Understanding and valuing Aboriginal and Torres Strait Islander ways of working: Opportunities for change in health service provision to Aboriginal and Torres Strait Islander peoples

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Statement of originality

This is to certify that to the best of my knowledge, the content of this thesis is my own work.

This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Signature:

Name: Michelle Dickson

Abstract

This thesis draws on an analysis of the experiences of Aboriginal and/or Torres health professionals to argue that the Australian health system is missing opportunities to create something better for Aboriginal and Torres Strait Islander health clients and health professionals. In 2018 *Closing the Gap*[1] will be 10 years old and despite 10 years of national policy designed to close the gap on Aboriginal and Torres Strait Islander disadvantage in Australia, only one of the seven key measures remains on track to meet the goals set for 2020 (Department of the Prime Minister and Cabinet, 2017). There is an immediate need to make change in Aboriginal and Torres Strait Islander health through changes in national policy, systems and practices.

This thesis investigates the workplace experiences of Aboriginal and Torres Strait Islander health professionals working in mainstream and in community controlled health services in the Australian Aboriginal and Torres Strait Islander health sector. I have explored this from an Australian Aboriginal (Koori) perspective that was informed by Indigenous[2] theories including decolonisation, Cultural Interface and Indigenous Standpoint Theories. As a Koori scholar undertaking doctoral research in a Western academy I respected and upheld both my cultural and my Western academic ethics and requirements: Yarns, including my own, are central to this thesis. I have used Indigenous research methods, Yarning and PhotoYarning, the latter having been developed as a new Indigenous research method by me within this doctoral study. Fifteen

[1] *Closing the Gap* is a formal commitment by all levels of the Australian government to achieve Aboriginal and Torres Strait Islander health equality within 25 years. (Council of Australian Governments, 2009).
[2] Indigenous refers to First Nations peoples of the world.

Aboriginal and Torres Strait Islander health workers from diverse health services across Australia contributed data.

The empirical chapters highlight Aboriginal and Torres Strait Islander ways of working in Australian health services. For the Australian health sector to provide culturally safe services that meet the needs of Aboriginal and Torres Strait Islander peoples of Australia it needs to better engage with Aboriginal and Torres Strait Islander ways of being, knowing, doing and seeing.

With respect and deep gratitude

I am first in family to complete the final year of high school and go on to study at university. I never imagined that I could complete a PhD. I believe that I have been guided in this direction by wisdom that came before me, and I am so thankful for that guidance. I have received incredible support from a large number of people who gave me a range of gifts throughout the PhD journey. Thank you for these gifts of insight, honesty and encouragement. Thank you for those things that are not easily described by words and the things that are, like cups of tea, study space and a supply of inspirational chocolate. Most PhD journeys are long and have their own story. My PhD has had several long, unplanned and unwelcomed periods of enrolment suspension due to an acute health condition that involved two rounds of radiation treatment and long term pain. Such disruption to a PhD progress plan meant that there was a significant break between my data collection and analysis and thesis submission. Over those years I juggled the personal and the professional, faced heartbreak and heart warmth, experienced both losses and gains. I feel a deep sense of respect, gratitude and love for those who journeyed with me. Thank you all.

My family have given me such a solid ground upon which to stand. My parents, my grandparents (deceased) and extended family all have taught me life lessons that have in many ways contributed to the approach I have taken in my PhD study. You have set the bar high, and I only hope that I can provide the same for my own children and future grandchildren.

Huge respect and thanks to my colleagues who have reminded me to keep going, encouraged me to follow my instincts and stand proud as a fellow academic. I might not have reached the

finish line had it not been for the support of Professor Glenn Salkeld and Associate Professor Joel Negin. You both role modelled authentic leadership to me in your roles as Head of School, Sydney School of Public Health, encouraging me to take opportunities while still completing my PhD. Thank you both for ensuring I dedicated PhD space inside my busy and wonderful workload. Your faith in me reminded me of how important this work is.

My supervisory team have been nothing short of inspirational. Dr David Cairns (deceased)[3], Dr Julie Mooney-Somers and Dr Jo Lander - I thank you all. You have each brought something unique to my research but one thing you all have insisted on is that I stay true to my authentic self. When I was experiencing the height of academic imposter syndrome you reminded me that I was not alone, and encouraged me to keep pushing. Importantly you gave me confidence to ground my PhD in the Koori[4] ways I know best of all, and assured me through the challenges I had with the tensions and disconnect between Western and Aboriginal and Torres Strait Islander academic paradigms. You reminded me that my PhD could validate and honour both ways of being, knowing, doing.

To my dear friends Vladimir Williams and Alison Birt, thank you; you always remind me of how I walk in the world and encourage me to stand strong in my way and reflect that strength in the way I write.

[3] Pseudonym “James” in Appendix C

[4] As an Aboriginal woman from New South Wales I call myself Koori. I will use this term throughout this thesis, when referring to myself.

I want to thank the Aboriginal and Torres Strait Islander Team Members[5] of this study. The aim was to privilege your voices, make them prominent and acknowledge your experiences of being Aboriginal and Torres Strait Islander people who work in Australia's health system. Your willingness to share and to maintain the ongoing PhotoYarning[6] about your workplaces has provided new depth to important issues. Indeed, sharing your experiences will empower others to seek a better understanding of working as an Aboriginal and Torres Strait Islander person in health, or to speak out about it and not stay silent. Importantly, we worked hard to find a shared research space that was confidential and safe, allowing for deep engagement and connection about issues that are often difficult to name. I hope this thesis honours your work and celebrates who you are. The Yarns[7] you have shared with me, and with others who read this thesis, are gifts that teach us about triumphs and challenges. Thank you for our Yarning.

At one point in my PhD study I did not have a computer in my home, and night time was my writing time. Back then I had a couple of angels who found a way to make a computer move in with me. Debs and Julie I thank you with all of my being. Not only is that computer still

[5] Throughout this PhD 'research participants' were named Team Members. This term represents the true engagement between me ('researcher') and Team Members ('research participants') throughout the whole research process (described in more detail in the methodology section). Team Members in this doctoral study represented a number of diverse professions and specialisations, with few of them employed under the title Aboriginal Health Worker. However, many of them were called 'the Aboriginal Health Worker' in their workplace, but for some the title did not reflect the specific nature of their role (for example, the specialist drug and alcohol officer). As such the use of the title Aboriginal and Torres Strait Islander health professional will be used throughout this thesis, as an attempt to be inclusive of all roles and responsibilities performed by Team Members.

[6] This thesis later describes an emergent method, PhotoYarning, the result of careful, purposive and responsive research planning, implementation and journeying. This was developed as part of my PhD research and is further discussed in Chapter 3.

[7] For many Australian Aboriginal and Torres Strait Islander peoples Yarning is part of everyday life. It is verbal, a way to share information, ideas and knowledge. The term Yarning might be used to describe a casual conversation or it might be used to describe a more formal process of knowledge exchange. Yarning, in many forms, plays a central role in this thesis and will later be explained in more detail.

functional, it now supports the study and work tasks of my adult children. Your act of kindness cannot be measured, it went beyond the call.

When I started my PhD life for me was very different and my four children were much younger. Back then they observed the note I hung on my study space door “Mum is doing her homework” and gave me that space. In recent years I didn’t need to hang a sign, my beautiful four young people just knew that when I was at the computer I was “in the zone”. Thank you, Rhoie, Jasper, Heath and Mahlia for your hugs and kisses, your reassuring words, your gentle questions around my PhD submission plan, and for allowing so much of my family time to be shared with my PhD. Helen, while my ways of seeing the world are so often opposite to yours, our PhD debriefs, our shared study space and your brain have given me strength.

A final confession to my family: Despite the fact that I might have eaten all of the red lollies and used the last of the coffee, please know that a large part of my reason for doing this PhD is all of you. I love you.

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Chapter 1: Setting the scene

1.1 The research question

My research sought to explore how a group of Aboriginal and Torres Strait Islander health professionals worked in the Australian Aboriginal and Torres Strait Islander health sector; I wanted to explore what it was like for each of them to work *and* live in their own community and I wanted to research their ways of being, knowing and doing within the context of health service provision to Aboriginal and Torres Strait Islander peoples.

The hope I hold for my research is that it contributes to developing a better understanding of Aboriginal and Torres Strait Islander ways of being, knowing, doing, seeing and working in health service provision. I also hope that the subsequent greater level of understanding of Aboriginal and Torres Strait Islander ways of working in the Australian health system will be better valued in health service provision in Australia.

1.2 Initial context

1.2.1 Looking back over 25 years

As an Australian Aboriginal (Koori) researcher I am privileged to work at the Cultural Interface (Nakata, 1997) with Koori ontology and epistemology within a Western academic paradigm; but I am also exhausted. I deeply engage with my Koori ways of seeing and ways of knowing the world and those things sustain me as I navigate working in the Cultural Interface while I feel my ways are not often as valued or understood as ways of being, knowing and doing aligned with a Western academic space.

At the time of writing this thesis I have worked in Aboriginal and Torres Strait Islander health and in the higher education sector for just over 25 years. During this time, I worked alongside other Aboriginal and Torres Strait Islander health professionals who often shared stories with me about not being understood in their workplaces, or stories about their work with clients not being valued. These stories expressed a reality that I knew all too well; the exhaustion experienced when one's authentic self, one's entire being, is not valued, appreciated nor seen in a workplace; the exhaustion resulting from constantly being one of the people being researched, taught about or serviced in a health care setting; the exhaustion from working in non-dominant ways in a workplace privileging the ways of the dominant culture. I knew exactly what the Aboriginal and Torres Strait Islander health professionals had experienced, as I too had worked in health services that questioned my ways of working (as an Aboriginal health professional with my Aboriginal and Torres Strait Islander clients). I now work with non-dominant ways of doing research within an academy which (mostly) places a higher value on Western ways of doing research. Whilst undertaking this doctoral study I discovered a theory that explained my own feeling of exhaustion, namely Racial Battle Fatigue (RBF) (Smith, Allen, & Danley, 2007). While not a theory that dominates my research, it certainly helped me understand my own position (and experience of fatigue) as a Koori researcher undertaking PhD research, and it helped me understand those stories belonging to the Aboriginal and Torres Strait Islander colleagues and students that provided much inspiration for my research.

William Smith, a prominent scholar of Critical Race Theory (CRT) (Smith (2004); Smith, Allen & Danley (2007); Smith, Yosso & Solórzano (2006); Yosso, Smith, Ceja, and Solórzano (2009)), developed the concept of RBF and described "unavoidable front-line racial battles in historically

white spaces [that] leads to people of color feeling mentally, emotionally, and physically drained" (Smith et al., 2006, p. 301). CRT and RBF center on the lived experiences and knowledges of "people of color" (Smith et al., 2006, p. 299), privilege non-dominant voices and engage the concept of counter narratives to challenge the dominant discourse in academic, or other, spaces (Smith et al., 2006, p. 300); I used the concept of counter narratives in my research as I developed the methodology and methods of my research to address the RBF I felt as a Koori researcher; I wanted to focus on Koori ways of thinking, being, knowing and doing rather than aligning my research with research methods that have long been recognised and accepted by the Western academy. Used as a vehicle for exploring RBF, "CRT scholarship combines empirical and experiential knowledges, frequently in the form of storytelling, chronicles, or other creative narratives" (Smith et al., 2006, p. 300). I experience RBF in the work I do as a Koori scholar within a university (mostly) dominated by Western approaches to research. As a Koori scholar I have long utilised forms of storytelling (Yarning) in efforts to challenge a dominant academic discourse that frequently does not value or understand the way I research. It is exhausting but it is important for me to maintain my own authenticity. This doctoral thesis provided me with numerous examples of situations that increased my RBF. At times I felt so exhausted I wanted to stop researching and stop writing; other times the fatigue fueled a fire in my belly that gave me energy to push on. The Aboriginal and Torres Strait Islander health professionals who shared with me their Yarns of not being understood or valued in their workplaces created their own counter narratives, using forms of storytelling (Yarning) to maintain their authentic ways of being, knowing and doing and to help them push forward. In my research I engaged Yarning in several forms; I Yarned casually, I gathered data by using the

methods of Yarning and PhotoYarning and I Yarned with Team Members[8] verbally and in written forms. Listening to the Yarns of others throughout this research was not only an honour but a reminder that Yarns are often the life blood of the work we do as Aboriginal and Torres Strait Islander people working in dominant workspaces. As such, Yarning features strongly throughout this doctoral study.

1.2.2 Listening to colleagues and students

Over the past 25 years I have held a number of positions in the education or health sectors in Australia. While teaching or providing health services I heard many of my Aboriginal and Torres Strait Islander colleagues tell me how their work practices were criticised because their ways of working often did not directly align with other workplace practices and that their ways of working remained largely misunderstood. I have also taught and mentored Aboriginal and Torres Strait Islander students who worked in the Australian health system; they too had stories about their ways of working being misunderstood or not valued by their non-Indigenous Australian colleagues or managers. Like my colleagues, the Aboriginal and Torres Strait Islander health professionals, these students described their work as challenging the same health system and services that had been established to provide health care for Aboriginal and Torres Strait Islander clients.

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[8] Throughout this PhD 'research participants' were named Team Members. This term represents the true engagement between me ('researcher') and Team Members ('research participants') throughout the whole research process (described in more detail in the methodology section). Team Members in this doctoral study represented a number of diverse professions and specialisations, with few of them employed under the title Aboriginal Health Worker. However, many of them were called 'the Aboriginal Health Worker' in their workplace, but for some the title did not reflect the specific nature of their role (for example, the specialist drug and alcohol officer). As such the use of the title Aboriginal and Torres Strait Islander health professional will be used throughout this thesis, as an attempt to be inclusive of all roles and responsibilities performed by Team Members.

1.2.3 Inspired by my mentor's story

I have a particular memory of a former Aboriginal mentor who dedicated 40 years of her life to the Australian Aboriginal and Torres Strait Islander health system. Just prior to her passing she told me that she had never felt truly "seen" or valued in the work she did with her Aboriginal and Torres Strait Islander clients; she told me she felt her clients valued her ways of working with them but that she felt her colleagues and managers often did not. She told me that she felt her work was always positioned in the background of the work being done by non-Indigenous Australian colleagues. She felt tired, worn down by constant efforts to have her working ways and Aboriginal knowledge heard, understood and valued. She seemed to have experienced what now is referred to as RBF (Smith et al., 2007) but continued to live and work in authentic ways that were true to her own self and to the clients she worked with. However, her story deeply saddened me; she had mentored me for many years, supporting me through my own feelings of being at odds with other workplace practices and policies and had always reminded me of how valuable my work with clients actually was- even if others questioned what I did or how I did it. And yet, my mentor had experienced the very same.

My research was inspired by her story and by the other stories shared with me over 25 years by Aboriginal and Torres Strait Islander health professionals whose ways of working were not being valued or understood within an Australian health system that seemingly worked with

increasing efforts to ‘Aboriginalise’[9] itself in order to provide appropriate health service to Aboriginal and Torres Strait Islander clients.

1.2.4 Influenced by other Indigenous scholars

My research is also about a Koori researcher working together with Aboriginal and Torres Strait Islander health professionals (Team Members) to make an important contribution to Aboriginal and Torres Strait Islander research, resulting in a new Indigenous methodology, PhotoYarning. I worked within Western academic research traditions while maintaining my own authentic Aboriginal and Torres Strait Islander ontologies and epistemologies. My thesis was produced at the Cultural Interface, and I acknowledge both the challenges and strengths of being positioned there. Throughout my PhD I was guided, supported and inspired by the work of many Indigenous scholars from around the world including Linda Tuhiwai Smith (1999, 2006, 2007, 2014), Juanita Sherwood (2010, 2013a, 2013b); Sherwood and Edwards (2006); Sherwood and Kendall (2013); Sherwood et al. (2015) and Aileen Moreton-Robinson (2000, 2003, 2004a, 2004b, 2013). Their research and writing about Indigenous research became the ground upon which I felt safe to plant my own feet. Their work will be unpacked in later sections of this thesis. Their work encouraged my own ideas to find words for these pages.

Theories which have been foundational in my own research include Indigenous Standpoint Theory, for example Nakata (2007a, 2007b) and Foley (2003, 2006) and Indigenous Women’s Standpoint Theory (Moreton-Robinson, 2013); both theories have shaped the method and

[9] ‘Aboriginalise’ is not a word I use in my own language but it is a word that was often used by Team Members in this research to describe how health systems and services attempt to bring elements or examples of Aboriginal and Torres Strait Islander culture into their services. I choose to write it throughout using single quotation marks.

ethics within my research methodology and are explored in Chapter 3. I approached a PhD as an icon of my Western education and academic profession but I did so with an Aboriginal (Koori) ontology and epistemology. Adopting an appropriate methodology and choosing a theoretical framework that has well aligned methods and ethics presented a challenge, albeit a welcome one. I found this to be a "complicated and contested space that is the 'Cultural Interface' Nakata (2007a, 2007b) between Indigenous and Western knowledge systems, where hybridity is not always synonymous with balance" (Higgins, 2014, p.209). I needed to find a way to progress my PhD in a way that met the Western academic requirements and satisfied and respected Aboriginal and Torres Strait Islander ways of being, knowing and doing.

1.2.5 How to allow the thesis to tell the story it needs to tell

One of the greatest challenges I faced was how to construct this thesis in writing, how to allow the thesis to tell the story it needed to tell. Aboriginal and Torres Strait Islander protocols guided me to look at how other Indigenous researchers before me had faced a similar challenge. In this vein Kahakalau (2004) reminded me of working in the Cultural Interface to produce research that is "accountable to our indigenous community" (p.19) and also accountable to Western academia and appreciated as "sophisticated and scholarly to convince academia that they are of equal scope and breadth as established Western ways of research" (p.20).

My thesis has been written using an Indigenous (Aboriginal and Torres Strait Islander) methodology. It is written in a way to ensure Team Members experience an ongoing connection with my research that is safe, valid and useful (Kahakalau, 2004; Sherwood, 2010;

Smith, 1999). I have partly achieved this through the reciprocity of shared Yarns and partly by using a format that allows me to blend my thesis experience firstly as a Koori researcher and secondly as a PhD candidate fulfilling the requirements of a Western academic institution. A strength of my PhD is that it reflects what Kovach, in Brown and Strega (2015), considers central to Indigenous methodologies and research: First the PhD presents Aboriginal and Torres Strait Islander epistemologies (ways of knowing) and Aboriginal and Torres Strait Islander ontology (ways of being) as "legitimate ways of knowing" (p.28). Secondly the PhD uses Aboriginal and Torres Strait Islander methods (such as Yarning) as "a legitimate way of sharing knowledge" (p.28). Third the PhD embraces "receptivity and relationship between researcher and participants" (p.28) as core to its research methodology. Finally, it reflects "collectivity as a way of knowing that assumes reciprocity to the community" (p.28) by embedding throughout a collaborative approach to research development, data collection, analysis and final thesis production.

1.3 Locating myself in this PhD

It is Aboriginal protocol to position yourself within a relationship or place and I will write a Yarn to do this. This Yarn will position me within my research as a Koori woman and a Koori researcher (Fredericks, 2003, 2013; Moreton-Robinson, 2003, 2004a, 2004b). As a Koori researcher I feel privileged to have been educated both by my Aboriginal cultural education and my Western academic education. My Yarn brings to this PhD thesis my Aboriginal knowledges and lived experiences in a way that has helped me to reflect both of my ways of learning.

1.3.1 This is Me

I must start this Yarn by paying attention to the responsibilities I have both as a Koori woman and a researcher. When Aboriginal and Torres Strait Islander people meet each other the first thing we do is ask questions like "Who is your mob (family/community)?" or "Where are you from?" These questions are the bedrock of cultural identity and of the relationships you build with others. Those questions locate you for others by connecting you to family, community, Country. Those questions build relationships.

I am Michelle Dickson. I am the oldest of four children to John and Deslie Dickson (nee Hayes). My family are from Ngarigo lands (in the Snowy Mountains region in New South Wales, Australia) and Darkinjung lands (on the Central Coast of New South Wales). Sadly, like many of my Aboriginal and Torres Strait Islander friends and colleagues, both sides of my family suffered the impact of what is now referred to as The Stolen Generation (Wilkie, 1997). Removing Aboriginal and Torres Strait Islander children from their families and communities was made official under various government laws and policies in Australia until 1969. I was born in 1967, so this was still happening in my own lifetime. Generations of children were taken away by governments, welfare and church organisations and either raised in institutions or fostered to non-Indigenous Australian people.

Connecting to culture has been a lifeline in my family and while such a connection is important it has not always been easy. However, it is my own journey that I can speak of here. I was born on Cammeraygal lands (north of the harbour in Sydney, New South Wales, Australia) and for much of my life I have lived and worked on the lands of the Eora nation in Sydney. I have four

(grown up) children of my own, Mahlia, Heath, Jasper and Rhoie, and I have many nieces and nephews. All of these young people stand proud in the upcoming generation of Aboriginal and Torres Strait Islander Australians. Most of my work focuses on trying to make some difference for the next generation, while not ignoring my own generation and those who have come before me. I am the Director of Teaching and Learning and a senior lecturer in the University of Sydney's Sydney School of Public Health and I started this PhD many years ago.

People often speak very openly with me. I welcome this. However, in this openness I find myself facing comments about my Aboriginality, comments that are often focused on the colour of my skin:

- "I wouldn't see you as Aboriginal if I didn't know you were"
- "But I'm blacker than you!"
- "Wow, Aboriginal. You could never guess."
- "Is your Mum or Dad really dark then?"
- "How Aboriginal are you?"
- "But you are so pale. How can you be Aboriginal?"

Clearly I am not the Aboriginal and Torres Strait Islander person that many people have in their head: I am confusing for them, and sometimes that confusion creates hurt for me. I am not a Koori woman who knows her traditional community languages, nor am I a Koori woman who grew up on the land, in a rural or remote location – both of these things that some people use to measure Aboriginality were taken away from my family when the government polices allowed my family to be removed from community. I am a Koori woman who has learnt through

listening to family stories and Yarns, who has learned through life experiences and through the life experiences of my family members, and for all of these positive and negative experiences I am thankful. And I had children to a man with blonde hair and blue eyes. Perhaps what hurts me most is that I have witnessed the efforts my own children make to authenticate their Aboriginality to those who question their cultural identification based on their physical appearances. And that's not OK. But it still happens in our own country, in 2018. My hope is that my grandchildren are born into an Australia where the emphasis on physical features as a measure of understanding Aboriginality is replaced by a greater understanding of what it is to *be* Aboriginal. We, as a nation, have much work to do if my hope is to become a norm.

As I have introduced myself as a Koori person, so too must I introduce myself in the relationship I have with my research. As a Koori woman I connect to the cultural traditions of learning through stories and conversations, or Yarns. I grew up listening and Yarning and learning, making meaning and finding understanding from a Yarn, even when the meaning might not have always been explicitly named. Some of the Yarns I have heard and learnt from throughout my life have helped me to understand some of the challenges I faced as a researcher throughout my PhD. As I faced questions about ethics, for example, I remembered a Yarn once told to me that taught me about making good choices, doing no harm. I could apply that learning to what I was facing in my research. I could draw on earlier learning as a way of making sense and finding meaning in the research I was doing.

King (2003) wrote about "saving stories", describing "stories that help keep me alive" (p.119). The data of my PhD was gathered by sharing stories (Yarning). These Yarns kept alive the

experiences of the Team Members and paid those experiences respect. Along the way I also engaged with the Yarns that kept my research and learning experiences alive, kept me working through the PhD process. As part of this research I have kept a research journal (Robson & McCartan, 2016) and have written down some Yarns; both have assisted me to reflect on experiences that have developed my capability and capacity as a Koori researcher.

I embraced Yarns that helped me juggle the personal and professional, Yarns that helped me learn and understand about research, about engaging with other Aboriginal and Torres Strait Islander people through research, Yarns about myself as a Koori woman, a Koori student, as a Koori person working in an academic role. I learnt very early in the PhD journey that I needed to tell Yarns in different ways to different audiences. And that did not surprise me.

Yarns became the glue that helped me cement the research together; they allowed me to connect my learning as a Koori woman with my learning as a Koori PhD candidate. I have written a paper based on the research journal I kept throughout my PhD candidature (Appendix C); it has been published in *The Qualitative Report*. In the future I will return to my research journal and my written Yarns and write up more parts of them for publication, hoping that they contribute to the body of knowledge about Aboriginal and Torres Strait Islander identity and the experience of developing as an Aboriginal and Torres Strait Islander researcher.

You see, I live and work in two worlds (Nakata, 1997) and I honour and respect them both. I live as an urban Koori woman in a suburb with very few others (other than my family) who identify as Aboriginal and Torres Strait Islander - this does not make me any more or less Aboriginal; it just makes me, me. I work as an academic in a University with colleagues who work (mostly)

within the dominant (Western) research methodology, and I work in the same place within an Indigenous methodology – this does not make me any more or less of an academic; it just makes me, me.

I feel strong in myself and my culture. Throughout my PhD research I used different ways of designing research, conducting research and writing up research. A long time ago I decided that I had a PhD to complete and submit and this needed to be guided by a Western academic paradigm *and* informed by cultural protocols and my own Aboriginal culture. I found a way to bring both together as I worked through my PhD. I am aware that my PhD might create some cognitive dissonance for those reading it, as it brings Aboriginal and Torres Strait Islander ontologies and epistemologies into a Western academic format. Finding a way to achieve this provided me with the opportunity to stand strong in a research space by creating a new Indigenous research methodology, PhotoYarning, described in more detail in Chapter 3.

1.4 Central thesis and chapter structure

Throughout this thesis I develop the argument that embedding and valuing Aboriginal and Torres Strait Islander ways of working would vastly improve the work experiences of Aboriginal and Torres Strait Islander health professionals (their ways of working would be better understood and more valued) and may positively change how Aboriginal and Torres Strait Islander clients experience health care service provision.

The chapters of my PhD thesis build theory, describe methodology and methods, provide an analysis of how Team Members work in the current Australian health system as Aboriginal and Torres Strait Islander people and present evidence of opportunities for better understanding

and engaging with Aboriginal and Torres Strait Islander ways of being, knowing and doing specific to working in the Australian health system.

Chapter 1: Setting the scene

In Chapter 1 I provide a context that reflects on 25 years of working in Aboriginal and Torres Strait Islander health and education. Importantly, as a Koori scholar, I locate myself within this research as I introduce my family and community. I pay respect to other Indigenous scholars, mentors, colleagues and students who have influenced the way I work and the way I have come to see the world.

Chapter 2: Literature: key issues and context

Chapter 2 provides a synthesis of the overarching literature related to this research. It presents an overview of the historical policy and systems context in which we lived and live, post the 18th century British invasion Aboriginal and Torres Strait Islander lands. Aboriginal and Torres Strait Islander health status, current policies and service frameworks and workforce issues are presented to provide a platform from which my research develops. It is important to note that each empirical chapter (Chapters 5 through 8) also has its own synthesis of literature related to the specific issues addressed in each chapter.

Chapter 3: Methodology and Methods

In Chapter 3 I introduce the theoretical framework of this research and highlight important theoretical influences. This framework privileges Aboriginal and Torres Strait Islander voice and develops a new body of knowledge that informs the chosen research design. Importantly this

chapter provides details of the use of Indigenous research methods, Yarning and PhotoYarning, the latter having been developed as a new Indigenous research method by me within this PhD research. The Team Members are introduced in this chapter within a description of how we built important relationships while undertaking this research. Yarning and PhotoYarning are described as the tools of data generation and the process used to conduct the analysis is described in detail.

I have not followed the traditional thesis structure of presenting the methodology chapter followed by the results chapters; instead I follow the methodology chapter with my reflective chapter. I have done this to reflect my Indigenous (Koori) methodology. While the two chapters need to be separate, they should be read together as a thesis "section" on methodology.

Chapter 4: My own Yarning

Central to the Indigenous methodology used in my PhD research is what I bring to the research both as a Koori woman and a Koori scholar. My own cultural, community, personal and professional experiences have, in diverse ways, informed the research process and as such Chapter 4 pays respect to the important connections between my Koori ways of being, knowing, doing and the research that forms this doctoral study. In this chapter I highlight the important role Yarning had throughout the research and I share several personal Yarns. My Yarns were shared verbally with Team Members and family throughout my doctoral study, often relating key research milestones or issues to my own Koori ontology and epistemology. I have converted some of those oral Yarns to written versions and included them here.

Chapter 5: "It's all about relationships": The use of friendship-like connections in the professional practice of Aboriginal and Torres Strait Islander health professionals.

This is the first of four thematic empirical chapters, each beginning with its own synthesis of related literature. In Chapter 5 we examine how Team Members developed ways of working with friendship-like connections with clients. Those connections were built up through client-worker interactions, both within the workplace and in the community. Chapter 5 presents four main themes: the first explores what working with friendship-like connections is and what it is not. The second theme explores why Team Members find it valuable to work with clients using friendship-like ways. The third theme synthesises how Team Members work with clients using friendship-like connections. An important part of this theme is an analysis of the professional boundary work Team Members engaged in. Finally, the fourth theme considers how other people in Team Members' workplaces perceive working with friendship-like connections, showing how Aboriginal and Torres Strait Islander health workers believe that their non-Indigenous managers differ markedly in their conceptualisation of appropriate connections between clients and Aboriginal and Torres Strait Islander health professionals.

Chapter 6: "My work? Well, I live it and breathe it." The seamless connect between the professional and personal/community self.

In a similar way to Chapter 5, the data in Chapter 6 reflect differing levels of appreciation and understanding of Aboriginal and Torres Strait Islander ways of working by providing examples of working in the health system with a seamless connect between the personal and the professional self. Team Members' data provide evidence of how they, as Aboriginal and Torres Strait Islander health professionals, have developed mechanisms for effectively managing living

and working in the same community, maintaining professional boundaries and retaining a seamless connect between their working and personal/community selves. Again, these ways of working are perceived and understood differently by their non-Indigenous colleagues, managers and health services.

Chapter 7: "I get a special feeling in this place": Aboriginal and Torres Strait Islander health professionals' use of everyday therapeutic landscapes in their work with clients.

In this chapter I explore a third way Team Members in this study worked to enhance service provision to their clients; in this case working outdoors and engaging everyday outdoor landscapes and spaces in a therapeutic way. I present four main themes related to using everyday landscapes therapeutically, beginning with how working outside in therapeutic landscapes has benefits for Team Members' own health and wellbeing. Second, I explore how engaging with therapeutic landscapes, including metaphorically, improves the work Team Members do with their clients. Thirdly I present how Team Members and clients share positive outcomes when engaging together in everyday landscapes therapeutically, especially when they share a connection with Country[10], and finally I introduce how Team Members persisted with the use of therapeutic landscapes even in the face of management and collegial disapproval.

[10] Being connected to Country describes Aboriginal and Torres Strait Islander peoples' sense of wellbeing achieved through the relationships they hold with cultural land, called Country.

Chapter 8: "When your own do it to you, well that's another level of sad": Australian Aboriginal and Torres Strait Islander experiences of workplace lateral violence in the health sector.

Sadly, Chapter 8 presents Team Members' experiences of lateral violence in their workplaces, with data highlighting what constitutes lateral violence and how it operates within a range of health services employing Team Members. I argue that lateral violence was enacted by Aboriginal and Torres Strait Islander health professionals to position Aboriginal and Torres Strait Islander health professionals against each other, creating an extremely negative, potentially damaging work environment that erodes people's confidence, motivation and drive and damaging cultural and professional identity. This final empirical chapter provides lessons for Aboriginal and Torres Strait Islander and non-Indigenous managers and colleagues in the Australian health system about how to avoid perpetuating or supporting the situations and practices described.

In Chapters 5, 6 and 7 I analyse examples of how Aboriginal and Torres Strait Islander Team Members worked with their clients as they delivered health care and argue that they offer positive opportunities to develop an understanding of Aboriginal and Torres Strait Islander ways of working and embed these ways of working in the health system. Chapter 8 serves as a reminder of what needs to be eradicated.

Chapter 9: Discussion and Conclusion

Chapter 9 weaves together the threads of findings from the empirical chapters and argues for making change to the health sector by learning from Aboriginal and Torres Strait Islander ways of working in health service delivery. Committing to understanding and valuing Aboriginal and Torres Strait Islander epistemologies and ontologies as legitimate ways of knowing, being and

doing is an essential element to making the changes that are required by our health sector. This chapter argues that current attempts to 'Aboriginalise' health are not enough, not sufficient and draws upon learnings from the empirical chapters, positioning those learnings as examples of leadership that have potential to create important change to Aboriginal and Torres Strait Islander health. Chapter 9 concludes by proposing some future areas of research that are related to this body of work and concludes with a reminder to privilege Aboriginal and Torres Strait Islander voices, epistemologies and ontologies in how we should know, be and do Aboriginal and Torres Strait Islander health.

Chapter 10: What have I learnt?

In the final chapter I close the circle of my research. I briefly summarise my key learnings as a Koori PhD student, provide a personal Yarn to assist in telling the story of my learnings and importantly, I feedback to my Team Members with a final Yarn.

Chapter 2: Literature: context and key issues

This chapter provides an historical context for the contemporary delivery of health services (government, non-government and Aboriginal community controlled) to Aboriginal and Torres Strait Islander peoples, thereby connecting existing health systems and policies to the history from which they emerged. It refers to literature that explores the impact of government policies and health systems on the way Aboriginal and Torres Strait Islander health services are delivered. It presents literature that demonstrates how more recently Australian health systems have attempted to 'Aboriginalise' services in an effort to better engage Aboriginal and Torres Strait Islander peoples with health service delivery to ultimately improve health outcomes. This literature also shows that health services often 'Aboriginalise' as a way to acknowledge and address the health disparities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. Importantly, this chapter presents literature describing the way the current health system still largely does not engage with, nor understand, Aboriginal and Torres Strait Islander ways of being, knowing, doing and thinking in the context of health service delivery. Those Aboriginal and Torres Strait Islander ways of being, knowing and doing in the context of health service delivery provide a foundation for the empirical chapters later in the thesis. This chapter is further supported later by literature at the start of each empirical chapter that relates more specifically to issues explored within each empirical study.

2.1 The Australian Aboriginal and Torres Strait Islander context

My culture and my people, the Aboriginal and Torres Strait Islander peoples, have lived together on the lands now called Australia for well over 70 000 years. The richness and diversity of our cultures was strongly supported by an in-depth understanding of how to care for (and be sustained by) the environment. Our highly developed social structures and systems of law (and lore) ensured our peoples maintained carefully tended personal, cultural and territorial relationships and boundaries. We lived in accordance with strict Men's and Women's business and guidance from Elders and ancestors. Connections to land, Country, ceremony and culture (in all of its forms) provided for hundreds of different language groups, belonging to different nations and clans, with diverse cultural, political, social and economic governance.

The lands we nurtured and cared for, the same lands which nurtured and cared for us in return, were invaded by British colonisers over 200 years ago. We were not recognised as the First Peoples of these lands; instead the invaders called the country 'Terra Nullius', a Latin term that translates into English to mean a land that belongs to nobody. This denial of our existence and sovereignty meant that the invaders did not see us as fellow human beings and with this came a future of dispossession and oppression. The colonisation process did not occur without resistance and battle (Broom, 2002; Dudgeon, Wright, Paradies, Garvey & Walker, 2010; Gooda, 2011; Harring, 1994; Loos, 2017; Pedersen & Woorunmurra, 2000;Reynolds, 2006); however the resources of the colonial forces facilitated the deployment of a range of government acts and policies that removed a range of basic human rights and human freedoms from members of the Aboriginal and Torres Strait Islander population.

2.1.1 Why is it important to engage with Aboriginal and Torres Strait Islander ways of being, knowing, doing

Understanding Aboriginal and Torres Strait Islander definitions of health and wellbeing is suggested as being "vital to working together respectfully, actively and effectively" (Sherwood, 2013b, p.37). This thesis provides specific examples of how the biomedical Australian health system does not fully understand or value Aboriginal and Torres Strait Islander health professionals' ways of working in health services.

The history of colonisation and past government policies has left a far reaching legacy in the Australian health system and in health service provision for Aboriginal and Torres Strait Islander peoples. Sherwood (2013b) highlights the impact that "historical, political and societal circumstances" (p.37) have had on Aboriginal and Torres Strait Islander peoples' health and wellbeing. She specifically charts a timeline that details government policies and actions since invasion that "have created determinants that influence the health and lives of Indigenous Australians" (p.36) and:

…impacted upon the health of Indigenous Australians be they children, mothers, fathers and grandparents; they have been maintained through problematic constructions of Aboriginal people that were established when the concept of Terra Nullius was applied to this continent. (p.37)

Important to my research is Sherwood's suggestion that it is important for those working in Aboriginal and Torres Strait Islander health service provision, research and scholarship to reflect on Aboriginal and Torres Strait Islander ways of knowing, doing and being (Sherwood, 2013b,

p.37) as a way of improving health service provision and health outcomes for Aboriginal and Torres Strait Islander Australians.

Seminal work undertaken in 1989 by the National Aboriginal Health Strategy Working Party resulted in creating a definition of "health" that has since been widely used to define Aboriginal and Torres Strait Islander health and wellbeing:

"Aboriginal health" *means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.*

Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and this bring about the total well-being of their community. (National Aboriginal Health Strategy Working Party, 1989, p.x)

While this definition clearly highlights important features of health and wellbeing, it has been critiqued by Lock (2007) who points out that a wider understanding of this definition and subsequent application of that understanding within a health service and systems context might be achieved by further research on defining health and wellbeing and Aboriginal and Torres Strait Islander ways of using "Indigenous knowledge systems" (p.12). Lock (2007) argues that it is difficult for policy makers and health systems to engage with Aboriginal and Torres Strait Islander constructs of health and wellbeing without a greater awareness and understanding of what Aboriginal and Torres Strait Islander ways of thinking, being, knowing and doing *are,* in the context of health service provision. The latter requires engaging with Aboriginal and Torres Strait Islander health and wellbeing as understood and as delivered through an Aboriginal and Torres Strait Islander lens. Mooney (2003) argues that "any health

care system is first and foremost a social institution built on the cultural stance of the nation it serves" (p.267). Arguably, the Australian health care system has been built according to Western paradigms, policies and practices. Not only does the Australian health system need to better engage with and understand Aboriginal and Torres Strait Islander definitions of health and wellbeing, it also needs to develop a deeper understanding of the Aboriginal and Torres Strait Islander "cultural stance" and embed that into the foundations of health service policy, planning and delivery.

There is a disjunct between Aboriginal and Torres Strait Islander and non-Indigenous Australian views of health and between Aboriginal and Torres Strait Islander and non-Indigenous Australian ways of working in health service provision (Sherwood, 2013b). My PhD thesis explores the latter disjunct; it highlights some of the challenges this disjunct presents to Aboriginal and Torres Strait Islander health professionals and suggests how allowing the disjunct to continue creates missed opportunities for health systems and services.

2.1.2 Early government policies and systems

Since European invasion in 1788 of the land now called Australia (and until recently), government policies relating to Aboriginal and Torres Strait Islander people were established by non-Indigenous Australian people under the belief that such policies of segregation, protection, assimilation, self-determination and reconciliation were for the good of Aboriginal and Torres Strait Islander people. These policies sought to use biology to separate Aboriginal people from the European invaders and consequently focused on Aboriginal 'blood quantum' as a way of creating further separations within the Aboriginal population itself. The position of first New

South Wales Protector of Aborigines was established as early as 1881 (Heiss, 2013). From the early 19th century our people came to be herded onto missions and government-established reserves where we were deemed to be a 'dying race' who could not be saved because of our supposed inferiority and inability to live in the 'modern world' (Gooda, 2011, p.57). Communities and families were separated and relocated to government reserves and religious missions; culture was not allowed to be practiced in any form and the assumed superiority of the colonial culture imposed disempowering systems and social structures that were both foreign and detrimental to Aboriginal and Torres Strait Islander-known ways of life (Human Rights and Equal Opportunity Commission [HREOC], 1997).

2.1.3 Use of early policies and systems to categorise and control Aboriginal and Torres Strait Islander peoples

Government protection and assimilation acts and policies not only instigated the removal of children from their families but also provided definitions of Aboriginal and Torres Strait Islander identity based on blood quantum and skin colour, rather than on cultural connection and one's sense of belonging (HREOC, 1997). By 1883 the New South Wales Aborigines Protection Board had been set up to legislate over Aboriginal people within that state and by 1890 the Board was removing Aboriginal and Torres Strait Islander children of 'mixed descent' from their families to be merged into the non-Indigenous Australian population:

The Board reasoned that if the Aboriginal population, described by some as a `wild race of half-castes' was growing, then it would somehow have to be diminished. If the children were to be de-socialised as Aborigines and re-socialised as Whites, they would somehow have to be removed from their parents. (HREOC, 1997, Chapter 3)

Government policies at the time of Federation in 1901, for example the Immigration Restriction Act, the Pacific Island Labourers Act and the Post and Telegraph Act (all 1901) that restricted non-European migration to Australia, operated to maintain Australia as a dominantly ‘white’ British colony. These Acts later became collectively known as the ‘White Australia Policy’ that largely prohibited non-white immigration to Australia. This collection of Acts operated for seven decades and was indicative of the dominant belief in British racial superiority. The desire to uphold a ‘white Australia’ policy also influenced policies relating to the Aboriginal and Torres Strait Islander population, particularly in government attempts to separate any Aboriginal and Torres Strait Islander ‘mixed race’ children from their families in an effort to integrate and assimilate those children to a British way of life. The 2011 Australian Human Rights Commissioner (Gooda, 2011) states that the Protection Acts (for example the Aborigines Protection Act 1909) “were intended to have a long-term effect, aimed at integrating the Aboriginal population into the broader population where possible, and isolating those that could not be integrated in accordance with the [Protection] Acts”(p.57). The Aborigines Protection Act (1909) defined Aboriginal and Torres Strait Islander peoples as ‘State wards’ and “limited the reproduction of part-Aboriginal offspring – the so-called 'half-caste menace” (Queensland Title Office, 1897). Protection Acts varied across Australian states and territories but they all had the capacity to classify Aboriginal and Torres Strait Islander people and determine how we lived our lives under those Acts (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2009). The Aborigines Protection Act operated in the state of Queensland until repealed by the Aborigines Act 1971 and the Torres Strait Islanders Act 1971 (McRae, 2009). Additionally, the original Constitution of the Commonwealth of Australia

excluded Aboriginal and Torres Strait Islander people, specifying that Aboriginal people needed "special laws" and that "Aboriginal natives" would not be counted in the numbers of people in the Commonwealth of Australia (Bennett, 2012).

It was not until the 1960's that several Commonwealth Government Acts became instrumental in granting appropriate political standing for Aboriginal and Torres Strait Islander people. Firstly, in 1962 the Commonwealth Electoral Act was passed, entitling all Aboriginal and Torres Strait Islander Australians to enrol and vote in Commonwealth elections. Secondly, the 1967 Referendum voted to change the two parts of the Constitution that were discriminatory against Aboriginal and Torres Strait Islander people. The Constitution Alteration (Aboriginals) Act (1967) firstly provided for Aboriginal and Torres Strait Islander Australians to be included, for the first time, in the census and secondly that Aboriginal and Torres Strait Islander Australians were subject to Commonwealth laws like other members of the Australian population. Prior to this Aboriginal and Torres Strait Islander people did not have the same civil and legal status as other members of the Australian population (Bennett, 2012). Historically, Australian government policies, Acts and laws were founded on non- Indigenous ways of being, knowing and doing and as such became mechanisms for systems, like the health system, to replicate a similar world view.

2.2 Aboriginal and Torres Strait Islander health

2.2.1 Health status

As at the last census on 30 June 2016, the Aboriginal and Torres Strait Islander population was estimated to be 744,956 or 3.1% of Australia's total population of 24 million people (Australian

Bureau of Statistics [ABS], 2011). The overall health status of Aboriginal and Torres Strait Islander Australians remains poorer than that of non-Indigenous Australians, as reflected in the fact that estimated life expectancy of Aboriginal and Torres Strait Islander people is on average ten years less than that of their non-Indigenous Australian counterparts (Australian Indigenous HealthInfoNet [AIHI], 2017). Additionally:

- chronic disease (including circulatory disease, diabetes and respiratory disease, cancer) contributes to approximately 70% of Aboriginal and Torres Strait Islander deaths (Department of the Prime Minister and Cabinet, 2017), with cardiovascular disease being "reported 1.2 times more frequently by Aboriginal and Torres Strait Islander people than by non-Indigenous people" (AIHI, 2017)
- diabetes accounts for 4% of the total of burden of disease for Aboriginal and Torres Strait Islander people, with Type 2 diabetes emerging in Aboriginal and Torres Strait Islander children and adolescents at earlier ages and in higher rates than their non-Indigenous counterparts: "8.3 times as high among 10-14 year-olds and 3.6 times as high for 15-19 year-olds" (AIHI, 2017)
- the prevalence of kidney disease, as a long-term health condition, is 3.7 times higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people. (AIHI, 2017)

An overview of the social determinants that impact on Aboriginal and Torres Strait Islander health status and outcomes indicates there is still much to be done to address the social disadvantage experienced by the Aboriginal and Torres Strait Islander population, (Steering

Committee for the Review of Government Service Provision, 2014). Honorary Ken Wyatt, Officer of the Order of Australia, Member of Parliament (Minister for Aged Care and Minister for Indigenous Health) reported that:

…over one-third of the average health gap between Indigenous and non-Indigenous people is the result of social determinants—the implications of housing, employment, justice and education. This rises to over 50% when combined with risky behaviours such as tobacco and alcohol use, poor diet and physical inactivity. (Wyatt, 2017)

Contemporary 'interventions' and health policy continue to recognise and develop ways to address this social disadvantage.

2.2.2 A snapshot of *Closing the Gap*[11]

Australia is facing failing attempts to address specific targets to improve health equity. Despite *Closing the Gap*, a national policy and practice initiative to improve the health status of Aboriginal and Torres Strait Islander peoples (Council of Australian Governments [COAG], 2009), the latest *Closing the Gap: Prime Minister's report 2017* (Department of the Prime Minister and Cabinet, 2017) suggests Australia is "still below expectations on most targets" (AIHI, 2017). As a national initiative, *Closing the Gap* promised to close the gap for Aboriginal and Torres Strait Islander Australians in the areas of health, education and employment. However, after ten years of national investment only one of the seven key measures was on track (year twelve school completion); of the other six health related measures, child mortality

[11] *Closing the Gap* is a formal commitment by all levels of the Australian government (federal, state and territory and local) to achieve Aboriginal and Torres Strait Islander health equality within 25 years. As a strategy it aimed to reduce disadvantage to Aboriginal and Torres Strait Islander people in the areas of life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes (Council of Australian Governments, 2009).

and life expectancy had made no significant progress (Department of the Prime Minister and Cabinet, 2017). There remain important questions to be asked of this national approach, given minimal change has been achieved and experienced to date.

2.2.3 Culture matters: current federal policy and frameworks for Aboriginal and Torres Strait Islander health and wellbeing

Closing the Gap (COAG, 2009), The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (Department of Health, 2013) and the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (Department of Health, 2014) call for increased engagement between Aboriginal and Torres Strait Islander people and health by closing the gap between health service access and provision and Aboriginal and Torres Strait Islander peoples. These plans also align with the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017); the latter articulates a vision important to my research:

This Framework shares the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 vision of an Australian health system that is free of racism and inequality, and where all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable; and that the health system is comprised of an increasing Aboriginal and Torres Strait Islander health workforce delivering culturally-safe and responsive health care. (p.6)

These national policy and strategic frameworks (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017; Department of Health, 2013, 2014) outline possible ways to improve Aboriginal and Torres Strait Islander health service delivery and health outcomes and still the Aboriginal and Torres Strait Islander health environment remains underperforming for its clients as demonstrated in the lack of progress in closing the gap in life expectancy and

health outcomes (Conifer, Leslie, Tilley, & Liddy, 2017; Department of the Prime Minister and Cabinet, 2017). The Australian health system also remains underperforming in the area of health professionals and staff, as evidenced in the aims established by the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023 (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017) that calls for the following outcomes[12]:

- Aboriginal and Torres Strait Islander people being **strongly represented across all health disciplines**;
- The representation of Aboriginal and Torres Strait Islander people in the **health workforce being proportional to the composition of the total population**;
- A health workforce that is able to **adapt to changing health needs and service delivery environments**;
- Health workforce planning that **optimises access to health care** for Aboriginal and Torres Strait Islander people;
- Workplaces that **attract, encourage and develop the talents of Aboriginal and Torres Strait Islander health professionals;**
- A **collaborative approach** to health workforce development that involves all relevant stakeholders;
- Aboriginal and Torres Strait Islander health professionals are supported to **lead the development of social, human, economic and cultural capital within the health workforce**;
- Aboriginal and Torres Strait Islander health professionals **playing a vital role in enhancing the Aboriginal health workforce capability** through a range of career pathways;

[12] I have highlighted details specifically relevant to my PhD research.

- Non-Aboriginal and Torres Strait Islander health professionals **recognise the trained skill sets and cultural knowledge of the Aboriginal and Torres Strait Islander workforce**; and

- Best-practice training to build a **culturally-safe and responsive health workforce.** (p.2)

These outcomes were developed by the Aboriginal and Torres Strait Islander Health Workforce Working Group (2017) who established the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework's (2017) key strategies, including the need:

- to improve recruitment and retention of Aboriginal and Torres Strait Islander health professionals in both clinical and non-clinical roles (Key Strategy 1)

- to build Aboriginal and Torres Strait Islander workforce skills and capacity (Key Strategy 2)

- for Health and related sectors be supported to provide culturally-safe and responsive workplace environments for the Aboriginal and Torres Strait Islander workforce (Key Strategy 3) (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017, pp.8-10).

The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2017) is founded on five key principles: centrality of culture, health systems effectiveness, partnership and collaboration, leadership and accountability and building evidence and data (pp.6-7); at the centre of all five principles is the Aboriginal and Torres Strait Islander health workforce. A further summary of the five principles of The Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2017) is provided in Appendix D.

2.2.4 'Aboriginalising' health service; a focus on the Aboriginal and Torres Strait Islander workforce

Increasing the number of Aboriginal and Torres Strait Islander people in the health sector is identified in the current policy frameworks as one mechanism for 'Aboriginalising' health service provision. Having Aboriginal and Torres Strait Islander people in the health workforce has been shown to impact positively on the patient experience (McDermott et al., 2015; Thompson et al., 2016). Some literature suggests that better Aboriginal and Torres Strait Islander engagement with health assessments and treatments (Davy et al., 2016; Gwynne & Lincoln, 2016; Mercer, Byrth, & Jordan, 2014; Treloar et al., 2014) and increased Aboriginal and Torres Strait Islander attendance at appointments are directly related to the work of Aboriginal and Torres Strait Islander people in the health workforce (Gibson et al., 2015; Kendall & Barnett, 2015; Mercer, 2013; Mercer et al., 2014; Roche, Duraisingam, Trifonoff, Battams et al., 2013).

The National Aboriginal and Torres Strait Islander Health Plan (2013) proposes a goal that highlights how health systems can better value and come to understand Aboriginal and Torres Strait Islander ways of working in health to enhance health service provision for Aboriginal and Torres Strait Islander clients and Aboriginal and Torres Strait Islander health staff:

Goal: The capabilities, potential and aspirations of Aboriginal and Torres Strait Islander people are realised and optimise their contribution as individuals to the health workforce and to strategies to achieve Aboriginal and Torres Strait Islander wellbeing. Institutional and organisational structures and processes harness human and community capability and enhance its potential (p.23).

Such a call provides scope for building the Aboriginal and Torres Strait Islander health workforce across the range of specialisations and professions, including growing the

employment of Aboriginal and Torres Strait Islander health professionals as a way to ensure "culturally safe workplaces…and infrastructure":

The employment of Aboriginal and Torres Strait Islander health professionals also contributes to the development and maintenance of culturally safe workplaces and assists in addressing institutionalised racism. Further, all health professionals delivering health care to Aboriginal and Torres Strait Islander people have the capacity to influence health policy and health professional systems and contribute to health research and infrastructure (pp.23-24).

The Implementation Plan (2014) states a vision to improve health systems effectiveness by aligning more closely with ways of working that are "culturally safe, high quality, responsive and accessible for all Aboriginal and Torres Strait Islander peoples" (p.9). Positioning the Aboriginal and Torres Strait Islander health workforce as the driver of this change is clearly recommended:

The strength of culture and cultural responses is recognised as central to ensuring engagement by Aboriginal and Torres Strait Islander peoples within the health system. This includes acknowledging Aboriginal and Torres Strait Islander leadership and enabling a transfer of skills and knowledge to continue across the community. Connecting with land, country and history, including traditional healing practices, ensures community members are building mind, body and spirit within a cultural context. (p.9)

Despite efforts by the Australian health system to develop plans and policies to address the disparities between Aboriginal and Torres Strait Islanders and non-Indigenous Australians, collaborators of The Redfern Statement[13] (2016) acknowledged that many attempts to 'Aboriginalise' the health system and services have not been successful in making change to

[13] National peak bodies came together to develop *The Redfern Statement* (National Congress of Australia's First Peoples, 2016) that called for urgent government action to support Aboriginal and Torres Strait Islander leadership in progressing the national goal to close the gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

health outcomes or other indicators that result in a "reduction in disadvantage among Aboriginal and Torres Strait Islander people with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes" (AIHI, 2017).

2.3 The Aboriginal and Torres Strait Islander health workforce

2.3.1 Definitions of the Aboriginal and Torres Strait Islander Health Worker

This study did not seek to solely consider working lives of Aboriginal Health Workers but sought to be inclusive of a range of positions held by Aboriginal and Torres Strait Islander people in the health sector. However, there exists some confusion over defining the role of the Aboriginal and Torres Strait Islander Health Worker (AHW) across health services nationally as many people use the title to capture the work done by a range of Aboriginal and Torres Strait Islander health professionals in their workplace. Health Workforce Australia (2014) provides a statement defining the diversity of the AHW role, stating that the role of an AHW has:

…evolved from a need to provide culturally safe clinical and primary health services to Aboriginal and Torres Strait Islander people whose health needs were not being met by mainstream services. (p.2)

Under this definition AHWs:

…respond to local health needs and contexts and perform different tasks depending on the services needed...[reflecting]…the wide degree of variation that exists in Aboriginal and Torres Strait Islander Health Worker roles, definitions, scopes of practice, education standards and career pathways. (p.2)

Identifying as Aboriginal and Torres Strait Islander is an essential component of the AHW role as is the capacity to do work that helps to ensure cultural relevance and appropriate health service delivery (Health Workforce Australia, 2011). It is important to recognise that the literature and the health sector itself use a variety of different names to describe AHWs, including drug and alcohol worker, social and emotional wellbeing officer, education officer, hospital liaison officer and health promotion officer (National Aboriginal and Torres Strait Islander Health Worker Association, 2017).

Defining the role of an AHW is complex given that the functions of that role, employment conditions and registration requirements still have variation across the country (Aboriginal and Torres Strait Islander Health Practice Board of Australia, 2016; Department of Health, 2013, 2014; The Australian Health Practitioner Regulation Agency [AHPRA], 2016; Willis, Reynolds, & Keleher, 2016). A move to regulate health practitioners (those specifically holding the certification of health practitioner) or health professionals who identify as Aboriginal and Torres Strait Islander is included in a wider national registration framework for all health workers, now auspiced by AHPRA. The APHRA Aboriginal and Torres Strait Islander Health Practice Board of Australia has a governance role in regulating Aboriginal and Torres Strait Islander health practitioners. Currently an Aboriginal and Torres Strait Islander individual health professional needs to be registered with AHPRA if they hold any of the following job titles:

- Aboriginal and Torres Strait Islander health practitioner
- Aboriginal health practitioner, and

- Torres Strait Islander health practitioner.

Originally, to be eligible for registration under this system an individual had to hold a minimum of “a Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care Practice, or equivalent as determined by the Board” (AHPRA, 2017); now, other qualifications are considered relevant in the application process. AHPRA’s 2015/2016 annual reports (Aboriginal and Torres Strait Islander Health Practice Board of Australia, 2016; AHPRA, 2016) indicate that 4,419 (0.7%) of their total registered health workforce (14 professions) identify as Aboriginal and Torres Strait Islander, with 587 (0.1%) of their registrants working in the profession of Aboriginal and Torres Strait Islander health practitioner. While this registration process does provide some workforce data, it only captures (a) those who are registered and (b) those who work in primary health care practice roles. A large segment of the Aboriginal and Torres Strait Islander workforce could be thus excluded from these data and as such it remains challenging to determine more accurate and representative Aboriginal and Torres Strait Islander health workforce data. As requisites for the employment of an AHW vary nationally, with a Certificate III in Aboriginal and Torres Strait Islander Primary Health Care generally accepted as the minimum training required, many Aboriginal and Torres Strait Islander people working in health have not yet become registered under the national framework and are thus not captured in that workforce database (Willis et al., 2016). However, a number of other sources of data provide some insight into the employment data of the Aboriginal and Torres Strait Islander workforce. The 2011 Census data (ABS, 2011) suggest that around about 1.6% of the Aboriginal and Torres Strait Islander population were employed in health-related occupations. This remains below the proportion of the non-Indigenous Australian population thus employed

(approximately 3.4%) (Department of the Prime Minister and Cabinet, 2014). This employment gap remains a focus of Aboriginal and Torres Strait Islander workforce development through the existing national health plans and policies (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017; COAG, 2009; Department of Health, 2013, 2014). In 2014-2015 the Australian Institute of Health and Welfare reported that Aboriginal and Torres Strait Islander peoples made up 53% of the workforce in Aboriginal and Torres Strait Islander primary health care organisations funded by the Australian Government (Australian Institute of Health and Welfare, 2016). The Department of Health 2015-2016 Annual report stated that 108 (2.1%) of their total employed health workforce identify as Aboriginal and Torres Strait Islander (2016). The paucity of accurate Aboriginal and Torres Strait Islander health workforce data (Department of Health, 2013, 2014) creates ongoing challenges for workforce development and workforce planning. While AHPRA states that Aboriginal and Torres Strait Islander health practitioner registration is growing (2016), more work is needed to gauge the number of non-registered Aboriginal and Torres Strait Islander health professionals, so adequate health workforce development plans and policies can be developed and enacted.

2.3.2 What do we know about the experiences of an Aboriginal and Torres Strait Islander person working in health?

More accurate workforce data would allow for effective Aboriginal and Torres Strait Islander health workforce capacity building and development. Gwynne and Lincoln's (2016) review of literature relating to developing the rural workforce to improve health outcomes for Aboriginal and Torres Strait Islander people identified nine papers that suggest Aboriginal and Torres Strait Islander health professionals are "likely to face challenges such as racism, family and

community responsibilities, isolation, stress and poor secondary education" (p.235). The reviewed literature spanned several different areas employing Aboriginal and Torres Strait Islander health professionals, including the drug and alcohol sector (Ella, Lee, Childs, & Conigrave, 2015; Roche, Duraisingam, Trifonoff, Battams, Freeman, Tovell, Weetra & Bates, 2013; Roche, Duraisingam, Trifonoff & Tovell, 2013), remote health services (Carson & McConnel, 2011) and nursing (Best, 2018; Best & Gorman, 2016; Goold, 1995; Nielsen, Stuart, & Gorman, 2014). This body of literature suggests that the Aboriginal and Torres Strait Islander health workforce needs to build capacity, increase retention rates, address racism and other workplace stress and develop collaborative ways of working between Aboriginal and Torres Strait Islander and non-Indigenous health professionals.

The need to build capacity

A major recommendation made by Gwynne and Lincoln (2016) was the need to build capacity of the Aboriginal and Torres Strait Islander health workforce by providing "specific support, such as education, training, mentoring, cultural and family leave provisions, as well as peer support, to address significant issues they face" (p.236). They argued it was equally important to develop "explicit strategies for acknowledging, preventing and dealing with racism; strategies to promote team cohesion and cooperation; recognition and respect of different knowledge (e.g. medical, cultural community); and ongoing cross-cultural training" (p.236).

Retention

Insight into contributing factors to poor retention can be gained from research undertaken on the Aboriginal and Torres Strait Islander alcohol and other drug workforce (Roche, Duraisingam,

Trifonoff, Battams et al., 2013; Roche, Duraisingam, Trifonoff & Tovell, 2013). Albeit specific to the alcohol and other drug sector, this research does highlight issues related to supporting and retaining an Aboriginal and Torres Strait Islander health workforce. Retention of Aboriginal and Torres Strait Islander staff in the alcohol and other drug field was found to be a challenge for the health system (Ella et al., 2015), with high staff turnover being a dominant feature. In a national workforce survey of alcohol and other drug workers Roche, Duraisingam, Trifonoff and Tovell (2013) stated that:

More Indigenous respondents reported shorter lengths of service in their current organisation compared with non-Indigenous respondents, which may indicate greater turnover and/or more recent recruitment initiatives. Nearly half the respondents from both groups had been employed in their organisation for 2 years or less. (p.19)

Similarly, Ella et al. (2015) reported that 78% of their surveyed Aboriginal and Torres Strait Islander alcohol and other drug workers health workers in New South Wales had worked in their current organisation for five years or less. A national survey to consider Aboriginal and Torres Strait Islander alcohol and other drug workers' wellbeing, stress and burnout also determined that:

Indigenous respondents reported shorter lengths of service in their current organisation compared to non-Indigenous respondents, which may indicate greater levels of turnover. Indigenous respondents were also less likely to hold permanent positions, and more likely to hold casual positions, which generally does not have longer retention rates. (Duraisingam, Roche, Trifonoff & Tovell, 2010, p.25)

A greater understanding of the factors contributing to poor retention across the Aboriginal and Torres Strait Islander health workforce is needed. Earlier research found that elevated levels of emotional exhaustion was one predictor of an Aboriginal and Torres Strait Islander person's intention to leave their job (Ducharme, Knudsen, & Roman, 2007; Duraisingam, Pidd, Roche, &

O'Connor, 2006; Duraisingam, Roche, Pidd, Zoontjens & Pollard, 2007; Knudson, 2015). A key retention strategy was "having a more supportive workplace" (Duraisingam, Roche, Trifonoff & Tovell, 2010, p.25).

