

SCHOOL OF NURSING, MIDWIFERY AND PARAMEDICINE

**Facilitating equity in mental health outcomes for Aboriginal people
within mainstream mental health services in
Western Australia: A grounded theory study**

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**This thesis is presented as part of the requirements for
the award of the degree of Doctor of Philosophy**

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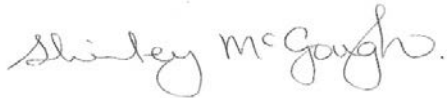
DECLARATION

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval South Metropolitan Area Mental Health Service Hospital Ethics Committee, HREC reference number 11/7 and from Curtin University Human Research Ethics Committee (EC00262), Approval Number: SON&M 35-2010.

Signed:

A handwritten signature in cursive script that reads "Shirley McGough".

Date: 1/12/2015

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There are many people to acknowledge who have supported me in this research. Many PhD studies are quoted as “journeys” and mine was no exception. However my journey took a major detour that threatened to derail it completely. However the assistance of many has supported me to complete this study and I appreciate it immensely.

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POSITIONING MYSELF WITHIN THE CONTEXT OF THIS RESEARCH

Cultural safety requires self-awareness of one's own cultural and positioning and how this may influence the provision of care to another person. It is therefore important to position myself in this research. During the course of this study, I was often asked "how did you get involved in this area?" It was also posed to me "what's a white woman" doing undertaking research in this area. Indeed it was a question I reflected on myself along with the personal and professional ambitions of undertaking this research.

I am the eldest child of an Irish mother and Scottish father. My parents met in Ireland, where I was born, before immigrating to Australia in the early 1970s. Growing up in Australia, I truly identified as being a "typical Aussie". As I matured into adulthood, although my links to my heritage remained strong, I still identified as an Australian and became a citizen in the 1980s and I have the certificate to prove it! While undertaking the research, I reflected on my knowledge of the history of Australia. Probably like most of my peers, I do not recall much being presented at school about colonisation of Australia or Indigenous people and culture. Of course we were informed that the Australian Indigenous people were the original inhabitants of Australia, but no discussion ensued around the impact on them of colonisation. Information on Indigenous culture at school was limited to idealised stories of "the dreamtime" provided by non-Indigenous teachers.

My interests in psychological health and emotional wellbeing prompted me to specialise in the area of mental health. With the move to academia, an opportunity arose to join an National Health Medical Research Council (NHMRC) funded capacity building grant at Curtin University called: "Building Mental Wealth: Improving the mental health outcomes for Aboriginal Australians" It was on joining this group and engaging with Indigenous and non-Indigenous academics and research students like myself, that I identified my topic of PhD research. As I read widely about mental health outcomes for Indigenous people, it became evident that there was a considerable gap in understanding amongst non-Indigenous health professionals of the issues of mental health and wellbeing for Indigenous people. This was a motivation for the focus of my PhD and was suited to my background as a mental health professional.

Engaging in the research, this study initially challenged my identity as an Australian. Recognising Australia's history, the treatment of Indigenous people and the governmental

controls placed on them raised emotions of sadness and shame. I later recognised this as feelings of “white guilt” and I also questioned what it meant to be an Australian. Was I really as proud to identify as an Australian, given the history of the last 200 years? I also questioned my relevance as an immigrant to this country. However, through this journey I have realised that these negative feelings can be barriers to opportunities to a concerted attempt to address the inequities in mental health outcomes for Indigenous people. As mental health professionals, it is about understanding the past, accepting it, critical reflectivity of clinical practice and engaging in practices that provide meaningful and safe mental health care for Indigenous people. I hope in some small way this thesis contributes to this end. I remain a proud Australian.

ABSTRACT

Indigenous people suffer a higher burden of emotional distress and associated mental health problems than non-Indigenous Australians, yet they do not engage with mainstream services and are less likely to receive timely and meaningful treatment interventions. This is attributed to the failure of these services to provide culturally safe care. Originating in New Zealand, cultural safety acknowledges cultural beliefs and the impact of colonisation on Indigenous groups. The concept of cultural safety is particularly relevant to mental health professionals as it seeks to promote cultural integrity, while supporting recovery based practice and the promotion of social justice, equity and respect.

While much has been written around the concepts of cultural safety and the related concept of cultural competency, it has not contributed to the understanding of non-Indigenous mental health professionals' multi-dimensional experience of providing culturally safe mental health care within mainstream mental health services. The purpose of this study was to develop a substantive theory that explores the provision of culturally safe care in a mental health setting and identify factors that inhibit or facilitate that experience. Using grounded theory methodology, this study presents the findings of interviews from 28 mental health professionals and memos documented through the study. Additionally, literature relevant to the findings of this study is also presented.

A substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* is presented in this thesis. Using the grounded theory method of constant comparative analysis of data revealed that the basic social psychological problem shared by participants was the experience of *being unprepared*. The problem of *being unprepared* consisted of two stages: "disruption to self-awareness" and "fluctuating emotions". Four conditions were identified as influencing the experience of *being unprepared*.

To address the problem of being unprepared, participants engage in a basic social psychological process of "*seeking solutions by navigating the labyrinth*". When participants engaged in this process, they moved from a state of *being unprepared* to one where they began to navigate the pathway to cultural safe practice. The process of "seeking solutions by

navigating the labyrinth” consisted of four phases: “neutralising the difference”, “taking the next step”, “seeking new solutions” and “becoming a culturally safe practitioner”.

At the time of being interviewed for this study, some participants were not fully engaged in the final phase of the process of *seeking solutions by navigating the labyrinth* and three conditions were identified as influencing the movement through this process.

This thesis presents the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. While the findings from this study support existing empirical literature, the substantive theory also presents new perspectives on providing culturally safe care from the viewpoint of the mental health professional. The findings of this study have implications for service providers, clinical practice, policy and planning, research and education and Aboriginal patients and other key stakeholders.

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PART ONE

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

CHAPTER 2

METHODOLOGY: THE GROUNDED THEORY METHOD

CHAPTER 1 - INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction and background

Disparities exist in the health outcomes between Indigenous and non-Indigenous Australians and notably in the area of mental health and wellbeing. Australia's national Close the Gap Campaign was developed by the Steering Committee for the Close the Gap campaign for Indigenous Health Equality (2008) to address the gap in life expectation and health inequalities for Indigenous people. This campaign was in response to the Social Justice Report by Australia's Human Rights and Equal Opportunity Commission (2005). The recent progress and priorities report of this campaign by the Close the Gap Campaign Steering Committee (2014) stated that there is a mental health crisis for Indigenous people that must be addressed. Indigenous people report high levels of psychological distress and associated mental health problems, however mainstream mental services are criticised for not addressing the specific cultural needs of this group. There remains a large gap between policy and practice with many mainstream services failing to provide holistic or culturally sensitive care. Indigenous people report that mainstream health services are unwelcoming and alienating, due to attitudes from staff, unfamiliar environments, lack of continuity of care, lack of information, and cultural, linguistic and educational differences (Hunter, Gill, & Toombs, 2013; Johnston & Kanitsaki, 2009). Mainstream services continue to be the primary provider of health care for Indigenous Australians and therefore there is an urgent need to improve the cultural sensitivity of these services, to improve accessibility for Indigenous people so they may feel welcomed and supported (Hunter et al., 2013, p. 219). It is within this context that this study explores the experiences of health professionals' in their provision of care to Aboriginal people.

This thesis utilised the grounded theory method to explore mental health professionals' experiences of working with Aboriginal people in mainstream mental health services. Chapter one provides the reader with important contextual information about the research and issues that are identified in the current literature. It details background information about the concepts of health and wellbeing and the disparities in Australian Indigenous health, particularly mental health and wellbeing. The chapter also discusses the delivery of mental health services in Australia and the issue of cultural safety. Finally, the scope and aim of the

study is outlined along with the research questions.

1.2 Health and wellbeing

Health is a dynamic concept with different meanings that are dependent on the context in which the term is used (Allen, 2010). How an individual defines health will vary according to their perceptions and relative to their age, gender, education, personal experiences and cultural background (Keleher & MacDougall, 2009). The World Health Organization (WHO) (1948, p. 100) defined health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. Despite the longevity of this definition, it is still well accepted today. Rattan (2013, p. 673) expands on this definition describing health as a “state of complete physical and mental independence in activities of daily living”. These definitions acknowledge the multiple dimensions to health, namely physical, mental, social and spiritual. Social dimensions to health, including links with family and friends, communication, social inclusion, employment, all influence health outcomes and are in turn affected by a person’s socio-economic status, gender, ethnicity, cultural customs, expectations and social economics of the environment (Allen, 2010). Thus social and economic circumstances, family and other personal interactions and the environment all contribute to the health of an individual. The health of the physical body is only one aspect of health. Mental health is an essential dimension of overall health and the capacity of an individual’s mental health and wellbeing, social supports and relationships can influence physical health outcomes. Mental health and physical health are explicitly connected and people experiencing serious mental illness are at a higher risk of also experiencing a variety of chronic conditions (Hert et al., 2011). Equally, those with a chronic physical illness also experience high rates of depression and anxiety. Poorer mental health is a risk factor for chronic physical conditions; those with serious mental health illness are at high risk of experiencing a chronic physical illness; and people with chronic physical conditions are at risk of experiencing poorer mental health (Robson & Gray, 2007; Scott & Happell, 2011). Prince et al. (2007) suggests that the burden of mental illness is possibly underestimated due to the insufficient recognition of the connection between mental illness and other health conditions.

1.3 No health without mental health

Good mental health is essential for overall health and wellbeing and consequently the WHO stipulates (2005) there is no health without mental health. Mental health is subjective and dependant on an individual's context and experience. Mental health incorporates a person's thoughts, emotions and behaviour. Elder, Evans, and Nizette (2009, p. 477) define positive mental health as;

“A state in which the individual has a positive sense of self, personal and social support with which to respond to life's challenges, meaningful relationships with others, access to employment and recreational activities, sufficient financial resources and suitable living arrangements”.

As with other dimensions of health, mental health can be influenced by a range of socio-economic factors. The WHO mental action plan 2013-2020 (2013) states that determinants of mental health include not only individual characteristics such as the ability to manage thoughts, emotions and relationships with others, but also social, cultural, economic, political and environmental factors. Casual associations exist between physical and mental health and wellbeing. Mental illness is associated with an increased risk to other threats to health including, poorer physical health and higher rates of death from several aetiologies including suicide (Australian Institute of Health and Welfare (AIHW), 2014a).

Certain individuals and communities may be more vulnerable to mental health conditions. According to WHO (2013), those at risk may include, those living in poverty, violence, chronic illness, minority groups, indigenous people, older adults, gay, lesbian, bisexual and transgender people and those exposed to conflict or disaster. Good mental health is linked to a range of positive outcomes including improved health status, higher educational opportunities, enhanced employment opportunities, closer social connections, improved interpersonal and family life and general improved quality of life. Further, positive mental health is also essential for managing adversity and conversely, poorer mental health hinders a person's capacity to positively engage in life to one's full potential and to contribute to their community (WHO, 2010). Mental health infers that the individual has the ability to engage with others, to perform social roles meaningful to their culture and manage change, recognise, acknowledge and communicate positive actions and thoughts as well as a range of emotions (Bhugra, Till, & Sartorius, 2013, p. 3). Mental illness or mental disorder describes an illness diagnosed according to the psychiatric classifications of the Diagnostic and Statistical Manual 5 (DSM-5) (American Psychiatric Association, 2013) or the International Classification of Diseases 10 (ICD-10) (WHO, 1992), that impairs a person's cognitive, emotional and/or social capabilities (Muir-Cochrane, Barkway, & Nizette, 2014).

Historically, mental health and substance use disorders were not seen as global health priority areas, particularly when compared to cardiovascular disease and cancers. Mental health disorders and substance disorders contributed to 7.4% of the global disease burden worldwide (Whiteford et al., 2013). The impact of mental disorders is further compounded by the associated effects on physical health, social wellbeing, stigma and discrimination, educational and social opportunities, thus perpetuating a cycle of marginalisation and socio-economic disadvantage (WHO, 2010). The burden of disease as a result of mental disorders is a global concern with the economic burden associated with mental disorders exceeding those associated with each of the other four major categories of non-communicable disease: diabetes, cardiovascular disease, chronic respiratory diseases, and cancer (Bloom et al., 2012). Mental disorders are highly prevalent globally affecting people across all regions of the world with one in five persons experiencing “a common mental disorder within a 12 month period” (Steel et al., 2014, p. 15). National figures confirm that one in five Australians will experience a mental illness in any given year (Department of Health and Ageing, 2013). Mental illness is one of the four leading causes of burden of disease and injury in Australia along with cancer, musculoskeletal disorders and cardiovascular disease, with mental illness accounting for 13% of the total burden of disease (AIHW, 2014a). People with mental illness experience higher rates of morbidity and mortality (WHO, 2013) with the risk exacerbated by the increased incidence of smoking, alcohol and other drug dependence and inadequate exercise and nutritional state in people experiencing serious mental illness (Morgan et al., 2012). As mental health problems are associated with higher rates of mortality, morbidity and increased exposure to health risk factors, they are regarded as a national health priority area (Tomlin & Joyce, 2013, p. 37).

People experiencing a mental illness are also at an increased risk of self-harm and suicide. Among young people worldwide, suicide is the leading cause of death (WHO, 2013). The mortality rate for people with a mental illness with other comorbid chronic illness is two point five times higher than the general population. Figures show that 1 in 100,000 deaths in Australia are attributed to suicide with the 75% of these deaths being male and 25% female (Australian Bureau of Statistics, 2015a). Those particularly at risk of suicide include people with a previous history of suicide attempt; those experiencing major depression or psychosis; excessive alcohol and or drug use; males and in particularly young Indigenous men. The higher rates of emotional distress and mental health related conditions in Australia’s Indigenous population has been well documented (Australian Indigenous HealthInfoNet

2015). Indigenous Australians are also at greater risk of morbidity and mortality from mental health related conditions (WHO, 2010).

1.4 Aboriginal people of Western Australia

Many names have been used to describe the Australian Indigenous Peoples since colonisation. The name “Aborigine” was used to describe the Indigenous people of Australia from the late 1700’s. However, the use of “Aborigine” or “Aboriginal(s)” has had negative inferences in some communities and can be regarded by them as offensive. The phrase “Indigenous Australians”, which also includes the Torres Strait Islander people, became popular in the 1980s. However, some groups are also opposed to this term (Taylor & Guerin, 2010). In Western Australia, the Noongar people who are the custodians of the land where this research was completed, prefer to be called Aboriginal Australians (Collard & Bracknell, 2012; Harben, van den Berg, & Collard, 2004) and for this reason the word “Aboriginal” is also used in all Western Australian government documents and correspondence. In keeping with this protocol, the word Aboriginal is used throughout this thesis unless the researcher is referring to Australia wide issues related to Aboriginal and Torres Strait Islander people. In those instances, the term Indigenous will be used. There is no disrespect intended to Aboriginal people living in other areas of Australia or Torres Strait Islanders.

Western Australia is the largest state in Australia accounting for one third of the land mass of the continent and supports less than 10% of the national population. Recent figures estimate the population of Western Australia at 2.57 million people with 79% living in the area surrounding the capital city, Perth (ABS, 2015b). In 2011, the estimated Aboriginal population residing in Western Australia was 88, 277, with more than 335 of the Aboriginal population living in the Perth metropolitan area (Australian Indigenous HealthInfoNet 2015). Noongar people are made up of 14 different language groups and each of these language groups is as diverse as the different ecological and geographic distinctions (South West Aboriginal Land and Sea Council, n.d.). Noongar people first came into contact with Europeans around 1825, following the establishment of a military base in at King George Sound in Albany and the ensuing colonisation of the Swan River area around Perth. Unlike other states in Australia, Western Australia was not settled as a penal colony, and there was a great demand for land from colonists. Much of the area taken by settlers had important ceremonial and economic meanings to Noongar people and many Aboriginal people were

killed in the struggle for land. Attempts of Aboriginal resistance were met by imprisonment on Rottneest Island, an island 19km off the coast or removal to remote areas and often off country (Australian Indigenous HealthInfoNet 2015; Green, 2011).

1.5 Indigenous perspectives of health and wellbeing

The global dominance of the Western medical system focuses on the bio-medical model of health and does not necessarily reflect Indigenous perspectives. While Western views of health and wellbeing stem from a biological model, Indigenous perspectives of health encompass social and cultural contexts (Taylor & Guerin, 2010). Social, emotional, cultural and spiritual wellbeing is a term that has come to embody the Indigenous expression of holistic health, mental health and wellbeing. This term endeavours to incorporate the expanded concept of self that involves essential relationships with others and the environment. Within this concept of health, it acknowledges that optimum health relies on a holistic view of health which embraces the social, emotional, spiritual and cultural wellbeing of the entire community (AIHW, 2009). It is this holistic view of health that reflects the Indigenous experience and perspective about the relationship between health and wellbeing and the correlation between the individual, their community, traditional land, kinship, ancestors and spirituality (AIHW, 2014b). Consequently, for Indigenous people, health encompasses not just the absence of illness, but healthy symbiotic relationships between family, community, land, sea and the spiritual world (Australian Indigenous HealthInfoNet, 2015).

1.6 Indigenous perspectives of mental health and wellbeing

For Indigenous people, mental health is embedded in a larger framework related to culture, historical events, social change and coping (Taylor & Guerin, 2010). Hellsten (2015) differentiates between mental illness and social and emotional distress, suggesting that the latter is a result of long-term socio-political disadvantage, which unlike mental illness, is not likely to be relieved by medical interventions. Ypinazar, Margolis, Haswell-Elkins, and Tsey (2007) explored Indigenous Australians' understandings regarding mental health disorders and found that it included the interactional and interrelated associations between multiple aspects of life's circumstances. In this review, Indigenous views of mental health shared

common themes including; culture and spirituality; family and community bonds; historical and socio-economic factors; fear and education and loss. Indigenous perspectives of mental health include the totality of an experience, including physical, mental, emotional, spiritual and cultural wellbeing (Westerman, 2004) and social and emotional wellbeing is central to the holistic view of health. It encompasses the connection between the physical, mental, emotional, spiritual and cultural wellbeing and the responsibility to self, community and land (Garvey, 2008; Ypinazar et al., 2007).

Western views and assumptions of mental health and wellbeing, with approaches and interventions including a “one size fits all” approach, have been challenged by several Indigenous and non-Indigenous academics and clinicians (Vicary & Westerman, 2004a) who highlighted the shortcomings in the ability of mainstream services to adequately address the health and wellbeing needs of Indigenous people (Vicary & Bishop, 2005; Westerman, 2010). Summerfield (2013, p. 346) adds that the notion of a global view of mental health is “an oxymoron and medical imperialism”. The disparities in health outcomes between Indigenous and non-Indigenous Australians are driven by socio-economic factors, racism and history (Waterworth, Rosenberg, Braham, Pescud, & Dimmock, 2014). The relationship between social justice and Indigenous health outcomes is obvious when viewed in the historical context of government policies aimed at Aboriginal people (Hellsten & Hakiha, 2012).

1.7 Historical impact on Indigenous health and wellbeing

Prior to British colonisation of Australia, it is estimated that Indigenous Australians lived in Australia for between 40,000 and 60,000 thousand years. In 1770, British Lieutenant James Cook took possession of the east coast of Australia for the British Crown. In an attempt to reduce the overcrowding of British prisons, and to assert Britain’s claim over the territory, a penal settlement was first established in 1788 in the area around Sydney Cove (West & Murphy, 2010). Colonisation of Australia by the English under the premise of “terra nullis” [empty land] completely ignored the original inhabitants and discounted their human rights (Hellsten & Hakiha, 2012; Taylor & Guerin, 2010). It is estimated that Indigenous population decreased by 90% between 1788 and 1990, with the main reasons for the decline including, the introduction of new diseases, settler possession of Indigenous lands, and violent conflict (Harris, 2003). Colonisation by the British had devastating consequences for

the health, wellbeing and survival of the Australian Aboriginal population and the experiences with white Australians has been marked by a history of violence, dispossession, genocide, introduction of disease, oppression, racism and stolen generations. Today, the impact of colonisation continues to effect individuals, community and all aspects of Aboriginal culture (Dudgeon, Wright, Paradies, Garvey, & Walker, 2010). It has been this cycle between these inequalities and that has continued to impact on the disadvantage experienced by generations of Indigenous people (Zubrick et al., 2014).

Policies impacting Indigenous Australians were instigated from the 1890's. Segregation formed the basis of this period, with missions and reserves established under the ideology that Aboriginal people required "protection", however it was also a period of protecting non-Indigenous people from the perceived threat from Indigenous people (Hellsten & Hakiaha, 2012). Violence towards Aboriginal people and dispossession of land also followed during this period. The Western Australian Aborigines Protection Act (1886) led to segregation and forced removal of Aboriginal children from their families and allowed the government of the day complete control over all facets of their lives. Children were denied their families, culture, customs and spiritual beliefs and language (Hellsten & Hakiaha, 2012). This was followed by a focus on integration between 1969-1972. Self-determination reforms were initiated during 1972-1975, with self-management policies from 1975-1996. From 1996 to 2007, a period of reconciliation followed as a time for mutual obligation and new assimilation. In 2008, the National Apology to the Stolen Generations and Indigenous Australians (Rudd, 2008) by the Prime Minister, Kevin Rudd finally acknowledged the negative impact of past government policies (Taylor & Guerin, 2010). This apology was an important step towards respectful new relationships between Indigenous and non-Indigenous Australians (Reconciliation Australia, n.d.-a).

The impact of colonisation and the historical government policies have resulted in poor health outcomes for Indigenous people including, shorter life expectancy, higher levels of chronic illness, limited education, higher unemployment, higher rates of imprisonment particularly amongst males, and poorer standards of housing (Taylor & Guerin, 2010). Social and economic disadvantage as a consequence of Australia's history of dispossession, racism and discrimination also places Indigenous people at higher risk of incarceration in prisons (Blair, Zubrick, & Cox, 2005). Indigenous people are over-represented in the prison setting and represent 25% of the total prisoner population (AIHW, 2009), despite comprising of only 2.3% of Australia's population. Aboriginal prisoner numbers also increased by 10% between

2008 to 2009, with Western Australia having the highest ratio of Aboriginal to non-Indigenous imprisonment rates in Australia at 20 higher than non-Aboriginal people (Kriege, 2006). Higher rates of incarceration place further health, social and financial burdens on individuals and their families (Blair et al., 2005; Kriege, 2006).

1.8 Disparities in Australian Indigenous health

While Australia's health care system and the population health outcomes rank highly internationally, the gap between the health and wellbeing of Indigenous and non-Indigenous Australians remains unacceptably wide with a disparity across all health statistics (Cooke, Mitrou, Lawrence, Guimond, & Beavon, 2007). Australia's history of colonisation and past government policies is now widely acknowledged as being a major determinant of Aboriginal and Torres Strait Islander health outcomes that exist today. The determinants of health are diverse and include social, historical, political as well as education, housing, employment, socio-economic status and racism (Newman et al., 2013). The disparity in health outcomes for Indigenous people compared to the non-Indigenous population is well recognised and this is due to the higher rates of chronic diseases, including respiratory disease, hearing and ear disease, heart and circulatory disease, diabetes and higher blood pressure (ABS, 2013a).

Indigenous Australians are recognised as having the poorest health within Australia and some would suggest the developed world (Taylor & Guerin, 2010). They not only experience poorer health outcomes compared to non-Indigenous Australians, but also when compared to the health of Indigenous people in other countries such as New Zealand and Canada (Booth & Carroll, 2005). Life expectancy is lower in the Indigenous population at 67.2 years for Indigenous males compared to 78.7 years for non-Indigenous males and 72.9 years for Indigenous females, compared to 82.6 years (AIHW, 2011). This disparity of life expectancy of between 11-12 years has remained stable since the 1980s (Phillips, Morrell, Taylor, & Daniels, 2014). Indigenous Australians have a higher death rate than non-Indigenous Australians across all age ranges, dying at five times the rate of the general population (AIHW, 2014a). Additionally, infant deaths in Indigenous children were 13% of the total number of infant deaths in Australia; however this rate reflects a fall in the rate during the period between 2001-2012 (AIHW, 2014a). During the period 2007–2011, Indigenous Australians were more likely to die from circulatory disease, (26% of all deaths), cancer (19%), and other causes such as suicide, falls, motor accidents and assaults. The largest gaps

between Indigenous Australians and non-Indigenous Australians was seen in circulatory disease (22% gap) and endocrine, metabolic and nutritional disease including diabetes (14% gap), The death rate in Indigenous people from these endocrine and metabolic disorders was three times the rate of the general population (AIHW, 2014a). Despite the seemingly higher rates of poor health, Aboriginal Australians access to health services do not reflect the higher incidence of poor health (Australian Health Minister's Advisory Council (AHMC), 2012), suggesting that the health services are not meeting the needs of Aboriginal people in Australia.

1.9 Disparities in Indigenous mental health and wellbeing

The landmark document, “Ways forward”: National Aboriginal and Torres Strait Islander mental health policy national consultancy report” (Swan & Raphael, 1995) stated that for Indigenous people there were strong relationships between mental health and wellbeing and physical health and that mental illness was a significant factor in the declining health of this group. However historically, the extent of mental illness in the Indigenous Australians has been inadequately documented. The rates of mental health and wellbeing were not systematically gathered at a national level until the “2004-2005 National Aboriginal and Torres Strait Islander Health Survey” (ABS, 2006) and the “2008 National Aboriginal and Torres Strait Islander social survey” (ABS, 2009). Since then, several studies have explored the psychological distress and social and emotional wellbeing of Indigenous people (Cunningham & Paradies, 2012; Gubhaju et al., 2013) and found that twice as many Indigenous people reported higher or very high levels of distress when compared to the general population (Gubhaju et al., 2013). Other researchers have reported rates to be three times as high as those of non-Indigenous people (Cunningham & Paradies, 2012). Thirty one percent of Indigenous people over the age of 15 years have experienced high to very high levels of psychological distress, which is considered twice the rate of the non-Indigenous population (ABS, 2010). Rates of self-harm among young Indigenous people aged 15–24 years are 2.5 times the rate of non-Indigenous young people (AIHW, 2014b). Suicide is also more prevalent in the Indigenous population, accounting for around 4.2 % of deaths as compared to 1.6% in the general population (AIHW, 2011). Suicides amongst males and females were respectively 2.5 to 3.4 times higher than for non-Indigenous Australians (ABS 2013a). The high incidence of suicide is a testament to the significant disruption to their level

of social and emotional wellbeing (Parker, 2010).

Hospitalisation rates for mental health conditions amongst Aboriginal people are also higher for Aboriginal people with males and females having rates 3.1 and 2.1 times higher respectively compared to non-Aboriginal males and females. Some statistics suggest that Aboriginal people also accessed community mental health services almost three times the rate of non-Aboriginal people (AIHW, 2011). Additionally, during the period 2001- 2005, Aboriginal males were 5.8 times more likely and Aboriginal females 3.1 times more likely to die from mental health related conditions than non-Aboriginal Australians (AIHW, 2009).

The rates of poverty, incarceration, and poor health are higher in the Aboriginal Australians than non-Aboriginal Australians (Henderson et al., 2007). Studies on the health of Indigenous people in Australia, New Zealand, Canada and the United States of America, indicated that Australia has performed the worst in improving the health and life expectancy of Aboriginal people. In the United Nations Development Programme's Human Development Index (HDI), Australia's non-Aboriginal population experienced an improvement in indices such as life expectancy, educational attainment, and income, while those of Aboriginal groups decreased, thus widening the gap between Aboriginal and non-Aboriginal Australians. This is despite HDI in the Indigenous peoples in North America and New Zealand improving at a faster rate than the general populations (Cooke et al., 2007). Abundant research continues to highlight data on Aboriginal hospitalisation, mortality and incarceration related to mental health conditions and the inconsistency of mental health and wellbeing amongst Aboriginal Australians (AIHW, 2009). Aboriginal people in Western Australian were hospitalised for "mental and behavioural disorders" related to alcohol use at a rate 6.8 times greater than non-Indigenous people in the period 2008-09 (Australia Steering Committee for the Review of Government Service Provision, 2011). Figures indicate that the rate of hospitalisation for mental health related conditions amongst Aboriginal people in Western Australian during the period of 2008-10 was 3.1 times higher in males and 2.1 higher in females as compared to the non-Aboriginal population (Australian Indigenous HealthInfoNet, 2015). However, the damaging effects of colonisation on the mental health and wellbeing of Indigenous people means they are reluctant to engage with mental health services, and when they do access services, it is at a more severe stage of their illness (Berry & Crowe, 2009; Vicary, 2002; Westerman, 2004, 2010).

Despite an increase in interest and research into the area of Indigenous mental health and

wellbeing over the past decade or more, there has been little change to health outcomes (Penman, 2006). Indigenous people are less likely to receive adequate assistance and intervention for issues related to mental health promotion and the early management of mental illness. In Western Australia Aboriginal social and emotional wellbeing continues to be affected by a number of social determinants of health, including colonisation, inter-generational trauma, limited access to health services, disadvantage, discrimination and racism (Larson, Gillies, Howard, & Coffin, 2007).

1.10 Racism

Racism remains a social problem in Australia (Nelson, 2014a; Redmond, Pedersen, & Paradies, 2014). Common understandings of racism depict it as the explicit rejection of other groups and their members, hostile and malicious behaviour, and supported by the belief in the superiority of one's own group over others (Dudgeon, Wright, Paradies, Garvey, & Walker, 2014, p. 15). While these elements characterise racism, the concept of racism is more encompassing. Paradies et al. (2009, p. 7) defines racism as:

A phenomenon that results in avoidable and unfair inequalities in power, resources or opportunities across groups in society and can be expressed through beliefs, prejudices or behaviours/practices and can be based on race, ethnicity, culture or religion.

Racism in Australia has a long history (Redmond et al., 2014). During Australia's Federation in 1901, racist views were reinforced by the Immigration Restriction Act (1901), also known as the White Australian policy (Nelson & Dunn, 2013). The Western Australian Aborigines Act (1905) has specific implications today because of the overwhelming destruction of rights, resulting in forcible removal of children and confinement of Aboriginal people to isolating, restrictive and oppressive reserves (Dudgeon et al., 2014). Australia's history "demonstrates how racist beliefs became legislation as Aboriginal people were believed to be less human" and such policies were used to control, confine and remove them from society (Dudgeon et al., 2014, p. 8). While these oppressive policies were retracted by the 1967 National Referendum, lasting damage to Indigenous people and culture had already occurred and few Indigenous people today have escaped direct or indirect effects of the controlling legislation which regulated their lives (HREOC, 1997).

Jones (2000) conceptualised racism on three levels: individual, institutional and cultural. This

framework of racism is useful in the discourse on race based differences in health outcomes and in designing appropriate interventions to minimise these differences (Jones, 2000, p. 1212). While these levels of racism occur simultaneously, they may be expressed differently with changes to society (Dudgeon et al., 2014). Berman and Paradies (2010) describe internalised racism as the process in which the individual incorporates beliefs within their world view which serve to preserve or intensified inequalities between racial groups. Racism is still experienced by marginalised groups, and continues to be invasive, pervasive and unrelenting and the responses to racism include influence self-esteem, feelings of mistrust towards the dominant culture, internalisation of racism and denial (Dudgeon et al., 2014). In overcoming racism, consideration must be given to the diverse and interrelated aspects of oppressive due to historical and contemporary influences. The need for prompt action to address the ongoing presence of racism in Australia has been acknowledged through government initiatives such as the National Anti-Racism Strategy (Australian Human Rights Commission, 2012).

Racism has major negative impacts on the health and wellbeing of Indigenous people. Many negative effects can be reduced through addressing the major determinants of health inequities and raising community awareness regarding racism and strengthening political commitment to addressing racism (Awofeso, 2011). Kelaher, Ferdinand, and Paradies (2014) reported that experiences of racism in the health care setting exposed Aboriginal people to higher levels of psychological distress, which in turn increases the risk for mental illness. Despite the push for cultural competency frameworks for clinicians to assess their practice and cultural position, Herring, Spangaro, Lauw, and McNamara (2012) argue that a major shortfall of these frameworks is the lack of recognition of the racism that Aboriginal people continue to endure.

1.11 Delivery of mental health services in Australia

In 1993, the Burdekin report, the report of the national inquiry into the human rights of people with mental illness, (Human Rights Equal Opportunity Commission, 1993) was released and focused on the violations of human rights of people with a mental illness. This report highlighted the quality of mental health services in Australia and the experiences of neglect and despair amongst patients and their families. The nation was propelled to address the inadequacies outlined in the report. This resulted in action by the Government, when in

1992, the Commonwealth government, states and territories, established a common National Mental Health Policy, which included the first national health plan covering a five year period from 1993-1998 (Australian Health Ministers, 1992). The national standards for mental health services (2010) were developed to assist the formulation and implementation of appropriate mental health practices, inform consumers and carers about what to expect from services and to direct quality improvement in acute mental health services. It advocated that services needed to consider the cultural and social diversity of its consumers and meet their needs (National Mental Health Strategy, 2010). The most recent national mental health reform *The Roadmap for National Mental Health Reform 2012-2022*, (Council of Australian Governments, 2012) reinforces Australia's commitment to mental health reform as a national priority. Emphasis is placed on engagement with key stakeholders and a commitment to reduce the stigma and discrimination associated with mental illness; reduce suicide rates; and ensure that people with mental illness and their families have access to appropriate services and support.

The Western Australian Aboriginal Health and Wellbeing Framework 2015–2030 identified a set of guiding principles, strategic directions and priority areas to improve the health and wellbeing of Aboriginal people in Western Australia for the next 15 years. The guiding principles promoted within this framework include; that the health and wellbeing of Aboriginal people is everyone's business; partnerships in care; Aboriginal community control and engagement; access and equality; accountability; and cultural security (Department of Health, 2015). The term cultural security was coined in Western Australia, and signals a shift in attitude, behaviour, and skills of the health system and the individuals working within it with the concept being assumed into the concept of cultural respect (Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), 2013). Cultural security is a commitment to the standard and the principles that the delivery of health services will not comprise the cultural rights, values and expectations of Aboriginal people. It also includes the recognition of the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health system administration (Coffin, 2007). A culturally secure health care environment is one in which an Indigenous person and their family feels secure, safe and respected because the system and health care professionals are committed in the drive to be culturally competent (CATSIN, 2013) with an aim to provide care that is culturally safe.

