racism occurring and reflections on attitudes and positions of power and white privilege are essential in providing cultural safety. Clinicians are accountable for their own attitudes and practices and therefore must examine their assumptions in order to critically reflect on whether current practices promote or compromise health and wellbeing. Clinicians are encouraged explore cultural safety training as part of ongoing professional and personal development.

Insights into the provision of cultural safety in the mental health setting may be facilitated by greater collaboration with Aboriginal families and communities, which may provide an opportunity to review care and practices. This collaboration should strive towards valuing knowledge and experience and respecting differences, with the aim to minimise assumptions and build capacity in cultural safety, for both the individual clinician and the health service. This study contributes to the body of knowledge and understanding of issues salient to mental health professionals' experience of providing cultural safety for Aboriginal patients. Acknowledging the needs of mental health professionals in will ensure cultural safety continues to be placed high on professional and organisational agendas as Australia continues to strive to improve mental health care for Aboriginal Australians.

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DISCLOSURE

The authors declare no conflict of interest.

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