Racism and other workplace stress

A greater understanding into the contributing factors to workplace stress of Aboriginal and Torres Strait Islander alcohol and other drug workforce can be appreciated in research undertaken by Roche, Duraisingam, Trifonoff, Battams et al. (2013) that reported "Racism was commonly experienced from co-workers and the mainstream community…[and]… There was a significant lack of understanding about 'Indigenous ways of working' resulting in conflict and clashes with mainstream colleagues and services" (p.3). Increased understanding of the workplace experiences of the Aboriginal and Torres Strait Islander workforce could provide opportunities to address some of the factors contributing to poor retention and worker stress.

Developing more collaborative approaches between Aboriginal and Torres Strait Islander and non-Indigenous colleagues in health

Poor levels of trust between Aboriginal and Torres Strait Islander and non-Indigenous colleagues in health have been noted by Zubrzycki, Shipp, and Jones (2017). Poor levels of trust often result in a lack of collaborative working relationships between Aboriginal/or Torres Strait Islander and non-Indigenous Australian health professionals and services: "the legacy of Australia's history, continuing Aboriginal health disparities and different ways of working can also cause these partnerships to be difficult and sometimes tenuous" (Taylor, Bessarab, Hunter, & Thompson, 2013, p.4). Several studies indicate that for many non-Indigenous Australian

health professionals the development of trusting and collaborative working relationships with Aboriginal and Torres Strait Islander health professionals is difficult, for example Bennett, Zubrzycki and Bacon (2011), or challenging and extremely complex, for example Wilson, Magarey, Jones, O'Connell and Kelly (2015). However, the development of effective and ongoing cross-cultural working collaborations between Aboriginal and Torres Strait Islander and non-Indigenous Australian health professionals and services is pivotal in challenging barriers to health service provision and engaging effectively with community. Specifically, Blignault, Haswell, and Jackson Pulver (2015) found collaborative, cross cultural partnerships to be useful in a national program that aimed to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander youth in remote and regional Australia; Singer, Bennett-Levy, and Rotumah (2015) reported a collaborative, community drive process to be 'transformative' in an Aboriginal mental health project and Zubrzycki et al. (2017) reported that the "formation of close working relationships between Aboriginal and non-Aboriginal health workers" enabled their cancer treatment team being to better address "high rates of mortality from cancer, poor access to cancer screening, and engagement with cancer treatment" (p.1316).

Working in 'culturally safe' ways

Working in health service delivery in a way that recognises and engages with cultural diversity and addresses inequities and disparities have been defined by a number of terms, including working with cultural respect, cultural awareness, cultural safety, cultural competence or cultural security (McGough, Wynaden, & Wright, 2018). While challenging to find the exact birth place of the term 'cultural safety' Papps and Ramsden (1996) and Koptie (2009) trace the

term to the experience of dissatisfaction with health care in the Maori population in Aotearoa, New Zealand in the 1980s. Specifically, arising from the discipline of nursing in Aotearoa, New Zealand, is Ramsden's (2002) foundational work on cultural safety. Ramsden, an Indigenous nurse described cultural safety as "a theory and…practice" (p.ii), locating the research in nursing and midwifery education. Ramsden's work has since been complemented by other significant work on cultural safety in the same space, including Best, 2017; Cox & Taua, 2012;2017. Additionally, Kirmayer (2012) defined cultural safety as a way of working at individual and institutional level to "Cultural safety in indigenous contexts means that professionals and institutions, whether indigenous or not, work to create a safe space for an encounter with patients that is sensitive and responsive to their social, political, linguistic, economic, and spiritual realities" (pp.157-158). Cultural safety moves beyond focusing on the skills and competence of an individual health professional to include "analyzing power imbalances, institutional discrimination, colonisation and colonial relationships as they apply to health care'' (National Aboriginal Health Organisation, 2008, p.3). While ensuring safe patient care and building safe systems and institutions are vital to ensuring cultural safety, my research further refines the focus of cultural safety to specifically explore how Aboriginal and Torres Strait Islander health professionals themselves experience "working with culturally safe ways". My approach does not negate the vital importance of the broader understanding of cultural safety but rather provides a lens through which to better understand "working with culturally safe ways" from a workforce perspective.

The Aboriginal and Torres Strait Islander health professional often works in partnership with other (non-Indigenous) health professionals as they provide health services to Aboriginal and

Torres Strait Islander clients and communities. This brings together ways of delivering health service that comprises Western and Aboriginal and Torres Strait Islander ways of working. In many cases health services remain dominantly structured and delivered according to a Western biomedical model of care that is not necessarily “sensitive and responsive to [Aboriginal and Torres Strait Islander] social, political, linguistic, economic, and spiritual realities” (Kirmayer, 2012, pp.157-158). Effective interprofessional collaborations between Aboriginal and Torres Strait Islander and non-Indigenous Australian health professionals are one mechanism for building cultural safety in health service delivery (Mercer et al., 2014; McDermott et al., 2015). Developing a collaborative way of working often requires sustained effort and time (Pressler & Kenner, 2012) but can produce a working relationship that is built on trust and has a deeper understanding of Aboriginal and Torres Strait Islander ways of working that can increase cultural safety for health practitioners and clients (Drummond, 2014).

Aboriginal and Torres Strait Islander health professionals have long been positively regarded for their role as cultural brokers, guiding their non-Indigenous colleagues and ensuring best practice of care for their Aboriginal and Torres Strait Islander clients (Deshmukh, Abbott, & Reath, 2014; Drummond, 2014; Sherwood, 2013a). Developing an understanding of Aboriginal and Torres Strait Islander health and health practice is considered to be culturally safe (Eckermann, Dowd, Chong, Nixon, & Gray, 2010) and ultimately provides scope for non-Indigenous Australian health professionals to better meet the needs of their Aboriginal and Torres Strait Islander clients : “a culturally safe practitioner uses his or her knowledge to navigate the system and apply flexible processes to ensure that they meet the cultural needs of Aboriginal and Torres Strait Islander patients” (Drummond, 2014, p.176).

Mercer (2013) states that the responsibility for building collaborative working relationships between Aboriginal and Torres Strait Islander and non-Indigenous Australian health professionals needs to be shared between health services and the individuals concerned; however Abbott, Gordon, and Davison (2008) place more responsibility on to health services and work environments, reporting that some Aboriginal and Torres Strait Islander health professionals indicated that their work was " strongly affected by the setting in which they work"(p.157). In addition to acknowledging the important role health professionals should play in building collaborative working relationships in Aboriginal and Torres Strait Islander health service provision, Mercer (2013) highlights the commitment required by health services and the health workforce policies that inform practice, suggesting that "the experience of each partner in the arrangement is heavily intertwined and influenced by the culture and support offered from within the workplace and across the workforces"(p.327). For the Australian health sector to provide culturally safe services that meet the needs of Aboriginal and Torres Strait Islander peoples of Australia it needs to better engage with Aboriginal and Torres Strait Islander ways of being, knowing, doing (Sherwood, 2010). Findings in the later empirical chapters build a body of evidence to support better engagement with Aboriginal and Torres Strait Islander ways of working in the Australian health system.

The literature outlines that health inequities are experienced by Aboriginal and Torres Strait Islander peoples and suggests that current efforts to address the inequities are falling short. While policies identify that culture matters in Aboriginal and Torres Strait Islander health, there remains a gap of understanding and valuing Aboriginal and Torres Strait Islander ways of

knowing, being and doing (Sherwood, 2010), specifically in the context of health service delivery.

My research explored how a group of Aboriginal and Torres Strait Islander health professionals worked in the Australian Aboriginal and Torres Strait Islander health sector and identified strategies that can bridge the gap of understanding and valuing Aboriginal and Torres Strait Islander ways of knowing, being and doing.

Chapter 3: Methodology and Methods

This chapter consists of two parts. The first covers the development of a theoretical framework and my Indigenous methodology that privileges Aboriginal and Torres Strait Islander ways of being, knowing and doing. The second will focus on ethics, recruitment, sample, data generation and data analysis.

3.1 Theoretical framework

3.1.1 Introduction

I am decolonising research. I listen to the participants [Aboriginal and Torres Strait Islander] and analyse their words really carefully, paraphrasing for emphasis. I make sure I write up my analysis carefully and write it up in a way that will be attractive to [XX] journal.

[Words of a non-Indigenous academic colleague: My research journal]

Of course I am decolonising research methods. Well, for one thing, I didn't sit at the desk and ask the participants [Aboriginal] to tick the survey boxes, I sat with them outside in the [office] backyard. That's decolonising research, I am using community space.

[Words of a non-Indigenous academic colleague: My research journal]

As a Koori academic I am committed to privileging Aboriginal and Torres Strait Islander ontologies. Internationally, research connected to First Peoples, including Australian Aboriginal and Torres Strait Islander peoples, does not always utilise Indigenous ontology (Cunneen & Rowe, 2014; Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011; Leeson, Smith, & Rynne, 2016; Rigney, 2006). Instead, many academic publications and research protocols for such research continue to reflect Western paradigms and Western ways of knowing (Bessarab & Ng'andu, 2010; Cunneen & Rowe, 2014; Rigney, 2006; Smith, 1999). Applying Western academic templates to research in an attempt to understand experiences of Aboriginal and Torres Strait Islander peoples perpetuates the colonisation of knowledge, privileging a

dominant non-Indigenous Australian academic discourse to communicate Aboriginal and Torres Strait Islander ontology. Excerpts from my research journal (shared at the opening of this chapter) remind me that while good work is being done to better engage with Indigenous knowledge and experience through research, like 'doing' research in community settings and listening 'really carefully' to research participants, neither is enough. In fact, both of those things should be considered best practice within any research.

Challenging the dominant use of Western academic paradigms has been suggested in the works of several Indigenous scholars including Moreton-Robinson (2000), Rigney (2006) and Smith (1999). Privileging Indigenous ontologies and epistemologies is one way to decolonise research methods. Importantly this approach should not be understood as the type of act of decolonisation described by Chilisa (2012) as recentering of the colonised to enable them "…to understand themselves through their own assumptions and perspectives" (p.13). Rather, privileging and supporting Indigenous ontologies and epistemologies in academic discourse provides scope for marginalised or oppressed voices to have "…space to communicate from their frames of reference" (Chilisa, 2012, p.14), instead of from within a dominant Western academic framework. Care needs to be taken by academics and researchers attempting to decolonise research to avoid using methods in ways that still privilege a Western academic voice.

3.1.2 An important influence on my theoretical framework

Early in the research process I re-engaged with the work of Linda Tuhiwai Smith (1999), work I had read with excitement many years earlier. As a Koori researcher I had felt silenced by some

Western research methodologies and methods that many of my colleagues utilised in their research; I felt that they and I did not 'fit'. However, through this PhD research I experienced a positivity around this cognitive dissonance as I found a research space that would acknowledge and profile my ways of thinking, being, knowing and doing. The work of Linda Tuhiwai Smith encouraged me to challenge "the deep underlying structures and taken-for-granted ways of organizing, conducting, and disseminating research and knowledge" (Smith, 2007, p.88). In her work I also found an important level of reassurance and safety for undertaking the challenge of being a Koori PhD researcher within the Western academy, who had at times felt she presented only half a voice in an effort to align with some Western academic traditions and epistemologies. Linda Tuhiwai Smith's work encouraged me to be political with my research process. I did not seek to discard the Western education that I had been so lucky to experience, but rather I sought new ways of challenging some of the existing Western research paradigms that did not align with my epistemological framework, challenging them with ways to privilege the Aboriginal and Torres Strait Islander voice and experience. Smith (1999) states that this process is "about reclaiming, reconnecting and reordering those ways of knowing which were submerged, hidden or driven underground" (p.69). Through Linda Tuhiwai Smith's work I found my research voice, and for that I am eternally thankful. Within this PhD I developed a new Indigenous method, PhotoYarning, which contributes to new ways of thinking about and doing research.

3.1.3 My early relationship with theories

Linda Tuhiwai Smith's (1999) seminal work on decolonising methodologies encouraged me to establish my research with its own strong theoretical foundation that had Indigenous epistemology and ontology as its bedrock. Following Smith (2014), my PhD research invites the reader to notice, listen to and engage with Indigenous epistemology and ontology and "begin again" (p.15). Smith's decolonising theories, specifically those that shift power away from some Western research traditions and maintain a focus on relationships in research, have provided me with confidence to reconsider research relationships "between the researcher and the researched, between researcher and indigenous community" (p.15) in a way that is inclusive, respectful and empowering for all people involved in the shared experience of the research. My research enabled me to close a gap between "researcher and researched" (Smith, 2014, p.18). I used Indigenous research theories presented by my cultural and academic research mentors to firmly position this research in the Aboriginal and Torres Strait Islander knowledge belonging to me (as a Koori researcher) and belonging to the Aboriginal and Torres Strait Islander Team Members. Both Team Members and I live and work with Aboriginal and Torres Strait Islander knowledges and Western knowledges, in a space Nakata (2004) refers to as the Cultural Interface, a contested knowledge space between Aboriginal and Torres Strait Islander knowledges and Western scientific knowledges. I drew strength from Linda Tuhiwai Smith's decolonising theories and Nakata's Cultural Interface theory to explore how Aboriginal and Torres Strait Islander people interact with the dominant Western health system and this was done through a theoretical framework that privileged Aboriginal and Torres Strait Islander epistemology.

3.1.4 Decolonising methodologies

As a Koori PhD researcher I had capacity to work with research both from within the Western paradigm and from within an Aboriginal and Torres Strait Islander paradigm. I reflected on the work of Rigney (1997) who wrote about research with Aboriginal people or on Aboriginal issues: “Indigenous peoples’ interests, knowledge and experiences must be at the centre of research methodologies and construction of knowledge about Indigenous peoples” (p.119). My research aligned with Rigney’s statement as I positioned ‘participants’ as Team Members, valued for their Aboriginal and Torres Strait Islander experiences and knowledges that remained central throughout the research. It also aligned to my own Koori worldview that values any “construction of knowledge about Indigenous peoples” (Rigney, 1997, p.19) to have been constructed from a place that respects and engages Indigenous ontologies and epistemologies. I also looked to the work of Porsanger (2004), an Indigenous Sami [14] academic, who wrote how:

…indigenous approaches to research on indigenous issues are not meant to compete with, or replace, the Western research paradigm; rather, to challenge it and contribute to the body of knowledge of indigenous peoples about themselves and for themselves, and for their own needs as peoples, rather than as objects of investigation. (p.104)

Like other Indigenous scholars, Porsanger (2004) described the process of decolonising research as being something that “requires new, critically evaluated methodologies and new, ethically and culturally acceptable approaches to the study of indigenous issues” and that these “…approaches may differ in various ways for indigenous and non-indigenous scholars” (p.107).

[14] Indigenous people inhabiting northern regions in Sweden, Finland and Russia

This theory was important to this research, as I sought to produce a Western PhD through research that would revise and rework some components of the Western academic paradigm. Through that process I also wanted to convince non-Indigenous people and non-Indigenous systems of the importance and value of thinking, being, knowing and doing in two paradigms.

Linda Tuhiwai Smith (1999) had stated that the decolonising of research is “about centering our [Indigenous] concepts and worldviews and then coming to know and understand theory and research from our [Indigenous] own perspectives and for our [Indigenous] own purposes” (p.39). Smith’s teachings encouraged me to decolonise the Western methodologies that had been causing me angst and engage my Koori epistemology to develop a methodology that could “make visible what is special and needed, what is meaningful and logical in respect of indigenous peoples’ own understanding of themselves and the world” (Porsanger, 2004, p.107). I did this by establishing processes that provided scope for me to Yarn at length about the research and about ethics; Yarning conversationally with potential Team Members demonstrated my commitment to reciprocity, respect and relationship building in research. I did this by always exercising reciprocity as I engaged Koori cultural protocols and introduced myself, my family and my Country in ways that were not common in most Western research methodologies.

Many theoretical frameworks that I had examined were framed by Western epistemologies that were relevant to informing particular research projects. In this study I was an Koori researcher researching Aboriginal and Torres Strait Islander issues in an Aboriginal and Torres Strait Islander health context and as such I was mediating the “space between researcher and

researched" (Smith, 2014, p.19). To do this I developed a theoretical framework that supported this particular research space, keeping Aboriginal and Torres Strait Islander interests, experiences and construction of knowledge at the centre (Rigney, 1997, 2006).

3.1.5 Theories that have influenced this study

Indigenist research

I have been influenced in particular by Rigney's Indigenist research methodology (2006) and the roots it has in Feminist research. Indigenist research methodology presents a more open, flexible and contextual approach to research (Roy & Campbell, 2015) than many of the research approaches that draw upon Western knowledge systems and processes, which are often incongruent with Indigenous approaches (Martin & Mirraboopa, 2003). Indigenist research is defined by Rigney (2006) as research that comprises three principles: "resistance as an emancipatory imperative; political integrity in Indigenous research and privileging Indigenous voices" (p.10). From Rigney's theories I have adopted and maintained the privileging of Aboriginal and Torres Strait Islander voices in my research and have worked with political integrity. However, I resisted adopting "resistance as an emancipatory imperative" (Rigney, 2006, p.10). I do not need to resist all Western research traditions for my own research framework to find a place. I research from a position that centres my Koori epistemology and ontology and I do that as I work in a University dominated by Western approaches to research and working to a health system similarly positioned. This research does not need to resist one over the other and as such the research framework informing this thesis has developed a way of working with research that (a) respects and honours Indigenous approaches *and* (b) will be appreciated by a dominant discourse.

Martin (2008) positions herself as an Aboriginal researcher who draws on her cultural heritage as a strength in her work, not working in opposition to Western research frameworks but stating “I research from the strength and position of being Aboriginal and viewing anything western as 'other', alongside and among western worldviews and realities” (Martin & Mirraboopa, 2003, p.205). Martin’s work (2008) extends Indigenist research principles, stating that “Indigenist research must centralise the core structures of Aboriginal ontology as a framework for research if it is to serve us well. Otherwise it is western research done by Indigenous people” (p.5). Research is about developing awareness and as such the research framework for my PhD develops awareness of Aboriginal and Torres Strait Islander people’s ontology and maintains the required academic rigour. From Rigney (2006) this thesis has adopted the privileging of Aboriginal and Torres Strait Islander voices and maintaining a political integrity. Importantly, this research has developed a way of privileging and centering Aboriginal and Torres Strait Islander ontologies and epistemologies in “alignment with aspects of western qualitative research frameworks” that are known, understood and existing within the Western academy (Martin & Mirraboopa, 2003, p.211).

The Cultural Interface

Carey and Prince (2015) wrote of Nakata’s exploration of the Cultural Interface and development of Indigenous Standpoints as encouraging: “…diversity in Indigenous scholarship by providing a framework by which the fissure between so-called Indigenous and western knowledges can be negotiated, while accommodating the need for ‘solidarity and cohesion’ between Indigenous scholars” (p.271).The Cultural Interface explores the contested knowledge

space between Indigenous and Western knowledges. Some literature refers to the "differences" between these knowledge systems as ontologically and epistemologically "irreconcilable" (Russell, 2005, p.166). However, differences at the epistemological and ontological levels can make it difficult to establish an effective working space at the Cultural Interface, particularly in workplaces that dominantly align with a Western knowledge system. Nakata (2007a) suggests that there has been more focus on exploring and understanding Indigenous cultures, rather than on understanding Indigenous knowledge systems, and that focusing on Indigenous knowledge systems "rather than of cultures, does bring Indigenous knowledge, its systems, its expressions, and traditions of practice into a different relation with Western science" (p.8). Cultural Interface Theory brings Indigenous knowledge into a context that does not seek to 'understand it' or 'see it' through the lens of Western knowledge systems, instead seeing it as a knowledge system itself rather than as "…conceptualised simplistically and oppositionally from the standpoint of scientific paradigms as everything that is "not science" (Nakata, 2007a, p.9).

Standpoint Theories

Moreton-Robinson (2013) reminds us of a challenge shared by both Indigenous and Feminist scholars, that being of the struggle against dominant, patriarchal production of knowledge and theories, stating that "Indigenous and feminist scholars share an understanding that their respective production of knowledge is a site of constant struggle against normative dominant patriarchal conceptual frameworks" (p.331). The development of Standpoint Theories (for

example, Feminist, Indigenous and Indigenous Women's) is an important outcome of these communal struggles.

Standpoint Theories contest that a person's Standpoint is influenced by their social, political, economic, and cultural perspectives, their life experiences and their worldviews; they know the world through their position in it and their experiences of it. Standpoint theories privilege the 'knower' based on characteristics of how a person knows and experiences their world.

Feminist Standpoint Theory

The relationship between power and the production of knowledge has been well explored in formative works by a number of feminist scholars including Collins (1986); Haraway (1988); Harding (1992, 2004); Hartsock (1983, 1998) and Smith (1974). These formative works continue to contribute to women's epistemological authority and the development of Standpoint Theories about women's knowledge production and power (Harding, 2004). Feminist Standpoint Theories are presented by Moreton-Robinson (2013) as having: "… assisted in mapping Feminism's epistemological boundaries. They have challenged dominant patriarchal paradigms, which discursively privilege men as knowing subjects, by exposing the partiality of the universal male standpoint" (p.332). Feminist Standpoint Theories position moral values and political beliefs as playing a role in knowledge production and as such shaping research. According to Feminist Standpoint Theories "all researchers' beliefs are inextricably a constitutive part of their standpoints" (Moreton-Robinson, 2013, p.335). In this research I specifically draw on Feminist Standpoint Theory for stating that researchers are "not detached from our morals and our values at any given stage of the research whether or not we are

invested or disinvested in the process” (Moreton-Robinson, 2013, p.334); I acknowledge that my morals and values shape my research.

Indigenous Standpoint Theory

Feminist Standpoint Theory has influenced Indigenous (Torres Strait Islander) scholar Martin Nakata (2007b) and his work on Indigenous Standpoint Theory and the development of Indigenous research methodologies. Nakata argues that an Indigenous Standpoint provides scope for consideration of how he works in the Cultural Interface, the space in which both Western knowledge paradigms and Indigenous knowledge paradigms exist. Nakata (2004) states that “Indigenous knowledge is different things in different places to different people” (p.283). As such Nakata (2002) proposes that Indigenous Standpoint Theory helps to provide agency to people to “generate accounts of communities of Indigenous people in contested knowledge spaces…[and] acknowledges the everyday tensions, complexities and ambiguities as the very conditions that produce the possibilities in the spaces between Indigenous and non-Indigenous positions” (p.217).

According to Nakata (2007b), Indigenous Standpoint Theory can:

…help unravel and untangle ourselves from the conditions that delimit who, what or how we can or can’t be, to help see ourselves with some charge of the everyday, and to help understand our varied responses to the colonial world. (p.217)

While it is clear that Feminist Standpoint Theory influenced Nakata’s development of Indigenous Standpoint Theory, Moreton-Robinson (2013) states that this new theory is “gender

blind" (p.338) and in response developed a body of work resulting in Indigenous Women's Standpoint Theory.

Indigenous Women's Standpoint Theory

Moreton-Robinson's (2013) foundational work on the development of Indigenous Women's Standpoint Theory has influenced many scholars, for example Bond, Phillips and Osmond (2015); Ingram (2016); Milne, Creedy and West (2016) and Walker, Fredericks, Mills and Anderson (2014). It has given "… voice to indigenous women, challenging the dominance of 'whiteness' and exposing this as a position of power and privilege" (Milne et al., 2016, p.2). Moreton-Robinson (2013) argues that "…our experiences will differ because as Indigenous women our social location within hierarchical relations of ruling within our communities and Australian society also factors into our standpoint as researchers within the academy as does our different disciplinary training" (p.339).

I found Indigenous Women's Standpoint Theory useful, from the perspective of a Koori woman and a scholar and academic at a University founded on Western bodies of knowledge. As I work at that Cultural Interface I acknowledge being influenced by a number of ontologies, epistemologies and axiologies but having my Standpoint as that of a Koori woman.

Applying this theory I was able to acknowledge my Aboriginality, the lived experiences and connections I have with the world as I identify as a Koori woman, and my academic discipline collectively as my Standpoint. Moreton-Robinson (2014) suggests such a position should be embraced:

To recognise our disciplinary knowledges and academic training as part of our standpoint, which is either taken for granted within feminist standpoint theory or is unacknowledged within some Indigenous research methodologies, does not diminish our claims to an Indigenous women's or men's standpoint theory. It strengthens them. It is not a case of being either Indigenous or academic but of recognising the epistemological, ontological and axiological complexity of being an Indigenous researcher that is politically challenging, intellectually creative and rigorous. (p.339)

As a Koori woman I brought to this research my own ontology and was able to position that within a methodology that reflected my commitment to building relationships, my passion for inclusion and reciprocity; these are important ways of being that I embody as a Koori woman. Some of my ways of knowing have been informed by experiences and knowledges shared by and with other Indigenous women, for example I share with other Indigenous women ways of knowing about being a (Koori) mother or auntie but to those ways of knowing I add my personal epistemology as I live as a Koori woman, my way. Indigenous Women's Standpoint Theory, despite being critiqued for its Indigenous (women's) essentialism (Moreton-Robinson, 2004a), provided a theory that centrally positioned my own Aboriginal ontology, epistemology and axiology in my research and helped to determine my Indigenous research methodology. It encouraged me to develop an Indigenous method (PhotoYarning) and place it within the Western research academy.

3.2 Research Design

The Indigenous methodology I outlined above helped me to decide what to do in my research and how to do it. In this PhD research I used two methods to fulfil the logic of my Indigenous methodology, Yarning and PhotoYarning; the latter being developed within my PhD research as a new Indigenous method. Yarning "can be loosely defined as a form of First Peoples' cultural

conversation" (Bessarab & Ng'andu, 2010, p.37). It is an intentional action that is undertaken with a collaborative purpose that engages people in the sharing of information, in negotiation and exploration of understanding and meaning. PhotoYarning is a research method that has Aboriginal and Torres Strait Islander epistemology and ontology at its core. It employs Yarning about photographs taken by Team Members as its primary method. It respects and values a person's own knowledge and expertise and privileges their life experiences through a process that focuses on photographs they have taken to describe particular themes, events or phenomena. Both research methods aligned with my Indigenous methodology and allowed me to address the research questions using Indigenous methods. Section 3.2.5 provides further details about Yarning and PhotoYarning.

3.2.1 Privileging Indigenous ethical and cultural protocols

I approached this research at a starting point that engaged with paying attention and respect to Indigenous ethical and cultural protocols. I was reassured by Smith's (2014) statement about the way Western research ethical guidelines had been positively influenced by Indigenous methodologies: "one contribution of indigenous methodologies has been in the arena of ethics, with guidelines being produced in Australia, Canada and New Zealand in relation to health research" (p.19). These guidelines focus on and promote the privileging of Indigenous ethical and cultural protocols in the research process. These guidelines are now part of the Western research process and are the minimum standard required by any researcher in Australia, Canada and New Zealand who engages in 'Indigenous research' (Aboriginal Health & Medical Research Council of New South Wales [AH&MRC], 2016a; Canadian Institutes of Health

Research, 2007; Canadian Institutes of Health Research; Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada, 2010; National Health and Medical Research Council [NHMRC], 2003; 2006, 2007; Social Policy Evaluation and Research Committee, 2008; Social Policy Evaluation and Research Committee and Aotearoa New Zealand Evaluation Association, 2007). Many of these ethical protocols have informed Western research processes; for example, in “all these guidelines, emphasis is placed on respect and integrity, and with Indigenous people, reciprocity” (Putt, 2013, p.2). Another key feature of these guidelines is the focus placed on taking time to build respectful research relationships (Putt, 2013). Such ethical protocols were not a minimum requirement that my research needed to apply, they were firmly embedded in my research process from the start and throughout. My research strongly upheld what Putt (2013) refers to as ethical core concepts: “integrity, respect, reciprocity and mutual benefit” (p.9).

Privileging Indigenous ethical and cultural protocols over theoretical frameworks at the start of this doctoral research helped build my capacity as a researcher. Acknowledging that positioning allowed me to progress my research, find positive strength and build my research capacity. Throughout the thesis I provide examples of how I conducted my research in an ethical manner that engaged Aboriginal and Torres Strait Islanders ways of thinking, being, knowing and doing. For example, in this chapter I describe how Team Members were engaged throughout the research process, rather than being subjects of research. While the inclusion of Team Members throughout the research did present some initial challenges for the ethics committees, their role throughout remained pivotal and essential to ensure my own ethical and cultural engagement with research. The empirical chapters provide further examples of ethical practice

in my research, as they present data that I collaboratively collected and co-analysed with Team Members. The personal Yarns I share in Chapter 4 demonstrate examples of how my own research design and process was influenced by important life experiences and learnings from my Elders and from other significant people in my personal and professional life; I used those Yarns to further explain research processes and practices to Team Members, to my family and to community members when they asked me about my PhD. Using my own Yarns felt right; it was a gentle and ethical way to engage people with research and provided scope for us to further Yarn about the concepts introduced through the Yarns. Yarning allowed us all to engage in research from a position that had no hierarchy; creating that space was an example of enacting ethical, respectful research practice. Yarning also provided me with a mechanism to constantly check in with Team Members, family and community and the research I was doing; this community process supported me throughout as I used it to help me navigate challenges and make sure I was thinking, being, knowing and doing the right things. It provided a penultimate ethics 'committee'.

3.2.2 Ethics approval: University Human Research Ethics Committee (HREC)

This PhD research was undertaken in part time mode and was commenced at Macquarie University in Sydney, New South Wales, Australia and the later stages completed at The University of Sydney, Sydney, Australia. Data collection and analysis was largely completed by 2008 at which point I was forced to take a long suspension from study due to a chronic health issue that later re-emerged and forced me to again suspend my studies. From the time of commencement to the time of submission of this thesis my research maintained Australian

Aboriginal and Torres Strait Islander epistemologies at its core and remained guided by current versions of documents produced by the NHMRC on ethical guidelines for Aboriginal and Torres Strait Islander research, for example NHMRC (2003, 2006, 2007, 2010) and the AH&MRC Guidelines for Research into Aboriginal Health Key Principles (AH&MRC, 2016b). The research had two components: (1) the Yarning Study and (2) the PhotoYarning study. Both studies were granted ethical approval through the relevant University's Human Research Ethics Committee (HREC) in 2005 (the Yarning Study) and 2006 (the PhotoYarning study).

I faced a number of challenges as I sought HREC approval, including the committee's concerns over how I proposed to (conversationally) Yarn with potential Team Members to explain the research so that they could choose to opt in (or not). I argued that this was respectful practice and also followed existing Western academic protocols of providing contact details for interested parties to use to seek further information; I was calling this process Yarning. Another concern was over my proposal that Team Members could opt for anonymity or not, respecting that they might be sharing cultural information that they wished to be aligned and connected with at a personal (not de-identified) level.

The use of photographs taken by Team Members was also a concern, with members of the HREC worried about protecting anonymity of other people and workplaces. The HREC approval process was neither smooth nor short but it provided me with rich lessons. I reflected on the process and recorded those reflections in my research journal. I have included a summary of some of those reflections in the article accepted for publication in *The Qualitative Report* (Appendix C).

3.2.3 Recruitment

Given my research sought to examine Aboriginal and Torres Strait Islander health professionals experiences (what it was like to work and live in their own community), I sought a purposive (Palinkas et al., 2015) sample. I knew my initial data collection method, Yarning, would generate a large amount of in-depth data through extended and sometimes repeated Yarning sessions. I responded to both the emerging Yarning data and the Team Members to design a subsequent data collection method, PhotoYarning, that generated further in-depth data.

My sample should be thought of as the data sample rather than the number of participants. The data corpus that I generated is rich, diverse and extensive. My responsive and relational approach to data collection (funding my travel to meet each Team Member, funding the travel of Team Members for group co-analysis sessions, sustaining contact over several years) mean I would have been unable to include significantly larger numbers even if I had wanted to. Funding, participant interest and available and PhD timelines are all real and material constraints that shaped the research process and outcomes.

Team Members were recruited via a call for expressions of interest, using participant information sheets and an expression of interest notice approved by the HREC. These were distributed throughout my existing Aboriginal and Torres Strait Islander networks in government, non-government and community-controlled health services that employed Aboriginal and Torres Strait Islander people; the research was largely welcomed and supported by health services. The expression of interest recruitment criteria required an interested person to identify as Aboriginal and Torres Strait Islander, be employed in a health-related role, be

interested in engaging in research about working in Aboriginal and Torres Strait Islander health and be available to engage, periodically, over 6-12 months.

I had phone calls from 32 people who expressed interest in participating. During these initial phone calls we spoke about the research, the time frames, the reasons why I was engaging in this research and why each caller was interested enough to make the first call. Each person had time to then reflect on the conversation, look over the Participant Information Sheet and Consent Form and then decide to opt in or not. Fifteen people opted in to the research out of the original 32 phone calls. Not being able to spend enough time participating was the reason most people cited as preventing them from opting in. Most Team Members who were recruited for the Yarning study also participated in the PhotoYarning study.

3.2.4 Team Members/ Participants

Yarning with Team Members about ethical guidelines and the research

At first I Yarned in an informal way with prospective Team Members; this was conversational Yarning not data collection Yarning. The first time I Yarned with each Team Member I fully explained the research and that ultimately I would be submitting a PhD that included the data. I also explained that I might later publish in academic journals and could present at conferences. I stressed that I would always acknowledge Team Members in any of these activities, and express appropriate respect, thanks and acknowledgement. I gave each Team Member as much time as they needed to ask any questions about the research.

As we Yarned, I explained that the research was not intended to do any harm and would be a safe experience and outlined the concept of anonymity and how a Team Member could choose to remain identified to any specific cultural knowledge they shared if that was important to them. I explained that they could withdraw from the process at any time at all, without any questions or troubles. It was important for me to highlight that the later (data collection) Yarning sessions would be recorded, with their permission, to help me transcribe later. I told potential Team Members that they would be given a copy of the transcript of each Yarn and explained that they could edit out any information that they did not want to be part of the data.

Potential Team Members seemed reassured when I outlined steps for ensuring data security. After we reached the end of questions, I explained how I would then send them a consent form to consider and that we could Yarn about the form before they decided to opt in, should that be their decision. I did not place time pressure on this. Again, I waited until each potential Team Member had received the consent form and then we again Yarned on the phone; I talked about the form and the ethical requirements and they freely asked questions. After this Yarn, potential Team Members were left to sign the form and return it to me, or to opt out. On the receipt of each consent form I contacted the Team Member and began making plans for further Yarning (data collection).

Later, when repeating this process for the PhotoYarning study I also explained the ethical requirements of ensuring no person or workplace could be identified in any photograph taken. I also highlighted that I would provide some training on how to use the information sheets and

photographic consent forms with any person who might appear in the photograph (even anonymously). I explained that the photographs, while used as data in the PhD, would remain the property of the Team Member and anyone who featured in the photographs.

It is important to note that Yarning was used between potential Team Members and me as conversations about the research process and about whether or not they chose to take part. These early Yarns were not data and were not recorded but were critical in building relationships, trust and respectful research processes. Later in the study Yarning was used as an activity to generate data. The time taken to Yarn through the ethical guidelines, forms, processes and requirements was essential. It gave me time to start building up a relationship of trust with each Team Member. It established a rapport that was essential to further Yarning. It connected us in the research process.

The Team Members

I was honoured to have fifteen Aboriginal and Torres Strait Islander health workers volunteer to work with me on my PhD studies. All worked in health services that provided health care to Aboriginal and Torres Strait Islander clients. Five worked in Aboriginal Community-Controlled Health Services, six worked in public (government-managed) health services and four worked in non-government health settings. Nine Team Members identified as female and six as male, with ages ranging from 24 to 52 years of age. The average number of years Team Members had worked in Aboriginal and Torres Strait Islander health was 13, with the longest term of employ being 30 years and the shortest, four years. All of the Team Members had a health-related qualification that was relevant to their current position. The highest level of qualification gained

by three Team Members was a postgraduate qualification; four held an undergraduate qualification, five held associate diplomas or diplomas and three had obtained Certificate IV level qualifications[15]. Team Members held a range of professional titles including Aboriginal health officer, Aboriginal and Torres Strait Islander health assistant, alcohol and other drug worker, health promotion officer, health education officer, nurse, nursing assistant, infant and maternal health worker, Aboriginal health worker. Specific information about each Team Member is included in Appendix A.

Building relationships with Team Members within the research: reciprocity

When I started this PhD it was clear to me that I would work within an Indigenous methodological space and a major part of that would be the importance I placed on the relationships within the research. As the research began, Team Members and I formed important connections, built relationships and shared Yarns that eventually became woven together to create the bigger Yarn that is represented by this PhD.

Even though I was undertaking the research as part of a PhD, I viewed parts of the research as a team effort and never positioned the Team Members as merely 'participants' in the research; I believed they held a far more pivotal and embedded role. The embedded role of the Team Members was an important part of my methodology and is described in more detail later in this chapter. Interestingly, early in the process, Team Members started to use the phrase 'Team Member' to refer to each other. Immediately I believed this was a culturally appropriate way to

[15] The qualifications are categorised according to the Australian Qualifications Framework (AQF), (2011).

refer to the people who not only Yarned with me in the data collection phase, but also played a role in shared data analysis (described in more detail later in this chapter).

Each Team Member had their own reason for wanting to be involved. One Team Member openly announced she wanted to be involved to try and sort out why she was finding work so hard. She loved her work but found it difficult, draining. She said if she could be involved in this project and get a space to look at that, then she'd be happy. I agreed and said it could clearly work for both of us – and that is exactly how I wanted it to be. Some wanted to learn more about doing research, some wanted a chance to talk to someone (external) about their working lives and some just wanted to be a part of research conducted with a Koori researcher. We all thought of these things as potential gifts that we could take away from the process. As such, Team Members identified practical ways they could directly benefit from participating in the research and we worked together on a series of activities that met those needs. We worked with reciprocity; Team Members shared Yarns and PhotoYarns with me and I worked with them on tasks they identified as important to their professional development. I provided feedback on a program evaluation framework, helped update a professional resume, and worked with one Team Member to develop an article for the local health service newsletter, profiling the work he and his team did. Another Team Member asked me to help her frame some of the photographs she had taken for this research so she could display them on walls around her workplace. Happily, Team Members and I found ways to mutually benefit from engaging in this research together. However, perhaps the most rewarding thing to witness was a shared passion for the research process itself. All Team Members were curious and wanted to develop research skills of their own; they were eager to participate in more ways than simply offering

data, something most of them had done for other researchers. This deep level of engagement provided scope for me to approach this research with an openness and responsiveness that allowed me to innovate; for the Team Members' passion and support of innovation I am eternally grateful.

My research travels took me to urban health centres, regional medical services, rural community centres and remote clinics. Establishing connections before my first visit was essential, and much time was spent on the phone talking about good times to visit ("The road isn't flooded then") and asking for tips on travel and a place to stay. Team Members got to know me as a Koori woman, a Koori who had worked in health, a Koori PhD researcher, a mother of four, an auntie, sister, niece, community member, daughter, friend, partner, wife, cousin. I was many things to the Team Members, as they were to me. And all of those parts of me were equally driven and engaged in my research with them.

I experienced a deep sense of awe each time I sat with Team Members. The depth of knowledge, skill, culture and wisdom that they shared was more than I had imagined possible for a PhD research project. I was struck by the dedication each had to improve the health and wellbeing of our people, and they enacted this dedication through the passion, thought, consideration, effort and energy they put into their work. This unique, passionate group of people shared their Yarns and PhotoYarns freely with me despite the fact that each one was already committed to heavy work schedules and workloads and honoured multiple personal, family and community responsibilities. I hope my research pays respect to, and privileges the voices of the Team Members, and honours their professional journeys.

Guided by listening: Developing a research question and method

The Indigenous research methodology I used for this study privileged Aboriginal and Torres Strait Islander epistemology and ontology and involved Team Members in a range of ways across the research in similar but not identical ways as those defined by community based participatory research (CBPR). CBPR has, at its roots, involvement of stakeholders in all stages of the research process (Israel, Schulz, Parker, & Becker, 1998). I developed the original research question after listening (for many years) to stories told to me from Aboriginal and Torres Strait Islander colleagues and students who were working in the health system. I thus consider the research question to be very much influenced by those shared stories. While I designed the overall research methodology I was also guided by suggestions from Team Members throughout the research process. Finally, data generation was a collaborative process as was the co-analysis (discussed below). Team Members Yarned about issues raised in each other's transcripts, asked questions about those comments and PhotoYarned about each other's photographs. This was helpful to the research process in a number of ways. Firstly, this approach utilised the culturally familiar process of Yarning as a research method as it drew on the traditions of oral storytelling and sharing of information; it also subsequently encouraged deep engagement from all Team Members. And secondly, it provided scope for Team Members to question, probe and critique each other's initial transcribed comments and photographs and this provided thick and rich data.

3.2.5 Methods

Yarning as a method

Yarning has been used as a method in mental health and wellbeing research (Nagel, Hinton, & Griffin, 2012), in a study on women's wellness (Walker et al., 2014) and in research by Jennings, Spurling, and Askew (2014) on health checks. Leeson et al. (2016) used Yarning in their research with incarcerated women in prisons across the Northern Territory and Western Australia, stating that it "was a way of ensuring cultural safety, respect and the utilisation of First Peoples ontology to research conducted with Aboriginal and Torres Strait Islander women" (p.1).

Yarning should not be regarded simply as a process that adopts "an informal cultural exchange rather than [undertaking] formal interviews" (Power, 2004, p.38). Regarding it as informal "undermines its strength and appropriateness… [and] detracts from the *intentional* purpose and negotiation that is an intrinsic part of Yarning and which is vital to research development, application and analysis" (Dean, 2010. pp.7-8).

Yarning, when used to collect data, privileges an Indigenous research space. It provides scope for reciprocity between the researcher and Team Members during the research process; it allows for the mutual sharing of knowledge with the intention of developing a shared understanding of the content of the Yarn. Leeson, Smith & Rynne (2016) state that "The utilisation of 'Yarning' as a data collection tool constitutes a means through which Aboriginal and Torres Strait Islander ontology, epistemology and axiology can be prioritised in the completion of research" (p.7). I approached my PhD with the aim of using Yarning as my

dominant research method. I wanted my research design to honour an Indigenous methodology through which the voices of my Team Members could be privileged.

Developing PhotoYarning as a method

During the Yarning Study Team Members would often draw diagrams to help explain a concept or idea they were Yarning about. At other times Team Members suggested that a visual prompt might enrich their Yarning, saying things like “If I only had a picture to show you, then you would know what I mean” (Tia, Team Member). I took notice of these comments as they grew in number and realised that there was an opportunity to explore a new way of gathering data, one that involved Yarning but also included a visual component. I also noticed that several Team Members asked me questions about other Team Member’s experiences and Yarns saying things like “I bet there’s at least one other Team Member who also has done this” or “I’d love to know how the others [Team Members] deal with this- I bet it might be the same”. The Team Members were expressing a curiosity that could also be engaged through small group process, bringing them together. As a result I developed and used PhotoYarning as my second method for this research. I Yarned with Team Members individually in the Yarning study and in the PhotoYarning study but in the latter also introduced conducting PhotoYarning in small groups.

I was aware of Photovoice (Wang, 2003, 2006; Wang & Burris, 1997) as a visual method in qualitative research. Typically, Photovoice methodology enlists a group of individuals to take photographs to represent community concerns that they want to explore and raise awareness about in the minds of policy makers. These photographs are then discussed in group settings to promote critical dialogue and produce shared knowledge that is communicated through

captions assigned to each the photographs (Maratos, Huynh, Tan, Lui, & Jarus, 2016; Seitz & Strack, 2016; Teti, Conserve, Zhang, & Gerkovich, 2016). The outcome of the Photovoice process is often a Photovoice exhibition aimed to increase awareness of the chosen issue and ultimately influence change (Adekeye, Kimbrough, Obafemi & Strack, 2014; LaPorte, Haber, Jackson-Diop & Holt, 2014). Group process is an important part of Photovoice, with group members sharing discussion about the photographs, producing the desired captions for each photograph (so that the story of the photograph can be told) and deciding which photographs should form their Photovoice exhibition. Photovoice groups often aim to achieve some change by inviting others to view the Photovoice exhibition and gain greater awareness of their chosen concerns, for example (Huang et al., 2016; Payne et al., 2016).

Photovoice allows participants to share personal knowledge of their individual experience of what might otherwise be an abstract concept. For example, Andonian (2010) asked participants with mental health challenges to explore the concept of community participation within an urban context. Participants took photographs on the concept of community participation and then described what each of their photographs meant to the rest of the group. This process situates the knowledge of community participation within the lived experiences of each participant, moving the exploration of the community participation away from the abstract towards something understood through personal lived experiences. Bryce (2013) states that Photovoice uses images "…to produce a rich, culturally relevant source of data, which grounds the research in a personal context, and situates it in the individual's experience" (p.35). Writing a narrative caption to accompany each photograph allows the image to communicate a

message that describes the experience and knowledge of the person who took the image, rather than being interpreted by the viewer of the image itself.

I did not feel that the Photovoice model would exactly fit in this research as it did not include an iterative process similar to what Castleden and Garvin (2008) described as "feedback loop" (p.1401) that was used in the Huu-ay-aht Photovoice project. The "feedback loop" was a modification to Wang's (2003, 2006) description of Photovoice as an effort to make the Photovoice process more culturally appropriate by "seeking input from the entire community at regular intervals throughout the project" (Castleden & Garvin, 2008, p.1401). This modification of Photovoice inspired me to develop the method of PhotoYarning to better suit the existing research process. Like Photovoice (Wang, 2003, 2006; Wang & Burris, 1997), PhotoYarning asks participants to produce documentary-type photographs about a particular concept; however, unlike Photovoice it uses the process of Yarning to share descriptions and stories about those photographs. As previously described, the process of Yarning often includes periods of conversation about issues not directly related to the photograph allowing important time for taking time to build and maintain the relationships between actual data generation. While PhotoYarning shares some of the foundational features of Photovoice, it differs in that it adopts the Yarning process in the exchange of knowledge and understanding of images and involves co-analysis of data. The process of Yarning as a research method provided a perfect opportunity for co-analysis as it contributed to the continual and important relationship building, we were undertaking throughout the research and "enriched… and enhanced the transparency and accountability of our research approach" (Schaal et al., 2016, p.9). Co-analysis helped to ensure that the diversity of Team Members' voices was acknowledged as it deepened our collective process of

identifying codes, clustering data and identifying themes. A more detailed description of the co-analysis process is in section 3.4.2.

3.3 Data generation

The primary data sources in this study are the Yarning and PhotoYarning sessions between Team Members and me. These two sources were used in the analysis and are presented in the empirical chapters of this thesis, Chapters 5 to 8. I used two additional data sources, generated by me; my own Yarns (written in narrative form) and a reflective research journal that I maintained throughout the research. I shared the Yarns with Team Members throughout the research process, mostly during Yarning or PhotoYarning sessions, as a way of building reciprocity and research relationships. My Yarns were also regularly shared with family and community members as a way of keeping them connected to what I was doing and as a way of opening up a research process to them to encourage reciprocal learning. I have included some of this secondary data, my personal written versions of Yarns, in Chapter 4; I have also included my paper, published in *The Qualitative Report* (Appendix C), advocating the use of reflective journals in research. I have done this to contribute to the overall Indigenous methodological approach taken in this research.

3.3.1 The Yarning and PhotoYarning studies

The process of Yarning

Working at the Cultural Interface required me to develop a set of twenty-two 'interview questions' that I called Yarning questions so the ethics committee would approve the 'semi-structured interview approach' (that I was calling Yarning). These Yarning questions (see

Appendix B) did provide a starting point for the initial Yarn; they included questions about a Team Member's current role and the work they did. After the initial questions were Yarned about the Team Member then elected what to include in further Yarning, with the intention of the Yarning being focused on their experiences at work.

Geia, Hayes, and Usher (2013) describe Yarning as "a movement of living language" (p.15) and highlight the diverse nature of Yarning, saying that "It [Yarning] ranges from the informal brief conversations or that 'knowing' look that elicits an emotional response, to the more formal ways of storytelling that have prescribed outcomes attached to it" (p.15). In this study Team Members and I Yarned across that spectrum. The initial phone Yarns were not data; they were conversations about the research process and about potential participation; they were both 'brief' (by my Koori standards of Yarning time) and quite informal, but they still had a purpose as they were an important part of the relationship building phase, sometimes known as the recruitment phase. The later Yarning used to generate data included knowing glances and were more formally focused on the Team Member's work experiences; all of these were done with purpose.

All of the Team Members and I identify as Aboriginal and Torres Strait Islander and all have Yarning as a central part of our lives and our life learning processes. Yarning was familiar to us all as we Yarn with people every day, and through this Yarning we make sense of our worlds and our lived experiences. As such, the Yarning sessions flowed with ease and were non-linear and highly interactive. At times we moved from quiet words to raucous levels of laughter interspersed with words. And there was an inevitable natural fluidity as Yarns were paused by

equally important but competing interests. Pausing so a Team Member could work with a drop-in client, pausing to help make afternoon tea for the Team Member's children (and their friends) as they arrived home after school, pausing to help bottle feed a bub[16] while Team Member mum attended to other family needs – all of these pauses (and so many others) were a welcomed part of the Yarning. Despite creating pauses in the Yarning process they acted as threads that held the other parts of the Yarn together. They also bonded us in the research process and in our developing relationship. In true Yarning form, threads of conversations were easily picked up (after the bub was fed or the client had moved on); the storyline was continued, often reinforced as it was picked up again, almost strengthened by the pause. This was our ontology. The data represented in the empirical chapters below has been somewhat 'cleaned' with many of the above-mentioned events and actions not included in the quotes. As such, the quotes might read as being far more concise then the original transcript. Importantly the data was not changed, rather, the environmental elements that accompanied the Yarning (data collection) have been omitted.

Despite having the Yarning questions that aimed to focus the Yarn on the lived experiences of the working life of the Team Member, it was natural to also hear about others during the Yarning- clients, colleagues, managers, partners, children. All of these significant others found a natural place in the Yarn. I expected this, as Yarning is rarely individualistic, with most Aboriginal and Torres Strait Islander people sharing their lived experiences with others. Thus it

[16] A bub is a colloquial term for a baby.

was natural for them to describe their own lived experiences as being inclusive of those important other people.

I visited each Team Member in their home/work community at a time that was convenient to them. All Yarns were held in spaces that the Team Member chose for their convenience or their familiarity. Most Yarning spaces were in Team Member's homes, public places (parks, community centres, cafes) with only two of the fifteen choosing to Yarn with me in their workplaces. The Yarning sessions were about the Team Member's experiences of working in the Aboriginal and Torres Strait Islander health space as an Aboriginal and Torres Strait Islander person and as such the Team Members mostly opted to Yarn away from their work settings.

The workplace-located Yarning, done with two Team Members, was done around existing work responsibilities; for example, one Team Member was on-call for drop-in clients so our Yarning stopped when a client arrived and resumed when they left. This was in no way problematic, as it reflected the true nature of how Yarning occurs in a community context – an ongoing narrative exchange that often picks up where it left off, whenever required. While this particular Team Member was working with the drop-in client I was invited to either have a cup of tea in the common room or "hang out" in the community room that provided a range of social and leisure activities for the community members that used the centre. I opted for both and enjoyed a cup of tea and a Yarn with a group of women who were doing some beadwork to sell at the local markets. This was a great opportunity for me to get to know a little more about the workplace and the community that the Team Member lived and worked in. The beading women were really keen to hear more about my family and about my own community, and

about local markets in my home area. I was not Yarning with them about the research, or in the role of researcher, I was a Koori woman Yarning in community with other women.

The research Yarns were recorded on a digital recorder, data were transcribed by me and scripts sent back to participants so they could check the accuracy of any facts and have an opportunity to delete any shared information that they had decided should not form part of the study. There were times when people, who had not consented to be in the research, entered the research space being used for Yarning and their voices were captured on the audio recording. When possible the recording was stopped while those visitors spoke. When it was not possible to stop the recording prior to a visitor speaking, I described the research and gave a reassurance that their voice would not transcribed. This protocol was followed at all times. Only four of the fifteen Yarning sessions were considered 'complete' at the end of the first session (the first allocated two hour period). I made an initial suggestion that the Yarning had come to a closure point, and if the Team Member agreed then the Yarning stopped. If the Team Member had anything else to contribute the Yarning would continue until a similar end point was acknowledged by both the Team Member and by me. The four that had reached a point of completion had come to a natural pause that indicated to me and to the Team Member that the Yarn was done. However, all four requested that we 'keep in touch', an important invitation that means the Yarning-connection stay open, to be picked up again later. Subsequent to this research, I remain in touch with all of these four Team Members. This reflects a respectful, reciprocal engagement that we established through the research process. There have been many times when Team Members phoned me to Yarn about other things, for example job

progression opportunities, family business, work ideas, Sorry Business/ Sad News[17]. While these 'topics' did not inform the study results (they were not recorded nor used as data) they remain an important part of the methodology- the commitment to a respectful, reciprocal connection through Yarning. This ongoing connection between me as a researcher and Team Members sits outside what Western research protocols would deem normal, or even acceptable. However, it sits very well inside my ontology.

Eleven Team Members engaged with me in more than one Yarning session. For some this took the form of a follow up phone call, picking up the thread of the original Yarn but introducing something new or reinforcing something already shared. A number of other Team Members asked if I could return, during that same visit either later the same day or a day or two later. I had always planned to spend several days (or as long as I could) in each Team Member's location, even though we might had only officially planned one two hour Yarning session. Allowing adequate time is paramount and respectful practice.

On several occasions I returned for a second or third Yarn with the same Team Member, Yarning each time with a different timeframe but always with the purpose of reinforcing, questioning, confirming or adding to the first Yarn that focused on their working lives. When it was not physically possible (for my own family or work reasons) or financially possible (I had very little financial support for my PhD and funded trips myself or took time away from work as leave without pay) to return to the Team Member's community after the first Yarning session

[17] Sorry Business is Aboriginal term that if often used when referring to the passing of a person. Sad News is a Torres Strait Islander term that is often used when referring to the passing of a person.

we opted to Yarn over the phone. These phone Yarns were always shorter and clearly devoid of important physical and non-verbal cues that we shared when we were in the same physical space. However, they served us both well given we had already engaged in the first Yarning session and had set good connections from which to build during the phone calls.

Another challenge with phone Yarning was the voice recording of the Yarn. Sometimes Team Members phoned impromptu and I was not prepared to record the call, so I needed to rely on taking down dot points as a summary, to which I added detail later as I reflected on the Yarn. Only five of the subsequent phone Yarns were voice recorded; my analysis used both verbatim transcriptions of the recordings and the reflective field notes I entered into my research journal.

The PhotoYarning study: the process

The second round of data collection engaged the process of PhotoYarning. This study occurred after the Yarning Study had been completed. All Team Members were invited to participate in the PhotoYarning study with twelve of the fifteen opting to do so; three were not able to participate due to work commitments. This data collection occurred prior to the digital camera and smart phone revolution and as such relied upon film cameras. I gave the twelve participating Team Members disposable cameras (or film for those who wanted to use their own camera) and asked them to take photographs that represented themselves at work and elements of their experiences at work. Following the approved protocol, Team Members posted their films to me and I had the photographs developed; I subsequently converted them to digital format. I provided each Team Member with a complete set of the images they had

taken and I retained one copy. These photographs formed the basis of PhotoYarning sessions, held between Team Members and me. With consent, I recorded and transcribed the PhotoYarning sessions. The PhotoYarning provided scope for deeper engagement as Team Members often built upon relational production of knowledge raised by the Yarning Study but this time Team Members used their photographs to make those deeper connections. Team Members typically began with an explanation of the image and how it related to their work or their experience of working as an Aboriginal and Torres Strait Islander person working in the health sector. I audio recorded and transcribed each individual PhotoYarning session. Each of the twelve Team Members participating in the PhotoYarning study checked their transcript to allow for editing out of any sensitive knowledge they did not want in a public domain. Only one Team Member asked for one part of their PhotoYarn to be edited out of a transcript; I followed that request.

The PhotoYarning study followed a different process to the Yarning study as it eventually extended beyond individual Yarning between me and the Team Member to also include small group PhotoYarning. For the second stage of the PhotoYarning study, I formed Team Members into three groups each comprising four Team Members, each group had one PhotoYarning session. I allocated Team Members to groups on the basis of geographical convenience, as the group PhotoYarning sessions were held in three separate geographical locations. In two of the small groups there were Team Members who were unable to travel and thus joined the small group PhotoYarning session by teleconference.

The Team Members in each small group agreed to share their own PhotoYarning transcript and the photographs they had taken with the other three members of their group. The original Yarning transcripts were not used in PhotoYarning as this process focused on the use of the images. As such, each Team Member received the individual transcripts from their three other small group members, in addition to their own. I asked Team Members read through the transcripts and looked over the photographs prior to coming together in the small PhotoYarning groups.

In addition to sharing transcripts and photographs between members of each small group I also spoke to Team Members on the telephone, describing what we aimed to achieve through the small group PhotoYarning sessions, making suggestions to them about how they might best prepare for the small group work. During the phone calls I shared comments that many individual Team Members had made as they expressed curiosity about each other's experiences and explained that it was their curiosity and interest in establishing common ground (or not) that inspired me to use small groups in PhotoYarning. I also explained that I felt an intense personal desire to bring individuals together to share the research experience in an even more collaborative way; by this stage of the research I felt like we were missing a sense of working as a group, despite the fact that the whole process was highly collaborative. This pre- group process gave me a valuable opportunity to continue to build trusting relationships with Team Members, particularly as they freely spoke about their anticipation, nerves or excitement about the forthcoming group sessions. The telephone calls also helped me to build Team Members' research capacity; by explaining the stages involved in data collection and analysis and by encouraging Team Members to critically reflect and prepare to PhotoYarn, I was able to

contribute to further building their research skills and knowledge and honour the time they were giving to this project. That was of particular importance to me as I felt a responsibility to uphold respectful reciprocity throughout the whole research process. The time commitment being made by each Team Member was enormous and was an indication of their interest in the research itself.

During the small group PhotoYarning sessions Team Members reflected on each other's photographs and transcripts. This was the first time Team Members had met each other in person and as such it was very important that I allowed time for Team Members to get to know each other. Team Members had already "met" each other as they read the shared transcripts and looked over the shared photographs, but they had not met the people belonging to the experiences reflected through the photos and transcripts. Ample time needed to be given to this process as this relationship building was vital to trust building. Establishing relationship this way also allowed for the enactment of reciprocity through the willingness to share the photographs and the individual PhotoYarning transcripts.

The photographs proved to be particularly important at this stage. Team Members would often make comments like "that photo says it all" or "I was finding it hard to say this, but looking at this photo I can now say…" The photographs provided a visual prompt that supported Team Members to PhotoYarn about things that they might have found difficult to do with words alone. Additionally, some Team Members made comments that acted as a catalyst, supporting other Team Members to participate in the PhotoYarn.

The small group PhotoYarning sessions moved from generating data from PhotoYarning about the photographs and related transcripts to engaging in co-analysis (described in detail below).

3.4 Analysis

I employed two data analysis processes in this research, solo-analysis (done by me) and co-analysis (done together with the Team Members). In both processes, thematic analysis was used to identify, organise, analyse, describe, and report themes found in the data (Braun & Clarke, 2006).

3.4.1 Solo-analysis of the Yarning study and the PhotoYarning study

I followed Braun and Clarke's (2006) six phases of thematic analysis to do the solo-analysis of original Yarning and PhotoYarning data. My solo-analysis for each study started with a reading of all transcripts prior to doing any coding. I believed that this would help me to identify possible patterns as I engaged with the entire data (Braun & Clarke, 2006). During this initial read-through I made notes, reflecting my thoughts for possible future coding. As I engaged deeply with the data I also captured my ideas in my research journal; this helped me to develop a sense of the stories the data told and how the data related (or not) to each other. I then re-read each transcript and established codes for responses in the data. I numbered each code and then grouped them into themes and sub-themes. I chose to do this process manually despite it requiring extensive amounts of time; I believed that my method of analysis would best engage me with the data. I read each transcript twice, established initial codes, themes and the sub-themes on the first reading and refined the codes, themes and sub-themes on the second reading. I used colour-coding to help me mark themes and sub-themes in the data;

colour coding also allowed me to identify quotes from the data that aligned with one (or more) themes and sub-themes.

I used the same process of solo-analysis with the data generated during the small group PhotoYarning sessions. I also used group co-analysis (described below) and followed that group co-analysis with additional solo-analysis where I built on analysis work done in the small groups.

3.4.2 Small Group Co-Analysis

As I conducted solo-analysis of the Yarning study I became aware of the enormous potential to further engage Team Members as co-analysts. I found myself thinking about what other Team Members might have said about each other's transcripts and questioned why I had not considered using co-analysis as part of the Yarning study. On reflection I knew I had missed an opportunity to engage with Team Members as co-analysts during the Yarning study and subsequently built co-analysis in to the second study, PhotoYarning. In summary, the Yarning study was analysed only using solo-analysis, however the PhotoYarning study was analysed using both solo-analysis and co-analysis. The experience of using co-analysis in the PhotoYarning study has since compelled me to include as much shared analysis as possible in my future research.