1.12 Cultural care

The nursing profession has long examined the impact of culture in health care dating back to the 1960s when nurse Madeleine Leininger first discussed the concept of transcultural nursing and later publishing the theory of transcultural nursing in *Culture Care Diversity and Universality* (Leininger, 1991). Transcultural nursing advocates that the nurse needs an understanding of different cultures and health preferences and behaviours. The limitation here is that it reduced cultural knowledge to potentially stereotypical views of how an individual may behave based on cultural background, with the notion of culture restricted to ethnicity (Taylor & Guerin, 2010). Since then, several frameworks have been proposed to address cultural diversity and health disparities in health. These include cultural awareness, cultural competence, cultural security, cultural respect and cultural safety. Cultural safety is considered by some, the third and final step in the level of cultural understanding (Taylor & Guerin, 2010). Cultural competence has been defined by several different authors including Suh (2004), who summarised it as an ongoing process with the aim of effectively working with diverse groups and communities, with specific awareness, knowledge, skills and professional and personal respect for the cultural similarities and diversity. It is generally acknowledged that cultural competency is not a single occurrence, but a continuous process. Cultural competency is a journey and a dynamic evolving process in which the health professional seeks to attain the ability to work effectively within the cultural context of an individual and their community and as such, requires the health professional to see themselves “becoming culturally competent as opposed to being culturally competent” (Campinha-Bacote, 2011, p. 5). This process involves the combination of cultural awareness, cultural knowledge, cultural skills and cultural experiences (Campinha-Bacote, 2008).

While there are similarities with the concepts of cultural competence, cultural safety differs in its history and focus on outcomes (McEldowney & Connor, 2011). The concept of cultural safety derived in the 1980s from nursing practice in New Zealand to address the retention issues Māori nurses and the poor health status of New Zealand’s Indigenous people. Cultural safe care considers the perspective of the patient with the understanding of historical power differences and personal biases (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012). Irihapeti Ramsden, the pioneer of the concept, asserted that nurses need to understand their own culture before attempting to understand their patient’s culture and encourage the nurse to reflect on their own culture, values and beliefs to better understand cultures different from their own (Wepa, 2015). The essential features of cultural safety include; understanding

of one's own culture; and acknowledgement of differences where care givers are consciously respectful of differences; it is informed by the theory of power relations and attempts to depoliticise it is a failure to understand the concept; is defined by the experience of the person receiving the care and not by the carer (CATSIN, 2013). Cultural safety advocates that both professionals and institutions work to establish a safe place for patients and one that is sensitive and responsive to their social, political, linguistic, economic and spiritual concerns (Kirmayer, 2012). In Australia there is no standardised or nationally accepted model of cultural education, however cultural safety is gaining acceptance as appropriate in the Australian context and has been endorsed by The Congress of Aboriginal and Torres Strait Islander Nurses, academics and advocacy groups (Taylor & Guerin, 2010).

A culturally competent health system acknowledges the benefits of diversity; assists health professionals and patients to achieve the most appropriate care; supports self-determination and values reciprocity for culturally and linguistically diverse groups: and commands professional and industry accountability for meeting the needs of its community members (National Health and Medical Research Council, 2005). The need for culturally appropriate health care has been emphasised as being essential to improving Indigenous health outcomes in several reports including the Fourth National Mental Health Plan 2009-2014 (Australian Health Ministers Conference, 2009); the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (Department of Health and Ageing, 2007); and the WA Aboriginal Health and Wellbeing Framework 2015-2030 (Department of Health, 2015).

There is extensive literature that identifies the need for the development of culturally sensitive and appropriate mental health care for Indigenous people (Durey, 2010; Eley et al., 2007; Vicary & Westerman, 2004b), but Australia has been slow to respond to the specific cultural needs within mainstream mental health care for Indigenous people (Cooke et al., 2007). While there are several concepts that could be utilised to meet the cultural issues in health care, the framework used in Western Australia is The Cultural Respect Framework (Department of Health, 2015). The Cultural respect framework for Aboriginal and Torres Strait Islander health, 2004-2009 (Australian Health Ministers Council, 2004), stipulated that the framework is not a tool focused on building cross-cultural competency, but rather recognises the need for a rigorous multidimensional approach to systematically raise the level of cultural competency in mainstream services. The emphasis of cultural competency includes competency at all levels of the health system; organisationally; systemically and individually. Effective strategies to reduce the disparity of health outcomes for Aboriginal

people are characterised by approaches that: are holistic which take into account the cultural, historical and social influences to health; include the active involvement of the Indigenous community; values and acknowledge Indigenous culture, beliefs and practices; develop staff, both Indigenous and non-Indigenous, who are committed to providing cultural awareness and diversity training; adopt strength-based perspectives of health and wellbeing; and have clear leadership and governance for initiatives with defined approaches to evaluation and improvement (Healey, 2014).

Despite the many different concepts used to denote providing appropriate care to Indigenous people in health care, for the purpose of this study the term used is cultural safety, as the focus is on the care delivered at an individual level. One of the limitations of the different approaches to cultural care is that there is little research around how it is implemented in clinical practice and there are limited guidelines that explicitly define how to practice culturally safety care. The standards for professional practice such as the *Standards of Practice in Mental Health Nursing* (Australian College of Mental Health Nurses Inc, 2010) outline standards of care which refer to the performance of mental health nurses including professional skills, attitudes and attributes. These standards refer to principles of cultural care, including respect for diversity, collaboration, and inclusion in care planning. Culturally safe mental health care is critical to effective mental health care recovery and in reducing the impact that social and emotional wellbeing problems have on lifestyle, substance misuse, economic status, incarceration rates and improved health outcomes in the Indigenous population. Taylor and Guerin (2010) have proposed that cultural safety holds a great opportunity for transforming culturally appropriate practice in Australia.

1.13 Need for the study

Indigenous health is a national priority area and significant health expenditure is directed at improving equity in outcomes between Indigenous and non-Indigenous Australians. The responsibility to improve Indigenous health outcomes must now rest equally with non-Indigenous health care providers, Indigenous communities and peak organisations. Non-Indigenous health care providers are key agents of change in bridging the gap in health outcomes for Indigenous Australians and they have a responsibility to create sustainable health policies that link effectively to practice changes. Without research into mental health care in mainstream services, Indigenous Australians will continue to be discriminated against

in this area, perpetuating the cycle of disadvantage and inequality. The delivery of care within a culturally respectful framework will enhance mental health professionals' ability to embrace the needs of Indigenous people and work collaboratively towards therapeutic alliances in the provision of mental health care. Improvements in service delivery and health outcomes will be a significant step forward in the reconciliation process and in bridging the gap between the health of Indigenous and non-Indigenous Australians. The findings of this research will have implications at both state and national levels and provide insights into what is needed to improve the delivery of mental health services to Indigenous populations.

1.14 Purpose of the study

The purpose of this study was to explore health professionals' experiences of providing culturally safe mental health care to Aboriginal people in Western Australia. Data were collected using semi-structured interviews and a substantive theory that detailed the experiences was developed. The developed theory also highlighted the barriers and facilitators that health professionals experienced when working with Aboriginal people and how these impacted the quality of care. The developed theory provides insights into policy and practice changes required to ensure mental health service delivery occurs to Aboriginal people within a culturally respectful framework of care.

1.15 Research objectives of the study

The objectives of the research were to:

1. Explore and describe mental health professionals' experiences of providing culturally safe mental health care to Aboriginal people in the Western Australian community;
2. Identify the factors that facilitate or inhibit that experience; and,
3. Generate a substantive theory that explains the interactional and structural aspect of care provision for Aboriginal people
4. Evaluate the developed theory within the context of existing international literature.

1.16 Significance of the study

There is a large body of research that documents the inequality of mental health and

wellbeing outcomes for Indigenous Australians (Hunter, 2007, 2013; Hunter et al., 2013; Jorm, Bourchier, Cvetkovski, & Stewart, 2012; Shepherd, Li, Mitrou, & Zubrick, 2012; Sun, Buys, Tatow, & Johnson, 2012; Westerman, 2010; Zubrick et al., 2014). Despite the contribution made by the existing literature, the understanding of non-Aboriginal health professionals' multi-dimensional experiences of providing culturally safe mental health care within mainstream mental health services to Aboriginal people is not well documented. This grounded theory study, undertaken in the Western Australian community and set within the framework of current scientific literature, has contributed evidence to informed health policy in the area of cultural safety in mainstream mental health services. It has also identified opportunities for a change in the provision of support and education for mental health professionals working with Aboriginal people. In light of mental health reform, both nationally and at a state level, the findings of this study provide valuable information on culturally safe mental health care to Aboriginal people within the Western Australian context.

1.17 Assumptions underlying the study

It is common practice for qualitative researchers to document any preconceived ideas they hold in relation to the phenomenon being research. Prior to data collection, I held several assumptions about mental health professionals and the quality of mental health care provided to Aboriginal people. These were;

- I. A better understanding of the facilitators and barriers to providing culturally appropriate care to Aboriginal Australians by mental health professionals in mainstream mental health services has the potential to improve mental health and wellbeing outcomes for Aboriginal people.
- II. There is a need for mental health professionals to collaborate with Aboriginal people to document the provision of culturally safe mental health care in mainstream mental health services.
- III. Non-Aboriginal health professionals have limited understandings of providing culturally safe care.
- IV. Current educational programs for health professionals are not adequate to prepare a health professional to work in a culturally safe manner with Aboriginal patients and their families.
- V. There is a lack of specialist interventions provided for Aboriginal patients and they

are treated the same as all other patients.

- VI. An increased understanding of the impact colonisation of Australia and the resulting trauma on Aboriginal people will increase health professionals' level of self-reflection.
- VII. Non-Aboriginal white Australian dominant culture impacts on Australian Aboriginal health outcomes.

1.18 Limitations of the study

This study was completed in Western Australia and documented the experiences of mental health professionals providing care to Aboriginal patients in mainstream mental health services in this state of Australia. This could be viewed as limitation of the study. However, the Noongar nation in Western Australia is one of the largest Aboriginal groups in Australia and their history since white settlement in Australia is representative of most Indigenous nations in Australia.

1.19 Summary

This thesis presents mental health professionals' experiences of providing mental health care to Aboriginal Australians in mainstream health services in the Western Australia setting. The developed theory is set within the context of the existing national and international scientific literature in the area. In the context of mental health reforms locally, nationally, and internationally, the findings provide valuable insights into the provision of culturally safe mental health care to Aboriginal people in Western Australia and can be generalised to other Indigenous populations worldwide.

1.20 Organisation of the thesis

Part one of this thesis comprises two chapters, with this first chapter containing a background to the study and the research purpose, objectives and justification for the study. Chapter two covers the methodology used in the study, giving an overview of grounded theory including its links to "symbolic interactionism". The chapter concludes with a description of the application of grounded theory research methods in this study.

Part two of the thesis (chapters three and four) describes the basic social psychological problem experienced by participants, *being unprepared*. Part three of the thesis (chapters five and six) presents the basic social psychological process of *seeking solutions by navigating the labyrinth* which participants engaged in to manage their experience of *being unprepared* and the conditions influencing this process (chapter six). The fourth and final part of this thesis (chapters seven and eight) presents the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* and discussion of literature pertaining to the substantive theory.

CHAPTER 2 - METHODOLOGY

2.1 Introduction

Chapter two of this thesis describes the methods used to investigate mental health professionals' experiences of the provision of culturally respectful care to Aboriginal people living in Western Australia. The rationale for using qualitative methodology and the choice of the ground theory method is presented. The origin of grounded theory is detailed, as well as a description of the grounded theory method. Ethical considerations, descriptions of participants, data collection and analysis and storage are also presented. Finally, an overview of participants and procedures undertaken to ensure trustworthiness, credibility and transferability of the findings will be presented.

2.2 Qualitative Research

Qualitative research refers to a variety of different but related methodologies that are grouped under the same paradigms. While quantitative methodologies gather numerical data to support or refute a hypothesis, qualitative research aims to provide genuine descriptions of individuals and social groups in their real-life settings, and thus is often used to gain insight into values, beliefs and practices (Borbasi, Jackson, & Langford, 2008). With its origins in the social sciences, a dominant feature of qualitative research is the close relationship between the researcher and the research participant, making it now also a popular methodology employed in the health sciences (Holloway, 2008). The value of qualitative methodologies lies in the ability to provide rich descriptions as an "interpretative and "naturalistic" approach is adopted to gain an understanding of the world and its phenomena and the methodology is frequently used to explore areas in which little is currently known (Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007; Tavakol & Sandars, 2014). Qualitative research aims to obtain an expansive understanding of the subject under investigation in its everyday context via interviews and or observations and by hearing the voices of those intimately involved in the experience (Smythe & Giddings, 2007).

Unlike a somewhat linear design often taken by quantitative research, the research plan in qualitative approaches is more fluid and flexible with sampling, data collection, analysis and

interpretation occurring at several stages of the research process (Polit & Beck, 2013). Qualitative research designs employ several data collection methods including interviews, direct observations, focus groups, and examination of journal or diary entries. Purposeful sampling methods are often used in qualitative research designs as they seek to recruit participants who have an experience of the phenomenon under investigation. Sample sizes vary and are determined at a point when no new data emerges, data captured is rich in descriptions and categories and themes are clearly identified and complete in their descriptions. This process is known as saturation (Glaser & Strauss, 1967b; Mason, 2010).

In qualitative research, data analysis exists at three levels; descriptive, conceptualisation and interpretation. In grounded theory, data analysis occurs continuously throughout the research process and analysed concurrently using a process known as the constant comparative method of analysis. This form of analysis guides further data collection and the use of purposeful and theoretical sampling until the grounded theory is fully integrated and well described (Birks & Mills, 2015). Trustworthiness, credibility and transferability of the data are ensured by providing detailed descriptions of research methodologies used with audit trails providing documented evidence of the process (Cope, 2014).

Grounded theory methodology was chosen for this study because it has the potential to discover new perspectives of the provision of culturally safe care to Aboriginal people in mainstream mental health services in Western Australia and it allows the researcher to develop a substantive theory to explain this unique world view.

2.3 The Grounded Theory Method

The original grounded theory method developed by Glaser and Strauss was selected for use in this study (Glaser, 1978, 1992, 2002; Glaser & Strauss, 1967b). Barney Glaser and Anselm Strauss, both sociologists, collaborated in their research into health professionals' interaction with dying patients, producing their influential works of a new methodology, termed grounded theory in *Awareness of dying* (Glaser & Strauss, 1965a) and later, *Time for dying* (Glaser & Strauss, 1968). Also emerging from their research was the landmark text, "*The Discovery of Grounded Theory* (Glaser & Strauss, 1967b). This book was viewed as groundbreaking at the time as it presented a method of inquiry which allowed the researcher to generate a theory derived directly from the data, in contrast to the then predominant logic-dominated deductive way of reasoning at the time (D. Walker & Myrick, 2006). Grounded

theory has now become an influential qualitative approach in many disciplines (Byrant & Charmaz, 2007). It is a popular research methodology in nursing, midwifery and health sciences as it focuses on the social processes in an attempt to explicate human behaviour and interactional relationships (Schneider et al., 2007).

Grounded theory provides strategies for data collection and analysis and aims to construct an inductively driven theory of social or psychological processes grounded in the data from which it is derived (Tweed & Charmaz, 2012). In grounded theory, research data collection and analysis are simultaneous. The characteristics of grounded theory include (1) the goal of theory development; (2) based on symbolic interactionism; (3) multistage process of data gathering and analysis with abductive logic (a cyclic process of theory development which combines inductive and deductive logic; and (4) key components of theoretical sensitivity, constant comparison, theoretical sampling and saturation (Birks & Mills, 2015; Oktay, 2012).

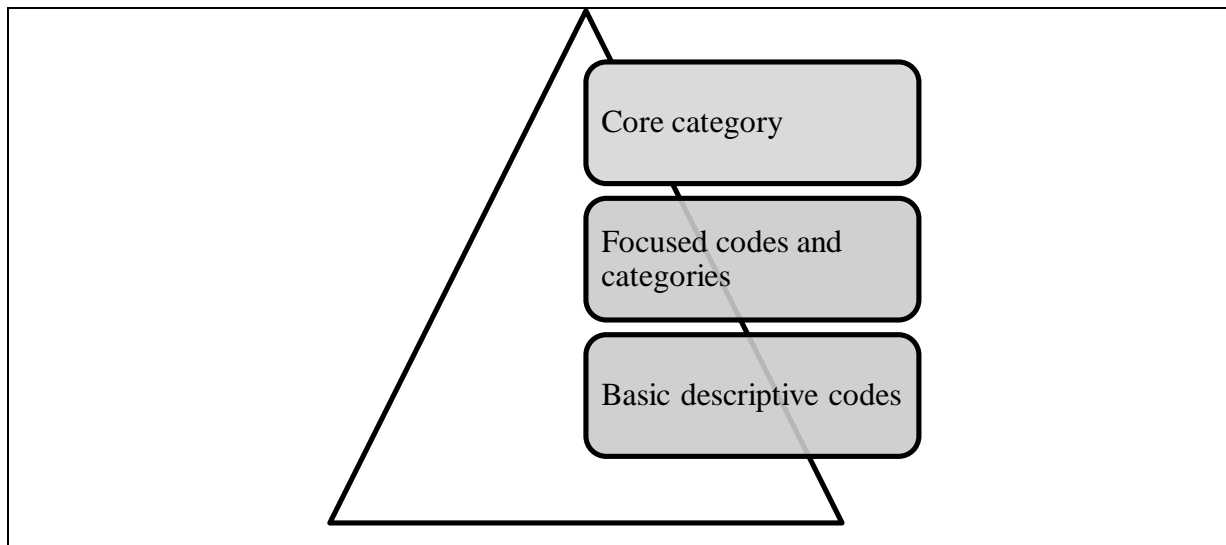
Symbolic interactionism underpins the theoretical perspective utilised in grounded theory. The underlying assumption of symbolic interactionism is that individuals act on the basis of the meaning that objects have for them (Milliken & Schreiber, 2012). The three assumptions of symbolic interactionism as defined by Blumer (1969) included (1) people act towards objects and others on the basis of meanings they have for them; (2) meanings are based on interactions with others; and (3) these meanings are revised from an interpretive process in order to make sense of the social context. Symbolic interaction views human behaviour as fundamentally social behaviour consisting of social acts where individuals attribute meaning from others' behaviour and modify their own behaviour (Holloway, 2008; Milliken & Schreiber, 2012). Using the assumptions of symbolic interaction, the researcher may delve into the participants' social world to gain perspective in order to understand the participants' perspective of the phenomenon under investigation (Birks & Mills, 2015). The awareness of symbolic interactionism's significance in grounded theory enables the researcher to develop a deep, rich and explanatory theory (Milliken & Schreiber, 2012).

Grounded theory employs an inductive process in understanding human behaviour rather than through hypothesis testing (Elliot & Lanzenbatt, 2005; Tavakol & Sandars, 2014). It involves the generation of a theory from data using systematic and rigorous research methods (Glaser & Strauss, 1967b). Glaser and Strauss postulated an inductive method in theory development through an exploratory process of abstraction (Timmermans & Tavory, 2012). As there are no assumed or preconceived ideas and hypotheses when collecting and analysing data, the

researcher is free to generate and formulate theoretical frameworks that are meaningful to the situation under investigation directly from the emerging data (Glaser, 1978, 1992, 1998, 2002). Grounded theory generates theoretical constructs or concepts that explain psychosocial processes common to individuals who have similar experiences of the phenomenon under investigation (Tavakol, Torabi, & Zeinaloo, 2009). Through the use of grounded theory, two types of theories can be produced; substantive and formal. Substantive theories are those which are generated within a specific area of enquiry using grounded theory methods (Glaser & Strauss, 1965b). Such is the focus of this research on mental health professionals' experience in working with Aboriginal people in mainstream mental health services. A formal theory may emerge from data across various substantive areas relating an abstract all-encompassing topic (Schneider et al., 2007).

The term grounded theory, is derived from the notion that the theory is generated or is "grounded" in an inductive approach, with the goal being a theory that gives understanding to the phenomena under investigation. The essential components of grounded theory as described originally by Glaser and Strauss (1967b) are; (a) cycles of data collection, coding, analysis, writing, designing and theoretical category development and data collection; (b) constant comparative analysis of the data against each other and to theoretical categories throughout each cycle; (c) theoretical sampling based on categories emerging from the ongoing data analysis; (d) theoretical saturation determines sample size; (e) the resulting theory is developed inductively from data; (f) codes emerge from data; and (g) the resulting substantive and or formal theory is the goal of the research rather than a purely descriptive narrative. During data analysis, raw data and basic descriptive codes are ascribed to the meaning of units. Next focused codes and categories are determined. This layer of codes and categories conceptualises the earlier codes noting a higher level of abstraction and interpretation. This process culminates in a core category, encompassing all the codes and categories derived from the data (Tweed & Charmaz, 2012, p. 132) (see figure 1, p. 27).

Figure 1: Pyramid representation of developing grounded theory.



The discussion of grounded theory would be incomplete without the discussion of the subsequent academic disagreement between Glaser and Strauss and the divergence of their interpretations of grounded theory. Strauss and Corbin (1990) developed an alternative language for coding and more complex coding procedures. Glaser (1992) considered these changes a significant shift away from the original principles of grounded theory and argued that Strauss and Corbin (1990) had introduced a different research method which forces data analysis to fit coding categories rather than allow the theory to be grounded in the data. Despite the different and individual revised versions of approaches to grounded theory, both include the essential elements of open coding; concurrent data collection and analysis; memo writing; theoretical sampling; constant comparative analysis; theoretical sensitivity; intermediate coding; selection of core categories and theoretical saturation (Birks & Mills, 2015; Hood, 2007; Moghaddam, 2006). Several alternative versions and adaptations of grounded theory have followed (Glaser & Strauss, 1967b) original grounded theory methodology including; constructivist grounded theory (Charmaz, 2006)); postmodern situation analysis (A. Clarke, 2005); a hermeneutics approach (Rennie 2000); and feminist approach (Wuest, 1995). The divergence of approaches may initially challenge the novice researcher, however Heath and Cowley (2004) suggest rather than ruminate over the differences, a novice researcher should select a method aligned with their own cognitive and analytical approach and stay consistent with this approach to minimise confusion and dilution of the emerging theory (Engward, 2013).

Any research methodology possesses potential limitations and grounded theory is not an exception. Grounded theory can be considered complex and time consuming as compared to other methods and the amount of data requiring coding can be a challenge to the novice researcher (Hussein, Hirst, Salyers, & Osuji, 2014; Moghaddam, 2006). Some suggest that the use of grounded theory to generate a theory is a subjective process which relies heavily on the researchers' abilities; however it could be argued that the value of the grounded theory actually lies in the researcher's insight into meanings coded in the data. This study adhered to the methodological approach of Glaser and Strauss (1967b) to gather and analyse data and theoretical sensitivity was employed to understand the meanings and nuances emerging from the data (Watling & Lingard, 2012). The researcher's approach to address theoretical sensitivity is outlined further in this chapter under the heading "Theoretical sensitivity".

2.4 Application of the grounded theory method for this study

The original works of Glaser and Strauss (1967b) guided study with influences from subsequent works (Glaser, 1978, 1992, 1998; Strauss, 1987; Strauss & Corbin, 1990, 1994, 1998). This inclusive approach allowed the researcher to explore the differences between the two approaches and to be receptive to the different ways of engaging in grounded theory research (Strauss & Corbin, 1997). Based on symbolic interactionism, grounded theory focuses on how people make sense of social interactions (Milliken & Schreiber, 2012; Polit & Beck, 2013). Grounded theory is particularly applicable to nursing research as it allows flexibility and options for data analysis in complex environments. It also facilitates the researcher's ability to provide insights into the experience of the participants (Hussein et al., 2014).

2.4.1. Data Collection

Data collection methods for this study included semi-structured interviews with mental health professionals working with Aboriginal people in main stream mental health services, using purposeful sampling techniques, field observations, memo writing and reflective journaling, and the subsequent review of relevant literature. Demographic data were collected from each participant including gender, age, and length of time working in mental health care.

2.4.2. Selection of participants

The credibility of research data is significantly influenced by the sample selection of the

participants (Draucker, Martsof, Ratchneewan, & Rusk, 2007). Qualitative research aims to provide an in-depth understanding of the world as viewed by those under investigation. Therefore the sampling methods must aim to select participants with these experiences. Initially a purposeful sampling technique was used to recruit participants who had experienced caring for Aboriginal people. Using this technique, participants did not need to be experts in this area, but rather just have had the experience and was able to discuss this to provide detailed descriptions of the phenomenon. Sampling techniques employed in grounded theory are driven by the developing theory (Glaser, 1992; Oktay, 2012). When categories began to emerge through analysis of the data, theoretical sampling was used to recruit participants with specific experiences, for example senior staff or novice staff. Theoretical sampling techniques was then used to drive and direct the constant comparative analysis of the data and was then employed when the researcher seeks to investigate the properties of a category, the conditions under which a category occurs or the dimensions and relationship between the categories (Birks & Mills, 2015). Through the process of theoretical sampling, the categories can be promoted to a more abstract level and the relationships between the categories can be tested. If the researcher wants to explore specific dimensions of a category, they may use theoretical sampling in the interviews with participants with the knowledge of this dimension (Connelly, 2013).

The concept of theoretical sensitivity purports that the researcher uncovers and interprets meanings from the data with awareness and sensitivity which is derived from personal and professional experiences (Glaser, 1992; Oktay, 2012). It refers to the personal attributes of the researcher which aid insight and the capacity to comprehend the significant elements existing in the data and is stimulated by self-reflection and memoing and the constant comparative method of analysis of the interview transcripts, directing when theoretical sampling techniques were need to be employed. The resulting sample size was determined by theoretical saturation or the inability to obtain new data and when a sense of closure was reached and categories were rich in descriptions, expansive and complete (Francis et al., 2010). Glaser and Strauss (1967b) defined theoretical saturation as the point when no additional data emerges to develop properties of the category. Theoretical saturation will be discussed further in the next section.

2.4.2.1. Inclusion Criteria

Specific criteria for selecting participants for this study include that the participants; (a) were

over eighteen years or age; (b) were a health professional employed in the area of mainstream mental health in WA.

2.4.2.2. Recruitment of participants

Once ethical approval to complete the study was obtained, the researcher initially approached clinical areas and potential participants regarding their interest in participating. An information sheet (see Appendix A) and consent form (see Appendix B) were sent to senior health services staff requesting that they circulate the information about the study to staff employed at the service. Interested parties responded and made contact with the researcher to express an interest in participating in the study. A meeting time was arranged at a time convenient with the participants, where the researcher explained the study, outlined their rights as a participant and answered any questions.

2.4.2.3. Description of participants

All participants were mental health professionals with experience in working in mainstream mental health services in Western Australia. Twenty eight mental health professionals participated in this study, including three psychologists and twenty five registered nurses. Demographic data gathered revealed thirteen participants between 46-55 years. Five were in the 25-35 year age range, with two participants over the age of 61 years. Twelve participants were Australian born, ten were born in the United Kingdom (UK) and six were born overseas, other than the UK. Participants included seventeen females and eleven males.

2.5 Research interviews

Semi-structured interviews are a popular technique used in qualitative research, which have several advantages, including synchronicity in communication between the researcher and participant (Opdenakker, 2006; Rabionet, 2011). Interviews ranged in length with the majority being around 35 – 45 minutes. Interviews were conducted in a private, mutually agreed location, thus minimising extraneous variables such as noise and interruptions from other people (Schneider et al., 2007). The purpose of the interviews was to obtain a deep understanding between the participant and the research of the subject being investigated and for the researcher to gain an insight into the world of others (Qu & Dumay, 2011). A semi-structured interview schedule was used (see Appendix C), with each interview beginning with the open-ended question “Can you please tell me about your experiences in working

with Aboriginal patients in mainstream mental health services in Western Australia". This semi-structured interview approach allows the researcher to prepare a planned interviewing approach to maintain some consistency with the questioning of participants, but also allowing for opportunity to further explore individual responses (Qu & Dumay, 2011). The interviews were digitally recorded to allow the researcher to focus on the participant and for transcribing purposes later and to allow the accurate and non-obtrusive collection of data in the field.

Active listening techniques were employed by the researcher during the interviews to facilitate an open and empathic relationship with the participants and to establish a supportive environment in which the participant felt heard (Louw, Todd Watson, & Jimarkon, 2011). Brief notes were taken by the researcher of what was said by the participant (Saldaña, 2011). The notes were also used as triggers for the researcher to prompt the participant to explore or elaborate further on a point of interest.

2.6 Field notes

Field notes are important documents in the research process, adding context and character (Glaser & Strauss, 1967a). They are unreserved accounts of the researcher's observations of events and interactions occurring during the data collection and assist the researcher to make sense of the data during the process of grounded theory (Montgomery & Bailey, 2007; Tracy, 2010). During and following the interviews, information pertaining to relevant observations was documented by the researcher. The observations included the setting of the interview and verbal and non-verbal cues used by the participant during the research process. These field notes added important contextual content to the study. The following is an example of a field note made after an interview with a participant.

[This] interviewee was someone who I believed shares similar values to me. The interviewee spoke of cultural awareness education sessions that the employer had arranged and was able to recall some things discussed in this forum. However, these seemed a sterile check list of dos and don'ts rather than a real understanding of cultural issues to be considered in the delivery of care. I was struck by the participant's limited understanding of issues. Questions around care of an Aboriginal person in mental health seemed limited to the referral to the resource person. The interviewee did not articulate on their practical and personal care delivery. There did not seem any personal connection with cultural safety between this person and the delivery of care to Aboriginal people. While the Aboriginal resource person was deemed to be invaluable, it was of note that they were not of Aboriginal or Torres Strait Islander descent, although as described by the interviewee, had dark skin and

“had the look”. Also if this resource person was the cultural resource that the clinicians defaulted to, how did they develop their own skills in providing culturally safe care?

I did reflect on what my responses would have been if the tables were reversed and before I had delved into the area of cultural awareness and safety. (FN 2, April, 2011).

2.7 Documents and literature as data

The use of literature in grounded theory remains one of the most controversial and misunderstood characteristic of this method (Birks & Mills, 2015). In Glaser & Strauss’ (1967b) original model of grounded theory, it was proposed that literature reviews not be undertaken prior to data collection and analysis, as it was seen to have the potential to taint the emerging categories, as there may be temptation by the researcher to make the data fit the literature,. Therefore traditionally, researchers in grounded theory have been steered away from a formal literature review in the early stages to avoid the influences from existing knowledge or theories contaminating the study process (Birks & Mills, 2015). However, it is acknowledged that no researcher exists in vacuum of knowledge and Glaser (1992) later conceded that the researcher may engage in a review of the literature in the beginning stages of the research, but only on the outer edges of the exact subject area to avoid corrupting the analysis of the data.

Literature is important in all stages of grounded theory and in summary, it can be used; to enhance theoretical sensitivity; as data during the phase of analysis; and to inform theoretical codes (Birks & Mills, 2015). In this study, an initial literature review was undertaken when preparing the proposal for this research in order to determine the existing knowledge and work undertaken in this area (Dunne, 2011; Urquhart, Lehmann, & Myers, 2010). No other search for relevant literature occurred during the initial data collection and analysis phase other than in the preparation of the research proposal. Additional literature reviews relevant to emerging findings were undertaken on an ongoing basis as coding, conceptualisation of categories and the write up of the theory began.

2.8 Bracketing researcher bias

In order for the qualitative researcher to understand the perspective of the participant, they must set aside their own ideas about a research topic (Tavakol & Sandars, 2014). This

process is referred to as bracketing and is an essential principle to ensure that researchers do not allow their assumptions to shape the data collection or to impose their influence on the data (Tufford & Newman, 2012). Through bracketing, the researcher sets aside what they think, feel or believe about the subject, in order to actively listen to the participants' and allow their reality to be revealed (Hamill & Sinclair, 2010). However it may be difficult for the researcher to suspend or bracket their assumptions if they do not have insight into these assumptions (Parahoo, 2006). Bracketing requires the researcher to maintain reflectivity in order to maintain objectivity (Tavakol & Sandars, 2014). While undertaking this study, the researcher reflected on their own gender, ethnicity, social class, values and beliefs and how these may influence their views of the emerging phenomenon. Throughout the research process, memos and journaling was used as a means of examining and reflecting upon the researcher's engagement with the data (Tufford & Newman, 2012).

2.8.1. Theoretical sensitivity

Theoretical sensitivity is a characteristic of the researcher which enables them to recognise the emerging theory from the data (Oktay, 2012) and refers to the researcher's ability to identify and reflect on the relevant data (Glaser & Strauss, 1967b). Birks and Mills (2015) define theoretical sensitivity as the ability to recognise and extract elements of data that have relevance for the emerging theory and includes three features. It reflects the sum of the researcher's personal, professional and experiential history; it can be enhanced by techniques, tools and strategies; and it increases as the research progresses.

In this study, theoretical sensitivity was increased through self-awareness and acknowledging the researcher's prior experience as a mental health nurse and academic. This researcher had extensive experience in this mental health working in both public and private services in Western Australia and as such, had knowledge and experience to understand the culture of these settings. The researcher also reflected on assumptions about working with Aboriginal people in mainstream mental health settings and perceptions of culturally safe clinical practice. The ability of the researcher to identify any preconceived ideas or assumptions about the study area is vital in developing a well-grounded substantive theory. In the initial development stage, the researcher reviewed her knowledge of Australian Aboriginal history and the Aboriginal meanings of mental health and wellbeing. Extensive literature acknowledges the gaps in mental health outcomes between Indigenous and non-Indigenous Australians. Literature also highlights the need to provide culturally appropriate mental care

in order to address the mental health outcomes. It was observed that literature had not fully explored the mental health professionals' experience with Indigenous people in mainstream mental health services. By using grounded theory, the researcher aimed to provide a more extensive review than currently found in the literature of how mental health professionals provide care to Aboriginal people in mainstream services in Western Australia. The final literature search was not undertaken until after data collection and analysis had begun and then the literature relevant to the emergent findings was obtained.

Finally, during the course of this study, the researcher's assumptions and preconceived ideas were discussed with colleagues, supervisors, Aboriginal academics and other team investigators in the NHMRC capacity building grant. A research reference group was also formed which is discussed further in the next section under the heading of "Research Reference Group". Feedback from these sources helped to clarify the overall methodological process and to address any potential researcher biases. Meetings with these key people and groups also facilitated theoretical sensitivity and assisting in giving new meanings and insights into the data.

2.9 Data preparation and computer management procedures

Each digitally recorded interview was transcribed verbatim to ensure the richness of the data was maintained and fully captured. The transcribed interviews were then imported to QRS*NVIVO computer software program which assisted in managing and sorting the written data (Bringer, Johnston, & Brackenridge, 2004; Holloway & Wheeler, 2010). This software program facilitated the management of coding of data, linking data and comparing categories identified in the coding stages and for retrieving data during constant comparative analysis.

2.10 Data analysis: The constant comparative method

Glaser and Strauss (1967b) first described the constant comparative method of analysis used in grounded theory. According to Glaser and Strauss (1967b, p. 105) constant comparison consists of four stages: (1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory. Holloway and Wheeler (2010) describe it as a process where each piece of data is compared with all other pieces of data. It is the constant comparison of "incident to incident, incident to codes,

codes to codes, codes to categories, and categories to categories” (Birks & Mills, 2015, p. 11). This method of constant comparison allows the researcher to sort data into similar categories and to build themes or concepts (Speziale & Carpenter, 2011).