The process of Yarning as a research method provided a perfect opportunity for co-analysis as it contributed to the continual and important relationship building we were undertaking throughout the research and "enriched… and enhanced the transparency and accountability of our research approach" (Schaal et al., 2016, p.9). Co-analysis helped to ensure that the diversity of Team Members' voices was acknowledged as it deepened our collective process of

identifying codes, clustering data and identifying themes. The co-analysis I used in this research aligns with the philosophy and values underpinning my Indigenous methods of Yarning and PhotoYarning. Co-analysis also abandons "the analyst's usual assumption of interpretative privilege" whilst "digging more deeply into their [in this case, my Team Members] interpretive capacities and your own" (Mulkay, 1985, p.76). Importantly, unlike Mulkay, I was asking Team Members to engage with a data set, not just with their own data, and as such continued to collaborate with me as co-researchers (Team Members).

I managed the transition from data generation to data analysis by drawing on Yarning methods that sought to identify when the natural flow of a Yarn ceased. When I noticed that the group had stopped PhotoYarning I asked if the group had anything else to add and if there was nothing more to add then I made the suggestion that we had completed the data generation stage and were ready to move to co-analysis. The small group PhotoYarning sessions took place over a whole day; I had planned an important meal break to support this transition. While one small group PhotoYarned and reached the completion of data generation before midday (allowing for an appropriate lunch break) the remaining groups continued to PhotoYarn for some additional time. I did not want to break the momentum of the PhotoYarning and just served lunch while we completed the data generation stage. When we had reached the completion point of data generation we had another short break prior to moving on start the co-analysis.

I voice recorded these sessions and later fully transcribed the recordings to assist me as I completed the analysis (solo-analysis), building on the work done through small group co-analysis, to write up the findings.

The analysis processes followed Braun and Clarke's (2006) six phases of thematic analysis, with me following the six phases of thematic analysis alone for the Yarning study. The method of co-analysis used in the PhotoYarning study was different, in that Team Members were co-analysing data that were theirs, sharing data (and analysis) with each other; however the co-analysis used in the PhotoYarning study but still followed Braun and Clarke's model. Following is a description of how we undertook co-analysis in the PhotoYarning study. The same process was used in all three small groups.

In Phase one (Braun & Clarke, 2006) we (Team Members and I) became as familiar with the data as possible by transcribing verbal data and reading and re reading it, "taking notes or marking ideas for coding that you will then go back to in subsequent phases" (p.17). I asked Team Members to read and review transcripts and photographs prior to coming to the small group sessions. I encouraged Team Members to make notes as they read and most Team Members arrived at the small group sessions with quotations from the data marked or highlighted, or with a list of questions or points they wanted to PhotoYarn about. We used this preparation initially as part of further data generation (as previously described). I was responsible for capturing the discussions on a whiteboard, in addition to voice recording for later reference. I drew maps on the whiteboard to attempt to capture the main points raised by Team Members, who actively kept my mapping in check, often suggesting I should use a

different word or phrase, or group certain ideas together. This was a visual process resulted in establishing a thematic concept map that assisted us all to collate our initial reflections.

Phase two involved us generating initial codes from the data, identifying “interesting aspects in the data items that may form the basis of repeated patterns (themes) across the data set” (Braun & Clarke, 2006, p.18). Our visual mapping helped us to do this but I also provided a summary of what this step might hope to achieve, describing the importance of being able to develop codes from the data to further assist our analysis. I remained the scribe but was very much guided by group processes that were highly interactive with Team Members critically reflecting on each other’s data coding.

In phase three we sorted codes into potential themes, to “consider how different codes may combine to form an overarching theme” (Braun & Clarke, 2006, p.19). At this point we identified themes and sub themes and selected quotes and photographs that had been coded and connected to those themes and sub themes. Together we identified the following main themes and the sub themes that also were in the related data:

a) Working with relationships in Aboriginal and Torres Strait Islander health

b) Working and living in the same community as an Aboriginal and Torres Strait Islander health professional

c) Using places and spaces in Aboriginal and Torres Strait Islander heath service delivery

d) Lateral Violence in Aboriginal and Torres Strait Islander health.

Those four major themes form the four empirical chapters of this thesis. We then reviewed the themes, developing a thematic map (phase four), that captured relationships between the different themes and provided "the overall story" (Braun & Clarke, 2006, p.21) the themes told about the data.

This process was lengthy; we were all very aware that some Team Members placed greater value or importance on some codes, while others saw more relevance in other codes. We Yarned extensively about each code, debating which codes should be counted as a theme and further analysed and which could be left behind. Each of the three groups eventually arrived at a decision about what topics should be considered as themes, with each group identifying a minimum of four themes. Lateral violence in the workplace, challenges working and living in the same community, lack of professional development opportunities, inequity over professional and clinical supervision, working in outdoor spaces and working with clients differently to other colleagues were some of the major themes identified through the small group co-analysis.

3.4.3 Integrating the analyses

Armed with themes chosen by each group I moved on to compare the nominated themes and I then selected those themes that had been identified by (a) all three groups and (b) more than one group. I proposed to Team Members that the themes selected using this method would then be placed together with the themes I had identified when I did the solo-analysis of the Yarns. I invited open conversation and evaluation of this proposal, highlighting to the Team Members that I would uphold my responsibility to the University to write up my research and would uphold my responsibility to them to privilege their experiences and voice throughout.

Team Members and I agreed that I needed to take the co-analysis, together with my individual analysis, and move to the next stage of my research, determining which themes would be included in the further detailed thematic analysis that I would later undertake and later write up in empirical chapters.

Research methods that engage participants in all stages of research have been acknowledged to be culturally acceptable in an Indigenous health context (Mooney-Somers & Maher, 2009; Erick, Mooney-Somers, Akee & Maher, 2008; Mooney-Somers, Erick, Scott, Akee, Maher & Olesen, 2009; Snijder, Shakeshaft, Wagemakers, Stephens & Calabria, 2015). The group process itself was not unfamiliar for all Aboriginal and Torres Strait Islander Team Members and for me; we all were very familiar with family or community-based discussions and debates about issues that required some level of agreement or consensus, often requiring long periods of Yarning time. The process used to identify themes mirrored our cultural ways of working, thinking, deciding. The detailed analysis (which was not a group activity) of those themes is presented in the empirical chapters in this thesis.

Following phases five and six (Braun & Clarke, 2006) I then undertook further in-depth analysis of each theme using the complete data set, refined “the overall story the analysis tells” (Braun & Clarke, 2006, p.87) and used extracts from the Yarning and PhotoYarning sessions to illustrate each theme within the empirical chapters of this thesis.

At this point I had taken back the final interpretive privilege; I found before me two sets of data, one from the Yarning Study and one from the PhotoYarning Study. I had my own analysis of the Yarning study, my own analysis of the PhotoYarns and the co-analysis done in the

PhotoYarning study. The task of drawing these together was enormous *and* rewarding. My work space became overrun with notes posted on walls and with large sheets of paper filled with analytic similarities and differences. Interestingly, there were more points of similarity than of difference. I had not used a qualitative data software package, preferring to work directly with the enormity of data manually. I am a very visual learner and I utilised my mapping skills to create complex maps that allowed me to bring together the multiple small group analyses to reveal the dominant story that was told through the data and developed an argument to address the research question.

I had Yarned with Team Members about the output (this PhD thesis) and had explained that I had a responsibility to them to write the story of the data but also explained I had a responsibility to argue the research question in the form of my PhD thesis. Team Members respectfully acknowledged the enormity and difficulty of drawing the small group Yarning analysis together and, in the spirit of trust, charged me with the responsibility of both!

I have offered Team Members a copy of the completed thesis post examination and have invited future collaborative work using some of the data that was generated through this study. The Yarning Study and PhotoYarning Study themes and subthemes are presented in the empirical chapters in this thesis (Chapters 5 to 8). Chapter 5 reflects data primarily from the Yarning study (and does not include photographs) and Chapters 6 through 8 all include photographs and reflect data from both the Yarning and the PhotoYarning study.

Chapter 4: My own Yarning

What matters is that lives do not serve as models; only stories do that. And it is a hard thing to make up stories to live by. We can only retell and live by the stories we have read or heard. We live our lives through texts. They may be read, or chanted, or experienced electronically; or come to us, like the murmurings of our mothers, telling us what conventions demand. Whatever their form or medium, these stories have formed us all; they are what we must use to make new fictions, new narratives. (Heilbrun & Politt, 2008, p.37)

4.1 Yarns are given and shared

Yarns have helped form me into the Koori person I am, the process starting when I was a child as I learned about the world around me through the Yarns given to me by family members. Yarns provided me with rich insight into my culture and taught me life lessons. Yarns have helped me to understand, develop, question, analyse, critique; they have been part of my Aboriginal experience of life and as such they fitted comfortably, respectfully and appropriately into the research I undertook for this thesis. Yarns became a central feature of the Indigenous methodology I used for this research, and they inspired me to develop a new Indigenous research method, PhotoYarning.

4.2 Yarns in this research

Yarns were employed throughout the research process, from the recruitment of Team Members through to data collection and analysis. Those Yarns involved other people (Team Members mostly) and resulted in data presented in the empirical findings of this research. However I also shared with Team Members Yarns that I had heard at some point in my life Yarns that were personal and yet connected to some part of our shared research process. This Yarning was mostly done during engagement over data collection but I often also wrote up

those Yarns as a way to engage my own cultural learning and knowledge with what I was learning and experiencing through this research. Reading over my Yarns often helped me to position myself in the next stage of my research or help me understand something that was presenting a challenge. The Yarns, written with a Western narrative construct, reflected my Aboriginal ontology and epistemology – they are examples of how I was positively operating with an Indigenous research methodology in the Cultural Interface in which I lived and conducted the research (Nakata, 1997).

4.2.1 Yarning validated our Aboriginal and Torres Strait Islander knowledges

Indigenous knowledges are passed down through cultural practices that validate those knowledges (Sherwood, 2010). In this research, Yarning stood as an example of Indigenous method that "constantly validated, reaffirmed and renewed" (Smallacombe, Davis, & Quiggin, 2006, p.9) Indigenous knowledge. As a Koori woman and researcher I have lived experiences and knowledge. Following Aboriginal protocol included in the work of other Aboriginal and Torres Strait Islander researchers, for example Fredericks (2003); Martin and Mirraboopa (2003); Moreton-Robinson (2004b) and Sherwood (2010), I brought this knowledge and lived experience to the research context. I believe it provided insight into the issues being explored throughout this research, provided opportunity for me to engage and build important relationships with Team Members through reciprocity of Yarning and ensured that I was not one of the "objective observers" in research who Kenny, Faries, Fiske and Voyageur (2004) referred to as an "not reveal(ing) their human identities as part of their research activities" (p.16). My position might be labelled as "insider/outsider research" but it was not as clear a

division as that label suggests (Guenther, Osborne, Arnott, & McRae-Williams, 2017; Lee, 2008; Weber-Pillwax, 2004). My positioning as a Koori woman with relationships and connections across a number of communities, as an Aboriginal health professional and an Aboriginal academic and research candidate in a Western academy meant that I faced what Smith (1999) called:

…a number of ethical, political and personal issues that can present special difficulties for indigenous researchers who, in their own communities, work partially as insiders, and are often employed for this purpose, and partially as outsiders, because of their Western education. (p.5)

My use of Yarning assisted me to navigate those “special difficulties” such as my own insider status as a Koori woman and my (partial) outsider status as a PhD candidate from a Western education institution. Yarning “constantly validate(d), reaffirm(ed) and renew(ed)” (Smallacombe et al., 2006, p.9) my own Koori knowledge and Aboriginal and Torres Strait Islander knowledge shared by Team Members. My methodological approach enriched my own development as a Koori researcher and enriched my Indigenous methodology.

4.2.2 Debates about authentic voice

I faced a fierce internal debate about maintaining my authentic voice within the pages of this written thesis. I had long discussions with my research supervisors, Team Members, community members and family about how I can maintain my authentic voice as I construct this thesis for PhD submission. My biggest challenge was trying to embed my Aboriginal epistemology (and the words and methods used to express this) within the required Western academic thesis

framework. I felt supported by Sherwood (2010); she discussed a similar dilemma, describing how she was navigating this space with Aunty Rose, an Elder:

Aunty Rose was unhappy about the type of language I was using and subsequently was not happy to read the chapters. To translate the work I had written to have meaning for her was essential to my journey. The translation they had already taught me was to simply provide examples back to them through story-telling. Aunty Rose wanted to see if I had captured her message in our ways of knowing, being, doing. This process of translation is as it should be, back to our ways of doing. (p.145)

The inclusion of some my own Yarns (in written form), Yarning in my research journal and the final Yarn for my Team Members (Chapter 10) are how I "provide examples back", they reflect my Aboriginal "ways of knowing, being, doing" and are embedded within this thesis in a way that would also be acceptable to and respected by Western knowledge systems. I feel strongly about including Yarns within the thesis, in addition to a more "abstract explication" (Kahakalau, 2004, p.30) of the research. Kahakalau (2004) considers this to be "a distinct contemporary indigenous research feature, because at the present time indigenous scholars like myself have to justify ourselves in two worlds" (p.30). I believe that my methodological approach will be valued and valid as I have applied rigour to meet the requirements and responsibilities both of my Koori practices and those required by the Western academy.

I have undertaken research as a Koori woman and as such I must firstly be accountable to the research Team Members and their Aboriginal and Torres Strait Islander communities across Australia, so using an Indigenous research methodology that is aligned with Aboriginal and Torres Strait Islander ways of knowing, being and doing is respectful (Smith, 1999).

4.2.3 Yarns in my research journal

Published in The Qualitative Report*, Journal Conversations: Building the Research Self-Efficacy of an Aboriginal Early Career Academic,* (Dickson, 2017) (Appendix C) weaves together many different Yarns that were recorded by me, throughout my candidature, in my research journal. I used Yarning to position myself within the research, to express reciprocity of experiences and knowledge with Team Members and as a reflective tool. The latter took the form of a written research journal that I maintained throughout my doctoral period.

My research journal provided me with scope to maintain Yarning that helped to build my capacity as a Koori researcher as I used it to reflect on key issues related to the research. It became an integral part of my chosen Indigenous methodology. Both my research journal (and the Yarns it captured) and my other written up Yarns (following in the chapter) came to be data that allowed me the opportunity to develop a deeper understanding of my PhD research and of the issues raised through Team Member's Yarns and PhotoYarns. They provided me, the researcher, with the invitation to Yarn, similar to the opportunities provided to Team Members. Yarning was a pivotal Indigenous method used across my research and my own Yarning firmly anchored me into my Indigenous methodology.

4.2.4 The Yarns I have included in this chapter

I have included a number of written versions of Yarns in this chapter. Many of my written Yarns will not be included in this thesis, and yet they remain important in having contributed to the shared Yarning that occurred between Team Members and me during recruitment, data

collection, analysis and beyond. However, the following Yarns have been chosen for their relevance and relatedness to key research challenges, learnings or milestones.

4.3 The Yarns

4.3.1 A Yarn shared with Team Members about respectful practice in research

During a group Yarning session (connected to the Yarning study) Team Members and I were talking about experiences of research; we spoke about the good, the bad and the ugly. Team Members asked me how I came to "do" research the way I was doing it in this study. I told them this Yarn as an explanation of how I learnt about respectful practice in research.

I recently spoke to a family member and was reminded of an important cultural practice:

"Tell me, Michelle, what do you look for when you walk in the bush?" I replied, saying that sometimes I was just looking for a peaceful place to visit but other times I was looking for wisdom or some guidance from the place.

"Yes, good. Either way you want something, right? So what do you do when you walk up to that place- y'know, before you walk right in?" I replied, describing the process I had been taught- make some quiet noises, then make a few louder noises to warn of my arrival. Pick up a stone or two and gently toss them in the path before me.

"Yes, you ask for a welcome into that space. You are the visitor and you are asking for the privilege of spending time, learning something. And how do you leave? What do you do?" I replied, telling how I always paused and remembered where that knowledge or peace had come from, embedding in my mind and thoughts and future actions the origins of that moment of peace or bit of knowledge I had gained.

"And when you speak of the peace you found, or the thing you learnt in that space? When you tell others? How do you do that?" I replied – I always praise that place first, and the people who have been there before me and created the peace and knowledge that I found there. I speak of their peace and their knowledge that they shared with me.

And with that my relative just nodded and smiled.

4.3.2. A Yarn about staying respectfully flexible during “data collection”

This Yarn was shared, with slightly differing details each time, with several Team Members who became worried about the apparent disruptions they were juggling during their Yarning sessions (data collection) with me. I wanted to reduce their anxiety about having to juggle time with me and their other personal, work or community responsibilities. I shared this Yarn as a way of describing my respect for their juggling of all of their responsibilities.

My maternal grandmother was at the core of my research design. Years ago she said to me “Give me a few minutes and we’ll talk, but sit and have a cuppa and I’ll really tell you a story”. This simple statement framed my research methodology. Cups of tea, stories (Yarns), time taken and time given. Intrinsically it was impossible for me to work in any other way, I knew that. The cups of tea and getting to know Team Members were not peripheral to the research process; they were the crux of it.

As I continued through my research journey other things joined the cups of tea as being pivotal to the research process (my methodology). I discovered that I did not even hesitate to accept the offer to share dinner with the family or community of my Team Members; I eagerly joined in the after work basketball scrimmage directed by a Team Member’s fourteen year old son; I happily fed a Team Member’s baby her bottle of milk while Yarning with her Mum; I embraced the youth sexual health team that invited me to their youth night and invigorated me with their questions about programs I had worked on elsewhere, asking questions about why those programs had worked, or why not. I was pleased to take a break from one Yarning session and help make afternoon tea for the hungry mob of kids who appeared at a health centre on the dot

of 3.30 – after all, dropping in to the clinic after school was their regular gig so who was I to change that?

4.3.3 A Yarn about happily living and working in my skin, despite experiencing racial battle fatigue

The concept of how Team Member Aboriginal and Torres Strait Islander cultural identity was defined by people in their workplaces emerged several times during Yarning and PhotoYarning sessions. Many of their Yarns about their identities were deeply personal and yet were shared with me as a sign of trust and respect. I shared this Yarn as a sign of my own reciprocal trust and respect.

I am a pale skinned Koori woman from Darkinjung/Ngarigo countries. I live my culture proudly and have never considered myself "less" Aboriginal because of my pale skin, or because I live in a suburban community or because I cannot speak my community languages. I am simply different to many of my Aboriginal family and community members, many of whom might have darker skin than me, might live "in the bush" and might be able to speak their community language(s). We are a diverse mob, really.

Years ago I felt far more judged about my Aboriginality and physical appearance, and it hurt. I had a colleague say to me "Gee, I am more tanned than you. Who's the Aboriginal one here?", and another colleague say "Wow. When you wear shirts like that, and those big beads, well, it reminds me you are Aboriginal". And when I took three days off work for Sorry Business[18] another colleague said to "Ah yes. That's right. You are Aboriginal. I just forget that. I just can't see you as Aboriginal". All of these colleagues worked in the higher education sector.

[18] Sorry Business is usually associated with the death of a relative or community member. It takes different forms and shapes in different communities and families. In this case I needed to travel out of Sydney to attend a funeral and support family for a few days.

I guess I do wear what some would call "Indigenous prints" on some clothing, and love to wear big, chunky beads (sometimes in the colours of the Aboriginal flag, red, black and yellow) and I proudly wear an Aboriginal flag tattooed on my skin; it is accompanied with a phrase "Always was, always will be" as a reminder that Australia always was Aboriginal land, and always will be. Incidentally, that phrase also was part of a slogan used in a health promotion campaign I worked on many, many years ago. It has deep significance to me. But, does all of that make me "look" Aboriginal? I don't think so, but clearly some other people do.

What happened to some people in my family and community (directly or generationally) under the policies and practice of the "Stolen Generations" is extremely hard to describe. I almost feel like putting words to that grief and loss is disrespectful. But I have learned that words (spoken or written) help keep us engaged with each other and with ourselves, and so I will write up this Yarn.

Appearances often frighten people. When people are removed from family and community in part because of skin colour, well, then skin colour matters. And it can be frightening. Some family Elders (themselves removed from community and family) made a choice to stow away much of their family and community history- and with it went connections, identity, and knowledge. Because family members had been themselves removed as children (with pale/paler skin) a fear of subsequent removal of the next generation set in. As such members of my family made efforts to keep their paler skinned children living together, blending them in with an appearance that was considered more "safe". To do this they often hid what meant the most to them.

A colleague and mentor uses a library metaphor in her teachings of psychology. In her teaching about self and identity she draws on the metaphor of a library stack section. She explains that sometimes, as in libraries, we shelve things in the deep, dark archive (or stack) sections, keeping them out of sight. But at the same time we often choose to display other things on our 'public' library shelves. Often the most important things get left in the dark stack sections of our libraries. Perhaps that is because it might be easier to display the "safe" things on the public shelf- you run no risks in doing that. Show people what is familiar to them and you blend in, they don't question you. Hide the things they don't recognise or understand, or criticise you for, and you somehow become safe.

I recall my grandmother telling me that when she was all dressed up no-one would look at her any differently to the next person. She blended and didn't look "all of herself". But the moment she stepped out, hair frizzy black, in comfy home-clothes, with no makeup, well, then she encountered the full gaze. Other parts of her self were out in public, and her physical appearance made her "more like her real self". She said at times it was easier to keep making her hair iron-straight, and to always wear shoes…I completely understand what she meant. When her physical appearance was not cloaked in shoes, certain clothes, make up and ironed-straight hair, well suddenly she looked "more" Aboriginal. That was often scary for her.

Sadly, life was easier for her (and her children were safer) when she chose to put the important bits of herself hidden away in the dark stack section of her library- that way she didn't get the racist comments or the gaze from the world that judged her parenting just because her hair was gorgeous, black and frizzy, her feet were most comfortable without shoes and her house was

warmest when overflowing with family. Thankfully I was invited to shine a gentle torchlight on the library stack sections belonging to my family- and in doing so I have reconnected with some of that knowledge, identity, family and community that was shelved for years in a sincere effort to keep family protected from further removal, displacement, disconnection. So, for some, appearance often matters.

I feel that my PhD has invited me to shine a torchlight collectively, in unison with other Aboriginal and Torres Strait Islander research students and academics who also engage with research, to explore some of the valued treasures that might have remained in someone's remote library stack areas. Through research we are placing the exploration of Indigenous knowledges, histories and lived experiences proudly on our public shelves.

And my research aims to privilege Yarning and the role Yarning plays in knowledge exchange and meaning making. It was through the constant sharing of Yarns with family that I developed a true sense of my own identity and the identity of key people in my life. My maternal grandmother's Yarns still play a vital part in an evolving, meaningful research methodology that constantly seeks to privilege the Indigenous Standpoint while also defining my own identity and place in the research. As I listened to her stories about teaching her kids to play hide and seek when certain officials appeared knocking at her door- debt collecting or just checking up on things, I learnt much about what was meaningful to her. She chose to hide what was most important to her- her children, and elements of Aboriginality, and did so because of the removal of the paler skinned children in her family and community. Listening to her Yarns helped me to form a deep sense of her identity and a meaningful understanding of what she did and why (her

methods and her ethics). Imagine what I would have missed if I did not sit and Yarn and listen-no survey could have ever achieved the level of understanding I have of Grandma Rose's view of life and beliefs (the ontology and epistemology that shaped her own methodology).

Early in my academic career I felt like an academic imposter. Often I didn't approach teaching or research in the same 'way' as many of my colleagues, and some people made comments that devalued my working self. At times I gave in to these comments and spent hours wondering what I needed to do to change, so that I would feel less of an imposter in the academic space. In fact, I have lost far too much time to those negative thoughts.

Doing a PhD has encouraged me to claim a firmer space as an academic. Wide reading of works written by other Indigenous scholars significantly shifted my imposter syndrome. Over time I reduced the worries I had about 'fitting in' to an academic paradigm and ontology. Over time I grew a more passionate appreciation of the ways I was working in an academic space and saw that there was great benefit for me to be comfortable maintaining that position. I also realised that it didn't matter that other colleagues worked differently to me; what mattered was that I found a way of sharing my ways of working, thinking, researching, writing so that they occupy a space in academia. My mission, I believe.

4.3.4 A Yarn about learning from Country, and doing no harm (good ethics)

During early Yarning and PhotoYarning sessions several Team Members asked me about how I navigated parts of the research 'system', like obtaining ethical approval from the University. They also asked me how I, as a Koori researcher, find my way in research. I shared this Yarn as part of those discussions.

This story was shared through Yarning with Team Members. It draws on some important learnings from early in my life and from learning I more recently experienced as a PhD student. It is a story about connecting with Country, the cultural landscape filled with knowledge, guidelines, support and warnings. Team Members Yarned with me about how they connect with Country in their work, especially when they need to guide clients. Similarly, I go to Country when I need to reframe some thinking, be inspired or guided, or feel the need for a refresh and revitalisation. In the space described in this story I found lessons teaching me about feeling strong in the choices I was making as a researcher.

The image of an echidna engraved in the aging sandstone around Sydney reminds me of a whole story, a story that replays in my head in a voice that now lives far away, a voice I no longer hear anywhere other than in my head. That voice told me stories that made me think, learn, reflect, engage, question, evaluate. That voice used a connection to Country as an important link between a cultural landscape and life lessons. Importantly those stories made sense and were meaningful; because of that they stay with me. As a child the stories made me think carefully about where I walked in the bush, about caring for Country and people. As a child I could talk about how "good" I felt when I was in Country. As an adult I still feel all of those

things but those stories and being connected to Country also help me work through issues at work and in research that often feel big and unsolvable. The stories have also helped me as a PhD student; they have helped me to understand and learn about research as I connect to a "place" within my cultural landscape.

The echidna – spines on the outside, able to burrow into earth and leaves to find safety from the outside world. She is able to curl up and use the spines to protect herself. Protection- that's the echidna. I was told that I need to remember three things when I see an engraving of an echidna on sandstone outcrops all over Sydney (my home now), or when I am back in Country. First, stop and notice it, and think about protection of self. Am I taking care of myself? How do I do that? Why is taking care so important? Stop. Think. Plan. Move on with care.

Second, tread lightly. Look all around because echidnas can hide really well, so really look hard before you take the next step. Do no harm. Be aware of each step you take.

Third, remember that, in many places, engravings of echidnas signal that a Women's Place is close by. Observe that sign. Look around your environment. Boys and men also need to notice that sign, know how to read it and act responsively. Not every man or boy will know how to read that sign, so it is important to share that information in a meaningful way. Disseminate knowledge wisely and in ways that will be understood. For women and girls, the same sign means a very different thing – it means 'walk on', 'feel cared for', 'feel nurtured', 'be empowered by the knowledge of the place'. Oldest women walk first, treading the path for the younger who can learn where to step as they follow. Follow protocols. Same sign, different meanings. Know context and communicate with meaning.

And then, if an echidna guides you into a space that also shows you engraved footprints, well, smile, as you are walking towards a sacred space. Women have long walked that track before you, in another time. Follow those footprints; learn from where their path takes you. And with every step know that there is learning, and support and wisdom. But you must keep your heart and mind open – while your steps might look like they are heading in the same direction as the steps that were taken before you, there is always a difference.

In Country I heard the voice and the story and understood that the story also helped me understand some of the challenges I was facing as a PhD student particularly about my methods and methodology. Learning and knowledge, like the engraved steps, are different for us all. Some things provide a process, a means to an end (like the footsteps that lead to a sacred place) but how we walk those steps is entirely up to us. Make good choices about the way you step forward (choose your methods wisely), and about how you walk towards the sacred space (your methodology). And be sure of why you are taking those steps and be strong in your choice of direction.

Just as the echidna is set in stone to look after special places, those special places will also teach and look after you. Those stories, the voice and those places that helped me feel strong and make good choices as a child and young woman now also helped me feel strong in my choice of methodology and of research methods.

4.3.5 A Yarn about Recalling Lily – the parts of our self not always immediately seen, or understood (but well understood through Yarning)

Several Yarns about invisibility at work were shared between Team Members and me. A number of Team Members shared Yarns about their own experiences of not being 'seen' as Aboriginal by people in their workplaces, mostly due to those colleagues equating having pale skin as being somehow less Aboriginal. It was in the context of those Yarns that I shared this.

*In my early professional life I had the great pleasure of visiting Uncle Bill Neidjie and his family as part of a work immersion. A team of us travelled from Redfern, New South Wales to Kakadu in the Northern Territory to consult on cultural sites and history. Uncle Bill was often called Big Bill Neidjie, Kakadu Man***,** *the last remaining speaker of Gagudju language. It was Uncle Bill who gave me the name Lily.*

After long Yarning about sites and significance, culture and place we all sat around Uncle Bill's fire. It was late afternoon and we were about to be treated to a dinner feast of fresh water turtle, hunted especially for our visit. We listened to stories Uncle Bill told us about the Old Man croc who lived in the nearby billabong –they respected each other and happily cohabited. We listened to stories about the burst of colour on the billabong when the water lilies came into bloom. And we were invited to walk to that billabong with Uncle Bill, he said we needed to see something for ourselves. I don't remember the walk to the billabong, but I do remember Uncle Bill's finger pointing to a clump of white water lilies just at the side of the billabong. He told me to go look closer and tell me what I saw. All eyes were on me as I manoeuvred closer to the white lilies, worried about Old Man Croc. I described what I saw "white lily petals and a black centre". Uncle Bill told me that lily was me, and I needed to know that. He explained to me that

my other name was to be Lily, with my white skin (the lily petals) living together with my inner black being. At the time I wondered if he sensed the fire in my belly, fuelled by the external judgments of me and my pale skin, or if he felt my desire to be acknowledged for my whole self and not just seen for having pale skin, or if he was simply making me feel welcome. Actually, he was doing all of those things.

Ever since then my work team called me Lily. Back at work in Redfern I answered to this name, received birthday cards written to this name, was listed on meeting minutes as Lily. Sadly I rarely see the people I once worked with back then, but they will still call me Lily.

Back then Uncle Bill told me that many people might first see me as the outer white petals of the lily, but those who would take time to know me, to Yarn with me, would look into my centre and immediately see the whole me. It is important to be seen as who you really are.

4.3.6 A Yarn about lateral violence: about being hurt by your own people who themselves strive to overcome previous disempowerment and disrespect

I shared this Yarn with a group of Team Members who were Yarning with me about the hurt they felt when their own mob at work made negative comments about who they were or the work they did.

Being defined by others as being Aboriginal, or not Aboriginal enough, has taken on a range of shapes and forms during my PhD; but in many cases people have used my skin colour as a way of defining me.

I was always interested in how people saw me. They saw me as a quiet child, almost even a vague child, instead of seeing the deep thinking that dominated my headspace most of the time. Later in life I heard people talk about my Koori ways of thinking, learning, celebrating. My large, busy family encouraged me when I consistently found employment within Aboriginal and Torres Strait Islander communities, and shared my joy at studying Indigenous issues, but others who saw me through another lens did not understand me well.

Many did not see me as a proud, pale skinned Koori woman living and working in my culture. Instead, many just saw me as pale skinned and were even judgmental about my connection with things Aboriginal. Sometimes the judgment even came from fellow Aboriginal and Torres Strait Islander mob who didn't know me and my family. It hurt me most when my identity was challenged from within.

Being classified and labelled by others really made me angry. But I had a choice; external labelling and classification based on my skin colour could either feed the fire in my belly or it

could inspire me to create change. For a while I was angry, very angry. Thankfully I had a wonderful person in my family who took no prisoners on this issue and could see that my belly-fire could be destructive. They told me I had the chance to take that fire in my belly and do something good with it. They said if I didn't learn to manage that fire it would manage me. It was good advice.

Like some of the Aboriginal and Torres Strait Islander Team Members in this study I have pale skin. Like all of the Aboriginal and Torres Strait Islander Team Members in this study I introduce myself through family and community. Like many of the Aboriginal and Torres Strait Islander Team Members in this study I have experienced comments in my workplaces that are enactments of lateral violence from my Aboriginal and Torres Strait Islander colleagues.

I have been questioned about how I "action" my Aboriginality. I was applying for cultural leave. Many workplaces don't have such leave allowances, so I did feel I was in a privileged position. My grandmother had passed, and the entire family were in varying stages of mourning, grief and loss. She was our matriarch, we all miss her. As eldest grandchild I had cultural duties. I needed to be with her relatives, I needed to speak at her funeral, I needed to host the wake, and more. I needed time to do what I needed to do. I spoke to HR. I needed to provide evidence of her passing- that was stressful enough. I was given two days. When I got back to my office a close Aboriginal colleague said "Ah, you are a real Koori now, taking cultural leave!" As if the action of taking cultural leave "made" me Koori. However, clearly in her eyes, my act of taking cultural leave defined me as Aboriginal. It didn't sit right in my gut.

I also have experienced lateral violence from some fellow Aboriginal and Torres Strait Islander peers and colleagues who made comments to me about my pale skin, about the lifestyle I lead and about my educational 'privilege'.

These comments probably have hurt me most of all. They have hurt me because they have come from my own people, and they have hurt me because they tell me that my people (these ones) see my pale skin first, before my Aboriginality. My people use my pale skin to bring me down, to keep me down.

4.3.7 A Yarn about working in a system that sometimes makes you feel invisible (and culturally and racially fatigued)

I shared this Yarn with Team Members as we were discussing workplace dynamics related to how colleagues still often privilege a darker skin tone over a paler skin tone.

For most of my working life I have worked in the Aboriginal health and higher education sectors and have worked with some amazing people who mentored me, guided me, encouraged me. I also worked with some amazing people who mentored me, guided me, and hurt me. I have been subjected to comments that reduced my Aboriginality to simple, external factors like the clothes I wore, the way I wore my hair, the colour of my skin: A non-Indigenous manager said to me "Whoa! What a necklace! I am noticing that you are wearing more and more, big, chunky jewellery- earrings, necklaces- when you wear things like that you ***are*** *very Koori looking!" Another Aboriginal colleague said "You should let your hair turn grey. A good Koori woman doesn't spend time grooming her hair- it is a sign of a wise Koori woman to let your hair turn grey. Stop colouring your hair- it makes you look like one of us, and not one of them".*

I have experienced a level of invisibility in some of my workplaces, invisibility based on my light tone of skin. I have faced comments about who is the "real" Aboriginal, as I was compared to a dark skin colleague. A non-Indigenous manager said to me "It will be great to have her working around here [speaking of a visiting, darker skinned Murri colleague from a remote community who was on a short secondment to my workplace]. Everyone will jump on her and ask her everything they want to know about Aboriginal issues. They don't do that to you, they see you as different, maybe more like themselves and less Aboriginal".

I was working in a workplace that awarded me certain rights and status based on my Aboriginality, I mostly felt that I was a valued member of staff and that my Aboriginality was also valued. Many assumptions filled my colleague's words.

What I heard was that because my Murri colleague was darker in skin tone than me and had lived in a remote community she was seen as 'more Aboriginal' than me. What I felt, as I experienced that comment, was that my pale skin and urban lifestyle didn't seem to qualify me enough to be a point of contact on Aboriginal issues. These comments too often caused me deep hurt.

Being measured by a non-Indigenous colleague based on skin tone is disempowering. My cultural identity is not skin deep, it is a deeply connected sense of self, a self connected to my culture, history, family, kinship and community. Ultimately when my authentic Aboriginal self has been defined by a quantum of blood or my skin colour, well I deeply hurt. I have often been left feeling that my Aboriginal and Torres Strait Islander status was invisible, and invalid; I felt ultimately disempowered by having what I connect with- kinship, community, and culture - devalued in an external perception of Aboriginality.

4.3.8 A Yarn about the importance of taking time; relationships are important (even in research!)

This Yarn was shared with Team Members as they spoke about the different ways they have experienced research. Team Members asked me how I came to give such a high value on Yarning and PhotoYarning within my research. They also asked me how my study of research helped me to develop skills I was using in this study. Team Members were curious about how Yarning was so privileged in the research.

My grandmothers spoke more than my grandfathers, not that they always had more to say, they just said things using words, using Yarns. Those Yarns helped me define and understand my own identity and place in life.

One of my grandmothers Yarned about teaching her kids to play hide and seek when certain officials appeared knocking at her door, just in case they were at risk of removal. I only understood that because I had listened and Yarned with her about what came before. From those Yarns I learnt much about what was meaningful to her. She chose to hide what was most important to her, her children, and did so because of her experiences of the removal of the paler skinned children in her family and community. Listening to her Yarns about wanting to protect her pale-skinned Aboriginal children helped me to understand her deep sense of identity and listening to her reasons helped me understand what she thought and why. I didn't know it at the time but that Yarning was formative, it was teaching me excellent skills in listening, asking questions and critical reflection. All of these things helped form and support my research methodology.

So, at the core of my research you will most often find the sharing of a Yarn or two, or as many as possible! Despite having been educated in a Western scientific research paradigm that encouraged a researcher to position themselves in an objective place within their research, I value the element of sharing in my research. Despite what I was taught in Quantitative Research 101 many years ago about objectivity I realised that what was valuable to me in my growth as a researcher was the trust and value I place on subjectivity. I have learnt that what some call subjective, I call engagement and involvement – both key values in any good research relationship.

I sat in many lectures that aimed to teach me how to be objective as a student researcher. And I understood what they were teaching me, and why. It just didn't sit well with me, didn't match the way I viewed the world. I struggled through many a clinical prac, failed several research designs and trial studies and constantly had questions about why we needed to stay one step away from the research we were doing. I struggled, big time. I allowed myself to stay in that struggle zone for the best part of three years. Research fascinated me and I wanted to have it in my future in some shape, so I kept trying very hard to learn a way of thinking and being and doing that was not mine.

The words of my grandmother give me a complete sense of what I value in my own research-sharing time with people and really listening to what they have to say. Those words even helped me to come to understand my preference for qualitative research methods, over quantitative methodologies. For a period in time I worked in a department that highly valued quantitative research, and positioned anything qualitative as existing on a blurry fringe. I faced much

pressure to focus on quantitative research, to the point that I felt I might not progress in my academic career if I did not embrace quantitative research methods. I felt like an imposter.

Don't get me wrong, I had done my time on research that used quantitative methods but I felt a deep sense of something missing in that research- it was the fact that I didn't have a chance to "sit and have a cuppa" and share stories. I really was not turned on by the results; I wanted research relationships with people, not numbers.

I have always experienced a deep sense of involvement with my work in the health sector, my teaching, my community. At the core of all of these things were people- building relationships. Through honouring relationships with people, and engaging deeply in Yarning with those people, I have learnt how to appreciate difference and similarity. I have learnt that a group of people might experience the same event but it might have different meaning and impact for each member in group. Imagine what I would have missed if I did not sit and Yarn and listen- no objective survey could have ever helped me to achieve the level of understanding I now have of my Grandma's life, her thoughts and her lived experiences. My early learning and valuing of relationship building positioned me well to be able to make decisions about "how" I engage in research.

I am thankful for that learning.

Chapter 5: “It’s all about relationships”: Aboriginal and Torres Strait Islander health professionals value the use of “friendship-like” (Reimer, 2014) connections in the professional practice.

5.1 Introducing this chapter

In this chapter I explore the “friendship-like” (Reimer, 2014) connections that Aboriginal and Torres Strait Islander health professionals build and use in their work with clients. Specifically, I define what friendship-like connections are in this context, examine the strategies Aboriginal and Torres Strait Islander health professionals have developed to enable them to develop and use friendship-like connections and describe why they value using them in their professional practice.

Team Members lived and worked in the same community as their clients, but no Team Member reported a client who was a “mate” or friend. Yet they valued and prioritised friendship-like connections with their clients. These connections were built up through client-worker interactions, both within the workplace and in the community. This chapter presents four main themes: the first explores what working with friendship-like connections is and what it is not. The second theme explores why Team Members find it valuable to work with clients using friendship-like ways. The third theme synthesises how Team Members work with clients using friendship-like connections. An important part of this theme is an analysis of the professional boundary work Team Members engaged in. Finally, the fourth theme considers how other people in Team Members’ workplaces perceive working with friendship-like connections, showing how Aboriginal and Torres Strait Islander health workers believe that their non-

Indigenous managers differ markedly in their conceptualisation of appropriate relationships between clients and Aboriginal and Torres Strait Islander health professionals.

5.2 Literature specific to this chapter

This section synthesises literature on health professional/client relationships, professional boundaries, navigating the space between the personal and professional ways of being, knowing and doing in health care provision and working with friendship-like connections with clients.

5.2.1 Clinical relationships

Appropriate relationships between clinicians/ health workers and their patients/clients have been extensively described (and prescribed) over many decades, for example, Bray (2011); Kendall et al. (2011); Kitson, Marshall, Bassett, and Zeitz (2013) and Nelkin (2015). Such relationships can be viewed on a continuum from uninvolved and clinical at one end to personally involved and invested at the other. The type of relationship considered appropriate depends on historical and cultural variables. For example, concepts of desirable clinical interaction in Western medicine have morphed from an error-prone "sympathetic" approach involving "emotions and subjectivity" in the nineteenth century to "detached concern" in the twentieth to an empathic approach which "allows emotions to be used in the service of deeper understanding" in the twenty-first (Pounds, 2010, pp.141-142). Communication is a large part of empathic relationships, as are emotions, since, if "managed appropriately", they can provide "valuable insight" into patient conditions and concerns and give patients "a sense they have been understood and their needs respected" (Pounds, 2010, p.142).

Another current concept in clinician/ patient relationships is patient-centredness. Exploring health policy, medical and nursing literature Kitson et al. (2013) identified that effective client-centred approaches establish and maintain "a genuine clinician-patient relationship; open communication of knowledge, personal expertise, and clinical expertise between the patient and professional" (p.11). While the definition of a "genuine clinician-patient relationship" has been thoroughly explored for differences and similarities, for example, Kelleher (2006); Tutton, Seers, and Langstaff (2008), Kitson et al (2013) suggest there should be some common features across all definitions, including the free flow of information and personal experience between the clinician and the patient.

5.2.2 Professional boundaries

Core to relationships between clinician/ health worker and patient/client is setting and managing boundaries between the professional and the personal, regardless of whether the relationship is with an individual or community. The concept of professional boundaries has been defined as "a line that should not be crossed in client–practitioner relationships. When crossed, relationships become dysfunctional, that is over- or under-involved in varying levels of seriousness, potentially causing harm to one or more of the parties involved" (Fronek & Kendall, 2016, p.1). Doel et al.(2010) define the term professional boundary as "the boundary between what is acceptable and unacceptable for a professional to do, both at work and outside it" (p.1867), viewing the health professional in a more extended role, and accounting for a professional responsibility both in the workplace and beyond.

Professional boundary work is described by Green, Gregory and Mason (2006) as “a stretchy piece of elastic” (p.450), with health professionals adopting a highly personalised approach to their work with clients that often includes an appropriate use of the personal self-disclosure and reciprocity, all while acknowledging the coexistence of a professional role and any power imbalance that might accompany that (Pugh, 2007; Reimer, 2014).

As the literature above suggests, there is an assumption that working with clients in the health sector does require careful navigation of professional boundaries and that appropriate training enables health professionals know where boundaries lie in their work and know how to successfully manage them. However, Fronek et al. (2009) describe how professional boundaries can be challenged when there is a conflict between the personal and professional components of a relationship. Professional boundaries are often described, for example by Gardner (2010) and Shepherd (2013), as being challenged by engaging with personal communication within a professional context; Reimer (2014) calls that type of communication friendship-like communication (p.1).

5.2.3 Professional boundaries and codes of conduct

Healthcare service delivery is bound by a range of professional ethical codes and practices that define the concept of professional boundaries and support maintaining professional boundaries for the safety of both the client and the healthcare professional; for example, the Nursing and Midwifery Board of Australia Code of Professional Conduct for Nurses (Nursing and Midwifery Board of Australia, 2016) and the Australian Medical Association’s Code of Ethics (Australian Medical Association, 2016). However, the existence of such codes does not automatically mean

they always represent the best way of providing health service to all clients, including in Aboriginal and Torres Strait Islander contexts.

Often the diversity of their work requires Aboriginal and Torres Strait Islander health staff to respond to unique client and community needs, maintaining close proximity with community cultural, social and political knowledge in addition to their role and connection with community health (Deshmukh et al., 2014). Such ways of working may be at odds with professional codes of conduct. For example, in one study Aboriginal and Torres Strait Islander women experienced improved health outcomes and engagement with maternity services that employed Aboriginal and Torres Strait Islander health staff and health students, partly due to familiar communication styles and relationships that extended beyond "the boundaries of a clearly defined professional relationship" (Kelly et al., 2014, pp.3-4). That research also indicated that some Aboriginal and Torres Strait Islander student-midwives found it challenging to attempt to maintain this way of working while also maintaining professional boundaries according to their current code of practice. A suggestion made by Kelly et al. (2014) was that the current Code of Professional Conduct for Midwives in Australia (Nursing and Midwifery Board of Australia, 2016) be revised so that optimum midwifery care can be given to Aboriginal and Torres Strait Islander women. Currently the code suggests that "over-involvement" could include ''boundary crossings, boundary violations and inappropriate relationships with the woman, her partner or family by the midwife'' (Kelly et al., 2014, p.4), however there is no clear definition of a boundary crossing or an inappropriate relationship.

Within a social work context Doel et al. (2010) describe working in a way that is either perceived as crossing professional boundaries or as "entering the shadows" (p.1866), relating professional boundary challenges with working in a widely undefined, shadowy space. Doel et al. (2010) suggest that codes of professional conduct, used to establish and maintain professional boundaries between health professionals and clients, might exist more to protect the health systems and services rather than the client and might "seem to be rather like insurance policies that are only brought out from the bottom drawer when the front-room carpet has been spoiled to see whether a claim can be made" (p.1884). Hart's (2015) research suggests a better approach is to regularly engage with codes of practice and boundary-based scenarios as a whole of service activity that includes clients to develop a greater understanding of the potential, in some cases, for working in "the shadows" when crossing perceived boundaries works to benefit the client, "but this must be in a transparent and considered manner (p.1885).

5.2.4 Friendship-like connections

Towards the more 'involved' and empathic end of the continuum are relationships between health professionals and clients that have been described as friendship-like. These relationships position the professional 'expert' role in a secondary capacity to a more personalised connection (Austin, Bergum, Nuttgens, & Peternelj-Taylor, 2006). In this chapter the concept of friendship-like connections with clients is pivotal to understanding the ways in which Team Members work with their clients.

A friendship-like approach to working with clients features an "egalitarian approach, recognition of a common humanity, mutuality and reciprocity" (Reimer, 2014, p.6), in this case with respect to social work professionals. Part of effectively using a friendship-like approach is to acknowledge the power differential between health professional and client (Pugh, 2007; Turney, 2010) and to work with a client in a highly personalised, non-distant way (Cooper, 2010; Doel, 2010; Green et al., 2006). Such a way of working could involve an appropriate use of self-disclosure and, at times, appropriate physical contact (for example a hand on the shoulder or arm indicating engagement) between health professional and client (Maidment, 2006; Turney, 2010). Reimer (2014) suggests that friendship-like connections between health professional and client could contribute to a more effective working relationship but also concludes that the focus always remains on the needs of the client.

In exploring how social work professionals build effective working relationships with clients in a professional family work context, Reimer (2014) suggests that "Effective working relationships are those which are characterised by close personal contact, even friendship-like in nature, contained within professional boundaries" (p.1); this definition of "effective working relationships" aligns with those described by Team Members in this study.

While working with friendship-like, personal ways was highly valued by clients in Reimer's study that noted:

…pressure is placed on workers through disagreement [about working with highly personal ways] in the professional sphere regarding ethical practice… workers carefully and thoughtfully provided a sophisticated professional service, yet they did this in a profoundly personal manner. (Reimer, 2014, p.22)

5.2.5 Attitudes to friendship–like ways of working

There are two diametrically opposed views about professional boundaries and friendship-like ways of working with clients in health service provision. One view considers it vital to maintain strict professional boundaries between health professional and client; this viewpoint sees any blurring of professional boundaries (including friendship-like way of working) as both unprofessional and not good for the client. This viewpoint considers any boundary blurring as akin to boundary violation, and both operate to the detriment of not only the client but also the health professional. While boundary blurring, boundary violation or transgression are all forms of boundary crossing, I would argue it is important to maintain some distinctions. A boundary violation or transgression refers to an abuse of the patient-health professional relationship by the professional taking advantage of a patient's vulnerability, or taking actions for the benefit of the health professional, including financial exploitation, abuse of health professional personal disclosure, or instigating intimate relationships (Thompson, 2015). Such boundary violations or transgressions are not addressed in this study. Boundary blurring, on the other hand, represents an apparent failure of a professional to observe an arbitrary dividing line between patient/client and clinician/health worker but this is (mostly) done without the intention to exploit the patient/client, and with the intent of not creating negative outcomes for the client. Another factor to consider is that professional blurring of boundaries and professional boundary violations are relative to the individuals involved (one person's violation could be another person's blurring) and that they are not easily determined categories; this is a difficult space.

A second viewpoint suggests that friendship-like ways of working are essential for creating an optimal working relationship between health professionals and their clients. This viewpoint does not consider working with friendship-like ways to be violating professional boundaries; rather working with friendship-like ways represents a way of working that creates better health outcomes and engagement for the clients and reflects a more client focused and client responsive way of working within a professional space. Kitson et al. (2013) reviewed models of patient centred care that have potential to enhance care as they focus more on developing professional relationships with clients including more open communication between health professional and client that could "transcend professional boundaries" (p.13). Similarly, Warren, Hamilton and Roden-Foreman (2013) suggests that working with spinal injury patients often extends over long periods of time requiring a health professional to develop a relationship with a client that is "up close but not too personal" (p.303) while being aware of not moving the relationship from the professional to the personal as the relationship is built on trust and over time. While developing more open, communicative relationships over time was suggested as positive, Warren et al. (2013) noted that being "not too personal" (p.303) meant being mindful of maintaining sexual, contextual, cultural and religious boundaries, upholding appropriate time limitations on interactions with clients and retaining the focus on the client's need and not on the needs of the health professional.

5.2.6 Impacts on patient care

Research suggests that under certain circumstances patient care can be enhanced by having a friendship-like connection within the professional relationship. The study showing improved

health outcomes for maternity services employing Aboriginal and Torres Strait Islander staff and students was noted above. Kitson et al. (2013) review models of patient centred care that have potential to enhance care as they focus more on developing professional relationships with clients rather than simply providing health services. Specifically, Kitson's review highlighted that the relationships between patient and health professional engaged "open communication of knowledge, personal expertise, and clinical expertise between the patient and the professional" (p.11) and that consideration of the appropriateness of the context where the health care is delivered is a contributing factor to enhancing service.

A specific example of 'crossing traditional boundaries' concerns sharing of personal experiences. Personal experiences are often considered taboo in the working relationship between a health professional and client, and embedding any level of personal disclosure of such could be considered as an example of crossing traditional professional boundaries. Oates, Drey, and Jones (2017), researching in the area of mental health nursing, describe the health professional's personal experience of mental health issues as having potential to increase their professional expertise. This "expertise by experience" (Oates et al., 2017, p.2) has been noted as a valued component of mental health service design and delivery aspect of service design and delivery (Gillard, Edwards, Gibson, Owen, & Wright, 2013). Relatedly, health professionals in Oates et al. (2017) stressed that personal "disclosure was used 'with a purpose' in the context of their nursing work" (p.6) as a means of enhancing their work with clients for the advancing of client outcomes, and not for their own personal gains or needs.

Welch (2005) and Gardner (2010) also described the use of personal disclosure as appropriate in pivotal moments in therapeutic relationships, when a health professional opted to disclose personal information as a means of increasing client engagement, rapport and trust.

Warren et al. (2013) suggests there is boundary work that (mostly) would be obvious to a health professional, like not engaging in a sexual relationship with a client, and awareness of relevant ethical codes of professional conduct continue to inform professionals. However, being 'up close but not too personal' might involve a health professional talking to a client about some elements of their personal life but drawing the boundary line at providing a personal phone number or home address. Warren et al. (2013) also suggests that a health professional can be 'close' enough to a client to talk about their personal life but must know when that level of 'closeness' is impacting (negatively) on the client's therapy time, taking up too much time or distracting from the health care provision that is at the focus of the interaction.

5.2.7 Challenges posed by friendship-like connections

There is still much to learn about how health professionals' work with the challenges those friendship-like connections might pose in their daily work.

Challenges faced by youth workers, for example, are explored by Hart (2015) who provides examples of how important it is for youth workers to negotiate and maintain boundaries with their clients in order to enhance service and ensure solid client engagement. Hart (2015) explains that "The youth work relationship has elements of friendship which makes boundary setting more difficult than in other social professions" (p.878) and that these require the workers to "engage in 'peer like' ways, without becoming too close" (p.878). An important

finding in Hart's (2015) research was that it is not only the worker who determines the boundaries within their professional relationship with the client, but the youth (client) also "have agency over who they interact with and how close they allow workers to get" (p.878). This is an important finding as it highlights the reciprocity that exists in the working professional relationship that empowers both parties to be responsible for setting and maintaining the boundaries in their interactions. This challenges the power differential by respecting user (client) defined boundaries in collaboration and consultation with worker defined boundaries (Doel et al., 2010). Hart's (2015) research on establishing and maintaining boundaries between health professionals and youth (clients) recognises that the young people (clients) "could have an equal partnership in negotiating boundaries… [and]… that boundaries are being used to protect the organisation rather than to work in the best interests of the young people (p.880); here clients are challenging the existing dominant top-down power dynamic established by many health services and systems.

5.2.8 Being perceived as working with blurred professional boundaries by working with friendship-like connections with clients

There are two main challenges health service staff might face if they are perceived as working with blurred professional boundaries as they work with friendship-like connections with clients: personal burdens and professional reputation. For example, Corbett and Williams (2014) explored working as a (mature) nurse in aged care in a rural context in which the health professional and client share the same knowledge of community and community history, often have existing knowledge of each other outside the health service relationship that might invite a personal burden within the working role, for example in "community nursing environments

where older adults are socially isolated and dependent on their health care professionals for social interaction" (p.15). However, nurses in that study often used lengthy conversation, sharing some personal information with clients as a way of building trust and improving their interactions but were mindful of maintaining professional boundaries to ensure personal confidentiality and an external perception of working with professionalism.

Being perceived by colleagues as blurring professional boundaries because of developing friendship-like connections with clients has been acknowledged in literature on working in helping professions (Austin et al., 2006; Green et al., 2006), mental health settings (Gardner, 2010), rural communities (Kilpatrick, Cheers, Gilles, & Taylor, 2009), with children and youth (Shepherd, 2013; E. Thompson, 2015) or when working with clients who have long term, permanent injury (Warren et al., 2013). In these cases health professionals experienced external challenges (being perceived as not working professionally) or internal challenges (being concerned about the level of personal information being shared) when they worked within their health discipline. Regardless of the challenges, some still developed friendship-likeconnections with clients that were perceived to enhance their health service delivery or the expereince for clients. Gray et al., (2014), for example, considered that working in an open, familiar way with clients enhanced their alcohol treatment.

The above literature on friendship-like connections is pertinent to this chapter which explores the way Team Members build and maintain these relationships in their work with clients. This chapter presents data on Team Members working with clients using friendship-like connections, which they describe as pivotal and foundational in their work. As such it addresses

a gap in knowledge concerning ways Aboriginal and Torres Strait Islander health professionals use friendship-like connections in their daily work. It also explores how such connections are regarded in Team Members' workplaces, showing that in many cases there is a lack of knowledge and acknowledgement of Aboriginal and Torres Strait Islander ways of working in health.

5.3 Findings

The analysis presented in this chapter comes from data generated through Yarning sessions. Four themes will be presented: (1) What is working with friendship-like connections and what is it not? (2) How Team Members 'do' friendship-like connections in health care interactions (3) Why do Team Members find it valuable to work with clients using friendship-like ways? and (4) How people in Team Members' workplaces perceive working with friendship-like connections and the consequences of these perceptions for Team Members.

I will highlight the complex nature of working with friendship-like connections in this context and show how Team Members engage boundary work to ensure they provide appropriate and client focused health services to their clients. I will argue for a re-visioning of what is perceived as an appropriate working relationship between an Aboriginal and Torres Strait Islander health professional and their client.

5.3.1 What is a friendship-like relationship with a client?

Throughout the research Team Members strongly argued that they were able to build a friendship-like connection with a client while performing their professional duties, seeing a friendship-like connection with a client as a very different thing to a friendship. Many Team Members described how making a friendship-like connection with a client was not problematic because they did it while they were at work while being explicitly mindful of boundary work:

It is OK to build up a friendly way with a client as long as you still can provide them with the safe and appropriate health care.

(Helen)

Helen describes drawing a boundary around her own work practices rather than limiting clients' actions as a way of working with friendship-like connections, thus taking responsibility for monitoring how she provides her clients with "safe and appropriate health care". Helen articulates that she is doing her work when making a friendship-like connection with a client, not developing a friendship:

When I make a friendly relationship with a client I am doing MY WORK. I am clear about that.

(Helen)

Despite believing that he could have developed friendships with some clients had they met prior to being a client, Bill maintains his boundary between friendship-like ways of working at work and keeping friendships for non-clients outside of work:

I think I could have actually been real friends with a few of the clients I have worked with through here. You know, if we had met at a BBQ or at a footy game, I think we would have hit it off as friends. You know when you just know that? But because I met them through my work, this service, well they came here for a service not for a friendship with me. That's the difference.

(Bill)

For Team Members, friendship was something that occurred with others (friends) outside of work and did not happen with a client. At work the relationships they made with clients were based on a friendship-like connection but clients were not considered to be friends.

Sharing food and drinks with clients

Team Members described how they would have "coffee and Yarns" for as long as the client needed, and then somewhere during that time they established a way to provide them with

whatever support or health service they needed; being friendship-like over food and drinks helped the Team Members to do their job. Sometimes it was more than a cup of tea or coffee, with Team Members sharing a meal with a client as a way of helping the client relax:

I know [the client] never gets to a café and it is a treat…. The way I see it [the client] feels like she is doing something special and relaxes enough to really open up about what we need to work on.

(Kim)

It's true. I bring out a few bickies (biscuits) and make a cuppa and we both sit and focus on that for a bit. I can just feel the client start to relax into things and before I know it we are talking about the hardest of hard things. It's like those bickies and cuppas are magic.

(Maureen)

Sharing coffees and meals with clients was perceived by Team Members to be an important part of the health service provision especially if a client had skipped breakfast or had no lunch. It helped them to do their jobs by meeting the basic human needs, for example providing food:

I just know I am doing my job well when we [client and Team Member] have had a coffee and a Yarn outside the office. It is then that we [client and Team Member] really can hit the hard talk, make good plans that mean something for the client, and achieve a session goal.

(Jimms)

Team Members also perceived that sharing a meal or a coffee then created a working space in which clients would relax and engage in discussions that focused more on their more complicated health needs:

I know a client can go from being edgy to calm just over a cuppa and a bit of toast! Hell, who doesn't relax over a bit of food? Sometimes it is actually easier to talk about the really hard stuff, healthwise, when you are also busy stirring a coffee or buttering a bit of toast.

(Justin)

Justin acknowledged that providing food and drink for a client is far more than that; it provides a client with a helpful distraction, with something to do with their hands and body while they talk.

Clients understood the boundaries of friendship-like connections

Team Members perceived their clients to understand the difference between friendship and the friendship-like connections they establish in the health care interactions they had with Team Members, suggesting clients "get it":

It is funny, I think my clients keep coming to me because I work this way. They get it. They know we can be friendly and still get their health work done.

(Helen)

I think my clients really understand where to pull back on the friendly stuff, y'know. When to move on to talk about something else. They seem to know what is OK to talk about, and just how friendly we can be, and still know they will walk out with what they came here for- their health service.

(Justin)

After all they have come to see me for help with their health, not to make a new mate.

(Macca)

They are clear about that. It is not like we will head out for a drink after work – that is what friends do, not what a client and a health worker do.

(Bill)

Team Members perceived that their clients understood how they worked with friendship-like ways, and understood these not to be the same thing as a friendship.

5.3.2 How Team Members 'do' friendship-like connections in health care interactions

All Team Members highlighted that setting boundaries early always sets the professional scene, showing that the focus was on the meeting the client's health needs and ensuring wellbeing. Part of boundary setting is building trust with clients. Team Members described how they established friendship-like connections with their clients in ways that allowed the client to trust and confide in them:

This health service works with clients who often are caught up in really hard stuff- drugs, maybe crime, tough child custody battles, housing issues. They need to trust me with all of their stuff so we can work together to get the best health outcomes possible.

(Bill)

I talk about me too, share a bit and build up that good connection. I want them to know from the start that I care.

(Teena)

Developing connection through reciprocal sharing

Team Members spoke of having real concern and care for their clients and that a friendship-like connection helped to build relationships within their professional scope. They stressed they were not building friendships with clients; instead they were working on a friendship-like level by using reciprocity to establish relationality. This valuing of reciprocity reflects Green et al.'s (2006) theory of "stretching the elastic" (p.449) of professional distance between the client and health service provider, as Team Members adopt a highly personalised approach to their work with clients that often includes an appropriate use of personal self-disclosure.

Being friendship-like, for Team Members, was about reciprocity, building trust through mutual, safe sharing. Macca described sharing “a bit” with a client so they had enough of an understanding of him to trust him in their working connections.

I wouldn’t know how else to build up the trust I need with a client without offering myself as friendly. I need to work with clients on really tricky health issues and without trust nothing gets done. My being friendly helps them settle, learn a bit about me, enough to trust me, so I can do my job really well.

(Macca)

Team Members chose what stories of their own health and life they share with clients, being vulnerable through the sharing but sharing with measure and intent. This expression of trust invites reciprocal sharing and trust building into their working relationship. Being seen as real meant that the Team Members tried to relate to their clients person to person and this was achieved by developing a two-way friendship-like connection. At times Team Members realised they had something in common with the client, and were willing to share that common ground experience; many saw it as a way of establishing a trusting connection. Team Members said they viewed the client firstly as a person and secondly as the client, and so some mutual exchange of information helped to create a real bond from which their professional role could work most effectively. This reciprocity respects Aboriginal and Torres Strait Islander cultural protocols about introducing oneself using personal information like family name and connections held with Country or by establishing family or community connections:

I am happy to tell clients little bits about me, you know the things they might relate to, or the things we find out we have in common. It is not like building up a close friendship, it is about starting a functional relationship.