This method of analysis is inductive as the researcher begins to examine data critically and draw new meaning from the data, rather than a deductive approach which defines at the inception what will be found (Glaser, 1965). There are two basic steps to the constant comparative method of coding. Firstly, data sets must be constantly compared for similarities and differences. As concepts emerge, this process must be repeated (Corbin & Strauss, 2008). Secondly, the research must observe emerging concepts and decide which category or property of the category the concepts belongs and then name this category. These steps secure the generation of categories and their properties from the data (Glaser, 1992). Additionally they highlight the need for an increase in the theoretical sample to further clarify, define or consolidate categories and properties through open coding. Constant comparison of the different conceptual levels of data determines the theoretical sampling and the ongoing collection of data. It is this constant and repetitive method of constantly analysing, collecting and comparing data that results in sophisticated categories rich in meaning (Birks & Mills, 2015). Glaser’s (1978) coding methods were simple and focused and divided the process into stages; substantive and theoretical coding. Substantive coding was concerned with generating categories and their properties through open and selective coding. Theoretical coding is more conceptual and includes entwining the substantive codes together to form a theory. Coding and category formation was frequently checked and verified throughout the data collection period by the principal supervisor. If there were discrepancies, coding continued until consensus on terms was reached between the researcher and principal supervisor.

2.10.1. Open coding

Open coding is the initial step of grounded theory analysis and involves breaking down the data into pieces through scrutinising the data line by line and labelling words or segments that convey meaning. Throughout open coding, multiple codes were generated from the data which were mainly descriptive in nature (Glaser, 1978). During the phase of open coding it is important for the research not to prematurely jump to abstract levels too early. (Oktay, 2012) suggest the following cues to consider when open coding; (1) look for code words and phrases that describe or evoke strong emotions; (2) search for words and phrases that describe

actions; (3) codes should reflect symbolic interactions; (3) consider “red flag” comments that reflect assumptions, like “always”, “never”.

Through open coding, concepts are joined with other concepts to form larger categories (Oktay, 2012). This is the next phase in open coding group codes into broader concepts and categories. This intermediate step in the process of coding and categorising becomes more abstract (Connelly, 2013) and the categories become theoretically saturated when ongoing analysis only reveals codes that are associated with existing categories (Glaser, 1978). In this way grounded theory differs from other qualitative methods, as it is based on two processes; asking questions and making comparisons. Using the constant comparative method, relationships are made between cases or incidences, dimensions and properties of concepts and categories become evident (Glaser, 1992; Oktay, 2012). With ongoing analysis, a core category is identified which embodies the grounded theory. This is a highly conceptual process which can only be reached when the core category and all other sub-categories are theoretically saturated (Wuest, 2012).

2.10.2. Theoretical coding

Theoretical codes are based on abstract concepts and assist the researcher to link theory to existing theory (Oktay, 2012). Theoretical coding is described as the use of advanced abstractions to provide a framework for enhancing the descriptive power of a grounded theory. Often metaphors can be used, as theoretical codes are often used to explain a theory by clarifying relationships between the categories and provide descriptions for several components (Birks & Mills, 2015).

Glaser (1978) outlined a number of families of theoretical codes that guide data analysis and theory development. These provide a theoretical framework to assist in the organisation and integration of codes into theoretically meaningful relationships (Simmons & Gregory, 2005). One example of a theoretical family referred to by Glaser (1978) is the six C's ;causes; context; covariance; conditions; contingencies; and consequences. This family of theoretical codes guides the types of questions asked during analysis of the data. For example, what was the cause of this behaviour? What were the stages in this process? These questions further directed data collection strategies as part of theoretical sampling.

2.10.3. Selective coding and theoretical saturation

Selective coding occurs once the researcher has identified a potential core category. Further

data collection and coding is then delimited to that which is relevant to the emerging conceptual framework (Byrant & Charmaz, 2007). Through selective coding, the researcher can move through the relevant data, with the aim of saturating selected categories forming the basis of the emerging theory. The selective data collection and analysis continues until the data sufficiently explains and integrates the core variable, its properties and connections to other relevant categories (Byrant & Charmaz, 2007). Strauss (1987) proposed six criteria used to assist researchers select a core category including; (i) that the core category must be central and related to all other categories; (ii) it must occur frequently in the data; (iii) it must relate meaningfully to other categories; (iv) a core category in a substantive theory has clear implications for the development of a formal theory; (v) as the properties of the core theory are analysed further, the development of the theory progresses; (v) and the core category facilitates a robust analysis of the data and the ability to identify the dimensions, properties, conditions, consequences and strategies which related to the core category. Once the core category “*being unprepared*” emerged, the analysis moved to identify the relationship of this category to all other categories. Selective coding was used to integrate and refine the association of all the categories to the core categories. This method may help clarify other new categories and may also lead to further data collection using theoretical sampling techniques (Holloway, 2008). Through the analysis of data in this study, a major category *being unprepared* emerged, representing the basic psychological problem experienced by mental health professionals working with Aboriginal people in mainstream mental health services in Western Australia. The core category *being unprepared*” evolved from the data and the data defined its properties and relationships to all other categories.

This process was repeated while reviewing the data and through the further evaluation of concepts with participants through theoretical sampling. This phase of the data analysis involved two processes: sorting and saturation. Glaser (1978, p. 72) defined sorting as “weaving” the broken pieces of the story back together again. This includes sorting through the theoretical memos and coding families. Constant comparison of categories and concepts continues until no new properties emerge, reaching a point whereby a concept has been theoretically saturated. Strauss and Corbin (1998) suggest that saturation should focus on the point where further data becomes counter-productive or does not add to the overall developing theory or framework. Therefore, achieving saturation is vitally important to achieving a conceptually sound theory. Through coding and further analysis, and as the analysis became more abstract, a basic social psychological process also emerged. The core

category of *being unprepared* was broad in scope and able to provide explaining to the other emerging categories (Strauss, 1987). This process described how participants in this study managed the basic social problem.

2.10.4. Theoretical memos

Theoretical memos are constructed on coding notes and on broad connections between the data that gradually is exposed. Writing theoretical memos requires the researcher to look beyond the descriptions about the data and engage in a higher level though and abstract thinking. Several different types of notes are employed by the researcher engaged in grounded theory research. These can include written or visual illustrations of emerging concepts. They provide a record of the researcher's abstract thinking as they arrive at categories and relationships between concepts. Memo writing encourages the researcher to conceptualise thoughts about the emerging data (Glaser, 1978) to keep records of ideas for theoretical sampling and track the developing of the theory and are important part of the audit trail (Elliot & Lanzenbatt, 2005; Oktay, 2012). Memos and diagrams are continually created during the research process and became more complex as the data analysis continued. Oktay (2012) describes writing memos as a creative process and suggests some tips for memo writing including writing memos often throughout the data collection and analysis process; refraining from criticising memos and allow creativity to flow; frequently refer to the memos and revise as data collection continues; and use diagrams or concept maps. Many memos in this research were made during the initial or open stage of coding to flag the researcher's thoughts and ideas for further exploration and elaboration, so they are not lost (Strauss, 1987). The following is an example of a theoretical memo flagging these ideas.

- *Unprepared - to open the Pandora's box & deal with the complex issues associated with Indigenous health & wellbeing.*
- *Unprepared how to deal with people*
- *System is unprepared.*

Unprepared to reflect on cultural safe practices

- *Self-unprepared*
- *Professional self - knowledge, skills, profession, discipline Personal self - knowledge, interpersonal*
- *Not prepared to cross the bridge of cultural safe practice*
- *Links in the chain of cultural safe practice.*

Memo. February, 2013

Diagrams were also used to assist in data analysis to facilitate the emergence of the basic

social and psychological problem and process. Diagrams enabled the researcher to move from the descriptive to analytical level of analysis using Glaser's (1978) six coding families, including causes; contexts, contingencies, consequences, co-variances and conditions. The basic social psychological problem of being unprepared emerged and the coding families were able to identify the links to other categories. Diagram 1 is a visual example of an emerging category.

Diagram 1: Example of emerging category



2.10.5. Research Reference Group

The positioning of the researcher is significant in the relationship between the participants and the issues under investigation and provides an insight to how they may engage and deduce meanings from data. The researcher needs to understand the influence of self has in the formation of assumptions and to monitor the potential influence of their basis, beliefs, values and personal experiences in their interpretation of the data (Berger, 2015). A reference group (RG) was established to maintain cultural safety of the research process (Shahid, Bessarab, Howat, & Thompson, 2009; Smith, 1999) and to facilitate theoretical sensitivity. Bishop, Vicary, Andrews, and Pearson (2006) suggest that culturally sensitive research strategies include self-critical reflectivity to aid to minimising the colonial and oppressive impacts of research on Aboriginal people. Once the research objectives and goals were established and academic ethics approval granted, steps were undertaken to establish a RG

for this specific study. The first stage was to identify the purpose of this reference group as opposed to other RGs. Although this study was targeting mental health professions rather than Aboriginal people, the researcher still wanted stakeholders involved in guiding the researcher to find meaning in the data. The members of the RG included an Aboriginal cultural consultant, an Aboriginal health professional, and a member with extensive experience in delivering education programs in cultural safety for non-Indigenous health professionals. While the initial numbers were small, sentiments out in the community were positive. The purpose included to liaise informally and to help maintain cultural safety during the research process. The membership of the RG for this study remained open to interested parties, either on a one off or more permanent basis. At the meetings, notes were kept by the researcher for field note purposes. This assisted the researcher to ensure theoretical sensitivity and trustworthiness of data in all sections of the thesis.

2.10.6. Comparison with existing theories

The final stage of data analysis involves comparing the study findings with related and relevant theories existing in the literature. Comparison with the existing literature is done at the end of analysis when using grounded theory, rather than the beginning, to minimise the risk of imposing preconceived ideas on the analysis of the data (Glaser, 1978). The substantive theory developed in this study was compared with related theories identified in the literature. Those relevant and related theories were considered and are discussed in chapter 8.

2.11 Writing the grounded theory

Once saturation was reached and the basic social psychological problem and process was identified, the researcher began the process of documenting the framework of providing culturally safe care to Aboriginal clients in mainstream mental health services in Western Australia. A substantive theory emerged from the data that was broken down through open coding and theoretical memos and developed through theoretical selective coding. When reporting the findings of this research, a large amount of direct quotes from participant interviews are offered to provide examples and thick descriptions and to assist the explanations of concepts and to give participants a voice (Hunt, 2011). In documenting the responses from the participants in this study, the following procedure was followed:

- Each quote by a participant is identified by a participant number, for example, P.1.
- Each field note is recorded by number and date, for example, FN, 1 June 2012.
- Each memo is recorded by number and date, for example, M, 1 June, 2012.
- Major conceptual terms used in the substantive theory were placed in italics.
- Square brackets [] were used in direct quotes when additional information was added by the researcher.
- Names of participants, patients and health facility were removed from the quotes to protect the identity of relevant parties.

2.12 Trustworthiness, credibility, and transferability of findings

The credibility of a research study is dependent on the measures employed to ensure quality during the research process (Birks & Mills, 2015). In qualitative research, trustworthiness is often discussed in terms as credibility, dependability, confirmability, transferability, and authenticity (Elo et al., 2014). The specific requirements of grounded theory methodology which relate to trustworthiness, credibility and transferability of the findings are that; the theory fits the substantive area where it will be applied; it is understood, and generally is applicable to different situations (Glaser & Strauss, 1967b). Sampling strategies used in this study ensured the experience described by the participants was the experience of the population of mental health professionals working with Aboriginal people in mainstream mental health services and that the data was saturated and comprehensive. Credibility of findings was achieved by the descriptions of similar experiences by many of the participants. The credibility and trustworthiness of the findings of this study also add to the transferability of the findings and the substantive theory developed in this study that may be applied to mental health professionals working with Indigenous populations in other geographical areas and with other minority groups. Trustworthiness, credibility and transferability of data in this study were secured by using the meticulous process of constant comparative analysis, which is central to the grounded theory method. Raw data were broken down to concepts and assigned to relevant categories that were conceptually linked. Glaser and Strauss (1967b, p. 105) described this as a four stage process that includes (1) comparing data applicable to each category, (2) integrating categories and their properties, (3) defining the theory, and (4) writing the theory. Data analysis began at a descriptive level, where data were coded and categorised. Coding progressed to a conceptual level and comparisons between patterns of responses to the phenomenon were made. Data analysis encompassed the use of theoretical

memos about emerging concepts and exploration of codes, hypothesis, categories and the emerging grounded theory. Thus, the basic social psychological problem experienced by the participants and basic social psychological process employed to overcome the problem were identified.

The constant comparative method of analysis and theoretical sampling ensured that all categories were fully explored until theoretical saturation was reached and no new data emerged. During the study, the researcher met on a regular basis with research supervisors in order to seek consensus of the categories identified from the data. An audit trail allows independent review of the data. Six types of records were used to create an adequate audit trail: (1) the raw data; (2) theoretical notes; (3) process notes; (4) reflective notes; (5) instrument developed information; and (6) data reconstruction (Polit & Beck, 2013). This audit trail gives another dimension to the trustworthiness, credibility, and transferability of data (Borbasi et al., 2008).

During the course of the study, the researcher met frequently with research supervisors. The discussion and feedback from these meetings with the supervisors provided support for the trustworthiness, credibility and transferability of the findings. Working with an Aboriginal co-supervisor was invaluable in providing feedback in developing chapter one and in embedding of Indigenous literature in this thesis. Finally, the substantive theory of *seeking solutions by navigating the labyrinth to overcome being unprepared* was compared to the existing literature. This literature is presented throughout this thesis and adds to the credibility, trustworthiness and transferability of the data and validation of the findings of this study.

In summary, descriptions of the research process, identification of an audit trail, linkages between data and notes and comparisons with existing literature, facilitates the trustworthiness, credibility, and transferability of the findings. These findings also provide the basis for further development and refinement of theory through similar studies in different contexts.

2.13 Ethical considerations

In response to past human rights violations, various codes of ethics have been developed to guide acceptable standards of conduct when conducting research (Polit & Beck, 2013). The

underpinning themes of the various ethical codes and standards focus on the following principles; protecting the research participant; conducting a high standard of research; ethical integrity; informed consent; protection of confidentiality; management of risk, and transparency of the research process (Hardicre, 2014). In Australia, The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007) provides the standards for Human Research Ethics Committees (HRECs) and researchers and includes the principles of research merit and integrity, justice, beneficence and respect. Permission was obtained from Curtin University's Human Research Ethics Committee, the South Metropolitan Area Mental Health Service Hospital Ethics Committee (see Appendices D & E). The main aspects of these ethical guidelines are now presented.

2.13.1. Informed consent

Informed consent respects the individual's autonomy to make decisions about participating in research. In order for consent to be informed, the individual must have the all relevant information to make that decision and secondly, the capacity to make this decision (Pick, Berry, Gilbert, & McCaul, 2013). Participants in this study were informed verbally and in writing that the study was voluntary and they could withdraw from the study at any time. Participants were provided with an information sheet outlining the nature of the study, information on confidentiality and voluntary participation (see Appendix A). A signed consent form was obtained to convey the participants' willingness to participate in the study and to have the interview digitally-recorded (see Appendix B).

2.13.2. Privacy and confidentiality

Privacy and confidentiality are essential parts of the research process. The researcher must therefore ensure the participants' identity remains confidential. In this study, participants' confidentiality was ensured by assigning numerical codes to names on all documents used. Any data linking the numerical codes to the participants was only available to the researcher in this study. References to individuals, other mental health professionals or patients that may reveal their identity were also omitted from the discussion of the data. Confidentiality in research process stipulates that identities of the participants will not be linked to the information they supply and that this information remains secure (Schneider et al., 2007). Participants were informed that data collected in the course of this research would only be accessed by the researcher who was they only one that could link them with any data.

2.14 Data storage, access and disposal

All the interviews, field notes and reflective notes in this study were assigned a code number so participants could not be identified. Note books containing participants' names and links to code numbers were kept separately in a locked cupboard from the transcribed interviews and digital recordings. Transcribed data was stored in a locked cabinet in the researcher's office and will be destroyed seven years after the completion of this research. Electronic data was secured on a password protected computer on a University secure drive, only accessible to the researcher. Written publications arising from this research will also maintain the participants' confidentiality. Interview transcript extracts that may be published will not identify participant sources.

2.15 Overview of major findings

The emerging data identified the core category as *being unprepared* as the basic psychological problem experienced by the mental health professionals working with Aboriginal clients in mainstream mental health services in Western Australia. The problem had two phases; *disruption to self-awareness* and *fluctuating emotions*. A major component of *being unprepared* that emerged from the data was categorised as *being overwhelmed* by not knowing enough or being adequately prepared to provide appropriate mental health care to Aboriginal patients in mainstream mental health services. The analysis of the data also identified that participants managed *being unprepared* by engaging in the basic psychological process *seeking balance by navigating the labyrinth*". The basic social and psychological problem and process will be presented in chapters three, four, five and six.

2.16 Summary

This chapter discusses the use of grounded theory method of qualitative research as first described by Glaser and Strauss (1967b). Data obtained during interviews from participants who had experience with the phenomena under investigation, field notes, methodological process and the constant comparison method was also described in this chapter. Once a substantive theory emerged, an inclusive literature review was conducted and the pertinent literature was added to the discussion of the thesis. Purposeful and theoretical sampling techniques were used in conjunction with the constant comparative method of analysis. The basic social psychological problem of *being unprepared* and the basic social and

psychological process of *seeking solutions by navigating the labyrinth* emerged from the data. The basic social psychological problem of *being unprepared* will now be presented in the following chapter 3 of this thesis.

PART TWO

CHAPTER 3

THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM: BEING UNPREPARED

CHAPTER 4

CONDITIONS INFLUENCING PARTICIPANTS' EXPERIENCE OF BEING UNPREPARED

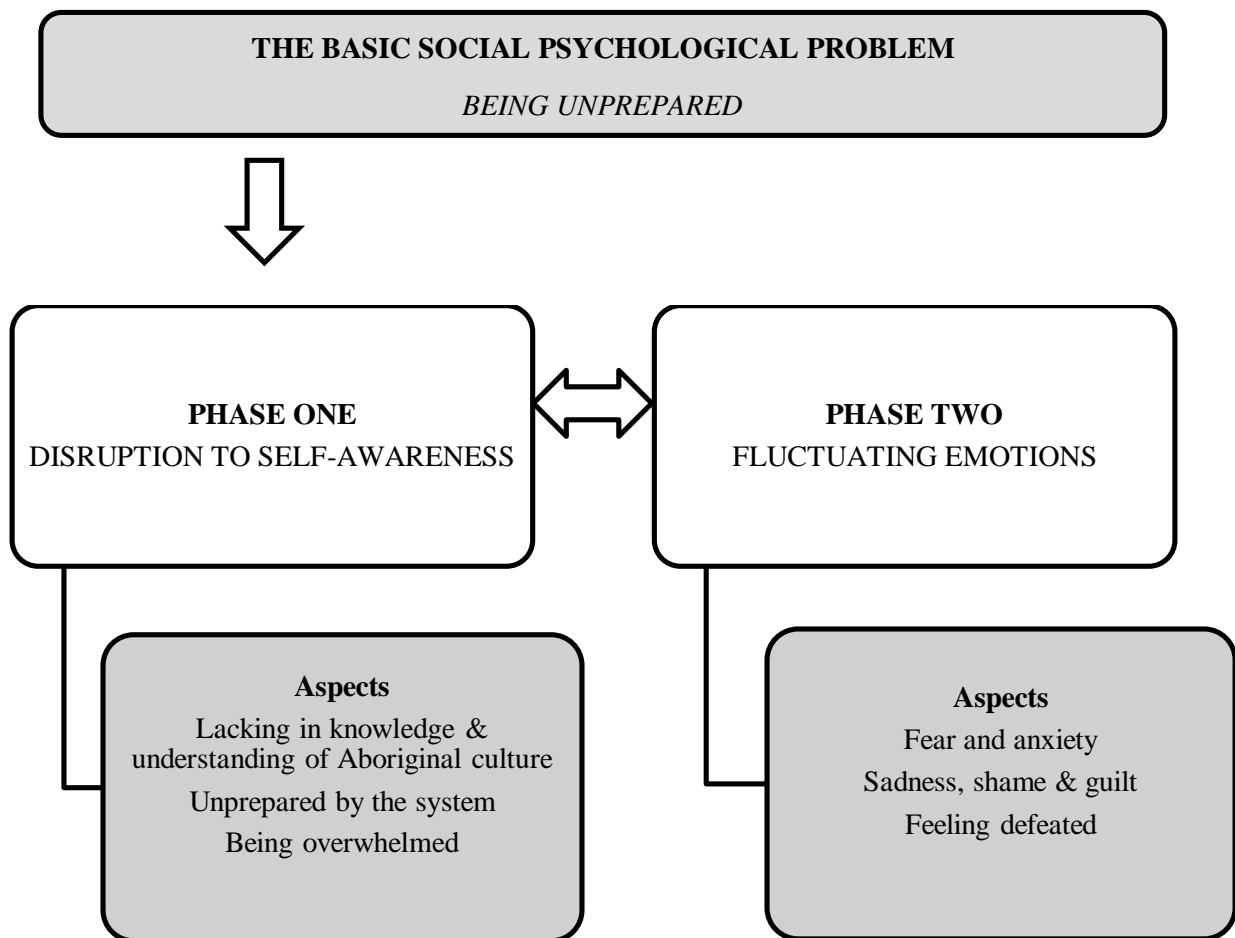
CHAPTER 3 - BASIC SOCIAL PSYCHOLOGICAL PROBLEM: *BEING UNPREPARED*

3.1 An Overview

When using grounded theory methodology, the researcher seeks to identify a core category and clearly identified links to subcategories to generate a theory that explains a pattern of behaviour relevant to the study (Glaser, 1978). In this study, a core category that emerged during data analysis was the basic social psychological problem of *being unprepared*. The data indicated that *being unprepared* was a common shared problem experienced by the majority of participants when working with Aboriginal people in the public mental health services in Western Australia. The Oxford English Dictionary (2015d, p. 9784) describes unprepared as “not ready or able to deal with something”. This description encapsulated participants’ experiences of being unprepared with most describing limited knowledge or experience of Aboriginal culture, Aboriginal history and Aboriginal concepts of health and wellbeing. This resulted in a sense of hesitation to work with Aboriginal people.

While participants’ experiences of *being unprepared* differed, for most it included feeling inundated by the issues around Aboriginal health and wellbeing and the complexity they encountered when working with Aboriginal people. Participants felt unprepared at both a personal and professional level and some experienced frustration at Australia’s inability to address the disparities in socio-economic and health gaps between Aboriginal and non-Aboriginal people and the impact of this on their professional practice. Participants described working in mental health as already challenging and these challenges increased when working with Aboriginal people. When participants felt unprepared, they felt powerless in the situations they were embedded. This was confronting for them and made them question their ability as a clinician; “I have to say that you felt you’ve not actually done anything worthwhile, in fact sometimes you felt like you’ve actually hindered their [Aboriginal patient’s] recovery” (P5). “I don’t feel confident to deal with an Aboriginal person and their cultural differences” (P26); “I don’t think I’ll ever really be prepared [to care for Aboriginal people]” (P25). The basic psychological problem of *being unprepared* was comprised of two phases: “*disruption to self-awareness*” and “*fluctuating emotions*” (see Figure 2, p. 48), and these will now be presented. Direct quotations from participants’ data have been included and participant numbers have been assigned to ensure confidentiality.

Figure 2: The basic social psychological problem: Being unprepared



3.2 Phase One: disruption to self-awareness

3.2.1. Introduction

The first phase of the basic social psychological problem, *being unprepared*, was conceptualised as *disruption to self-awareness*. Self-awareness is the knowledge and awareness of one's personality or character. It is the ability to recognise one's thoughts and emotions and their influence on self and interaction with others (Mersino, 2013). Participants experienced a *disruption to self-awareness* due to their limited experience, skills and knowledge to provide mental health care to Aboriginal people. Data analysis indicated that *disruption to self-awareness* consisted of three aspects: *Lacking in knowledge and understanding of Aboriginal culture; unprepared by the system and being overwhelmed*.

3.2.2. Lacking in knowledge and understanding of Aboriginal Culture

In phase one, *disruption to self-awareness*, participants' became aware they lacked knowledge and understanding of Aboriginal culture: "I actually don't know a lot, you know about the historical inner workings of the Aboriginal community. I just don't know" (P1). Participants reflected on events that triggered their awareness of their deficits in this area. For some, this was the awareness that despite growing up in Australia, they still had limited knowledge of Aboriginal culture and history. They recalled limited educational opportunities at school that discussed Aboriginal culture and history: "There was no recognition that there are different nations with different languages, different cultural [ways]. It was like, Aboriginal people, dreamtime, didgeridoo [and] boomerang" (P16); "I don't have a wide experience, my knowledge is absolutely minimal" (P7); "I would say I had almost zero knowledge" (P2); "I don't recall anything discussed at school" (P26).

Amongst the Western Australia population of approximately 2.5 million, over 31% were born overseas. Western Australia has been described as a state of migrants with over half of the population having at least one parent born overseas (Government of Western Australia, 2013). The United Kingdom, New Zealand and South African are the top three countries of overseas birth, with increased numbers now reported coming from India, Philippines and China (Government of Western Australia, 2013). Cultural diversity in Australia is also reflected in the nursing workforce. In 2011, one third (33%) of nurses in Australia were born overseas compared with one quarter (25%) in 2001. While traditionally many nurses originated from the United Kingdom (UK), this profile is changing. UK born nurse workforce

numbers have declined from around one third to about a quarter between 2001 – 2011. The largest proportional increase during this period occurred in Indian born nurses (ABS 2013b). Additionally, the percentage of overseas nurses working in Australia who trained overseas before migrating to Australia rose from 14% in 2004 to 16% in 2009 (AIHW 2013b). Australia relies heavily on recruiting health professionals from overseas (National Health Workforce Taskforce, 2009). The significance of a high number of the nursing workforce born overseas added to the complexity of working with Aboriginal people as this group of nurses are even less cognisant of Australian Aboriginal history and Australian born nurses.

Participants who were migrants clearly articulated the lack of knowledge and understanding of Aboriginal history and culture: “I suppose I came to Australia quite naïve and I’d never, ever considered Aboriginal health. It was never a concept I’d ever needed to consider” (P4); “When I was coming out here [Australia] I was a bit nervous thinking, Oh, I don’t know too much about Aboriginal care” (P5). The lack of exposure to Aboriginal culture increased participants’ feelings of *being prepared*; “Obviously when I first came from the [Country X] and when I first started working in [Hospital x] it was like I know nothing [about Aboriginal culture]” (P14); “When I first came to Australia, I knew nothing about Aboriginal culture or history. I knew nothing about the Stolen Generation” (P25).

Some participants discussed knowing a little about Aboriginal history and culture that was acquired on a superficial level: “So I know a little bit about the dreamtime and a little bit about the stolen generation and those sorts of things, but not a lot about [Aboriginal] social culture” (P5). Likewise, another participant discussed their understanding about Aboriginal beliefs about spiritual places: “I think that those sorts of links come into their wellbeing, be it mental, spiritual or physical. I think it’s all connected. I don’t [think] they separate it, like we tend to do” (P2). Some participants had more knowledge and understanding but were unsure of the origins of this information: “I have some knowledge but I don’t know necessarily where it comes from” (P16). The lack of knowledge and understanding created a challenge when asked to provide care as described by the following participants: “I wish I had it [the knowledge about Aboriginal history and culture] at orientation” (P2); “Part of their [health & wellness] journey is different, so I think we lack a lot of understanding” (P10).

For many participants, *the lack of knowledge and understanding of Aboriginal culture* meant that participants lacked conception of Aboriginal meanings of mental health and wellbeing. Some participants believed they had some knowledge of Aboriginal meanings of mental

health and used this limited knowledge in their interactions: “The word in Noongar [language] is “Kaarty” and that means crazy. There’s a massive stigma attached to that and it’s from within the Noongar people themselves, that’s their cultural stuff” (P 19). However most participants acknowledged that their understanding was severely limited and they had little information to guide their interactions and this increased their feelings of *being unprepared*: “I know in some cultures mental health isn’t a word, it’s not recognised, so I don’t know if that’s so for Aboriginals. I’ve no idea” (P7); “On a scale of one to ten, I feel I am at a five. I feel confident to deal with an Aboriginal patient as a person, but not with their culture” (P26).

Participants described how *lacking in knowledge and understanding of Aboriginal culture* created the challenge of understanding fundamental influences for Aboriginal people and exacerbated the problem of *being prepared*. This is articulated by the following participant who described not understanding a different way of life:

The other kind of challenge is that, you just don’t know sometimes where they come from and what kind of lifestyle they live and [what they], bring in terms of premorbid functioning. I don’t ultimately know where [they’re] coming from (P 16).

Participants also discussed *lacking in knowledge and understanding of Aboriginal culture* about the diversity of Aboriginal culture. While there is great diversity of Aboriginal cultural groups in Western Australia, mainstream mental health services are predominately delivered centrally in Perth and surrounds on Noongar land. Therefore staff are more likely to have experience with Noongar people than from other Aboriginal groups. Participants acknowledged that due to the diversity of Aboriginal cultural groups, understandings and experiences with one cultural group cannot be generalised to all Aboriginal groups and this added their lack of preparedness as the following participant explained:

There are so many different [Aboriginal] nations within Western Australia and they all have a different set of cultural values and beliefs, language. You can’t just blanket rule for them, because [it would be] like saying that Europe is one nation and they’re all the same culture, it just would be wrong (P16).

Aboriginal culture is diverse and dynamic, and different Aboriginal groups have different customs and conventions of social structure, language and relationship to each other (Hampton & Toombs, 2013). Noongar lore (law) and customs influence ways in which Noongar people define their rights and connection with country and how they care for the land. Noongar people consider their custodial status of the land a right and a privilege and

declare those who do not share these, need permission before they enter the land or use it. Traditionally, an Aboriginal person not part of the Noongar people effectively is a visitor in Noongar country and is exposed to the cultural Lore and customs of this cultural group, while being away from their own country and family group. This is confounded when a person is hospitalised for treatment on a land they are not culturally linked to. As previously stated, mainstream mental health services are predominately situated around Perth and surrounds and consequently, Aboriginal people from other groups may need to relocate to Perth [Noongar land] for mental health treatment. This causes additional stress to the distress of their symptoms by being away from the traditions of their family, land and community (McGrath, Holewa, Ogilvie, Rayner, & Patton, 2006). In the study by Kelly et al. (2011) of the experience of Aboriginal patients and their carers, they both stressed the significance of family for support for physical, economic, social, spiritual and emotional needs and for maintaining connections.

During the interviews with participants, many spoke of how their lack of knowledge and understanding impacted on their communication and interpersonal interactions with Aboriginal people. For example, the choice of appropriate topics of conversation and nuances: “You know, like I’ll quite often use humour with people once I’ve got to know them but certainly culture-wise you’ve got to worry about whether they understand that kind of humour and whether it might even be offensive to them” (P11). *Lacking in knowledge and understanding of Aboriginal culture* also amplified the participants’ ability to engage in therapeutic interactions with Aboriginal people and participants questioned the effectiveness of these interactions: “If anything, I did things that were damaging and did the wrong thing thinking that, perhaps they [Aboriginal people] were presenting as obstinate or rude” (P2); “I did often wonder if a white, middle aged and middle class woman was the right person to help an Aboriginal patient” (P28).

Several participants discussed how *lacking in knowledge and understanding of Aboriginal culture* influenced their ability to distinguish whether the presentation or signs and symptoms seen in Aboriginal people was part of the illness or related to cultural or other factors. This influenced many participants’ level of preparedness to assess key observations as part of mental health assessment, as the following participants explained: “Definitely delineating between what we might perceive to be psychotic phenomena and what they might consider to be culturally appropriate beliefs is a challenge” (P 16); “You don’t know how much of that was just plain illness or [the impact of] past experience” (P 11): “A lot of spiritual things,

which was really hard to work out whether they were delusional or whether they were actually part of [their] culture” (P 5); “How can you work out if it’s a delusion outside of a person’s cultural norm if you don’t know what the cultural norm is, you can’t” (P 19).

Understanding cultural differences for Aboriginal people is a significant factor, particularly when performing a mental health assessment and in implementing an appropriate plan of care. Limited knowledge and understanding of Aboriginal culture and history ultimately influenced participants’ experience to provide appropriate care.

Participants reported that *lacking in knowledge and understanding of Aboriginal culture* also affected their ability to appreciate the situation from the other person’s point of view. This decreased their ability to engage empathetically with the Aboriginal patient: “I suppose the main kind of challenges I’ve experienced is the perception from either side that we [health professionals] might not actually understand what’s going on for them [Aboriginal patients]” (P16). This challenge to empathetic understanding also influenced the formation of effective therapeutic relationships:

Well it makes it difficult to actually provide the psychosocial kind of interventions, because it’s hard to build that initial rapport because a lot of those are built on the initial respect and rapport that you build. It’s very difficult to break that down (P16).

The capacity to empathise and establish therapeutic relationships was reiterated by another participant when they were exposed to the complexity of mental health presentations in Aboriginal people: “I was quite struck by the differences in presentations I’d seen in Aboriginal people with mental health problems and it was actually far harder to engage [them] in a therapeutic intervention” (P4).

The experience *lacking in knowledge and understanding of Aboriginal culture* was also observed in studies involving health professionals. In the study by Durey, Wynaden, Barr, and Ali (2014) into improving forensic mental health care for Aboriginal Australians, participants believed that several factors were important in their capacity to provide care to Aboriginal people, including knowing about Aboriginal culture and history and the colonisation of Australia by the British. Similarly Wilson, Magarey, Jones, O'Donnell, and Kelly (2015) study of the attitudes and characteristics of health professionals working in Aboriginal health revealed four main groupings which ranged from a lack of practice knowledge; a fear of practice; a perception that it was too difficult; to learning to practice regardless.

In summary, during this first phase of the basic social psychological problem of *being unprepared*, participants described they lacked the knowledge and understanding to work effectively with Aboriginal people and this added to the complexity and challenge of providing quality mental health care to this group of patients.

3.2.3. Unprepared by the system

Subsequent to the experience of *lacking in knowledge and understanding of Aboriginal culture*, participants also spoke of being *unprepared by the system* to work with Aboriginal people. This second aspect of phase one disruption to self-awareness consisted of three components: 1) education system; 2) discipline preparation; and 3) the health system.

Some participants, despite growing up in Australia, stated a lack of knowledge and understanding about Aboriginal culture and history that could be traced back to primary and secondary schooling. Not being prepared by the school system amplified their later experiences in *being unprepared*: “To be honest, my perception of what we were taught at school was that Aboriginal culture was one thing [and] there was no recognition that there are different nations with different languages, different cultural [ways]” (P16); “Look, it’s not wide, my knowledge is absolutely minimal” (P7); “There was very little taught [about Aboriginal culture] at school from memory” (P26). For the following participant, being *unprepared by the system* in the formative school years resulted in barriers to working with Aboriginal people in a professional role: “There’s actually not a lot of people who grew up and who were schooled [in Aboriginal culture and history] and had that information who are working within the area and that’s a huge barrier” (P5).

Several participants described *being unprepared by the system* by the limited amount of information attributed to Aboriginal culture and health and wellbeing provided in their professional training: “I think we’re not educated from the outset” (P5); “During my undergraduate degree, there was some discussion about Aboriginal culture, but very little” (P26). Others had vague recollections about how they were prepared by the system and how it contributed to their experience of *being unprepared*: “I just don’t know; there may have been something taught but it just doesn’t jump out at me” (P7). “During my training, there was some discussion around Aboriginal cultures, but it was rather ad hoc. It was mainly about communication rather than assessment” (P24). The following participant who completed their undergraduate training within the previous ten years and then completed a post graduate degree in mental health felt that neither course of study had prepared them

adequately:

We had socio-cultural perspectives [in the undergraduate training] of health and a little bit of Indigenous content there, but when we came to [the mental health specific content] for example, I would say I had almost zero knowledge [about Aboriginal issues]. In orientation, [to the clinical practicum experiences], we may have been told “Read this chapter” or “Do that reading” [but] if you can’t link the relevance and if you don’t have that experience, [then] learning is not reinforced (P2).

Participants who completed their mental health qualifications more than twenty years ago, also felt *unprepared by the system*, and recalled negative experiences in their training which exacerbated the problem for them: “I think I need to increase my knowledge base [to provide culturally safe care], because I have an old institutionalised experience that I don’t like” (P7). For other participants, further professional studies were also viewed as lacking in the content in relation to Aboriginal culture and health and wellbeing: “I did some postgraduate nursing studies, there was a component [Aboriginal], but not a large component” (P5).

Limited opportunities to attend ongoing or professional development in the area of Aboriginal health and wellbeing were highlighted by several participants. For example: “I’ve had no training about Aboriginal culture in the workplace” (P26); “You do your training way back and things change and evidence-based practice changes what we’re doing but there’s a lack of professional development support [within the work environment]” (P19); “I think when you look at what the service provides in relation to awareness and being able to engage appropriately culturally, I think that’s limited” (P12).

While some employer professional development was available to participants, accessibility was problematic for a number of reasons, including getting time off the ward, staffing availability and work priorities: “There’s always training on the go but unfortunately on this ward we never get to them. We just never get released for the training, which is disappointing” (P3). This left the participants feeling unsupported in their effort to obtain professional development as outlined by the following participant:

At the hospital, over the years it became harder and harder to have the time to do that [professional development] because of staffing. There is never any time to do your own professional development on the wards, particularly if you are in the coordinator role (P2).

The promotion of and accessibility to written or online resources in the workplace also added to participants’ feelings of being *unprepared by the system*: “Later on I came across written

resources that were available or online and you know you think oh, gee that would have been great two months ago when I needed it” (P2). Similarly, participants’ felt *unprepared by the system* due to the limited emphasis or requirement by the organisation for staff to engage in cultural awareness or cultural safety training. Participants reported varied experiences with requirements to attend training: “I don’t recall there being any cultural awareness” (P7); “The organisation requires you to do the mandatory training, but there is no requirement to repeat it as part of ongoing professional development” (P24). Another participant provided this insight:

We have to do our manual handling [training] every year and they pay us to take time off the ward to go and I have to do my CPR [cardio-pulmonary resuscitation training], but I don’t have to do any cultural [training] on a regular basis. It’s not mandatory, and I think [this is] not necessarily helpful (P19).

Other participants reported that although cultural training was compulsory at their service, the content was not necessarily Australian Aboriginal history and culture: “There’s a thing that’s become mandatory, called multicultural awareness training. It’s not specific to Aboriginal people, it’s about people from abroad. There’s another training that is not mandatory, and [that training] deals with Indigenous patients” (P1).

Participants who were able to attend cultural awareness programs in the workplace expressed mixed feedback on how this education impacted on their experience of *being unprepared*: “It wasn’t Aboriginal-specific, it was all cultures, [and] it was very generic. To be honest, I don’t think I could pinpoint one thing I took away, but I don’t think there was anything specific” (P14). “It’s just a tick box exercise for the health department to say they have provided cultural training” (P24); “It [training] was just a tick box mentality, we need more” (P28). Another participant described it as tokenistic and not specific to Aboriginal health and wellbeing:

I have to admit I’ve felt a bit like that as well, very tokenistic and it was multicultural and there was a small component [about Aboriginal culture], but I wanted to learn about the health of Aboriginal people and how I should be working with them, we only got a small amount of stuff about Aboriginal [culture, history] (P5).

Other researchers have identified that cultural training programs that are not Aboriginal specific may not address Australian Aboriginal history or acknowledge the impact of colonisation, which forms the foundation to cultural awareness (Downing & Kowal, 2011). Furthermore, in the background paper on Cultural Safety Training Standards, The National Aboriginal Community Controlled Health (NACCHO) (2011) asserted that cultural training

that does not openly discuss racism and discrimination prevents participants' from developing an understanding of the experiences of Aboriginal Peoples and their interactions within the health system.

Several participants questioned the relevance of the training provided and how they were able to apply this to their clinical knowledge and practice. The following participant still felt *unprepared by the system* after attending workplace training:

I think there's a one day mandatory cultural diversity training that everybody turns up to ... but in relation to the content I got from the presentation, I wouldn't have considered I walked away any more knowledgeable specifically. In relation to us engaging culturally appropriately with Aboriginal [people], did the one day overview give us an insight into that? My view was no, not really (P12).

Participants also claimed workplace cultural training programs were not an effective use of time and resources with little gained from it: "I can't remember what was in it, but it was a waste of time. I didn't learn anything from it" (P19). Another participant, felt bored by the training: "It was two days of excruciating boredom and I'm just really glad that I did it and I only ever have to do it once" (P1).

In summary, during phase one of the basic psychological problem, *disruption to self-awareness*, participants experienced being *unprepared by the system*. Many felt they had not been adequately *prepared* in their schooling and in their educational preparation as a mental health professional. Participants also experience being unprepared by the system via limited or inadequate ongoing professional development.

3.2.4. Being overwhelmed

The third aspect of *disruption to self-awareness* was conceptualised as *being overwhelmed*. These feelings emerged when participants were asked to work directly with Aboriginal patients. The experience of being overwhelmed is described as "having a strong emotional effect on"(Oxford English Dictionary, 2015b, p. 6529). Situations that created feelings of *being overwhelmed* for participants developed in a variety of ways. For some, it related to particular patient scenarios where they felt inadequate to provide support to Aboriginal people as the following participant described: "One [patient] that comes to mind is quite recent really, this particular case [patient] I'm quite clear that, we're not going to be in a position to help this young person." (P1). For others, the experience of *being overwhelmed* was attributed to multiple encounters with Aboriginal people: "You know I don't really think

the system is geared up to look after Aboriginal clients particularly” (P3). The severity of issues in relation to the health and wellbeing for Aboriginal people left participants *being overwhelmed* by the work required and their ability to be effective as clinicians. Participants experienced *being overwhelmed* by the complexity of socio-economic and health issues affecting Aboriginal health people. One participant used the analogy of using a Band-Aid on a huge wound: “[Regarding] mental health outcomes for [Aboriginal] people, I think staff attitudes is like putting a Band-Aid on a gaping abdominal wound. Staff attitudes and [their] approach are a minor solution to what actually needs to be happening” (P4). Another participant gave this analogy:

When [Aboriginal] people are absolutely in crisis...they’ll come and talk about all sorts of awful things that have happened to them through their life, but it’s like you do a little bit of work with them and as soon as they’ve got the capacity there to actually patch that back up...they’ve got the lid back on Pandora’s Box [In Greek mythology Pandora’s Box was a vessel containing all of human ills that once opened releases many complex problems, therefore it is best left shut] (P 19).

Similarly, feelings of *being overwhelmed* related to health professionals’ lack of confidence were reported by Wilson et al. (2015) along with high levels of discomfort regarding the complex socio-cultural determinants related to Aboriginal health and wellbeing and how to work with Aboriginal people.

3.2.5. Summary

The first phase of the basic social psychological problem, *being unprepared*, was called *disruption to self-awareness*. It was comprised of three aspects: *lacking in knowledge and understanding of Aboriginal culture*, *being unprepared by the system* and *being overwhelmed*. Through this phase, participants became involved in situations when working with Aboriginal people in mainstream mental health care system that was multifaceted and extremely challenging for them. When this occurred, they experienced feelings of *being overwhelmed*. Participants moved to the second phase of the basic social psychological problem while being aware of their feelings of *being unprepared*. The second phase, called “*fluctuating emotions*”, will now be described.

3.3 Phase Two: fluctuating emotions

3.3.1. Introduction

Participants entered the second phase of the basic social psychological problem of being unprepared, called fluctuating *emotions*, as a result of experiencing a disruption to self-awareness. Movement from one phase to the next varied for each participant but *fluctuating emotions* was a common experience reported by all participants. Emotions are psychological responses that include subjective experience, expressive behaviour and a physiological response (Gross & Feldman, 2011). Winkielman and Berridge (2004) suggested that emotions result in a change in physiology, cognition, motivation, behaviour and consciousness. The term is often used to describe the experience of anger, fear, surprise, sadness, happiness, contempt and disgust. Although emotions are considered automatic responses to an experience or event, they are also shaped by life experiences (Ekman & Cordaro, 2011). Human emotions are complex and dynamic and an experience can generate a range of fluctuating emotions as a response. This phase had three aspects: “*fear and anxiety*”; “*sadness, shame and guilt*” and “*feeling futile*”.

3.3.2. *Fear and anxiety*

Participants experienced feelings of *fear and anxiety* when working with Aboriginal people: “I remember not feeling I had enough understanding and I was scared of Aboriginal people. My first impressions were they were very loud and I’d heard negative things [about them] from other staff” (P25). The experience of fear and anxiety also included dealing with historical treatment of Aboriginal people. Participants were also cognisant of their position within a government organisation and feared being labelled racist by the Aboriginal people they came into contact with. This fear of being disliked or not trusted by Aboriginal people is difficult to reconcile as articulated by the following participant: “I think it’s, you know, we’re white, we’re public health service, we’re part of the government, we’re an institution, there’s a perception they may be that fearful of us” (P12).

Fear and anxiety was a common theme from participants and many sensed that Aboriginal people mistrusted and were suspicious of them and that this mistrust and suspicion was enduring and pervasive: “I know what happened and I actually see where the mistrust comes from” (P13); “I think really essentially people are frightened, they’ve had years of not even questioning what they’ve been taught [about non-Aboriginal people]. It might be generational” (P10); “My suspicion is that we probably don’t get the full picture of what we’re dealing with [when] we’re dealing with Aboriginal people ...because and they don’t trust us enough, [and] I suspect that comes from their own past experience” (P18).

Participants experienced feelings of tension due to the guardedness between Aboriginal and non-Aboriginal people attributing it to issues of mistrust stemming from the process of colonisation. For many participants, feelings of mistrust and suspiciousness between Aboriginal and non-Aboriginal people added to the experience of *being unprepared*, and they expressed how this mistrust affected the basic therapeutic relationships with Aboriginal people:

Well, it makes it difficult to actually provide the psychosocial kind of interventions because it's hard to build that initial rapport because a lot of those are built on the initial respect and rapport that you build. So if that's a perception from either side, then it's very difficult to break that down (P16).

Similarly, another participant provided this insight into the feelings of *fear and anxiety* surrounding perceived ability to empathise with Aboriginal people as a non-Aboriginal mental health professional:

There's lots of times where I've been accused [by Aboriginal patients] "You don't understand what's going on for me, you don't know where I come from, you don't know about my people [and] you don't know about my culture. Why should I be listening to you in terms of my recovery?" (P16)

Several participants reported feelings of *fear and anxiety* due to the level of mistrust and disrespect they believed there was between Aboriginal people and non-Aboriginal people: "[There's] a lack of respect for whites" (P13); "They will tend to say "You guys" or "You whites" or "I'm sick of white people's [swear word]", so it can be challenging" (P12). The following participant provided this perspective about the difficulties in engaging in a context of tension and apprehension: "So you're trying to engage somebody who has preconceived ideas about you, I found that quite shocking. I've actually lost count of how many times I've been called a white [swear word], that presents difficulties with engagement" (P4).

Some participants expressed high levels of *fear and anxiety* that the poor perception of them held by Aboriginal people was a catalyst to greater hostilities. Some participants reported experiencing reverse racism: "I think almost always the race issue comes up; "You racist [swear word] something, something". You know what its like that seems to always be in a conversation" (P2). Another participant, who identified as being "white" and had no prior experience of hostility from other people before coming to Australia, developed their *fear and anxiety* on arrival in Australia: "The [Aboriginal] patient immediately mistrusted me because I was white. They immediately felt aggressive towards me because of the historical [events]. I'd never been racially abused before I came to Australia" (P4).

Other participants reported experiencing less *fear and anxiety* and seemed to be able to tolerate being called derogatory names; “You get the [occasional Aboriginal person]....that calls us all [swear word] white [swear word] and you get that. That’s the way they [communicate], you can’t condemn anybody [for] that” (P17). Similarly, the following participant did not take these comments personally, nor did it raise their level of *fear and anxiety* and took it as a matter of course: “Obviously “white [swear word]” is something that’s being flung around a lot, I don’t generally take too much offence to it” (P16).

The following participant remarked that despite the limited experiences in working with Aboriginal people, they noticed vast differences in the signs and symptoms of mental illness in Aboriginal people and these noticeable differences increased their level of *fear and anxiety*: “I was quite struck by the differences in the presentations that I’d seen of Aboriginal people with mental health problems, they are usually more aggressive” (P4). This was echoed by another participant:

I remember [an Aboriginal] lady who I was frightened of because she was physically aggressive. Now, she was probably physically aggressive for a reason. I don’t know why that was, so I was always apprehensive looking after her. I would look after her but I was always a bit cautious because I knew I could get hit. So, for me, that was about I don’t like being hit. I wonder whether [it’s] because someone is Aboriginal or because of their behaviour or both (P7).

The experience of fear about working with Aboriginal people has also been reported by other researchers. Wilson, Magarey, Jones, O'Donnell & Kelly’s (2015) study into the attitudes and characteristics of health professionals working in Aboriginal health found participants feared being racist and saying or doing the wrong thing. Similarly, in Wilson’s (2011) study of non-Aboriginal dietician’s experiences of working with Aboriginal people was seen as “stepping into unknown territory” and fear was linked with not understanding Aboriginal culture and a fear of doing something wrong. Fear in working with Indigenous people was also described in the study by B. Bennett, Zubrzycki, and Bacon (2011), into the experience of social workers working alongside Aboriginal people. One non-Aboriginal participant working in mental health reported “I think the biggest challenge is getting people to get over the fear of working with Aboriginal people” (B. Bennett et al., 2011, p. 26).

In summary, the *fear and anxiety* was an aspect of phase two, *fluctuating emotions* and contributed to the experience of *being unprepared*. Participants’ emotions of *fear and anxiety* included a fear of how they were perceived by Aboriginal people, a fear of being labelled

racist, fear of anger and aggression directed towards them and general fear and anxiety towards engaging with Aboriginal people.

3.3.3. *Sadness, shame and guilt*

The next aspect of the second phase was feelings of *sadness, shame and guilt*. These feelings arose when participants reflected on Australia's history and treatment of Aboriginal people: "Living here, [in Australia] you start to critically think. I was made more aware of those kinds of issues [how Aboriginal people were treated]" (P16). Some participants reported feelings of guilt over Australia's political policies impacting on Aboriginal people: "Some of them came from a very sad difficult life because of the Stolen Generation" (P15). For other participants, the experience of *sadness, shame and guilt* was evoked by acknowledging a pattern of chronic illness in Aboriginal people. One participant was recognisably emotional when expressing their *sadness, shame and guilt* over the health outcomes for Aboriginal people: "It does my head in [teary], well, as you can see [I get] really emotional" (P1). *Fluctuating emotions* and feelings of *sadness, shame and guilt* was echoed by another participant: "Those who end up with addiction to poly substance abuse ... They come through admission and then they get lost in the system and they become like a revolving door [come back to hospital on numerous occasions], this is a bit sad" (P15). For some participants, feelings of sadness, shame and guilt came from their preconceptions and misperceptions they held towards Aboriginal people: "I'm probably guilty to a certain extent because I see the people on xxx Street and [I think] no wonder they get a bloody bad name because they're on alcohol and drugs and they're screaming and swearing" (P14).

Participants' experiences of *sadness, shame and guilt* also came from looking at the history of local Aboriginal groups: "The Noongar people had a very, very difficult time in terms of what they've gone through" (P10). Another participant admitted to being unaware of the issues for Aboriginal people prior to their arrival in Australia, and they acknowledged they may have some biased views: "Initially [on coming to Australia] I did not have preconceived ideas [about Aboriginal people], I probably do now (P4)".

Other participants' feelings of *sadness, shame and guilt* came from the impact of colonisation and Australia's repressive policies directed at Aboriginal people and culture: "I only know of [the] history, it must be difficult for Aboriginal people to go through that" (P13); "Years of oppression and the treatment [of] Aboriginal people. They have lost their land, they've lost their family, and they've lost their culture, it's all been sort of pulled apart" (P10). Similarly

from another participant who recalled feelings of guilt related to traumas experienced by Aboriginal people:

Clearly it's been a very traumatic history of which the British rule has been instrumental in causing great trauma to Indigenous Australians. Quite a horrific shameful history: of land being taken; of children being taken; of events being managed very crudely and very inhumanely (P 4).

For many participants, shame resulted from the realisation that these practices and policies were part of Australia's recent history: "I now understand about the stolen generation and I understand where their trauma comes from" (P25). Similarly from this participant:

I didn't really know about the past- sort of settlement history and that was obviously kept nice and quiet by the Government. I was actually horrified to find out it had lasted [until recently]. I have an interest in the Native Americans and their history is very similar to the Aboriginal history. To find that what was happening [there] was stopped in the early 1900s [but] was still going on here in the 1970s, is just like absolutely crazy. I mean, if I was them I wouldn't have anything to do with us either. (P11)

Feelings of *sadness, shame and guilt* are common emotions expressed by non-Aboriginal people when recognising the resulting impact and harm to Aboriginal people as a result of colonisation. Dottolo and Stewart (2013) described these feelings of guilt for racial injustice as "white guilt". Caouette and Taylor (2015) suggest it is important to shift the focus away from attributing blame and instead towards taking responsibility. They suggest that rather than taking personal responsibility, these feelings can generate the social responsibility to address these issues. Maddison (2011) state that "white guilt" has left many non-Aboriginal people paralysed, with a sense of helplessness in addressing the generational impact of colonisation, while others have turned this emotion outwards, in anger of the failure of Aboriginal people to exploit the advantages that came with colonisation. Additionally, Maddison (2011) asserted that the failure to address this impact of colonisation has resulted in continued tensions between Aboriginal and non-Aboriginal people and the attempts to resolve this tension can only be addressed with a new way of thinking and talking about the events of the past and how discussion on how Aboriginal and non-Aboriginal people might live together in the present and for further generations.

In summary, *fluctuating emotions* was experienced by many participants as they spoke of *being unprepared* to work with Aboriginal people in mainstream mental health services. Participants were particularly unprepared for the negative feelings that contact with Aboriginal people evoked in them along with feelings of *sadness, shame and guilt* when

considering the contribution that Australia's history on the health and wellbeing of Aboriginal people had caused.

3.3.4. Feeling defeated

The final aspect of the second phase "fluctuating emotions" was the experience of "*feeling defeated*" and this occurred when participants involved in the ongoing care of Aboriginal people were confronted with the complex experiences of working within the public in mental health settings. The following participant compared their work with Aboriginal people in mental health to their partner's experience who worked with Aboriginal people in a different context:

It often frustrates me. My [partner] works in [industry]. They've had a lot to do with Aboriginal people in terms of land and country and site. Often he has much nicer times than mental health where everyone's always kind of angry. You feel like you're doing a pretty miserable job. (P10)

For other participants, experiences of *feeling defeated* came when they were confronted with the severity of health issues seen in Aboriginal people: "You know, the trauma and the damage has been done before they even see people" (P4). For the following participant, the experience of *feeling defeated* arose from their perception of the experience of Aboriginal peoples' struggle with systems and institutions: "The treatment of Aboriginal people and their lack of voice [and] lack of empowerment. They don't have legislative power and then they're expected to try and function in a white world that doesn't support their health" (P10).

Participants experienced feelings of *feeling defeated* by the limitations in the health system to provide better mental health outcomes for Aboriginal people. Frustration and helplessness were components of *feeling defeated* that arose when participants felt the health needs of Aboriginal people were not being addressed: "[Aboriginal] people often don't really have a good awareness of their health issues and long-term understanding of the consequences of poor diet and poor use of medication. This is not something we can just fix in one generation" (P18). Similarly from the following participant:

We have this huge and obviously very clear problem, yet there is no active solution at this point ...Changes that need to be made about breaking the cycle of poverty, about [changing] everything that comes with that. The trauma and the damage are already being done. I think we need to get that right (P4).

While participants' experienced *feeling defeated* by the limitations of the nation and the

health system to address the needs of Aboriginal people, they also were overwhelmed by their role in mainstream mental health services. Participants were exposed to systemic and emotional barriers to addressing the poor mental health outcomes for Aboriginal people:

The level of frustration and anger that's expressed toward Aboriginal people rather than understanding I find a huge barrier, and people's inability to want to talk about their role as part of the solution rather than a blaming kind of there are all these problems and they need to fix them, rather than saying "What's our role?(P10)

Experiences of *feeling defeated* were also attributed to the generational manifestation of complex psychosocial factors for Aboriginal people as discussed by the following participants: "There's significant underlying factors, [like] parental history of alcohol and drug misuse [and] with parental historical experience of family violence and these in turn are becoming features of the next generation's life experience" (P 1); "I think the whole cycle of life, that occurs within some Aboriginal communities are very hard to change and once that cycle has started" (P 4); "We're not dealing with problems in the Aboriginal population until they get to the point where they're dangerous and they're really out of control and they become a threat to society' (P 3); "They'll talk about awful things that have happened to them, but you do a little bit of work with them and soon ...they [Aboriginal people] have got the lid back on Pandora's box and just leave it closed" (P19).

Participants also attributed the experience of *feeling defeated* to the lack of clear objectives in providing mental health care to Aboriginal people. The following participant felt that perceptions and intentions were often misguided: "I think we're really good at looking at what we can do to change the immediate problem as we see it, in isolation of the precipitating events and often [make] misinformed, ill-informed choices we have imposed previously" (P18). This was reiterated by another participant who expressed *feeling defeated* over the experience that health and welfare needs escalated for some Aboriginal people resulting in dire consequences:

It seems to me we're not dealing with problems in the Aboriginal population until they get to the point where they're dangerous, when they're 16 years old and they're really out of control and they become a threat to society [because of] drugs and violence, extreme violence and psychotic behaviour. We're just getting them and locking them up, because nobody's dealt with it before and then suddenly you've got a 16 year old on a rampage (P3).

Participants' experiences of *feeling defeated* generated emotional responses as they recalled particular examples of Aboriginal people who they came into contact with in mental health

services. The participants' response arose from their perceptions of the real impact that the mental health system or the individual participant could offer to improve the mental health of an individual Aboriginal person or community. The following participant pondered the real value of culturally appropriate therapeutic interactions in the context of larger sociological factors for Aboriginal people in her recollection of a particular patient as she articulated *feeling defeated* by the experience:

We saw a woman who came in; this is an example of many. She has kids in the house. She was returned to that house. I can sit down and be as therapeutic with her as I like, I can be as politically culturally aware as I can be, but as long as she's returned back to her house, fuelled with alcohol and violence, it's not going to make any difference really. Or to her children who are there witnessing that. We're foolish to think that our impact would be significant (P4).

This participant had known a particular patient over several years and had established a rapport with her. In this case, the patient met an ultimate death and this had an emotional impact on the participant and leaving them *feeling defeated*:

One particular patient comes to mind, had multiple admissions. She's now actually deceased. She was really unwell and came into hospital and [the] the last time I saw her was in 2006. It's close to me. I would always make sure I would nurse her when she came in. I had that rapport with her and she knew me. She did present as quite challenging in her behaviour. When I found out that she actually committed suicide [it] really was devastating (P2).

One participant felt their personal efforts were inconsequential and had a limited impact without a more comprehensive and multiple strategy aimed at improving health care and social outcomes:

I think we're fooling ourselves in thinking we can make a significant difference before any clear infrastructure or major changes are made. We're not. It's like pouring a bucket of water over the towering inferno. It's not going to make a huge difference (P4).

Participants' experiences of feeling defeated are similar to the experience described in Wilson et al. (2015) into the attitudes and characteristics of health professionals working in Aboriginal health. In Wilson's study, non-Aboriginal health professionals who had worked in Aboriginal health frequently experienced it as "too hard". Similarly, in this current study health professionals did not feel they could adequately address broader social determinants affecting the health of Aboriginal patients.

In summarising this section, participants experienced feelings of *feeling defeated* for the

following reasons. They were overcome by the constantly *fluctuating emotions* and the experience of *being unprepared* to work with Aboriginal people in mainstream mental health services. Frustration and discontent were identified as the most consuming components of the aspect *feeling defeated*.

3.3.5. Summary of basic social psychological problem

The grounded theory study identified those participants who were mental health professionals working with Aboriginal people in mainstream mental health services in a Western Australian community, shared a common basic social psychological problem of *being unprepared*. The first phase of the two-phase problem was entitled, *disruption to self-awareness* and included the aspects; *lacking in knowledge and understanding of Aboriginal culture; being unprepared by the system; and being overwhelmed*. The first phase of the basic social psychological problem continued until the participant moved to phase two, when they were cognisant of the changes to self-awareness triggered by *being unprepared* entered the second phase called *fluctuating emotions*. The second stage of the basic psychological problem, called *fluctuating emotions* phase had three aspects; *fear and anxiety, feelings of sadness, shame and guilt; and feeling defeated*. A number of conditions were identified in the data as influencing participants' experience of *being unprepared* and these influencing factors will be presented in the next chapter of this thesis.

CHAPTER 4 - CONDITIONS INFLUENCING THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM OF BEING UNPREPARED

4.1 Introduction

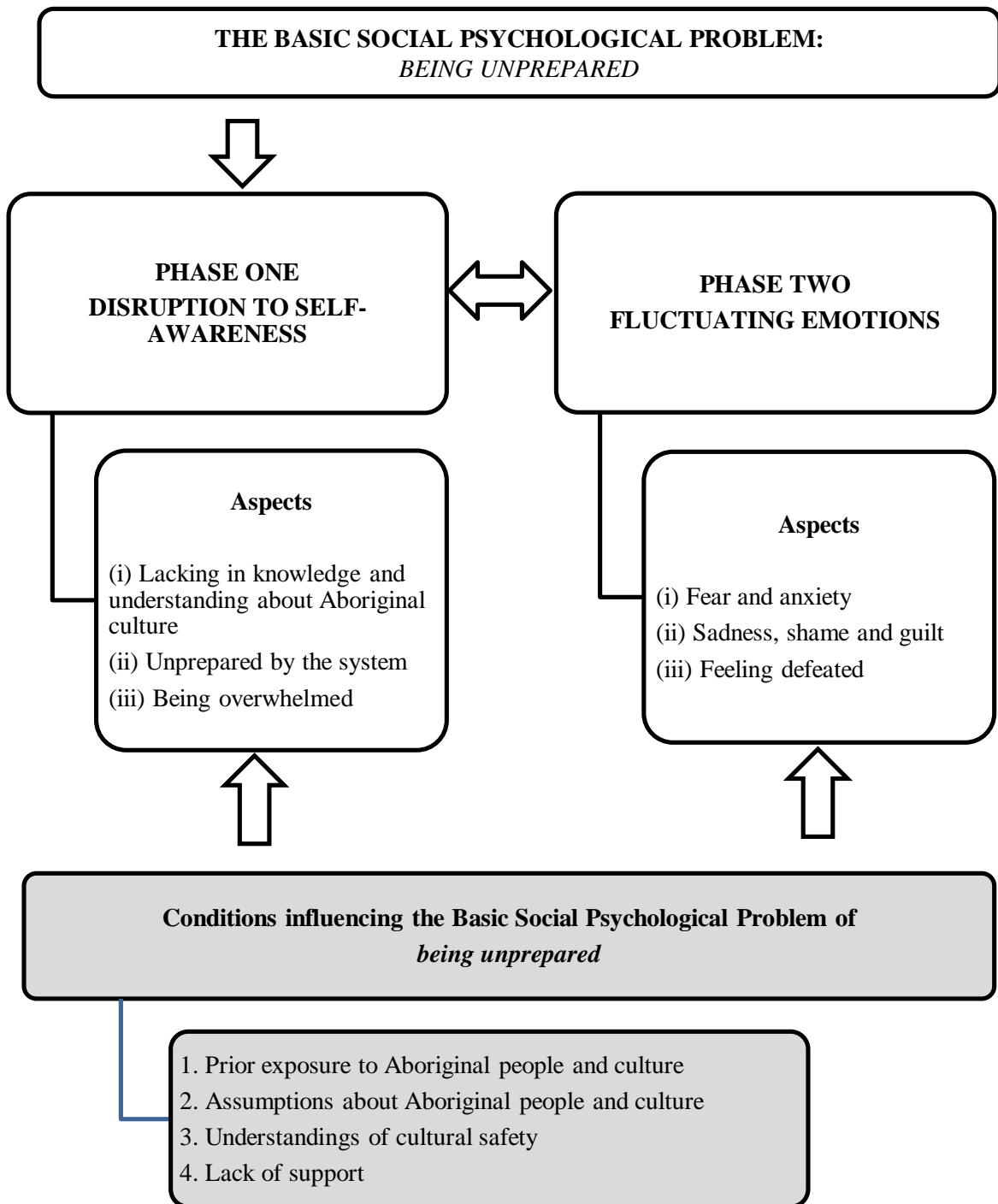
This chapter presents the conditions that influence mental health professional's experience of providing culturally safe care to Aboriginal people in mainstream mental health services in Western Australia. Data analysis identified four conditions that influenced participants' experiences of being unprepared (see Figure 3, p. 69). These were: 1) *Participants' prior exposure to Aboriginal people and culture*; 2) *Assumptions about aboriginal people and culture*; 3) *Understandings of the concept of cultural safe safety*; and, 4) *Lack of support*. Each of these conditions will now be described.

4.2 Prior exposure to Aboriginal people and culture

Participants' prior exposure to Aboriginal people and culture was the first condition influencing the experience of being unprepared. Many of the participants spoke of this: "My exposure [to Aboriginal people] has been limited" (P4); "I would say I had almost zero knowledge [of working with Aboriginal people]" (P2); "You know, I don't know very much [about Aboriginal people]. I'm learning all the time but I actually don't know a lot" (P1); "I've not had specialised intensive involvement with working with Aboriginal patients with mental health problems. However, I have had contact when they've come into generic services, so my exposure has been limited" (P4); "My contact with Aboriginal people in some ways always been probably been fairly [limited]" (P18).

Participants' lack of prior exposure affected their ability to understand issues affecting Aboriginal people and heightened their experience of being unprepared; "You're not an Aboriginal, what the hell do you know?" (P13); "I suspect there're times when we don't actually get involved [with Aboriginal people] or are [adequately] equipped" (P18). The following participants described not feeling confident and questioned the effectiveness of their interactions with Aboriginal people; "I went out [to work] with very limited, [knowledge in this area], if anything, I did things that were damaging" (P2); "To be honest, it was a case of winging [making do] it until you got to know a bit more about Aboriginal culture" (P14); "I suppose contact with Aboriginal communities is often limited...you look at what comes through the door and you work from that" (P18).

Figure 3: Conditions influencing the basic social psychological problem of being unprepared



Several participants reflected on their ability to find a commonality with Aboriginal people “It was actually far harder to engage in a therapeutic intervention...I certainly found that hard. Whether that’s my cultural differences, [or other causes]....they were clear standout differences for me” (P4); “I think [there is] an assumption of the lack of common ground” (P6); “The other kind of challenge is that you just don’t know where they come from and what kind of lifestyle they live and [their] premorbid functioning” (P16); “You can as a white person, think that you need a specialist Aboriginal health worker [because] I’m a white person. Therefore I can’t understand this or they’re not going to want to talk to me” (P19). From the same participant: “At times, there’s a sense of perhaps not really fully understanding and having to ask, what do you mean by that and can you explain that to me, because I don’t actually understand what you mean”(P19). Cultural differences between patients and health professionals may inhibit access to treatment, accurate assessment and appropriate care. Kirmayer (2011) claimed that clinical interaction must recognise cultural diversity and find common ground in order to identify the health problem, culturally appropriate care and positive health outcomes.

The following participants described mixed experiences when interacting with Aboriginal people: “I’ve had some really positive times [and] really negative [experiences]. It’s easy sometimes to concentrate on the negative times. I’ve had lots of really rewarding times with all patients, including [Aboriginal] patients. I’ve looked after some quite famous [Aboriginal] Australians” (P16); “You get the odd one [Aboriginal patient] that’s a bit prejudiced and loves his booze [alcohol] and he calls us [derogatory terms]. Most of the time, if they’re sober and they’re clean they’re absolutely lovely people” (P17).

Previous negative experiences with Aboriginal people were frequently spoken about by participants: “Some were nasty when they were unwell” (P22); “The [prior experience] that springs to mind, [is] one Aboriginal gentleman who had a long forensic history and lots of alcohol use [and] some marijuana. He came to us extremely aggressive, and would have this explosion of violence” (P11). Participants also reflected on how this negative prior exposure affected their future interactions and it intensified their experience of being unprepared:

I’m very aware my experience of Aboriginal people, with exceptions, has largely been negative. I don’t know any country that it’s okay to go up to somebody at a checkout and say “out the way you [swear word]”... I’ve had very little positive experiences with [Aboriginal] Australians outside of work and inside work things are very problematic in their presentation (P4).

For other participants, more positive prior exposures were reported: “Overall I’ve had a good experience with them [Aboriginal people]. I’ve not had any major issues” (P3); “I don’t normally have problems with Aboriginals or non-Aboriginals, because I’m conscious of how I approach people” (P13).

Comparisons by participants about working with Aboriginal women and men were mixed. Several participants viewed more positive prior exposure with Aboriginal women: “You know, the ladies, they really are beautiful and you don’t sense any antagonism on their behalf” (P17); “The one female Aboriginal I’ve dealt with seemed to be far easier to deal with than the males. Males I think even though they’re living in this societythey’ve kind of still got that tribal element” (P11). Other participants described positive previous experiences with Aboriginal men: “I’ve found the most beautiful people are what I call the pure bloods that come from up north and you get some down [here], they are absolute gentlemen” (P1); “I’ve looked after lots of male patients. I find they’re a lot calmer than the females. I must say I probably have a preference to look after the Aboriginal blokes [men]” (P16).