(Tia)

Willingness to self-disclose brought personal connection to the front of the relationship they built with their clients, allowing the clients to appreciate them as 'real' people:

I share some of my own stories with my clients. I don't let my professional role mask anything about the real me. Like, I shared my experiences with grog [alcohol], and how that impacted on me and everyone around me. But what I was able to do was to talk about what changes I made and why- what I learnt about grogging on [drinking]. I wasn't coming across all "you gotta stop drinking", but what they could hear was a real me, telling my real story and sharing how things changed for the better when I made some decisions and took action. Sure, it was my story, but it was also theirs.

(Justin)

Setting boundaries

Developing friendship-like connections does not involve indiscriminate friendliness and openness; rather, Team Members regularly exercise boundary work. They actively, thoughtfully and consciously make decisions about how much of themselves they share with clients (and with whom) and how much they keep hidden. Ethically and practically this boundary work protects both the Team Member and the clients as it maintains the importance of providing a health service experience that is for the benefit of client health outcomes above all else. Team Members explained that this level of working made their professional relationships with clients authentic and respectful. While they spoke about being employed to provide a supportive professional role they did so by using friendship- connections, in what Marlene described as a "safe way":

I put myself in their shoes. I like to go and see [a health professional] who sees me as a person not a health problem or a number, and so I take that same approach- I am a person first who works as a health professional. My work is all about providing supportive service to the client but I do that because I am a person who cares. Part of building a connection is putting time in to get to know each other a little bit. Safe way of course.

(Marlene)

Some Team Members said they were very honest about telling clients they were sharing only part of their story, that the rest was their deep personal journeys, and the clients understood that and didn't push for anything more than they were given:

I said, straight up, I'll share a little bit of what happened to me. The rest though, well, that's my personal stuff, eh. But for me things got rough and when I found myself drinking earlier and earlier each day, well that's when I knew I was in trouble. But lots went on, so much more between understanding that and doing something about it. But that is my part of the story.

(Macca)

Using this approach, the Team Members report they were still giving their personal side to the client and they perceived they were being real within their professional role, and Team Members reported that made them feel comfortable to share what they decided to share. Team Members also suggested they knew how to make decisions about which clients they could share personal stories with, and those clients they kept a little further away:

When [Sharon] first started at the clinic I realised I could talk to her a bit about my own challenges with smoking. We seemed to have lots of things in common, especially having young kids and looking after sick rellies. So for her it was natural for me to want to tell her about the day I had "quit" and how I ran around like a chook with its head cut off just trying to keep busy so I didn't smoke … It made her see me as a real person, juggling things just like she was. So when she used to come in looking flustered I would be comfy to say "Geez you look like a chook with no head today", but I wouldn't feel comfy saying that to all clients- they might take it the wrong way and see me as not professional. It's important to be able to make that call, you know?

(Cindy)

Interestingly, Team Members chose to share past experiences, learnings and challenges with their clients, rather than sharing anything from their present lives. This enabled Team Members to use their own resolved issues as a resource for their clients. Through this type of sharing

Team Members did not seek any resolutions or advice from their clients, rather they gave their clients something that might be useful to them.

While Team Members engaged boundary work around what they share of themselves they also engage boundary setting around their role. Team Members reported that they create trusting spaces in their work with clients and this is often built upon working in a friendship-like way. Within that space, however, they claim to be very explicit with their clients, reminding them that they are not a friend, they are their health worker and as such they have limits on what they can and should share with each other. Bill explained that his clients respond well to him being upfront about this:

Clients respect taking the upfront approach. I make it clear that whatever we talk about during our appointments stays within the room- and that means what they say or I say. And then I explain that we can have a good connection within the health service, share a few personal stories but that doesn't make us friends that hang out. It keeps us friendly but still doing what they have come here for- and that is to get their health better.

(Bill)

Team Members also worked both conscious boundaries around their working space and their professional responsibilities:

So I explain about mandatory reporting, about crime and safety and say that if they speak about those things, they cross that line. Then we all know and I can remind them about the line if they sound like they are about to cross it!

(Macca)

They're not going to get that by being told to "stick to the facts", they need to trust me. So I work hard to get all that right, early on. They confide in me but they know there is a line. Sometimes I even draw a line on a piece of paper and put that on the desk. We usually laugh, but it is a good way of explaining what we can yarn about and what needs to stay out of the room.

(Pete)

Another strategy for ensuring professional health service delivery coupled well with a personal connection was setting limits for the interactions between client and health professional so that they maintain a balance between time for Yarning and time for getting "the work done":

…I am straight up about setting limits for our sessions. I usually say to a client that we should aim to spend the first twenty minutes Yarning and getting things off our chests and then the rest of the hour focused on working on [the health issue]. Of course we still have time for short stories while we get the work done, but if it starts to take hold of the session again, well it is my job to bring us back on track and back to work.

(Teena)

Teena's time boundary setting helps her ensure that she follows appropriate cultural protocols and allows time for her and her client to exchange some personal conversations but it also sets up a boundary within which they both work. Team Members also set other time limits as they worked with their clients; while they wanted to be as available for their clients as possible they made it clear to the client that they had "a job to do":

I have a job to do and that is why I am here. While I am not here to make friends I can be friendly along the way, while I do my job y'know? I make sure the clients know my working hours and that I will make myself available for them as often as they need, as long as it fits here with work- y'know hours, and meetings and appointments. But I am upfront about that.

(Teena)

Setting and reinforcing boundaries with clients

Having friendship-like connections with clients often resulted in Team Members receiving invitations to attend special events in a client's life, however these types of invitations would ordinarily be given and received between family and friends and not between health professional and client. These were examples of what Team Members clearly defined as acts of

friendship. One Team Member spoke about how she managed real challenges in her workplace, with clients who liked her and kept inviting her to their special life events- like their birthday BBQs and their children's birthday parties:

The first time was when I got asked to a client's birthday BBQ at the lake. Then another client asked me to help her at her son's tenth birthday party. When I thank them and say no I can see they are often upset, but they understand where I am coming from. They know that I would be crossing that old line in the sand if I went along to anything.

(Helen)

Another Team Member was asked to an engagement party and needed to reinforce her boundaries:

The toughest invite was to an engagement party- …it was a client I had worked with for ages and ages, and I knew she had lived through a string of awful relationships before she met this really great fella. I had been so happy for her when she told me, during a counselling session, that they had gotten engaged. Really, I couldn't hold back my happiness for her- I think I got a bit misty eyed, really. Well, the invites are always so genuine and I receive them with thanks and the respect they deserve- but I always say thank you, but I am unable to come.

(Carlee)

Helen, like other Team Members, thought that invitations from clients were a sign of respect for the friendship-like connection they had built between themselves and a client. However, she also was very clear that the invitations were from a client, at work:

Funny though, for each of those invites- well, if I had met those clients outside of work I reckon we'd be good mates and I would be going to the BBQ, kids party - true! But we ***didn't*** *meet as friends, we met here as client and [health provider] – and that is the big difference.*

(Helen)

Managing the personal stress burden of friendship-like connections

Acknowledging common lived experiences between client and Team Member was considered an important part of work practice. However, sometimes finding common ground, when working with a client, evoked stress for Team Members, as they either recalled their own personal struggles or related to a situation that caused them grief. They often found out very personal things about their clients because of the close relationship they had developed and sometimes those personal things related to the Team Member's own journey. Team Members spoke about sharing the same feelings as the client, having empathy, as the client talked about particular personal issues. While this often caused stress, Team Members still regarded it as a really important part of work. Tia recalled a time when she felt empathy over shared experiences of breast cancer. Tia had built a trusting friendship-like connection with her client and felt it was OK for her express her empathy and talk about her own experiences. Tia later reported to me that it was important to have the capacity to be able to express herself this way:

When she told me that her sister and her Auntie both were battling breast cancer, my heart sank. I knew exactly how that felt, in my own family. I saw her sadness and I felt her sadness. She confided in me, telling me that stuff. It was perfectly right for me to tell her I knew how she felt, and tell her a little bit about my family too- not everything, you know, just what felt OK within our relationship connection.

(Tia)

One stress that several Team Members experienced was stress around wanting to do everything possible to help their clients but being worried that others at work would perceive this as an act of friendship, rather than as a professional who has a friendship-like working

connection with a client. Justin described being worried that he might be negatively perceived as giving a client “special service”:

I got along really well with him … we laughed a lot each time he came to the service and most of the time we stopped and had a cuppa while he was here. But when I found myself starting to think about what else the service could do for him, you know, outside of the program he was on, well, that’s when I pulled myself up. I was doing for him what any other health professional in my service would do, and that was the truth- no more, no less. The difference was that we had a closer connection- but that didn’t mean he got special service!
(Justin)

Macca’s experience was similar:

Honestly, I am tested when I feel heartbreak for what the client is going through. You know, we have gotten to a point where we do share a little of me in the work I do with them, and I have that, I dunno, emotional feeling. But when I start thinking about how I can give them more than we are funded to give, then I stop myself in my own tracks.
(Macca)

5.3.3 Why do Team Members establish friendship-like connections with clients?

Team Members established friendship-like connections with clients that respected and upheld important cultural protocols; as Jimms said “it is just our way [Aboriginal and Torres Strait Islander way] to get to know each other well…it is important to know each other’s mob [family], what’s going on in community”. Friendship-like connections also helped Team Members to establish thoughtful and considered boundaries that supported them to achieve good health outcomes for their clients; Justin described this “…both the client and me really think about the lines we both draw in the sand and that is healthy, we both know where we stand and then relax so we get better health work done”. Some Team Members suggested that a professional relationship, and health service delivery, might not have happened had the friendship-like

connections been overlooked – “it brings the human side right to the core of our business” (Helen).

Friendship-like connections (getting to know the client) equips the worker to better meet client needs

Several Team Members specifically stated that they purposefully took a more familiar, friendship-like approach with a client when they were first building up the professional relationship. They said that if they stuck to a tighter, more “clinical” approach they would risk losing engagement with the client:

My clients wouldn’t come back after day one if I just followed the paperwork on first visit approach. Of course, the paperwork gets filled out, but it doesn’t dominate the first session I have with a client- that has to be about them getting to know me well enough to feel safe and comfortable and want to come back for a second consult. If I can achieve that, and get the forms filled out, well I am doing a good job.

(Tia)

Having a friendship-like connection to a client also meant that the Team Members felt they understood what the client was capable of doing, in terms of treatment or health service planning. Team Members believed that a closer knowing of the client allowed them to really work more effectively and efficiently on their health service provision in a way that other health professionals in their workplaces might not be able to do so quickly:

She had confided in me about her many times in rehab. She had been so honest. I knew what didn’t work for her and which medications made her feel sick, so she wouldn’t take them. So I could actually use that info to plan her a detox and rehab[19]. One of my colleagues[who didn’t know her so well] kept pushing me to sign her up for the “x” rehab centre and plan, insisting that it would take less time and cost less money- but I KNEW it wouldn’t work for

[19] Here Marlene is describing how she used information from a client to develop a detoxification and rehabilitation plan for that client.

her so I stuck to my guns. I wouldn't have done that if we hadn't shared those personal stories.

(Marlene)

At debrief my manager explained what referral plan [the client] was going on and my heart just felt heavy. I knew she wouldn't like that plan, I knew it wouldn't fit her lifestyle but I also knew that was what the service budget could provide. My manager didn't know her any more than from what was on her intake form, and he couldn't be blamed for the decision. I just had more insight into the real her, and knew she would be back again in a couple of months, needing another referral and more help.

(Maureen)

Team Members established friendship-like connections with clients for a number of reasons including using them to respect and uphold important cultural protocols, to establish thoughtful and considered boundaries and to support them to achieve good health outcomes for their clients.

5.3.4 How other people in Team Members' workplaces perceive working with friendship-like connections and the consequences of these perceptions for Team Members

Team Members articulated how they work with clients through specific terms; they talked about 'connections', 'friendly relations', 'friendly-like ways'. However, Team Members reported that many colleagues and managers refer to the same way of working as being 'friendships', highlighting a misunderstanding of the way Team Members work:

I know my manager is confused by the way I make connections with clients. She said to me 'You just blur those professional boundaries in your friendship with the clients. But I guess we can cover the referrals and assessments, if you keep them happy' – she doesn't see I am doing both!

(Macca)

Although Macca reported that his manager was “confused” by the way he worked with clients in a friendship-like way, Justin’s explained that his supervisor praised his work practice, in particular noting how effectively he enacted boundary management strategies:

She [the supervisor] said to me “well, I don’t know how you manage it, but you have good close connections with your clients, AND respect all of the professional protocols. I don’t think I could do it the way you do- makes me both proud and jealous!

(Justin)

However, in general, Team Members reported experiencing other work colleagues and their managers perceiving friendship-like connections with clients as being a negative way to work. These perceptions suggested that Team Members were violating workplace norms and not respecting professional boundaries. Kim described to me how she successfully worked with clients over coffee in a café but said she struggled to have her manager understand it was how she worked; reporting that her manager said she was “treating her [client] like a friend, not a client”. Kim expressed frustration over the disconnect between what she understood she was doing and what her manager understood her to be doing, and said to me “Shit, this is confusing”.

Jimms also expressed feeling frustrated as he tried to explain the way he worked to his manager:

I know exactly what I am doing and why. And I know it works for the clients because they make progress. But all my manager can see is me ‘being too friendly’. Shit. What else can I do or say to get them to see why I work this way?

(Jimms)

Managers and colleagues misunderstanding friendship-like connections with clients

Team Members were concerned that their managers and colleagues confused Team Members' friendship-like connections with clients with friendship:

My manager [non-Indigenous] treats me like I am a friend to the clients, not a health worker. Like blurred boundaries. Last week she said 'I have to remind myself you are one of us – you just seem like one of the guys out there in the group room, like their mate.'

(Jimms)

Jimms used the term "blurred boundaries" to describe his manager's misunderstanding of the way he works with clients (in a friendship-like way) with the act of friendship. Jimms' manager establishes an 'us and them', by referring to the clients as 'them' "out there in the group room" and health staff as 'us'. This implies an existing structural divide between health staff and their clients that, perhaps, is intended to be upheld to maintain what are considered by Jimms' as his manager's perceptions of appropriate professional boundaries.

Cindy's colleague, Ted, suggested to her that she cannot be friendship-like with clients and still do her job:

Ted [colleague] said to me 'Hey, don't know how you can be such a friend to them [clients] all the time. I couldn't do it. I have a job to do.'

(Cindy)

Managers and colleagues see friendship-like connections as unprofessional

A concern for most of the Team Members was that managers and colleagues made comments to them about making friends with clients, and those comments suggested that a friendship-like connection was unprofessional:

My workmate really struggled with the way I am with clients. He always says things to me like 'Better watch it, there. He'll start asking you to pick up his kids from school soon', or 'So, you going to catch up after work then, eh?' It made my skin crawl. Worst of all was when he says things like 'My training taught me about that stuff, you know being professional, and all that'.

(Scotty)

Scotty believed that his colleague is suggesting that the professionalism he was taught about in his professional training has developed his concept of what professional practice looks like with a client, and thus he imposes a different conception of professionalism onto his understanding of Scotty's professional practice with clients.

Kim suggests her manager accused her of violating accepted workplace practice and potentially damaging the service's professional reputation, through working with clients in a friendship-like way:

Once she [manager] said 'It might be a good idea for you to have a chat with David [human resources officer]. Might be good to talk about professional distance between you and your clients. We have to be very careful about keeping that line drawn in the sand. Our reputations depend on it'.

(Kim)

Kim perceived that her manager suggests that she does not maintain appropriate professional boundaries in her professional practice. Kim believed that her manager felt she was positioned

in a role that allowed her to make a judgement about how Kim worked with her clients and with boundaries. Kim expressed that her manager sees Kim's friendship-like connections as challenging what the manager perceives as professional. Kim did not believe she violated any professional boundaries. Unlike Kim's manager, I did not believe I was in a position to judge the rightness of her practice but rather took her word that the way she worked was productive and helpful for her clients.

Tia perceives that her manager sees her way of working as creating challenges for how the service manage client appointments:

I don't know… [my manager] said maybe I have been too open and had a bit too much Yarning with her. She is worried the clients will come and go whenever it suits them…but they don't. How do I say that to [my manager]?

(Tia)

Tia suggests that she struggles to explain to her manager that her clients don't see her friendship-like connections as blurring her professionalism.

Many Team Members had colleagues or managers who thought that they were not getting their job done if they were seen as working differently to others in the health service. Several Team Members explained to me that their colleagues and managers thought that having a meal or a coffee with a client was purely social and undermined their professional practice. One Team Member was very worried about how her supervisor misunderstood how she worked with her clients over coffee, seeing it as unprofessional practice:

I feel my supervisor really judges me when I tell her that [the client] and I are taking the [counselling session] to the café next door. For me, it's perfectly appropriate- she [the client] likes coffee and feels more relaxed Yarning over a cuppa in the cafe, and I love my coffee

too. No harm done, and a good job is getting done. But my supervisor always gives me this look, like she is saying "unprofessional" just in that one facial expression. I really wish she wouldn't see it that way.

(Kim)

Kim spoke about what her manager worries about:

My line manager asked me to explain why I have my sessions with [client] over coffee at the café when I could just make a cup here at work. She said to me 'really it's like you two are going to catch up like friends with gossip or something. Can't you just have coffee here in the office'?

Here Kim's manager imposes her own understanding of professional practice onto what she expects of Kim. Referring to Kim and her client as "you two" enacts an imbalance of power, treating Kim and her client as children who should be reprimanded. Kim worries that her manager does not value her ways of working, which is highly insulting to Kim. Sadly Kim is accused of absconding from the workplace to have coffee at a café, rather than seen as utilising a shared café experience to better engage and work with her client. Kim's manager may prefer to keep Kim's work practice in her own domain of control, in the workplace and in the manager's sight. One interpretation of this is about Kim's manager wanting to maintain control over Kim and the way she works with clients, having Kim work in a clearly defined workspace and not in a space like a café that might be perceived as a social space, not a working space. Another interpretation is that Kim's manager perceives Kim to be shirking her work responsibilities as she takes the client to a café to talk. This perception implies Kim is a lazy Aboriginal employee who escapes work as often as possible by taking her clients to coffee at a café; what it does not do is value that Kim has developed this work practice to best suit the needs of her clients and sees it as one of the ways she works.

Professional duties curtailed and professionalism called into question

At times Team Members had colleagues or managers remove professional decision making from them because of the friendship-like connection Team Members had with their clients:

My line manager took over [client's] care after our last team meeting, saying I was "too close to [the client] to be able to make professional decisions about her future care. It just upset [the client] to no end. The service almost lost her over taking me out of the picture.
(Helen)

I couldn't believe it when I turned up to work and saw that [client] had been handed over to another staff member. I was really making progress with [client]. The manager said it was time for [client] to "work with someone new because we (me and [client]) were just too close now". I got the shits. They have no idea how hard we had worked together. They saw our friendly work as mateship instead of something that was helping us make progress.
(Jimms)

Helen and Jimms both used friendship-like connections in the health service work they did with clients but both had this work misinterpreted by management, who felt that such connections made it impossible for Jimms and Helen to make decisions about the future care plans of their clients. This misunderstanding led to the professional disempowerment of Helen and Jimms.

Another Team Member recalled having his manager question a clinical decision, asking him if he was "sure about that call, y'know… are you too close as a friend here?" (Scotty). Scotty did not consider himself a friend to this client, he did not have a relationship with the client outside of his professional health service capacity. Scotty believed his manager misconstrued as friendship the way Scotty used a friendship-like connection in the work he did with his client.

Similarly, Cindy told me several times she was "over it", telling me she had "had enough of trying to explain why she did what she did at work". Cindy said:

I feel like I have explained the way I work so many times. Some of my colleagues look back at me real blank. So I try again, using a different way of describing to them how I work with clients. More blank stares. And then my boss just says "yeah, righto Cindy", sounding like she's saying enough is enough, putting me back in the box, y'know. Well, right now I think it is just better to keep doing what I do and let them think whatever they like!

(Cindy)

Cindy's frustration has led her to feel isolated at work, feeling like she was put "back in the box", tucked away, not seen or understood and yet Cindy believed so strongly in how she worked with clients that she chose to keep working her way regardless. While this shows Cindy's resilience it also highlights the workplace's inability to appreciate, value or understand Cindy's working practice. While Team Members felt clients understood that friendship-like connections could exist within the health care service interactions, Team Members felt that their managers and colleagues largely misunderstood these relationships and saw their ways of working as violating workplace norms.

Managers and colleagues selectively utilising notions of friend-like connections (and misunderstanding their nature)

Team Members reported that some managers or colleagues mistook friendship-like ways of working for friendship between a Team Member and a client, and then sought to use that 'friendship' to get work done that they thought aligned with such a 'friendship'. Macca recalled his manager saying it would be most appropriate for him to "go in and have a chat to the fella [client]", explaining that it would be beneficial for "an Aboriginal client to touch base with an Aboriginal worker, a friend". In this case Macca's manager suggests that being a 'friend' makes it easier for Macca to do his work. Macca described to me how his manager does not understand "the way [he] makes connections with clients" and tells Macca that he blurs

"…those professional boundaries in your friendship with the clients". However the same manager quickly utilises the connection Macca makes with Aboriginal clients, and often uses Macca as a point of engagement with a new Aboriginal client, asking him to "go in and have a chat".

What Macca's manager is privileging is Macca connecting with the Aboriginal client purely on cultural grounds, suggesting Macca is "a friend" rather than a health professional. Macca's manager is calling on the cultural connection between two Aboriginal and Torres Strait Islander people, perhaps assuming that such a cultural connection implies automatic friendship. Macca's manager appears to suggest this action as being a positive workplace practice, but it remains an example of how Macca's friendship-like ways of working with clients remained misunderstood.

Team Members also reported that colleagues perceived Team Members to have split loyalties because they are 'friends' with clients and that this meant that the Team Member was only in a position at work to enact that friendship, through meeting and greeting and making cups of tea. The example below highlights that Helen's colleague does not see her friendship-like way of working as part of her working practice, but as part of who she is as an Aboriginal person meeting another Aboriginal person (the client). Sadly this implies that Helen's workplace practices separate being friendship-like and doing the job. However, Helen clearly understands that she works in a way that can achieve both:

My colleague told me to be the one to do the meet and greet at the door. She said 'You are a friend to these guys [clients], so you should greet them, make them a cuppa and settle them in. Then I can come and do their clinical review. She got really confused when I told her I could do both at the same time.

(Helen)

5.4 Discussion

The aim of this chapter was to explore how Team Members made purposeful decisions to create friendship-like connections (Reimer, 2014) with clients, how they embedded these friendship-like connections within their professional role responsibilities and how they valued this as a way of working with clients. Team Members showed a strong belief that using friendship-like connections was a better way for them to work with clients than other, more dominant and normalised ways of working preferred by managers and colleagues.

My findings show that Team Members saw friendship-like connections as a valuable and necessary part of their practice with their Aboriginal and Torres Strait Islander clients, and had developed very conscious and well-thought out ways to manage the boundaries; however my findings also show that their practice was treated with deep suspicion by colleagues and managers.

My findings are broadly in line with published research, especially in relation to how Team Members carefully work with clients in ways that are friendship-like (Reimer, 2014), using reciprocal sharing of selective personal information and empathy to give clients “a sense they have been understood and their needs respected” (Pounds, 2010, p.142). However, there are some differences in the specific practice of friendship-like ways of working that are due to the cultural context that is shared by Team Members and their clients. Team Members use personal disclosure more often than just in ‘pivotal moments’ in therapeutic relationships (Welch, 2005) or merely as a way to increase client engagement, rapport and trust (Gardner, 2010). The cultural context shared by Team Members and their clients provided opportunity for

Team Members to use “expertise by experience” (Oates et al., 2017, p.2), drawing upon shared Aboriginal and Torres Strait Islander ways of being, knowing and doing to enhance their work with clients for the advancing of client outcomes, and not for their own personal gains or needs.

Team Members established and valued important boundaries in their work with clients that aligned with Green et al.’s (2006) theory of professional boundary work having the potential to be “a stretchy piece of elastic” (p.450), allowing Team Members to uphold their professionalism whilst also attending to the important friendship-like ways of working. Importantly the findings align with the work of Kelly et al. (2014) on how Aboriginal and Torres Strait Islander student midwives navigated boundary work as they provided “additional support [that] extended beyond the provision of clinical care and reflected the holistic ways in which Aboriginal Health Workers operate”(p.6), with Team Members sharing food and drink with their clients, giving them time to Yarn about important matters that are not necessarily related to the immediate health care provision. Such work could challenge existing professional boundaries, however I argue, as does the work of Kelly et al. (2014), that my findings provide evidence for revisiting existing professional codes of conduct and to include “the holistic ways in which Aboriginal Health workers operate” (p.6).

The capacity that Team Members demonstrated in being able to maintain their professional health service provision while working in friendship-like ways is also supported by research done by Hunt (2006) on midwifery and Aboriginal and Torres Strait Islander clients. Like Team Members, Hunt’s Aboriginal and Torres Strait Islander midwifery service staff had “strong links

with the community, and … focused on meeting women's social and practical as well as health-care needs" (p.54). Similarly, Panaretto et al. (2007) reported that "sustained access to a community-based, integrated, shared antenatal service has improved perinatal outcomes among Indigenous women in Townsville" (p.18), again supporting the embedding of Aboriginal and Torres Strait Islander ways of being, knowing and doing into health service provision. Above all, Kelly et al. (2014) (referring to her midwifery study) captured the essence of the ways of working demonstrated by Team Members in this study:

Aboriginal and Torres Strait Islander midwives bring to the woman-midwife partnership a unique skill set that non-Aboriginal and non-Torres Strait Islander midwives do not possess. This skill set includes a shared understanding of the lived experience of being an Aboriginal and Torres Strait Islander woman in a mainstream culture. An Aboriginal and Torres Strait Islander midwife is able to act as a bridge between the two cultures and relate to other Aboriginal and Torres Strait Islander childbearing women in a culturally appropriate way. (p.161)

In my study Team Members also demonstrated ways of working with clients that provided scope for boundaries to be established and valued by both Team Members and the clients they were working with. Hart (2015) provided examples of how important it was for youth workers to negotiate and maintain boundaries with their clients in order to enhance service and ensure solid client engagement, explaining that "The youth work relationship has elements of friendship which makes boundary setting more difficult than in other social professions" (p.878) and that these require the workers to "engage in 'peer like' ways, without becoming too close" (p.878). An important finding in Hart's (2015) research was that it is not only the worker who determines the boundaries within their professional relationship with the client, but the youth (client) also "have agency over who they interact with and how close they allow workers to get"

(p.878). This finding aligns with my research as both highlight the reciprocity that can exist in the working professional relationship between client and health service provider that can empower both parties to be responsible for setting and maintaining the boundaries in their interactions. This challenges the power differential by respecting client-defined boundaries in collaboration and consultation with worker-defined boundaries (Doel et al., 2010). Hart's (2015) research on establishing and maintaining boundaries between health professionals and youth (clients) is similar to my research, showing shared establishment and maintenance of boundaries between Team Members and clients, and both challenge the existing dominant top-down power dynamic established and upheld by many health services and systems.

My findings are supported by other work on being perceived by colleagues as blurring professional boundaries because of developing friendship-like connections with clients (Austin et al., 2006; Gardner, 2010; Green et al., 2006; Kilpatrick et al., 2009; Shepherd, 2013; Thompson, 2015; Warren et al., 2013).

Team Members described strategies that allowed them to build up a solid friendship-like connection within a service delivery role, but a key message was that the Team Members clearly defined the connections with clients as "working" connections; this echoes work by Bennett et al. (2011); Ella et al. (2015) and Kelly et al. (2014). Team Members work involved setting limits and boundaries with clients early, and judging appropriate self-disclosure. The strategies they used to politely decline the party invitations and manage shopping centre conversations kept them working well within professional boundaries while still connecting with the client on what they perceived to be a deeper, more familiar level.

Many of the Team Members reported experiencing a different understanding about their friendship-like connections with clients from their managers and colleagues who worried about the nature of those relationships. As a result of this Team Members experienced a series of negative impacts on their own experience at work, including having their professional role ill-defined and misunderstood, receiving feedback that suggested their practice was unprofessional, having their professional capacity undermined and being accused of not getting the job done.

Despite the thoughtful, purposive, nuanced and respectful boundary work constantly reported by the Team Members in this study, they perceived others in their workplace (managers and colleagues) considered their friendship-like connections with clients as detrimental to professional practice, suggesting that such connections blurred professional boundaries and decreased professionalism. Thus there was a disconnect between what Team Members value and what Team Members thought their colleagues and managers value.

Chapter 6: "My work? Well, I live it and breathe it." The seamless connect between the professional and personal/community self.

6.1 Introducing this chapter

In this chapter I explore how Aboriginal and Torres Strait Islander health professionals juggle the challenges of working and living in the same community in ways that are positive for both themselves and their clients. Specifically, I learn about the strategies Aboriginal and Torres Strait Islander health professionals have developed to enable them to feel empowered by the sense of being always visible, or perceived as being always available. While some literature describes a risk of burnout when Aboriginal and Torres Strait Islander health professionals do not have 'down time' from living and working in the same community, for example Wilson (2013); Conway, Tsourtos, and Lawn (2017) and Josif, Kruske, Kildea, and Barclay (2017). At the time of conducting this research, Team Members identified strategies to allow them to work with a comfortable, seamless connect between their work and community roles and not burn out. Data is presented that provides examples of how Team Members established a seamless working self, including how they often held different perspectives to many work colleagues, how Team Members were always visible to community and how Team Members were comfortable to be seen as working when not at work.

The analysis presented here comes from data generated through PhotoYarning sessions. Team Members in this study all work in health care settings in the communities in which they also live, they manage an extremely complex network of interactions and relationships in their daily working lives. They occupy an ambivalent, and sometimes ambiguous, position as representing

both their health profession and their community. This chapter explores examples of what working with seamlessness involved, with findings citing four main themes: (1) Being fellow members of their cultural community, (2) the feeling of always being visible to community as a health worker, (3) the feeling of always being available as a health worker to community even when not at work and (4) the need to set an example. While creating this seamlessness was not easy, Team Members considered it an important feature of the work they did and vital if they were to be able to provide quality health service to their community. However, they reported that the seamless working self was at odds with the way many of their non-Indigenous Australian colleagues worked and it was not well understood.

6.2 Literature specific to this chapter

In Chapter 5 I introduced concepts of appropriate relationships between health workers and clients, of setting boundaries and of friendship-like connections, all in the context of working with individual clients. This chapter broadens the scope to include the relationship of health workers with the communities they live and work in and the roles they take on as health workers and community members.

6.2.1 Community-based health workers improving client engagement with, and experience of, health service provision

It is now acknowledged that health workers who either live and work in the same community as, or share a cultural connection with, their health clients can enhance health systems, in part because of their community engagement, community knowledge and cultural connections (Durey et al., 2016; Kok et al., 2016). In an Australian context we have evidence that some

health services (and their clients) have benefitted from employing Aboriginal and Torres Strait Islander health staff who not only share cultural backgrounds but also share the community with their clients by living and working (community-based) in the same place. We saw this in Chapter 5, where Aboriginal and Torres Strait Islander women experienced improved health outcomes and increased engagement with maternity services that employed Aboriginal and Torres Strait Islander health staff and health students, partly due to familiar communication styles, community familiarity and relationships that extended beyond “the boundaries of a clearly defined professional relationship” (Kelly et al., 2014, pp.3-4). Several studies from the alcohol and drug sector also highlight the importance of familiarity (Duraisingam et al., 2006; Ella et al., 2015; Roche, Duraisingam, Trifonoff, Battams et al., 2013; Roche, Duraisingam, Trifonoff & Tovell, 2013).

6.2.2 Unofficial roles and additional responsibilities

In addition to their clinical and health-based roles, Aboriginal and Torres Strait Islander health workers often maintain close connections with community cultural, social and political knowledge (Deshmukh et al., 2014; Mercer et al., 2014), and perform additional roles, responding to unique client and community needs by liaising between community and health services, performing community visits and engagements, and supporting clients from the community who might not directly be within their own work caseloads (Deshmukh et al., 2014; Mitchell & Hussey, 2006; Roche, Duraisingam, Trifonoff, Battams et al., 2013). While some health services have positions, such as Aboriginal liaison officers, that recognise these duties as part of the job, other services consider these activities as informal and often do not recognise

them as part of the position descriptions of an Aboriginal and Torres Strait Islander staff member (Ella et al., 2015). Even though many of these 'unofficial' roles might not be documented in position descriptions, they are often seen by the Aboriginal and Torres Strait Islander health staff themselves as being essential to the work they do, albeit at times challenging:

Bearing the load of community expectation can be very tiring when combined with the responsibilities of work and family. We cannot go out after work and relax, as community members may want to unload their problems on us. (Mitchell & Hussey, 2006, p.530)

6.2.3 Health services and health workers' community engagement

While it is documented that health care can be improved through genuinely improving engagement and partnership with Aboriginal and Torres Strait Islander clients and their communities, there remains a need to adopt a better way of achieving such engagement and partnership (Durey et al., 2016; Taylor et al., 2013). Willis et al. (2016) suggest a power shift is needed that "requires a shift from expecting Aboriginal patients to adapt to the expectations of the health service to the health service being more inclusive, collaborative and flexible in responding to the needs of Aboriginal people in ways that are respectful and more likely to build trust and strengthen relationships" (p.10). Often working relationships between Aboriginal and Torres Strait Islander health professionals and their clients align with "cultural and social structures based on family, kinship and community relationships" (Kelly et al., 2014, p.3) that also determine how Aboriginal and Torres Strait Islander people interact with each other.

A recent study noted that some Aboriginal and Torres Strait Islander health professionals feel "restricted in their capacity to practice in their communities" (Bennett et al., 2011, p.68), partly due to their health service not understanding that "Indigenous practice" and "best practice" could coexist (p.68); the health professionals were not restricted by personal factors but by the lack of workplace support to work this way. In another study, Aboriginal and Torres Strait Islander health professionals considered developing respect for Aboriginal and Torres Strait Islander ways of practice in health service provision to be essential to improving the health service experience for Aboriginal and Torres Strait Islander clients; this was also considered as a means of increasing positive health outcomes (Lowell, Kildea, Liddle, Cox, & Paterson, 2015). However it was also acknowledged that "sufficient organizational commitment", understanding and respect is required to integrate Aboriginal and Torres Strait Islander ways of practice into the dominant Western health care system (Lowell et al., 2015, p.11).

6.2.4 Roles and identities

The discussion above touched on roles, responsibilities and community membership, concepts related to identity. It is not within the ambit of this thesis to explore these concepts. However, Lander (2014) supports the working definition of identity used in this thesis; that is, identity if "contextually specific, fluid, a conjoint construction created … in interaction with others" (p.34). As a Koori researcher I choose to privilege two theories as an overarching theoretical framework for this chapter. Cultural Interface Theory (Nakata, 1997, 2004, 2007a, 2007b) helps explain how Team Members work in a space between a dominant Western health system and an Aboriginal community with different expectations and needs, and Indigenous Standpoint

Theory (Foley, 2003, 2006; Moreton-Robinson, 2013; Nakata, 2007a, 2010) that helps us understand how Team Members enact their Aboriginal and Torres Strait Islander ways of being, knowing and doing in the work they do with clients as they avoid separation between the work they are doing in community as a health professional and their membership of the same community.

6.2.5 Balancing roles and identities

Studies have identified both benefits and challenges in maintaining multiple workplace connections and relationships. For example, Brownlee, Halverson, and Chassie (2015) and Pugh (2007) report on the benefits and challenges of maintaining multiple relationships and professional connections when working in a rural context where a health service provider is often also a member of other social and cultural parts of the same community. It cannot be assumed that clean boundaries can be maintained based on the assumption that a health professional and a client live in separate worlds. Boundary work becomes increasingly difficult to maintain when the worlds of the client and health professional are the same, or shared. For example, this difficulty has been explored in the context of mental health clinicians working in rural Australia (Cosgrave, Hussain, & Maple, 2015), in rural and remote community work (Jervis-Tracey, Chenoweth, McAuliffe, O'Connor, & Stehlik, 2012), in rural social work, and in remote Australia (Onnis & Pryce, 2016), when clients and clinicians share the same cultural background (Kelly et al., 2014).

Stets and Burke (2000) remind us that people often simultaneously perform multiple, possibly conflicting or complementary, roles. Aboriginal and Torres Strait Islander health workers who

live and work in the same community face complexities. Their identities may be based on their role as health professionals within a community context in which they also have a role (or roles), while their workplace also provides a social group or context they belong to. They will prioritise one role or another based on its importance to their identity, and this may change. However, as the findings below show, for most Team Members their sense of themselves as health worker and as a community member were equally important and blended seamlessly together.

6.3 Findings

The chapter focuses on how Team Members established a comfortable, seamless connect between their professional identities and personal/community identities which I have called the 'seamless working self'. Team Members described being able to work in a seamless way as meaning they were able to maintain their responsibilities and roles as both Aboriginal and Torres Strait Islander community members and Aboriginal and Torres Strait Islander health professionals. Team Members provided examples of what this seamless connect involved, citing four main aspects: (1) being fellow members of their cultural community, (2) the feeling of always being visible to community as a health worker, (3) the feeling of always being available as a health worker to community even when not at work and (4) the need to set an example. They described having worked hard to overcome the many challenges they faced as they work and live in their own communities and detailed the strategies they developed to allow them to work this way without burning out. While creating this seamlessness was not easy, Team Members considered it an important feature of the work they did and vital if they were to be able to provide quality health service to their community. Team Members did not provide examples of feeling burnt out; instead they spoke about the strategies they had developed and established that facilitated their work with clients while also keeping them functional and healthy members of a workforce and a community. However they reported that the seamless working self was at odds with the way many of their non-Indigenous Australian colleagues worked and it was not well understood.

6.3.1 Being a fellow member of my cultural community

Tia explained that she had invited her new manager over to her home for dinner and described how she and her new manager had been approached by a client 'Kev' while shopping together for dinner items:

Photo: The royal finger! [Tia]

Sometimes my work mates get the finger from a client and then turn and ask me what they have done. I live in a small community, you know, everyone knows everyone. Our health service had a new manager and she was coming to my place for dinner. She was with me in the shop when "Kev" came over to me and started to talk.

I introduced Kev to my new manager and then Kev started to tell me some news about his health. My new manager was shocked and tried to grab my arm and pull me back to my shopping. She said something like "Nice to meet you Kev, well, make an appointment with Tia and you can talk about it then." She kinda gave him the finger, like this photo.

Tia continued to talk about the impact that her manager's action had on Kev, and on her:

Kev noticed she wanted me to move and got real embarrassed, apologised and then walked on. I was furious. Kev vanished before I could go yarn with him again. I looked at my new manager and said "What did you do that for?" She just said "Well, you are doing your shopping and after all he is only a client."

Right then I knew she wouldn't last in this community, in this job. I had to work hard to get over the shame that caused both me and Kev. I had to build up all that trust [with Kev] all over again. The manager, she didn't learn a thing from all that.

In this PhotoYarn Tia highlighted how she became angry at her new manager who, Tia believed, separated her personal self and professional self. Her manager, a non-Indigenous person, said to Tia that Kev "is only a client", and while she too lived and worked in the same community and would be considered a member of the broader community, did not adopt the same seamless approach to her work/personal identities as did Tia. Tia explained that Kev saw her (Tia) as something more than simply his health worker, he also saw her as a fellow member of the cultural community. Tia explained that she knew Kev's family, and they knew hers and as such they had professional connection that was interwoven with a range of cultural and community obligations, roles and responsibilities that she had to uphold.

This example illustrates the cultural complexity faced by Tia as she worked and lived in the same community; she had developed a strategy to maintain her professional identity alongside her community identity. Tia could clearly see the impact her manager's reaction had on her client. Tia named that both she and her client felt Shame, a word broadly used in Aboriginal and Torres Strait Islander communities to refer to a personal, public, family or social display that breached accepted Aboriginal and Torres Strait Islander "norms". These might include, but are not limited to, shameful behaviour, rudeness, embarrassment, lack of respect or displays of self-importance. Tia expressed that this Shame would create difficulties for her client (who, she believed, felt he had done the wrong thing), for her (she challenged her new manager's behaviour and realised the episode meant she (Tia) would need to rebuild trust with the client).

She also knew it would create difficulties for her manager, whose actions, in Tia's opinion, might make it hard for her (the manager) to be accepted in community. This shows Tia working in the Cultural Interface (Nakata, 2007a) as she is familiar with both sets of cultural expectations and needs to make decisions about who or what to challenge, accommodate or repair. Because Tia knows both cultural spaces she can see the space that is contested and can develop strategies for working in that contested space by engaging with her clients in a friendship-like way (as previously described in Chapter 5) while maintaining appropriate boundary work.

Marlene described a similar incident with a colleague who was worried about bumping in to a client outside of work, suggesting that she and Marlene avoid him:

I have been walking at lunchtime with someone from the office here and we see a client coming our way. I said "Hey, it's "Charlie" and my workmate says, "Maybe we should cross the street". I couldn't believe it. And Charlie could clearly see us. She was really panicked about seeing that fella. I laughed because I thought she was joking, but then saw her face. I couldn't say a word to her. I felt sick that someone who worked with this guy (Charlie) could even think about not seeing him, ignoring him.

Rather than avoidance, Marlene's priority was to engage with Charlie. In this quote Marlene refers to the next photograph, *Always seen*, that she used here in her PhotoYarning:

Photo: Always seen. [Marlene]

…We kept walking, and she [colleague] really pulled back a bit, but I kept my pace. Charlie saw us - shit, he could have run or crossed the road so he didn't talk to us, but y'know what?...His face lit up with a big smile. He started to walk a bit faster, y'know with a bit of a step in his walk, and said "G'day ladies. How's things?" I smiled back and said "Yeah, good Charlie, just out getting' some lunch. How about you? How's your day?" Charlie than said "Ah, well, y'know a bit of this and a bit of that. All good though." Charlie looked at [colleague], and she said nothing.

I didn't even look at her I was so shocked by her first reaction. My concern was Charlie- I didn't want him to think I was like her, or pick up some bad vibes, y'know?

We might have been on our way to lunch but Charlie still saw us in that TV reflection- my colleague [non-Indigenous] might have had the TV switched off and thought she had a blank screen but me, well I know there is always a reflection on my TV screen.

Unlike her colleague, Marlene described always being "on the screen" and visible in community and to clients, demonstrating her awareness of community practices and expectations, and her sense of being a community member who is obligated to other community members in need. However, Marlene is also aware of the professional practices of her colleague that support

turning off or being somewhat invisible during breaks at work or after work. Marlene lives and works in the contested space of the Cultural Interface and understands both ways of being, knowing and doing. She has developed strategies that allow her to maintain her professional responsibilities and her community responsibilities concurrently. Marlene used friendship-like communication with her clients, previously described in Chapter 5, to communicate with empathy while maintaining boundaries that were respected by both her clients and herself. Being on an official lunch break did not make Marlene feel invisible to clients; she had seamless visibility and has friendship-like ways of working to support her seamlessness.

6.3.2 The feeling of always being visible to community as a health worker

Marlene PhotoYarned about the photo she had taken, *Always seen* (presented on the previous page), and described the reflection on the TV screen as being like her identity at work and in community. The photograph allowed her to Yarn about how she always felt visible to community, and that visibility extended to all parts of her life in the community in which she lived and worked:

See this TV screen? Well it is off but you can still see an image on the screen. That' how I am – I might finish up my day at work but people can still see me in community, see who I am and what I do. And they see me as many things- their family member, the health worker, the person doing her shopping one night and talking to them at the clinic the next morning… [extended pause]… Like this reflection on the screen, people can always see me. I can't turn it off. Sometimes I can put it in the background a bit, but it is still there, ready to pop back into my head anytime. Don't get me wrong. I love my job, love what I do. But sometimes I'd like to go to sleep and not be worrying is my client is going to binge overnight, or if another client is going to stay dry over Christmas. Things like that.

Marlene says that she is always being seen by others, whether she is at work or away from work, and indicates the difficulty of being in that position, stating “I can’t turn it off”. Being

always visible, and working seamlessly, does create an emotional burden for Marlene who finds it hard to stop worrying about her clients overnight. Not being able to turn off from work has been recognised as a contributing factor to burn out (Lee et al., 2017) and while Marlene identifies this as a challenge for her she also had established strategies that prevented her from being overwhelmed completely by the emotional burden of her work.

In the extract below we can see Marlene has clearly identified that she had a different philosophy about being visible to community to her colleagues. She indicates that her colleague leaves his work at work and then doesn't notice clients in the community outside, and clients don't notice him outside of work. She suggests this process made the clients invisible to him, but insisted that the situation was different for her, as she was always visible and always saw the clients as visible too:

Actually although I say it worries me I wouldn't want to be like [colleague] who pushes his chair under his desk, and leaves it all there as he walks out that office door. Y'know, at least I know the clients by name if I see them in the street, or at the school or the shops. [Colleague's name] pretends he doesn't see them- like clients are invisible as soon as they leave here, like a ghost. But like things on this TV screen, people can been always be seen. And I know I am always on that screen.

Marlene's awareness of working in the Cultural Interface is evident here; she is aware of both dominant work protocols and practices (leaving work at work at the end of the day, not 'seeing' clients outside of work) and of community protocols and practices (actively engaging with other community members regardless of the context, being available for community). Her awareness affords her the privilege of making choices and developing strategies so she can uphold both spaces.

Helen took this photo and used it to PhotoYarn about the open connection between her professional self and personal identity in the community in which she worked and lived. She described working with seamlessness; finding a place at which she was completely comfortable being identified as the health worker, regardless of the time or location:

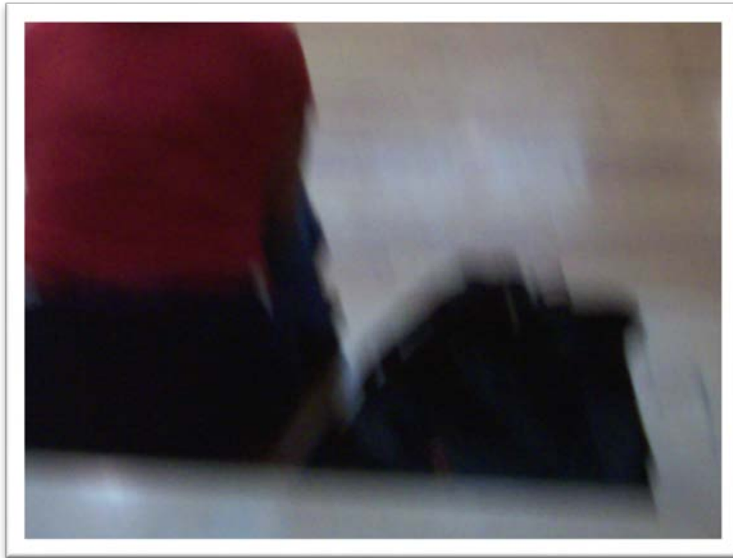

Photo: I don't get blurred like this. I can be seen. [Helen]

This is a client of mine – but I took a real blurry picture of her. She said it was fine to photo her, as long as I don't see her face so we thought it was a good idea to take one from the back, and make it real blurred…I work closely with this client and as we talked about how to take this photo she said that everyone in community knows her anyway so she didn't mind a front on photo, but people outside the community don't, so she wanted to stay blurred. That made me smile because she and I were so alike – everyone in community knows me too, they see me and know I am the health worker who also lives here. There's no blurring who I am.

Helen was comfortable knowing that she was identified as a health worker even when she was not 'clocked on' during working hours, community knew her to be that person and knew as a community member that her professional role would always be seen as part of her 'complete' self, that her personal and professional selves are connected:

Even when I am not clocked on at work I am still clocked on- people don't look at me differently, they just see the part of me that works as a health worker and it's like that never goes away or gets blurry. I reckon even a photo of me taken from behind would be recognised in community!

According to Helen, she might not be constantly seen as the health worker if she had another job elsewhere. She believed that part of feeling comfortable being seen in her professional identity all the time was due to the fact there was so much contact with clients, even in a community setting. There was no room for anonymity or for a differentiation between her professional and personal/community identity because they were one and the same. Helen's lived experience of the Cultural Interface provided her with scope and awareness to adopt ways of being, knowing and working that were seamless, that aligned the contested space between dominant professional ways of working and Aboriginal and Torres Strait Islander ways of being, knowing and doing:

But if I were to work in another place well, they wouldn't know me as I walked out of the office and down the street would they? I might never see a client again if a worked in another place, but here I see clients all the time, even when they are not officially in client mode and I am not in work mode. It is just how it is. How could I live here and be blurry? Just seeing me for my whole person is important. I like that y'know.

6.3.3 The feeling of always being available as a health worker to community even when not at work

Kim asked a work colleague to take this photo for her, because she wanted to be in it. She wanted a photo that showed her having a coffee with a client, explaining that she did that all the time, both during work hours and after work hours:

Photo: This is not just a coffee. [Kim]

So this time we [Kim and her client] had gone and bought a good coffee- not just the stuff we normally drink at work. I think it was because this client had reached a big milestone, so the good coffee was a celebration of that. She would have normally celebrated with drugs, so sitting with her and sharing a good coffee was a huge step. Of course she often thinks about celebrating with other things, and I think that is what we were talking about in this photo, actually.

Kim spoke about how her community saw her health professional identity as part of her self all the time, not just when she was officially at work. Kim did not believe this reflected poor boundary setting, but rather she felt honoured that community saw her that way as she, and other Team Members chose not to hold an impenetrable boundary between the personal and the professional selves:

Sometimes I am 'off work' and a client comes up to me, say in a shopping centre for example, and they are so proud that they have done something good for their health. They want to tell me about it. Imagine if I turned and said 'Hey how about we talk about that on Monday at the clinic?'…well, they'd think I was not interested, or worse, think I don't care! And that's just not me.

The earlier example (photo of *The royal finger*!) described how another Team Member, Tia, had developed ways of communicating with her client, Kev. Tia welcomed Kev's approach in the

supermarket when she was officially off work; she appreciated that Kev had good news and had already established ways of working with Kev that allowed them both to engage in an out of work context that was safe and appropriate for both of them. Showing a client care and giving them time was important for Kim and Tia; their examples show how they both work with seamlessness by using friendship-like ways of communicating with clients. Both had found a way to provide clients with that time and interest, even when officially "off work"; Tia named exactly how it was for her "I live in a small community, you know, everyone knows everyone" and didn't see Kev's approach as a challenge for her. And while Kim was still doing boundary work she was doing it from within a space that was informed by her experience of the Cultural Interface:

My clients know I live here and they know that they can yarn with me when they see me outside of work. Sometimes we end up having a cuppa like this…talking about their health (which is work stuff for me) but I wouldn't turn them away. They see me as who I am, and I am their health worker. Sometimes I have had my kids with me, so we don't stop for a coffee like this, but have a quick yarn up about it. Y'know, respectful listening and a pat on the back – but sometimes a coffee is the way to go.

6.3.4 The need to set an example

Marlene's PhotoYarning focused on how she was always aware of her professional identity, even when she was not officially at work. She spoke about how people looked at her as a health professional in community even when she was not at work and how she felt a responsibility to that professional identity. As such Marlene was always aware of what she was doing, even when she socialised. While not always a pleasant way to be, this awareness was a strategy Marlene had developed that allowed her to blend her professional and community identities. Marlene felt that many of her colleagues did not share the same feeling. Marlene PhotoYarned about the ongoing connection between her identity in a professional space and in a social/personal space:

Photo: Do what we say, not do. [Marlene]

*I took this [photo] at a work do. We were out as a team celebrating something, you know?...But something I thought was real funny. Here we all were- we are all drug and alcohol workers, or nurses or doctors, and the amount of alcohol that was on the table was unreal!... I don't judge people at all- I just choose not to drink, you know? Clients see **me** in community and they look at what I am doing… Well, I guess I just thought it was a bit funny. We, our team, work with clients about their drinking habits. We did a lot of work on safe*

drinking and amounts to drink that keep them safe- and here we were, as a team, doing lots of drinking (lots) and I was wondering I wondered why it was OK for us [to be over drinking] and not OK for our clients?

Marlene was very concerned about how her work team sees their drinking behaviours as being different to the community's drinking behaviours, but equally her seamlessness was creating a challenge for her during this work-social event. Marlene was worried that no other colleague appeared to be concerned about clients/community seeing them drinking in large amounts, and that made her wonder about why it worried her so much. Here Marlene adopted a position of role model and held herself to a high standard; she understood the contested space between herself as a health professional who was celebrating with colleagues and herself as a health professional who lived and worked in a community that experienced problems with alcohol. Armed with both sets of knowledge, Marlene developed strategies for being able to accommodate this example of collegial celebration and appropriate role modelling:

And so I sat there "celebrating in style" and thought about whether we [the team of health professionals] are fake. That worries me. I had to take the photo to remind me of those things I was thinking. Never want to be fake in the work I do- or in anything. As I sat there I got more and more worried as everyone drank more and more.... Well it didn't sit right with me, it is not how I am seen in community, even if I am not at work! Why didn't everyone else feel this too?

Marlene clearly felt that she had a different perspective on seamlessness than her colleagues, however her enactment of seamlessness highlights some challenges for Marlene who, unlike some of her non-Indigenous colleagues keeps "thinking about things at work" even at the end of the working day:

....I am pretty sure most of the team won't even think twice about the drinking they did that day. But I think about things like that, because it is who I am….I don't think I could ever just clock off the job. Y'know what I mean? I mean, I struggle when I hear a work colleague say "That's it I am out of here, not thinking about that until tomorrow". Gee. I just don't think like that. For me, even if it is the end of the day, I seem to keep thinking about things at work… [long pause]… It's all me, y'know? My work and other bits of my life. They are all me and all connected.

Within a range of work and social spaces, Marlene's colleagues were making their own choices about how they individually managed their personal and professional identities. Marlene resolved the contradiction as follows:

…I waited a while and then I told them I had to go and pick up the kids. Shit, I really didn't but I just was worried sitting there and needed to leave. Shit, that was being fake, wasn't it? Pretending I had to pick up the kids. But I couldn't tell them what I was worried about, 'cause they'd laugh, or something, and I just didn't want that. So I left.

Pete took this photograph and Yarned about it, explaining to me that the kangaroo was like the community he lived and worked in:

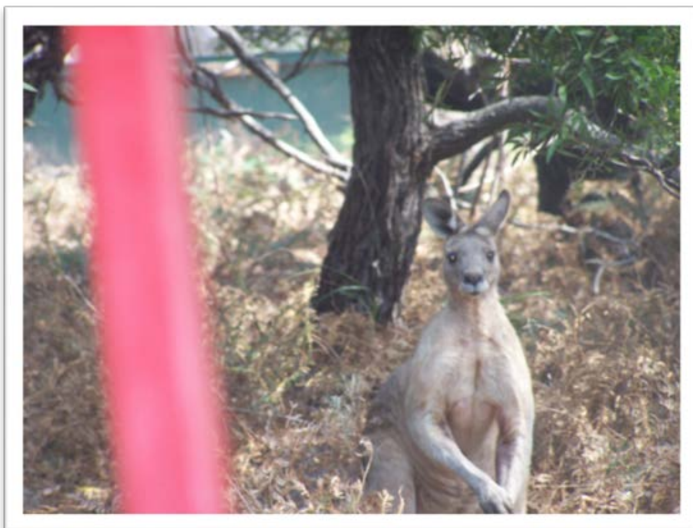

Photo: I am watched, always. [Pete]

Good story here. I took a photo of this old fella- I asked him first! He is important to me, and I think he was sent to make me think on this day I took the photo. I had just had a work mate

tell me that he didn't understand how I managed my personal stuff outside work. He wanted me to go for drinks at the local and I said no because I know lots of our clients drink there. He said I shouldn't put my clients first. Well, I do put my clients first, it's how it is for me. Anyway, I went off for a walk at lunch and saw this big 'roo. And I thought to my self- That's it. My community are always watching me, just like this big roo was watching me on my walk.

Pete was acutely aware that he remained visible to community members (who were also health service clients) even when not at work; Pete lived and worked at the Cultural Interface. His knowledge of that space informed his decision not to participate in certain social activities in "out of work" hours. Pete struggled because his work colleague did not understand the decisions he was making from living and working in the Cultural Interface; Pete acknowledged "community always see me and watch me" and had developed a level of comfort about that, stating "it's not a big deal for me":

And I know they see me all the time, they know I work in the health clinic and so I feel that need to be responsible with my own life and health. Imagine if I went off boozin' up and my clients saw me that way. Well, I would feel like I was letting them down, like I was a fake because I was telling them to be as healthy as they could be, and then they see me drinking on and on… just like this 'roo, community always see me and watch me. I know that. It's not a big deal for me, but my work mate just didn't get it. He thought I was being rude not going for drinks.

Pete preferences his own way of working over the choices his work colleagues make. Pete's strategy for working with seamlessness it is be mindful of "always being watched' and as such he makes choices that he believes enables and supports his ways of working and living in the same community. Pete does not see the position or perspective taken by his colleague who chooses to maintain a personal self (who enjoys going out for drinks) and a professional self who encourages people not to drink (dangerously). Like Marlene, Pete referred to working

seamlessly as not being “fake”, being real and not hypocritical. This suggests Pete and Marlene practice consistency and authenticity in their work through working with seamlessness.

6.4 Discussion

The aim of this chapter was to explore how Aboriginal and Torres Strait Islander health professionals juggle the challenges of working and living in the same community in ways that are positive for both themselves and their clients. While Team Members faced complex identity and role-based challenges, they developed strategies that empowered them to live and work in the same space. Team Members established a comfortable, seamless connect between their professional identities and personal/community identities which I have called the ‘seamless working self’. They described being able to work in a seamless way as meaning they were able to maintain their responsibilities and roles as both Aboriginal and Torres Strait Islander community members and Aboriginal and Torres Strait Islander health professionals. Team Members provided examples of what this seamless connect involved, citing four main aspects: being fellow members of their cultural community, the feeling of always being visible to community as a health worker, the feeling of always being available as a health worker to community even when not at work, and the need to set an example. They described having worked hard to overcome the many challenges they faced as they work and live in their own communities and detailed the strategies they developed to allow them to work this way.

The research I citied in the introduction to this chapter provided a foundation for the findings, especially regarding some of the identity complexities faced by Aboriginal and Torres Strait Islander Team Members who were living and working in the same community. Nakata’s Cultural

Interface Theory (Nakata, 1997, 2007a) helped me understand how Team Members navigated the space between working with a client (in a work context) and maintaining a connection with the same person, in a community context. The data here highlight that navigating identity often depends on the context and relationships attached to each role. As such, Team Members adopted an Indigenous Standpoint as they worked and lived in their communities and it is from this theoretical positioning that the data in this chapter is best understood. Team Members did not position themselves by 'role' nor did they attempt to privilege one 'role' over another in order to decide how best to work and to live. As they worked in the Cultural Interface they used their Indigenous Standpoint as a tool for empowerment; they knew both the professional space and the community/cultural space they lived and worked within and were able to develop strategies that enabled them to work seamlessly. They operated in the Cultural Interface and used two-way knowledge to develop ways of being, knowing and doing that were comfortable in both their work and living spaces.

This chapter highlights that, while Team Members identified strongly with their professional role, they did not rank that role as more important than their community role and as such allowed their professional identity to be influenced by their community identity, and vice versa. This positioning is well supported by Indigenous Standpoint Theory, with Team Member's enacting their Aboriginal and Torres Strait Islander identities (and cultural protocols and processes) as they worked at the Cultural Interface. Team Members developed a "seamless working self" that engaged Aboriginal and Torres Strait Islander ways of being, knowing and doing while challenging some of the dominant practices and processes in their workplaces. The strategies developed by Team Members reflect working in the Cultural Interface; while that

space is understood by the Team Members, it is a space that could be better understood and valued by the dominant health system and by non-Indigenous colleagues who hold different perspectives on how to effectively live and work in the same community. Lander's definition of identity as "contextually specific, fluid, a conjoint construction created … in interaction with others" (2013, p.34) more accurately describes how Team Members in my study negotiated their professional and personal/community identities with seamlessness and aligns with Indigenous Standpoint Theory (Foley, 2003, 2006; Moreton-Robinson, 2013; Nakata, 2007b, 2010). This helps us understand how Team Members enact their Aboriginal and Torres Strait Islander ways of being, knowing and doing in the work they do with clients as they achieve no separation between the work they are doing as a health professional as they work in community while living in the same community.

My findings in this chapter show that Team Members' seamlessness also involved working with friendship-like ways, described in Chapter 5. However, in Chapter 5 Team Members described working with friendship-like ways to uphold professional boundary work and to respect community connections. In this chapter Team Members engaged friendship-like ways of working but did so to uphold personal boundary work with clients and that difference was best achieved through developing seamless working ways. Team Members' reported a feeling of always being watched, of being aware of working in the Cultural Interface between dominant work protocols and practices (for example, leaving work at work at the end of the day) and community protocols and practices (using empathy and actively engaging with other community members regardless of the context, being available for community). Their awareness of this space, their seamlessness, afforded Team Members the privilege of making

choices and developing strategies so they could uphold both spaces, ultimately having developed a level of comfort about working with seamlessness, as highlighted by one Team Member who said “it’s not a big deal for me”. Being able to uphold both spaces (living and working in the same community) was important to Team Members because they were aware of, and valued, both cultural *and* professional obligations, roles and responsibilities. Team Members valued being a fellow member of the cultural community in which they also worked and expressed not wanting to “let them [cultural community] down”. Such a deep engagement with cultural, social and political responsibility seems to obligate Team Members to develop ways of working that were seamless, as noted by Marlene “My work and other bits of my life. They are all me and all connected”. This obligation was not seen as a negative factor, but just as a given “I do put my clients first, it’s how it is for me” (Pete).