Participants’ country of origin influenced their degree of prior exposure to Aboriginal people as one participant born overseas explained: “I came to Australia quite naïve and I’d never ever considered Aboriginal health. It was never a concept I’d ever needed to consider (P 4). Generally, overseas born participants had varied levels of understanding about issues affecting Aboriginal people: “I [knew] the history before I came here [as] it was taught in school. I grew up in Canada and they have an Indigenous population there and I knew that their history and Australian history [was] not unlike the Indigenous problems. They’re not [that] different” (P3); “I knew nothing [about Aboriginal people] when I came to Australia” (P22).

Australian born participants also described different levels of prior exposure to Aboriginal people: “So my knowledge really came from my post-graduate [studies], when I actually went to an allocated Aboriginal study day” (P2); “I started my [career] in [hospital] so, I graduated in [year]. I worked at a large psychiatric institution. It was in the institution that I [first] had encounters with people who were Aboriginal” (P7); “Obviously you knew they were a sort of nomadic tribe and they travelled huge distances, but didn’t really know about the post-sort of [colonial] settlement history” (P11).

In summary, many participants had little or no prior exposure and this exacerbated their

experience of being unprepared. Both overseas and Australian born mental health professionals reported varied amounts of prior exposure with negative prior exposure increasing participants' feeling of unpreparedness for future encounters.

4.3 Assumptions about Aboriginal people and culture

The second condition influencing *the basic social psychological problem of being unprepared* was participants' assumptions about Aboriginal people and culture. Participants noted that assumptions about Aboriginal people and culture were sometimes difficult to change and discussed how this influenced their experience of being unprepared. The following participant provides this insight:

Some of the other things [challenges in working with Aboriginal people] were strange things about me, I suppose, initially interpreting when an Aboriginal patient wouldn't give me eye contact that this wasn't part of their mental state, but then realising that's part of some of their culture sometimes that you don't get that eye contact that you would expect... Yeah, it was just those little quirks that I didn't understand (P14).

Participants also held assumptions about how they believed they were perceived by Aboriginal people and the ability to engage therapeutically: "It is far more difficult to engage Noongar people in ongoing treatment" (P19). The following participants describe their assumptions of trust and antagonism between Aboriginal and non-Aboriginal people; "[The] mistrust and suspicion of services breeds that venomous racism towards you, which is easy to deal with because I think it's not actually towards me, it's towards the system itself (P11); "Often there is a lack of trust because they will tend to say sometimes "You guys" or "You whites" or "I'm sick of white people's (swear word)" (P13); "I felt there was always an initial premise of mistrust because I was white. They immediately felt aggressive towards me because of the historical factors, land rights and all of those things" (P4).

Participants also provided assumptions about the mental health experiences of Aboriginal people: "I [am] really concerned about young men who've disengaged from society and have mental health issues and basically almost isolated themselves. They're the group that are not going to seek help. It's [a] classic problem" (P8). Another participant provided this example:

"[Aboriginal] males who are unwell, you will definitely get a lot of threats to begin with. It's like a challenge... Males can be quite closed and it takes quite a long time to actually build a rapport with them... The female Aboriginals I've dealt with have actually always seemed to be far easier to deal with. As long as you're listening to

them [they're] quite happy to engage (P11).

Similarly:

“I find a lot of the [Aboriginal] women I've looked after come in with really complex kind of issues of alcohol and drugs and psychosis and almost to the point of delirium where you just can't medicate them because you need to wash them out [detox] and they're requiring intensive intervention. While the blokes that I've generally cared for have been schizophrenics [people with a psychiatric diagnosis of schizophrenia] who might be experiencing such severe psychosis that you can't really talk to them, but they'll just listen to what you've got to say. It's not the constant intervention like a female in those kinds of circumstances” (P16).

Participants' *assumptions about Aboriginal people and culture* also shaped who they identified as being Aboriginal: “It [Aboriginality] was either handed over from the nurse manager or from the paperwork. So from their appearance or documentation (P13); “Sometimes you deducted it [Aboriginality] from the mental state, appearance and behaviour, dark skinned. Occasionally we had a patient that would appear Caucasian, but the patient would voice “No, I'm part-Aboriginal” and you just would have overlooked it” (P2). Fredericks (2013), writes that it is not uncommon for those from the dominant society to overlook claims of fair-skinned Aboriginal people and for this group to be considered less Aboriginal than those with darker skins.

The following participant compared their experiences with Aboriginal people in Western Australia to another Australian state; “My experience here [is with] individuals that have come from a far broader geographic area. Individuals identifying as Aboriginal [in Western Australia are] very Aboriginal” (P12). From the following participants: “You get a lot of the urban, Aboriginals [and], they're not pure bloods” (P17); “Further remote culture is a bit more intact and people have more of a connection with their country” (P10); “I think because of the remote area and the lifestyle and because in Aboriginal culture [they've] got subcultures to their belief system, some of them are open to Western medicine, but some of them still have their cultural beliefs (P15); “[Some] have been brought up within the white society and they are a division of their own race [and] are assimilated and affiliated with everybody around them. They've mixed in” (P17); “It's different today to what it was in the 1970s and 1980s, there's more urbanised young Aboriginal people” (P1); “They're living in this society now I guess they've still got that tribal element amongst them. Even though [they live] in Western society, you still find that tribal element” (P11). In reality, over seventy percent of Aboriginal people live in urban areas of Australia (ABS 2006). Fredericks (2013) also identified that Aboriginal people living in urban areas were frequently considered “less

Aboriginal” than those living in rural and remote areas. However, Fredericks (2013) states that it is false to suggest that Aboriginal people living in urban areas are less Aboriginal as they do not seem to fit the clichéd view of traditional or “real” Aboriginal.

Assumptions about Aboriginal people and culture also influenced participant’s understanding of Aboriginal expressions of health and wellbeing: “From my understanding, [Aboriginal meanings of health] is a spiritual connection with the land and the dreaming and the stories are told over the generations and it’s almost like their spiritual map [and] the thread that guides them” (P2); “I’m acutely aware that there’s so many different [Aboriginal] nations within Western Australia. You can’t just blanket rule for them, because [that would be] like saying that Europe is one nation and they’re all the same culture” (P16). Participants also spoke of their assumptions of Aboriginal beliefs of mental health: “I know in some cultures, mental health isn’t a word, it’s not recognised. I don’t know if that’s so for Aboriginals. I’ve no idea” (P7); “[Mental wellbeing is] attached to the land and it’s depending on the, I don’t know if I’m using the right word, [but] the holiness of the land and spiritual places. I think that comes into their wellbeing be it mental and spiritual wellbeing” (P2).

Assumptions were also made about the type of Aboriginal person who accessed main stream mental health services: “They’ll come and see you and attend in crisis, but to then work beyond that is more difficult. I think that comes down to the stigma attached to having a problem” (P19); “I think often people assume, they’ve all got drug and alcohol problems or they’re violent. There’s a lot of assumptions I think made openly about people rather than [considering] there might be other reasons[for] this person coming to [hospital]” (P10); “They often come in crisis and they’re very much just part of the ward population. You often don’t have a sense of a wider perspective, often there’s a whole host of family problems and domestic problems” (P19).

Participants’ assumptions also extended to their participation in care, nomadic lifestyles and use of substances: “The lack of engagement [and] the itinerancy that sometimes presents [is] probably more of a challenge to us, because we want to follow-up appropriately. It’s more difficult at times and [Aboriginal people are] lost to follow-up” (P19); “The presentations were usually more aggressive and the presentations usually contained substance misuse and it was actually far harder to engage in a therapeutic intervention” (P4); “A lot of presentations are related to drugs and alcohol [use]” (P22). Other assumptions were about Aboriginal peoples’ socio-economic circumstances and their presentation to mental health services:

“These patients who come from a poor demographic and because of financial [and] economic situation, end up with addiction to poly- substances” (P15); “Younger women who are coming through in their mid-30’s have a very different view of mental health and, you know what they feel is important for them is different and they [are] really almost separating themselves from the previous generation” (P8).

Participants’ experience of *being unprepared* was intensified by their negative *assumptions about Aboriginal people and culture*: “I see young Aboriginal people having a lifestyle that is breathtakingly hideous and they have children. That cycle is never going to stop” (P 4); “[Aboriginal people are] using a lot of drugs, beating each other up. In a lot of cases and there are huge protection issues and huge trauma issues, intergenerational trauma, all of these things, are characteristic of a large section of the Indigenous population” (P1).

Some participants recognised their assumptions added to their experience of *being unprepared* to work with Aboriginal people: “I’m probably guilty to a certain extent because I see the people on [name] Street and it’s no wonder they get a bad name because they’re screaming and swearing and with the grog [alcohol] and stripping off and fighting” (P14); Some days I just wonder if there are any people that are okay out there. I have to remind myself of that. You’ve got to remember there’s a lot of okay people too” (P1); “I’m willing to accept my experience is limited to [suburb] and when I’ve spoken to Australian friends they have suggested maybe the culture that exists in [suburb] is not the best representation and I hope that’s true” (P4). The connection between assumptions and stereotyping of Aboriginal people was made by several participants; “I’ve worked with [Aboriginal] people, [those] that do work and hold jobs. But I think a lot of people, as I do, see the people on the street and think seriously, you wonder why you get a bad name?”(P14). Additionally from the following participants; “If you’re walking down a dark street at night and there’s an [Aboriginal] chap walking towards you and [they’re] dressed [like me]. Do you cross the road to avoid [them]?”(P12); Growing up in Australia, my assumptions about Aboriginal people were that they were lazy, all drunks, at the lower end of the socio-economic spectrum and we avoided them. This has changed with my experience of working with Aboriginal people” (P27). Other participants provided these examples:

I think there’s stereotyping [of Aboriginal people]. The assumption will be that the majority [are] unemployed, and they are in the Emergency Department because they’re alcoholics [and] drug users. They’re [in Emergency Department] because basically they don’t have good jobs and if they had good jobs, they wouldn’t be in the Emergency Department, [so they’re] less capable of looking after themselves (P18).

Walking round the city you might see some drunks [Aboriginal] people in the park and you know they're the really small percentage. You don't see the ones that are actually at university and getting a job and doing all these kinds of things that we think is acceptable (P16).

The notion of stereotyping was also discussed by one participant who recognised it in themselves:

There's a difference between conscious mind and the subconscious mind, and I am not necessarily happy to admit it, but I will, subconsciously sometimes when you walk down the street [because of past experiences] and you see an [Aboriginal] person you might do something like just put your hand on your wallet or something like that. It's something that unfortunately I do and I can't necessarily help it. You try and justify it and there's no real justification for it (P16).

Other *assumptions about Aboriginal people and culture* included their connection to family: "I love their family commitment. They really love their family and they will do anything for their family, [which is] anybody who lives within a certain radius...The Aboriginals have very much a family friendly policy (P17); "Aboriginal people are just as open-minded as the next person in my view...The problematic ones, they're just really, really problematic (P1); Browne and Varcoe (2006) suggest that some assumptions about Aboriginal people and culture could be interpreted as "romanticising" and "eroticising" culture through a cultural gaze, with the potential to perpetuate the notion of Aboriginal people as exotic "others". Alternatively Browne and Varcoe (2006) suggest that it may also be viewed as a genuine regard.

In summary, participants' *assumptions about Aboriginal people and culture* was a condition that influenced their experience of *being unprepared*. Participants expressed a range of *assumptions about Aboriginal people and culture* and how these increased their experience of being unprepared.

4.4 Understandings of cultural safety

Understanding of the concept of cultural safety was the third condition influencing the *basic social psychological problem of being unprepared* and the level of understanding varied amongst the participants. Cultural safe care recognises and respects the cultural identities of others and safely meets their needs, rights and expectations. Within a clinical setting, cultural safety is explained as a health professionals' understanding of cultural beliefs and how these may impact on the provision of care to others, irrespective of race or ethnicity. The concept

of culturally safe care has evolved from cultural awareness and cultural sensitivity and while they are both important foundational building blocks, cultural safety extends beyond awareness and sensitivity (Eckermann et al., 2010; Ramsden, 1993; Richardson, 2004).

While participants had some knowledge of the term cultural safety, others only had a vague grasp of the concept: “I just don’t, you know, there may have been something taught but it just doesn’t jump out at me” (P7). Some participants had not heard of the term but made assumptions about the meanings, for example: “I think it might refer to is a service that an Aboriginal person could feel comfortable in approaching and accessing. That they could have some positive expectations of that service without having to have prior experience of it (P1)”; “It means somebody that can relate to another culture, [and I] can understand and respect and treat them the same regardless of that difference or basically be able to provide the same care, regardless of the difference” (P13); “The importance of country and what that actually means to Aboriginal people. We need to understand because it’s part of who they are” (P19): “I haven’t heard the term cultural safety, but cultural competence is about understanding cultural differences in others” (P27); “I think most people are in the right head space [state of mind] about cultural sensitivity and treatment of Aboriginal people in mental health, but they’re lacking in some good quality education” (P19).

Participants differed in their understanding of meaning behind the concept cultural safety: “Cultural safety, [is the] meaningfulness of the service for the clients or people’s perception of that, so to have it to resonate with them. For it [care] to have meaning as well as clinical effectiveness” (P6); “I would say it would mean having the knowledge and awareness to understand what is important for that cultural group and that individual because I think you probably take it [beyond] the individual level” (P7): “I would say that in general a lot of practitioners are poorly versed” (P8). Several participants discussed the concept of cultural care in a wider context and viewed it as relevant to a broader range of people, not just Aboriginal people: “[It’s about] Trying to find out about different cultures, not just Aboriginal, there are your Halals [Muslims], its a case of just finding out and making sure you’re not instilling your values on people” (P13); “I think it’s important to understand the trauma [but] is their trauma more relevant than anybody else’s trauma? I think it’s important to have an awareness of everybody’s cultural needs, not just Aboriginal culture” (P4).

The limited understanding of term cultural safety was also reported in Johnstone and Kanitsaki (2007b) exploratory study of health care provider and consumer understandings of

cultural safety and competency in Australian health care. In this study many participants, including health care providers, were not familiar with these terms, however deduced that the term included providing care to patients from racial minorities and diverse backgrounds that was “safe” and did not induce harm due to culturally inappropriate practices.

Participants’ understanding of cultural safety influenced their ability to work confidently with Aboriginal people: “I guess, to be honest, it was a case of winging it until you got to know a bit more about Aboriginal culture” (P14); “I think I can look back and think that I didn’t do too much if any harm, [considering] what I knew and the resources I had at the time” (P6); “I don’t feel confident to work with Aboriginal people....but you do your best” (P26); “I don’t know whether I did it badly or whether I did it well [culturally safe care]” (P13); In [previous state of Australia] we didn’t see a lot of Aboriginal patients, particularly in the locked [secure wards] area we probably didn’t practice safe care” (P5); “Generally, I don’t think we [health care system] do culturally care very well. There’s a lack of understanding about lots of diverse cultures, Muslims for example” (P25).

Participants who felt comfortable about their understanding of cultural safety experience less effects of being unprepared; “I think I engage Aboriginal clients quite well. Now I ask them what tribe, what mob, what language group they’re from, which lets them know that I have some understanding of them as a person” (P19); I used to have an interest in the north native Americans and, obviously their history is very similar to the Aboriginal history and to find that what was happening to the native Americans and was stopped in the early 1900s was still going on here in the 1970s it’s just absolutely crazy (P11). The following participant who moved from another state felt confident in their understanding of cultural safety, however felt that WA was not in line with other states: “Western Australia has a lot further to go, not that [another state] has it right by any means” (P10).

Overseas participants compared the understanding of cultural safety in Australia to their country of origin and how this influenced their experience of being unprepared:

Yeah, I think Canada is a lot further ahead with their cultural sensitivity than here. When I was growing up there, it would have been the early 1970s, they [Indigenous population] were probably going through the problems that we’re [Australia] going through now and they’ve surpassed those problems now (P3).

Another overseas participant gave this feedback: “Australia has a different cultural mix compared to [Asian Country]” (P22). A participant from Australia’s nearest neighbours, New Zealand added this perspective:

I've trained in New Zealand. Quite a different system than our system... in terms of, the most important thing is acknowledging biculturalism. Where I come from, acknowledging the relationship between the Indigenous people and those that have come later. That to me is the foundation [of cultural safety], from which everything else comes (P10).

Several participants' discussed their *understanding of cultural safety* working with Aboriginal people as compared to other cultural groups: "Somebody that can relate to other cultures, can understand and respect and treat them the same regardless of that difference or basically be able provide the same care regardless of the difference" (P12); "It's the same as working with an Asian, an African. What's the difference? We're all exactly the same. I haven't met anybody with three ears yet" (P17); "I would like to think my practice is not influenced by anybody's race or gender [and] whilst I have an awareness of people's culture, age, gender, my interactions [are] based on their health and doesn't change from person to person" (P4).

The view that the all patients have the same needs and experiences regardless of background or social position was also identified by Tang and Brown's (2008) when the authors asserted the premise that everyone is the same regardless of culture and ignores the reality of racism and discrimination. In O'Sullivan's (2013) Australian study of health professionals' experience of providing cancer care to Aboriginal people, while participants acknowledged that cultural identity may be important to Aboriginal people, the meaning of cancer and the cultural needs for Aboriginal patients receiving treatment were not explored. This notion was based on the assumption that there was no significance difference in the experience of cancer between Aboriginal and non-Aboriginal people.

Participants described their experiences of attending cultural training with the following participant describing it as tedious, uninteresting and irrelevant; "I did it out of curiosity before it became mandatory and it was two days of excruciating boredom telling me how to suck eggs. I'm just really glad that I only ever have to do it once" (P1). There is a lot of political correctness [and] at times basic needs are overlooked wrapped up in trying to be culturally delicate. If there wasn't cultural sensitivity, then maybe solutions would be more actively sought (P4); "There's a risk of positive discrimination. There seems to be a sense in the [health] service that if it someone comes from an [Aboriginal] background, to cover your arse. Make sure all the Is are dotted and Ts are crossed" (P12). The following participant discussed the history of Australia's treatment of Aboriginal people and the relevance to culturally safe practice in today's environment:

I know what happened [Aboriginal history] and I actually see where mistrust comes from. However that was a different time, different generation, different people [and] different situations. That's no longer relevant really. What happened, happened, it's past and let's deal with what we have today. But it can be difficult at times to convince them otherwise... When it comes to inter-cultural acceptance, inter-cultural respect, most if not all the responsibility is left to the [non-Aboriginal] Australian population. I think [we all] should take responsibility to actually assimilate, to adjust. So that's unfair. I think it's really [non-Aboriginal] Australians that actually are left with all the responsibility to do all the hard work (P13).

Several studies have discussed the impact of cultural training programs on participants (J. Bennett, 2013; Bezrukova, Jehn, & Spell, 2012; Kowal, Franklin, & Paradies, 2013). Bezrukova et al. (2012) reported that training programs that highlight differences, inequalities, and discrimination between cultural groups may promote a hostile response from participants who may feel they are being blamed and held responsible for past history, prejudice or other imbalances in treatment. Kowal et al. (2013) recount that although cultural awareness and diversity program are aimed at reducing racism and the impact of discrimination, they run the risk of exacerbating these effects. In the study into the training of mental health professionals in cultural capacity, J. Bennett (2013) suggested that cultural training should aim to produce health professionals who are willing to understand, appreciate and accept different racial and ethnic groups and cultures and to utilise this knowledge to provide culturally effective services. Johnstone and Kanitsaki (2007a) comments that despite decades of multicultural policies and programs in Australia and extensive government mandates and guidelines in providing effective health care to Australia's culturally diverse population, health care providers continue to lack the knowledge and understanding of the concept and implications for cultural safety and cultural competence in health care. Quine, Hadjistavropoulos, and Alberts (2012) added in their study of Canadian nursing students' ability to care for Indigenous patients with diabetes, that the hesitation to care for Indigenous clients is concerning as it potentially hinders the nurses' ability to address the psychosocial, emotional and physical needs of the patient and impacts the process of therapeutic engagement.

In summary, participants' understanding of cultural safety was a condition that influenced their experience of being unprepared. Participants' understanding of cultural safety and related terms varied. Some participants claimed they had not previously heard the term cultural safety used in mental health care and estimated the meaning. The majority of participants expressed they had a limited understanding of the concept and this increased the

experience of being unprepared.

4.5 Lack of support

The fourth condition influencing the participants' experience of "being unprepared" was lack of *support*. Support in three areas was discussed by participants as impacting on their experience of being unprepared. These were support from peers, supervisors and the organisation.

Several participants reported a lack of support from their organisation: "There was no cultural training. I [don't] remember any sessions. It [cultural safety] wasn't even mentioned" (P21); "There is a general lack of sufficient knowledge about cultural safety and there is no support from the organisations" (P25). "I regret not getting to one of those [training sessions] earlier on in my career" (P2).

Many participants felt that the support through education in cultural safety from the organisation was superficial and did not contribute to knowledge or skills in cultural safety; "I felt that was quite a glossy presentation and really didn't address the nitty-gritty of what we really see or what we really are exposed to. I felt that was quite glossy (P4); "The cultural awareness study day I did, didn't go into that detail" (P2); "I know the people who run [the program] and they're respected colleagues. I've got a lot of time for those [people] but it's [the training is] just so dull" (P1); "I can't remember what was in it, but it was a waste of time. I didn't learn anything from it. There was nothing new in there, nothing I didn't know, and I'm not sure there was anything specific on Aboriginality" (P19); "What's happened to [Aboriginal] people [has] had a massive impact through generations and it's not something that you can do in a workshop in a day, in an afternoon" (P10).

Other participants describe the support from the organisation as incidental for example; "After being in the job for about six months, [I] realised there was an Aboriginal GP Liaison Service, that I never knew anything about" (P18); "Everyone is trying to do the right thing by everyone regardless, but with Aboriginals, we are aware there is a difference in manners and culture and so we [just] try to be sensitive" (P13). This incidental and ad hoc support from the organisation was discussed by several participants: "It's a whole lot easier if it [cultural safety] starts at the top. I don't believe it can work ad hoc, I think it has to be actually a shift of a foundation" (P1); "If it's not on the agenda, not on the radar you'll just get sporadic

[support], [and] if it's not really embedded, then it doesn't happen" (P7); "So many times I've gone to conferences or workshops put on by the [government department] and not had any acknowledgement to the traditional owners" (P10). Another participant provided this perspective:

[On] an administration and education side, there is probably quite a lot of [resources], but in terms of actually changing practice, the education [doesn't] necessarily change practice. It can make the organisation look good, but it doesn't necessarily change what the frontline staff provide [to patients] (P16).

Participants described a lack of support from the organisation for them to attend cultural safety education and related programs: "My experience in gaining professional development at the hospital over the years is [that] it is harder and harder to have the time to do because of staffing issues" (P2); "There's always training on the go, but unfortunately in this ward we never get to them. We just never get released for the training" (P3); "Staffing levels on the ward always affected the release of staff [to attend training programs]" (P22).

Participants' lack of support from supervisors and peers were also seen as important to their experience of being unprepared; "My supervisor is probably no better informed than I am" (P1); "If the leaders are walking the talk and are modelling the way and if there's support and guidance and education it [culturally safe practice] would happen over time. Things like that have to be on the agenda" (P7); "The manager is always, a very good source. [However] knowledge, understanding, respect, vary greatly across the managers. Some are better than others clearly and in wanting to help in that area" (P2). The following participant stressed the importance of a supportive collegial environment in providing culturally appropriate care: "It's a culture of our ward itself [that] actually promotes this kind of attitude and approach. Our staff [are] all from different backgrounds and culture in general is very well nurtured" (P13). Another participant provided this example:

Our previous psychiatrist was actually an [Aboriginal] lady herself so we had that opportunity of presenting culturally appropriate care. She would sometimes do little seminars for us, so we were quite informed. She could give us hints on anything we were stuck with, we could take that up with her but unfortunately she's been gone for about a year now. She was a great loss to us (P3).

In summary, participants differed in their views as to how the lack of support influenced their experience of being unprepared. Some participants found levels of support from a range sources and areas. However, the majority of participants described a lack of support from several areas including peers, supervisors and the organisation, which increased the

experience of being unprepared. Data identified that several conditions influenced participants' experience of *being unprepared* and these conditions were present throughout both phases of the problem. These were *prior exposure to Aboriginal people and culture; assumptions about Aboriginal people and culture; understanding of cultural safety and lack of support*. In an effort to address the problem of *being unprepared* to work with Aboriginal people in mainstream mental health services in WA, participants engaged in a basic social psychological process entitled *seeking solutions by navigating the labyrinth*. The next part of this thesis details this process.

PART THREE

CHAPTER 5

THE BASIC SOCIAL PSYCHOLOGICAL PROCESS: SEEKING SOLUTIONS BY NAVIGATING THE LABYRINTH

CHAPTER 6

CONDITIONS INFLUENCING THE BASIC SOCIAL PSYCHOLOGICAL PROCESS: SEEKING SOLUTIONS BY NAVIGATING THE LABYRINTH

CHAPTER 5 - THE BASIC SOCIAL PSYCHOLOGICAL PROCESS: SEEKING SOLUTIONS BY NAVIGATING THE LABYRINTH

5.1 An Overview

When the basic social psychological problem of *being unprepared* experienced was identified fully described, further analysis of the data were undertaken to identify the basic social psychological process (BSPP) that mental health professionals engage to manage their experience of being unprepared. Analysis of data revealed a process entitled *seeking solutions by navigating the labyrinth*.

The definitions of words used in the title of the basic social psychological process were obtained to ensure they fit with the data. The word seeking implies a search and an attempt to obtain or achieve something (Oxford English Dictionary, 2015c). The word solution in this case refers to solving a problem or dealing with a situation. Navigating is the action of plan or direct a course or to travel a distance carefully or with difficulty (Oxford English Dictionary, 2015a). Participants sought to reduce the experience of *being unprepared* by navigating their position and negotiating the resulting changes to their self-awareness and emotions. The term labyrinth is used to describe a complex and confusing series of pathways (Bloos & O'Connor, 2002; Ulliyatt, 2010) and as a metaphor for describing situations that are testing and arduous.

The meanings of *seeking, solutions, navigating and labyrinth* as described above were relevant in the context of this study. For participants, the process of *seeking solutions by navigating the labyrinth* allowed them to move towards counteracting their experience of *being unprepared* (See Figure 4, p. 87). To manage the basic social psychological process, participants were required to work through several phases. The importance of *seeking solutions by navigating the labyrinth* was expressed by the following participant: “When we get Aboriginal referrals...it [is] about navigating that family, that particular family group (P10).

Prior to the first stage of the basic social psychological problem, *disruption to self-awareness*, participants' capacity to work with Aboriginal patients was influenced by their past experiences. Participants experienced a *disruption to self-awareness* resulting from the feeling of *being unprepared*. When faced with continued *disruption to self-awareness* some participants experienced *fluctuating emotions*.

To manage the experience of *being unprepared*, participants engaged in a four-phase basic social psychological process. Phase one of the core process was called *neutralising the differences* and this phase was predominant when participants were first asked to care for Aboriginal patients. The other three phases, *moving forward*; *seeking new solutions*, and *becoming a culturally safe practitioner* occurred as they moved through the phases and developed strategies to address the core problem of *being unprepared* (see Figure 4, p. 87).

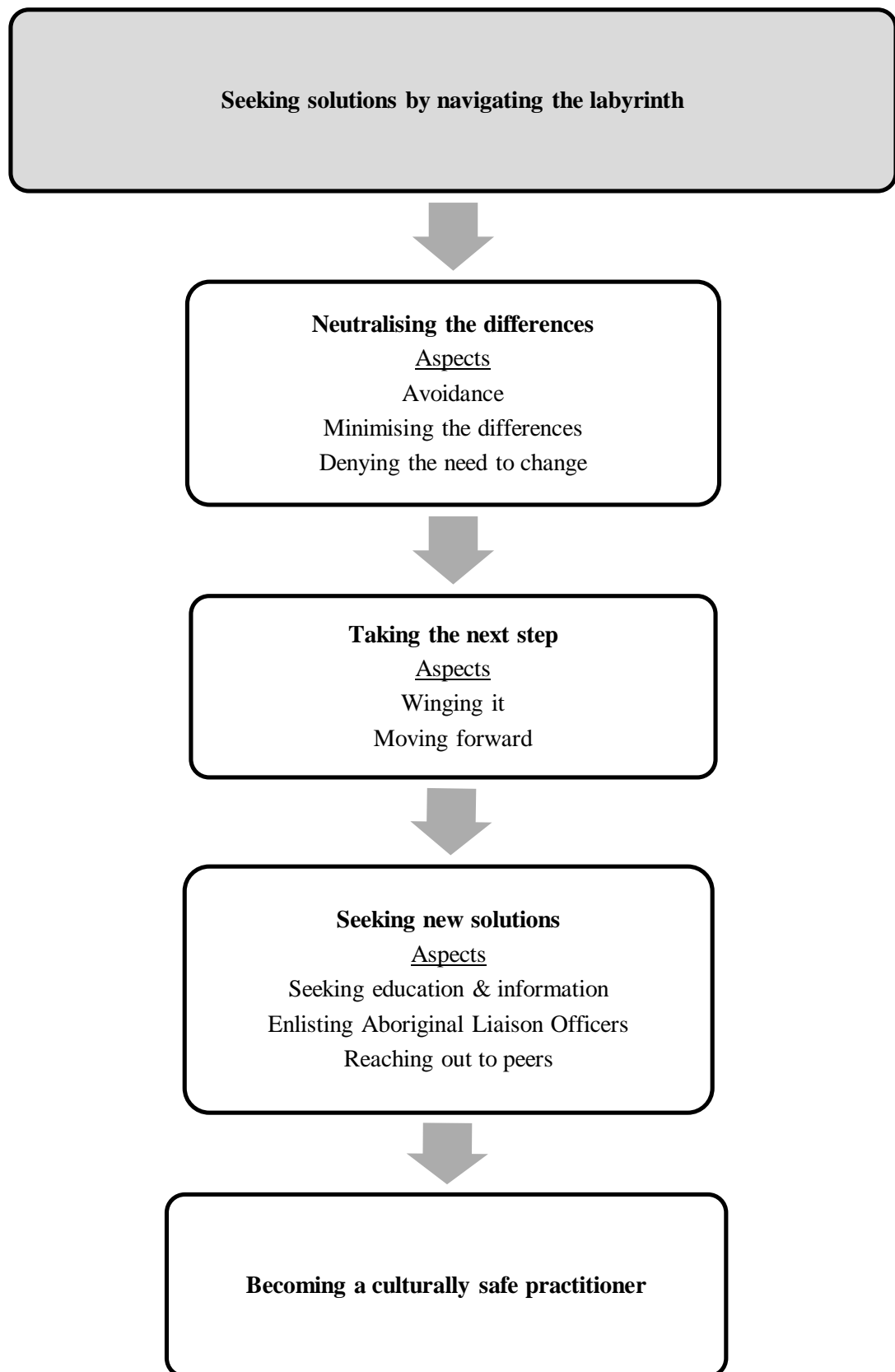
At the time of being interviewed for this study, not all participants had moved through all four phases of the basic social psychological process. Four participants were still in phase one, sixteen were in phases two and three, while eight had navigated the labyrinth to the final phase. Participants' movement through the phases of basic social psychological process varied and were not determined by the previous level of experience in working with Aboriginal patients.

Several authors have also discussed navigating the labyrinth to address complex experiences. Rebeiro (1999) used the analogy of labyrinth to describe the experience of working with bureaucracies and services in community mental health. Participants in Rebeiro's study, believed people with a psychiatric disability became lost in the labyrinth and as a result were underserved. In Yarwood's (2008) study into the ways in which nurses integrated family care into their practice, the theme "the labyrinth of family nursing" was also identified. Eagly and Carli (2007) also used the metaphor of navigating the labyrinth to describe the process that women went through when striving for leadership and recognition in the business world. The four phases of the basic social psychological process will now be described.

5.2.1. Introduction

Phase one of the basic social psychological process (BSPP), *neutralising the differences* was experienced by participants as they began to work with Aboriginal people and became aware of their limited knowledge and experience to work with this patient group. This challenged participants' behaviours and caused them to experience a disruption to self-awareness and fluctuating emotions. As a result, they experienced a range of uncomfortable feelings and sought to stabilise their emotions by *neutralising the differences*. *Neutralising the differences* included a range of behaviours that sought to counteract or counterbalance the negative feelings and behaviours they were experiencing. This first phase of the core process consisted of three aspects: *avoidance*, *minimising the differences* and *denying the need to change*.

Figure 4: The basic social psychological process: Seeking solutions by navigating the labyrinth



5.2.2. Avoidance

In seeking ways to *neutralising the differences*, participants used the strategy of *avoidance*. In health psychology terms, avoidance is an effort used to avoid dealing with a stressful situation and is a coping behaviour that attempts to protect the individual from psychological harm. *Avoidance* allowed the participants to minimise or delay dealing with the problem and seek strategies to avoid the problem or stressor directly, or one's response to it (Littleton, Horsley, John, & Nelson, 2007). The following participants provided examples of the use of avoidance: "The fact they're Aboriginal doesn't stand out because it [is] about dealing with the mental health issues. So in that regard, it was dealing as you would with everybody" (P9); "I think there is a lot of political correctness and at times basic needs are overlooked wrapped up in trying to be culturally delicate ...[and] sometimes that's not always an advantage. Sometimes that hinders solutions I think" (P4).

This strategy assisted participants to deny any cultural differences between Aboriginal and non-Aboriginal people: "Mental health is mental health" (P20); "They speak [Aboriginal patients] English, same as we do" (P4); "I've never found them [Aboriginal people] particularly any different to anybody else.... mental health is mental health at the end of the day" (P14); "Mental health problems are the same for everyone. Aboriginal people have the same struggles [as non-Aboriginal Australians]" (P27). Cultural differences were minimised as participants tried to adopt a race-neutral approach. The following participants provided examples of this race-neutral or colour-blind attitude they used to neutralise any differences: "Whether they're black, white, yellow [or] come from anywhere. I don't mind. I just love people and I don't have any prejudices for one over the other" (P17).

A colour-blind attitude is an ideology that supports that racial and ethnic differences are irrelevant to the provision of care (McCabe, 2011; Neville, Awad, Brooks, Flores, & Bluemel, 2013; Neville, Lilly, Duran, Lee, & Browne, 2000; Tarca, 2005). While a colour-blind approach may be seen as a viable position to take to reduce discrimination by treating everyone equally, regardless of race or culture, it encourages the use of a framework to intentionally or unintentionally avoid or minimise racial inequalities. It also denies negative experiences, discards cultural heritage and invalidates personal perspectives (Neville et al., 2000). A colour-blind approach to care denies the opportunity to explore conflicts related to culture and excludes the health professional from seeing the patient holistically (Williams, 2011). Chao (2013) recommends that increased cultural sensitivity is needed to be able to

competently care for culturally diverse patients. In the study by Beagan and Kumas-Tan (2009) of physicians' approaches to managing diversity in family medicine, participants sought to treat patients as individuals in order not to stereotype. However, the authors proposed that this inhibited the recognition of the sociocultural factors that influence health and health care. This attitude also negates the trauma of that Aboriginal populations carry through generations.

Avoidance was employed by other participants in this current study to manage the problem when they felt uncomfortable or practically unable to handle the situation. The following participants provided these examples: "People get very focused on that [cultural diversity] and depending on the pressure of the work, cultural awareness isn't part of that appreciation (P9)"; "I think mental health clinicians miss out on the spiritual component for everybody. I personally believe that's part of everybody's experience and I think we miss that because ...we're not comfortable with it" (P19); "We try our best to meet their needs....What can we really do?" (P23); "Once you've built up some rapport ... and they're [Aboriginal people] quite open with you ...[but] some things you just don't want them to be open about, [you think] keep that to yourself, I don't want to know that" (P11).

Engaging in task based care was also an *avoidance* strategy for participants: "As much as we've tried over the years that things shouldn't be task orientated, [with] everything you've got to do, the more you've got this plan you've got to follow" (P9); "If you are coordinating a ward [then] you prioritise certain things. People are woken up ... showered ... have their medication [and] ... are fed.if another request comes in for something that isn't [routine], then it's easy [to say] -No, not happening, can't deal with this today" (P16).

For other participants, *avoidance* included reverting to previous ways of practice from their country of origin in the area of promoting cultural diversity and ethnicity. The following examples of the influence of previous practice overseas were provided: "In England ...the principles of our [clinical] practice was promoting ...ethnicity and diversity...it was part of our working culture and advocate for different cultures, whether it's Aboriginal or other cultures" [P24]; "In England there wasn't a need to discuss racial issues because the historical past that has occurred in England isn't as traumatic as this [here in Australia]" (P4); "I think coming from another country helps because I'm not embroiled in all this racism that is here" (P3).

Avoidance also included adhering to behaviours and practices participants felt comfortable

with and participants discussed how they addressed working with Aboriginal people in mental health care, suggesting there was no deviation from usual practice: “[You need] somebody that’s got some understanding and treats them as a human being... I see that as fundamental to what we should be doing with all our clients” (P19); “For all our clients we do individual care management plans. So we look at any needs they have and factor that into their management plan” (P3); “We do the bio-psycho-social [assessment] on everybody” (P9); “What we’re doing [in clinical practice] is looking at trauma informed care and it’s not just Aboriginal people, it’s focused on every mental health patient...it’s being addressed whether you’re Aboriginal or another background” (P24). Similarly, Newman et al. (2013, p. 438) highlighted the beliefs held by health professionals that illness like cancer, affected individuals regardless of their cultural background as articulated by the following participants’ response: “It doesn’t discriminate”.

In summary, during the first phase of the core process, *neutralising the difference*, participants used *avoidance* to manage the uncomfortable experience of *being unprepared*. *Avoidance* has long been considered an unconscious coping strategy to protect the individual under stressful circumstances (Freud, 1992). *Avoidance* was also a conscious process employed by participants which facilitated routine and existing ways of behaviour.

5.2.3. *Minimising the differences*

The second aspect of this phase was *minimising the differences* and this occurred when participants downplayed the significance of the problem: “It’s very basic practical stuff. I think in mental health [there’s] a lot of stuff [that] isn’t mental health [related]” (P1). For some participants, *minimising the differences* included placing less significance on history of Aboriginal people in Australia and the impact of colonisation and the outcomes in health and wellbeing. The following participant sought to de-emphasise the impact of historical events: “I think sometimes there’s a bit of over-emphasis on that [lost generation], that’s not helpful for health...I think it’s important we have an understanding of it but ...we’ve moved beyond that” (P5).

For other participants, minimising the differences included holding the belief that the experience of mental health and illness was the same between Aboriginal and non-Aboriginal people: “People cope, or the way they cope with their life problems is [irrespective whether] you’re talking about Indigenous Australians or white Australians or whatever background” (P8); “I had known the [Aboriginal] history before I came here, it was taught in school. I

grew up in Canada and they have an Indigenous population there and I knew their history and Australian history as well... the Aboriginal problems are not [that] different” (P3).

Other participants recognised cultural considerations in mental health care, but minimised the significance for Aboriginal people: “I have an interest in the north native Americans and obviously their history is very similar [to Australian Aboriginal people]” (P1); “There’s your Somali group you have to be aware of, your Chinese group, there’s your Croatian, your Italian. So everybody has slightly different things” (P9); “You’ve got a bit of awareness. Trying to find out about specifics of different cultures, not just Aboriginal [culture], all sorts of cultures. Aboriginals are one thing but then there’s your Halals [Muslims]... There’s all those different cultures” (P14); “I think it’s important to have an awareness of everybody’s cultural needs not just Aboriginal culture” (P4); “The clients that come from Aboriginal backgrounds I’ve worked with, they seem no different to any other” [P24]; “The actual experience of distress, if you look at function [of behaviour] there are similarities across all people” (P8).

Using this approach, participants downplayed the significance of historical violence and trauma towards Aboriginals: “Is [Aboriginal people’s] trauma more relevant than anybody else’s trauma? I’d say they’re all on par. Trauma is trauma in your life, wherever it’s comes from” (P4); “I think people [with mental health problems] are disadvantaged but I wouldn’t say Aboriginals are [more] disadvantaged” (P12).

Finding commonalities with non-Aboriginal people was another strategy used in *minimising the differences*. The following participant provided one perception of patient disengagement with mental health services: “I think sometimes because of their lifestyle choices [they may disengage with services] but they’re no different from other lifestyle choices that Caucasians make. Is their [Aboriginal people’s] outcome poorer or better? I don’t think there’s much difference at times” (P12). Similarly, the following participant provided an example of minimising Aboriginal experiences through equating experiences for non-Aboriginal people; “I think we need to highlight the issues, yes, drug and alcohol issues are a big problem [in the Aboriginal population] but they’re a big problem in the Caucasian population as well and I think we need to keep that in perspective” (P5).

This strategy allowed participants to *minimise the differences* and to seek comfort in existing practices without considering the specific mental health experience for Aboriginal people: “I don’t think it changed my practice [with Aboriginal people]. I hope I’ve always been

professional and I assess that on an interaction basis” (P4); “To me personally [there is] no difference. Like anybody else, if I notice they’re different [and] there is actually a need for me to adjust and to amend my behaviour towards Aboriginals, I do, but usually, [there are] no problems” (P13).

While this approach may have served to manage participants’ negative emotions, Marsh, Coholic, Cote-Meek, and Najavits (2015) assert that underrating the historical treatment of Aboriginal people avoids the complex psychosocial and health effects of transgenerational trauma on individuals and the Aboriginal community today. Favouring the idea that race does not matter, may indicate a lack of understanding of the ways racism is manifested and its effect on minority groups (Loya, 2011).

To sum up, in the second aspect of the first phase, participants’ engaged in minimising the difference to an attempt to manage the problem of being unprepared. Some of these approaches included placing less significance on the impact of history on the health and wellbeing of Aboriginal people; using colour-blind strategies and reverting to existing ways of practice and behaviour.

5.2.4. Denying the need to change

The third aspect was *denying the need to change*. This was not seen by the participants as passive strategy, but rather a pro-active way of managing the experience: “We treat everyone the same” (P23); “I suppose in terms of delivering clinical services you treat everybody the same” (P1); “When a patient presents [to hospital] they should be treated as a patient and their individual needs, whatever race they are” (P17).

This approach was a way of addressing differences between all cultural groups, not just for Aboriginal people, as explained by the following participants: “I don’t think I treat an Aboriginal person any different than a Caucasian or any other ethnic minority” [P24]; “I’ve always approached people exactly the same. I don’t think I’ve ever ... approached any cultural [group] in a different way: (P11); “I suppose it’s just about treating people like anyone else” (P16); “Do we feel as if we have to go the extra mile because they are Aboriginal or do we treat that person as we do everybody else? I believe we treat them as everybody else” (P12); “Therefore I just approach people with the same respect as I would do [to] yourself or other (people)” (P17).

For the following male participants, strategies included finding a common bond with male

patients, for example: “My experience with Aboriginal males, is we have this one language and it’s sport....we’ve got the same interests whether it’s AFL [Australian Football League] or soccer...it gives you something in common” [P24]; “It’s just trying to find some common ground with the patient...[there] was a male patient that I escorted to Halls Creek and found out that he used to work as a ‘jackaroo’ or something [similar], so we started talking about horses... and then that would help break down those kind of barriers” (P15).

For other participants, it meant considering the needs and experiences of Aboriginal people with a mental health illness were the same as non-Aboriginal people: “We don’t do anything different for Aboriginal clients” (P20); “It [care] ... regardless of your background... [is] just one approach suits all” (P7); I think you then need to manage it like you would manage any other therapeutic relationship” (P4); “Realistically, I’ve never found them [Aboriginal people] particularly any different to anybody else...mental health is mental health at the end of the day, I guess” (P14). The idea of uniformity of needs and experiences of people with mental health illness was also generalised to other cultural groups: “I may awareness [of diversity but] my interaction doesn’t change” (P4); “We’re all human. We care for them like anyone else” (P21). The following participant used the term “cultural friendly” and explained it as the following; “Cultural friendly means to me somebody that can relate to other cultures, can understand and respect and treat them the same regardless of that difference or be able to provide the same care regardless of the difference” (P13).

A similar aspect of *denying the need to change* and treating them all the same was also revealed by Newman et al. (2013) study of health professionals’ accounts of providing cancer care to Aboriginal people in which participants justified “everyone is the same”. Participants held the belief that Aboriginal and non-Aboriginal people had the same needs in relation to cancer care and services and there was no significant difference in the cancer experience between the two cultural groups. Strategies that *deny the need to change* along with attempts to treat everyone the same, overlook the unequal power relationships which is based on socially constructed differences between people coming from different cultural backgrounds (Tang & Browne, 2008).

In summary, participants used the strategy *denying the need to change as part of neutralising the differences*. This included the premise that working with Aboriginal people in mental health as no different to working with other patients and the conscious belief that the experience of mental illness was consistent across the human experience, therefore

supporting this approach.

5.2.5. Summary

Phase one of the basic social psychological process, called *neutralising the differences* occurred when participants became mindful of their limitations in working with Aboriginal people in mental health settings. Participants seeking further strategies to manage their experience of *being unprepared* moved to the second phase of the basic social psychological process entitled, *taking the next step* which will now be described.

5.3 Phase Two: taking the next step

5.3.1. Introduction

The phrase “taking the next step’ can literally refer to either a short distance or a path taken and suggests a small progress or improvement to a situation and a gradual process taken to advance a course of action. The data indicated that the meaning of *taking the next step* was relevant in the context of this study. Participants sought new skills in interaction and communicating with Aboriginal patients, while reconsidering existing ways of working and planning for future experiences. The phase commenced as participants moved beyond *neutralising the differences* and were more in control of managing their experiences of *feeling unprepared*. The length of this phase was different for each participant and was determined by their experience of navigating the labyrinth and conditions influencing this experience.

Phase two consisted of two aspects: *winging it* and “*moving forward*. Participants in this phase improvised and engaged in adlibbing or *winging it*, with varied results. *Moving forward* was the second aspect of this phase whereby participants appraised their experience to date and began to consider additional strategies.

5.3.2. Winging it

The first aspect of *taking the next step* was *winging it*. This was employed when participants sought ways to address the problem through improvisation. Here participants began to consider ways of managing their feelings of *being unprepared* but did not have an exact plan on how to achieve this: “I guess to be honest, it was a case of winging it until you got to know... a bit more about Aboriginal culture” (P14); “I just do my best” (P27); “You look at

what comes through the [hospital] door and you work from that” (P18). Some participants sought to use existing approaches and the following participant improvised in anticipation to finding alternative solutions: “I suppose knowing what’s out there and what can help you is [the] key until you just sort of stumble on them” (P2).

For some participants, using this approach enabled them to test strategies which were familiar to them: “You need to listen to people ... this really works with Aboriginal people, but the truth is it works with everybody...you just really need to listen to people” (P19); “I think you then need to manage it like you would manage any other therapeutic relationship” (P4); So it’s a case of just finding out about it [cultural differences] I suppose and making sure you’re not instilling your values on people ... because it’s your value, it’s not necessarily theirs (P14); “I went to [university] and we had quite an intensive training on cultural appropriateness with the [Aboriginal] population and I felt I used that in my general nursing, and I would certainly use it here [mental health] as well” (P3).

For other participants *winging it*, facilitated their attempts to trial new ways of approaching the problem. This included testing ways of interacting and being confident in ones’ own abilities: “You try to engage them [Aboriginal patients] on whatever level they’re willing to engage on and as quickly as you can [within] the parameters of what is professional” (P4); “I suppose it’s just practice to one degree ... and not being afraid to get yourself involved in those kind of situations and conversations [about different cultural values and beliefs]” (P16). Trialling new approaches included retesting approaches that had previously been successful such as finding a foundation of mutual understanding and shared interests: “Everybody has slightly different things [cultural needs], so that’s ... in my head of things for consideration” (P9). Finding a common ground and understanding was also trialled by participants: “Generally over time ... just trying to find a mutually accepted ground of interest and again that’s not really specific to just indigenous people either. It’s just trying to find some common ground” (P16). Similarly, from the following participant:

At times there’s a sense [of] not really fully understanding [cultural values] and having to ask, ‘What do you mean by that?’ I’m aware at times of really needing to actually stop and say “Well, can you explain that to me because I don’t actually understand what you mean?” (P18).

Participants also discussed their previous experiences of *winging it*: “It depends how you approach them... they usually respond okay” (P13); “If anything I did things that were damaging and did the wrong thing...the way I approached it I made it worse” (P2). This approach was viewed by several participants as an opportunity to be creative and innovative:

“So you just have to think outside the square. You have to do things differently” (P18); “So [the] individual needs to think, how can I creatively get this done?”(P7). Another participant provided this insight:

So we try to get to know that [cultural beliefs and values] through interviewing, interacting, engaging and asking questions about what they practice, what language, what religion and all the sensitive issues in terms of providing holistic care for the patient...and from there we'll just go step by step and we continue learning... we continue to ask what else we can do to meet [their] individual needs (P13).

Another participant provided this perspective:

The other kind of challenge is that you just don't know sometimes where they [an Aboriginal person) come from and what kind of lifestyle they live ...So [an Aboriginal person's] perception ... might [be] “You don't know where I come from, you don't know about my people”. You know, it's true; I don't know and I think I've just had to say that to them “You know, you're right, I don't know...I don't ultimately know where you're coming from [but] I would like to know, and please let me in (P16).

Hanley and Fenton (2007) suggested that rapidly changing contexts have long required health professionals to demonstrate improvisation. They define improvisation in clinical care as a blending of knowledge, interpersonal skills, empathy and sensitivity to patients' needs, capacity for change and use of existing resources (Hanley & Fenton, 2007). Improvising care was also a conscious strategy employed by participants in the study by Namasivayam, Lee, O'Connor, and Barnett (2014), into nurses' perception of caring for families of the terminally ill. This approach was utilised in response to the different expectations in their interactions and experiences with families. The concept of improvisation has also emerged as a feasible strategy in organisational management to deal with unexpected experiences in the workplace (Magni & Maruping, 2013).

To summarise, participants used several approaches in *winging it* in an effort to reduce their problem of *being unprepared*. Some of these approaches included trialling previous ways or working and retesting strategies, while other participants viewed it as an opportunity to be more creative in their clinical practice.

5.3.3. Moving forward

The next aspect of phase two was called *moving forward* and signalled a shift and progress towards *seeking solutions by navigating the labyrinth*. For many participants, *moving forward* included re-examining attitudes and re-thinking professional practice. The following participants gave examples of re-examining their attitudes towards working with Aboriginal people and recognising the significance of Aboriginal identity for an individual: “To be

cognisant of the Aboriginal identity and some of the things about being admitted to hospital, ... and having people ... that they identify with being able to advocate or being able to be part of their care, and choice about food and all those things” (P4); “It would mean having the knowledge and awareness to understand what is important for that culture group and that individual ... and it wouldn’t be one size fits all (P7). Participants’ attitudes were adjusted as a result of evaluating their knowledge, attitudes and skills as described by the following participant: “For me it was more about understanding the impact of the Stolen Generation in relation to us engaging culturally appropriately with Aboriginals” [people] (P12). Another participant examined their cultural identity as a child of immigrant parents.

My parents are Ten Pound Poms [colloquial term for British citizens who immigrated to Australia after World War 2, on an assisted passage migration scheme]. My perception of what we were taught at school was that Aboriginal culture was one thing. There was no recognition that there are different nations with different languages, different cultural [groups]... and obviously as an adult I’ve learnt that’s not the case...I started to go through obviously living here, [being] a tenant [of Australia] you start to do the critical thinking [about the impact of colonisation] and you start looking at those kind of things and so I was made more aware of those kind of issues (P16)

Similarly, the following participant also re-examined their cultural identity as it relates to working with Aboriginal people.

I think I’ve changed my view on working with Aboriginal people and this has come, not from professional development, but from listening to Aboriginal patients... [you think] as a white person you need specialist Aboriginal health workers or Aboriginal mental health workers [but] there are actually a large number of Noongar people who would rather talk to a Wadjela [Aboriginal term for white person], but somebody that’s got some understanding and treats them as a human being (P19).

Several participants began to see the multi-dimensional aspect of mental health and wellbeing for Aboriginal people: “Aboriginal health is tied in with the broader health issues and its part and parcel.... “Intergenerational trauma [is a] characteristic [of] a large section of the Indigenous population’ (P1); “Acknowledging the pain and the journey that people in this country have gone through and acknowledging what’s happened to people. It’s had a massive impact on their psyche through generations” (P10). From another participant this insight:

Mistrust goes back way in history ... the way they were treated and what happened when the whites first moved in [to Australia]... and I completely understand that lack of trust and I probably would feel the same. So I understand, I do sympathise with them (P13).

The following is an example of a participants’ reflection of a culturally safe mental health service: “Designing a health service that’s culturally safe. I’m not surewhat that means”

(P1). This participant explored this concept further in the following example: “A service that an Aboriginal person could feel comfortable in approaching and accessing, that they could have some positive expectations of that service” (P1). Participants also considered the impact historical events may have had on the engagement of Aboriginal people in mainstream mental health services: “When you look at historical stuff [events], alarm bells [ring]. ... we are white, we are a public health service, we are part of the government, we are an institution [and] ... maybe [Aboriginal people] are fearful of us as a service. Is that a reason why people don’t engage with us?” (P12); “We need to do something different to engage [Aboriginal people in mental health care... you’d be pretty blinkered not to be aware ... of ... that part of history ... you’d really have had to have had your head in a box” (P11).

For several participants, the underpinning premise of *moving forward* was acceptance and respect: “The foundation of working with any group is about being respectful and about acknowledging difference and about being open and willing to work in different ways” (P10); “I think apart from [differences in] culture, I get to know the patients and get to know their individual culture [and] individual personality” (P13); “The importance of country and what that actually means to Aboriginal people, we need to understand [that] because it’s part of who they are” (P19). Understanding extended to acceptance and validation as discussed by this participant:

Validating the person, listening [to] the person, asking the person, asking them questions. Thanking them when they teach you something, but you have to be confident to do that. If you’ve got [a] rocky self-esteem, you’re not going to ask for help from a patient. I’m not Noongar... I wasn’t born with this knowledge, I wasn’t raised with this knowledge, go ask the patient [and] they’ll tell you (P19).

In this phase, several participants began to critically review their level of cultural awareness: “Maybe if I were more culturally aware... because I don’t know very much. [But] I’m learning all the time” (P1); “Well I think I need to increase my knowledge base, because I have an old institutionalised experience I didn’t like and I would really need to refresh, ... and I’d love to learn more” (P7). Another participant gave insight:

I think it is really being prepared to say well, if you don’t understand this, then be prepared to acknowledge you don’t understand and ask [questions] and trying to be aware [that] you could be dealing with someone who is unfamiliar with what you see as normal. Trying to check out what the person is [thinking] or using a relative or asking someone [else] (P18).

Critical examination of the individual’s foundational belief systems is the key to taking the next step in moving towards culturally appropriate care according to Jull and Gilles (2012).

Moving forward included making adjustments to approaches to providing care and ways to modify their practice as discussed by the following participants: “It’s doing things that are more person-centred” (P7); “It’s not about the dos and don’ts, it’s actually about the understanding of who you are and respecting people and recognising difference” (P10). In *moving forward*, participants began to take an active approach to managing the core problem and this included sharing their concerns openly. The following participant did this by providing feedback to others: “I generally don’t wait to be invited to share my perspective...so you can provide that feedback back into the system” (P1). For other participants, sharing their concerns included engaging in peer review through the formal process of clinical supervision as participants described: I’ve done some clinical supervision with my peers” (P23); “I’ve engaged with some peer supervision with a couple of colleagues....and I’ve provided some informal ad hoc supervision to others.” (P1). “Certainly my clinical teacher role allowed me to really look at things in depth because I shared my experiences of what I did well and what I didn’t do so well with my students” (P2).

The following participants described utilising a humanistic approach: “The foundation of working with any group is about being respectful and about acknowledging difference and about being open and willing to work in different ways” (P10); “I try to recognise stereotypical thoughts and don’t judge others...[and] open communication, so [that] I am able to continue to be respectful” (P22); “Positive regard for the individual... and I think that applies ...to any minority group and it applies to the Aboriginal client. That’s really important that we’re conscious of that [that] I’m validating you as a person (P19) “Get to know what they think of the treatment plan. Get them involved to participate so they have a say in the treatment plan... and gain their trust, open up” (P15). Another provided this feedback:

Working in a sensitive way with people; working with families, working with Elders, working alongside peopledeveloping a relationship with them so they feel safe to tell you a story. Not make it all about the problem, but make it about getting to know this person and their life and what their journey has been and where that mental health component fits as part of that and as part of that family and as part of that group (P10).

In taking an active approach to managing the problem, participants were able to employ different ways of working with Aboriginal people: “You need to ensure you’ve assessed that person [and] you’ve established what their specific requirements are” (P7); “Draw them into a collaborative, problem solving relationship where they’re coming up with what’s available,

what's possible within the resources...so in many ways appropriate practice involves very good understanding that person's social context" (P8); "It's like building a relationship with people...they really don't care how smart you are, they don't care what you know or what you can do, they're only interested if you care and [are] interested and that [is what] makes an impression" (P1).

This approach required participants to be quite creative in modifying their practices: "You get to know the same surnames. Not necessarily first blood relatives, but cousins. In a way they were like gatekeepers to finding out what their needs were; who to contact; accommodation, family members [and] what's appropriate" (P2). Also from this participant:

Where they might saying "You don't know where I come from, you don't know about my people"; You know, it's true; I don't know and I think that I've just had to say that to them "You know, you're right, I don't know. I wasn't raised ... in that situation as you were, I don't ultimately know where you're coming from. I would like to know, and please let me in" (P16).

Similarly from this participant:

There was an Aboriginal man who came into hospital from a remote area. He didn't like being on the ward and became agitated at night. After collaborating with the Aboriginal liaison officers and the Elders, the ward was able to allow him to sleep outside the secure section of the ward, with nursing supervision overnight. Through discussing the patient's source of agitation we found a compromise (P27).

Several participants discussed using ward and resource management as way of *moving forward*: "On the ward we had a strict two visitors per family and with [Aboriginal] families you would have a whole mob turn up. We just had to change our management and we tried to accommodate those cultural needs" (P2); "It can be as simple as someone wants 10 family members to visit at a time as opposed to one and ... and it's just trying to be aware ... and try and facilitate it" (P16). Other participants considered that *moving forward* could include much simpler approaches to managing the problem including dietary choices and meeting welfare needs as discussed by the following participant: 'Offering like kangaroo or emu at dinner, different meal choices.... They didn't always take it up, but it was there...[and providing] just simple welfare things [because] they usually came in with nothing" (P2). The following participants described the importance of allocating patients to staff according to gender as they recalled different patients they had cared for: "The interesting thing is that the lady I looked after, well, she was female and being female helped in some ways" (P5).

To summarise, in *moving forward* participants progressed in confidence and managing their experience of *being unprepared*. This included being active in re-examining attitudes, skills

and behaviours and introducing new ways of providing care for Aboriginal people. In this phase participants, gained an increased awareness of self and their own interactions, while others considered how they could instigate changes in ward management and organisational process to achieve positive outcomes.

5.3.4. Summary

The second phase of the basic social psychological process was called *taking the next step*. Participants engaged in *winging it* and improvisation as part of the core process. In the second phase, *moving forward* participants felt more confident to continue to explore ways of managing the core problem. They began to become more reflective and active towards achieving their goal to reduce the experience of *being unprepared*.

This phase of the basic social psychological process saw the participants increase in confidence and beginning to develop new ways of managing the change. When participants began *taking the next step* and progressed through the two aspects of the phase, they move to the next phase of the basic social psychological process, entitled *seeking new solutions* which will now be presented.

5.5 Phase Three: seeking new solutions

5.5.1. Introduction

The third phase of the basic social psychological process was entitled, *seeking new solutions*. When participants entered this phase, the experience of *being unprepared* had reduced due to the use of strategies in the first two phases. In moving through the first two phases, participants began to productively *seek solutions by navigating the labyrinth*. When this occurred, they sought new ways to address their difficulties. This third phase consisted of three aspects: *seeking information and education, enlisting Aboriginal liaison officers and reaching out to peers*.

5.5.2. Seeking information and education

As a result of their experience to date, participants were motivated to pursue information and knowledge to manage the basic social psychological process. The following is an example of participants incentives in seeking information and education: “I need more education as to what’s normal [for Aboriginal people]” (P20); “I think it’s really important that we actually

pursue [education] for our own sakes and professional development, so we get a little bit of understanding about what the issues are [for Aboriginal people]" (P19); "We need more training on Aboriginal culture and the importance of family support and connections in Aboriginal communities. We need to understand the specific problems they have and the stressors" (P27).

For the following overseas born participant, information and knowledge came via real life experiences; "When I first came from the UK [United Kingdom] and when I first started working... I knew nothing, but obviously as time goes on you get to know more" (P14). Similarly, the following participant from overseas sought to increase their understanding of Aboriginal culture; "Coming from England I didn't have a lot of education [about Aboriginal culture] my knowledge was very limited but I'm working on that now" (P23). Formal in-service education was also used by participants in *seeking education and information* as the following participants discussed: "The cultural [awareness training] ...made me aware there was such a thing [and] that there was a level of [cultural] awareness" (P1); "The cultural stuff [training] we had when I was in the country service ... and at [name of health service] ...and they talked about the same things...the importance of country and what that actually means to Aboriginal people (P19): "It was very interesting to have a study day presented by Aboriginal people about Aboriginal people" (P4); "For me it [the training] was more about understanding the impact of the Stolen Generation in relation to us engaging culturally appropriately with Aboriginal [people]" (P12).

Information and education also came from other sources including written information, online learning and links with other services as described by these participants: "I know there are resources and who I can tap into if I'm stuck. I do get to a point where I think, right, I need help now" (P2); "There are pamphlets around on who to contact if you need help [with providing cultural care] (P27); "There are e-learning packages for people who haven't had any training or [been] exposed to Aboriginal people ...I've made some links with the State Aboriginal Service...so we are all on the same wavelength [same thoughts] in how to support each other" (P24).

To sum up, *seeking information and education*, meant that participants acquired knowledge to assist them. It included accessing in-service education or outside cultural training. Online materials and written resources were also accessed. This strategy assisted participants in managing the basic social psychological process.

5.5.3. *Enlisting Aboriginal liaison officers*

Procuring support from Aboriginal liaison officers was another aspect of the managing the basic social psychological process. The role of the Aboriginal liaison officer was highly regarded as articulated by the following participants: “That was the key, the Aboriginal liaison officer. I think that was the key is getting the right people to talk [to Aboriginal people] (P2); “We have an Aboriginal liaison officer and she is pretty knowledgeable [about] certain things we should provide or do for patients while they are in hospital” (P22); “When we get Aboriginal referrals, I tend to go to our Aboriginal liaison officer and ask advice...about navigating that family group or how he thought best to approach it... so it’s really great having that support” (P10); “The beauty of working at [name of hospital] with Aboriginal patients is that we had an Aboriginal liaison officer [who] was always there” (P14); “Having that assistance from the Aboriginal Liaison Officer is great because you can then sort of find a little bit more about what’s going on within the community” (P10). For some participants just knowing they could call upon the Aboriginal liaison officer was comforting as discussed by the following participants; “When I’ve needed some information I knew I could ... track down those people and consult them ...[and] there is a State-Wide Aboriginal Mental Health Service and that notion impresses me a lot” (P1).

Participants sought to manage the basic social psychological process, but additionally they saw the value in this connection for Aboriginal patients: “The role they [Aboriginal liaison officer] play is just such a different dynamic in relation to engagement with patients” (P12). This participant provided this insight:

Aboriginal liaison officers have been really great...so we did our stuff [care] but he [the patient] also benefitted from having some extra cultural support ... We’ve actually had some very good people working in Aboriginal liaison and social work that know the communities, know the people. So they’ve actually been able to be very good at connections for those people (P9).

Moreover, *enlisting Aboriginal liaison officers* was used not just to gain cultural information but also as part of the overall management of Aboriginal patients and in promoting culturally appropriate assessment and care as outlined by the following participants; “I think the challenges for us is when we’ve got acute presentations to services and engagement [with Aboriginal patients] and sometimes we don’t do that well...but you introduce a liaison officer and that does help” (P12).

In terms of management of Aboriginal patients on the ward, on admission, or if we knew they were coming in, one of the first things that we did was made sure that

[name], the Aboriginal Liaison Officer was contacted and at the soonest possible [so] that he could come in and make contact with the patient as well as the family ...I always relied on [name] our Aboriginal liaison officer to perhaps make those inroads and give us the handover back....I think having that Indigenous presence on the ward, so they're [Aboriginal people] not feeling like they're the only one there I think that was important and [name] did try and do that whenever he had the time to do (P2).

I worked at [name of hospital] and they had a really good Aboriginal liaison person who would actually co-case manage somebody of Aboriginal descent with you. So that was really helpful because he was actually, accepted by their mob and was able to go and seek people out where I couldn't necessarily (P5).

The following participants recalled a specific example in the care of an Aboriginal patient.

I remember one situation actually where a patient [was seeing] dead relatives... we were lucky enough to have an Aboriginal liaison officer at that particular hospital who came in, talked to her, talked to her where she [and] her family [were from] and which nation she came from and how she was raised and came back and told us...that [the symptoms] wasn't what she was led [raised] to believe, so it is psychotic phenomena (P16).

In summary, *enlisting Aboriginal liaison officers* further developed participants' in *seeking new solutions*. They were seen as valuable resources, that assisted participants in their understanding of Aboriginal culture and who provided practical assistance to engage with Aboriginal people appropriately. Participants also discussed their importance as a means to bridging the gap between cultures and providing some comfort to Aboriginal people while in hospital.

5.5.4. Reaching out to peers

In moving through the basic social psychological process, participants began *reaching out to peers*. Peers included colleagues who were seen to have knowledge or skills or particular insights into Aboriginal culture and could assist the participant: "I've been curious and have asked a lot of people what happened and [in Aboriginal history]...and what was [their] ... what were you taught at school" (P5). Networking was also a way of *reaching out to peers* as discussed by the following participants: "Through networking, education, one to one, group education...case study discussion... I've learnt a lot"(P24); "There are other key people in the community you can connect with and have a conversation with and just pick up the phone" (P2); "We have our colleagues and other professionals who are willing to help and support you...that's very important (P13). "I ask my peers and sometimes the manager is helpful" (P26). The following is an example a participant's experience of *reaching out to peers*.

“Since I’ve been on this ward we have had cultural [education]... plus it’s a culture of our ward itself, it actually promotes this kind of attitude and approach and we have staff from different backgrounds and culture in general. Its [cultural awareness] very well nurtured (P13).

For other participants, *reaching out to peers* included those who were viewed as having particular knowledge and skills in working with Aboriginal people: “If I don’t know something, I will ask one of my peers or the nurse manager (P27); “One of our [staff members] also consults at Derbarl Yerrigan, [an Aboriginal community controlled health service] so we’ve always got him to ask’ (P17). Similarly from the following participants:

The nurse manager is always a very good source of information ...and of course other nursing staff around me, if they had known the patient previously, [and] they’ve got that rapport [with the patient]” If I couldn’t get hold of [name of Aboriginal liaison officer] I’d go to [name of another health worker]... He also had a great relationship with [name of Aboriginal liaison officer]. You know, he talked the talk. There’s a language they use and the lingo [jargon] and the gestures and he was able to make that connection [with Aboriginal people] (P2).

We have a trans-cultural group here...and [name] he’s [part of] the trans-cultural team that deals a lot with the Aboriginal patients in the community and Derbarl Yerrigan [an Aboriginal community controlled health service] and he’s got a link with some of the counsellors and the mental health nurses and we work closely with them if we need help (P15).

The following participant recounted the experience of working alongside a colleague who bridged the cultural gap for them when working with Aboriginal people.

I remember having a placement at the Aboriginal Medical Service and I found that fascinating... there was a great woman there who was a white Australian ... and she was one of the healthcare workers and she seemed to be the one that translated the information to us (P7).

For some participants, *reaching out to peers* extended to reaching out to Aboriginal peers. The following participants gave examples of reaching out to Aboriginal peers: “Where there’s been specifics, I’ve just talked to one of my colleagues who are Aboriginal people (P1); “Our previous psychiatrist, she’s just left recently, was actually an Aboriginal lady herself so we had that opportunity of presenting culturally appropriate care... she would sometimes do little seminars for us herself about trauma and about cultural issues (P3); “I’m lucky enough to be somewhat welcomed by the Aboriginal service at [name] Hospital. They generally ask a nurse if they want to come [on a community visit]. I generally try and jump in if I can” (P16).

To summarise, *reaching out to peers* was another aspect of *seeking new solutions* in which participants sought assistance from colleagues to manage the process. Collaborating with

peers added in developing new insights and understandings of how to manage *being unprepared*. Participants sought out those senior colleagues, those with perceived proficiency and other Indigenous peers. In *reaching out to peers*, participants continued to work through the phase of *taking the next step*.

5.5.5. Summary

The third phase of the basic social psychological process was named *seeking new solutions*. This phase had three aspects: *seeking information and education; enlisting Aboriginal liaison officers; and reaching out to peers*. Participants sought knowledge and wisdom to help them reduce the experience of *being unprepared*. This phase of the core process saw participants gain some confidence and capacity to *seeking solutions by navigating the labyrinth* to manage the basic social psychological process and moved to the last phase *becoming a culturally safe practitioner*. The final phase of the core process will now be described.