My findings also highlighted how Team Members’ roles and responsibilities, in addition to their clinical and health-based roles, meant that they maintained close connections with community cultural, social and political knowledge (also noted in Deshmukh et al., 2014; Mercer et al., 2014). Team Members spoke of always being aware of their professional identity, even when they were not officially at work. They reported that people always looked at them as a health professional in community and how they felt a responsibility to that professional identity. Being aware of this was a strategy Team Members had developed that allowed them to blend their professional and community identities in a positive, role-modelling capacity rather than seeing that position as a burden.

Thus my study presents findings that suggest Team Members have found ways to allow their professional and personal/community identities to coexist, allowing them to work and live in the same community with seamlessness; these strategies included using empathy as they communicated with clients, establishing and valuing boundaries that were understood by clients and the Team Members themselves and developing friendship-like connections with clients. Studies presented earlier in this chapter identified both benefits and challenges in maintaining multiple workplace connections and relationships (Brownlee et al., 2015; Pugh, 2007). While my findings align with this literature, they differ in specifically reporting the benefits and challenges of maintaining multiple relationships and connections when working in a context where Team Members (health professionals) were also members of other social and cultural parts of the same Aboriginal and Torres Strait Islander community.

While creating this seamlessness was not easy, Team Members considered it essential in the work they did. However they reported that the seamless working self was at odds with the way many of their non-Indigenous Australian colleagues worked and it was not well understood. Team Members were not being considered unprofessional because of their seamless working ways; rather they felt that their colleagues and managers saw them as always being too close to work and clients, implying that was not good for them at a personal level. However the lens through which Team Members viewed their seamless ways of working is different to the viewing lens of (most) of their non-Indigenous colleagues. Team Members cultural lens highlighted their high levels of cultural and community responsibility and called on community values of reciprocity, giving and sharing; those values greatly influenced Team Members' working with seamless ways.

While it cannot be assumed that establishing and maintaining boundaries is clean and simple if the health professional lives and works in different communities, the findings in this chapter suggest that, when living and working in the same community, cultural connection is one important contributing factor to being able to develop ways of working with seamlessness as it provided Team Members with a strength and a status that supported their work; one Team Member reminding me that working with seamlessness was about "the cultural connection to her community [that] committed her to working that way". In my final empirical chapter, Chapter 8, I will explore the implications of this seamlessness between professional and community roles and identities for health service provision.

Chapter 7: “I get a special feeling in this place”: Aboriginal and Torres Strait Islander health professionals’ use of everyday landscapes therapeutically in their work with clients.

7.1 Introducing this chapter

In this chapter I explore a third way Team Members in this study worked to enhance the way they provide service to their clients; in this case working outdoors and engaging everyday outdoor landscapes and spaces in a therapeutic way. Team Members developed ways of working with spaces beyond an enclosed office space (with its expectations and rules), they found everyday landscapes a source of healing for themselves and their clients and they used landscapes as a source of metaphor for working on health issues.

This chapter begins with a synthesis of foundational literature. I then present four main themes related to using everyday landscapes therapeutically; namely that (1) working outside in therapeutic landscapes has benefits for Team Members’ own health and wellbeing, (2) engaging with therapeutic landscapes, including metaphorically, improves the work Team Members do with their clients, (3) Team Members and clients share positive outcomes when engaging together in everyday landscapes therapeutically, especially when they share a connection with Country, and (4) Team Members persisted with the use of therapeutic landscapes even in the face of management and collegial disapproval.

7.2 Literature specific to this chapter

This section synthesises literature on the theory and types of therapeutic landscapes, connecting with such landscapes and 'Aboriginalising' (Devlin, Disbray, & Devlin, 2017; Liaw et al., 2015; Smethurst, 2016) workspaces, and flags that there is a gap in knowledge surrounding ways in which health workers utilise therapeutic landscapes.

7.2.1 Landscapes for healing

The theory of therapeutic landscapes suggests that specific places have the potential to enhance health and wellbeing, in that they "support a holistic understanding of health as emerging out of complex interactions among physical, spiritual, mental, emotional and social elements" (Plane & Klodawsky, 2013, p.2). Similarly, Abraham, Sommerhalder and Abel's (2010) synthesis of literature "conceptualising landscape as a health resource" (p.59) provides a framework describing "the potential of landscape as a resource for physical, mental and social well-being" (p.59). Masuda and Crabtree (2010) describe therapeutic landscapes as places where "physical and built environments, social conditions, and human perceptions combine to produce an atmosphere which is conducive to healing" (p.657).

Recent research on place-based health has included a focus on the relationship between a natural environment and health; for example, Astell-Burt, Feng, and Kolt (2013) suggest that greater access to green space promotes improved sleep patterns and subsequent health outcomes. On the other hand, cultural landscapes, landscapes with which a person has a cultural, spiritual or emotional connection, have long been considered an influence on a person's perception of their world, on choices they make in their lives and on how they

understand their health and wellbeing (Thompson, 2011). Rose (2012) examined possible therapeutic use of landscapes or places resulting from “the significance of prior familiarity with representations of specific landscapes” (p.1381) that a client had, that enabled their known landscapes to “be apprehended metaphorically” (p.1381) in health care provision. Such metaphorical apprehensions are an important theme in the findings of this research.

A body of literature supports a strong connection amongst Indigenous peoples between a cultural landscape and cultural beliefs and experiences for health and healing. In a case study about the connection between Maori culture, place and health, Panelli and Tipa (2007) argue that “key sociocultural and environmental dimensions need to be integrated for a culturally appropriate approach to Maori well-being” (p.445). They state that while cultural and environmental connections with place differ across Maori *iwi* (tribes), the “Maori culture-environment relations and customary obligations provide both opportunities and responsibilities between people and their environments which can support well-being” (p.446). Connections between spiritual and cultural therapeutic landscapes and healing in a Canadian context are described by Wilson (2003) who suggests that the “health of First Nations peoples can be improved by including their cultural conceptualizations of health and place” (p.91). Additionally, Willox et al. (2013) stated that a “feeling of emotional wellness and wholeness came from being able to spend time on the land”, highlighting the affective impact of maintaining cultural practices and connections to land and place. Specific to my study, Kingsley, Townsend, Henderson-Wilson, and Bolam (2013) describe the connection with Country that an Aboriginal and Torres Strait Islander person has as being “a fundamental component” (p.678) of

health and wellbeing, while the concept of caring for Country as a parallel measure of caring for human health is described by Townsend, Phillips and Aldous (2009).

7.2.2 Theoretical framework: extraordinary and everyday therapeutic landscapes

This chapter draws its theoretical base from the framework of therapeutic landscapes proposed by English, Wilson, and Keller-Olaman (2008). Health and healing can be influenced by two types of therapeutic landscapes: *extraordinary* therapeutic landscapes (places like health services or clinics where people only spend short periods of time) and *everyday* therapeutic landscapes (those available in one's day to day life).

Positive connections between people, place and health can operate in both extraordinary and everyday contexts. The way physical health service environments and buildings, their gardens and artworks (extraordinary therapeutic landscapes) might impact on emerging wellbeing (Andrews, Chen, & Myers, 2014; Martin, Nettleton, Buse, Prior, & Twigg, 2015) was of interest to my study, as I explored how Team Members opted to use outdoor environments, rather than built environments and in their delivery of health services. Also relevant is work done on understanding the "mutually reinforcing and reciprocal relationship between people and place" (Cummins, Curtis, Diez-Roux, & Macintyre, 2007, p.1) in health services and how that relationship can contribute to improving health service provision, which demonstrates that there is potential for using everyday landscapes therapeutically. Moving a client's health service provision from "one place to another" (Gatrell, 2013, p.98), for example, has been considered as having potential for positive health gains.

The potential of ordinary therapeutic landscapes (those existing in the clients' and health workers' environment) for enhancing health has been mentioned above, ranging from physiological responses to cultural, spiritual and emotional connections.

The Team Members in this research access both extraordinary and everyday landscapes in their daily practice. The extraordinary landscapes are mostly the built environments of their health workplaces and, although often referred to by Team Members, are not the primary focus of this chapter. The everyday landscapes that feature in Team Members' daily practice with clients include the homes of their clients, community settings and local natural environments, and these everyday landscapes are the focus of this chapter.

7.2.3 'Aboriginalising' health workplaces and workforce

Health service provision can be constructed or manipulated to include greater use of place (therapeutic landscapes) for improved health outcomes and experiences of health (Andrews, 2004; Andrews et al., 2014; Gastaldo, Andrews, & Khanlou, 2004). The issue of finding an effective way to provide a health service that authentically meets the health and wellbeing needs of Aboriginal and Torres Strait Islander Australians has been explored in the literature, including consideration of the role of Aboriginal Medical Services (Baba, Brolan, & Hill, 2014) and the embedding of cultural competence in health care provision; for example working "with Indigenous Australian communities to culturally tailor interventions (customising content, approach or messaging) to improve the quality of care and patient satisfaction with care" (Bainbridge, McCalman, Clifford, & Tsey, 2015, p.20).

Some health services in Australia have made changes to their built working environments and staffing in an attempt to create more engaging, welcoming and positive service provision for Aboriginal and Torres Strait Islander clients (Hayman, Askew, & Spurling, 2014; Hayman, White, & Spurling, 2009). In particular, the Aboriginal Medical Services (AMS) and the Aboriginal Community Controlled Health Services (ACCHS), consistently work to create a service delivery place that is welcoming to Aboriginal and Torres Strait Islander clients (Baba et al., 2014; Couzos & Murray, 2008; Dimer et al., 2013). A welcoming space could include employment of Aboriginal and Torres Strait Islander staff in a health worker capacity or as front desk staff to provide a familiar face in the service delivery structure, visually representing Aboriginal and Torres Strait Islander cultures through installing artworks and posters in the waiting areas or clinic zones, playing videos or radio with an Aboriginal and Torres Strait Islander focus, ensuring staff engage with cultural awareness education and implementation strategies, engaging with the local community and working in collaboration with other sectors (Hayman et al., 2009, p.604). A number of services also offer clinics open only to Aboriginal and Torres Strait Islander clients. Welcoming health services also encourage clients to use the space as community space where people meet and socialise while waiting for medical care (Aspin et al., 2012; Jowsey et al., 2012). Specifically, Jowsey et al. (2012, p.200) describe how some Aboriginal Medical Service "…waiting rooms are constructed as meeting and speaking spaces, where people happen to be sick" rather than mainstream health service waiting rooms that "are constructed as quiet and formal sick spaces". Jowsey et al. suggest that this has a positive impact on clients as:

…the environment of the clinic waiting room is discursively formed into an informal environment within a formal setting where enjoyable interactions are mobilised around community seemingly as much as sickness. Something of the specialness of the space, then, is linked to the quality and tone of interactions between peers. Patient and carer constructions around sociality in the waiting room negate and deflect representation of the space use as one that is solely about sickness. (2012, p.200)

A review of the implementation of Australian health services for Aboriginal and Torres Strait Islander people concluded that "Effective implementation was supported by clearly defined management systems, employment of Indigenous health workers as leaders, community control, partnerships, tailoring for diverse places and settings; and active facilitation methods" (McCalman, Bainbridge, Percival, & Tsey, 2016, p.1). Of particular interest to this study was the suggested need to tailor health services "for diverse places and settings".

7.2.4 How health workers use therapeutic landscapes as a metaphor for improving health and wellbeing

Although much has been written about the therapeutic potential of landscapes experienced through a spiritual, cultural or emotional connection or as a built environment, little attention has been paid to the ways in which health workforce utilises landscapes in their work with clients to improve health and wellbeing. Specifically, while efforts to 'Aboriginalise' health services reflect organisation-level approaches, there remains little understanding of how Aboriginal and Torres Strait Islander health professionals are themselves utilising workplaces and changing their workplace practices to provide more effective health services to their clients, which itself is a culturally competent way of 'Aboriginalising' health service provision.

This chapter takes its cue from the observation that "like places, diseases (and health) are not fixed realities but are situated and socially produced in particular historical, social, economic,

cultural and political contexts" (Smyth, 2005, p.490) and that a client's connections with place, be those physical connections with place or "more subtle and invisible experiences that shape health and wellbeing" (Sunderland, Bristed, Gudes, Boddy, & Da Silva, 2012, p.1056) can be utilised therapeutically. Team Members in this study used everyday landscapes in ways that Andrews (2004) refers to as "mind-and-body therapies" (p.315), extending the physical connection with an everyday landscape to cognitive, spiritual or emotional connections as they worked with clients on achieving positive health and wellbeing. Thus this chapter presents findings addressing the abovementioned gap in our knowledge by providing insight into how Team Members in this study developed workplace practices that utilise everyday landscapes therapeutically as they connect to physical places in emotional, spiritual and cultural ways.

7.3 Findings

This chapter explores the ways Aboriginal and Torres Strait Islander health professionals use everyday therapeutic landscapes in their work. In the data that follows Team Members show that (1) working outside in therapeutic landscapes has benefits for their own health and wellbeing, (2) engaging with therapeutic landscapes, including metaphorically, improves the work they do with their clients, (3) they share, with their clients, positive outcomes when engaging together in everyday landscapes therapeutically, especially when they share a connection with Country, and (4) they persisted with the use of therapeutic landscapes even in the face of management and collegial disapproval. I argue that the latter do not understand nor value how and why Team Members work therapeutically in everyday landscapes.

7.3.1 Working outside in therapeutic landscapes has benefits for Team Members' own health and wellbeing

This section outlines ways in which Team Members describe using everyday landscapes therapeutically for their own wellbeing, for example by helping them become more relaxed and positive, providing a respite from the pressures of work and fostering clarity of thought.

Team Members described examples of experiencing health and wellbeing benefits from working outdoors; a range of landscapes were nominated that provided Team Members with a positive therapeutic impact. Of particular importance to this research is the connection between working outdoors in therapeutic landscapes and experiencing a sense of refreshment, support and capacity to keep working, even in challenging times. Team Members developed working practices that took them into a range of landscapes as they sought such a refresh or

support. Team Members did not often describe utilising dominant ways of seeking support in the health care workplace, such as consultation with line management, mentors or peers, or engagement with professional or clinical supervision. Rather, they adopted practices that saw them take themselves away from their workplace, alone, into a therapeutic landscape, returning to the workplace with a renewed sense of energy and readiness.

Maureen spoke about the therapeutic benefits she found by taking herself to a local fishing spot:

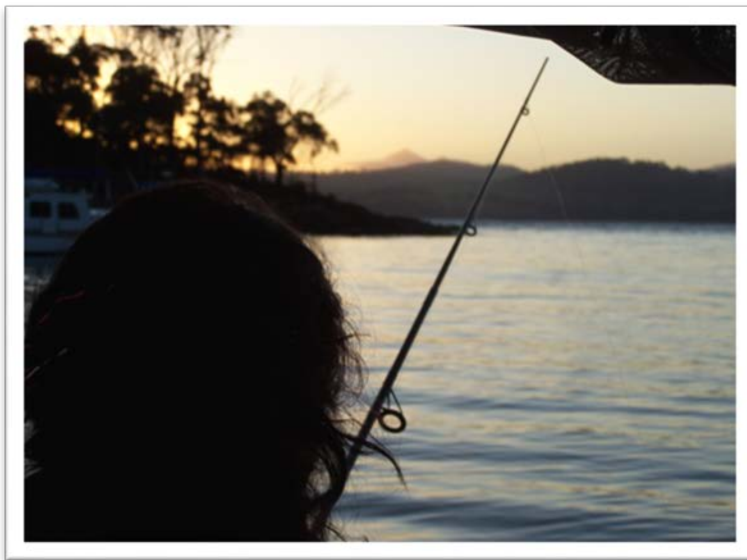

Photo: Open waters, open talking [Maureen]

… being in that space makes it easier for me to be at work in this space [work office]- quite different space, because I feel refreshed when I come back from fishing…sometimes work gets on top of me and I need to think through some tricky stuff. I do it here. If I didn't do this I am not sure I'd be able to handle the work I do.

The benefits of engaging in outdoor spaces were also well recognised by Carlee who reported that she often sought rejuvenation for herself in a local park:

Photo: Getting as clean as it is here [Carlee]

…when I go to this one spot and I am by myself…I find these two old fellas [the trees in the photo], look at their great bark, how strong they stand, and listen for their leaves. Great stuff- couldn't buy that feeling if you tried! I feel clean and healthy, not all crowded in by my office furniture and all the paperwork!...I go back [to work] feeling sooo much better. I have been known to walk here, spend even a couple of minutes, walk back to work and do amazing work all arvo! It is important to take time out, you know?

Feeling healthy at work was important for Carlee, as she feels a responsibility to be healthy and strong so she can do good work with her clients:

I have to be strong like those trees- because those kids look to me for help. What good would I be if I can't stand up straight like that [like the trees], look at life in the eye, and work on it with them? I'd be useless.

Kim used her photo called *Clouds and good vibes* to PhotoYarn about how working outside gave her “good vibes” that carried her through her working day. Kim described the act of being outside as helping her to know she “can keep going” with her work.

Photo: Clouds and good vibes [Kim]

I work in a city health service, in a small clinic and my office space is probably the smallest space in the building… Walking outside, even around the city, gives me good vibes. It might be energy, or the fact that we are out in the open, or it might be the sky, like this one- blue and clouds, just looking up to that makes me feel good, positive. One look up at this and I can keep going with the other work all day!

Despite working in an urban setting Kim still found working outdoors therapeutic:

…y’know, I look up to a sky like this and no matter how busy and hectic everything else is I stay focused and feeling positive. I need to find that positive feeling at work as often as I can, if I don’t I start to feel down and closed in. Even unhappy.

The sky was always available to Kim, and she used it to keep herself “fresh” and “positive” at work, so she could do the work she needed to do with her clients.

Justin PhotoYarned about his photo, *If I had a fire***.** This photo is of a fire Justin would love to have access to at his current job:

Photo: If I had a fire [Justin]

Well there are not many fires like this at work, but if I could I would do most of my work around a fire. People relax, people do get warm, stare into the flames, it is easier to talk. And fires relax me too! You know, you've got something to look at. Fire is like that- makes you stare. In my old workplace we had a fireplace and I lit it up all the time. Fire draws people in and calms them down. It did that for me at that work. I just felt calm and happy when I sat near that fireplace. Sometimes, if I felt a bit low, I would light that fire up and I knew my mood would lift.

Justin's landscape was a fireplace. It was therapeutic for him in his work context, engaging with the fire would provide him with a feeling of renewal. Justin asked to hold our PhotoYarning session next to a campfire, in one of his everyday therapeutic landscapes that made him feel "comfy" at work. Perhaps the feeling of relaxation and renewal Justin experiences as he sits around a fire is fairly common to most people when they sit around a fire, but what is unique here is that he accesses this in a workplace context.

In a shared PhotoYarning session Marlene's attention was drawn to this photo, taken by Tia, who called it "You only see part of me".

Photo: Baby ducks sitting in the sun, all comfy [Marlene]
Photo taken by Tia who called it- You only see part of me[20]

Marlene explained that there was a place that looked just this one near her work but she hadn't taken a photo of it. Marlene said if she had taken a photo like this she would have called it "Baby ducks sitting in the sun, all comfy". Marlene asked Tia if she could use Tia's photo to describe a few things that she had on her mind:

Can you see in the middle there? A few baby ducks sitting in the sun?…. This space is real special to me too. When I am here I feel completely safe, comfortable with myself and what I am thinking. Sometimes at work, in my office, I double think what I am doing, or maybe I overthink, but here I just let myself be- be comfortable with my thoughts and I am always happy at how clear those thoughts become.

[20] This is an example of how Team Members used each other's photos in the PhotoYarning sessions. In this case the original photo was taken by Tia, but the image resonated with other Team Member, Marlene, who gave it her own title in effort to represent what the image meant for her.

This space gave Marlene time out from worrying thoughts that come out of the work she does, a space for thought processing and reflection, quite different to the constant action required at her built workplace. As such it acted as a therapeutic space that supported her at work. Marlene related to a certain level of calm or peace that certain natural landscapes provided; she felt safety in this space. Tia, who took this photo, said to Marlene:

I am so glad this was a good photo for you. I know exactly what you mean. When I go to this place I think people can only see part of me, and that means the other part of me is resting, getting stronger and ready for my next client. This photo means the same thing for us.

Tia and Marlene shared the clarity of thought that this image inspired, highlighting not only their shared need to find ways to refresh and find clarity of thought but also a shared mechanism for doing so.

7.3.2 Team Members make metaphoric connections between everyday landscapes and responding to the stress of work

Several Team Members used therapeutic landscapes as metaphors for responding positively to ways of working that they considered sub optimal, and at times stifling. For example, Marlene called this photo *In the middle of nowhere:*

Photo: In the middle of nowhere [Marlene]

Marlene used the turtle as a metaphor for herself.

Sometimes I feel just like this turtle- in the middle of nowhere. I really do find myself with things all around me, but nowhere to go. This turtle here has water all around and could jump in and swim, but he is taking his time and thinking about it. The only thing that is keeping him dry is the branch of the old tree. Y'know I feel like that at work- I could dive in and swim in the water around me, but what I prefer to do is to stay dry a bit, see what is going on around me and then think about taking the next step.

Visiting this space allowed Marlene to "get things into perspective" and helped her to build resilience:

I go visit this old turtle place as often as I can. It helps me get things into perspective for work. Like the turtle, I stop, breathe and then know I can deal with whatever else work throws up at me.

Like Marlene, Aimee found visiting everyday landscapes provided her with a sense of calm and peace that energised her for the difficult parts of her work in child protection.

Aimee took the following photo, *Protect me* and PhotoYarned about this “beautiful place” that gave her a sense of peace and wellbeing and protection from the overwhelming regulations, policies and paperwork she maintained as she worked within the child protection and healthcare system.

Photo: Protect me [Aimee]

… I wanted to have a photo about protection. My job involves a lot of child protection issues. Hard stuff, but that’s my job. In this photo there is a beautiful bush, with flowers and rain drops, but are also leaves that are sharp, and there’s a spider living there, she needs somewhere for protection. This is a beautiful place. I am like the spider- I go to this place when I need protection. When I feel like curling up and hiding I do what the spider does, I go to this place.

The hiding spider is a metaphor for Aimee’s own need to feel protected as she moves through her daily work of protecting others. The wellbeing effects of visiting this place were very clear to Aimee:

It's really easy to tell you why I spend time in this place. It is because there is nowhere else that I can make sense of some of the things that I see in my working life. I have tried sitting at work and processing things in the tea room, or in our office, or even in a group meeting session. But nothing really works there. Here, well I feel freed up to just let things work themselves through my head. Sure, I might be curling myself up in this space, hiding a bit from time to time, but shit, without this space my head would be overloaded and my heart, well, that would just be sad and sick.

Aimee has tried to use her built workplace as a space in which to unwind or process difficult work matters but finds that being in the outdoor space is more supportive of that process.

Carlee called this photo of hers *Swimming against the water***.** She PhotoYarned about the challenges she faced in her daily work life:

Y'know work is hard... I am constantly up against it, y'know challenging the system, or trying to find a better way of doing things. That's what I do best at work- but I call it pushing shit up hill. Like these ducks I have to work hard against a lot of things, just to get to where I want to go. I sometimes swim against the management, the healthcare system, the job I am told to do, the clients even.

Carlee's use of this space to highlight her own experience of "challenging the system" at work is important. She referred to the ducks in this space as a metaphor for who she is at work, and what she faces:

Photo: Swimming against the water [Carlee]

Carlee knew how this space helped her understand things about her working self:

But if I don't swim like that, if I don't push that crap uphill then it all falls on top of me. So I learn heaps from going to watch those ducks! Reminds me that what I am doing is all good, it's all OK. And when I know that I feel good. I feel strong and healthy even.

Carlee learned about herself in this therapeutic landscape. She acknowledged the challenges of her job and saw herself doing exactly what the ducks were doing. This space helped Carlee find a sense of wellbeing, even a feeling of good health.

Some outdoor spaces served Team Members as a reminder that good health, and thriving, was possible. Many Team Members expressed feelings of being challenged by the systems and structures required by their workplaces; Aimee said "extreme amounts of paperwork and reporting feel like they will soon swallow me up" and Helen said "having to work inside a stone

building with very little natural light feels like I work inside a coffin". As Team Members took themselves out into therapeutic landscapes they were reminded of life and noticed elements in the landscapes that represented longevity, survival and ongoing growth and life. As Helen said "when you do work outside you see that trees grow, water flows, flowers bloom"; all reminders of survival.

Taking care of the natural environment was aligned with taking care of themselves as health professionals. Helen took the photo, *Flowers growing through stone:*

Photo: Flowers growing through stone [Helen]

Just look at how these flowers are popping up and growing out of the stone!…They are signs that life can go on even in the hardest times. When I feel like I have reached that point when you are no good to anyone, you know, tired or overwhelmed or whatever, well, I come and sit here. And there are always different flowers here-no matter what time of year. These flowers remind me that I can go on. I love this place. It tells me to look after myself in the work I do. And it does that without words. Best advice ever.

Helen used the resilience of the flowers growing out of stone in this outdoor space to remind herself of her own capacity to continue doing her work with clients even through difficult times; she saw in Nature a reminder to have hope. Helen described finding good self-care advice from this space as it allowed her to reflect on the need to take care of herself, especially if she felt she was struggling at work. In many workplaces this level of support and advice is found in conversations with people; but for Helen, and many other Team Members, outdoor everyday spaces provide the support and advice.

Pete visited a place that he photographed and called *Old tree, new life.* Like Helen he found restoration in this space, as it reminded him that life has cycles and challenges, but it does go on:

Photo: Old tree, new life [Pete]

Pete used the tree as a metaphor for himself, "The big old tree is dead now. No more branches, no more leaves, no more birds in it. This is how I feel each year when we need to re-apply for our service funding- stripped bare". Pete described a funding cycle dilemma that would be

common to many people working in the health sector, likening it to creating a feeling of being "stripped bare". Pete often worked with chronically ill people who were facing the end of life, but he found support by visiting this tree:

It's a hard thing to keep doing your job while you deal with really sick people, y'know who might not make it to the next day. When I feel like that I visit this old tree.

Like Helen, Pete engaged with this outdoor space therapeutically, for himself. He focused on signs of life surrounding the tall, bare tree and was reminded that he could find strength to continue working:

Yeah, it is dead but what this photo doesn't show are the new little trees popping up around it. Those are the things that give me hope. Signs of new life. I need to see that from time to time, so I come here and see it. Surviving and feeling healthy when you work as a health worker is really important. Surviving and good health is important to everyone I guess, but sometimes it is hard to stay feeling healthy when you are surrounded by so much bad health.

This was a place Pete looked after, because he believed looking after this place was like looking after his health:

I come here and make sure those young trees aren't getting crowded out by weeds, or damaged. I look after them. When I do that I feel like I am looking after myself too. I get a special feeling in this place that is like a refresh, it is pretty special.

Carlee also looked after an outside space, believing that a clean environment, a natural landscape not cluttered with rubbish, gave her a feeling of good health. Carlee PhotoYarned about her photo *Getting as clean as it is here* (shown on page 215):

This is just one of my favourite places to go to… It's really clean there. I guess people love it so much that they keep it clean. When I am there I feel clean, and healthy.

Carlee perceived the place to be “clean” because people showed it respect, people did not pollute it and as such it stayed fresh, clean. This reciprocity of place and person, the taking care of each other, strongly featured in Carlee’s reflections of the everyday landscapes she engaged therapeutically.

Team Members in this study focused on everyday therapeutic landscapes, such as parks and waterways, places that they could access in their daily lives, rather than focusing on the extraordinary spaces (English, Wilson, and Keller-Olaman,2008), like clinics or hospitals, designed for a specific therapeutic purpose. Team Members PhotoYarned about many positive health and wellbeing outcomes connected to being in everyday outdoor places. These places had therapeutic qualities for themselves and in their work contexts.

7.3.3 Engaging with therapeutic landscapes, including metaphorically, improves the work Team Members do with their clients

Being able to take time to work with clients in a space used by clients in their everyday lives really mattered to the Team Members. Team Members reported that some clients relaxed more and were more confident when talking in a space they frequented when they were well, when they were in a space they had a positive emotional connection to, rather than in a clinic that they only came to when they felt sick. Team Members reported that they also felt more relaxed and comfortable working with clients in those spaces, in contrast to a shared discomfort when they worked with the clients in their built office spaces.

Pete PhotoYarned about his photo *Logs in the open – a good place for open talk*, telling me that in that place has was able to talk through the "tough stuff" when working outdoors with his clients. Pete said that his clients automatically "breathe free" when they are outside and "don't feel like they are about to be asked to fill out a form or get medically assessed". He suggested that working in this open space provided clients with a space to relax and engage with him about their health issues, rather than feeling constricted by working in the physically closed space of his office that represents institutional administration, medical assessment, control or even surveillance.

Photo: Logs in the open – a good place for open talk [Pete]

Pete described how he encouraged his clients to be in that outdoor space, where he walks with them:

Some of them think I am mad when I tell them to go climb a tree, or balance on one of these logs, or sit on a rock and chat with a mate. They look at me like I am crazy, you know?... Sometimes the kids tell me "Shame, you're too old to be walking on these logs and stuff", but I just laugh and say "Never too old". They might laugh at me there but it is there that they open up and tell me the real stuff that's goin' on for them, y'know, the really tough stuff. Guess it is easier for them to tell me that stuff while we are in the open. They wouldn't be so open in here [his office].

Pete acknowledged that the use of open space encouraged his clients to be more "open"; he encouraged them to physically engage with the space knowing that this physical connection ultimately leads to a feeling of being "open", a space in which he was able to do good health service provision.

Pete reminded me that he still completes "every bit of paperwork and reporting" that his workplace requires, but he does it in a way that is less intrusive and controlling.

Maureen PhotoYarned about her photo *Open waters, open talking* (shown on page 214), and described how she took clients there on fishing afternoons, especially when they had shut down, were not responding to her suggestions or when they had something really difficult to talk about, process or understand:

I always find my thoughts, or answers to things, in a fishing space. So it is natural for me to want the same for my clients. It works; a fishing space. It's nothing special, just open space that helps for open talking and open thoughts. Fishing time like this, in this place is a healthy thing. I want that health for my clients, and this is the place that helps me do my job.

Maureen told me that the physical act of keeping a client's body occupied as they fished gave the client's mind time and space to think. She described the everyday fishing space as a place that encourages clients to process thoughts and situations that ultimately impact on health and wellbeing:

Y'know, lots of my clients go fishing, but it is different when your health worker goes fishing with you. Sure, we talk about the fish, but it doesn't take long for them to start telling me the real hard things that are getting in the way of their good health plans. It's healing to be able to talk so openly. As hard as I try I never can get clients to talk so openly about the real hard stuff in the health clinic.

The fishing spot worked therapeutically for Maureen's clients who felt relaxed enough to engage in difficult conversations whilst there. Like other Team Members Maureen believed she would not be able to achieve the same result for her clients "in the health clinic".

7.3.4 Team Members engaged with metaphors as they work with their clients in everyday landscapes therapeutically

Naturally occurring events in the outdoor space (for example, seeing ducks swimming on ponds or watching streams of running water) provided focal points that the Team Members used when they worked with their clients and their health issues. Cindy explained that she often took her clients to this place in the photo she called *Running water – trying to stay clean and healthy*. She described how she sat with them there and worked with them to make plans and develop actions to help them get clean (to stop using drugs) and to feel healthier:

Photo: Running water – trying to stay clean and healthy [Cindy]

Poor old river. I love this photo' cause it shows a busy river, but an unhealthy one. This river is like clients I work with- some of them are real busy people, but they don't look after themselves. Some of them use drugs that do real harm to their health and their minds. Most of them are always racing around, running as fast as this water, so I take them to this place and use it to Yarn through things with them.

Cindy believed this space represented the clients she worked with, who were facing "pollution" of their own health and attempting to manage a fast flowing chaotic way if life:

At this place I point out the fast running water, and compare it to the speed or chaos of their lives. The river is also a bit polluted, with rubbish and big old logs and things, and I point those things out and we talk together about the things that are polluting their health. Sometimes we then talk about the drugs, or whatever it is creating their bad health…and we Yarn, really Yarn about those things while we watch the water flowing past us…I don't think I would be able to even start those Yarns without this place.

Cindy used the metaphor of the speed of the "fast running water" as a teaching tool. Further, she extended her metaphorical health promotion by highlighting to her clients the pollution in the river and then says "we talk together about the things that are polluting their health". This space became a metaphorical therapeutic landscape.

Carlee referred to her photo *Swimming against the water* (shown on page 223) and used it to explain that these ducks gave her a good example to draw on for some work she was doing with clients:

These ducks here are doing things hard. They are, like, swimming against the water...I bring clients here to watch them all the time. Most of my clients are just like the ducks- swimming against the water, y'know up against it all, facing lots of chaos and trauma. We walk up here and sit and watch those ducks. I talk about how they look all calm, floating on the water, but underneath those legs are full speed! They just give me a perfect example to use when I am working with my clients about finding ways to reduce chaos in their lives. These ducks help me do my work. And the clients just get it. Some of them even start quacking out loud, just for laughs, y'know.

Carlee engaged this therapeutic landscape to help her clients learn about chaos and how to manage it; and Carlee explained that her clients "just get it".

Cindy used this photo, *Bashed to bits and lying all over the ground,* to tell me the importance of this place in the work she did with her clients:

Photo: Bashed to bits and lying all over the ground [Cindy]

This is a place I call work…It's not pretty, eh? It's all crashed down. That's what this shows, how things crash. Something that was once something- a building or wall or something strong. But now it is all broken and in bits.

This place was familiar to Cindy and was a space she has used therapeutically for some time:

This place has been looking like this for ages, and it is right near work, so I bring some clients here- when we need to talk about once being strong and then being broken.

Cindy used this space as a therapeutic landscape, as she worked with clients who were trying to rebuild their lives and their health:

This is not a place that we stay at for long, but it helps me make a point to the clients I work with. We usually go for a walk and I then make sure we walk past here. We stop and I start talking about how easy it is to one day be strong and the next be broken, like what's left of this old building. Clients understand it. I use this broken building as an example for the clients. It's funny because it gives the clients a way to heal differently. Sure, they are not breathing in sunshine at this place but what they get is the right message- you can be strong, can be broken and then can be rebuilt. That's a good message for them to understand and keep in their heads. Makes them feel like they can rebuild too. That's where the good health starts- thanks to this pile of old building!

Pete used his photo *Fire cleans everything up* to PhotoYarn about how he held regular campfire sessions for his clients. He described using this everyday space in a very therapeutic way:

Photo: Fire cleans everything up [Pete]

I know that living with alcohol and drugs is like this fire, here- burns big and bright, and then runs itself down to a slow coal. This fire made me think of the big, hot spaces my clients face… Fire sweeps things clean, y'know? That's what I talk about with clients, how they can sweep things clean. This campfire space, well it helps me explain getting clean to them.

Pete used the campfire as a metaphor for teaching health promotion, describing to his clients the act of how a fire helps the country "get clean" and suggests that they too "can sweep things clean" in their own lives:

We make the fire and talk about the things that make it burn. But, like most fires, when we take away the things that give it life and eventually it dies off….I need to find ways of getting my clients to get rid of the things that feed their fires, y'know the grog or whatever, so their fires die down. Then it is my job to make sure they can see the new grass popping through the burnt ground- now that's the hard bit of my job…But the whole sitting around a fire and talking about that process, well I can't do that in any other space, can I?

Pete believed he did vital work with clients as they sat around the outdoor campfire space.

7.3.5 Team Members and clients share positive outcomes when engaging together in everyday landscapes therapeutically, especially when they share a connection with Country

Team Members described how they felt they could deliver good health care when they could take work outside the built environment of the health service buildings. Being outside allowed Team Members to feel relaxed and to focus on their job of providing good health care to their clients and to feel more connected to Country. Being connected to Country describes Aboriginal and Torres Strait Islander peoples' sense of wellbeing achieved through "relationship to their traditional land (known as Country)" (Kingsley et al., 2013, p.678). Many Team Members worked on their own cultural lands and in those cases they experienced a cultural connect with Country. In many cases their clients lived on their cultural lands and when that occurred both Team Members and clients could experience a common cultural connect to their shared Country. In a number of cases Team Members or clients had cultural connections to other land, to the land of their birth or the land of their Elders. In these situations Team Members still

reported sharing a connection, with clients, to the Country in which they lived and worked; while they might not have experienced their personal cultural connect with Country of origin, they did share a cultural connect to the Country they shared.

Sharing a connection to Country helped Team Members and clients connect through shared family, shared place, shared culture. I argue that such a sharing of Country facilitates a deeper engagement between Team Members and their clients; Team Members perceived that working in Country provided them with a therapeutic landscape within which to work.

Justin took this photo, *Old, wise thing,* of a tree just outside his clinic building. In a PhotoYarn Justin explained that this tree connected him to Country and was an important part of the work he did with clients:

Photo: Old, wise thing [Justin]

This old tree was the best counselling room I have ever used. It was where I would meet loads of clients, sit down and really get into some good work. I dunno, maybe it was the age of the tree- you know old, wise thing, that made us all feel comfortable.

He PhotoYarned about this connectedness to Country, in the landscape surrounding that tree, for himself and for his clients. Justin spoke about feeling close to this tree and the Country it grew from, and connected that feeling of closeness to a sense of comfort:

It is a feeling that is a bit hard to put in words. But I felt it strongly each time I even stepped out of the building and moved closer to that old tree. Funny, when clients sat there with me they just looked more relaxed, they told me stories about Country and what that meant for them. Sounds all fuzzy but we just could sit there and be…sometimes I would catch a client just looking up, like in this photo, and smiling. I know what that feels like, feeling happy and in the right place. I did my best work with clients out there.

Interestingly, Justin then told me about a time when his health service had to move closer in to town while the building was renovated and in the move he lost clients:

This tree was the thing I missed most. When my health service was moved into town, into this building, I lost many clients. I guess they felt more connected to that tree space than the new building… The job I was doing was the same, I was the same, just the place was the different thing… Who knows? Whatever it was, I miss that feeling. Sometimes I would drive past and stop and just sit there a bit, it made me feel good. Maybe it's the old knowledge, y'know- not the type I handed out in those brochures over there [in the new building]!

Justin felt a loss of connection to Country when his service temporarily moved to a more urban location, and he lost clients, which he directly related to the move away from Country. He suggests that the connection to Country that he had in that therapeutic landscape was that tree and its "old knowledge", again making a connection between Country, culture and learning. Justin referred to health service knowledge, as being different to knowledge he shared with clients in the therapeutic landscape, suggesting that clients did not come to the new service location because they were not seeking the knowledge he shared with them in his built work environment, but preferred the knowledge he used to be able to share when they all felt the

shared connection to Country. His sense of disconnect was so great he would actively renew that connection to Country by spending time in the old workplace.

Carlee PhotoYarned about, *Growing up Country,* describing how both she and her clients feel the positive connection to Country when they work together in this outdoors space:

Photo: Growing up Country [Carlee]

This photo is of a fern, just growing up. I love this spot- it is just near my workplace. I took a photo of this because a bit like this fern, my clients [youth] are struggling to grow up and be as strong as the Country around them. This place gives us both the feelings of being strong. We feel connected to that strength when we are here Yarning about their things. As we Yarn the strong feeling of the place makes us feel strong.

Carlee saw this place as a strong place, the Country that both she and her clients felt a connection to. She uses the metaphor of the growing fern in this landscape to describe that, when she and her clients positions themselves firmly in Country, growth can occur. Here she refers to the landscape as a source of nutrition and support for the fern, however she

metaphorically attributes her own strength of connectedness, and that of her clients, to engaging in this therapeutic landscape:

In this photo you can see things all around that little fern. That is the Country of the fern, supporting it. When I come here with the kids (clients) I talk about that little fern and how it is connected to a strong Country around it. The kids understand exactly what I say when I then talk about their connection to Country as being something that can make them strong and well. It's so important y'know. Connection to our Country does make us feel well, feel strong just like that little fern. I don't have that fern in my office so I can't talk so easily about the connection to Country that makes them strong, so this place is where I have to do it. It's perfect.

Carlee believed this place was "perfect" for helping her clients feel strong from a solid connection to Country. She acknowledged that she wouldn't be able to explain the same thing as well if she was working in her office. It is important for Carlee to teach her clients that staying connected to Country will help them stay well, and this space provides the perfect everyday therapeutic landscape to teach clients about that. Carlee perceived that her best work occurred in the landscape shown in this photo.

7.3.6 Team Members persisted with the use of therapeutic landscapes even in the face of management and collegial disapproval

Several Team Members reported that their managers and colleagues did not approve of their use of outdoor spaces in their work with clients, but stressed that they kept working that way regardless. Maureen believed she was more able to cope with the stresses of work after she had relaxed and found a sense of calm in an outdoor space. She also believed that her use of that place was not understood by her manager who "…didn't get it at all":

Too funny. You know, when I told my work manager I had taken this photo she said "but they were meant to be photos about you and your work, who you are at work". I smiled at her and said "That's right. This is me. I work here. Get some of the best thinking and talking done with clients at this spot. I bring this fishing spot with me to work every day, it is a bit part of me, helps me work." She didn't get it at all.

Like Maureen, Carlee explained that she felt drawn to the healing landscape of the trees in the park (*Getting as clean as it is here*, shown on page 215) especially when she has been told (by her manager) to work in her office with clients who simply don't respond to being in small spaces:

There are times when my manager insists I do all my work with clients inside my office. She insists, no question. Well, for some clients being in a small room, sitting across from another person is just too much. Makes them feel bad and they just switch off. That gives me the shits. Not with the client, but with my boss. She says things to me like "Your office is nice, it's got good art on the walls and is small and cosy, friendly. I don't know why you would want to work outside'. And then she gets upset when I get nowhere with a client…when that happens I also need to take off, for a bit at least.

Carlee reported that her manager lacked understanding about the ways she worked with clients in therapeutic landscapes; she missed the opportunity to embrace Carlee's outdoor work as a workplace practice that not only benefitted Carlee's clients but also provided benefit to Carlee herself. Carlee reported she could not convince her manager of the potential and relevance of working this way. However, she maintained her commitment to working with clients in outdoor therapeutic landscapes despite facing reprimand from her manager who, she believes, did not see the same space as a functional or appropriate workplace.

Despite working in an urban setting Kim still found working outdoors therapeutic and maintained the practice regardless of disapproval from her colleagues:

I really love working here, y'know in the city...But I get a bit, um, stir crazy when I am in that small clinic for hours and hours. And I know the small space stirs up my clients too. It seems natural to me- go for a walk and a Yarn, but some of my mates at work don't see it that way. They think I am just shirking work…don't get me started on that! The reason I do get out when I have a client with me is so that I can stay fresh for them, y'know.

Justin described how having a fireplace or campfire at his current job could improve the work he was currently doing.

However, he didn't think a campfire at work would be appreciated by other colleagues at work, telling me he would "get strange looks from others" if he was seen as "the guy who is always sitting around the fire":

…They'd see me sittin' back, kickin' back around a fire. Lazy, maybe not doing my job. Yeah, they might not think we were actually Yarning about what is important for the client- they don't get that. Funny, I spend the same time now Yarning with clients in my room here and I never get called lazy for doing that!

Justin is familiar with working this way, and with seeking renewal by engaging with thinking and Yarning around a fire. His assumptions of what his colleagues might think about this part of his work are built upon his awareness of just how different their work practices are.

7.4 Discussion

This chapter presented four themes that captured how Team Members used everyday landscapes therapeutically; (1) working outside in therapeutic landscapes had benefits for Team Members' own health and wellbeing, (2) engaging with therapeutic landscapes, including metaphorically, improved the work Team Members do with their clients, (3) Team Members and clients shared positive outcomes when engaging together in everyday landscapes therapeutically, especially when they share a connection with Country, and (4) Team Members persisted with the use of therapeutic landscapes even in the face of management and collegial disapproval.

Team Members demonstrated an appreciation of how landscapes and outdoor spaces reinvigorated them at work. For some, working in such a way cared for their own wellbeing, made them feel positive and relaxed and these effects made them feel that they could better help clients. For others, outdoor spaces gave them an opportunity for time out from the pressures of work, allowing them to gain clarity of thought that then helped them continue doing good work with their clients.

In the Team Members' experience, engaging in the everyday outdoor landscapes with their clients created a more effective connection between people, their culture and health service provision than engagement in built health service environments. Team Members found that they more easily explored emotions such as frustration or sadness with their clients when working in an outdoor space. English et al. theory of therapeutic landscapes (2008) suggests there is an important emotional aspect in therapeutic landscapes. In these therapeutic

landscapes Team Members were able to provide emotional support to clients and thus developed a strong sense of connection with a particular landscape as a place of wellbeing and healing.

Working outdoors provided Team Members and clients with an opportunity to share the benefits of the therapeutic landscape. For example, Maureen explained how taking her clients fishing, as part of working together, helped her clients to clear their thoughts, but also helped her to do the same. Carlee outlined how engaging in therapeutic landscapes gave her and her clients a sense of feeling “clean”, well, refreshed. And Pete highlighted how he works with clients around a fire and in doing so both he and his clients experience a cleansing effect of the fire – similar to the impact firestick farming has on the bush, decluttering it and making way for fresh new growth.

Team Members employed specific features of the everyday therapeutic landscapes metaphorically to highlight stories and learnings about health and healing, to explore what it meant to feel healthy in a clean outdoor space, and to inspire deep conversations about difficult health related issues. They used metaphors to frame health messages for their clients; for example Pete spoke with clients about their ability to make changes to their drug and alcohol usage by referring to the metaphor of a fire being able to “sweep things clean”. Team Members also made reference to using everyday landscapes metaphorically for themselves, like Helen who spoke about using an outdoor space for self-care “I can go on…this place…tells me to look after myself…’ and Pete who spoke about the signs of new life, “new little trees”, in an outdoor space that “give [him] hope” enough to stay healthy himself.

Team Members in this study adopted cultural beliefs and practices, by connecting to Country in outdoor spaces with their clients, and recognised the therapeutic benefit of doing so for their clients and for their own practice. Embracing the use of an outdoor space made both clients and Team Members feel a strong connection to Country. This connection to Country aligns health and healing to the cultural experience of Country and plays an important role in the work done by Team Members with their Aboriginal and Torres Strait Islander clients. Research conducted by Townsend et al. (2009) highlighted that being in Country, having a cultural connection to a landscape often created a positive sense of identity, wellbeing and strength:

…the role of Country in strengthening Aboriginal Victorian peoples' self-esteem, self-worth and pride, fostering self-identity and belonging, cultural and spiritual connection, enabling positive states of wellbeing and acting like a sanctuary to escape pressures. (p.687)

Similarly, Team Members in this study found engaging with meaningful landscapes and connecting with Country and health as conducive to better service provision for their clients; they felt that this connection enhanced their work practice and believed this enhancement would therefore be experienced by the clients they worked with. This research provides non-Indigenous people working in health examples of how connection with Country matters, and gives specific examples of how Team Members share Country with their clients as they provide health services.

Importantly, Team Members described how they continued to use everyday outdoor landscapes therapeutically despite the fact that managers were unconvinced of the value of this way of working and colleagues likely to consider it shirking. This lack of understanding and valuing of Team Members' ways of working and relating to others has also been highlighted in

previous empirical chapters, Chapters 5 and 6. Despite this, Team Members often rejected the *extraordinary* therapeutic landscapes represented by their offices and health workplaces, many of which employed Aboriginal and Torres Strait Islander staff at the front desk and in other roles and hung Aboriginal and Torres Strait Islander artworks and posters, in favour of *ordinary* therapeutic landscapes such as parks and waterways. Interestingly, some Team Member's health services had attempted to 'Aboriginalise' the service by making adjustments to the built environment, like installing culturally relevant artwork, (Armstrong & Hayman, 2014; Hayman et al., 2014; Hayman et al., 2009; Kowal & Paradies, 2005) but still resisted listening to their Aboriginal and Torres Strait Islander staff (the Team Members) and continued to disapprove of or devalue of their ways of working. For example, a collegial lack of appreciation for Kim's capacity to find ways of refreshing herself in an outdoor space angered her and highlighted how a lack of understanding about her ways of working could perpetuate a "lazy worker" myth within the workplace.

While other research highlights the importance of creating welcoming and culturally warm health service built spaces (Jowsey et al., 2012) this chapter extends this by exploring what working in Aboriginal and Torres Strait Islander ways looks like in terms of using outdoor spaces with clients, and valuing them, in a therapeutic way that explores shared belief systems, attitudes, cultural knowledges and experiences, all enveloped by a connection to culture and Country.

This chapter presents ways that Aboriginal and Torres Strait Islander health professionals engaged in therapeutic landscapes at work and highlights how these ways are not understood

or valued by their managers. This topic will be further addressed in the discussion chapter when I argue the health sector could greatly benefit from improved understanding and recognition of Aboriginal and Torres Strait Islander ways of being, thinking and doing in health service delivery for Aboriginal and Torres Strait Islander clients, particularly as the practice supports the culturally important connection to Country.

Chapter 8: “When your own do it to you, well that’s another level of sad”: Australian Aboriginal and Torres Strait Islander experiences of workplace lateral violence in the health sector.

8.1 Introducing this chapter

The ways Team Members experienced and managed non-Indigenous colleagues and managers has been a strong thread through the previous three empirical chapters. In this chapter, I shift the focus to peers, other Aboriginal and Torres Strait Islander health professionals. I explore how Aboriginal and Torres Strait Islander health professionals work together and the issue of lateral violence in the workplace and in the health workforce. In this study, perpetrators of lateral violence used various personal characteristics to focus their lateral violence but I will focus particularly on how challenging Team Members’ professional capability and professionalism *and* challenging their Aboriginal and Torres Strait Islander identity drove the lateral violence. In keeping with the literature, my analysis reveals that lateral violence enacted by Aboriginal and Torres Strait Islander health professionals creates an extremely negative, potentially damaging work environment that erodes people’s confidence, motivation and drive.

As a Koori academic with a background working in the health sector I debated whether focusing on lateral violence in our Aboriginal and Torres Strait Islander health workforce adopted a damaging deficit approach (something I always avoid), but I decided that exposing lateral violence was responsible and if I choose not to focus on it then I would be guilty for keeping the problem alive and growing. Mick Gooda reported having a similar internal debate when investigating and reporting about lateral violence for the Human Rights Commission, but

reported “the damage and impact caused by not doing anything about lateral violence is, in my view, far greater than the risk of speaking out” (Gooda, 2011, p.53).

I am acutely aware that some people choose to maintain silence on certain critical issues related to Aboriginal and Torres Strait Islander experiences, for example the experience of lateral violence, and I appreciate that those choices could be actions of self-protection (Gorringe, Ross , & Fforde, 2009) or an effort to edit the external gaze that frequently highlights the deficit approach to understanding the collective Aboriginal and Torres Strait Islander contemporary life in Australia. I have a deep and sincere respect for our people who have spoken out against violence only to be silenced for example, Clark, (2014); Kurtz, Nyberg, Van Den Tillaart, & Mills, (2008); Nungarrayi Price, (2009). I also firmly believe that maintaining the ‘culture of silence’ common to oppressed groups of people (Freire, 2000) only contributes to a perpetuation of the violence itself and disables any potential for the empowering process of critically exploring the issue and making change. This chapter does not position lateral violence as a problem only of Australian Aboriginal and Torres Strait Islander people but rather aims to locate it within the Australian health sector workplace settings belonging to the Team Members, thus highlighting it as a broader problem socially and professionally. The focus is not to place blame on any one individual or workplace setting, but rather to raise awareness of the lived experience of lateral violence to facilitate a more rigorous addressing of it at a workplace level.

8.2 Literature specific to this chapter

This chapter begins with a synthesis of literature on lateral violence and identifies a gap in the literature specifically about how lateral violence operates in the Aboriginal and Torres Strait Islander health workplace.

8.2.1 What is lateral violence?

Lateral violence (also known as horizontal violence, workplace bullying, workplace incivility or harassment) is the "repeated offensive, abusive, intimidating, or insulting behaviour, abuse of power, or unfair sanctions that make recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence" (Vessey, DeMarco, & DiFazio, 2010). Lateral violence can also be referred to as 'pull down' behaviours (Doyle & Hungerford, 2015) or Tall Poppy Syndrome (Gooda, 2010). Expressions of lateral violence include shaming others, verbal attacks, sabotage, jealousy and gossip (Bombay, 2014; Gooda, 2010, 2011). It is particularly damaging when delivered by someone from the same cultural background (Gooda, 2010, 2011; Langton, 2008); experiencing lateral violence intra-culturally can make an Aboriginal and Torres Strait Islander person feel culturally rejected, affecting "identity and wellbeing" (Clark & Augoustinos, 2015, p.43), evoking feelings of being "unwanted by the Aboriginal community and of being less worthy and less Aboriginal" (Bennett, 2014, p.186). In his role as Aboriginal and Torres Strait Islander Social Justice Commissioner from 2010 to 2016, Mick Gooda focused on lateral violence in his 2011 Social Justice Report, stating that:

The theme of the Social Justice and Native Title Reports for 2011 will relate directly to the Social Justice Commissioner's priorities concerning the relationships between Aboriginal and Torres Strait Islander peoples within their communities and giving full effect to the United Nations Declaration on the Rights of Indigenous Peoples (the Declaration). This is also in line with the Australian Human Rights Commission's priority of tackling violence, harassment and bullying. (p.1)

Gooda highlighted lateral violence as the theme of his 2011 annual Social Justice and Native Title Report, positioning it as a social justice and human rights issue and not as something that is inevitable or just happens. Gooda (2011) comprehensively defined lateral violence and provided a human rights framework for understanding and addressing lateral violence, stating that "human rights standards are the first step in empowering communities" (p.102) and subsequently help to address "the causes and consequences of lateral violence" (p.102).

The United Nations Declaration on the Rights of Indigenous Peoples provided Gooda with "internationally recognised standards that governments have already committed to…[and]… a less confrontational and potentially more transformative way to talk about lateral violence" (Gooda, 2011, p.102). Importantly Gooda's report (2011) started to direct more attention towards the need to develop tools and strategies to address lateral violence, suggesting that "The first step is simply saying 'enough is enough' and declaring a zero tolerance for this sort of abuse" (p.166).

8.2.2 Theoretical framework of this chapter: Lateral violence and oppressed group behaviours

Freire (2000), writing about oppressed group behaviours, theorised that the oppressed feel devalued within a dominant culture that promotes itself as superior. Those oppressed people (as in the case of colonised Australian Aboriginal and Torres Strait Islander people) live with a

lack of power and an ongoing experience of living under threat and often begin to direct their disdain for such oppression inward, towards themselves (resulting in poor self-esteem), towards each other and towards those who they perceive as being less powerful than themselves (Clark & Augoustinos, 2015; Doyle & Hungerford, 2015). Lateral violence is theorised to be triggered by a sense of threat or low self-esteem and by differences in levels of income earning, educational or social status, cultural connections, or physical characteristics such as skin colour (Bombay, Matheson, & Anisman, 2014). However, lateral violence most often occurs between peers, colleagues or people who share some similar status or characteristic (for example, a shared cultural heritage) (Doyle & Hungerford, 2015). Being oppressed oneself and experiencing low self-esteem, a person might feel they need to be superior to others to succeed, and thus adopt characteristics of the oppressors (Gooda, 2011), in order to achieve that success.

8.2.3 Lateral Violence in Aboriginal and Torres Strait Islander communities: "Crabs in the bucket"

Within the Aboriginal and Torres Strait Islander Australian community, lateral violence is often talked about as being like 'crabs in the bucket' (Miller, 2015), drawing on the behavioural characteristic of crabs when in a bucket who will always try to pull down the ones who are trying to climb out ahead of them. This metaphor is at the core of lateral violence as conceived of in this chapter; however, the phrase has been attributed to many sources internationally. Padilla (1998) claims it to be part of a Mexican folk story:

A man stumbles upon a fisherman who is gathering crabs and placing them in a bucket with no lid. When the passerby asks the fisherman whether he is concerned that the crabs might climb out of the bucket and crawl away, the fisherman replies that there is no need to worry.

"You see," he says, "these are Mexican crabs. Whenever one of them tries to move up, the others pull him down. (p.778)

It has also been attributed to a Polish writer who called his immigrant community 'crabs in a bucket' (Miller, 2015) and Filipino peoples attribute it to writer Ninotchka Rosca who made reference to crab mentality (Rosca, 2007).

Lateral violence has been reported as reaching endemic levels in Australian Aboriginal and Torres Strait Islander communities (Gooda, 2010; Hunter & Onnis, 2015; Julien, Wright, & Zinni, 2010; Wingard, 2010). Some authors have argued that the process of colonisation and the subsequent oppression of Aboriginal and Torres Strait Islander people in Australia are contributing factors to lateral violence in Aboriginal and Torres Strait Islander communities (Gooda, 2010, 2011; Gorringe et al., 2009; Langton, 2008; Wingard, 2010). Australia's colonisation was enacted through the enforcing of government policies and actions that set about controlling the Aboriginal and Torres Strait Islander population. Historically, blood quantum and skin colour were defining features that supported the Australian government's acts and policies dictating the removal of Aboriginal and Torres Strait Islander children from their families and communities. Such government blood quantum and skin colour classification of Aboriginal and Torres Strait Islander identity established cultural division that can still be seen to emerge in acts of lateral violence as we turn on ourselves and use skin colour or other cultural means of defining our identity to make us feel strong enough to overcome oppression. Generations of children were taken away by governments, welfare and church organisations and either raised in institutions or fostered to non-Indigenous people; these children are known

as The Stolen Generation[21]. Removal of children from their families and communities remained official under various government laws and policies in Australia until 1969 (Wilkie, 1997). These colonial and postcolonial government acts and policies have had cumulative and intergenerational impacts on our culture and on our people (Gooda, 2010, 2011) that may contribute to contemporary cases of lateral violence as we struggle to overcome a sense of disempowerment that such loss and grief creates by fighting each, pulling each other down, as an act of survival (Coffin, Larson, & Cross, 2010; Glover, Dudgeon, & Huygens, 2005).

8.2.4 A gap in our knowledge

In Australia, workplace lateral violence has been predominantly researched in the nursing profession with a notable increase in publications in the last decade (Anderson, 2011; Hopkins, Fetherston, & Morrison, 2014; Hutchinson & Jackson, 2013; Hutchinson, Jackson, Wilkes, & Vickers, 2008; Hutchinson, Wilkes, Vickers, & Jackson, 2008). This leaves a significant gap in our understanding regarding the experience of lateral violence in other professions in the Australian health workforce (Butler, 2012; Clark & Augoustinos, 2015; Doyle & Hungerford, 2015; Hopkins et al., 2014), with even less research focusing on Aboriginal and Torres Strait Islander people working in the health sector in areas other than nursing (Demir, Rodwell, & Flower, 2014). Thus, despite a growing acknowledgement of the existence of lateral violence in Aboriginal and Torres Strait Islander communities and settings (Gooda, 2010, 2011; Wilson, 2014), there is limited research on how lateral violence operates in the Aboriginal and Torres

[21] For more information about the removal of Aboriginal and/or Torres Strait Islander children from their families and communities please see (Wilkie, 1997)

Strait Islander health workplace/workforce (Clark & Augoustinos, 2015). This is the focus of this chapter.

8.3 Findings

In this chapter I will examine four specific practices that constituted lateral violence in the Team Member's Yarns about their workplaces: (a) ambiguous communication to mask being nasty (including the use of disclaimers like "no offense, but..", humour and reverse compliments); (b) surveillance (being monitored at work for 'mistakes'); (c) exclusion from social and professional opportunities in the workplace; (d) white anting (undermining or belittling); (e) having their commitment to work questioned. I will show how all of these practices are fundamentally about enhancing the perpetrator's power through challenging Team Members' professional capability and professionalism or challenging the authenticity of Team Member's Aboriginal and Torres Strait Islander identity. In this latter case, perpetrators of lateral violence in this study accessed the tools of the oppressors (Gooda, 2010, 2011; Hunter & Onnis, 2015; Wingard, 2010) as they chose to focus on skin colour to insult and attack Team Members' identity and cultural authenticity (Clark & Augoustinos, 2015; Gooda, 2010).

(a) Ambiguous communication to mask nasty comments

Sadly, the acts of the oppressor, the defining of Aboriginal and Torres Strait Islander people according to blood quantum or skin colour, were adopted and used by Aboriginal and Torres Strait Islander work colleagues. A number of Team Members described experiences of lateral violence where their Aboriginal and Torres Strait Islander colleagues used their skin colour as an indicator of their of Aboriginal authenticity, with darker skin being framed as indicative of a more authentic Aboriginality. Gorringe, Ross and Fford (2009) have explored stereotyping 'legitimate' Aboriginality by continuing to use the colonial oppressive act of seeing skin colour

as a measure of identity. Here, Teena describes receiving comments that were couched as jokes or masked by jokey language.

Teena recalled two connected incidents with her Aboriginal colleague Sal:

Yeah, just last week Sal said this to me, right in front of Bob [another Aboriginal colleague] and two other [non-Indigenous] colleagues –"Hey Teens. I reckon you get off easy because the mob [clients] walk in here, check out all of us and always walk up to me or Dave. Reckon that's because we are the real blacks in here, eh? [Sal and Dave laugh] Jokes, sis, just jokin'".

I wore a light coloured t-shirt one day and Sal said to me 'Hey, that shirt is the same colour as your skin. It even makes your skin look whiter than it is!' She said this in a joking way, and laughed at the same time.

Although delivered in a jokey way, Teena heard in the second incident a challenge to her identity and suggestions about how her Aboriginality was perceived or valued by clients.

I dunno, maybe she would have said the same to another person wearing that shirt, but when those words come out of the mouth of someone who has already told me that a client might want someone who looks more Aboriginal, well, y'know, it is no joke.