5.6 Phase Four: becoming a culturally safe practitioner

5.6.1. Introduction

The fourth and final phase of the basic social psychological process was entitled, *becoming a culturally safe practitioner*. When participants entered this phase, their experience of *being unprepared* had diminished due to the use of adaptive responses and by improved knowledge and understanding of working with Aboriginal people achieved in the prior three phases. Movement through the first three phases enabled participants be better prepared and allowed them competence in providing culturally safe care. When this happened, they entered the fourth and final phase, *becoming a culturally safe practitioner*.

Only eight participants moved to final phase of *becoming a culturally safe practitioner* at the time of being interviewed for this study. However participants varied in the level of emersion in this final phase, with some just starting and with others more further along the continuum of *becoming a culturally safe practitioner*. The majority of participants in this study were in the previous phase, with three participants in the first phase managing the core process at the time of interview.

5.6.2. Becoming a culturally safe practitioner

Due to their experience to date, the participants who reached this state felt more self-assured

in managing the problem and moving through the labyrinth to *becoming a culturally safe practitioner*. The following participant provided this reflection on what is needed to move towards providing culturally safe care:

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

In becoming more confident, participants were able to reflect on their capacity to provide culturally safe care:

I was looking after an Aboriginal man who I'd known quite well and had worked with [Aboriginal liaison officer] with this man, so I had actually some rapport [with the patient]. A student came and was trying to interview this person and he was an older student, a more mature student, so I was a bit surprised that he voiced "He [the patient] doesn't want to know and he doesn't, you know, he's being difficult". It was clearly cultural, because he interacted with me a whole lot differently and interacted with the other members of the team. So he wasn't being difficult, he was being culturally appropriate, but the student didn't see it that way. I'm not saying I'm perfect in this, but in this instance I was able to reflect on what I knew (P5).

The following participant recounts a previous experience with a patient and describes their move towards *becoming a culturally safe practitioner*.

I clearly remember ... an Indigenous patient...and I almost got into a confrontation with this patient when I really should have been ... talking to the family... if anything the way I approached it I made it worse...but now with years of experience and the knowledge, of course I'd approach it differently now, but I was very junior [then] (P2).

Recognising and valuing differences, respect and collaboration were also ways participants sought to manage the basic psychological process: "Where I have been somewhat successful is when I have asked an Indigenous person about where they come from ...then most of the time they're likely to want to tell you and it can be quite educational for you" (P16). Another participant provided this example:

On first meeting the person, I consider the cultural needs as a whole and then [as an] individual because we know they [Aboriginal people] live and come from different [cultural groups], and sometimes different languages and cultural beliefs and values. So we kind of try to get to know that through interviewing, interacting, engaging and asking questions about what they practice, what language, what religion [they practice] and all the sensitive issues in terms of providing holistic care for the patient. I usually try to do that by establishing the therapeutic relationship with the patient and I [use a] non-judgemental approach... I get as much information as I can from them to learn about the care they deserve and the help they need (P13).

Similarly:

Working ...with people, working with families, working with Elders, ... developing a relationship with them, so they feel safe to tell you a story, [and] not make it all about the problem, but make it about getting to know this person and their life and what their journey has been and where that mental health component fits as part of that and as part of that family and as part of that group and obviously doing that with assistance and sensitivity ...they can't, understand every sort of skin group (P10)

For this participant, *becoming a culturally safe practitioner* included diverse experiences with Indigenous peoples and acquiring knowledge:

I grew up in Canada [and] they have an Indigenous population there and I knew that their history and that Australian history [was]...not unlike it [Canada's]... and then my own education at [Perth University] ... and then doing my own Masters [degree], I've broached the subject on numerous occasions [P3].

Acquiring knowledge was an important part of becoming a safe practitioner as described by this participant: "I tried in my own time to educate myself on a range of cultural issues. I did some reading, looked through articles and read literature by XXX [Indigenous psychologist and academic]" (P25). Recognising cultural differences and the impact this has on Aboriginal patients' wellbeing was also a feature of *becoming a culturally safe practitioner*:

The Aboriginal [man] that that flashed into my mind was someone from up north [Northern Western Australia], who didn't have a lot of family support here...who was becoming stroppy [ill-tempered]...and I said [to other staff] what would you do if the person wasn't Aboriginal? It certainly was that he didn't feel he was being understood...and he really doesn't get your policies and that [practices] (P9).

A culturally safe practitioner needs to understand their own culture and the impact this has on power relationships with patients in their care Nursing Council of New Zealand, 2005).

Furthermore, the principles of social justice and equity that advocate for the acquisition of knowledge, mutual respect and negotiation, form the basis of culturally safe health care.

Eckermann, Dowd, and Jeffs (2009) also asserted that being a culturally safe practitioner includes reflecting on one's own culture and the attitudes and beliefs about others. This

required the individual to (1) reflect one's self, culture, profession and power imbalances; (2) apply basic communication skills; (3) develop trusting relationships; (4) Seeking knowledge

and outcomes through bi-cultural relationships; and (5) understand the effect of culture shock. Duke, Connor, and McEldowney (2009) reason that the process of becoming

culturally competent and culturally safe practitioner can be placed in the context of generic skill development and competency and compare this advance to Benner's (1982) framework

of skill development from novice to expert. This framework, they argue, can also be used to

track the developing cultural competence in the health practitioner.

To sum up, participants entered the final phase of the core process, *becoming a culturally safe practitioner*, when they acquired some capacity in managing the basic social psychological problem. In working through this final phase of the process, participants considered cultural differences and the impact this has on Aboriginal people, accepted the historical impact of colonisation on the social, cultural and health outcomes for Aboriginal people and participants engaged in critical reflection of their own experiences and values.

5.6.3. Summary of the basic psychological process of seeking solutions by navigating the labyrinth

The basic social psychological process of *seeking solutions by navigating the labyrinth* consisted of four phases: *neutralising the differences*; *taking the next step*; *seeking new solutions*; and *becoming a culturally safe practitioner*. In the first phase, participants sought to manage the uncomfortable emotions arising from the experience of the core problem by *neutralising the differences*.

When participants sought further strategies to manage the process, they moved to the next phase, entitled *taking the next step*. In the second aspect of the second phase, participants felt increasingly confident and continued to explore the core process and sought new ways to manage the problem. At this point they progressed to the third phase, *seeking new solutions*.

In the third phase of the process, participants began *seeking out information and education*. This provided them factual material on Aboriginal history and culture and implications for health care. Strategies in this phase assisted the participants in acquiring the ability to successfully reduce the negative experiences and gain confidence and aptitude in the movement towards *seeking solutions by navigating the labyrinth*.

Participants move to the final phase, becoming a *culturally safe practitioner* when they engaged in a deeper level of self-reflection, critical reflection of their beliefs and values and in recognising and accepting the historical treatment of Aboriginal people and the influence on mental health outcomes. The engagement in the final phase was not determined by the length of their experience as a mental health professional, but by their experience of the core process and conditions influencing that experience. The data identified three conditions that influenced the participants' experience of *seeking solutions by navigating the labyrinth* and these conditions will now be described in Chapter 6 of this thesis.

CHAPTER 6 - CONDITIONS INFLUENCING THE BASIC SOCIAL PSYCHOLOGICAL PROCESS

6.1 Introduction

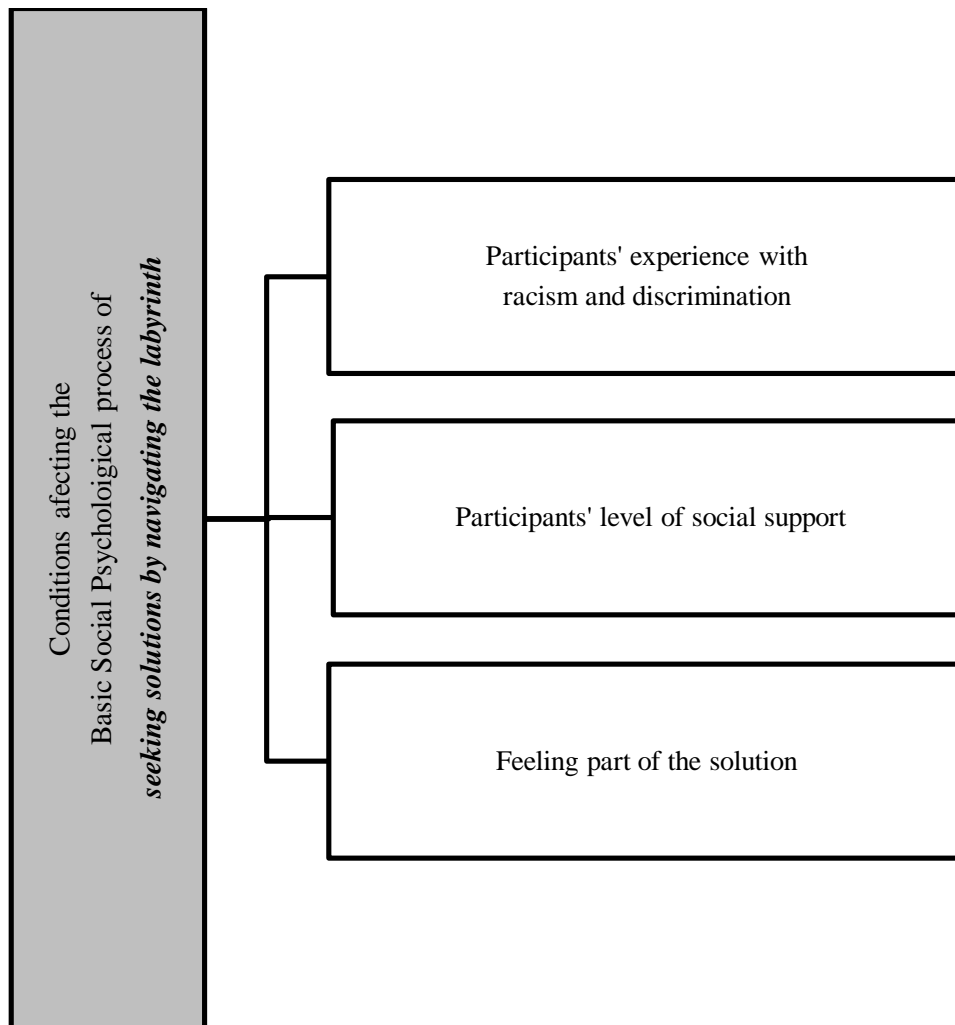
This chapter describes the conditions that influenced participants' experience of *seeking solutions by navigating the labyrinth* to overcome the problem of *being unprepared*. These conditions were present throughout all four phases of the basic social psychological process and were: *participants' experience of racism and discrimination*; *participants' level of social support*; and *feeling part of the solution* (see Figure 5, p. 111). Each of these conditions will now be described in detail.

6.2 Participants' experience of racism and discrimination

The first condition identified as influencing participants' experience of *seeking solutions by navigating the labyrinth* was *participants' experience of racism and discrimination*.

Discrimination is defined as treating people differently because of race, ethnicity, culture, religion, or individual characteristics such as gender or sexual orientation. Racism is described as the different treatment of others due to presumed distinctions based on racial differences (Taylor & Guerin, 2010). The related concepts of stereotyping and prejudice, occur when people use categories such as race to create or perpetuate beliefs about a particular group of people or make a judgement about a person based on race (Ranzijn, 2009; Taylor & Guerin, 2010). Racism and discrimination can be considered as any activity which maintains or intensifies inequality in ethnic or racial groups and can be conveyed through racist beliefs, prejudice or discriminator behaviours and practices (Berman & Paradies, 2010). Schmid (1996) asserts that racist ideologies and behaviour serve to rationalise the cause of the inequalities of privileges, goods or services and the animosity or prejudice towards different racial groups. Participants reported *experiences of racism and discrimination* and this increased their experience of *being unprepared* as they were unsure of how to manage these experiences. The following participant's description was representative of participants' experiences: "I think Western Australia is incredibly racist and I suppose you can't say that [inclusively] but the stuff you hear come out of people's mouths at different times; you think "Where did that come from?" (P12).

Figure 5: Conditions affecting the basic social psychological process



In this study, participants described experiences of racism and discrimination occurring on three levels: society, institutional; and at an individual level. The following descriptions from participants are examples *experiences of racism and discrimination* in society towards others: “People get defensive around the idea of racism as nobody wants to think of themselves as being racist, but we’re still a pretty racist society” (P28); “Growing up I experienced discrimination due to my ethnic background. However, now it’s a bit more acceptable to be ethnic” (P26): “I was actually quite shocked at the level of racism when I arrived here [Australia]” (P3); It’s rife, absolutely rife and it’s not even very veiled [covert]. People are so blatantly racist ... it’s right there” (P10): “[White] Australians are generally racist towards anyone who is not [a white] Australian” (P26). Other participants provided the following insights:

It's rife. It's rife in the world...People are incredibly judgemental ...I think that trying, because we'll never [be] perfect, but trying not to judge yourself and others is really important...I think people are politically correct and so if they hold racist views they would be careful, but I personally think my people [Anglo-Saxons] are racists, even when people consciously are attempting not to be. Everybody and I would include myself in that because, like I said, no-one's perfect (P19).

I think there's quite a bit of stigma here in [Australia] about Aboriginal people in general, that they're [a perception that they are] most likely to be violent, most likely to have alcohol and substance problems, that there's issues around how they treat their children and their primary health, diabetes and those sorts of issues. So I think they're actually portrayed negatively and most people have unfortunately, a negative view [of them] (P5).

I feel racism is alive and well in Western Australia. To me it's really evident in the population; I see examples of that at work, to be honest, probably not so much at work but in [the] general population. It's a rich state [Western Australia], we've got the resource boom [gas and oil], we've got lots of blue collar workers with lots of disposable income and there seems to be little tolerance for others culturally (P12).

People treat them [Aboriginal people] in a certain way just because of the stereotypical people on Murray Street [some Aboriginal people who live in the city]...I guess it's the same as [when] I worked with a few people down in [hospital name]; that were from South Africa, black South Africans. They were all stereotyped the same as [with] African people, [they say] they're this and they're that and they steal and do that. Seriously, do they all? (P14).

The following participants gave this description of personal reflections of racism and discrimination:

There's a difference between the conscious mind and the subconscious mind and I am not necessarily happy to admit it, but I will admit it, that subconsciously sometimes when you walk down the street, because of what I've been told by my Dad and [my] experiences, that sometimes when you see an Indigenous person you might do something like, just put your hand on your wallet or something like that. It is really dodgy [dubious] but it's something that unfortunately I do and I can't necessarily help it ...It's like walking round the city and you go into Wellington Square [area of the city] , you might see some drunk [Aboriginal] people in the park and you know they are a really small percentage [of the population], the people you see... You don't see the ones that are actually at university and getting a job and doing all these kind of things that we [white people] think is acceptable... you don't see that and it can actually change your whole attitude (P16).

I think it's quite big [problem] and to be honest I'm probably guilty to a certain extent just because I see the [Aboriginal] people that are on Murray Street [a major street in the city of Perth] and it's no wonder they get a bloody bad name because they're on Murray Street and they're screaming and [swearing] with the grog [alcohol] and stripping off and fighting, so I think it's what causes them to have a bad name (P14).

I think essentially people are frightened [and] they don't understand. They've had years of not even questioning what they've been taught [about Aboriginal people]. It might be generational; it is often generational. People don't talk about "Well, why do

I have this belief”...People don’t challenge that [their prejudices]. I get in trouble a lot. My [family member], refers to Aboriginal people as “Abos”. I said “Stop”. I said “I actually find that really offensive”, and I said “Look, I think that’s really not appropriate to say” and that was in their house (P10).

Conversely, the following participant described a different view of racism and discrimination in Australia: “There’s always going [to be] racism. I think what racial interactions that [are still] negative [are] ... not from us [white Australians]. They’re from some of the other cultures, you know. (P17). Another participant provided the following insights:

I’m sure that Aboriginal people, Indigenous people do experience racism, although by and large the average white Australian I’ve met, I wouldn’t necessarily suggest were racist. I have met racist white Australians, there are exceptions to that rule also, but I would say the average white Australian I’ve met is not necessarily racist people publically [overtly] (P4).

Many participants described *experiences of racism and discrimination* directed at them personally. The following participant, came from a white background and was born overseas and had a thick accent, gave this example “The Australian society, I find generally intolerant, even of myself” (P3); This participant for whom English was a second language provided the following insight: “Growing up in Australia, because I wasn’t fluent in English and mixed my two languages up, people assumed I was retarded” (P27); “Even for me coming from England, on first meeting my new neighbour, he said “Oh you’re a POM [slang for an English person], you don’t wash or have showers” (P26). The following participant, who had dark skin and was from a European background also provide this example:

You do see racism and also at times I’ve experienced it as much as anyone else. Every so often I’ve had it.., certainly as a high school student moving to a small country town into a community [with] white Anglo Saxons with blue eyes and blonde hair...and you have olive skin and dark hair and every so often I’d have people ask me “Are you mixed race?” or, “Where are you from?” You can’t be [European] with brown hair or black hair and brown skin”; I’ve certainly seen it [racism] on [name of ward]. Every so often I’ve seen Anglo-Saxons, particularly Anglo Saxon patients will say to people comments like “Where have you come from? Well why don’t you go back to where you’ve come from? Probably in the last year I’ve had one comment directed at me (P18).

This participant reported examples of racism occurring between Aboriginal patients from different cultural groups:

I see a conflict even between ... fellow Aboriginals, because some of them get called “white whatever” [due to their white mixed with Aboriginal ancestry] and those people with that attitude don’t appreciate ... shall we say, the white Aboriginals, the people who are assimilated and affiliated with everybody around them (P17).

Participants also described *experiences of racism and discrimination* occurring during their

interactions with Aboriginal people and how this influenced *seeking solutions by navigating the labyrinth*: “You [hear], “you racist effing [swear word] something, something” that seems to always be in a conversation” (P2); I’ve heard lots of racist comments directed at me...[the] “white C-word” is something that’s being flung [used] around a lot” (P16).

Examples of racism were also described by the following participant who had migrated to Australia from the United Kingdom: “I found that quite confronting that somebody would immediately dislike me because I was white and in their country” (P4). Similarly the following participants provided other examples:

I’ve never come across an issue [of discrimination before]. In fact a lot of the times I find the issue is reversed, that mistrust and suspicion of services breeds that sort of venomous racism towards you, which I find easy to deal with because I think, I figure it’s not actually towards me, it’s towards the system itself (P11).

Mistrust goes back way in history I think and it would happen in the way they were [mis]treated and what happened when the whites first moved in [colonisation of Australia]. I think that [there is] stigma attached and they tend to believe and brush all whites with the same brush (P13).

Several authors discussed the notion of reverse racism or discrimination, a condition in which discrimination is directed at the dominant racial group and is considered as special treatment, in favour of the minority group. This may occur for several reasons, including attempts at addressing historical events (Norton & Sommers, 2011). However, Taylor and Guerin (2010) report that it is not usual to discuss racism in reference to fair skinned groups, as the whiteness concept reinforces how the dominate white culture are afforded privileges, many of which are not acknowledged or recognised. Scant empirical literature exists around the notion of reverse discrimination in Australia. Kowal (2010) reports that stigma associated with “whiteness” is not usual as it is associated with privilege, education and wealth, rather than the usual categories of stigma, like disability, sexual orientation, substance use or race. However, Bonnett (2000) conceded that whiteness comes with a range of undesirable connotations, including exploitation, colonisation, imperialism and general dominance over non-whites, which Kowal (2008) terms negative occidentalism. While the experiences of perceived reverse racism should not be devalued, McDermott (2008) declared that non-Aboriginal Australians cannot fully understand how racism impacts Aboriginal people and stated the repetitiveness and the depth of racism has continuous and unrelenting consequences. Nelson (2014b) supports reflectivity and dialogue around white privilege in the broader conversation of anti-racism and to focus on more than racial attitudes. McIntosh (1990) compared white privilege to an invisible knapsack full of assets and resources

afforded to her purely due to her skin colour and position in society. White privilege implies that living in a westernised environment, white people enjoy advantages not afforded to non-whites, with the term representing obvious and less obvious advantages that a person may not recognise they have. Privileges extending from one's whiteness are often not considered. Discussion around how the notion of "whiteness" corresponds to the concepts of cultural safety, as the focus is on the dominant culture and how an individual's whiteness and position in society affects them and others around them (Taylor & Guerin, 2010). For participants in this study, personal *experiences of racism and discrimination* negatively influenced their ability to move through the phases of the basic psychological process.

The *experiences of racism and discrimination* at an institutional level in the workplace were described by the several participants. Institutional racism or systemic racism is used to describe the systematic disadvantage of minorities through the system or institution and the integration of racist views into bureaucratic and organisation practices and can sometimes be difficult to identify, but justifies individual racism (Hampton & Toombs, 2013; Taylor & Guerin, 2010). The following participant gave this example: "Institutional racism [exists including] the exclusion [of] people [on] so many levels [for example] when they're not acknowledged in the community (P10). Another participant provided the following insights:

We had a young female at [name] hospital, ... She was rejected from a state-wide accommodation place...because her sister had actually beaten up one of the members of staff and so she was actually excluded in this area because of the family history, not of her personal history and I know that happens with Caucasian people as well, but it did seem racially biased I guess (P5).

Experiences of racism also influenced participants in *seeking solutions by navigating the labyrinth*. The following participants gave examples of racism in the workplace: "I wouldn't say [racism and discrimination] is overt ...perhaps people are telling derogatory jokes I think it's very subtle. Occasionally you do hear the comments ... with some rotten joke. Oh yeah it's there [racism]" (P2); "I've heard lots of racist comments ... in the nursing station" (P16); "I could give a hundred examples of racism occurring in the workplace" (P25); "I'm not clear that it's systemic anymore, not like it once was, but it depends because individuals make decisions that affect ...clients" (P1); "I think overt racism is on the decline, but covert racism is endemic" (P28); "People's prejudices about different cultures in society, [these] same people...who are particularly rude perhaps to Indigenous students or patients were also rude to refugees. So there was like this common theme" (P2); "I was shocked by the use of the word wog [racial slur]. It's a very derogatory word where I come from" (P25).

Many participants gave specific examples of interpersonal racism and discrimination occurring in the workplace. These experiences influenced the basic social psychological process, *seeking solutions by navigating the labyrinth*: “For example, when you’re trying to explain things [about an Aboriginal person or culture] to a junior staff member and you get the rolled eyes ... their own attitudes, definitely their own prejudices,....racism exists within the workplace, that’s a fact” (P2) “ I was working with a [mental health professional] and she called Aboriginal people “boongs”, and tried to mimic their accent. I’m even uncomfortable saying the word out loud and I was surprised that a health professional would use that word” (P24).

Other participants gave these examples:

I have a recollection of a patient who was admitted [with] a brain injury as a result from petrol sniffing and there may have been an underlying psychiatric disorder previously to that I don’t know...I remember he had very short-term memory and repeated things constantly and I remember at times he was ridiculed...It’s awful to say and I hated seeing staff do the ridiculing (P7).

There was a family who had come into one of these settings and they had very poor hygiene. So after the workers spent an hour with this family and they left, the room actually did smell really bad and I think it was a social worker at the time said, you know, “I need the Glen 20” [air freshener] and then there were some jokes being made about, you know having to sanitise the place after... If it was perhaps a very intoxicated white Australian homeless guy, it would have probably been the same [response] (P8).

Another participant gave an example of racism in the workplace coming from other patients:

The worst racial stuff we have is amongst some of the patients because we get people [from] multicultural [backgrounds] ...and they can get a little bit racist towards them [Aboriginals]. Sometimes a lot of the racial stuff comes from the patient themselves. They don’t realise ...their attitude and they come in and they say the same things that they would say at the pub [public house] or in the family or in their workplace (P17).

Other participants reported different experiences of racism in the workplace: “I don’t think I’ve ever actually come across anyone, well, I’ve never worked with anybody...certainly not overtly, never heard of overt [racism] (P11); “Personally I haven’t seen any racism here...on this ward certainly, [we] have been trying to be culturally appropriate to whatever clients [we have], [but it] probably is a problem in the bigger picture” (P3); I didn’t witness any of that kind [racism] in here. I’m sure some people feel different about different things, but I personally didn’t experience anything. I didn’t observe anything like that. Everyone is trying to do the right thing (P13); I think most people are in the right space, head space [attitude] as far as cultural sensitivity goes and treatment of Aboriginal people in mental health, but

they're lacking in some good quality education probably (P19). Similarly from the following participant:

I tend to think mental health employees in general are very respectful. I don't have any [examples of] racial discrimination that's overt. You can't change individuals be it Aboriginal or be it any other race, so there may always be a little bit of concern with people, but generally no (P17).

Many participants in this study were unaware of the forms of racism occurring and were oblivious of the impact that racism and discrimination had on Aboriginal people or how it contributed to health outcomes. Delgado (1988, p. 407) states that "white people rarely see acts of blatant or subtle racism, while minority people experience them all the time". A lack of awareness of existing racism and discrimination can unconsciously influence decisions for care and interactions between Aboriginal and non-Aboriginal people, thus perpetuating discriminatory practices and ultimately contributing to disparities in mental health care outcomes for Aboriginal people (Dovidio & Fiske, 2012). Several authors have contended that the existence of white privilege, ethnocentrism and unintentional racism can hinder the development of cultural competency (Maxie, Arnold, & Stephenson, 2006; Mindrup, Spray, & Lamberghini-West, 2011). Many authors have advocated for improved cultural competency and reducing racism in health care as a way of closing the gap in health outcomes between Aboriginal and non-Aboriginal people (Durey & Thompson, 2012; Durey, Wynaden, & O'Kane, 2014; Kelaher et al., 2014).

Addressing forms of racism and discrimination includes critical reflectivity of one's own bias, values and those of the profession and is a constant and ongoing process and which includes evaluating feedback of our behaviour and attitudes (Ranzijn, 2009). Understanding racism moves beyond understanding individual attitudes, but also the function of power imbalances occurring as part of 'white privilege' (Ranzijn, 2009). Further, while an individual clinician may challenge personal assumptions and biases, the individual is always connected to their society and positioned within the systems of inequality (Gough & McFadden, 2001). Within Australia "whiteness" or Anglo-Australian cultural values are considered the norm that influence the lives of all in society and are the standard for which deviations to this standard are judged or ignored (Trask, 2003). Those who conform to the ideal of whiteness are frequently blind to the associated privilege that whiteness affords and therefore the impact of inequity of power relationships in mainstream services is not apparent (Pease, 2010). Failure to recognise and address the impact of these relationships contributes to the ongoing cycle of discrimination and negative health outcomes for Aboriginal people

(Larson et al., 2007).

In summary, participants' *experiences of racism and discrimination* were a condition that influenced the basic social psychological process. Negative encounters of racism and discrimination hindered participants' movement through the phases of the basic social psychological process. Less exposure to *experiences of racism and discrimination* facilitated participants' movement towards *seeking solutions by navigating the labyrinth*.

6.3 Participants' level of social support

The second condition identified as influencing the basic social psychological process was participants' level of support. Research has long promoted the benefits of utilising social support to ameliorate the effects of stressful situations (Cohen & Wills, 1985) and the benefit to wellbeing (Burke, Moodie, Dolan, & Fiksenbaum, 2012; Cortese, Colombo, & Ghislieri, 2010; Ganster, Fusilier, & Mayes, 1986; Othman & Nasurdin, 2013). In this study, participants received support from others and within the organisation and this influenced their movement through the phases of the basic social psychological process.

6.3.1. Support from others

The support provided to participants by others emerged from the data as a key factor influencing participants' experience of *seeking solutions by navigating the labyrinth*. Support from others was an important factor as articulated by the following participant: "There were certainly some great nurses that you could see had a real passion and a knack and an interest [in working with Aboriginal people] (P7)". The following participant lamented on the limited opportunities to work with Aboriginal nurses: "We [didn't] have any Indigenous nurses ... but that would have been an exploited resource" (P2). An example of the importance of support from others was provided by the following participant.

We have our colleagues and other professionals who are willing to help and support you. They're behind your ideas and your decisions. That's very important. Since I've been on this ward we have [had] cultural nursing [training], not sure exactly what it's called, but we have that, and plus, it's a culture of our ward itself, it actually promotes this kind of attitude and approach and we have staff, from different backgrounds and culture in general (P13).

Other participants had different experiences of support from others: "If the leaders are walking the talk and are modelling the way and if there's support and guidance and education

... [but] things like that have to be on the agenda” (P7). The data revealed the significance of Aboriginal liaison officers in providing support to participants: “We did have an [Aboriginal] liaison person within the hospital and the unit that I worked [that] was attached to a general hospital. It wasn’t a mental health specific liaison person, it was a liaison person [for] the whole hospital” (P5); “I think they’ve got one Aboriginal worker in the hospital, but not specific to mental health...I’m sure if there was a major drama, the Aboriginal liaison person, ... would assist if she could” (P14); “There’s certainly been a lot more cultural training...[and] bringing in the Aboriginal liaison officers and the state-wide Aboriginal service...people are actually [more] aware [of cultural issues] (P9); “There’s a guy who’s a member of the local community and [he] is great ...[we] work under the same roof and he will always stop and talk” (P1); “So we’ve got [whatever] his name and then we’ve got XXX [name of worker] here you know not just Aboriginals but obviously for you know, all races, sort of thing (P14). The following participants summarised their experiences of support from others: “In the mental health area ...we do have more access to the Aboriginal liaison officer, so people generally in the mental health area [are] generally more culturally sensitive to things” (P9).

Other participants provided further insight into their experiences of support from Aboriginal liaison officers: “Many areas provide Aboriginal liaison officers to talk to, but they finish at five o’clock, so if they were around, they were a great resource...but in terms of getting assistance at eight o’clock at night, it was very difficult”(P26); “When I’ve wanted something, [cultural support] ... I don’t feel like I got much back...but I figured they [the service] probably need more resources too. That’s the assumption I’ve made” (P1); “The experience has been that the Aboriginal liaison officers do not turn up in a timely fashion ... Is that because they’re overworked? For the people they do turn up and see; I know that works really well” (P9).

In summary, *support from others* was an important element of the condition, *participants’ level of social support* influencing the basic social psychological process. The practical and collegial support provided positively influenced participants movement towards *solutions by navigating the labyrinth*. *Support from others* offered new perspectives, insights and opportunities for their practice. Support from others from cultures, other than their own, also provided cross cultural perspectives to care. Less support from others negatively influenced the progress of participants through the phases of the process.

6.3.2. Support from the organisation

The organisation and health care environment was another source of support for the participants. The following participants gave examples of support received from the organisation where they worked: “We get information and knowledge, we get education [and] we get training [on] how to do it. We have support” (P13); “I used to work at [name of hospital]. They were very lucky [because] they had the State-Wide Aboriginal Mental Health Service ... I suppose we were spoilt there compared to how we are now. We don’t have that at all here” (P16). Many participants reported on their experiences of support from the organisation through cultural training programs: “Doing the multicultural training I had to do...trying to find out about specifics of different cultures, not just Aboriginal” (P14); “[Name of health service] have a really good [program] ... and they have a really good network of telehealth presentations that staff are encouraged to go to and that’s across the board for all sorts of professional development” (P19). “I’ve attended the cultural awareness study days. It’s important to gain an understanding or a wider breadth [about] a culture. [It] was very interesting to have a study day presented by Aboriginal people about Aboriginal people (P4); “Attending the training and hearing about the history of Australia, I gained an appreciation of where all the trauma comes from” (P26); “The [Hospital] has a handbook that was designed by ED [Emergency department] which gave quite a very clear outline of the kind of cultural norms for the specific Aboriginal groups” (P18).

Other participants provided further examples:

We do the multicultural training which is mandatory. So that’s obviously going some way towards helping. I guess and the trans-cultural service as well....I think it was just more reinforcement of that mindfulness that people have got different cultures [and that you can’t impress your own opinions on other people [and] that you’ve got to try and be non-judgemental. I think it was that stuff that you already know but it just reinforced it (P14).

I came from a multicultural background hospital [with] a multi-cultural team, and [I] attended a lot of conference courses, not here, but in [the] other place and because I used to be an educator before and [in] the previous hospital I worked, we had 64 different nationalities. So, as part of the Education Department we [conducted] cultural courses in different kind of backgrounds ...to train the staff; we have a trans-cultural group here ...that deals a lot with the Aboriginal patients in the community and [with] Derbarl Yerrigan [major metropolitan Western Australian Aboriginal health care service] (P15).

Other participants had different experiences of support received from the organisation:

“There’s a thing that’s become mandatory which, I suppose it’s called multicultural

awareness training [but] it's not specific to Aboriginal people. Probably it's as much or more about people from abroad" (P1); "The training I attended wasn't specific to Aboriginal people. It didn't assist me in understanding the importance of family for Aboriginal people for example and it didn't provide any practice advice" (P26): "I felt that it [training] was quite a glossy presentation and really didn't address the nitty-gritty [specifics] of what we really see or what we really are exposed to" (P4); "I found the training program patronising and I expected more. I didn't take much in" (P28). Similarly from the following participants:

We do have a mandatory multicultural day that we have to go to and it's treated like all the other mandatory training and I think that's unfortunate. I have to admit I've felt a bit like that as well. That it was kind of very tokenistic. It was multicultural and there was a small component [about Aboriginal culture] and there was a strong emphasis on the lost generation (P5).

When you look at what the service provides in relation to [cultural] awareness [and] being able to engage appropriately culturally, I think that's limited. I think there's a one day mandatory cultural diversity training that everybody turns up to and that's it. (P12).

The Aboriginal specific cultural training provided by [name of non-government organisation] was much more specific. It was interesting and focused on applying the recovery based model of care for Aboriginal people. We got involved in different exercises and it gave a good insight into Aboriginal culture (P26).

[Name of health service] does a much better job of a professional development and support of their staff. ... I know there's a mandatory thing that [name of hospital] staff have to do. Culturally, it's just not of the same quality. It's just not...I can't remember what was in it, but it was a waste of time. I didn't learn anything from it. The cultural stuff that we had when I was in the country service really was very specific and I've been to one over here at [name of agency] and ... talked about the same things like the importance of country and what that actually means to Aboriginal people (P19).

Little evidence exists on the effectiveness of cultural training programs in health care environments. The study by Chapman, Martin, and Smith (2014) into the effectiveness of a cultural awareness program in an Australian emergency department setting, revealed that although the program influenced perceptions, it did not change staff' attitudes towards Aboriginal people. The effectiveness of cultural training depends on a number of factors. Cultural competency must be interconnected with policy and organisational values and objectives with high levels of leadership displayed by organisational management. Furthermore, it needs to be encompassed within professional standards and frameworks and at an individual level delivered in a setting that promotes opportunities for applying cross-cultural knowledge and skills (Bean, 2006). Downing and Kowal (2011), discussed the limitations of the effectiveness of cultural training, proposing that organisational barriers

frequently place the responsibility of cultural practice on the individual health care worker. Kowal et al. (2013) proposed further features in training context to help promote cultural awareness including opportunities for critical reflectivity in a supportive environment, rather than a didactic transmission of value and beliefs. Downing, Kowal, and Paradies (2011) proposing a shift towards a model of cultural safety may be a more effective model for cultural training. The timeliness and practicalities of educational opportunities was another area considered by the participants in this study: “There’s always training on the go, but unfortunately in this ward we never get to them. We just never get released for the training, which is disappointing” (P3); “I don’t think there’s enough education and enough appropriate education” (P19). Likewise from the following participants:

I wish I had it [cultural awareness training] at orientation at my grad [graduate nurse] program... because my experience in gaining professional development at the hospital, over the years it’s become harder and harder to have the time to do that because of staffing issues... and there’s never any time to do your own professional development on the wards...I didn’t get to the Indigenous study days as soon as I would have liked...[I finally] went to an allocated Indigenous study day where I was given all that information, that you really should have at orientation I believe... actually I regret not getting to one of those earlier on in my career (P2).