During her yarns, Teena repeatedly talked about the effect this "joking" had on her:

Well, I didn't find that a joke, but the horrible thing that happened- everyone else laughed! It kills me most when it is said in a "joke". Well, it is no joke to me.

Sal's comments suggest that having darker skin (as an Aboriginal and Torres Strait Islander person) represents more cultural legitimacy and with more cultural legitimacy comes more cultural power. Sal is explicit that authenticity is highly valued by the community. By evoking her own darker skin, Sal positions herself as more authentic than Teena. This is in a context

where Teena was employed as an Aboriginal health professional and as such her cultural identity was formally interwoven with her professional appointment. Teena is accused of getting off easy, having lower client caseloads than Sal and her colleague Dave, because of her lighter skin colour.

Teena also experienced an Aboriginal colleague (Jason) using the denial “no offense” to mask being hurtful about her Aboriginal authenticity:

My Aboriginal colleague [Jason] once said to me, …‘Well, no offence Teena, but if your skin was a little darker then you’d look so much more Aboriginal’.

Episodes of lateral violence were often prefaced by words that seemed to make it acceptable for the violence to occur, or perhaps the preface/ disclaimer is used to indicate that something could be an offence but that telling the truth was more important than worrying about offending. Research on the use of disclaimers to qualify a derogatory statement, for example van Dijk (1996); Harris, Palazzolo, and Savage (2012); Wodak and Reisigl (2015) suggests that users of qualifiers and disclaimers like “no offence, but…” do so to reinforce power relationships based on some point of difference. They maintain “social relations of domination” (Wodak & Reisigl, 2015, p.646). When Jason offers the disclaimer “no offence” he suggests that his comments might be interpreted as rude or offensive, and he gives Teena a cue not to see them that way. Jason’s disclaimer “no offence” actually creates space for subsequent comments that are indeed offensive by “providing the veneer of political correctness” (Wodak & Reisigl, 2015, p.648).

(b) Surveillance: Always being watched

A number of Team Members Yarned about how experiences of lateral violence influenced how they felt at work, feeling they were under constant surveillance. Jimms described how he felt like his Aboriginal colleague (Trace) was always watching everything he did at work: "Sometimes I feel like I am just being watched, looked at all the time, checked up on even. Paranoid, eh? I dunno." Trace was not Jimms' manager and had no need to keep a track of Jimms' work. Jimms' recalled:

Yeah, I started to feel so paranoid that I second guessed things I was doing. Now, that's just not like me, y'know. I am straight to the point and confident. But I really felt like Trace was watching every phone call, every yarn with every client. I even felt she watched what I was saying in meetings.

Jimms recalls his colleague, Trace's surveillance of him at work:

It made me think she was waiting for me to trip up, y'know catch me out on something I shouldn't have done. Shit. Work became real hard for me then. There were days when I felt like I couldn't make a move in any direction.

Trace's constant watchfulness made Jimms feel paranoid, an unhelpful feeling to have in the workplace; a feeling that disempowered Jimms. Trace also sustained this lateral violence over a long period of time, and through many different workplace situations. This is typical of lateral violence described in other research (Lee, Brotheridge, Salin, & Hoel, 2013; Namie, 2003; Namie & Lutgen-Sandvik, 2010). Lateral violence is damaging as a once off, but it gains momentum and impact if it is sustained over a long period of time.

(c) Exclusion in the workplace

Exclusion is a common form of lateral violence. Aimee described several different forms of exclusion by her colleague Sam (and collusion by other colleagues): not being invited to be in the work football tipping competition (that Sam was running), not being put on the morning tea roster (also part of Sam's planning duties), being excluded from meetings, staff lunches and social events:

I can't even count the number of times I walked through the door to find everyone else sitting having a staff meeting, and I was never even told about them.

At the end of lunch one day I just popped in to the local café to buy a coffee to take back to work, and there was Sam and the three others from our unit. They all had shared lunch together and I was the only one from our unit that wasn't sitting at that table. Sam saw me at the coffee machine but just kept talking as if I wasn't even there.

Aimee recalled her worst experience of being left out, at the end of her first year in employ:

It was the last day of work before the Christmas break and I was feeling great because I had actually been invited to the end of year lunch! I was stoked. But when I got there I realised that everyone else had a 'Secret Santa' present to share with colleagues. I hadn't been told about this at all. I was so Shame.

Being invited to the lunch and then excluded from the tradition of the Secret Santa gift made Aimee feel unwanted and uncomfortable, she felt deep "Shame" even though the error was not hers. Being excluded meant that Aimee could not participate in the present giving and receiving, something that they did at work every year. She could not be part of the team because she had been excluded. She told me:

Mick, my Koori manager, walked over and told me to 'just pop your Secret Santa' over on the corner table. I told him I didn't know about it. He could see I was real embarrassed. 'That

was Sam's job- he told me everyone knew about this. Don't worry, nobody will notice.' Well, I knew, and so did everybody else.

I asked Aimee what made her tell Mick, her manager, that Sam had not told her about the Secret Santa, and she explained:

After a full year of Sam's behaviours I think I had just reached my breaking point. Honestly, a silly thing like a Secret Santa had brought tears to my eyes- and I am not that kinda' person. So I guess it just came out of my mouth before I could stop it. I should have stopped myself from telling Mick…people will treat me like the workplace whinger and take Sam's side anyway.

Aimee's experiences of lateral violence had silenced her for a long time. The Secret Santa exclusion was her breaking point; until then Aimee had chosen not to speak up about lateral violence. The Secret Santa exclusion drove Aimee, almost unintentionally, to tell her boss; but telling her boss was clearly not something she wanted to do. Aimee feared retribution because she had named and made public the lateral violence she was experiencing at work. She clearly regretted speaking out as it made her feel like a whistle-blower.

After PhotoYarning for a while longer, I asked Aimee why she wished she had not told Mick, and why she had stayed silent for so long. She said "Sam never got challenged over that, or anything else he did or didn't do". Lateral violence gains power when it is not addressed or acknowledged. The fact that Sam "never got challenged" nor faced reprimand for his behaviour reinforced Aimee's sense of powerlessness in the situation. Aimee PhotoYarned about the impact the lateral violence exclusion had on her:

Not being told about a meeting, then walking into it just is Shame. It makes me look really bad, like I don't care or I ignore the importance of the meetings. After a few times I felt so bad I had to talk to my manager. She told me that Sam always told her that he had let

everyone know about the meetings. I was speechless. Really, why would he do this to me over and over again?

Consistent exclusion sends a loud message to the receiver; Aimee felt "Shame" and realised it made her appear to not care about her work meetings. But what impacted most on Aimee was the fact that Sam had directly left her out of the meeting notifications- it was a deliberate reoccurring act, and left Aimee to wonder why she had been targeted.

(d) White anting; undermining or belittling to erode internal confidence

Pete had worked in Aboriginal and Torres Strait Islander health for 30 years. When we first started Yarning he spoke about his plans for career advancement:

Yeah, it's time I stepped into the management role here. I've done my time and I really do know my work. It's good really, 'cos my current manager is the one who is supporting my application for the promotion. Yeah, I am ready.

Subsequently Pete reflected on some comments made to him by another Aboriginal person in his workplace (Ted) that resulted in him not moving forward with the promotion application:

Ted said to me 'I guess you have been here longer than me, so on those grounds you're ripe for that promotion', y'know, built me up a bit, but then he went on to say 'But that degree in community management gave me new ways of looking at things. But you do kinda know this community I guess', and snap, cut me right down.

Pete's experience of lateral violence here made him re-think a move that would develop his career. Ted's comment "But you do kinda know this community I guess" suggested to Pete that his knowledge is personal not professional. Ted's suggestion was that Pete just had some experience ("you do kinda know this community") but Ted had the qualifications and those were rated higher in their workplace than community knowledge and community experience.

Cindy also describes how lateral violence made her think twice about advancement, in this case self-nominating to lead a health promotion project that she was very much interested in:

She (Toni, Aboriginal colleague) said to me 'Really? You?'… I just totally lose my confidence when she says things like that to me. I was ready to put my hand up to lead that health initiative and I know I am more than ready for it, but when she said to me 'Do you think you really have what it takes? I mean you missed the last three planning sessions because your bub was sick. But…if you really think you've got what it takes…'. I catch myself giving in and not putting my hand up for anything!

Cindy yarned about another photo she had taken:

Photo: Shattered confidence [Cindy]

This photo is how I feel when Toni says things to me at work. I feel like all my confidence breaks down. I feel like my knowledge and skills are not good enough, even shattered like this photo. I have worked in this field for 11 years, and I know what I am doing. But sometimes Toni says things that make me feel like I am back at day one on the job. She says things like "Gee, I never saw you in that role" or "Ah well, I guess you have been here long enough to go to that meeting- but what if bub gets sick again?" She even said "Are you sure you can do that?" right in front of the others here at work!

Cindy described herself to me as “confident and experienced”, yet questioned her own participation in aspects of work, after experiencing Toni’s lateral violence, experienced in the form of the white anting comment “Gee, I never saw you in that role”.

Bill PhotoYarned about June, an older Aboriginal colleague, who constantly belittled him. Here Bill described June speaking in a whisper, suggesting she didn’t want others to hear what she said:

One time June said ‘I don’t know what it is about you young ones, you think you know it all’…Really, all I was doing was answering a question from my manager. She said it just so I could hear it, nobody else. She does that a lot. Once she almost whispered ‘young upstart’ as I walked past with a client. I don’t think the client heard, or at least I hope she didn’t.

June was belittling Bill’s work and suggesting that his age made him a “know it all”; she was challenging Bill’s legitimacy as a professional. June is not paying any respect to Bill’s other skills at work. She is attempting to belittle Bill as she sees him succeed in the work he was doing with clients. June is acting like a crab in a bucket, trying to pull rank over Bill based on being older than he. June is focusing on age as Bill’s primary characteristic in the workplace, rather than focusing on his professional skills and capability.

Another example of belittling behaviour occurred during a staff meeting, where client case management workloads were being planned:

June just sat there and stared right at me and smiled. Then she said to the rest of the team ‘Are we sure Bill can handle that many clients? I mean, he is our young one here and he always looks so stressed- our clients don’t need that stressed look’. Y’know I don’t know what I was more offended by- the fact that she even said all of that, the fact that she assumed my capacity at work was relative to my age, or that she commented on my appearance!

June's white anting comment "Are we sure Bill can handle that many clients? I mean, he is our young one here…" is an example of lateral violence towards Bill. June was suggesting that Bill's age was a deficit in his work practice and enhanced her white anting by trying to engage the support of other work colleagues. Lateral violence grows if other people choose to join in; in this case June was trying to engage her colleagues by suggesting to them that Bill would not work well for "our clients". June undermined Bill firstly by suggesting his age made him not professional enough and then she insulted him further by commenting on his personal appearance to other colleagues.

Bill PhotoYarned about a photograph he took, describing how he felt threatened by the constant demeaning comments that undermined him at work, and how older Aboriginal colleagues seemed to use his age against him:

Photo: Cooked alive [Bill]

See this pot here, well I felt like some of my colleagues have chopped me up and thrown me in and cooked me alive. That's what it feels like- like they are getting ready to eat me!

Bill reflects on experiences at work when he had older Aboriginal colleagues speak about his age as an impediment to his professional practice:

It's weird, they were all young and starting out not long ago, but they really think it is OK to make comments about how young I am, making me feel like I am not ready for this job, not good enough, or just not right. Maybe they think that trash talking my work makes them look better? It just makes me feel really open to attack.

The description of being "chopped…up…thrown...in and cooked…alive" does not reflect positively on Bill's work colleagues. Bill identified that here the lateral violence took the form of "trash talking" [22] about his age. This form of white anting had the potential to belittle and undermine Bill. Trash talking is also something that is often used to enlist the support of others. Trash talking invited others in Bill's workplace to join in on the lateral violence that positioned his age as a deficit in his professional practice.

Bill talked about the lateral violence as making him feel "not ready", "not good enough" and "not right" at a time in his professional career development when mentoring from older colleagues normally plays an important role. Instead of finding solidarity and support from other older Aboriginal colleagues, Bill found a bucket of crabs trying to pull him back down:

I look up to them, y'know, they are my Elders here at work. But being called 'the youngen' and 'bubs' at work upsets me. They seem to be trying to pull themselves up so they are so much higher than me at work. But that's not needed -it shouldn't be that way.

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[22] "Trash talking" is when a person uses disrespectful or boastful comments to intimidate, demoralise or humiliate another

(e) Having commitment to work questioned

There is a body of literature exploring the concept of Aboriginal identity, specifically focusing on skin colour, authenticity and stereotypes. Of relevance to my research is work done by Hickey (2015), Johnston, Bennett, Mason, and Thomson (2016), Maddison (2013), Dodson (1994). Hickey (2015) and Mellor (2003) who explored racial stereotypes of Aboriginal people, including common welfare dependency, abuse of welfare systems, beliefs about darker skin equating to cultural superiority and beliefs about a lack of will to. Stereotyping of Aboriginal and Torres Strait Islander peoples was also evident in a relatively recent Australian public debate about the case of Andrew Bolt, a legal journalist who was found guilty of racial vilification (Aggarwal, 2012; Gelber & McNamara, 2013; Stone, 2015). Bolt claimed that a particular group of fair skinned Aboriginal professionals were not “real Aborigines” (Eatock v Bolt (No. 2) [2011] FCA 1180) and suggested that their cultural identities provided them with a range of advantages. This recent public debate resulted in a plethora of opinions about what a “real Aborigine” is in the minds and eyes of the general public in Australia; opinions ranged from an appreciation of cultural identity both complex and rich in diversity to stereotypes about racial privilege and laziness. The debate was fierce (Bodey, 2011; Crook, 2011; Holmes, 2011).

Tia Yarned about a photograph she took, describing an experience of lateral violence she called “the real Blackfella thing”:

Photo: The real Blackfella thing [Tia]

Jill is a good mate of mine [Jill identifies as Aboriginal]. We’ve worked together for a while now and I took this photo because of how she talks about my skin colour. It’s something I can’t get my head around- she says ‘Hey, you always get it easy. You can do the real blackfella thing and go have another coffee or something, I’ll sit here busting my gut with more client paperwork. G’on off you go, leave the hard shit to little whitey me.’ This is a photo of Jill’s desk. She says I go off and leave her to this busy work on her desk – but my desk is just as full as hers! Whoa. How can she even think like that about me, and then say it out loud! Accusing me of slipping out for a nice coffee break while she works on, and because I can do the ‘real blackfella thing’, whatever that is? Shit, really?

Tia was insulted by Jill’s suggestion that her darker skin allows her to “do the real Blackfella thing”, insinuating that Tia avoids work and leaves the workload to Jill. Jill has embraced another tool of the oppressor- connecting Tia’s darker skin to a lack of work ethic. Tia is shocked that Jill, an Aboriginal person herself, uses talk like that, accusing her of things that have become embedded across Australia’s long history of classifying and stereotyping Aboriginal people based on skin colour or blood quantum (Bodkin-Andrews & Carlson, 2013).

Tia PhotoYarned about another incident where others made assumptions about her based on her dark skin. Some people at work assume that her status as a Torres Strait Islander person won't be challenged because they see her dark skin affording her a higher cultural status than her paler skinned colleagues. Tia described this as being akin to experiencing a double edged "compliment" about having darker skin as a Torres Strait Islander person.

Well, that bloke [Frank, Aboriginal colleague] just said to me 'Ah, you don't have to worry. Nobody will challenge your identity. Must be easy having skin like yours, you don't have to justify yourself to anyone. You could get away with anything having that skin colour!' Hah! How about that! Yep, he saw B.L.A.C.K. skin and thought that makes it easier for me. Well, I'll tell you, it didn't make it any easier to know he was judging me on my colour. That's just stuffed, old school and it doesn't belong here!

Frank's comment is grounded in the assumption that Tia's darker skin confers power, meaning that Tia does not have to work hard at claiming a position as an Aboriginal and Torres Strait Islander person. Tia was offended by the innuendo that an Aboriginal and Torres Strait Islander person with darker skin could "get away with anything", that a darker skin person would be damned by other people's low expectations as demonstrated in other research by Dandy, Durkin, Barber, and Houghton (2015); Houston (2016); Riley and Ungerleider (2012); Sarra (2014); Tarbetsky, Collie, and Martin (2016); Wilson (2013); Yunkaporta and McGinty (2009). Tia explained:

I am a professional working with people's health. Why would I want to 'get away with' things? How does Frank see me then? Those words make me think Frank sees me using my skin colour to dodge hard work- y'know that old 'lazy blackfella' thing. Shit. He is keeping that myth alive isn't he?

Tia Yarned about her photo:

Photo: You only see part of me [Tia]

Working in [Aboriginal and Torres Strait Islander] health usually means working with your own mob, as well as others. When we work together (our mob) we have a real sense of pride, we support each other- y'know all for one and one for all. You can't see the whole scene in this photo – you are looking through a crack. That's how I feel Frank looks at me at work- he looks at me through a small crack and only sees one part of the picture of 'me'. So all he sees is my skin colour. It's so it's sad when our own mob only see part of us.

Tia PhotoYarned about her photograph, explaining that there was another Aboriginal colleague who had "suggested" that she gets off easy because of her darker skin. She said:

It just brings me right down. Pulls me down to the ground level, or even lower. To be looked at as a colour in this age is just wrong. And to be judged as lazy because I am black skinned, well, how hard have we all worked to pop that bubble? Yeah, there are still some racist people who look at a blackfella and think 'lazy', but when your own do it to you, well that's another level of sad.

Tia's experiences of lateral violence have come directly from those Aboriginal and Torres Strait Islander colleagues she works most closely with, people who she knows well and some of

whom she has worked with for some time. Even though Tia spoke about racism still being in the workplace, these examples of lateral violence from her own Aboriginal and Torres Strait Islander colleagues impact greatly on her wellbeing; many times throughout our Yarning Tia repeated words like “it’s so sad when it happens”, “makes me feel deeply sad”, “it just makes me ache with sad”. Her profound sadness is mixed with the feeling of disbelief that her colleagues are taking that position against her “Shit, really?”, “How can she even think about me like that”, take its toll on Tia. She explained this feeling: “Y’know those words cut so deep. I feel betrayed by my own workmates. Makes me just want to cry. And y’know what, I often do”. Tia feels deeply betrayed by her colleagues, misrecognised when her colleagues attribute a negative motivation to her.

8.4 Discussion

This study builds on existing work on lateral violence (Coffin et al., 2010; CreativeSpirits, 2016; Gooda, 2010, 2011; Nungarrayi Price, 2009; Rainford, Wood, McMullen, & Philipsen, 2015) to provide insights into how lateral violence operates specifically in the context of Aboriginal and Torres Strait Islander health service workplaces. This chapter explored the lived experiences of people subject to lateral violence by describing the characteristics of lateral violence and the way it operated in the context of the working lives of fifteen Aboriginal and Torres Strait Islander people who work in the health sector in Australia.

Lateral violence is never about absolutes. Significantly, this study described how colleagues used lateral violence to try to gain power over others by attacking their authenticity, challenging their identity as an Aboriginal and Torres Strait Islander employee. Team Members

experienced the corrosive effect of being constantly monitored and excluded from meetings and social events, and had colleagues and managers use insidious, ambiguous forms of communication to deliver compliments that either belittled them or masked racism, like the disclaimer “no offence”. Lateral violence did not privilege dark skin over light skin, or vice versa; both were used in different situations to suggest that Team Members were not valued, incapable of performing professionally, or somehow inferior to others. Acts of lateral violence suggested pale skin Team Members were “less Aboriginal” and thus less capable of doing their job; dark skinned Team Members were stereotyped as being “lazy” and unprofessional.

This chapter offers a more nuanced understanding of the nature and characteristics of lateral violence in the context of the working lives of Aboriginal and Torres Strait Islander people working in the Australian health sector. Throughout the chapter Team Members outlined some of the impacts lateral violence had on them including how they felt bad at work, resisted complaining about their experiences of lateral violence for fear of repercussion and had their professional confidence eroded. Team Members’ wellbeing was impacted as they were often disabled by lateral violence, remained silenced in the workplace or chose not to apply for professional development and promotion opportunities.

These findings highlight the need to educate the wider workforce about the impact lateral violence can have on Aboriginal and Torres Strait Islander staff. While this awareness raising is important, the study specifically seeks to inform health service managers so they can better identify lateral violence; for example, managers need to be able to see when humour or disclaimers are used to mask nasty comments, identify when an Aboriginal and Torres Strait

Islander colleague uses skin colour as mechanisms to define another's 'authenticity' as an Aboriginal and Torres Strait Islander person and they need to notice white anting, belittling and exclusion in the workplace. Managers who can better identify lateral violence in the workplace should then be better placed to develop skills to prevent it impacting on their Aboriginal and Torres Strait Islander staff and more widely on their organisation. Gooda (2011) identified cultural safety and cultural security as tools to address lateral violence within a human rights framework (pp.120-166). He defined a "culturally safe and secure environment" as:

> …one where our people feel safe and draw strength from their identity, culture and community. Cultural safety and security requires the creation of:
>
> • environments of cultural resilience from within Aboriginal and Torres Strait Islander communities
>
> • cultural competency by those who engage with Aboriginal and Torres Strait Islander communities (p.11).

This definition is important to the findings of this research, as it is a poignant reminder that cultural safety and security is the responsibility for everyone in the workplace, regardless of their cultural positioning. Within a proposed a set of recommendations, Gooda (2011) insists that cultural safety and security be at the core of all activities when working with Aboriginal and Torres Strait Islander peoples and that "education and awareness-raising sessions on lateral violence for both Aboriginal and Torres Strait Islander and non-Indigenous staff" (p.167). He also calls for further research to be undertaken to develop an evidence base to "further shape our responses to lateral violence" and to contribute to developing tools to better address lateral violence (Gooda, 2011, p.166). Importantly, Gooda (2011) insists that both Aboriginal and Torres Strait Islander and non-Indigenous staff learn about lateral violence so they can not

only identify it but build capacity to provide support and initiative to stop lateral violence in their workplaces; instead of backing off and letting people sort it out themselves workplaces and managers need to have capacity to step in and either prevent lateral violence before it takes a hold or address it in its early stages. My analysis makes a valuable contribution to this important work.

Sadly, the accounts from Team Members suggests that lateral violence has been normalised in many workplaces. Individuals and workplaces alike run the risk of being worn out by lateral violence. This workplace norm needs to be challenged and broken to avoid further damage to the important human capital in our Aboriginal and Torres Strait Islander health workforce. It is essential that the health sector, and all professions working therein, become more aware of lateral violence and better understand the impact it has on individuals in the Aboriginal and Torres Strait Islander workforce in the Australian health sector. While this research focused on the individual experience of lateral violence there remains a need to explore our systems and the role they play in upholding, permitting or supporting lateral violence in Aboriginal and Torres Strait Islander health.

Chapter 9 Discussion and conclusion

> Decolonising processes require all individuals to explore their own assumptions and beliefs so that they can be open to other ways of knowing, being, and doing. For the health departments and their employees it requires evaluating what is not working and being big enough to accept that change needs to happen. This change needs to be informed by Aboriginal people, the experts of their own health. Aboriginal health bodies and health professional associations have experience in effective ways of knowing about Aboriginal health and need to be heard, as do the communities they serve. (Sherwood & Edwards, 2006, p. 188)

9.1 The Australian health system: making commitments. Who and what do we value?

In 2006, Sherwood and Edwards sent the above powerful call to action and invited the Australian health sector to take responsibility and make changes to their systems and to membership of the health workforce in an effort to impact on positive health outcomes for Aboriginal and Torres Strait Islander peoples. And yet, despite national efforts to close the gap on the disparity between Aboriginal and Torres Strait Islander health and the health outcomes of the wider Australian population (COAG, 2009), much work remains to be done. Nakata's (1997, 2007a) Cultural Interface theory helps to understand how people (like Team Members) can work in a space that comprises Western and Indigenous knowledges and systems. My recommendations have potential to extend Nakata's theory in a way that engages the Australian health system in non-othering Aboriginal and Torres Strait Islander ways of working in health by embedding Aboriginal and Torres Strait Islander knowledge and practice systems as central to good health service delivery.

A number of guiding national policies and frameworks (COAG, 2009; Department of Health, 2013, 2014; Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017) position Aboriginal and Torres Strait Islander culture as a core concept in Aboriginal and Torres Strait Islander health; my research highlights a gap existing between rhetoric and enactment. The essence of transforming the Aboriginal and Torres Strait Islander health sector from rhetoric to enactment could be achieved through the health sector making a number of commitments, highlighted through my findings.

9.1.1 Commitment 1: Develop a greater understanding how the Aboriginal and Torres Strait Islander health workforce practice professional boundary work as they work at the cultural interface.

All Team Members identified that there were two constants in their lives (1) being an Aboriginal and Torres Strait Islander person and (2) the community context in which they worked and lived. Combined, these two constants informed the professional identities of Team Members who all expressed their health professions role as not only existing between working hours. As Marlene stated "…*My work? Well, I live it and breathe it. My job does not stop at a 5pm bell. I am seen as the health worker whatever time of day it is, or wherever I am. That's just how it is".*

Living and working at the cultural interface, Team Members were constantly engaged in boundary work; I explored this in two ways of working: working with friendship-like ways and working seamlessly. In Chapters 5 and 6 I explored how Team Members conceived of themselves and their roles and showed how this was enacted via friendship-like connections with clients in a work setting, and via a seamlessness when in community.

In Chapter 5 I described how Team Members made purposeful decisions to create friendship-like connections with clients, how they embedded these friendship-like connections within their professional role responsibilities and how they valued this as a way of achieving best outcomes for clients. Team Members showed a strong sense of knowing how better to work with clients using friendship-like connections rather than other, more dominant and normalised ways of working used by others in their workplaces.

Team Members built friendship-like connections with clients through building trust and by developing relationality through valuing reciprocity (Green, Gregory, & Mason, 2006). Examples of how friendship-like connections worked in health care interactions were provided by Team Members who described the importance of identifying and managing any possible ‘danger zones’, finding a balance between health work talk and relationship-building talk, working in a way that is described by Green et al. (2006) as being “a stretchy piece of elastic” (p. 450). Team Members believed that friendship-like connections with clients worked when conscious, controlled boundaries were both set and managed. Team Members clearly defined the relationship as “working” (Bennett, Zubrzycki, & Bacon, 2011; Ella, Lee, Childs, & Conigrave, 2015; Kelly et al., 2014). The strategies Team Members used to politely decline the party invitations and manage shopping centre conversations kept them working well within professional boundaries while still connecting with the client on a deeper, more familiar level (Brownlee, Halverson, & Chassie, 2015; Warren et al., 2013). Developing strategies to manage boundaries (MacNaughton et al., 2013) was important as Team Members worked and lived in the same community or region, and therefore probably would see their clients in some capacity around community (Brownlee et al., 2015; Cosgrave, Hussain, & Maple, 2015).

Team Members' building of friendship-like connections with clients within their professional roles placed "people at the heart of care' (Brannelly, Boulton, & te Hiini, 2013, p.2). Using cultural protocols Team Members invited reciprocity in their interactions with clients, often beginning with both Team Member (health professional) and client sharing cultural and familial links and connections to Country. This initial process provided a foundation that acknowledged an existing connection, from which a new connection was invited. An interesting parallel exists between Team Members' use of friendship-like connections with clients and Feminist health care ethics (Baylis, Kenny, & Sherwin, 2008; Fotaki, 2015; Sherwin, 2000). Both question power relations and power structures within health care delivery and support a similar privileging of relationality. Further research could explore this parallel in greater depth with the aim of providing an additional theoretical framework for managers and health systems to better understand and appreciate the ways Aboriginal and Torres Strait Islander staff work with professional boundaries.

The friendship-like connections Team Members made with their clients challenged dominant beliefs and practices in health care service provision, like maintaining objectivity and observing normalised professional boundaries. Brannelly et al. (2013), in a study exploring the relationship between the Ethics of Care (Gilligan, 1982; Tronto, 1993) and Maori worldview, explored how health services that maintain rigid objectivity, pre-determined boundaries and adhere to dominant power structures "emphasise distance in the relationship" (p.2) between healthcare professional and client; they suggest that " people who care in their everyday lives are encouraged into professional practices that ask them not to demonstrate care" (p.2). Team Members in this study demonstrated an ethic of care as they constructed their professional

identity as an extension of self. While patient centred care has long been the goal of much health service provision (Kitson, Marshall, Bassett, & Zeitz, 2013; Parish, 2015; Richards, Coulter, & Wicks, 2015) additional effort is required by health services to better understand and embrace the ways many Aboriginal and Torres Strait Islander staff work with their clients.

Working with friendship-like connections is a practice used by some others in the wider health care profession. Studies have described friendship-like connections in aged care nursing (Corbett & Williams, 2014), in an integrated care model (Hughes, Moyes, Dutton, Morton, & Woon, 2014), as a preferred model in renewed primary health care teams (MacNaughton, Chreim, & Bourgeault, 2013), in social work teams (Sanders, Bullock, & Broussard, 2012) and in working with spinal cord injury patients (Warren, Hamilton, & Roden-Foreman, 2013). My research suggests that health care, more broadly, has something to learn from working with friendship-like connections with clients.

Yet most of the Team Members described colleagues and managers who misunderstood their friendship-like connections with clients, and worried about them. Team Members experienced a series of negative impacts on their own experience at work, including having their professional role ill-defined and misunderstood, receiving feedback that suggested their practice was unprofessional, having their professional capacity undermined and being accused of not getting the job done (Kelly et al., 2014; Lowell, Kildea, Liddle, Cox, & Paterson, 2015). Managers and colleagues perceived their friendship-like connections with clients as detrimental to professional practice, suggesting that such connections blurred professional boundaries and

decreased professionalism. Thus there was a disconnect between what Team Members, on the one hand, and colleagues and managers on the other, saw as good practice.

In Chapter 6 I described Team Members' pride in being always visible in the work and in their community; they valued being available for clients, they took pride in knowing client's names and developed strategies to enable them to continue to engage with clients if they met clients outside of work in community settings. While such a sense of pride in being able to work in seamless ways featured in the experiences of Team Members in this study there is also a body of research that challenges that state of working in a seamless way. For example, burnout and stress in Aboriginal and Torres Strait Islander health professionals working in the alcohol and other drug field has been connected to a sense of being always seen or being expected to always be available to the community in which one lived and worked (Duraisingam, Pidd, Roche, & O'Connor, 2006; Duraisingam, Roche, Pidd, Zoontjens, & Pollard, 2007; Duraisingam, Roche, Trifonoff, & Tovell, 2010; Durey et al., 2016; Roche, Duraisingam, Trifonoff, Battams et al., 2013; Roche, Duraisingam, Trifonoff & Tovell, 2013). It is important to note that these latter experiences were different to those described by Team Members at the time of doing this research; perhaps the strategies developed and employed by Team Members have provided them with the capacity to avoid burnout or stress related to always being visible in their communities. It would be interesting to further compare the strategies developed by Team Members in this study with strategies developed and used by other Aboriginal and Torres Strait Islander health professionals who did experience stress and burnout.

Again I showed that Team Members' lived experiences and ways of working, here with a seamless working self, challenged some of the Western paradigms upheld by their colleagues, who took a different view on maintaining professional boundaries when working with clients in a health care context, constructing lines between their personal and professional identities (Hayman et al., 2009; Jowsey et al., 2012). Team Members chose not to privilege one role identity over another and established ways of working that allowed them to work seamlessly between their professional and personal selves (the seamless working self). This allowed Team Members to create a working and community space that supported good working practice and supported their clients. The concept of a seamless working self could pose concerns for management of workloads, boundaries and role identities, but is only challenging when viewed from a particular ontological lens that does not engage with Indigenous ontology and epistemology (Martin & Mirraboopa, 2003; Nakata, 2007a).

A major concern expressed by Team Members in this study was the lack of understanding their colleagues had about the way Team Members worked, largely reflecting a lack of ability to see or appreciate more than one world view. If Team Members' managers and colleagues were encouraged to develop an understanding of how Team Members work at the Cultural Interface Team Members could potentially reap the emancipatory effects as their colleagues expand their world view and interpretations to include other people's world views and ways of being, doing and knowing (Foley, 2003).

Drawing these two sets of findings together, makes it clear that I argue for health services to better understand and value the friendship-like (Reimer, 2014) connections Team Members

develop and engage in their work with clients. Team Members in this study adopted practices with clients that they felt comfortable with; they developed ways of being at home in community that they felt comfortable with. At the same time, they sought to perform their professional role with care, professionalism and cultural safety while keeping client service provision and care at the focal point. We need to attend to this disconnect between Aboriginal and Torres Strait Islander health professionals' experiences and perspectives and their workplaces. The rhetoric of trying to address this disconnect is evident in the National Aboriginal and Torres Strait Islander Health Plan (2013) as it proposes how health systems can better value and come to understand Aboriginal and Torres Strait Islander ways of working in health to enhance health service provision for Aboriginal and Torres Strait Islander clients and Aboriginal and Torres Strait Islander health staff:

> Goal: The capabilities, potential and aspirations of Aboriginal and Torres Strait Islander people are realised and optimise their contribution as individuals to the health workforce and to strategies to achieve Aboriginal and Torres Strait Islander wellbeing. Institutional and organisational structures and processes harness human and community capability and enhance its potential (p.23).

This speaks of making change to models of care, to workplace management and supervision, of building capacity and capability of the health workforce – of making institutional and systemic change. However, my research findings reflect Team Members' experiences of not having their "capabilities, potential and aspirations …realized". Their ways of working were very evidently not seen to "optimize their contribution as individuals to the health workforce and to strategies to achieve Aboriginal and Torres Strait Islander wellbeing" (Department of Health, 2013, p.23).

If we are committed to supporting, valuing and embracing the work being done by Aboriginal and Torres Strait Islander members of the health workforce, then we need research to understand the factors contributing to collegial and managerial opposition to the reality of Aboriginal and Torres Strait Islander health professionals' ways of work.

9.1.2 Commitment 2: Recognise the use of everyday therapeutic landscapes by Aboriginal and Torres Strait Islander health staff as a best practice model that values a spiritual and cultural connection between place and health

Team Members used outdoor spaces regularly in their work with clients and that challenged the current theory that positions the use of outdoor spaces in health service provision as being something special (Abraham et al., 2010); the dominant framing of working outdoors as being 'special' makes Team Members' working outside so problematic for their managers and colleagues. I argue that the use of outdoor spaces in the work undertaken by Aboriginal and Torres Strait Islander health staff should be considered as a regular (everyday) work practice instead of an extraordinary work practice as this could enhance or improve both service provision for clients and working conditions for Aboriginal and Torres Strait Islander health sector employees. There is a growing body of literature that recognises the therapeutic connection between landscapes and spaces, and health and wellbeing for health clients, for example Jiang (2015), Lengen (2015), Liamputtong & Suwankhong (2015), Wendt & Gone (2012). However, there is little research specifically on working with therapeutic landscapes in the context of Australian Aboriginal and Torres Strait Islander health. This study contributes to developing an understanding of how therapeutic landscapes operate in the context of an Aboriginal and Torres Strait Islander health and provides a unique perspective of the benefits of

working with therapeutic landscapes from the point of view of Aboriginal and Torres Strait Islander health professionals who engage those spaces in their daily work.

While there is some literature exploring the health and wellbeing benefits, for Australian Aboriginal and Torres Strait Islander peoples, of being connected to Country (Green & Martin, 2016; Kingsley, Townsend, Henderson-Wilson, & Bolam, 2013; Townsend, Phillips, & Aldous, 2009) there remains a gap in the literature on whether working regularly in outdoor spaces can enhance or improve both service provision for clients and working conditions for Aboriginal and Torres Strait Islander health sector employees. Team Members in this study adopted cultural beliefs and practices, by connecting to Country in outdoor spaces with their clients, and recognised the therapeutic benefit of doing so for their clients and for their own practice (Kingsley et al., 2013; Melody et al., 2016; Willox et al., 2013). Team Members used specific features, metaphorically, of the everyday therapeutic landscapes in which they worked to highlight stories and learnings about health and healing, to explore what it meant to feel healthy in a clean outdoor space, and to inspire deep conversations about difficult health related issues.

Team Members in this study found that they more easily explored emotions with their clients when working in an outdoor space. English's (2008) theory of therapeutic landscapes suggests there is an important emotional aspect in therapeutic landscapes. In these therapeutic landscapes Team Members were able to provide emotional support to clients and thus developed a strong sense of relationship between a particular landscape as a place of emotional support and healing (English, 2008; Davidson and Milligan, 2004; Grieves, 2009;

Kearney, 2009). Throughout this study Team Members expressed that they were more able to understand a client’s emotion and provide an emotional connection within specific space. Davidson and Milligan (2004, p.524) refer to this concept as an “emotion-spatial hermeneutic: when emotions are understandable—'sensible'—only in the context of particular places. Likewise, place must be *felt* to make sense. This leads to our feeling that meaningful senses of space emerge only via movements *between* people and places”.

In Chapter 7 I offer a specific understanding of how Team Members in this study utilised an emotional and cultural connection between place and health in their work with Aboriginal and Torres Strait Islander clients. This provides health services with a particular model of service delivery that focuses more on using outdoor space and less on the built environment. It also proposes a practice model showing the creative use of metaphor in therapeutic landscapes to work with Aboriginal and Torres Strait Islander clients about health and wellbeing. Additionally, the health and wellbeing of the Aboriginal and Torres Strait Islander health professionals in this study was enhanced by their own engagement with therapeutic landscapes, providing scope for further consideration of how working in therapeutic landscapes can also support Aboriginal and Torres Strait Islander staff health and wellbeing. More effective use of everyday therapeutic landscapes in Aboriginal and Torres Strait Islander health settings has potential to benefit both the workforce and the clients.

Team Members often embraced the use of an outdoor space in their work with clients as it made both the client and themselves feel a strong connection to Country (Kingsley et al., 2013; Townsend et al., 2009). This connection to Country aligns health and healing to the cultural

experience of Country connection and plays an important role in the work done in outdoor spaces by Team Members with their Aboriginal and Torres Strait Islander clients. Research conducted by Townsend et al. (2009) highlighted “the role of Country in strengthening Aboriginal Victorian peoples’ self-esteem, self-worth and pride, fostering self-identity and belonging, cultural and spiritual connection, enabling positive states of wellbeing and acting like a sanctuary to escape pressures” (p.687). Similarly, Team Members in this study found working with clients outdoors and making this connect between culture and health as conducive to better service provision for their clients; they felt that this connection enhanced their work practice and would result in better care for their client. The health sector could greatly benefit from greater understanding and recognition of the potential use of therapeutic landscapes in the work done by their Aboriginal and Torres Strait Islander employees, particularly as the practice supports the culturally important connection to Country held by Aboriginal and Torres Strait Islander people (Kingsley et al., 2013; Townsend et al., 2009).

Some health services attempt to create a cultural connect between a client and health service delivery but most of this focuses on making adjustments to the built environment (Armstrong & Hayman, 2014; Hayman et al., 2014; Hayman et al., 2009; Kowal & Paradies, 2005), or the extraordinary spaces created within a health service (English et al., 2008). While it remains important to create welcoming and cultural warm health service built spaces (Aspin et al., 2012; Jowsey et al., 2012) my analysis highlights the greater potential for using outdoor spaces in a way that engages culture therapeutically (Meurk, Broom, Adams, & Sibbritt, 2013; Wendt & Gone, 2012; Wilson, 2003).

Throughout this research Team Members explored emotional connections and experiences with their clients in a range of everyday places, and as such respect those places as everyday therapeutic landscapes. I was unable to find any research on how Aboriginal and Torres Strait Islander health professionals specifically used therapeutic landscapes in their work with clients. This research informs that space by providing examples of how Aboriginal and Torres Strait Islander health professionals worked with therapeutic landscapes in their daily work with clients. Team Members provided examples of how their work with clients is enhanced by the use of a shared connection to Country and by simply sharing an open space that allows their clients to feel more relaxed than they might feel in the rooms of a health service. Team Members metaphorically used landscapes elements to help them frame health messages for their clients and also demonstrated an appreciation of how landscapes and outdoor spaces also reinvigorated them as they work with clients. Team Members and their clients shared a connection with outdoor spaces to support and encourage positive health, wellbeing and rejuvenation.

9.1.3 Commitment 3: Place culture at the core of the Aboriginal and Torres Strait Islander health sector and not at the core of challenging one's authenticity culturally or professionally.

Sadly, Team Members experienced lateral violence in their workplaces, thrust upon them by their Aboriginal and Torres Strait Islander colleagues. In many cases, cultural concepts and beliefs were used as vehicles for lateral violence as Aboriginal and Torres Strait Islander health professionals that would either disempower (the lateral violence victim) or empower (the perpetrator). This must stop. We will not be able to actively participate in real change for the Aboriginal and Torres Strait Islander health sector until we collectively value our own cultural

diversity, and therefore embrace our culture as a strength and not a something to be used to gain some type of power over each other.

A clear distinction between this study and other studies on lateral violence is the Aboriginal and Torres Strait Islander workplace context that provides scope for lateral violence to challenge workplace roles, responsibilities and professional practice. The important difference highlighted in this study is the focus lateral violence maintains on challenging and attacking cultural identity in a healthcare workplace context. This is particularly important to note given lateral violence in this study is exchanged between people of shared Aboriginal and Torres Strait Islander cultural backgrounds. Skin colour, the focal point for much of the lateral violence, was used to challenge cultural authenticity, at times positioning a darker skinned person as being culturally superior to a lighter skinned person (Dodson, 1994; Hickey, 2015; Mellor, 2003). Team Members' colleagues suggested that darker skinned people were more sought after by clients than lighter skinned health professionals, stereotyping (CreativeSpirits, 2016a) a darker skinned person as 'being more Aboriginal'. However, darker skinned Team Members were also accused of being 'a real Blackfella', implying they were lazy. Some lighter skinned Team Members experienced lateral violence comments about looking 'less Aboriginal' and being able to 'fit in' at work, suggesting their lighter skin helped them to 'fit in' with their non-Indigenous colleagues, as if this was something they were seeking to do (Butler, 2012; Clark & Augoustinos, 2015). Regardless of skin colour, lateral violence took hold and allowed for colleagues to challenge Team Members' authenticity and legitimacy both as health professionals and as Aboriginal and Torres Strait Islander people.

My analysis in Chapter 8 builds on what is already generally known about lateral violence (Coffin, Larson, & Cross, 2010; CreativeSpirits, 2016b; Gooda, 2010; Nungarrayi Price, 2009; Rainford, Wood, McMullen, & Philipsen, 2015) and further provides insights into how lateral violence operates in the context of Aboriginal and Torres Strait Islander health service workplaces. I demonstrated the damage such lateral violence caused to members of the Aboriginal and Torres Strait Islander health workforce. My findings highlights an immediate need for workforce development for Aboriginal and Torres Strait Islander health professionals.

As an Aboriginal academic with a background working in the health sector I debated whether focusing on lateral violence in our Aboriginal and Torres Strait Islander health workforce adopted a damaging deficit approach (something I avoid) but decided that exposing lateral violence was responsible, and choosing not to focus on it just keeps the problem alive and growing. Mick Gooda, Australia's Aboriginal and Torres Strait Islander Social Justice Commissioner (2010-2016), reported having a similar internal debate when investigating and reporting about lateral violence for the Human Rights Commission, but reported "considerable appetite within our communities to confront and deal with Lateral Violence" (Gooda, 2010). While I have a deep and sincere respect for those Aboriginal peoples who have spoken out against violence only to be silenced (Clark, 2014; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; Nungarrayi Price, 2009) I firmly believe that maintaining the culture of silence common to oppressed groups of people (Freire, 2000) only contributes to a perpetuation of the violence itself and disables any potential for the empowering process of critically exploring the issue and making change.

9.2 Moving on from policy and workplace rhetoric

This research builds on the work of Prodan-Bhalla et al. (2016) who sought to "build a bridge between two cultures in an attempt to deliver culturally responsive [service provision]" (p.1). The work I have presented in this thesis indicates there needs to be an ongoing conversation between Western service provision beliefs, policy and practice and Aboriginal and Torres Strait Islander service provision beliefs, policy and practice to "build a bridge" between diverse service provision models. Finding ways of moving from a workplace rhetoric about cultural awareness to culturally aware practice should be the goal of all health services (Freeman et al., 2014; Kendall & Barnett, 2015). Using an Aboriginal and Torres Strait Islander cultural stance supported Team Members to work therapeutically with clients in outdoor spaces (that were often culturally meaningful to clients) rather than doing all health business indoors, allowed Team Members to establish friendship-like ways of working to negotiate their work dynamics as they provided health care to people in their own community and provided scope for Team Members to negotiate personal dynamics when being a community person in a community where they also had clients.

While some policy documents have established the need for health service staff "to build respectful, trusting and effective partnerships between NSW Health and the Aboriginal communities" (Thoits, 2012, p. 4) there remains limited direction on how to achieve this. Aboriginal and Torres Strait Islander health professionals are providing very clear examples of what such respectful, trusting and effective partnerships should look like, but as I have repeatedly shown, they are being ignored, actively discouraged, criticised and chastised by their

non-Indigenous managers and colleagues. Sadly, the current federal government, responsible for establishing health policies that inform practice and service delivery, still appears to have difficulties establishing appropriate ways of being “informed by Aboriginal people”, evidenced by the recent lack of response to both The Redfern Statement (National Congress of Australia's First Peoples, 2016) and The Uluru Statement (Conifer, Leslie, Tilley, & Liddy, 2017) that both offered the health sector (and other sectors) Aboriginal and Torres Strait Islander perspectives, ideas and actions. The health system is, itself, a social determinant of health (Browne, Varcoe, Lavoie et al., 2016; Browne, Varcoe, Wong et al., 2012). Earlier in my thesis I drew upon work by Mooney (2003), who argues that “any health care system is first and foremost a social institution built on the cultural stance of the nation it serves” (p.267); the Australian health care system has been built, and continues to operate, according to Western paradigms, policies and practices. My overarching argument demands that the Australian health care system needs to better engage with, and understand, Aboriginal and Torres Strait Islander ways of being, knowing and doing and embed an Aboriginal and Torres Strait Islander “cultural stance” into its foundations of health service policy, planning and delivery. It is within this broader argument that my findings and their significance are best understood.

Prior to my research there has been a greater focus in the health system to pay attention to understanding Aboriginal and Torres Strait Islander cultures, rather than Aboriginal and Torres Strait Islander knowledge systems (ways of knowing, being, doing). I suggest that this focus potentially has led our health system to believe that hanging Aboriginal and Torres Strait Islander art on walls is enough of a signal that understanding has been achieved. Current attempts to ‘Aboriginalise’ the Aboriginal and Torres Strait Islander health sector are not

enough. My research argues for the health system to move its focus away from only understanding Aboriginal and Torres Strait Islander cultures to a focus that seeks understanding and valuing of Aboriginal and Torres Strait Islander knowledge systems (ways of knowing, seeing, doing). While hanging Aboriginal and Torres Strait Islander art on the walls of health service buildings, making health service buildings more welcoming and increasing the number of Aboriginal and Torres Strait Islander staff are appropriate initial steps to take more needs to be done (Aspin, Brown, Jowsey, Yen, & Leeder, 2012) to genuinely engage with Aboriginal and Torres Strait Islander ways of knowing, being and doing in health.

The complexities faced by Aboriginal and Torres Strait Islander Team Members who were living and working in the same community are presented throughout the empirical chapters of my research. Across the findings Team Members demonstrated that boundary work is essential in their work and they provided examples of how they used friendship-like ways to negotiate work dynamics when working with community members as clients and how they enacted seamless working ways as they negotiated personal dynamics when being a community person in a community where they had clients. Team Members established ways of working to uphold the boundaries they required in order to live and work in the same community and did so with passion and positivity. However, their boundary work (and the ways the upheld their boundaries) were constantly scrutinised and critiqued by their non-Indigenous managers and colleagues who had little understanding of their ways of working and less valuing of those ways as being legitimate.

Nakata's Cultural Interface theory (Nakata, 1997, 2007a) helped to better understand how Team Members navigated the space between working with a client (in a work context) and maintaining a relationship with the same person, in a community context. Team Members in this study identified strongly as both a community member and a health professional, both within the same community. As such most had developed strategies to maintain a professional identity within their personal and community space, and a community identity within their professional space. Team Members recognised they operated at the Cultural Interface and were comfortable with the ways they lived and worked in that space. Indigenous Standpoint Theory (Foley, 2006; Moreton-Robinson, 2013; Nakata, 2007b) supports how Team Members work in an Aboriginal and Torres Strait Islander health space as Aboriginal and Torres Strait Islander health workers who identify strongly with their professional and community responsibilities and thus developed a space in which both could be honoured. While Team Members identified strongly with their professional role they did not rank that role to be more important than their community role and as such allowed their professional identity to be influenced by their community identity, and vice versa. This positioning is well supported by Indigenous Standpoint theory, with Team Member's Aboriginal and Torres Strait Islander identities always overarching the "personal" or "professional" identity at any one time. By embracing an Indigenous Standpoint and recognising they work at the Cultural Interface Team Members developed a "seamless working self" that enveloped their multiple role identities, despite often being misunderstood by work colleagues. As previously detailed, The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (2014) states a vision to improve health systems effectiveness by aligning more closely

with ways of working that are “culturally safe, high quality, responsive and accessible for all Aboriginal and Torres Strait Islander peoples” (p.9). Positioning the Aboriginal and Torres Strait Islander health workforce as the driver of this change is clearly recommended by the Implementation Plan:

> The strength of culture and cultural responses is recognised as central to ensuring engagement by Aboriginal and Torres Strait Islander peoples within the health system. This includes acknowledging Aboriginal and Torres Strait Islander leadership and enabling a transfer of skills and knowledge to continue across the community. Connecting with land, country and history, including traditional healing practices, ensures community members are building mind, body and spirit within a cultural context. (p.9)

The Redfern Statement (National Congress of Australia's First Peoples, 2016) suggested “that the transformative opportunities for Government action are yet to be grasped” (p.2). My findings underline the need for the Australian health system and services to be transformed and demonstrates the transformative opportunities of Aboriginal and Torres Strait Islander ways of working. My findings also highlight non-Indigenous ways of not valuing or supporting Aboriginal and Torres Strait Islander ways of working. My argument moves the concept of ‘Aboriginalising’ health services and service delivery further on from what is currently happening and considered good practice, into a more culturally infused way of providing health service that systemically privileges Aboriginal and Torres Strait Islander leadership, epistemology and ontology.

9.3 Future work inspired by this research

There is always room to do more research, especially when there still remains a large body of work to be done in the health sector to improve Aboriginal and Torres Strait Islander health. I would like to do more using the same methodology as I used in this study; however I would aim to include several other focal points that I did not access in this PhD research design.

9.3.1 Focus on current policy documents

I would like to think that some things might have changed in the health sector in Australia since I collected the data for this PhD. The lack of achievement on meeting the original *Closing the Gap* key performance indicators and the subsequent revisiting of those performance indicators present as an opportunity for the health sector to do things differently. However, I remain acutely aware of Aboriginal and Torres Strait Islander voices remaining marginalized during this period of planning change. Aboriginal and Torres Strait Islander ways of knowing, being and doing have been presented through collective actions resulting in The Redfern Statement (National Congress of Australia's First Peoples, 2016) and The Uluru Statement (Conifer, Brennan, Higgin, Crothers, & Wellington, 2017) and yet both statements remain little understood and little valued as legitimate knowledge. I am curious about what data I might now collect from a cohort of Aboriginal and Torres Strait Islander health professionals in this current climate. If I were to replicate my research I would include specific focus on current policy documents that have been established to improve Aboriginal and Torres Strait Islander health. I did not bring the policies overtly into the Yarning or PhotoYarning in this research and, while I did not ignore any Yarning about them, if I had a ‘next time’ I would be explicit about

including them in the Yarning/PhotoYarning data collection. I believe the current workforce might have interesting Yarns to share about how, specifically, their ways of working align (or not) with policy – or more interestingly, how policy might have changed to align with their ways of working. There is also the possibility that I might hear the same Yarns and PhotoYarns again, and that in itself tells a great story.

9.3.2 Explore perspectives of non-Indigenous colleagues and managers working in Aboriginal and Torres Strait Islander health

This doctoral thesis deliberately privileged the epistemology and ontology of Aboriginal and Torres Strait Islander health professionals as they did their work. I did this in an attempt to profile their ways of working so they might be better understood and more valued in health service provision. However, the findings of this research suggest that it is important to explore how non-Indigenous colleagues and managers make sense of Aboriginal and Torres Strait Islander ways of being, knowing and doing in the health sector. That body of knowledge could identify where specific work needs to be done with non-Indigenous managers and colleagues in health services to support and engage Aboriginal and Torres Strait Islander ways of working.

9.3.3 Explore client and community perspectives on Aboriginal and Torres Strait Islander ways of working in health

The current methodology would lend itself very well to exploring community and client Yarns and PhotoYarns about how Aboriginal and Torres Strait Islander health professionals do their work. Team Members in this study shared some reflections on the benefits they perceived that their clients and communities experienced as a result of their working ways but it was out of scope of this research to explore client and community perspectives directly. I can see great

value and potential for influencing policy and practice, by replicating this study with community members and clients as the 'Team Members'.

9.3.4 Inactive bystanders and perpetrators: further work on lateral violence

Chapter 8 presents a partial picture of a complex and upsetting phenomena as I did not have access to the perspectives of Aboriginal and Torres Strait Islander people who perpetrate lateral violence, nor data capturing the experience of witnessing it as bystanders or inadvertently colluding by not challenging it. Nor did I have the perspectives of non-Indigenous colleagues and managers. If we are to understand the processes and the social, cultural, systemic conditions under which lateral violence occurs so that we can address it, we need to include the perspectives of those not included here. Further research is needed to understand the perspectives of perpetrators and bystanders of lateral violence in the health sector.

9.4 A final word: How we need to know, be and do Aboriginal and Torres Strait Islander health

In my introduction I wrote that I had hope for my research; I hoped that it would contribute "to developing a better understanding of Aboriginal and Torres Strait Islander ways of being, knowing, doing, seeing and working in health service provision" and that "the subsequent greater level of understanding of Aboriginal and Torres Strait Islander ways of working in the Australian health system will be better valued in health service provision in Australia" (see p.16). Team Members in this study shared experiences of working in a health sector that's policy documents state Aboriginal and Torres Strait Islander peoples involvement is a key to successful health service delivery for Aboriginal and Torres Strait Islander people (Department

of Health, 2013, 2014); and yet I have presented extensive evidence of limited support of Aboriginal and Torres Strait Islander health staff. Team Members experiencing hard times at work reported finding more support and restoration when they engaged in outdoor spaces rather than engaging in supervision and debrief from their managers. I have presented even more limited understanding and appreciations of ways Team Members work; Team Members' managers accused Team Members of avoiding work as they chose to work in outdoor spaces with clients or included cups of tea or coffee in their work sessions with clients and other managers challenged Team Members' professionalism by questioning how Team Members managed to maintain connections with clients outside of work through using friendship-like ways of working and seamlessness between work time and community/personal time. Such lack of valuing and understanding is far from what Gooda (2011) called for when he stated that cultural safety and security be at the core of all activities when working with Aboriginal and Torres Strait Islander peoples. My findings highlight an opportunity to build on the existing body of work on cultural safety that privileges the safety of patients (including Best, 2017; Ramsden, 2002; Cox & Taua, 2012;2017) to include focusing on privileging the cultural safety of our Aboriginal and Torres Strait Islander workforce as they deliver health services.

The findings of my research present a concerning workforce issue; while facing hostility, professional and cultural scrutiny and a lack of support from managers and colleagues, Team Members continued to provide health services to their clients in ways they developed, established and carefully maintained. Team Members in my research met the challenges and demonstrated proficiency in upholding cultural boundaries and professional boundaries and did so within a healthcare system that misunderstood and scrutinised their achievements. Team

Members worked in ways that went against a dominant approach of delivering health services and often carried the burden for doing so. However, they quietly continued to deliver the services, internalising that burden.

When the voices (and ways of working) of Aboriginal and Torres Strait Islander health staff are silenced or placed on the margins of service delivery, the health system officially reflects only a dominant, Western framework (Durey & Thompson, 2012; Josif, Kruske, Kildea, & Barclay, 2017; Larkin, 2014). Under this model Team Members' Aboriginal and Torres Strait Islander epistemologies and ontologies were not understood, valued or positioned as legitimate knowledge. Under this model the cultural authority of the Aboriginal and Torres Strait Islander health workforce is not acknowledged nor valued. This needs to change if we are ever to close the current health disparity gap. A vital component to change is developing an Aboriginal and Torres Strait Islander culturally infused health system that values and seeks to understand Aboriginal and Torres Strait Islander knowing, being and doing. Importantly, this will only be achieved by listening to those who know, be and do.

Chapter 10: What have I learnt?

10.1 My Yarn: "What have I learnt from doing this PhD?"

At home and in community we often speak about what we have learnt, about the lessons that accompany our everyday experiences. It really is very common for me to say to my own children the words I heard as a child "So, what did you learn from that?", and I am certain that my parents and their parents heard a similar question. And the answer to that question is usually a rich reflective story, commonly shared as a Yarn. Today I ask myself, "What have I learnt from doing this PhD?" let me Yarn about that.

As a researcher and an Aboriginal woman, I have learnt that is both challenging and rewarding to work in the Cultural Interface. It is a challenge to engage with research in a space that bridges my Western academic life and its protocols and my Aboriginal life and its protocols. But that space is also rewarding because that space houses all parts of me, and in that space I explore ways of being effective and working in a meaningful way. Importantly, I have learnt that working in that space is hard, really hard but giving in to the hard means choosing to privilege one part of that space, and I choose not to do that as I would lose part of myself.

I have learnt many lessons from my 25 years of working in higher education and health but I was not always as an engaged researcher as I am now. Of course, the PhD has been a vehicle for carrying me into that role, but I have learnt that it is not just the PhD that is keeping me engaged in research. An important lesson for me was developing an understanding of the potential benefits of research for all parties involved. Of course there are researcher/academic benefits of research (PhD completion, papers published, academic engagement, seeing research

embed into practice) but importantly there are meaningful benefits of research for the people who might be called research participants or Team Members, and benefits for communities. However for Team Members and communities to experience meaningful, beneficial research the academics involved must do a good job. And so a major lesson for me goes back to something I also heard a lot in my childhood "If you want a good job done, learn to do it yourself" and so, over time, I have learned "to do" this PhD. With that challenge comes empowerment and growth, awareness of the impact that a "good job" can have on yourself and others, responsibility and a heightened sense of respect for process and outcome.

And, well, that all sounds like a definition of good, meaningful research to me.

10.2 Closing the circle – connecting my experiences to the research findings

This research was inspired by 25 years of Yarns shared with me by Aboriginal and Torres Strait Islander colleagues and students in the health sector who told me how their work practices were misunderstood, undervalued or criticised by their non-Indigenous Australian colleagues or managers because work practices did not align with workplace policies and practices. Many of these voices Yarned about being employed through initiatives to effectively 'Aboriginalise' the health system or their health service (Aspin, Brown, Jowsey, Yen, & Leeder, 2012; Hayman & Armstrong, 2014; Hayman, Askew, & Spurling, 2014; Hayman, White, & Spurling, 2009; Kowal & Paradies, 2005). Like them, Team Members 'Aboriginal' ways were not understood or valued in their workplaces. Increasing Aboriginal and Torres Strait Islander employment in the health sector will do little to make change until the Aboriginal and Torres Strait Islander workforce are respected and valued for the ways they do the work they do.

This research was inspired by my mentor who dedicated 40 years of her life to the Australian Aboriginal and Torres Strait Islander health system but told me that she had never felt truly "seen" or appreciated by her non-Indigenous colleagues. She felt her work was always positioned in the background to the work being done by non-Indigenous Australian colleagues. She had Yarned with me about feeling tired and worn down by constant efforts to have her working ways and Aboriginal knowledge heard, understood and valued. Throughout her life she experienced incredible Racial Battle Fatigue (RBF) (Smith, Allen, & Danley, 2007) but continued to live and work in ways that were true to her own authentic self and to the work she did with Aboriginal and Torres Strait Islander clients in the health system. Team Members in my research established mechanisms of countering RBF in their workplaces by using Aboriginal and Torres Strait Islander ways of being, knowing, doing and thinking. Valuing and developing a better understanding of Aboriginal and Torres Strait Islander ways of working in the health system will help to address some of the contributing factors to RBF in the Aboriginal and Torres Strait Islander health workforce.

The way I researched was inspired by Indigenous scholars in Australia and beyond, particularly including Linda Tuhiwai Smith (1999, 2006, 2007, 2014); Juanita Sherwood (2010, 2013a, 2013b); Sherwood and Edwards (2006); Sherwood and Kendall (2013); Sherwood et al. (2015) and Aileen Moreton-Robinson (2000, 2003, 2004a, 2004b, 2013). Their research and writing about Indigenous research became the ground upon which I felt safe to plant my own feet, establish my own ideas and find ways of maintaining my authentic self as I completed my PhD. This research reconfirmed for me the transformative power of listening to and learning from others; this thesis argues that the wider health sector could be transformed by listening to and

learning about Team Members' ways of working in the current Aboriginal and Torres Strait Islander health system.

The way I made sense of my own and the Team Members' struggles with identity, and culture and work was inspired by a number of theorists. Indigenous Standpoint Theory, for example Nakata (2007a, 2007b) and Foley (2003, 2006) and Indigenous Women's Standpoint Theory (Moreton-Robinson, 2013) shaped the method and ethics within my research methodology. While I approached my PhD as an icon of my Western education and academic profession I did so with an Aboriginal (Koori) way of seeing, being, knowing and doing. I found myself in a "particular in between space", the space between theory, method, ethics and methodology (Higgins, 2014, p.209) and I found this to be a "complicated and contested space that is [Nakata's] 'Cultural Interface' (2007a, 2007b) between Indigenous and Western knowledge systems, where hybridity is not always synonymous with balance" (Higgins, 2014, p.209). These theories assisted me to find a way to progress my PhD in a way that met both Western academic requirements and satisfied and respected Aboriginal and Torres Strait Islander ways of being, knowing, seeing and doing, resulting in a new Indigenous methodology, PhotoYarning. At the core of this research is an Aboriginal and Torres Strait Islander ontology and epistemology; both guided, informed and inspired the ways I worked as I conducted the entire doctoral research. Like the Team Members I too developed ways of working that respected my cultural ways while I worked within the ways of the Western academy. I am deeply engaged to my Koori ways of seeing and ways of knowing the world. The strengths and challenges of working for 25 years at the Cultural Interface provided me with bedrock from which I was able to allow this thesis to tell the story it needed to tell. I was able to ensure it remained

“accountable to our indigenous community” Kahakalau (2004, p.19) while also accountable to Western academia, aiming for it to be “sophisticated and scholarly to convince academia that they are of equal scope and breadth as established Western ways of research”(p.20). Interestingly, this thesis argues for a similar approach to be taken by the Australian Aboriginal and Torres Strait Islander health sector; find ways of Aboriginal and Torres Strait Islander being, knowing and doing health within an established Western health system.

10.3: A final Yarn: For my Team Members.

I can hear you all asking me, “So, how did it go?” It went well, in the end.

Under the Yarning tables of my childhood I had learnt to listen and by learning to listen I also learnt how to draw together the rich threads of other people’s Yarns; that learning served me well. From then I truly understood the importance of taking time to listen, to think, to form your own thoughts and to share them with people you trust and know. That is exactly what happened to us in this research – we all took turns to listen, to think, to form our own opinions and perspectives and then we Yarned/PhotoYarned and we did so largely because of the trust and respect we have for each other. Through this PhD research I have learnt many things, learnt how to live and work in the same place, learnt how to develop friendship-like ways of connecting and working with people, learnt how to do work in ways that make a difference, and sadly, learnt how to notice when our mob are pulling each other down instead of boosting each other up. I have learnt that our ways of being, knowing, doing do not yet hang in frames on health service walls alongside the framed certificates of academic and professional achievements; but I do hope that is something I will see in my lifetime.

I have learnt to name that I live and work in a space that has me walking with two different shoes on my feet at the same time. I have found a way to make them both feel comfortable. They both to do important things for me and for the world in which I live and work. I live and work in a space together with other people who see me through a lens that is often different to the lens through which I see the world. I have found a way to understand that other people have different lenses. They all have taught me different things about the world in which I live and work. I live and work in a space in which I often "be", "do" and "know" in ways that are not dominant. I have found a way to privilege the way I "be", "do" and "know". That is important for me and for the world in which I live and work.

References

Abbott, P., Gordon, E., & Davison, J. (2008). Expanding roles of Aboriginal health workers in the primary care setting: seeking recognition. *Contemporary Nurse,* 27(2), 157-164.

Aboriginal and Torres Strait Islander Health Practice Board of Australia. (2016). *Annual report Summary 2015/2016: Aboriginal and Torres Strait Islander Health Practice Board of Australia*. Retrieved from http://www.atsihealthpracticeboard.gov.au/

Aboriginal and Torres Strait Islander Health Workforce Working Group. (2017). *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016-2023)*. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/ Content/4A716747859075FFCA257BF0001C9608/$File/National-Aboriginal-and-Torres-Strait-Islander-Health-Workforce-Strategic-Framework.pdf

Aboriginal Health & Medical Research Council of New South Wales. (2016a). *Aboriginal Health & Medical Research Council Guidelines for Research into Aboriginal Health: Key Principles*. Retrieved from http://www.ahmrc.org.au/media/resources/ethics/ethics-application-resources/271-ah-mrc-guidelines-for-research-into-aboriginal-health-key-principles-1/file.html

Aboriginal Health & Medical Research Council of New South Wales. (2016b). *Guidelines for Research into Aboriginal Health Key Principles*. Retrieved from http://www.ahmrc.org. au/media/resources/ethics/ethics-application-resources/ 271-ah-mrc-guidelines-for-research-into-aboriginal-health-key-principles-1/file.html

Abraham, A., Sommerhalder, K., & Abel, T. (2010). Landscape and well-being: a scoping study on the health-promoting impact of outdoor environments. *International Journal of Public Health, 55*(1), 59-69.

Adekeye, O., Kimbrough, J., Obafemi, B., & Strack, R. (2014). Health literacy from the perspective of African immigrant youth and elderly: a photovoice project. *Journal of Health Care for the Poor and Underserved, 25*(4), 1730-1747.

Aggarwal, B. (2012). "The Bolt case: silencing speech or promoting tolerance." *More or Less: Democracy & New Media. Albert Park: Future Leaders.*

Anderson, K. (2011). Workplace aggression and violence: Nurses and midwives say NO. *Australian Nursing and Midwifery Journal, 19*(1), 26.

Andonian, L. (2010). Community participation of people with mental health issues within an urban environment. *Occupational Therapy in Mental Health, 26*(4), 401-417.

Andrews, G. (2004). (Re) thinking the dynamics between healthcare and place: therapeutic geographies in treatment and care practices. *Area, 36*(3), 307-318.

Andrews, G., Chen, S., & Myers, S. (2014). The ‘taking place’ of health and wellbeing: Towards non-representational theory. *Social Science & Medicine, 108*, 210-222.

Armstrong, R., & Hayman, N. (2014). Health services for Aboriginal and Torres Strait Islander people: handle with care. *The Medical journal of Australia, 200*(11): 613.

Aspin, C., Brown, N., Jowsey, T., Yen, L., & Leeder, S. (2012). Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: a qualitative study. *BMC health services research, 12*(1), 143.

Astell-Burt, T., Feng, X., & Kolt, G. (2013). Does access to neighbourhood green space promote a healthy duration of sleep? Novel findings from a cross-sectional study of 259 319 Australians. *BMJ open, 3*(8), e003094.

Austin, W., Bergum, V., Nuttgens, S., & Peternelj-Taylor, C. (2006). A re-visioning of boundaries in professional helping relationships: Exploring other metaphors. *Ethics & Behavior, 16*(2), 77-94.

Australian Bureau of Statistics. (2011). *2011 Census data.* Retrieved from http://abs.gov.au/

Australian Indigenous HealthInfoNet. (2017). *Overview of Aboriginal and Torres Strait Islander health status 2016*. Retrieved from http://www.healthinfonet.ecu.edu.au/health-facts/overviews

Australian Institute of Aboriginal and Torres Strait Islander Studies. (2009). *Protector's Reports : to remove and protect : Aboriginal lives under control online collection.* Retrieved from http://www1.aiatsis.gov.au/exhibitions/removeprotect/index.html

Australian Institute of Health and Welfare. (2016). *Aboriginal and Torres Strait Islander health organisations: Online Services Report-key results 2014-15. Aboriginal and Torres Strait Islander health series no. 7.* Retrieved from https://www.aihw.gov.au/reports/indigenous-health-welfare-services/health-organisations-osr-key-results-2014-15/

Australian Medical Association (2016). *Australian Medical Association Code of Ethics.* Retrieved from https://ama.com.au/media/new-code-ethics-doctors

Australian Qualifications Framework Council (2011). *Australian qualifications framework.* Retrieved from https://www.aqf.edu.au/

Baba, J., Brolan, C., & Hill, P. (2014). Aboriginal medical services cure more than illness: a qualitative study of how Indigenous services address the health impacts of discrimination in Brisbane communities. *International Journal for Equity in Health, 13*(1), 1.

Bainbridge, R., McCalman, J., Clifford, A., & Tsey, K. (2015). "Cultural competency in the delivery of health services for Indigenous people." *Issues paper* (13).

Baylis, F., Kenny, N., & Sherwin, S. (2008). "A relational account of public health ethics." *Public Health Ethics* **1**(3): 196-209.

Bennett, B., Zubrzycki, J., & Bacon, V. (2011). What do we know? The experiences of social workers working alongside Aboriginal people. *Australian Social Work, 64*(1), 20-37.

Bennett, B. (2014). How do light-skinned Aboriginal Australians experience racism?: Implications for social work. *AlterNative: An International Journal of Indigenous Peoples, 10*(2), 180.

Bennett, S. (2012). The 1967 Aborigines Referendum. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/1301.0Feature%20Article12004

Bessarab, D., & Ng'andu, B. (2010). Yarning about yarning as a legitimate method in Indigenous research. *International Journal of Critical Indigenous Studies, 3*(1), 37-50.

Best, O. (2017). The Cultural Safety Journey: An Aboriginal Australian nursing and midwifery context. In Best O & Fredericks B (Eds) *Yatdjuligin: Aboriginal and Torres Strait Islander Nursing and Midwifery Care for Indigenous Australians*. Cambridge University Press. 2nd Edition.

Best, O. (2018). Training the ‘natives’ as nurses in Australia: so what went wrong?. In *Colonial caring*. Manchester University Press.

Best O., & Gorman, D. (2016). “Some of Us Pushed Forward and Let the World See What Could Be Done”: Aboriginal Australian Nurses and Midwives, 1900-2005. *Labour History Journal*, 11,1-16.

Blignault, I., Haswell, M., & Jackson Pulver, L. (2015). The value of partnerships: lessons from a multi-site evaluation of a national social and emotional wellbeing program for Indigenous youth. *Australian and New Zealand Journal of Public Health*, *40*(S1).

Bodey, M. (2011). Andrew Bolt loses racial vilification court case. *The Australian*. Retrieved from http://www.theaustralian.com.au/business/media/andrew-bolt-x-racial-vilification-court-case/news-story/3c920f44a5d5e4bf26fd3119588c3fb2

Bodkin-Andrews, G., & Carlson, B. (2013). Racism, Aboriginal and Torres Strait Islander Identities, and higher education: reviewing the burden of epistemological and other racisms. *Diversity in Higher Education, 14*, 29-54.

Bombay, A., Matheson, K., & Anisman, H. (2014). *Origins of lateral violence in Aboriginal communities: A preliminary study of student-to-student abuse in residential schools.*Aboriginal Health Foundation.

Bond, C., Phillips, M., & Osmond, G. (2015). Crossing Lines: Sport History, Transformative Narratives, and Aboriginal Australia. *The International Journal of the History of Sport, 32*(13), 1531-1545.

Brannelly, T., Boulton, A., te Hiini, A. (2013). "A relationship between the ethics of care and Māori worldview—the place of relationality and care in Maori mental health service provision." *Ethics and Social Welfare 7*(4): 410-422.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Bray, J. (2011). *Maintaining professional boundaries in community care: Essential skills for managers and personal care workers*. Aged and Community Care Tri-state Conference, Albury. Retrieved from http://www. jennybray.com.au/storage/pdfs

Broome, R. (2002). Aboriginal Australians: Black responses to white dominance. Crows Nest, Australia: Allen and Unwin.

Brown, L., & Strega, S. (2005). *Research as resistance: Critical, indigenous and anti-oppressive approaches*: Canadian Scholars' Press.

Browne, A., Varcoe, C., Wong, S., Smye, V., Lavoie, J., Littlejohn, D., Tu, D., Godwin, O., Krause, M., & Khan, K (2012). Closing the health equity gap: evidence-based strategies for primary health care organizations. *International Journal for Equity in Health 11*(1): 59.

Browne, A., Varcoe, C., Lavoie, J., Smye, V., Wong, S., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC health services research 16*(1): 544.

Brownlee, K., Halverson, G., & Chassie, A. (2015). Multiple relationships: maintaining professional identity in rural social work practice. *Journal of Comparative Social Work, 7*(1).

Bryce, H. (2013). Navigating multiple roles as a researcher in a Photovoice project. *Groupwork, 22*(3), 33-48.

Burgess, C., Johnston, F., Berry, H., McDonnell, J., Yibarbuk, D., Gunabarra, C., Mileran, A., & Bailie, R. (2009). "Healthy country, healthy people: the relationship between Indigenous health status and" caring for country"." *Medical Journal of Australia 190*(10): 567-572.

Butler, B. (2012). Zero tolerance to lateral violence to improve the health and wellbeing of Aboriginal and Islander peoples in Australia 2012 [Web log message]. Retrieved from http://lateralloveaustralia.com/social-determinants-of-indigenous-health-lateral-%20violence-paper-2012/

Canadian Institutes of Health Research. (2007). *Canadian Institutes of Health Research Guidelines for Health Research Involving Aboriginal People.* Canada: Canadian Institutes of Health Research. Retrieved from http://www.cihr-irsc. gc.ca/e/29134.html

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada. (2010). *Research involving the First Nations, Inuit and Metis peoples of Canada' Chapter 9, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, December 2010.* . Retrieved from http://pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9/

Carey, M., & Prince, M. (2015). Designing an Australian Indigenous Studies curriculum for the twenty-first century: Nakata's 'cultural interface', standpoints and working beyond binaries. *Higher Education Research & Development, 34*(2), 270-283.

Carson, D., & McConnel, F. (2011). Indigenous health and community services employment in remote Northern Territory: a baseline examination of 2006 and 2001 Census data. *Australian Journal of Rural Health, 19*(5), 225-258.

Castleden, H., & Garvin, T. (2008). Modifying Photovoice for community-based participatory Indigenous research. *Social Science & Medicine, 66*(6), 1393-1405.

Chilisa, B. (2012). *Indigenous Research Methodologies*: SAGE.

Clark, G. (2014). Speaking out on Aboriginal violence. *Quadrant, 58*(9), 69.

Clark, Y., & Augoustinos, M. (2015). What's in a name? Lateral violence within the Aboriginal community in Adelaide, South Australia. *Office Bearers of the APS College Of Community Psychologists, 27*(2), 19.

Coffin, J., Larson, A., & Cross, D. (2010). Bullying in an Aboriginal context. *The Australian Journal of Indigenous Education, 39*(01), 77-87.

Collins, P. (1986). Learning from the outsider within: The sociological significance of Black feminist thought. *Social Problems, 33*(6), s14-s32.

Conifer, D.,Brennan, B., Higgin, I., Crothers, J.,& Wellington, S. (2017). *Indigenous advisory body rejected by PM in 'kick in the guts' for advocates.* Retreived from http://www.abc.net.au/news/2017-10-26/indigenous-advisory-body-proposal-rejected-by-cabinet/9087856

Conifer, D., Leslie, T., Tilley, C., & Liddy, M. (2017) *Closing the gap: Australia is failing on Indigenous disadvantage goals*. Retrieved from http://www.abc.net.au/news/2017-02-14/closing-the-gap-report-card-failing/8268450

Conway, J., Tsourtos, G., & Lawn, S. (2017). The barriers and facilitators that indigenous health workers experience in their workplace and communities in providing self-management support: a multiple case study. *BMC health services research, 17*(1), 319.

Cooper, A. (2010). What future? Organisational forms, relationship based social work

practice and the changing world order. In G. Ruch, D. Turney & A. Ward (Eds.), *Relationship based social work: getting to the heart of practice* (pp. 229-243). London: Jessica Kingsley Publishers.

Corbett, S., & Williams, F. (2014). Striking a professional balance: interactions between nurses and their older rural patients. *British Journal of Community Nursing, 19*(4).

Cosgrave, C., Hussain, R., & Maple, M. (2015). Factors impacting on retention amongst community mental health clinicians working in rural Australia: a literature review. *Advances in Mental Health, 13*(1), 58-71.

Council of Australian Governments. (2009). *National Indigenous reform agreement (closing the gap)* Canberra: Council of Australian Governments.

Couzos, S., & Murray, R. (2008). *Aboriginal primary health care: an evidence-based approach*. Australia: Oxford University Press.

Cox, L., & Taua, C. (2012). Cultural safety: cultural considerations. In Forbes, Helen & Watt, Elizabeth (Eds.) *Jarvis's Physical Examination and Health Assessment.* Elsevier, Chatswood NSW Australia, pp. 40-60.

Cox, L., & Taua, C. (2017). Understanding and applying cultural safety: Philosophy and practice of a social determinants approach. In Crisp, Jackie, Douglas, Clint, Rebeiro, Geraldine, & Waters, Donna (Eds.) *Potter and Perry's Fundamentals of Nursing - Australian Version [5th ed.].* Elsevier, Chatswood, N.S.W, pp. 260-287.

CreativeSpirits (2016a). *Aboriginal culture - People - Aboriginal Identity: Who is 'Aboriginal'?* Retreived from www.CreativeSpirits.info

CreativeSpirits. (2016b). *Aboriginal culture - People - Bullying & lateral violence.* Retrieved from www.CreativeSpirits.info

Crook, A. (2011). *Bolt decision: guilty of discrimination, judge declares.* Retrieved from https://www.crikey.com.au/2011/09/28/bolt-decision-guilty-of-discrimination-judge-declares/

Cummins, S., Curtis, S., Diez-Roux, A., & Macintyre, S. (2007). Understanding and representing 'place' in health research: a relational approach. *Social Science & Medicine, 65*(9), 1825-1838.

Cunneen, C., & Rowe, S. (2014). Changing narratives: Colonised peoples, criminology and social work. *International Journal for Crime, Justice and Social Democracy, 3*(1), 49-67.

Dandy, J., Durkin, K., Barber, B., & Houghton, S. (2015). Academic Expectations of Australian Students from Aboriginal, Asian and Anglo Backgrounds: Perspectives of Teachers, Trainee-teachers and Students. *International Journal of Disability, Development and Education, 62*(1), 60-82.

Davidson, J., & C. Milligan. (2004). Embodying emotion sensing space: introducing emotional geographies, *Social & Cultural Geography,5(*4),523-532.

Davy, C., Cass, A., Brady, J., DeVries, J., Fewquandie, B., Ingram, S., Mentha, R., Simon, P., Rickards, B., & Togni, S. (2016). Facilitating engagement through strong relationships between primary healthcare and Aboriginal and Torres Strait Islander peoples. *Australian and New Zealand Journal of Public Health, 40*(6), 535-541.

Dean, C. (2010). A yarning place in narrative histories. *History of Education Review*, *39*(2), 6-13.

Demir, D., Rodwell, J., & Flower, R. (2014). Antecedents and Consequences of Workplace Aggression in the Allied Health Context. *Social Work in Health Care, 53*(3), 250-267.

Department of Health. (2013). *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. Canberra: Department of Health,.

Department of Health. (2014). *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. Canberra: Department of Health.

Department of the Prime Minister and Cabinet. (2014). *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report: Aboriginal and Torres Strait Islander people in the health workforce*. Canberra: Department of the Prime Minister and Cabinet.

Department of the Prime Minister and Cabinet. (2017). *Closing the Gap Prime Minister's Report 2017*. Canberra: Department of the Prime Minister and Cabinet.

Deshmukh, T., Abbott, P., & Reath, J. (2014). 'It's got to be another approach': an Aboriginal Health Worker perspective on cardiovascular risk screening and education. *Australian family physician, 43*(7), 475.

Devlin, B., Disbray, S., & Devlin, N. (2017). A Thematic History of Bilingual Education in the Northern Territory, *History of Bilingual Education in the Northern Territory* (pp. 1-10). Singapore: Springer.

Dickson, M. (2017). Journal Conversations: Building the Research Self-Efficacy of an Aboriginal Early Career Academic. *The Qualitative Report, 22*(12), 3154-3171.

Dimer, L., Dowling, T., Jones, J., Cheetham, C., Thomas, T., Smith, J., McManus, A., & Maiorana, A. (2013). Build it and they will come: outcomes from a successful cardiac rehabilitation program at an Aboriginal Medical Service. *Australian Health Review, 37*(1), 79-82.

Dodson, M. (1994). *The end in the beginning: re (de) finding Aboriginality*. Retrieved from https://www.humanrights.gov.au/news/speeches/end-beginning-redefinding-aboriginality-dodson-1994

Doel, M. (2010). Service-user perspectives on relationships. In G. Ruch, Turney, D. and Ward, A., (Eds.), *Relationship-based social work: getting to the heart of practice.* (pp. 199-213). London: Jessica Kingsley Publishers.

Doel, M., Allmark, P., Conway, P., Cowburn, M., Flynn, M., Nelson, P., & Tod, A. (2010). Professional boundaries: Crossing a line or entering the shadows? *British Journal of Social Work, 40*(6), 1866-1889.

Douglas, K. (2014). NURsEs EAT ThEIR oWN. *Australian Nursing and Midwifery Journal, 21*(8), 20.

Doyle, K., & Hungerford, C. (2015). Leadership as a Personal Journey: An Indigenous Perspective. *Issues in Mental Health Nursing, 36*(5), 336-345.

Drummond, A. (2014). Working with Aboriginal and Torres Strait Islander health workers and health practitioners. *Yatdjuligin: Aboriginal and Torres Strait Islander Nursing and Midwifery Care*, 163-188.

Ducharme, L., Knudsen, H., & Roman, P. (2007). Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support. *Sociological Spectrum, 28*(1), 81-104.

Dudgeon, P., Wright, M., Paradies, Y., Garvey, D., & Walker, I. (2010). The social, cultural and historical context of Aboriginal and Torres Strait Islander Australians. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, 25-42.

Duraisingam, V., Pidd, K., Roche, A., & O'Connor, J. (2006). *Satisfaction, stress and retention among alcohol and other drug workers in Australia*. Retrieved from http://nceta.flinders.edu.au/files/8112/6101/8422/1973991936EN144.pdf

Duraisingam, V., Roche, A., Pidd, K., Zoontjens, A., & Pollard, Y. (2007). *Wellbeing, stress and burnout: A national survey of managers in alcohol and other drug treatment services*. Retrieved from http://nceta.flinders.edu.au/files/4612/6102/4325/EN407.pdf

Duraisingam, V., Roche, A., Trifonoff, A., & Tovell, A. (2010). *Indigenous AOD Workers' Wellbeing, Stress, and Burnout: Findings from an online survey*. Retrieved from http://nceta.flinders.edu.au/files/8013/3291/0487/EN440_Duraisingam_2010.pdf

Durey, A., & Thompson, S. (2012). Reducing the health disparities of Indigenous Australians: time to change focus. *BMC health services research 12*(1): 15.

Durey, A., McEvoy, S., Swift-Otero, V., Taylor, K., Katzenellenbogen, J., & Bessarab, D. (2016). Improving healthcare for Aboriginal Australians through effective engagement between community and health services. *BMC health services research, 16*(1), 1.

Eckermann, A., Dowd, T., Chong, E., Nixon, L., & Gray, R. (2010). *Binan Goonj: bridging cultures in Aboriginal health*. Australia: Elsevier.

Ella, S., Lee, K., Childs, S., & Conigrave, K. (2015). Who are the New South Wales Aboriginal drug and alcohol workforce? A first description. *Drug and alcohol review, 34*(3), 312-322.

English, J., Wilson, K., & Keller-Olaman, S. (2008). Health, healing and recovery: Therapeutic landscapes and the everyday lives of breast cancer survivors. *Social Science & Medicine, 67*(1), 68-78.

Erick, W., Mooney-Somers, J., Akee, A., & Maher, L. (2008). Resilience to blood-borne and sexually transmitted infections: The development of a participatory action research project with young Aboriginal and Torres Strait Islander people in Townsville. Aboriginal and Islander Health Worker Journal, 32(6), 5.

Foley, D. (2003). Indigenous epistemology and Indigenous standpoint theory. Social Alternatives, 22(1), 44.

Foley, D. (2006). Indigenous Standpoint Theory. *International Journal of the Humanities, 3*(8).

Fredericks, B. (2003a). *Us speaking about women's health: Aboriginal women's perceptions and experiences of health, well-being, identity, body and health services.* Central Queensland University, Australia.

Fredericks, B. (2013b). 'We don't leave our identities at the city limits': Aboriginal and Torres Strait Islander people living in urban localities. *Australian Aboriginal Studies*(1), 4.

Freeman, T., Edwards, T., Baum, F., Lawless, A., Jolley, G., Javanparast, S., & Francis, T. (2014). Cultural respect strategies in Australian Aboriginal primary health care services: beyond education and training of practitioners. *Australian and New Zealand Journal of Public Health 38*(4): 355-361.

Freire, P. (2000). *Pedagogy of the oppressed*. USA: Bloomsbury Publishing.

Fronek, P., Kendall, M., Ungerer, G., Malt, J., Eugarde, E., & Geraghty, T. (2009). Towards healthy professional-client relationships: The value of an interprofessional training course. *Journal of Interprofessional Care, 23*(1), 16-29.

Fronek, P., & Kendall, M. (2016). The impact of Professional Boundaries for Health Professionals (PBHP) training on knowledge, comfort, experience, and ethical decision-making: a longitudinal randomized controlled trial. *Disability and Rehabilitation*, 1-8.

Gardiner-Garden, J. (2003). *Defining Aboriginality in Australia.* Canberra, Department of the Parliamentary Library.

Gardner, A. (2010). Therapeutic friendliness and the development of therapeutic leverage by mental health nurses in community rehabilitation settings. *Contemporary Nurse, 34*(2), 140-148.

Gastaldo, D., Andrews, G., & Khanlou, N. (2004). Therapeutic landscapes of the mind: Theorizing some intersections between health geography, health promotion and immigration studies. *Critical Public Health, 14*(2), 157-176.

Gatrell, A. (2013). Therapeutic mobilities: walking and ‘steps’ to wellbeing and health. *Health & place, 22*, 98-106.

Geia, L., Hayes, B., & Usher, K. (2013). Yarning/Aboriginal storytelling: towards an understanding of an Indigenous perspective and its implications for research practice. *Contemporary Nurse, 46*(1), 13-17.

Gelber, K. & McNamara, L (2013). Freedom of speech and racial vilification in Australia: ‘The Bolt case’ in public discourse. *Australian Journal of Political Science 48*(4): 470-484.

Gibson, O., Lisy, K., Davy, C., Aromataris, E., Kite, E., Lockwood, C., Riitano, D., McBride, K., & Brown, A. (2015). Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: a systematic review. *Implementation Science, 10*(1), 1.

Gillard, S., Edwards, C., Gibson, S., Owen, K., & Wright, C. (2013). Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenges. *BMC health services research, 13*(1), 188.

Gilligan, C. (1982). *In a different voice*. USA, Harvard University Press.

Glover, M., Dudgeon, P., & Huygens, I. (2005). Colonisation and racism. In G. Nelson and I. Prilleltensky (Eds.), *Community Psychology: In pursuit of liberation and well-being* (pp. 330-344). New York: Palgrave Macmillan.

Gooda, M. (2010). *Social Justice and Aboriginal and Torres Strait Islander peoples access to services*. Retreived from https://www.humanrights.gov.au/news/speeches/social-justice-and-aboriginal-and-torres-islander-peoples-access-services-2010

Gooda, M. (2011). *Social Justice Report 2011*. Retrieved from http//www.humanrights.gov.au /sites/default/files/content/social_justice/sj_report/sjreport11/pdf/sjr2011.pdf

Goold, S. (1995). Why are there so few Aboriginal registered nurses? In G. Gray & R. Pratt (Eds.), Issues in Australian nursing (Vol. 4, pp. 235–253). Melbourne, VIC: Churchill Livingstone.

Gorringe, S., Ross , J., & Fforde, C. (2009). *Will the real Aborigines please stand up: Strategies for breaking the stereotypes and changing conversation*. Retrieved from https://aiatsis.gov.au/publications/products/will-real-aborigine-please-stand-up-strategies-breaking-stereotypes-and-changing-conversation

Gray, D., Wilson, M., Allsop, S., Saggers, S., Wilkes, E., & Ober, C. (2014). Barriers and enablers to the provision of alcohol treatment among Aboriginal Australians: A thematic review of five research projects. *Drug and alcohol review, 33*(5), 482-490.

Green, D., & Martin, D. (2016). Maintaining the Healthy Country–Healthy People Nexus through Sociocultural and Environmental Transformations: challenges for the Wik Aboriginal people of Aurukun, Australia. *Australian Geographer:* 1-25.

Green, R., Gregory, R., & Mason, R. (2006). Professional distance and social work: stretching the elastic? *Australian Social Work, 59*(4), 449-461.

Grieves, V. (2009). *Aboriginal spirituality: Aboriginal philosophy, the basis of Aboriginal social and emotional wellbeing,* Cooperative Research Centre for Aboriginal Health, Darwin.

Guenther, J., Osborne, S., Arnott, A., & McRae-Williams, E. (2017). Hearing the voice of remote Aboriginal and Torres Strait Islander training stakeholders using research methodologies and theoretical frames of reference. *Race Ethnicity and Education, 20*(2), 197-208.

Gwynne, K., & Lincoln, M. (2016). Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: a systematic review. *Australian Health Review*, 234-238.

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies, 14*(3), 575-599.

Harding, S. (1992). Rethinking standpoint epistemology: What is" strong objectivity?". *The Centennial Review, 36*(3), 437-470.

Harding, S. (2004). *The feminist standpoint theory reader: Intellectual and political controversies*: London, Psychology Press.

Harring, S. L. (1994). The Killing Time: A History of Aboriginal Resistance in Colonial Australia. Ottawa L. Rev., 26, 385.

Harris, K., Palazzolo, K., & Savage, M. (2012). 'I'm not sexist, but...': How ideological dilemmas reinforce sexism in talk about intimate partner violence. *Discourse & Society, 23*(6), 643-656.

Hart, P. (2015). Young people negotiating and maintaining boundaries in youth work relationships: findings from an ethnographic study of youth clubs. *Journal of Youth Studies*, 1-16.

Hartsock, N. (1983). The feminist standpoint: Developing the ground for a specifically feminist historical materialism *Discovering reality* (pp. 283-310). Dordrecht: Springer.

Hartsock, N. (1998). *The feminist standpoint revisited and other essays*. USA: Westview Press.

Hayman, N., White, N., & Spurling, G. (2009). Improving Indigenous patients' access to mainstream health services: the Inala experience. *Medical Journal of Australia, 190*(10), 604-606.

Hayman, N., & Armstrong, R. (2014). Health services for Aboriginal and Torres Strait Islander people: Handle with care*. The Medical journal of Australia 200*(11): 613.

Hayman, N., Askew, D., & Spurling, G. (2014). From vision to reality: a centre of excellence for Aboriginal and Torres Strait Islander primary health care. *Medical Journal of Australia, 200*(11), 623-624.

Health Workforce Australia. (2011). *Growing Our Future: the Aboriginal and Torres Strait Islander Health Worker Project Final Report*. Canberra: Department of Health.

Health Workforce Australia. (2014). *Australia's Health Workforce Series Aboriginal and Torres Strait Islander Health Workers / Practitioners in focus*. Canberra: Department of Health.

Heilbrun, C., & Politt, K. (2008). *Writing a Woman's Life*. New York: WW Norton & Company Incorporated.

Heiss, A. (2013). Barani, Sydney's Aboriginal history. *Government policy in relation to Aboriginal people.* Retrieved from http://www.sydneybarani.com.au/sites/government-policy-in-relation-to-aboriginal-people/

Hickey, S. (2015). 'They say I'm not a typical Blackfella': Experiences of racism and ontological insecurity in urban Australia. *Journal of Sociology*, *52*(4), 725-740.

Higgins, M. (2014). Rebraiding photovoice: Methodological Métissage at the cultural interface. *The Australian Journal of Indigenous Education, 43*(02), 208-217.

Holmes, J. (2011). *Bolt, Bromberg and a profoundly disturbing judgment.* Retrieved from http://www.abc.net.au/news/2011-09-29/holmes-bolt-bromberg-and-a-profoundly-disturbing-judgment/3038156

Hopkins, M., Fetherston, C., & Morrison, P. (2014). Prevalence and characteristics of aggression and violence experienced by Western Australian nursing students during clinical practice. *Contemporary Nurse, 49*(1), 113-121.

Houston, S. (2016). MY ACCOUNT. *Med J Aust, 205*(1), 17-18.

Huang, Q., Tan, Y., Chen, Y., Yang, J., Yi, W., Zhou, Y., Huang, Y., & Wang, L. (2016). A good practice on child drowning prevention in rural areas in China. *Injury Prevention, 22*(Suppl 2), A294-A294.

Hughes, C., Moyes, B., Dutton, D., Morton, R., & Woon, S. (2014). Tick-Tock, Tick-Tock: Valuing patient's time by creating a collaborative of health-care providers and crossing traditional boundaries. *International Journal of Integrated Care 14*(9).

Human Rights and Equal Opportunity Commission. (1997). *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Retrieved from http//http://www.humanrights.gov.au/social_ justice/bth_report/report/index.html

Hunt, J. (2006). Trying to make a difference: a critical analysis of health care during pregnancy for Aboriginal and Torres Strait Islander women. *Australian Aboriginal Studies*(2), 47.

Hunter, E., & Onnis, L. (2015). 'This Is Where a Seed Is Sown': Aboriginal Violence–Continuities or Contexts? *Violence and Mental Health*, 221-241.

Hutchinson, M., Jackson, D., Wilkes, L., & Vickers, M. (2008). A new model of bullying in the nursing workplace: Organizational characteristics as critical antecedents. *Advances in Nursing Science, 31*(2), E60-E71.

Hutchinson, M., Wilkes, L., Vickers, M., & Jackson, D. (2008). The development and validation of a bullying inventory for the nursing workplace. *Nurse Researcher, 15*(2), 19-29.

Hutchinson, M., & Jackson, D. (2013). Hostile clinician behaviours in the nursing work environment and implications for patient care: a mixed-methods systematic review. *BMC Nursing, 12*(1), 1.

Ingram, S. (2016). Silent drivers| driving silence-Aboriginal women's voices on domestic violence. *Social Alternatives, 35*(1), 6.

Israel, B., Schulz, A., Parker, E., & Becker, A. (1998). Review of community-based research: assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*(1), 173-202.

Jennings, W., Spurling, G., & Askew, D. (2014). Yarning about health checks: barriers and enablers in an urban Aboriginal medical service. *Australian Journal of Primary Health, 20*(2), 151-157.

Jervis-Tracey, P., Chenoweth, L., McAuliffe, D., O'Connor, B., & Stehlik, D. (2012). Managing tensions in statutory professional practice : living and working in rural and remote communities. *Australian and International Journal of Rural Education, 22*(2), 97-111.

Jiang, S. (2015). *Encouraging engagement with therapeutic landscapes: Using transparent spaces to optimize stress reduction in urban health facilities*. USA, Clemson University.

Johnston, M., Bennett, D., Mason, B., & Thomson, C. (2016). Service Learning in an Urban Aboriginal Community:“Real Aborigines Don't Just Live in the Bush” *Engaging First Peoples in Arts-Based Service Learning* (pp. 193-210). Cham: Springer.

Josif, C., Kruske, S., Kildea, S., & Barclay, L. (2017). The quality of health services provided to remote dwelling Aboriginal infants in the top end of northern Australia following health system changes: a qualitative analysis. *BMC Pediatrics, 17*(1), 93.

Jowsey, T., Yen, L., Ward, N., McNab, J., Aspin, C., & Usherwood, T. (2012). It hinges on the door: Time, spaces and identity in Australian Aboriginal Health Services. *Health Sociology Review, 21*(2), 196-207.

Julien, M., Wright, B., & Zinni, D. (2010). Stories from the circle: Leadership lessons learned from Aboriginal leaders. *The Leadership Quarterly, 21*(1), 114-126.

Kahakalau, K. (2004). Indigenous heuristic action research: Bridging western and indigenous research methodologies. *Hulili: Multidisciplinary research on Hawaiian well-being, 1*(1), 19-33.

Kearney, A. (2009). Homeland emotion: An emotional geography of heritage and homeland. *International Journal of Heritage Studies 15*(2-3): 209-222.

Kelleher, S. (2006). Providing patient-centred care in an intensive care unit. *Nursing Standard, 21*(13), 35-40.

Kelly, J., West, R., Gamble, J., Sidebotham, M., Carson, V., & Duffy, E. (2014). 'She knows how we feel': Australian Aboriginal and Torres Strait Islander childbearing women's experience of Continuity of Care with an Australian Aboriginal and Torres Strait Islander midwifery student. *Women and Birth, 27*(3), 157-162.

Kendall, E., Sunderland, N., Barnett, L., Nalder, G., & Matthews, C. (2011). Beyond the rhetoric of participatory research in indigenous communities: Advances in Australia over the last decade. *Qualitative Health Research*, *21*(12), 1719-1728.

Kendall, E., & Barnett, L. (2015). Principles for the development of Aboriginal health interventions: culturally appropriate methods through systemic empathy. *Ethnicity & Health, 20*(5), 437-452.

Kendall, M., Fronek, P., Ungerer, G., Malt, J., Eugarde, E., & Geraghty, T. (2011). Assessing professional boundaries in clinical settings: The development of the boundaries in practice scale. *Ethics & Behavior, 21*(6), 509-524.

Kenny, C., Faries, E., Fiske, J., & Voyageur, C. (2004). *A holistic framework for Aboriginal policy research*. Ottawa, Canada: Status of Women Canada.

Kilpatrick, S., Cheers, B., Gilles, M., & Taylor, J. (2009). Boundary crossers, communities, and health: exploring the role of rural health professionals. *Health & Place, 15*(1), 284-290.

King, T. (2003). *The truth about stories: A native narrative*. Canada: House of Anansi.

Kingsley, J., Townsend, M., Henderson-Wilson, C., & Bolam, B. (2013). Developing an exploratory framework linking Australian Aboriginal peoples' connection to country and concepts of wellbeing. *International Journal of Environmental Research and Public Health, 10*(2), 678-698.

Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry, 49*(2), 149-164.

Kitson, A., Marshall, A., Bassett, K., & Zeitz, K. (2013). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing, 69*(1), 4-15.

Knudson, S. (2015). Integrating the self and the spirit: strategies for aligning qualitative research teaching with indigenous methods, methodologies, and epistemology. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research 16*(3).

Kok, M., Ormel, H., Broerse, J., Kane, S., Namakhoma, I., Otiso, L., Sidat, M., Kea, A., Taegtmeyer, M., & Theobald, S. (2016). Optimising the benefits of community health workers'unique position between communities and the health sector: A comparative analysis of factors shaping relationships in four countries. *Global Public Health*, 1-29.

Koptie, S. (2009). Irihapeti Ramsden: The public narrative on cultural safety. *First Peoples Child & Family Review, 4*(2), 30-43.

Kovach, M., Brown, L., & Strega, S. (2015). Emerging from the margins: Indigenous methodologies. *Research as resistance: revisiting critical, Indigenous, and anti-oppressive approaches*, 43.

Kowal, E., & Paradies, Y. (2005). Ambivalent helpers and unhealthy choices: Public health practitioners' narratives of Indigenous ill-health. *Social Science & Medicine, 60*(6), 1347-1357.

Kurtz, D., Nyberg, J., Van Den Tillaart, S., & Mills, B. (2008). Silencing of voice: an act of structural violence: urban Aboriginal women speak out about their experiences with health care. *International Journal of Indigenous Health, 4*(1), 53.

Lander, J. (2013). *Negotiating community and knowledge in asynchronous online discussions in higher education.* (PhD), University of Technology, Sydney. Retrieved from http://epress.lib.uts.edu.au/research/handle/10453/21828

Langton, M. (2008). The end of 'big men' politics. *Griffith Review*(22), 48.

LaPorte, T., Haber, M., Jackson-Diop, D., & Holt, B. (2014). Mental health systems transformation through participatory research and action: The Young Adult Appreciative Inquiry/Photovoice Project. *Global Journal of Community Psychology Practice, 5*(1).

Larkin, S. (2014). *Race matters: indigenous employment in the Australian Public service*. Australia, Queensland University of Technology.

Lee, K., Freeburn, B., Ella, S., Wilson, S., Harrison, K., McEwan, M., & Conigrave, K. (2017). Supporting the Aboriginal alcohol and other drug workforce in New South Wales, Australia. *Drug and alcohol review, 36*(4), 523-526.

Lee, R., Brotheridge, C., Salin, D., & Hoel, H. (2013). Workplace bullying as a gendered phenomenon. *Journal of Managerial Psychology, 28*(3), 235-251.

Lee, T. (2008). Transforming research through indigenous cultural protocols: Issues of access, privacy, and respect. In B. Jegatheesan (Ed.), *Access, a Zone of Comprehension, and Intrusion* (pp. 125-139). United Kingdom: Emerald Group Publishing Limited.

Leeson, S., Smith, C., & Rynne, J. (2016). Yarning and appreciative inquiry: The use of culturally appropriate and respectful research methods when working with Aboriginal and Torres Strait Islander women in Australian prisons. *Methodological Innovations, 9*.

Lengen, C. (2015). The effects of colours, shapes and boundaries of landscapes on perception, emotion and mentalising processes promoting health and well-being. *Health & place 35:* 166-177.

Liamputtong, P., & Suwankhong, D (2015). Therapeutic landscapes and living with breast cancer: The lived experiences of Thai women. *Social Science & Medicine 128:* 263-271.

Liaw, S., Hasan, I., Wade, V., Canalese, R., Kelaher, M., Lau, P., & Harris, M. (2015). Improving cultural respect to improve Aboriginal health in general practice: a multi-methods and multi-perspective pragmatic study. *Australian family physician, 44*(6), 387.

Lock, M. (2007). *Aboriginal holistic health: A critical review*. Australia: Cooperative Research Centre for Aboriginal Health.

Loos, N. (2017). Invasion and Resistance: Aboriginal European Relations on the North Queensland Frontier 1861-1897. Boolarong Press.

Lowell, A., Kildea, S., Liddle, M., Cox, B., & Paterson, B. (2015). Supporting Aboriginal knowledge and practice in health care: lessons from a qualitative evaluation of the strong women, strong babies, strong culture program. *BMC Pregnancy and Childbirth, 15*(1), 1.

MacNaughton, K., Chreim, S., & Bourgeault, I. (2013). Role construction and boundaries in interprofessional primary health care teams: a qualitative study. *BMC health services research 13*(1): 1.

Maddison, S. (2013). Indigenous identity,'authenticity' and the structural violence of settler colonialism. *Identities, 20*(3), 288-303.

Maidment, J. (2006). The quiet remedy: A dialogue on reshaping professional relationships. *Families in Society: the Journal of Contemporary Social Services, 87*(1), 115-121.

Makosky Daley, C., James, A., Ulrey, E., Joseph, S., Talawyma, A., Choi, W., Greiner, K., & Coe, M. (2010). Using focus groups in community-based participatory research: Challenges and resolutions. *Qualitative Health Research, 20*(5), 697-706.

Maratos, M., Huynh, L., Tan, J., Lui, J., & Jarus, T. (2016). Picture This Exploring the Lived Experience of High-Functioning Stroke Survivors Using Photovoice. *Qualitative health research*,*26*(8), 1055-1066.

Martin, D., Nettleton, S., Buse, C., Prior, L., & Twigg, J. (2015). Architecture and health care: a place for sociology. *Sociology of Health & Illness, 37*(7), 1007-1022.

Martin, K., & Mirraboopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for indigenous and indigenist re-search. *Journal of Australian Studies, 27*(76), 203-214.

Martin, K. (2008). *Please knock before you enter: Aboriginal regulation of outsiders and the implications for researchers*. Brisbane: Post Pressed

Masuda, J., & Crabtree, A. (2010). Environmental justice in the therapeutic inner city. *Health & place, 16*(4), 656-665.

McCalman, J., Bainbridge, R., Percival, N., & Tsey, K. (2016). The effectiveness of implementation in Indigenous Australian healthcare: an overview of literature reviews. *International Journal for Equity in Health, 15*(1), 1.

McConnel, F., Demos, S., & Carson, D. (2011). Is current education for health disciplines part of the failure to improve remote Aboriginal health? *Focus on Health Professional Education: A Multi-disciplinary Journal 13*(1): 75.

McDermott, R., Schmidt, B., Preece, C., Owens, V., Taylor, S., Li, M., & Esterman, A. (2015). Community health workers improve diabetes care in remote Australian Indigenous communities: results of a pragmatic cluster randomized controlled trial. *BMC health services research, 15*(1), 1.

McGough, S., Wynaden, D., & Wright, M. (2018). Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing, 27*(1), 204-213.

McRae, H. (2009). *Indigenous Legal Materials: Commentary and Materials* . Australia: Thomson Reuters.

Mellor, D. (2003). Contemporary racism in Australia: The experiences of Aborigines. *Personality and Social Psychology Bulletin, 29*(4), 474-486.

Melody, S., Bennett, E., Clifford, H., Johnston, F., Shepherd, C., Alach, Z., Lester, M., Wood, L., Franklin, P., & Zosky, G. (2016). A cross-sectional survey of environmental health in remote Aboriginal communities in Western Australia. *International journal of environmental health research,* 1-11.

Mercer, C. (2013). The Experiences of Aboriginal Health Workers (AHWs) and Health Professionals Working Collaboratively in the Delivery of Health Care to Aboriginal Australians: A Systematic Review. *HNE Handover: For Nurses and Midwives, 6*(1).

Mercer, C., Byrth, J., & Jordan, Z. (2014). The experiences of Aboriginal health workers and non-Aboriginal health professionals working collaboratively in the delivery of health care to Aboriginal Australians: a systematic review. *The JBI Database of Systematic Reviews and Implementation Reports, 12*(3), 274-418.

Meurk, C., Broom, A., Adams, J., & Sibbritt, D. (2013). Rurality, mobility, identity: Women's use of complementary and alternative medicine in rural Australia. *Health & place 20:* 75-80.

Miller, C. (2015). *A Phenomenological Analysis of the Crabs in the Barrel Syndrome. Academy of Management Proceedings*, No. 1, p.13710.

Milne, T., Creedy, D., & West, R. (2016). Integrated systematic review on educational strategies that promote academic success and resilience in undergraduate indigenous students. *Nurse Education Today, 36*, 387-394.

Mitchell, M., & Hussey, L. (2006). The Aboriginal health worker. *Medical Journal of Australia, 184*(10), 529.

Mooney, G. (2003). Inequity in Australian health care: how do we progress from here? *Australian and New Zealand Journal of Public Health, 27*(3), 267-270.

Mooney-Somers, J., Erick, W., Scott, R., Akee, A., Maher, L., & Olsen, A. (2009). Sexual health through the eyes of Indigenous youth: Community-based participatory research with young Indigenous people in Townsville. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW.

Mooney-Somers, J., & Maher, L. (2009). The Indigenous Resiliency Project: a worked example of community-based participatory research. New South Wales Public Health Bulletin, 20(8), 112-118.

Moreton-Robinson, A. (2000). *Talkin' up to the white woman : Aboriginal women and feminism*. Australia: University of Queensland Press.

Moreton-Robinson, A. (2003). Researching whiteness: Some reflections from an Indigenous woman's standpoint. *Hecate, 29*(2), 72.

Moreton-Robinson, A. (2004). Whiteness, Epistemology and Indigenous Representation. In: A. Moreton-Robinson,(Ed.).*Whitening Race: Essays in Social and Cultural Criticism.* Canberra: Aboriginal Studies Press, 2004: 75-88.

Moreton-Robinson, A. (2013). Towards an Australian Indigenous women's standpoint theory: A methodological tool. *Australian Feminist Studies, 28*(78), 331-347.

Mulkay, M. (1985). *The word and the world: Explorations in the form of sociological analysis*. London: Allen & Unwin

Nagel, T., Hinton, R., & Griffin, C. (2012). Yarning about Indigenous mental health: Translation of a recovery paradigm to practice. *Advances in Mental Health, 10*(3), 216-223.

Nakata, M. (1997). *The cultural interface: An exploration of the intersection of Western knowledge systems and Torres Strait Islanders positions and experiences.* Australia, James Cook University.

Nakata, M. (2004). Indigenous knowledge and the cultural interface. In A. Hickling-Hudson, J. Matthews, & A. Woods, (Eds.), *Disrupting preconceptions: Postcolonialism and education* (pp. 19-38). Australia: Post Pressed.

Nakata, M. (2007a). The Cultural Interface. *The Australian Journal of Indigenous Higher Education, 36*(S1), 7-14.

Nakata, M. (2007b). *Disciplining the Savages: Savaging the Disciplines*. Australia: Aboriginal Studies Press.

Nakata, M. (2010). The Cultural Interface of Islander and Scientific Knowledge. *The Australian Journal of Indigenous Education, 39*(S1), 53-57.

Namie, G. (2003). Workplace bullying: Escalated incivility. *Ivey Business Journal, 68*(2), 1-6.

Namie, G., & Lutgen-Sandvik, P. (2010). Active and passive accomplices: The communal character of workplace bullying. *International Journal of Communication, 4*, 31.

National Aboriginal and Torres Strait Islander Health Worker Association. (2017). *National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA)*. Retrieved from https://natsihwa.org.au

National Aboriginal Health Organization. (2008). *Cultural competency and safety: A guide for health care administrators, providers and educators* . Canada National Aboriginal Health Organization

National Aboriginal Health Strategy Working Party. (1989). *A national Aboriginal health strategy.* Retrieved from http://www.atns.net.au/agreement.asp?EntityID=757

National Congress of Australia's First Peoples. (2016). *The Redfern statement: Aboriginal and Torres Strait Islander peak organisations unite*. Australia: National Congress of Australia's First Peoples.

National Health and Medical Research Council. (2003). *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. Canberra: National Health and Medical Research Council.

National Health and Medical Research Council. (2006). *Keeping research on track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics.* Canberra: National Health and Medical Research Council.

National Health and Medical Research Council. (2007). *National Statement on Ethical Conduct in Human Research.* Canberra: National Health and Medical Research Council.

National Health and Medical Research Council. (2010). *The NHMRC Road Map II: A strategic framework for improving the health of Aboriginal and Torres Strait Islander people through research*. Canberra: National Health and Medical Research Council.

Neal-Barnett, A., Stadulis, R., Murray, M., Payne, M., Thomas, A., & Salley, B. (2011). Sister circles as a culturally relevant intervention for anxious Black women. *Clinical Psychology: Science and Practice 18*(3): 266-273.

Nelkin, M. (2015). Professional boundary issues in practice. *Journal of the Academy of Nutrition and Dietetics, 115*(6), 975.

Nielsen, A., Stuart, L., & Gorman, D. (2014). Confronting the cultural challenge of the whiteness of nursing: Aboriginal registered nurses' perspectives. *Contemporary Nurse, 48*(2), 190-196.

Nungarrayi Price, B. (2009). 'I Have Seen Violence Towards Women Every Day Of My Life': Australia, 2009. *Australian Feminist Law Journal, 30*(1), 149-150.

Nursing and Midwifery Board of Australia. (2016). Nursing and Midwifery Board of Australia Code of professional conduct for nurses. Retrieved from http://www.nursingmidwiferyboard.gov.au

Oates, J., Drey, N., & Jones, J. (2017). 'Your experiences were your tools.' How personal experience of mental health problems informs mental health nursing practice. *Journal of psychiatric and mental health nursing*, *24*(7), 471-479.

Onnis, L., & Pryce, J. (2016). Health professionals working in remote Australia: a review of the literature. *Asia Pacific Journal of Human Resources, 54*(1), 32-56.

Padilla, L. (1998). Social and Legal Repercussions of Latinos' Colonized Mentality. *University of Miami Law Review, 53*, 769.

Palinkas, L., Horwitz, S., Green, C., Wisdom, J., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533-544.

Panaretto, K., Mitchell, M., Anderson, L., Larkins, S., Manessis, V., Buettner, P., & Watson, D. (2007). Sustainable antenatal care services in an urban Indigenous community: the Townsville experience. *Medical Journal of Australia, 187*, 18-22.

Panelli, R., & Tipa, G. (2007). Placing well-being: A Maori case study of cultural and environmental specificity. *EcoHealth, 4*(4), 445-460.

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care, 8*(5), 491-497.

Parish, E. (2015). BMJ roundtable debate: How can we get better at providing patient centred care? *BMJ 350:* h412.

Payne, D., Hickey, H., Nelson, A., Rees, K., Bollinger, H., & Hartley, S. (2016). Physically disabled women and sexual identity: a PhotoVoice study. *Disability & Society, 31*(8), 1030-1049.

Pedersen, H., & Woorunmurra, B. (2000). Jandamarra and the Bunuba resistance. Magabala Books Aboriginal Corporation.

Plane, J., & Klodawsky, F. (2013). Neighbourhood amenities and health: Examining the significance of a local park. *Social Science & Medicine, 99*, 1-8.

Porsanger, J. (2004). An essay about indigenous methodology. *Nordlit, 8*(1), 105-120.

Pounds, G. (2010). Empathy as' appraisal': A new language-based approach to the exploration of clinical empathy. *Journal of Applied Linguistics & Professional Practice, 7*(2).

Power, K. (2004). Yarning: A responsive research methodology. *Journal of Australian Research in Early Childhood Education, 11*(1), 37-46.

Pressler, J., & Kenner, C. (2012). Interprofessional and interdisciplinary collaboration in nursing. *Nurse Educator, 37*(6), 230-232.

Prodan-Bhalla, N., Middagh, D., Jinkerson-Brass, S., Ziabakhsh, S., Pederson, A., & King, C. (2016). Embracing Our “Otherness” A Mutually Transformative Journey in Delivering an Indigenous Heart Health Promotion Project. *Journal of Holistic Nursing*, *35*(1), 44-52.

Pugh, R. (2007). Dual relationships: Personal and professional boundaries in rural social work. *British Journal of Social Work, 37*(8), 1405-1423.

Putt, J. (2013). *Conducting research with Indigenous people and communities*. Australia: Indigenous Justice Clearinghouse.

Queensland Title Office. (1897). *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* Retrieved from Australia: http://foundingdocs.gov.au/item-sdid-54.html#significance

Rainford, W., Wood, S., McMullen, P., & Philipsen, N. (2015). The Disruptive Force of Lateral Violence in the Health Care Setting. *Journal for Nurse Practitioners, 11*(2), 157-164.

Ramsden, I.M. (2002). *Cultural Safety and nursing education in Aotearoa and Te Waipounamu.* Unpublished PhD thesis. Victoria University of Wellington, New Zealand.

Reimer, E. (2014). Using friendship to build professional family work relationships where child neglect is an issue: Worker perceptions. *Australian Social Work, 67*(3), 315-331.

Reynolds, H. (2006). The other side of the frontier: Aboriginal resistance to the European invasion of Australia. UNSW Press.

Richards, T., Coulter, A., & Wicks, P. (2015). Time to deliver patient centred care. *BMJ 350:* h530.

Rigney, L. (1997). Internationalism of an Aboriginal or Torres Strait Islander anti-colonial cultural critique of research methodologies: A guide to indigenist research methodology and its principles. *Research and development in higher education: advancing international perspectives, 20*, 629-636.

Rigney, L. (2006). *Indigenist research and Aboriginal Australia*. United Kingdom: Ashgate.

Riley, T., & Ungerleider, C. (2012). Self-fulfilling prophecy: How teachers' attributions, expectations, and stereotypes influence the learning opportunities afforded Aboriginal students. *Canadian Journal of Education, 35*(2), 303-333.

Roberts, S., Demarco, R., & Griffin, M. (2009). The effect of oppressed group behaviours on the culture of the nursing workplace: a review of the evidence and interventions for change. *Journal of Nursing Management 17*(3): 288-293.

Roberts, S. (2015). Lateral Violence in Nursing: A Review of the Past Three Decades. *Nursing Science Quarterly, 28*(1), 36-41.

Roche, A., Duraisingam, V., Trifonoff, A., Battams, S., Freeman, T., Tovell, A., Weetra, D., & Bates, N. (2013). Sharing stories: Indigenous alcohol and other drug workers' well-being, stress and burnout. *Drug and alcohol review, 32*(5), 527-535.

Roche, A., Duraisingam, V., Trifonoff, A., & Tovell, A. (2013). The health and well-being of Indigenous drug and alcohol workers: Results from a national Australian survey. . *Journal of Aubstance Abuse Treatment, 44*(1), 17-26.

Rosca, N. (2007). *Lily Pad.* Retrieved from http://ninotchkarosca.blogspot.com.au/2007/09/postscript.html

Rose, E. (2012). Encountering place: A psychoanalytic approach for understanding how therapeutic landscapes benefit health and wellbeing. *Health & place, 18*(6), 1381-1387.

Roy, S., & Campbell, B. (2015). An Indigenous epistemological approach to promote health through effective knowledge translation. *Journal of Indigenous Research, 4*(2015), 2.

Russell, L. (2005). Indigenous knowledge and archives: accessing hidden history and understandings. *Australian Academic & Research Libraries, 36*(2), 161-171.

Sanders, S., Bullock, K., & Broussard, C. (2012). Exploring professional boundaries in end-of-life care: Considerations for hospice social workers and other members of the team. *Journal of social work in end-of-life & palliative care 8(*1): 10-28.

Sarra, C. (2014). *Strong and smart–Towards a pedagogy for emancipation: Education for First Peoples*. United Kingdom: Routledge.

Schaal, J., Lightfoot, A., Black, K., Stein, K., White, S., Cothern, C., Gilbert, K., Hardy, C., Jeon, J., & Mann, L. (2016). Community-guided focus group analysis to examine cancer disparities. *Progress in Community Health Partnerships: Research, Education, and Action, 10*(1), 159-167.

Seitz, C., & Strack, R. (2016). Conducting public health photovoice projects with those who are homeless: A review of the literature. *Journal of Social Distress and the Homeless, 25*(1), 33-40.

Shepherd, J. (2013). Messy boundaries: younger students' experiences of nursing young people in hospital: Jean Shepherd examines the personal challenges that face nursing students when caring for patients close to their own age. *Nursing Children and Young People, 25*(8), 23-26.

Sherwin, S. (2000). A relational approach to autonomy in health care. *Readings in health care ethics*: 69-87.

Sherwood, J. (2010). *Do no harm: decolonising Aboriginal health research.* University of New South Wales Australia.

Sherwood, J. (2013a). An Aboriginal health worker's research story. *Indigenous Pathways Into Social Research: Voices of a New Generation*, 203.

Sherwood, J. (2013b). Colonisation–It's bad for your health: The context of Aboriginal health. *Contemporary Nurse, 46*(1), 28-40.

Sherwood, J., & Edwards, T. (2006). Decolonisation: A critical step for improving Aboriginal health. *Contemporary Nurse, 22*(2), 178-190.

Sherwood, J., & Kendall, S. (2013). Reframing spaces by building relationships: Community collaborative participatory action research with Aboriginal mothers in prison. *Contemporary Nurse, 46*(1), 83-94.

Sherwood, J., Lighton, S., Dundas, K., French, T., Link-Gordon, D., Smith, K., & Anthony, T. (2015). Who are the Experts Here?: Recognition of Aboriginal women and community workers in research and beyond. *AlterNative: An International Journal of Indigenous Peoples, 11*(2), 177-190.

Singer, J., Bennett-Levy, J., & Rotumah, D. (2015). "You didn't just consult community, you involved us": transformation of a 'top-down' Aboriginal mental health project into a 'bottom-up' community-driven process. *Australasian Psychiatry, 23*(6), 614-619.

Smallacombe, S., Davis, M., & Quiggin, R. (2006). *Scoping Project on Aboriginal Traditional Knowledge, Report of a study for the Desert Knowledge Cooperative Research Centre*. Retrieved from http://www.desertknowledgecrc.com.au/resource/DKCRC-Report-22-Traditional-Knowledge.pdf

Smethurst, J. (2016). Cultural competency training with black card. *Australian Midwifery News, 16*(3), 56.

Smith, D. (1974). Women's perspective as a radical critique of sociology. *Sociological Inquiry, 44*(1), 7-13.

Smith, J. (1994). Towards reflexive practice: Engaging participants as co-researchers or co-analysts in psychological inquiry. *Journal of Community & Applied Social Psychology, 4*(4), 253-260.

Smith, L. (1999). *Decolonizing methodologies: research and indigenous peoples*. London: Zed Books

Smith, L. (2006). Researching in the Margins Issues for Māori Researchers a Discussion Paper. *AlterNative: An International Journal of Indigenous Peoples, 2*(1), 4-27.

Smith, L. (2007). On tricky ground. *The Landscape of Qualitative Research, 1*.

Smith, L. (2014). Social Justice, Transformation and Indigenous Methodologies. In R. E. Rinehart, K. N. Barbour, & C. C. Pope (Eds.), *Ethnographic Worldviews: Transformations and Social Justice* (pp. 15-20). Dordrecht: Springer Netherlands.

Smith, W. (2004). Black faculty coping with racial battle fatigue: The campus racial climate in a post-civil rights era. In D. Cleveland (Ed.), *A Long Way to Go: Conversations About Race By African American Faculty and Graduate Students at Predominately White Institutions* (Vol. 14, pp. 171-190). United States of America: Peter Lang Publishers.

Smith, W., Yosso, T., & Solórzano, D. (2006a). Challenging racial battle fatigue on historically White campuses: A critical race examination of race-related stress. In C. A. Stanley (Ed.), *Faculty of Color: Teaching in Predominately White colleges and universities*(Vol. 69), (pp. 299-237). United States of America: Anker Publishing.

Smith, W., Allen, W., & Danley, L. (2007). “Assume the position... you fit the description” psychosocial experiences and racial battle fatigue among African American male college students. *American Behavioral Scientist, 51*(4), 551-578.

Smyth, F. (2005). Medical geography: therapeutic places, spaces and networks. *Progress in Human Geography*, *29*(4): 488-495.

Snijder, M., Shakeshaft, A., Wagemakers, A., Stephens, A., & Calabria, B. (2015). A systematic review of studies evaluating Australian indigenous community development projects: the extent of community participation, their methodological quality and their outcomes. *BMC public health*, *15*(1), 1154.

Social Policy Evaluation and Research Committee. (2008). *The Social Policy Evaluation and Research Committee (SPEaR) Good Practice Guidelines* Retrieved from http://www.spear.govt.nz/good-practice/statement-purpose.html

Social Policy Evaluation and Research Committee and Aotearoa New Zealand Evaluation Association. (2007). *Report on the SPEaR Best Practice Māori Guidelines Hui 2007.* Retrieved from http://www.spear.govt.nz/documents/good-practice/spear-bpg-maori-final-report-anzea.pdf

Steering Committee for the Review of Government Service Provision (2014). Overcoming Indigenous disadvantage: key indicators 2014. Australia, Productivity Commission.

Stets, J., & Burke, P. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, 224-237.

Stoecker, R. (2009). Are we talking the walk of community-based research? *Action Research, 7*(4), 385-404.

Stone, A. (2014). The Ironic Aftermath of Eatock v. Bolt. *Melbourne University Law Review. 38*: 926.

Sunderland, N., Bristed, H., Gudes, O., Boddy, J., & Da Silva, M. (2012). What does it feel like to live here? Exploring sensory ethnography as a collaborative methodology for investigating social determinants of health in place. *Health & place, 18*(5), 1056-1067.

Tarbetsky, A., Collie, R., & Martin, A. (2016). The role of implicit theories of intelligence and ability in predicting achievement for Indigenous (Aboriginal) Australian students. *Contemporary Educational Psychology*,*47*, 61-71.

Taylor, K., Bessarab, D., Hunter, L., & Thompson, S. (2013). Aboriginal-mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance use issues. *BMC health services research, 13*(1), 12.

Teti, M., Conserve, D., Zhang, N., & Gerkovich, M. (2016). Another Way to Talk: Exploring Photovoice as a Strategy to Support Safe Disclosure Among Men and Women With HIV. *AIDS Education and Prevention, 28*(1), 43-58.

The Australian Health Practitioner Regulation Agency. (2016). *Annual Report 2015/2016: The Australian Health Practitioner Regulation Agency and the National Boards, reporting on the National Registration and Accreditation Scheme*. Retrieved from https://www.ahpra.gov.au/annualreport/2016/

The Australian Health Practitioner Regulation Agency. (2017). Aboriginal and Torres Strait Islander Health Practice Board of Australia. Retrieved from http://www.atsihealthpracticeboard.gov.au/

The Department of Health. (2016). *Annual Report 2015-2016*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/annual-report2015-16

Thoits, P. (2012). Role-identity salience, purpose and meaning in life, and well-being among volunteers. *Social Psychology Quarterly*, *75*(4), 360-384.

Thompson, C. (2011). Linking landscape and health: The recurring theme. *Landscape and Urban Planning 99*(3): 187-195.

Thompson, E. (2015). Necessary boundary crossings in pediatrics. *AMA Journal of Ethics, 17*(5), 461.

Thompson, S., Haynes, E., Woods, J., Bessarab, D., Dimer, L., Wood, M., Sanfilippo, F., Hamilton, S., & Katzenellenbogen, J. (2016). Improving cardiovascular outcomes among Aboriginal Australians: Lessons from research for primary care. *SAGE Open Medicine, 4*, 2050312116681224.

Townsend, M., Phillips, R., & Aldous, D. (2009). "If the land is healthy… it makes the people healthy": The relationship between caring for Country and health for the Yorta Yorta Nation, Boonwurrung and Bangerang Tribes. *Health & place, 15*(1), 291-299.

Treloar, C., Gray, R., Brener, L., Jackson, C., Saunders, V., Johnson, P., Harris, M., Butow, P., & Newman, C. (2014). "I can't do this, it's too much": building social inclusion in cancer diagnosis and treatment experiences of Aboriginal people, their carers and health workers. *International Journal of Public Health, 59*(2), 373-379.

Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care,* London, Psychology Press.

Turney, D. (2010). Sustaining relationships: Working with strong feelings. III. Love and positive feelings.*Relationship-based social work: Getting to the heart of practice*, 133-147.

Tutton, E., Seers, K., & Langstaff, D. (2008). Professional nursing culture on a trauma unit: experiences of patients and staff. *Journal of Advanced Nursing, 61*(2), 145-153.

van Dijk, T. (1996). *Discourse Studies: a Multidisciplinary Introduction*. United States of America: Sage Publications.

Vessey, J., DeMarco, R., & DiFazio, R. (2010). Bullying, harassment, and horizontal violence in the nursing workforce the state of the Science. *Annual Review of Nursing Research, 28*(1), 133-157.

Walker, M., Fredericks, B., Mills, K., & Anderson, D. (2014). “Yarning” as a method for community-based health research with indigenous women: the indigenous women's wellness research program. *Health Care for Women International, 35*(10), 1216-1226.

Wang, C., & Burris, M. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior, 24*(3), 369-387.

Wang, C. (2003). Using photovoice as a participatory assessment and issue selection tool. *Community Based Participatory Research for Health*, 179-196.

Wang, C. (2006). Youth participation in photovoice as a strategy for community change. *Journal of Community Practice, 14*(1-2), 147-161.

Warren, A., Hamilton, R., & Roden-Foreman, K. (2013). Invited Grand Rounds Article—Up Close But Not Too Personal: Establishing Appropriate Boundaries with Individuals Following Spinal Cord Injury. *Sexuality and Disability, 31*(4), 303-311.

Watson, K., Young, J., & Barnes, M. (2013). What constitutes ‘support’for the role of the Aboriginal and Torres Strait Islander child health workforce? *Australian Health Review 37*(1): 112-116.

Weber-Pillwax, C. (2004). INDIGENOUS RESEARCHERS AND INDIGENOUS RESEARCH METHODS: CULTURAL INFLUENCES OR CULTURAL DETERMINANTS OF RESEARCH METHODS. *Pimatisiwin: A Journal of Aboriginal & Indigenous Community Health, 2*(1).

Welch, M. (2005). Pivotal moments in the therapeutic relationship. *International Journal of Mental Health Nursing, 14*(3), 161-165.

Wendt, D., & Gone, J. (2012). Urban-indigenous therapeutic landscapes: A case study of an urban American Indian health organization. *Health & place 18*(5): 1025-1033.

Wilkie, M. (1997). *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Retrieved from https://www.humanrights.gov.au/sites/default/files/content/pdf/social_justice/bringing_them_home_report.pdf

Willis, E., Reynolds, L., & Keleher, H. (2016). *Understanding the Australian health care system*. Australia: Elsevier Health Sciences.

Willox, A., Harper, S., Edge, V., Landman, K., Houle, K., & Ford, J. (2013). The land enriches the soul: On climatic and environmental change, affect, and emotional health and well-being in Rigolet, Nunatsiavut, Canada. *Emotion, Space and Society, 6*, 14-24.

Wilson, A., Magarey, A., Jones, M., O'Donnell, K., & Kelly, J. (2015). Attitudes and characteristics of health professionals working in Aboriginal health. *Rural and Remote Health, 15*(2739).

Wilson, J. (2014). *Noongar Women's Birth Experience.* Australia, University of Notre Dame.

Wilson, K. (2003). Therapeutic landscapes and First Nations peoples: an exploration of culture, health and place. *Health & Place, 9*(2), 83-93.

Wilson, N. (2013). Strong and Smart–Towards a Pedagogy for Emancipation: Education for First Peoples. *Journal of Critical Realism, 12*(3), 400-404.

Wingard, B. (2010). A conversation with lateral violence. *International Journal of Narrative Therapy & Community Work, 2010*(1), 13.

Wodak, R., & Reisigl, M. (2015). Discourse and racism. *The Handbook of Discourse Analysis, 2*, 576-596.

Wyatt, K. H. A., MP,. (2017). *Better Indigenous Health*. Canberra: Ministery for Aged Care and Indigenous Health Retrieved from https://nacchocommunique.files.wordpress.com/2018/02/ahha-ctg-2018-feature.pdf

Yasui, M., Pottick, K., & Chen, Y. (2017). Conceptualizing culturally infused engagement and its measurement for ethnic minority and immigrant children and families. *Clinical child and family psychology review 20*(3): 250-332.

Yosso, T., Smith, W., Ceja, M., & Solórzano, D. (2009). Critical race theory, racial microaggressions, and campus racial climate for Latina/o undergraduates. *Harvard Educational Review, 79*(4), 659-691.

Yunkaporta, T., & McGinty, S. (2009). Reclaiming Aboriginal knowledge at the cultural interface. *The Australian Educational Researcher, 36*(2), 55-72.

Zubrzycki, J., Shipp, R., & Jones, V. (2017). Knowing, Being, and Doing: Aboriginal and Non-Aboriginal Collaboration in Cancer Services. *Qualitative Health Research*, 1049732316686750.

Appendices

Appendix A: Team Members

Tia

Tia is a Torres Strait Islander woman, who worked in a remote government health service. Tia lived in the Northern Territory of Australia and had worked in the Aboriginal and Torres Strait Islander health sector for nearly 30 years. She has several biological and foster children and grandchildren. At the time of this research, adult children and some grandchildren were living with her.

Macca

Macca is an Aboriginal and Torres Strait Islander man who worked in an urban government health service in the Northern Territory of Australia. Macca has biological and foster children, all of whom lived with him and his partner at the time of this research. Macca had worked in the Aboriginal and Torres Strait Islander health sector for nearly a decade.

Kim

Kim is an Aboriginal woman who worked in an urban government health service in Queensland, Australia. Kim had worked in the Aboriginal and Torres Strait Islander health sector for 20 years. At the time of this research she lived with her children and nephew, all of whom were school aged.

Maureen

Maureen is a Torres Strait Islander woman who worked in a regional government health service. At the time of this research she lived in Queensland with her children and niece. She had worked in the Aboriginal and Torres Strait Islander health sector for 10 years.

Pete

Pete is an Aboriginal man who worked in a rural government health service. Pete had worked in the Aboriginal and Torres Strait Islander health sector for 30 years. He has children and several grandchildren, some of who lived with him at the time of this research.

Scotty

Scotty is an Aboriginal man who lived in Queensland. He worked in an urban non-government health service and had worked in the Aboriginal and Torres Strait Islander health sector for over a decade. Scotty has several children and grandchildren. At the time of this research Scotty had nephews and a grandchild living with him.

Carlee

Carlee is an Aboriginal woman who lived in Queensland, Australia. She had worked in the Aboriginal and Torres Strait Islander health sector for several years and worked in a regional non-government health service. At the time of this research Carlee lived with her school-aged children. She cared for two close relatives, both of whom had chronic health conditions and lived with her.

Justin

Justin is an Aboriginal man who lived in New South Wales, Australia. He had worked in the Aboriginal and Torres Strait Islander health sector for 20 years and worked in a regional non-government health clinic. At the time of this research Justin lived with his partner and children, grandchildren and foster children. Justin is carer for his partner who has limited mobility due to a chronic condition.

Aimee

Aimee is an Aboriginal woman from New South Wales, Australia. She worked in a regional government health service and had worked in the Aboriginal and Torres Strait Islander health sector for a few years. At the time of this research Aimee was a single parent to school aged children, one of whom lived with a chronic medical condition that required frequent hospitalisations.

Jimms

Jimms is an Aboriginal man who had worked in the Aboriginal and Torres Strait Islander health sector for several years. At the time of this research Jimms worked in an urban non-government clinic in New South Wales, Australia and lived with his partner and their preschool aged children. Jimms' sibling, nieces and nephews also lived with him during this research.

Marlene

Marlene is an Aboriginal woman from New South Wales who has worked in the Aboriginal and Torres Strait Islander health sector for close to two decades. She has several children and grandchildren. Throughout this research Marlene had some of her adult nephews living with her. She worked in a rural government health service.

Teena

Teena is an Aboriginal woman who lived in New South Wales, Australia. She had worked in the Aboriginal and Torres Strait Islander health sector for nearly a decade and worked in an urban non-government health service. During this research Teena lived with her partner, and their biological child and foster (related to her) children.

Bill

Bill is an Aboriginal man from Victoria, Australia. Bill had worked in the Aboriginal and Torres Strait Islander health sector for several years and worked in an urban non-government health service. Bill lived with a sibling and their children, who he supported throughout the period of this research.

Cindy

Cindy is an Aboriginal woman from Victoria, Australia. She worked in a regional government health service. She had worked in the Aboriginal and Torres Strait Islander sector for over a decade. Cindy had one of her adult children and some of her grandchildren living with her throughout this research.

Helen

Helen is an Aboriginal woman from South Australia. At the time of this research she had worked in the Aboriginal and Torres Strait Islander health sector for several years and worked in a regional non-government health clinic. Helen has adult children and several school-age grandchildren. During the research she lived with her partner and one of her grandchildren.

Appendix B: Yarning questions

These questions were used as a starting point for Yarning. They provided a platform from which open and in-depth Yarning occurred:

1. Please tell me about your current job/role as an Indigenous health professional:
   - Who?
   - Where?
   - Why here?
   - How long here?
2. What are the main responsibilities/main duties?
3. What is the most enjoyable part of your job? (Why?)
4. What is the least enjoyable part of your job? (Why?)
5. Why did you decide to become an Indigenous health professional?
   - Where you influenced by any other person/issue?
6. What skills or expertise do you think an Indigenous health professional should have? (Why?)
7. Should they have any other qualities?
8. Have you undertaken any form of education or training?
   - Was this informal or formal- a blend of the two?
   - How long did it take?
   - What value did it have for you?
9. Do you have any particular memories about your training and education?
   - Application process?
   - Starting the course?
   - Readings?
   - Assignments?
   - Completing the course?
   - Things learnt?
   - People involved?
   - Other?
10. Do you have any particular memories about your:
    - Training and education?
    - Previous role/s?

- Current roles?
- People involved in your work/career?
- Things learnt in your work/career?
- Getting started in this job (or another job)?
- Other?

11. What professional development opportunities are open to you here?
    - Do you take these on?
    - What is the most useful about these?
    - What is the least useful about these?
12. What are your current and future plans for your role as an Indigenous health professional?
    - Plans for you, personally?
    - Plans for community?
    - Plans for the role?
13. How would you describe the way you work here?
14. What works well (in the work you do), and why?
15. Could you please tell me a favourite Yarn (story) about your work?
16. Could we talk about your work and what stands out for you as enjoyable? (Why?)
17. Could we talk about what is challenging at work? (Why?)
18. What supports you to get your work done? (Why? /How?)
19. Can we Yarn about the images you chose to take (photographs). These were taken to represent something about your work that is important for you, or that you wanted to Yarn about. Please tell me about the images.
20. What do the images represent?
21. What do they “say” about your work as an Indigenous health professional?
22. If you had to choose four mages that best describe your work and identity as an Indigenous health professional which images would you choose and why?

(Subsequent questions followed the flow of the Yarn, as guided by the participant’s initiation of each Yarn

Appendix C: Journal Conversations: Building the Research Self-Efficacy of an Aboriginal Early Career Academic

Journal Conversations: Building the Research Self-Efficacy of an Aboriginal Early Career Academic

Michelle L. Dickson
University of Sydney, Sydney, Australia

This paper shows how I used my research journal mainly as a reflective tool throughout the process of applying for and completing a PhD. Embarking on a PhD can be daunting for anyone and I was challenged by my lack of academic self-efficacy. In the absence of a formal academic mentor my research journal became my confidante, a tool that helped me make progress at times when barriers to research seemed insurmountable. It helped me decrease the cognitive dissonance I was experiencing about issues of subjectivity/objectivity and the positioning of my self in the research. This paper shares research journal entries as I take you on my research journey. The entries make public some of the values I uphold for my research and show how I found ways to embed my own epistemology as an Australian Aboriginal (Koori) researcher into a PhD that also meets a Western academic research paradigm. *Keywords: Aboriginal and Torres Strait Islander, Research Journal, Research Diary, Indigenous, Research Self-Efficacy, Early Career Academic, Qualitative Methods, Reflective Research*

Introduction: Family, Fear and Kissing with Noses

When Aboriginal and Torres Strait Islander people meet each other, we ask questions like "Who is your mob (family/community)?" or "Where are you from?" These questions are the foundation of cultural identity and locate you for others by connecting you to family, community, country. I will follow this Aboriginal protocol by writing a Yarn (usually a verbal exchange of knowledge/a shared story) to position myself within this paper. This paper is not a traditional research report; rather, it utilises some of my research journal entries to describe how using a research journal was pivotal in helping me to blend my own epistemology as an Australian Aboriginal (Koori) researcher with a Western academic research paradigm. Yarning (Leeson et al., 2016; Walker et al., 2014) has increasingly been recognised as a culturally appropriate and respectful way to collect research data. Yarning was pivotal in the data collection process of my PhD as part of the Indigenous methodology I used. Throughout my PhD "research participants" were named Team Members. This term represents the true engagement between me ("researcher") and Team Members ("research participants") throughout the whole research process.

I Yarned with Team Members and with my own family during my PhD. A fellow academic once suggested my Yarning was "mere naval gazing" (MD: research journal), completely misunderstanding their value and importance. In fact, Yarns were woven throughout my entire methodological approach; they aligned with theory presented by (Kovach, Brown, & Strega, 2015). In my PhD research, Yarns helped me to present my ways of knowing as an Indigenous (Aboriginal) researcher, they used an Indigenous process as a research method, they were shared between me and Team Members as we built and maintained our research relationships and they demonstrated a way of reciprocal sharing of knowledge.

My research journal allowed me to have an ongoing Yarn throughout the entire PhD process. It was an important part of the larger Indigenous research methodology that had ethical approval from the relevant bodies (more details are provided later in this paper). At times when I did not have a person to Yarn with face to face, I used my research journal. At times when I needed to Yarn about something that might have been difficult to do face to face, I used my research journal. Although my research journal took a written form I viewed it as a being valuable, supportive, ongoing Yarning process that helped me to build my research capacity and self-efficacy as an early career researcher.

My Yarn (below) contains reflections and stories that are either my own or belong to members of my family. I share them with permission, pride and with reciprocal respect.

I am Michelle Dickson. I am an Aboriginal[23] woman from Ngarigo lands (in the Snowy Mountains region in New South Wales, Australia) and Darkinjung lands (on the Central Coast of New South Wales). I have three younger siblings and my parents are John and Deslie Dickson (nee Hayes). Born north of the harbor in Sydney, New South Wales on Cammeraygal lands, I have lived and worked mostly on the lands of the Eora nation in Sydney. My four children are proud to be the next generation of Aboriginal and Torres Strait Islander Australians.

The Stolen Generation (Wilkie, 1997) made a huge impact on both sides of my family. Until 1969, various government laws and policies in Australia enforced the removal of children from their families and communities, resulting in what is now called The Stolen Generation. This generation of children were removed and raised in institutions or fostered to non-Aboriginal and Torres Strait Islander people. Some of these children eventually found their way home, or were found again by family members, others never found home or family. For some, being Aboriginal was something to hide. The experiences one generation encountered left in them a fear for the next generation. Familial stories identify more safety in being told we "come from the Islands" or have "Spanish blood way back." My paternal grandmother, an intelligent and loving person, told me that her own "flat nose" was because of the "Eskimo heritage." When she told me this I was looking at an old photo she had dug out from the depths of her private tallboy (wardrobe). The photo was of her Aboriginal relatives. She smiled as I questioned the "Eskimo" comment, and said to me "Michelle, you know Eskimo people kiss with their noses, and I think we must have done a lot of kissing – look at my nose!"

[23] Australian Aboriginal and/or Torres Strait Islander peoples are the original inhabitants and custodians of the land now known as Australia. I identify as Aboriginal. Use of appropriate cultural terminology is highly important. As an Aboriginal woman from New South Wales I call myself Koori. I will use this term throughout this paper, when referring to myself. When referring to other Indigenous people from Australia I will use the term Aboriginal and/or Torres Strait Islander, unless I know they identify by using another term.

A Koori Academic

I am also an Australian Aboriginal (Koori) early career academic. On both sides of my family I was first to complete year 12 at high school, and the first to attend and graduate from University. I am a self-confessed nerd and love learning. My undergraduate honours degree inspired me towards postgraduate qualifications, including a Masters. I have many photos of my first graduation day, but one photo speaks volumes for me: it is a photo of my two grandmothers proudly holding my testamur, the legal certification of your degree given to you at the time of your graduation, with me in the middle. That journey was not just mine. Like a number of my Aboriginal and Torres Strait Islander academic colleagues, and colleagues from non-dominant cultures around the world (Tuitt, Hanna, Martinez, del Carmen Salazar, & Griffin, 2009), I have worked in the tertiary education sector for many years (25 years at the date of publication) and have had minimal career progression during that time - but not through lack of trying. Over the years my teaching skills developed, and my teaching load and community outreach remained a dominant force, but that teaching/service load meant that there was minimal space for research in my work profile. I wanted to change that. I wanted to progress alongside my other colleagues to the realm of "Professor-dom" and beyond - but to do that I needed a PhD. So somewhere along my journey I also became a PhD student, exploring the lived work experiences of Australian Aboriginal and Torres Strait Islander people who worked in the Australian health sector. At the time of writing this paper I am employed by The University of Sydney; but for you to understand my present I need to journey back to the past, to my employ at another University. And that is certainly a story.

The Lone Koori Academic in the Faculty

At my former employ I started working as a casual academic on a suite of postgraduate programs within a well-established University faculty. Soon after, I found myself with a heavier teaching role that also led me to take over coordination of the programs. I loved this job despite being employed on rolling six- or twelve-month contracts over a long period of time. I really put everything I had into the job and worked at a level far beyond my paid level of employ, that of an associate lecturer. When I first talked about enrolling in a PhD I assumed I would have overwhelming collegial support from my fellow academics. I thought they would welcome me into the world of research and help me navigate my way in the realm of Aboriginal and Torres Strait Islander research: I was, after all, the lone Koori academic in the faculty. I already worked very closely and collegially with a large number of peers who asked me to help "embed Aboriginal content" into the faculty's core business. I truly believed that the faculty had a desire to learn more about Aboriginal and Torres Strait Islander epistemology and ontology. The guest lectures I developed and delivered (in units coordinated by other colleagues) were all well received by both students and staff, and the staff development workshops I enthusiastically designed and facilitated were warmly embraced. I assumed that my emerging research would be seen as contributing to the faculty's growing body of knowledge about Aboriginal and Torres Strait Islander world views and lived experiences. Sadly, I was wrong.

Journals in Research, and How I Used My Journal

Snowden (2015) suggests that two types of journal are commonly used in the research process; the first is a personal journal used by a researcher to record their experiences throughout the research process and the second a journal "used by the researcher as a data collection tool" (p. 36). According to Robson and McCartan (2016) the first type of research journal provides scope for the researcher to record a chronology of their research experiences and their reflections about those experiences, including recording the complete research process from design through to publication of results. Snowden (2015) highlights that research rigor can be enhanced by using a research journal to record the research process and the document the researcher's thinking and experiences. Some disciplines, like the sciences, have used research journals as a regular component of the research process; these research journals record each step taken in the investigation and note what worked and what didn't, and reflect on why.

Clarke (2009) advocates for the use of research journals to enhance and support the researcher's learning, especially for the early career researcher. She suggests that the research journal encourages both "creative and critical thinking" (p. 76) that promotes increased transparency in the research process and was for her a "vehicle for learning in my roles as researcher and analyst" (p. 76).

In qualitative research the research journal is considered a valuable means for learning about the experience of engaging in research and equally valuable for collecting data. Lamb (2013c) states that "writing a research journal is critically important to the documentation of the researcher's personal research journey and help validate the authenticity of research data collected using this method" (p. 90). Lamb (2013a) and Borg (2001) both suggest that early career researchers might learn from the "realities of research" (Lamb, 2013a, p. 37) through engaging in other researchers' research journals.

While research journals are often excluded from some more traditional research methods, Ortlipp (2008) suggests the research journal allows researchers to clarify research experiences by reflective journaling. Davidson (2012) suggests the research journal also allows the researcher to explore the "I" in their research, to explore the juxtaposition of objectivity and subjectivity in research, a particularly relevant debate for me as my own research methods encouraged my "self" to be very present in my research.

My research epistemology was underpinned by the work of Peshkin (1988) who believed that researchers should develop a method for systematically unearthing their subjectivity during the entirety of the research process, not simply exposing it at the end when the research data has been collected, analysed and written up. Peshkin (2001a; 2001b) also believed that subjectivity is always present in one's research and non-research life "like a garment that cannot be removed" (Peshkin, 1988, p. 17). Like Bradbury-Jones (2007), I too adopted Peshkin's theory and explored how the use of a reflective research journal as data provides a means for systematically exploring my subjectivity as a researcher.

Interested in establishing methods for enhancing credibility in qualitative studies, Bradbury-Jones used a research journal to construct an audit trail (Meyrick, 2006; Rolfe, 2006). The journal was used as data to track decisions made throughout the research process, to make explicit research positioning and prejudices (Koch, 2006), and importantly, to enhance rigor by making explicit the influence of the researcher on the research process (Bradbury-Jones, 2007).

From the early days, my research journal was a trusted, safe space. I freely explored questions I had about research, bias, positioning, subjectivity, academic expectations:

> *Sometimes, in my researcher mode, I really feel like I am in trouble: Even like a child sitting outside the School Principal's office, waiting for a "talking to." He said to me: "So, Michelle, how exactly will you recruit then? Snowballing? Will you stick to that or will you take a more casual approach? You know, talk about your research with your community? Direct contact? Recruit that way? Ah…Michelle. That's not allowed, you know? Not favoured in the academic world at all." ... [breathe Michelle…He is an academic colleague who you quite like.]*
>
> *Well, #!#!. Smack my bottom (hah). YES. I…DO…KNOW!*
> *I am boiling over, sitting here. Where did this comment come from? And from a colleague who I hold in esteem and respect! Is this an assumption about me? An assumption about my academic rigor? My capacity? Direct contact. Subjectivity. Can you be objective? Do I know what is expected of me academically?* (MD research journal: shortly after acceptance of my PhD proposal)

My Journal, My Academic Mentor (in the Initial Absence of a Human Mentor)

Despite the fact that I had worked as an academic in the same faculty for several years I had not connected with an academic mentor for research. I had colleagues who were also friends, one of whom worked with qualitative research – the paradigm I aligned myself most closely with. But we were busy with other things, she was already supervising other PhDs and we were aware of maintaining a certain boundary. I needed to talk to another academic about my apprehension, about my sense of self-worth as a researcher. I needed to build my confidence up enough to actually apply for a PhD, but I didn't know anyone in the faculty who I felt I could talk with about those things. At that time academic mentoring was not built in as a formal process in that job and I found it difficult to "confess" to colleagues that I was worried that "I didn't have what it took" to do a PhD and embark on a research career:

> *I am not sure why I feel such an intense sense of lack, a low level of capacity. I feel so confident in other areas of my work, but in approaching a PhD, I feel lacking. Actually, I feel like an imposter. I am not sure I have what it takes to do a PhD, but I want to do one. Without a PhD I really can't progress my academic career – should I even be doing the job I am doing without a PhD? Maybe I am truly an imposter? Can I do this? What does it take to make me feel like I can? What will they think of me if I can't?* (MD research journal: PhD contemplation)

Contemplation. A PhD. Am I Good Enough?

As a first in family academic, I didn't have a relative who had gone before me, someone I could share a conversation with about university level study, about worrying over my capacity for a PhD. There were a couple of Aboriginal and Torres Strait Islander academics in other

faculties at the University, but they might as well have been on the moon. Their work spaces were so overloaded; they were so constantly busy that I felt I would only be an added burden. I was worried that a confession of that type, to a colleague in my Faculty, might create a whole range of unwanted stereotypes (Rochecouste, Oliver, Bennell, Anderson, Cooper, & Forrest 2016; Tarbetsky, Collie, & Martin, 2016) about me:

> *What if I don't get it done? Will I been seen to be lazy? Not up to it academically? What if life gets in the way and really puts up walls- will that be seen as "Aboriginal"- too much chaos and not enough focused effort? I know I will work my #!#! off to do this. Just to prove all of that wrong. Just hope I don't kill myself in the process.* (MD research journal: contemplating PhD)

Stereotype threat (Hickey, 2015; McInerney, 2016; Rochecouste et al., 2016; Tarbetsky, Collie, & Martin, 2016; Wall & Baker, 2012): it was alive and kicking in my head and in my journal:

> *I remember when I really felt inadequate as an academic. A colleague, new to the department, was introduced to me. I was introduced as "This is Michelle. Michelle is an Aboriginal member of our faculty. She is involved in the graduate counselling programs."*
>
> *Hmmm…did that person know I was actually running six graduate programs? They should know- they hold a senior management position in the faculty. I wasn't just involved in them, I was steering the ship!*
>
> *But it wasn't that comment that made me feel inadequate. It was the new member of faculty who replied, "So, Michelle…do you have a university degree, or are you here on a training program?" Grrr…I remember it felt like it took me hours to make my response. Time just stopped.*
>
> *"Actually, I am the program coordinator and lead lecturer for the six graduate counselling programs. I do have a university degree. Actually, I have more than one!"*
>
> *That was hard. Hard to be nice. I didn't really even want to be nice.*
> *But then out it came. Out of the mouth of another colleague who was listening in "Ah, but Michelle doesn't have a PhD. Maybe one day, eh?"*
>
> *BANG. Shot down, left feeling like the imposter in the room otherwise filled with academics. "Maybe one day?" Paternalistic #!#!. Condescending. Made me feel like I was not good enough. Or is that just my own thoughts, about myself?*
> *I need to feel like I can do a PhD. I need to know I can.* (MD research journal: PhD contemplation)

I was raised with a social and community norm that said it is not right to "talk yourself up," nor was it right to "speak up" or challenge one's Elders. Throughout my research journal I reflected on comments made to me by my academic elders to whom, at that point in my academic trajectory, I felt unable to "speak up" to. My research journal played an important role in processing the comments that I felt unable to vocalise. By writing them down I was able to see the merit in making such responses (when I felt I was ready to do so).

And the Advert Read: "Desperately Seeking Supervisor"

Thankfully, in my PhD contemplative period, I found an academic who expressed excitement about my "challenging" research ideas. "James" became my first supervisor[24] and applauded that I was keeping a research journal. I thought that the journal would be a vehicle for me to use, to keep track of my thoughts, keep a record of my progress, a place to record key information. And while all of that was true, James also suggested that the journal could give me space to reflect on some of the cognitive dissonance I was experiencing as a potential PhD student. He also suggested that later it would document my research journey. Tick. PhD candidate and supervisor on the same page.

Early pre-supervision sessions covered deep discussions about qualitative and quantitative research. Interestingly James was a senior academic with almighty expertise in quantitative methods and I was a student of qualitative research. Our supervisory relationship was built upon respect and on reciprocal learning. I felt safe to share some of my journal entries with James and found in him a colleague with whom I could confess my belief that I was an academic imposter:

> *It's funny how differently I am seen by James. After I read out my journal entry today he looked at me and smiled and said something like "You don't see it do you? You really don't see your worth, your mind? Do it Michelle- get the paperwork filled out. Bugger others – remind yourself you want this, and remind yourself you have it in you."* (MD research journal: PhD contemplation)

Many things challenged my self-efficacy. Many journal entries explored doubt, self-doubt, perceptions of public doubt, and evidence of collegial doubt. While my newly appointed supervisor shared wonderful insights with me during early supervision sessions, my extremely poor self-efficacy continued to fill the research journal space.

Step One: Writing a Research Application – Am I in Trouble Already?

> *I am curious about how challenged I feel. As I sit writing up my PhD research proposal I feel both empowered and disempowered at the same time. I am empowered by my enthusiasm and vision of what the research journey will be like, and I feel disempowered by my inability to make my ideas fit into the required*

[24] My PhD was commenced at one University, under the supervision of "James." Sadly, James passed away during my early years of candidature, and I felt the loss. I completed at a new University with a new supervision team.

research proposal template. Are my ideas and methods wrong? Not academic enough? Not rigorous? "How will I maintain objectivity in my research?" Well, that's a great question. How do I answer that one? Do I want to maintain objectivity in my research practice? Is it as clear cut as research being either objective or subjective? So, if I talk about myself with my participants in research, will I dilute my PhD in the eyes and minds of academia? What I do know, is that if I don't Yarn about myself during the research process I will dilute myself. How can my research participants share with me if I don't share with them? To ***not*** *share "me" is disrespectful. #!#! it. The research proposal template needs a rewrite!* (MD research journal: writing a PhD proposal)

As I started to write up my PhD proposal I thought about what the academy would require of me, and how my research might fit. I had lots of questions and took myself off to the University Higher Degree Research advisor to find some answers. My preliminary discussions with the higher degree unit encouraged me to think deeply about research bias and subjectivity:

Well. That was interesting. The advice about "checking in" to make sure my research methodology is sound and transparent was welcomed. I imagine most students get offered that gem. But I wonder if other students get asked questions about juggling personal interactions during research? "You need to think about the position you take when you talk to your research subjects. I mean, you wouldn't want to dirty your data by getting personal. I guess it would be easy to move away from data collection into more of a chat. You need to show us how you would avoid that." Hmm… getting personal. I should have asked him exactly what he meant by that. And of course, I would chat! Oh wow. Am I in trouble already? (MD research journal: pre-submission of research proposal)

I was acutely aware that there was an interesting interplay between the connectedness of my own professional and personal identity and that of the health workers who were part of this research. I was an Aboriginal woman (who also worked in Aboriginal health) researching the working lives of Aboriginal and Torres Strait Islander health workers. I saw that combination as exciting and empowering, but the higher degree unit clearly saw it as a challenge. My chosen research process engaged this identity interplay; it drew upon all parts of my "self" - my gender, my personal history, my professional history, and my Aboriginality. It felt natural to me that these parts of my "self" had to be shared with the research participants, and be part of the research itself (Day, 2002), creating a respectful research space that was highly fluid, albeit challenging of the traditions of academic research (Crick, 2002).

Just as Ochieng (2011) does, I firmly believe that personal and professional identities are shaped by life experiences and similarly that the research process is shaped by our personal and professional identities. My belief system immediately blends the objective and the subjective, seeing them not as oppositional positions but as useful allies in research. Bhopal (2009; 2010) and Phoenix (2000) explored the roles of the personal and professional attributes of the researcher, examining how attributes such as cultural background and gender can influence the research process. They also explored how interconnectedness between the identities of the

researcher and the research participants has potential for methodological and ethical complexities. I was acutely aware of this but didn't perceive there to be any potential negative ethical complexities; rather, I saw the connection between researcher identities and research participant identities as adding a richness or thickness to the research. However, I do believe that very few things are simple and perhaps strangely, I enjoy complexities. My faith in this was not shared at the higher degree unit:

> *So, they told me I needed to be very clear in my PhD application. Clear about me being the researcher and "them" being participants. "me" and "them" – hasn't there been enough "othering" in research? And how can I change who I am anyway? I am Koori. I have a history working in health, in jobs similar to those who I will be Yarning with. Doing a PhD doesn't take any of that away from me. Surely the similarity might even make things more enjoyable for everyone! I am not asking people to tick boxes on a survey, I am asking them to Yarn with me about themselves, their work….and that deserves time and relationship. That's it. They are worried I will have conflicting relationships within my role as a researcher. It's just weird that building that relationship is actually one of the first things I need to do, before any "research" starts.* (MD research journal: The Higher Degree Research Unit)

Finally, My PhD Application Accepted

It felt like a lifetime before my PhD application was approved. A short, stock-standard email advising me that my application had been approved. Nothing personal. The senders had no idea about the impact that short email would have on me, nor could they begin to imagine the depth of my mixed emotions:

> *Approved! Oh God. Here I go…let me be able to do this. Whoever might be looking over me, please help me to get this done. Don't let me fail- don't let those others have reason to say, "I told you so."* (MD research journal: PhD approval day)

Blurred Lines: A New Way of Looking at Subjectivity/Objectivity

As I embarked on my PhD journey I was given advice from several academic colleagues. They had read my research proposal and were concerned that I might not be able to maintain "pure research objectivity," often suggesting that my research methods might encourage a dangerous "blurring of lines" between my personal identity and my professional identity:

> *Get to know your research participants? Eh? That's a bit personal. Ah, but you will, of course, not just walk in and have a chat, or a Yarn as you say? Well, that'd be just dangerous. Think about it, Michelle. There are not too many of us around here who would spend that much time, if any, getting to know research participants.*

> *That's just asking for a dangerous blurring of the lines.* (MD research journal: shortly after PhD approval)

While I listened and understood their position I also sat firmly with my own belief that I would not be able to do respectful research if I did not blur those lines. I know about academic rigor. I respect it. I perform it daily in my job. I know a PhD needs to meet a whole range of standards- ethical, academic, legal, practical. And I am about to "do" a PhD. I know objectivity is believed to produce "clean" research. But if that is true then does subjectivity immediately make research "dirty"? I know my PhD needs to meet the academic standards, but I also know my research methods will make my work "dirty" by definition (Mosselson, 2010). I am not convinced it needs to be that clear cut and my journal helped me to work through my research processes (Alaszewski, 2006) rather than just focusing on research outcome:

> *There is something about the division between dirty and clean data that I don't understand. I mean of course I understand the difference, but why assume the methods I use in my research will dirty things up. It's all about keeping the distance between me (researcher) and the people who are willing to share their lived experiences with me…hmmm...that just does not sit right with me. Any good engagement has reciprocity as the foundation. But perhaps that is the problem. I see this as engagement and others see it as data collection. I am determined for it to be both, determined that I can share while I listen and "gather" (learn). And all in an action of respectful objective subjectivity!* (MD research journal: shortly after PhD approval)

Receiving a Summons: Meet the Ethics Committee Face to Face

I already had received one ethics approval for my first round of Yarns (in depth interviews in other words), and the interactions I had had with the human ethics committee for that were relatively straightforward. Not simple, just straightforward. Mostly the committee was treading very carefully around issues related to research with Aboriginal and Torres Strait Islander people, and I respect that. But after just one round of responding to written questions, my ethics application gained approval.

It was the second application that took me by surprise. I have to admit I was completely shocked when I received a letter requesting that my supervisor and I attend an ethics committee meeting and speak to my second ethics application. I had already answered two rounds of questions about the application, and the committee felt it best to "give [me] the chance to defend my application." It felt terribly official, almost as if I was being asked to attend a court hearing to defend myself, my honour. My supervisor tried hard to dissolve my fear and anxiety, however he had never heard of any such request in his entire academic career:

> *So, James tried hard today to make me feel OK about the request from ethics. But I could see he was almost as puzzled as I was. When he said "OK, I've never heard of this before, never in my whole career," well, it made me feel somewhat unique – and not in a good way. "Don't worry," he said. "We'll just explain what they don't*

> *understand, and it will be fine," he said. I don't have such a sense of "OK" at all. I am terrified.* (MD research journal: seeking ethics approval)

And so, James and I reviewed the application, and reviewed the first review of the application, and the second. I still did not feel OK, but realised that it was something I had to do. And what exactly was the issue? Well, it was all around using photographs in my "data collection" stage. It was about using photos as data, it seemed…but both James and I had another theory. We both agreed that it would be more about photographing Aboriginal and Torres Strait Islander people and workplaces, rather than just photos as data, and we were right.

I thought I would be most anxious about the actual day of the meeting, but that turned out to be less a challenge than I imagined. Sadly, a few days before our scheduled meet and greet with the human ethics committee, James fell terribly ill and was hospitalised. I had to face the squad alone. My turn-around was fascinating. I became more worried about James's health than I was about the ethics committee defense- suddenly that seemed like a walk in the park!

> *I knew James was sick but really didn't think he would be at this point, in hospital. Now that is something to worry about- the ethics meeting just fades, by comparison. I must go and do a great job defending my research proposal- James would expect nothing less. After all, this is what I want to do, what feels right. And I was actually responding to requests from my "participants," my Team Members as I called them.* (MD research journal: seeking ethics approval)

During round one of our Yarning sessions (in-depth interviews) we had all found ourselves drawing or signing with our hands to try and describe something that was hard to place in words. We all discussed how useful it would be to have something visual; you know the old "a picture paints a thousand words" thing. We all felt that to be true and decided that taking photos would infinitely assist in developing our extended Yarning about workplaces and lived experiences of work in the health sector. So, I applied for a second ethics approval, seeking permission for Team Members to take photographs that represented their lived experiences of work:

> *It feels really strange, having to ask an ethics committee for permission to allow the Team Members to take photos of their own work, their own photographs! All of the paperwork is prepared, checked with the legal department even. Nobody will be identified in any photo, nor will any workplace. Every photo will be taken with respect, permission, and dignity – and with signed photo releases! It just doesn't feel right that a committee, who will never meet the Team Members, can say yes or no to their own request to take their own photos. But…I understand. I have set this up with respect and all of my processes follow all of the required cultural, social, legal and academic protocols – but others might not be so vigilant. I understand. It just doesn't feel right.* (MD research journal: seeking ethics approval)

Questioning the Ethics: Mine? Theirs? Others'?

I realised I was experiencing a severe case of cognitive dissonance; I knew I needed to follow the ethics committee requests, but both my head and hart also felt that the process just was not right. Regardless, I fronted the committee, alone and anxious. I sat in the lone chair in front of the semi-circle of desks that housed the large ethics committee. I answered each question in as much depth as possible. And I smiled as much as possible – in fear that if I didn't smile I might just crumble. Some of the questions just sought clarification of my correctly applied protocols and processes. Those questions were easy because I had prepared all of my paperwork perfectly. The questions that I found difficult were ones that cast doubt on my "data collection methods," on the ability of my "participants" to actually take photos that "met with the high ethical requirements of anonymity," and on my "ability to maintain objectivity in my research." However, with each question I took a deep breath and just replied as best I knew how:

> *How could they even ask me if my "participants" would follow the protocols? Why wouldn't they? And the question about the "real need" for an image, when I already had gathered words! And suggesting that I was shirking my research responsibilities by asking the "participants to do [my] research data collection"!!! They really didn't get it.* (MD research journal: seeking ethics approval)

James got a laugh later, as I described how I answered questions for about forty minutes and then was asked to wait outside the room, told that they would need to discuss things before they made a final decision. After waiting for twenty minutes I was called back in, only to be told they needed more time to consider, and advised me that I "would hear from them in due course." And I did, eventually. But it took about four more weeks.

James, My Journal and Me:
Exploring My Academic Identity and Planning for "Data Collection"

While I eagerly awaited ethics approval on my PhotoYarning (Dickson, forthcoming paper "PhotoYarning") application I used my journal to explore my academic identity. James really encouraged me to use the journal for this. Together we used the research journal entries to pull apart my thoughts and feelings about being "an academic." James was worried when I explained I often struggled with juggling an academic identity with my personal identity and my community identity. I talked with James about how I often felt that other colleagues saw me more as "the Aboriginal colleague" and less as an academic colleague. And yet when I was out in community I got more comments about being the "big professor" and less about the personal me. I felt like I constantly juggled my identity. James was concerned that I might need to shift my identity before I went out to interview, or Yarn with, Aboriginal and Torres Strait Islander people working in the health sector:

> *Now I am thinking…. James's suggestion that I felt like I needed to leave my academic identity at the door before I walked in to a room to Yarn with a Health worker puzzled me. Do I think I need to do that? How in the hell can I do that? I am there as a PhD student, attached to a university. That is as much a part of my "self" as other things. I can't take off one coat and put on another, only to replace that*

first coat later on. How bloody confusing! Is that what the research process will make me do?.......So, does the same apply when I come back to my office at uni? Do I take off the coat of "me" that is my Aboriginality and replace it with a coat of academia? I don't think so! At the risk of overheating (hah) I wear all of the coats all of the time. (MD research journal: waiting for ethics approval)

Yarning, Yarning and More Yarning

Visiting the workplaces and communities of the fifteen Aboriginal and Torres Strait Islander Team Members was an honour, but it was not simple. Like Lamb (2013a, 2013b, 2013c) I used to reflect on the challenges and triumphs in my research journal, and talking with my journal like that often helped me to sort out some of the dilemmas that I faced along the way. At times the journal celebrated creative research with me:

What an amazing Yarning session today with [Team Member]. We were both surprised when the kids appeared at her office door after school- we had no idea that time had flown by so fast. It was so fun to pause the Yarn, go help make the kids afternoon tea, have a cuppa[25] while they told us about school, and then get back to the Yarn when the kids were safely playing in the office courtyard. Ahh, now that is data collection at its best! (MD research journal: Yarning)

And at times my journal helped me debrief the "hard stuff":

I knew something was wrong when the young fella met me at the driveway gate. "You Michelle?" "Sure am, hear to see [Team Member] - what's your name?" "Jack. But you can't come see him today. Uncle died. Everyone's gone. Sorry business[26], y'know? I stayed to tell you. And now I will go meet them too. [Team Member] said sorry."

And off he rode on his pushbike. And so, here I am in my room at the local pub, after driving ten hours to get here. Poor Jack. Poor [Team Member], and Uncle. Sadness. I'll have a drink and a feed, and think. And tomorrow I will drive home. And I will wait 'til [Team Member] calls me. He will, when the time is right. And then I will come back. Life. It is short. (MD research journal: Yarning)

My journal also captured some of the situations that might have been considered, by others, as ethical dilemmas:

Journal, I love my research. In the middle of our Yarning today [Team Member's] mum knocked on the door and cam in holding the most beautiful bubba – a hungry

[25] A cuppa is a colloquial term for a cup of tea.
[26] Sorry business is Aboriginal term that refers to the passing of a person. Sad news is a Torres Strait Islander term that refers to the passing of a person.

one! Granny had to suddenly go help someone and couldn't watch bub anymore, so there she was, all gorgeous and hungry in the office with us. And [Team Member] then got called outside to calm down a client who had started to make some noise in the waiting area. And, journal, I got the bubba! Yep, in the middle of our Yarning I had to pause the recorder and feed bub the bottle. I loved it. [Team Member] then returned and switched on the recorder again. She just kept on Yarning and left me to the bottle and burping. Seriously. Can't wait to tell James how happy this Yarning session was. (MD research journal: Yarning)

Juggling Identity. Of Course, I Am Not the Only One Who Does This.

Interestingly, the juggling of identity emerged in the Yarning data – as clear an issue for the health workers in my research as it was for me. It was a familiar story, experienced by me and told over and over again in the research Yarns. This common ground could potentially pose a challenge to the research process – my focus should be on the professional identity stories of the health workers, not on my personal experience of identity juggling. Again, the research journal provided space to explore this dilemma:

He could have been telling my story, but I was listening to him tell his. At work he is the health worker, expected to do his job and not get distracted by phone calls from family, or about community needs. At work he was the health worker, full stop. But after work, in personal time, he still took time to listen to the health needs of people in community. Community saw him as a community member who worked at the health service, so even at a BBQ he talked to people about their health, answering their questions. He didn't turn that part of himself off after work but at work he had to turn off the personal part of himself. Juggling identity. I know this well. (MD research journal: after a Yarn)

However, there were times when the identity juggle worked in favour of all parties:

Am I tired. A HUGE Yarning session with [Team Member] and then a community BBQ! But how much fun was it! When those kids [teenagers] came to the door as we were just finishing the Yarning I could feel that there was something else in store for me…and I was right. They talked to [Team Member] about the youth BBQ night and left to get things set up.

[Team Member] explained that the kids wanted to have a BBQ with the Elders, so they could help the Elders understand more about the importance of sexual health and sexual diversity education. The kids knew how important it was to know about things, but there was some reservation from the Elders. The whole BBQ was set up to help the Elders understand the need, and approve of a new program that would focus on sexual health and sexual diversity. It meant a lot to the kids… [Team Member] must have clued the kids in to my own background in the area, because they had actually dropped in to check I was still here. Little did I know they had

asked [Team Member] to get me behind the BBQ with the Elders, to Yarn with them about "stuff" and help them understand. No pressure, eh? And it was great. Sitting here I can say two things: (1) I smell of BBQ sausages and (2) I juggled my identities so well tonight. (MD research journal: after a Yarn)

And then There Was PhotoYarning

At times my research journal allowed me to critique my own ideas and provided scope for me to debrief when I returned to my hotel room after a PhotoYarning session. I travelled alone on those research trips around Australia and my journal was the next best thing to a debrief with my supervisor at the end of a day:

Amazing sharing of experiences and wisdom. The hard work (and nightmarish logistics) involving gathering of a few Team Members together around a set of photos all paid off. How do other researchers do this without sharing "self," positioning the 'me" in the process? I would feel very cold, clinical, detached if I didn't show reciprocity. When [Team Member] spoke about juggling her young children's needs around her workplace demands, well I had to agree…and my nodding head just invited the rest to ask me how I did it. Imagine if I declined to answer! They'd have walked right away. (MD research journal: PhotoYarning)

The richness we achieved today is amazing. It feels like months of Yarning took place around that one set of photos – and all in one afternoon. There is no way we could have shared such thick and engaging stories without the images and without each other. The whole [process supports sharing, encourages a process that establishes a common ground, common experience that screams "resilience." So much in common. So many gentle nods to acknowledge same/same. So much laughter when sharing good reflections, and so many tears – for many reasons. (MD research journal: PhotoYarning)

Shared Analysis: Working Through My Cognitive Dissonance as a Researcher

PhotoYarning initially was used to gather a richness of lived experiences that words struggled to voice. But quickly I realised it turned in to something so much more – and without a doubt I let it flow into being a natural process of shared data analysis. Of course, my journal helped me work through the cognitive dissonance:

I know this is how it is meant to be, but all I kept thinking about were research colleagues looking down on my process, our process. It was a natural progression. We Yarned about one photo until nobody had anything else to share, and then someone said "So, what does that all mean then?" … and we were off. EVERYONE contributed their thoughts, perceptions, their analysis. It was amazing to be a part of a process that was so collaborative – on the spot shared analysis. And when we reached a group agreement on what might be called an emerging theme, we paused and breathed again. That's when I saw just how excited we all were, how

> *eager everyone was to use the time this way. Who was I to stop this creative research activity? Sublime analysis.* (MD research journal: sharing the analysis)

Reciprocity: It Works for Me and For You

In my research journal I documented the give and take in our shared research process. This was important for me to do, because I consider research never to be a one-way street. Documenting what the Team Members were gaining from the research allowed me to ensure that reciprocity stayed at the core of our research relationship:

> *The PhotoYarning reeked of reciprocity. Team Members were eager to contribute to the process, to analyze the photos in a collaboratively way. Today Team Members pulled me up on saying "thank you" far too often: "What you thankin' us for, sis? We're getting just as much out of this as you are." Clearly this research is giving us all something – and that is exactly how it should be.* (MD research journal: on reciprocity)

And I Wrote Down My Tears

James's illness took an incredible hold and sadly, unexpectedly, James passed away. James had been my anchor, my colleague, my friend, my supervisor. He believed in me when I did not:

> *James. I will finish this. I promised you and you made me promise myself. I am not sure you knew how I appreciated the cup of coffee you would have with me during supervision – when you were on such restricted fluids that cup probably was most of your daily intake. I knew that. I felt privileged to share those cups with you. I am so sad. Deeply sad. Your knowledge and your wit, your honesty and your faith in me – I will miss all of you. Thank you, thank you, thank you.* (MD research journal: James)

James' death influenced me so significantly that I took a leave of absence from my PhD for a time. During that time, I changed jobs, moved to another University. After a settling in period I started to feel inspired by my new colleagues, by their support and encouragement. I found a kindred spirit with a reputation- respect, qualitative research, and patience. I pitched my PhD to her in hope that she might take me on, might encourage me to unpack the actual boxes of research paper and open the symbolic vault that had shut tight with James's passing. She was a brave woman. She became my new supervisor. After several years of helping me patiently chip away at the boxes and vaults she took a brief leave of absence – although she never removed herself fully from the supervisory relationship.

While she was living other parts of life she entrusted my supervision to two other kindred souls, colleagues who also have given me patience, deadlines, and support beyond expectation. I now have two amazing women supervising my PhD completion.

Discussion: Advocating for the Use of a Research Journal

Importantly a research journal can be the reflective tool that assists a researcher to build research self-efficacy, particularly in the absence of other support systems. Like Davidson (2012) my research journal helped me to reflect on the cognitive dissonance I was experiencing between objectivity and subjectivity in research. My journal allowed me to understand that, for my research, there was no one answer to the objectivity/subjectivity debate. My reflective journaling helped me to find my own position on that debate; by using my journal I was able to bring the issues of subjectivity/objectivity to the surface, to name them, make them public. In the process I had my own research ethics confirmed. My reflective journal entries helped the Koori academic in me find a space to name the value a subjective connect with the research process had for me, and by naming that I felt less like an academic imposter. I wish the same for any PhD student.

A research journal provided me with a reflective approach, allowing me to write about my research experiences, choices, assumptions, ideas, and actions (Mruck & Breuer, 2003). Choices that I was making throughout the research journey were really visible to me as I wrote them down on the pages of the research journal. In turn, the reflective practice of journaling allowed me to see how my decisions and choices were constructing my research outcomes (Borg, 2001; Mruck & Breuer, 2003). James commented about how the process of journaling was providing acknowledgement of my values as a researcher. It provided a reflective space to clarify what Davidson (2012) called the "I" in research. Initially we both saw the research journal as just that. However, it also encouraged me to sit well with the cognitive dissonance that was causing me grief that had me feeling like an imposter in the academy. I found security in the ease by which I shaped my research process and methods, using my journal reflections as evidence to support my decisions. I had found a way to embrace the familiarity I had with my Team Members' lived experiences without creating a negative impact on the research itself (Berger, 2015).

Still an Imposter in the Field of Academic Research?

My new supervisor ever so gently questioned whether my research journal was, in itself, data. At first, I was afraid to admit that I already knew it was, but I didn't let that fear stop me from answering "Yes, yes, it is." That response is highly significant. When did I become confident enough as an academic, a researcher, to make that brave statement? I wouldn't have answered that if James had asked that of me. Had my imposter academic self stepped aside and made room for an emerging Koori early career academic with creative research methods? Hell, yes.

References

Alaszewski, A. (2006). *Using diaries for social research*. Thousand Oaks, CA: Sage.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234.

Borg, S. (2001). The research journal: A tool for promoting and understanding researcher development. *Language Teaching Research, 5*(2), 156-177.

Bradbury-Jones, C. (2007). Enhancing rigour in qualitative health research: Exploring subjectivity through Peshkin's I's. *Journal of Advanced Nursing, 59*(3), 290-298.

Clarke, K. A. (2009). Uses of a research diary: Learning reflectively, developing understanding and establishing transparency. *Nurse Researcher, 17*(1), 68-76.

Crick, M. (2002). Shifting identities in the research process: An essay on personal anthropology. In J. Perry (Ed.), *Doing fieldwork: Eight personal accounts of social research* (pp. 24-40). Sydney, Australia: University of New South Wales Press.

Davidson, J. (2012). The journal project and the I in qualitative research: Three theoretical lenses on subjectivity and self. *The Qualitative Report, 17*(32), 1-13. Retrieved from http://nsuworks.nova.edu/tqr/vol17/iss32/1

Day, E. (2002). Me, my*self and I: Personal and professional re-constructions in ethnographic research. *The Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 3*(3).

Hickey, S. D. (2015). "They say I'm not a typical Blackfella": Experiences of racism and ontological insecurity in urban Australia. *Journal of Sociology, 52*(4), 725-740. doi:1440783315581218

Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing, 53*(1), 91-100.

Kovach, M., Brown, L., & Strega, S. (2015). Emerging from the margins: Indigenous methodologies. In L. Brown & S. Strega (Eds.), *Research as resistance: Revisiting critical, indigenous, and anti-oppressive approaches* (pp. 19-36). Toronto, Ontario: Canadian Scholar's Press.

Lamb, D. (2013a). Research in the first person: Reflection on the research experience using a research journal. *Market & Social Research*, *21*(2).

Lamb, D. (2013b). The Research Journey: Why it is Important to Think About it and Record it, as a Vehicle to Becoming a More Competent and Effective Researcher. In *ECRM2013-Proceedings of the 12th European Conference on Research Methods: ECRM 2013* (p. 178). Academic Conferences Limited.

Lamb, D. (2013c). Promoting the case for using a research journal to document and reflect on the research experience. *Electronic Journal of Business Research Methods, 11*(2), 84-92.

Leeson, S., Smith, C., & Rynne, J. (2016). Yarning and appreciative inquiry: The use of culturally appropriate and respectful research methods when working with Aboriginal and Torres Strait Islander women in Australian prisons. *Methodological Innovations, 9*. doi:2059799116630660

McInerney, D. M. (2016). Indigenous issues in education and research: Looking forward commentary. *Contemporary Educational Psychology*, *47*, 1-3.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology, 11*(5), 799-808.

Mosselson, J. (2010). Subjectivity and reflexivity: Locating the self in research on dislocation. *International Journal of Qualitative Studies in Education, 23*(4), 479-494.

Mruck, K., & Breuer, F. (2003). Subjectivity and reflexivity in qualitative research—The FQS issues. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *4*(2).

Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report, 13*(4), 695-705. Retrieved from http://nsuworks.nova.edu/tqr/vol13/iss4/8

Peshkin, A. (1988). In search of subjectivity—One's own. *Educational Researcher, 17*(7), 17-21.

Peshkin, A. (2001a). Chapter One: Ten Common Issues for the Beginning Researcher. *Counterpoints*, *112*, 3-19.

Peshkin, A. (2001b). Angles of vision: Enhancing perception in qualitative research. *Qualitative Inquiry*, *7*(2), 238-253.

Phoenix, A. (2000). Practising feminist research: The intersection of gender and “race” in the research process. In K.-K. Bhavnani (Ed.), *Oxford readings in feminism and “race”* (pp. 203-219). Oxford, UK: Oxford University Press.

Robson, C., & McCartan, K. (2016). *Real world research.* Hoboken, NJ: John Wiley & Sons.

Rochecouste, J., Oliver, R., Bennell, D., Anderson, R., Cooper, I., & Forrest, S. (2016). Teaching Australian Aboriginal higher education students: What should universities do? *Studies in Higher Education, 42*(11), 2080-2098.

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing, 55*(3), 304-310.

Snowden, M. (2015). Use of diaries in research. *Nursing Standard (Royal College of Nursing), 29*(44), 36-41. doi: 10.7748/ns.29.44.36.e9251

Tarbetsky, A. L., Collie, R. J., & Martin, A. J. (2016). The role of implicit theories of intelligence and ability in predicting achievement for Indigenous (Aboriginal) Australian students. *Contemporary Educational Psychology, 47*, 61-71.

Tuitt, F., Hanna, M., Martinez, L. M., del Carmen Salazar, M., & Griffin, R. (2009). Teaching in the line of fire: Faculty of color in the academy. *Thought & Action, Fall,* 65-74.

Walker, M., Fredericks, B., Mills, K., & Anderson, D. (2014). “Yarning” as a method for community-based health research with indigenous women: the indigenous women's wellness research program. *Health Care for Women International, 35*(10), 1216-1226.

Wall, K., & Baker, M. (2012). Race and education: Hidden links between media and Indigenous academic self-concept. *Journal of Student Engagement: Education Matters, 2*(1), 54-63.

Wilkie, M. (1997). *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Sydney, Australia: Human Rights and Equal Opportunity Commission.

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Appendix D: Aboriginal and Torres Strait Islander Health Workforce Strategic framework (2017): A summary of the five core principles

The following falls under the principle of “Centrality of Culture”:

- Effective, comprehensive and culturally-safe and responsive approaches to service delivery should have the flexibility to reflect the local context and the diversity of Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander health workforce participation is an essential element within all health workforce initiatives, settings and strategies.
- Cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander people are respected in the delivery of culturally-safe and responsive health services.
- Aboriginal and Torres Strait Islander health workforce initiatives, and the wider health system, acknowledge and respect a holistic view of health that includes attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance
- Cultural knowledge, expertise and skills of Aboriginal and Torres Strait Islander health professionals are reflected in health services models and practice (p.6)

Under the principle of “Health Systems Effectiveness” the Plan (2017) proposes:

- Developing a health workforce with appropriate clinical and cultural capabilities to address the health needs and improve the health outcomes of Aboriginal and Torres Strait Islander people is central to increasing access to health services that are effective, high quality, appropriate and affordable.
- Appropriate ongoing professional development and training that is recognised, supported and resourced is essential to achieving this.
- Workplaces must be free of racism, culturally-safe, supportive and attractive to the Aboriginal and Torres Strait Islander health workforce (p.6).

The principle of “Partnership and Collaboration” calls for:

- Respectful and effective partnerships and collaboration between Aboriginal and Torres Strait Islander peoples, government and non-government sectors (within and outside the health sector) that recognise

the need for community-led initiatives, with shared commitment and responsibility, are required when designing and implementing programs to grow and develop the Aboriginal and Torres Strait Islander health workforce in both clinical and non-clinical roles.

- Ongoing inter-professional collaboration, education and support is essential to build a strong and sustainable Aboriginal and Torres Strait Islander health workforce.
- All stakeholders, including the Aboriginal and Torres Strait Islander health workforce and communities, must be actively included in decision making (p.7).

The principle of "Leadership and Accountability" advocates for:

- Strong quality Aboriginal and Torres Strait Islander leadership at the senior manager and executive levels is essential to planning and designing culturally-respectful health care services for Aboriginal and Torres Strait Islander people.
- Intentional leadership and talent development initiatives are required to advance Aboriginal and Torres Strait Islander people in both targeted and mainstream positions.
- Creation of structured career pathways is a vital element in leadership development and retention of Aboriginal and Torres Strait Islander employees.
- Commitment to achieving a culturally proficient and safe health workforce must come from the top and then filter down through the different levels of each organisation. This is key to growing the Aboriginal and Torres Strait Islander workforce, and will require sound policy, budgetary directions and strong leadership across governments.
- Strong leadership from both Aboriginal and Torres Strait Islander and non-Indigenous health professionals is essential in building social participation and eliminating racism from the health system. Commitment and accountability across and between all levels of government and non-government sectors are critical requirements to support health workforce strategies.
- Workplaces must be encouraged to attract and develop Aboriginal and Torres Strait Islander people across all levels of the organisation, including management and representation in governance arrangements (p.7).

And the final principle, "Evidence and Data" proposes:

- Workforce models and strategies are needed to develop an effective Aboriginal and Torres Strait Islander health workforce. They must be based on community needs and evidence-based practice, which is supported by meaningful and reliable data (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017, p. 7)