After being in the job for about six months, [I] realised there was an Aboriginal GP Liaison Service I never knew anything about and I found it absolutely astounding ...it was like totally off my screen [awareness]...I wasn’t aware of that [service] until someone came and told me it was available (P18).

I understand the background [history] is really important and I kind of get that, but I wanted to learn about health of Aboriginal people and how I should be working with them. I felt we only got a small amount of stuff [information] about Aboriginal [culture] and it wasn’t aimed at health, it was aimed at social things that had happened in the past (P5).

The experience of participants in this study was similar to those found by Downing and Kowal (2011) study into the nurses experiences of the role of Indigenous training and the impact it had on their practice. Participants in this study reported the training did not provide a clear or specific description of what was expected of them in providing culturally safe care to Aboriginal people.

Support from the organisation in terms of operational management also emerged from the data, with examples provided from the following participants: “It’s too hard ... when you’re [in] a locked acute mental health unit and those places generally are at capacity [and] having the ability to be culturally sensitive to the different cultures” (P12): “Regardless of your background... it was just one approach suits all and I don’t recall there being anything

specific occurring for people of Aboriginal or diverse background...the approach was probably the same...it was [a] blanket approach. It [cultural awareness] probably wasn't on people's radar" (P7); "I don't think there was much consideration given to the specific cultural awareness of groups" (P12). Other participants reflected on the organisations' commitment in providing support and training and the commitment to supporting staff in exploring cultural diversity and providing culturally safe care to Aboriginal patients:

I don't really think the system is geared up [readiness] to look after Aboriginal clients particularly. I think it's lacking [in] Aboriginal Liaison Officers for a start. For example, we had a Chinese [client] a [while] ago and we had a liaison officer from his community come in and give us a good talk, but that hadn't happened when we'd had the Aboriginal clients in, which I thought was interesting (P3).

The division between the support received from the organisation and the operations of mental health care was reported by the following participants: "Sometimes you can be the target because of the way you manage somebody [and] it can come back on you because you're not doing things the way it's always been done." (P2); "It [cultural care] takes away from timely efficiency that bean counters need. You know, enquiring questions don't count" (P9). Also from the same participant: "Everybody's supposed to be in and out [of hospital] and so therefore some of the issues [aren't addressed] because they're not in hospital long enough" (P9). Other participants also provided further examples of the support received from the organisation and the detachment to clinical practice:

Some of the disconnect that happens on [the] day-to-day running of the ward, if you are busy and if you are coordinating a ward, you prioritise certain things. People are woken up, people are showered up, people have their medication [and] people are fed. So in terms of the hierarchy, that's what you want done and if you are running around to do that [and] another request comes in for something that isn't [routine], then it's easy for a coordinator to [say] "No, not happening, can't deal with this today" (P16).

I think it's often hard to do and particularly when you've got a busy kind of setting in the morning, you've got a busy run, you're trying to be inclusive and invite everyone to do something [therapeutic group activity] and to actually remember and to think well...there are others [cultural groups] on the ward ... without actually [considering, is this person actually going to be comfortable [with] this? (P18)

The barriers are that hospitals are false places. It doesn't matter what [cultural] group you come from, they are artificial and as much as we've tried over the years that things shouldn't be task orientated, the more efficient and effective and everything that you've got to [be] and the more you've got [a] plan you've got to follow. People get very focused on that and depending on the pressure of the work, cultural awareness isn't part of that appreciation (P9).

Several participants reported on policy, procedures and organisation guidelines in providing support. The following participants gave insights into organisational agendas and formal

structures:

So how are people supported and encouraged as workers or health professionals to support individuals? The overall policy and the strategy of that place; around how do they do it. If it's not on the agenda, if it's not on the radar, you'll just get sporadic [support]. You'll get people that are good people and have a passion, who understand and make the effort, but if it's not really embedded then it doesn't happen (P7).

The formal structures of the organisation are the things that make it difficult. We [can't] say "Oh, come with me, we'll just go out and see this person". You can't do it that way, everything's got to be accounted for and there's a computer system that [reports] on people's [work activity]" (P1).

This participant discussed the support from national organisations and professional standards:

Take the National Standards for Mental Health Services. It's a good example isn't it? I look at this [document] and I see diversity in standard four... key principles. Not really seeing any acknowledgement here [of Aboriginal culture]. Do they get any acknowledgement there? No, culturally and linguistically diverse which often doesn't include Aboriginal people. I just find it bizarre (P10).

A study by Cramm, Strating, Bal, and Nieboer (2013), reported that organisational and management support are essential to an innovative work culture. Several authors have also related the importance of social support in managing stressful situations. Abualrub (2004) study into social support amongst hospital nurses reported the importance of support from colleagues on job satisfaction and in the promotion of quality care and in reducing work related stress. Social support can act as a buffer and moderator in the relationship between stress, emotional responses and work performance (Pisaniello, Winefield, & Delfabbro, 2012; Rees & Freeman, 2009). Performance is influenced by organisational practices and by the culture and expected norms of the organisation itself, with supportive environments enabling supportive practice.

In summary, *support from the organisation* was another aspect of the condition, *participants' level of social support* that influenced participants' experience of *seeking solutions by navigating the labyrinth*. Positive experiences of support from the organisation assisted the participants in their movement through the phases of the basic psychological process. Less *support from the organisation* had a negative influence on the participants' movement through the phases.

6.4 Feeling part of the solution

Participants' capacity in *feeling part of the solution* was the third condition influencing the

experience of *seeking solutions by navigating the labyrinth*. In the context of this study, the meaning of the phrase *feeling part of the solution*, referred to the participants' sense of empowerment or control. Feeling confident and empowered to manage solutions is comparable to the concept of self-efficacy (Bandura, 1997). According to this theory, individuals with high self-efficacy have confidence in their ability to perform tasks and are more inclined to view challenging tasks as another opportunity for further mastery. The condition, *feeling part of the solution*, was helpful to participants in seeking *solutions by navigating the labyrinth* and this was influenced by internal and external factors. The following participants provided examples of individual factors: "In mental health [settings], cultural awareness is explored, but it's up to the individual [clinician] to identify it. Cultural awareness is not routine... it depends on the nurse. Cultural assessment can be seen as an additional burden" (P20). The support of peers and leaders was considered an important factor of the condition *feeling part of the solution* as described by this participant and assisting them in *seeking solutions by navigating the labyrinth*: "If the leaders are walking the talk and are modelling the way and if there's support and guidance and education ... Things like that have to be on the agenda" (P7). Likewise from the following participant:

I wish there were more like minded people because it's very rare to find people who share the same sort of non-judgmental values...It also comes back to strong leadership and if you don't have the good managers in place who are prepared to do the extra work...then it just all goes by the wayside [and] it gets ignored (P2).

Inflexible work practices and processes negatively influence participants *seeking solutions by navigating the labyrinth*. This included standardised care approaches which did not allow deviations to traditional routines and ways of working: "You try and do the best job and you come in full of knowledge and enthusiasm when you're newly graduated and your experience is developing. I could have stayed in that ward ... but I found that aspect of the job very, very draining" (P2). Likewise from the following participants:

I don't think there was much consideration given to the specific cultural awareness of groups. I think there was always an awareness of the tension associated with them being contained [in hospital] and in relation to how did they manage that or did they do anything specific to manage that? (P12).

Care is a blanket approach. I think it's because people who are different probably [aren't] valued or understood...There were certainly some great nurses that you could see had a real passion and a knack [natural skill] and an interest, but they were unusual" (P7);

Several participants reflected on the challenges of working within a Western biomedical model and how it *impacted on feeling part of the solution*: "Health services are westernised,

with a western model of care” (P28); “You’ve got to live with the medical model and yes, there are ... physical diseases ...but I think mental health [care] has a long way to go” (P8); “I think there might be some bits [culturally safe care] that they [the health systems] do pretty well, but I haven’t had any recent opportunities to observe it” (P1); “In terms of actually changing practice, and this sounds really terrible coming from an educator, that education and policy don’t necessarily change practice. It can make the organisation look good, but it doesn’t necessarily change what the frontline staff provide” (P16); “The lack of acknowledgement [of Aboriginal people], I think is fundamental. The level of frustration and anger that’s expressed ... and people’s inability to want to talk about their role as part of the solution rather than a blaming (P10)”; Services and staff...I think I’ve said it before, are politically correct. At its worst, they’re politically correct and best they’re genuinely aware of cultural sensitivity. Probably mostly they’re genuinely aware of cultural sensitivity” (P19). The following participant also provided insight into the experience of working within mainstream services:

What [were] the barriers? Was it environmental or the staffing [factors, or] the education associated with the cultural stuff within the staffing? I don’t know, I’m just surmising. The individual needs [of Aboriginal patients]: was it too hard or the culture of the workplace perhaps? When you say too hard I suppose when you’re looking at a locked acute mental health unit and those places generally are at capacity having the ability to be culturally sensitive to the different cultures...Can that be addressed or is it [care] systematised [and] we pigeonhole [assign to a restrictive category] (P12).

Similarly, participants also discussed the challenges to providing clinical care within the context of society and how this shaped their thoughts and perspectives of *feeling part of the solution*: “I think it [a culturally safe mental health care setting] would require cultural change within government, within the mainstream community and certainly within the public service [and] the health service. It’s a whole lot easier if it starts at the top” (P1); “I’m not a politician or an executive bureaucrat, but I think it needs to translate into money at the pointy end [an area where work gets done] of business. There aren’t enough clinicians for a start, there aren’t enough people to actually deliver services” (P1). The following participants, who were relative new comers to WA, reflected on the state’s response to cultural awareness and how this influenced their ability to navigate the basic psychological process: “I think Canada is a lot further ahead with their cultural sensitivity than here [Australia]. When I was growing up there... [in] the early 70s...they were probably going through the problems that we’re going through now and they’ve surpassed those problems now” (P3). Similarly from the following participant:

I was in [Australian state] for five years and it's definitely a step back coming to Western Australia as it has a lot further to go, not that [the previous Australian state] has it right by any means. I'm not saying that, but just that inclusion [occurred] 10 years ago [and] having Aboriginal mental health workers within mainstream community teams. They've only just started doing that here... In New Zealand [cultural awareness is] combined in our [university] curricula from day one and it runs the whole way through the three years and it's every week ... we have built on that sort of awareness [of] Biculturalism. In this country they will only talk about transcultural care and they'll talk about doing those other things before people have really acknowledged the fundamental kind of relationship with Aboriginal people (P10).

Conversely, the following participants had a different perspective of society's position in cultural awareness and inclusion:

They've [Aboriginal Australians] got to ...assimilate to some degree into our health services. It would be far too costly to set up two total sets [of health care services]. I mean, that's like South Africa [Apartheid] and who the hell wants that? No, I think assimilation is good (P17).

When it comes to assimilation, when it comes to inter-cultural acceptance, inter-cultural respect, most if not all the responsibility is left to the [non-Aboriginal] Australian population. Which I feel, being a foreigner myself, is not fair. I think all of us [are] responsible and all of us should take responsibility to actually assimilate, to adjust or whatever it may be. So that's unfair....I think it's really the [white] Australians that actually are left with all the responsibility to do all the hard work (P13).

The following participants gave their perspectives of *feeling part of the solution* and how it influenced them in *seeking solutions by navigating the labyrinth*:

I think staff's attitudes [are] like putting a band aid on a gaping abdominal wound. Staff's attitudes and the approach of staff is a minor solution to what actually needs to be happening... It's all about infrastructure and policies and staff's attitudes don't even get there... I agree it's important, absolutely important. I agree we need to be making sure we are doing the right thing...as a profession, absolutely we should be [doing] the best that we can in offering a service to Indigenous people, absolutely, but I think we're fooling ourselves in thinking we can make a significant difference before any clear infrastructure or major changes are made, we're not. It's like pouring a bucket of water over the towering inferno. It's not going to make a huge difference (P4).

This participant offered insights into their perspective into what was needed to promote *feeling part of the solution*:

We need to be more [culturally] aware, and I think it needs to start in undergraduate education. It needs to be meaningful and [we] need to get to the foundation of what it means and it's not about the dos and don'ts, it's actually about the understanding of who you are and respecting people and recognising difference and growing them in yourself and acknowledging the pain and the journey that people in this country have

gone through, and acknowledging what's happened to people. It's had a massive impact on their psyche, you know through generations and it's not something you can do in a workshop in a day, in an afternoon. It's something that takes years for people to do (P10).

Feeling empowered and *feeling part of the solution* has been discussed by several authors. Empowerment leads to autonomy which in turn promotes an increase in staff job satisfaction (Cicolini, Comparcini, & Simonetti, 2014; Laschinger, Finegan, Shamian, & Casier, 2000). Staff empowerment and satisfaction with work environment also contributes to quality care and in supporting other staff to engage in effective clinical practice (Kramer, Schmalenberg, & Maguire, 2004). In this study, feelings of empowerment and being in control, was attributed to the opportunities arising in the context of the workplace and society in general.

In summary, *feeling part of the solution* was an important condition influencing the basic social psychological process. Movement through the phases of the basic social psychological process was enhanced when participants had positive experiences with the condition, *feeling part of the solution*. Participants' negative experiences thwarted their ability to overcome the condition influencing the basic social psychological problem.

6.5 Summary

Three conditions were identified as influencing participants' experience of *seeking solutions by navigating the labyrinth*, with the first condition being participants' *experience of racism and discrimination*. Many participants had experienced or witnessed racism within society or the work setting and this undoubtedly influenced their ability and their movement towards *seeking solutions by navigating the labyrinth*. The second condition was participants' level of social support. Support was received from several avenues, including peers, colleagues, leaders and managers and the organisation. Participants' relationships with colleagues and peers were also important to their experience of *seeking solutions by navigating the labyrinth*. The third and final condition was *feeling part of the solution*. This was crucial for participants' movement through the process as feeling empowered and in control was an important element to the three of the four phases of the basic psychological process; *moving forward; seeking new solutions and becoming a culturally safe practitioner*.

In examining how these conditions influenced participants' experience of *seeking solutions to navigate the labyrinth*, it is pertinent to recognise that at the time of being interviewed, not all participants had reached the final stage of the process, *becoming a culturally safe*

practitioner. Further analysis of participant 4 and 10 is provided to demonstrate this point. Participant 10 had moved to phase four of the basic social psychological process and had progress in *seeking solutions by navigating the labyrinth*. When examining how the conditions influenced her experience of moving through the basic social psychological process, the data revealed they had minimal experiences of racism and discrimination and high levels of social support. Additionally, the participant felt part of the solution thus enabling successful navigation of the basic social psychological process. In contrast, participant four was at the other end of the continuum. This participant reported high levels of experiences with racism and discrimination and reported examples of racist comments directed at them personally. This participant was trained overseas and had also limited prior experience and knowledge of aboriginal culture and history. As their experiences with Aboriginal people was mostly negative, both inside and outside the work environment and they felt deeply affected by these. This participant felt they did not receive adequate social support and felt the organisation and systemic practices negatively impacted on positive interactions with Aboriginal patients. The significance of the influencing conditions on this participant's ability to *seeking solutions by navigating the labyrinth*, meant that at the time of being interviewed for this study, they were still in phase one of the basic social psychological process and unable to move forward in the process.

The substantive theory of seeking solutions by navigating the labyrinth to overcome being unprepared presented in the previous chapters will now be discussed further in relation to relevant scientific literature in part four of the thesis.

PART FOUR

CHAPTER 7

THE SUBSTANTIVE THEORY OF SEEKING SOLUTIONS BY NAVIGATING THE LABYRINTH TO OVERCOME BEING UNPREPARED

CHAPTER 8

IMPLICATIONS AND CONCLUSION

CHAPTER 7 - THE SUBSTANTIVE THEORY OF SEEKING SOLUTIONS BY NAVIGATING THE LABYRINTH TO OVERCOME BEING UNPREPARED

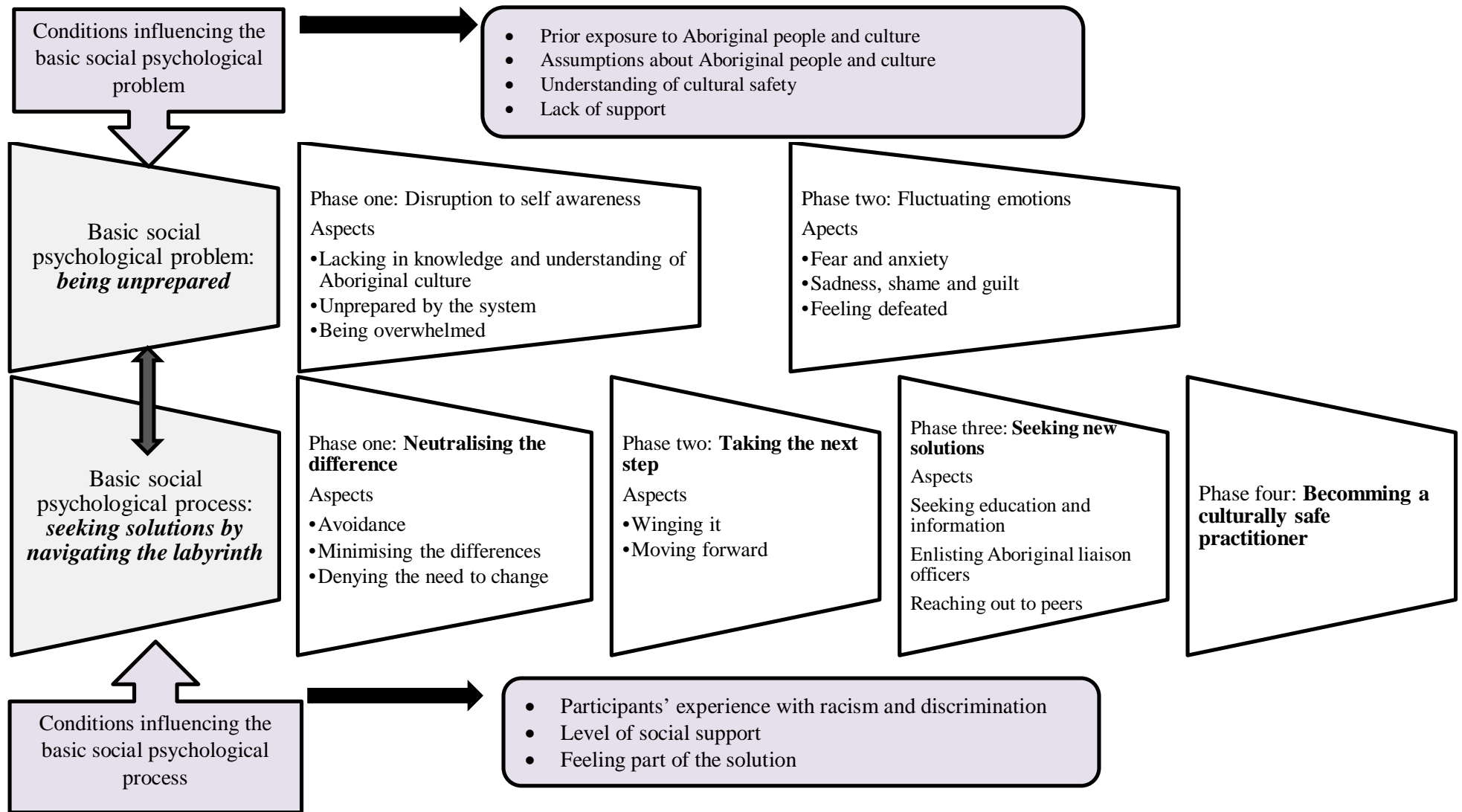
7.1 Introduction

The final objective of this research was to present the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* and place the substantive theory in the context of the relevant literature. Although relevant literature findings have been presented throughout this thesis, to illuminate the relevance to the developing theory, this final chapter will further explore relevant literature in more detail to further ground the substantive theory. Several theories were identified which captured various aspects and components of the newly developed substantive theory. These theories include works by Bandura (1995); Bennett (1986); Dreyfus and Dreyfus (1980); Benner, (1982); Fishbein and Ajzen (1975); Leninger (1988); Watson (1997) and the contemporary recovery orientated framework. Finally, a comparison of relevant research related to providing cultural care in health will also be presented to further position the theory.

7.2 The substantive theory of seeking solutions by navigating the labyrinth to overcome being unprepared.

Ground theory methodology implies the assumption that participants with a shared experience of the phenomenon under investigation will share a basic social psychological problem or a central issue of concern. The shared issue may not be expressed as a problem by participants, but the concern is addressed through their engagement in a basic social psychological process. The developed substantive theory involved a process called *seeking solutions by navigating the labyrinth*, which participants engage in to manage the problem of *being unprepared*. Participants' movement through the phases of the basic social psychological process was influenced by their experiences and conditions influencing that experience (See Figure 6, p. 132). For participants, *seeking solutions by navigating the labyrinth* allowed them to consider their position and negotiate a complex multidimensional experience. Participants made adjustments to their attitudes, thoughts and behaviour that influenced their ability to provide culturally safe care to Aboriginal patients in the mental health setting. For participants, the process of *seeking solutions by navigating the labyrinth*

Figure 6: The substantive theory of seeking solutions by navigating the labyrinth to overcome being unprepared



allowed them to move towards neutralising their experience of *being unprepared*. As participants negotiated these changes, they developed capacity to provide culturally safe care to Aboriginal patients.

The basic social psychological process of *seeking solutions by navigating the labyrinth* was a four phase process and on entering the final phase, participants' experience of *being unprepared* had diminished significantly due to the strategies implemented in the previous three phases. Participants entered the final phase, *becoming a culturally safe practitioner* when they had attained mastery in providing culturally safe care. At the time of being interviewed for this study, not all participants had moved to the final phase. Eight (8) participants had progressed to this phase *becoming a culturally safe practitioner*. Three conditions were identified as influencing the experience of *seeking solutions by navigating the labyrinth* and these were; *participants' experiences with racism and discrimination*; *level of social support*; and *feeling part of the solution* and by engaging in the basic social psychological process.

Participants moved from *being unprepared* to a state where they began to pursue solutions and navigate the complexities of the shared concern. While some participants were able to reach a point where they had significantly reduced the experience of *being unprepared*, other participants were still in the first phase of the basic social psychological process at the time the interview was conducted. In particular, one participant remained overwhelmed by their experience of *being unprepared*. This participant migrated to Australia several years previously and acknowledged they had no knowledge of Aboriginal culture or history prior to coming to Australia. Experiences with Aboriginal people both in the workplace and in daily experiences were negative and at times traumatic. This participant described being confronted by these experiences of racism and discrimination. They did not *feel part of the problem* and saw the many challenges in providing culturally safe care beyond their level of control and perceived that their contributions would have little impact on the health outcomes for Aboriginal people. These issues affected their experience in *seeking solutions by navigating the labyrinth* and were instrumental in extending the participant's experience of *being unprepared*.

In summary, in the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*, participants from a position of *being unprepared* and feeling overwhelmed by this experience to a situation where participants actively sought solutions

and strategies to become more prepared. In *seeking solutions by navigating the labyrinth*, participants developed capacity in providing culturally safe care. The substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* will now be compared with existing research findings and other theories.

7.3 Comparison of the substantive theory of seeking solutions by navigating the labyrinth to overcome being unprepared with other research findings and theories

This discussion compares the similarities between the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* with other research findings and theories. No identical theory was found to the newly described substantive theory; however there were several theories in the literature that reflected important elements of the substantive theory.

7.3.1. Comparison with other research findings

While a plethora literature exists on the concepts of providing culturally appropriate care, there are limited studies on the experiences of mental health professionals in the provision of culturally safe care to Aboriginal patients. Several researchers have contributed to the evidence of providing culturally appropriate care both in the Australian and overseas context (Cranley, Doran, Tourangeau, Kushniruk, & Nagle, 2012); (Durey et al.,2014); (Foster-Boucher, 2010);(Harrison & Turner, 2011);(Johnstone & Kanitsaki, 2007a); (Wilson et al., 2015). However, they have not captured the multi-dimensional experience of providing culturally safe care in mainstream mental health services. Research into the experience of providing culturally safe care in this setting is important, as it is a complex and multidimensional experience affected by a range of internal and external forces. These recent studies will now be compared with the newly developed substantive theory.

7.3.2. Comparison of the substantive theory with Johnstone and Kanitsaki (2007a) “An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context”

Johnstone and Kanitsaki's (2007a) exploration into the construct of cultural safety and its applicability to the Australian health care context, included a purpose sample of 145 participants, using individual interviews and focus groups with nurses, allied health professionals, cultural liaison officers, patients and families, interpreters and cultural education trainers. Key findings in the study focused on knowledge and understandings of cultural safety and perceptions and experiences of cultural safety. The three research questions investigated included: (i) What do health care providers and consumers of diverse cultural backgrounds know and understand about the notion of cultural safety as it might be applied to Australian health care? (ii) What are health care providers' and consumers' perceptions experiences of cultural safety as a process in multicultural Australian health care settings? and (iii) To what extent can the concept of cultural safety be applied as a risk management strategy in the multicultural context of Australian health care settings (Johnstone & Kanitsaki, 2007a, p. 249). Findings revealed that health care providers do not have an adequate knowledge or understanding of cultural safety and cultural competency in healthcare or the impact it has on health outcomes. Few health care providers recalled previously hearing the term, but offered several different definitions for what they believed it to be, including "doing things safely" for culturally diverse patients or that the patient received "safe care" or was free from harm because "staff lacked cultural knowledge and awareness" (Johnstone & Kanitsaki, 2007a, p. 249). This is comparable to the findings of this current study where only a few participants had an understanding of the term or concept. Like the participants in Johnstone and Kanitsaki (2007a) participants in this current study guessed the meaning of cultural safety which included "It means somebody that can relate to another culture, [and] can understand and respect and treat them the same regardless of that difference or basically be able to provide the same care, regardless of the difference" (P13). Johnstone and Kanitsaki (2007a) also reported that some participants held quite descriptive views of culturally safe practice, with certain actions not to be contravened. This was also comparable to the findings of this study in which participants sought to prescribe to a perceived notion of non-verbal interactions with Aboriginal people, specifically eye contact, for example: "Some of the customs you should try and respect, [for example] not looking them in the eye [and instead] looking at their shoulder and that was certainly [considered] when we came to [completed] mental state examination" (P1). Racism and discrimination also featured in participants' responses in the study by Johnstone and Kanitsaki (2007a) in which immigrant health care providers had witnessed negative behaviours and described experiences where they had been the focus of racism and discrimination. Johnstone and

Kanitsaki (2007a) concluded that operationalising cultural safety depends on crystallising the concept as an outcome of the process of cultural competence as a crucial element in operationalising this concept is competent practice at both an individual and organisational level (Johnstone & Kanitsaki, 2007a).

7.3.3. *Comparison of the substantive theory with Durey et al. (2014)*
***“Improving forensic mental health care for Aboriginal Australians:
Challenges and opportunities”***

While the literature describing the experience of providing culturally safe care in a mental health setting is limited, Durey’s et al. (2014) study of mental health professionals working in a forensic setting in Western Australian, described several factors that influenced the quality of care provided to Aboriginal patients. Using both quantitative and qualitative methods they gathered data from non-Aboriginal health professionals. In the first part of the study, surveys collected to gather information about participants’ views of factors that helped or compromised their care of Aboriginal patients; and education, training and support and factors that strengthened relationships with Aboriginal patients and their families (p. 197). Several factors influencing good quality care to Aboriginal patients was report by participants including knowing about Australian Aboriginal culture (72% of participants); knowing about Australian history and colonisation (51% of participants); and education and training to work with Aboriginal patients (51%). An increased awareness of cultural protocols and a willingness to engage with Aboriginal culture and practices was also identified at 49% and 47% respectively. Only one of the participants reported that the existing education and training programme was adequate with the other participants wanting more education on Aboriginal views of mental health and illness (65%); culturally-appropriate assessment (47%) and ways to reduce discrimination against Aboriginal people (45%). In order to strengthen relationships with Aboriginal patients and families, participants identified the following important factors: culturally-appropriate communication between staff and patients (55%); more communication between health providers and patients’ families and community (51%); and employing full-time Aboriginal health workers/support staff at the service (40%).

In the second stage of the study, Durey et al. (2014) used semi-structured interviews to collect richer descriptions of these issues. Several themes emerged from the data including better education and training in culturally-safe care for Aboriginal patients; embedding Aboriginal health workers and support staff in the service; negotiating the intersection between health and secure care; and improving relationships with Aboriginal people. Barriers

to providing culturally safe care in the forensic mental health setting included limited educational training opportunities. The findings revealed the majority of participants supported ongoing training in caring for Aboriginal patients in order to apply the concepts of cultural safety in clinical practice, with one participant referring to the need to have culturally safe concepts and principles embedded into personal and systemic ways of working: “It needs to be embedded, and if you look at our patient populations, we have a very high proportion of Aboriginal people who come through here, and that needs to be recognised by the service and followed through” (Durey et al., 2014, p. 198). This was similar to the description of participants in this current study: “So if it’s [cultural safety] not on the agenda, if it’s not on the radar [and] you’ll just get sporadic [approaches]... it’s not really embedded, then it doesn’t happen” (P7).

In the current study, similar components were also identified as part of the substantive theory. The *level of social support* from peers, colleagues and the organisation and the participants’ experience of feeling part of the solution were conditions affecting the process of *seeking solutions by navigating the labyrinth*. Phase three, *seeking new solutions* and the *aspects of seeking education and information, enlisting Aboriginal liaison officers* and *reaching out to peers* were similar to the findings identified in Durey et al. (2014).

7.3.4. A comparison of the substantive theory with a study by Foster-Boucher (2010) “Quest for cultural safety: A grounded theory study of cultural spaces between Aboriginal patients and hospital nurses”

Foster-Boucher (2010) used a grounded theory to explore the processes used by hospital nurses in caring for Aboriginal patients in Western Canada. The research statement in this study included: How do nurses understand cultural spaces that exist between themselves and Canadian Aboriginal patients in hospital; and how does this understanding inform and guide patient nurse interactions and care? (Foster-Boucher, 2010, p. 16). The data revealed the basic social psychological problem was imbalanced between the hospital nurses’ professional ethical expectations and actual practice. Imbalance was the experience between the way cultural interactions were anticipated and how they were in reality. Feelings of tension, uncertainty and anxiety defined the experience of imbalance for participants (Foster-Boucher, 2010). The emergent theory of quest for cultural safety described how nurses managed and overcame the basic problem of imbalance. The quest for cultural safety included four stages with several influencing conditions. The movement through the stages of cultural safety was dependent on social conditions such as the health care environment, cultural education, social

political context and personal conditions such as intrinsic motivations to seek knowledge and disincentives (Foster-Boucher, 2010, p. 22).

The four phases were identified as part of the quest for cultural safety and included: recognising tension; searching for solutions; turning to a new vantage point; and acquiring knowledge. Consequently, this process was described as cyclical and continuous, with nurses either choosing to remain inactive in their knowledge and imbalanced or to reach for new knowledge to assist them in their quest for cultural safety. The process of the quest for cultural safety began when the nurse was new and continued as they accumulated experience in their career, with the process being repeated as needed to provide care to culturally diverse patients (Foster-Boucher, 2010, p. 22).

Progress through the stages of the process was different for each nurse and was dependent on their individual experience. The time taken to move through the stages ranged from days to years, with the potential for stagnation in the process (Foster-Boucher, 2010, p. 24).

Similarly, in this current study, the movement through the basic social psychological process was different for each participant and was also affected by the conditions influencing the process. Not all participants successfully navigated through all four phases with some remaining stagnant or immobilised in the earlier phases. Foster-Boucher's (2010) four phases; recognising tension; searching for solutions; turning to a new vantage point; and acquiring knowledge are comparable to the four phases in the newly developed substantive theory, *neutralising the difference; taking the next step; seeking new solutions* and becoming a *culturally safe practitioner*.

7.3.5. A comparison of the substantive theory with a study by Cranley et al. (2012) Recognizing and responding to uncertainty: A grounded theory of nurses' uncertainty

Data in the current study revealed the basic social psychological problem for participants was the experience of *being unprepared*. The Canadian study by Cranley et al. (2012) explored how nurses respond to uncertainty or being unprepared. The aim was to understand how nurses experience uncertainty and how they seek information when uncertain in their practice. Semi-structured interviews were used to collect data from nurses working in medical-surgical intensive care units at two teaching hospitals in Canada. The findings highlighted the importance of recognising uncertainty and collegial support in managing it. Nurses expressed uncertainty in situations that were unpredictable, unfamiliar, unexpected

and challenging or complex (Cranley et al., 2012). The three main patient care situations that led to feelings of uncertainty included feeling caught off guard, unfamiliar or unique orders and navigating grey areas of practice (Cranley et al., 2012, p. 152). In Cranley et al. (2012), the substantive theory emerging from the data was recognising and responding to uncertainty. Recognising uncertainty included assessing, reflecting, questioning and being able to predict features of patients' circumstances and participants overcame uncertainty through the use of cognitive-affective strategies. Nurses' responses to uncertainty included physiological and emotional responses, strategies to manage uncertainty and the outcome of managing uncertainty (Cranley et al., 2012, p. 154).

Factors influencing how uncertainty was managed included personal characteristics, patient variables and situational factors, like accessibility of information. Participants overcame uncertainty via strategies that included: (i) figuring it out for myself; (ii) collaborating and (iii) seeking evidence (Cranley et al., 2012). For the participants in Cranley et al. (2012), the experience of figuring it out for myself, represented cognitive, analytical reasoning and intuitive judgements. This is comparable to the aspect of "*winging it*" in the second phase, *taking the next step* in the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. Additionally, the aspects of collaborating and seeking evidence identified by Cranley et al. (2012) is comparable to the third phase, *seeking new solutions* in substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*.

7.3.6. A comparison of the substantive theory with Wilson et al. (2015) study

"Attitudes and characteristics of health professionals working in Aboriginal health"

An essential feature in this current study was the experience of health professionals providing care to Australian Aboriginals. In the study by Wilson et al. (2015), thirty-two non-Aboriginal health professionals described their experiences in working in Aboriginal health. Semi-structured interviews were used to uncover health professionals' experiences and confidence in working with Aboriginal people. Wilson et al. (2015) categorised the reported experiences into four main groups along a continuum ranging from a lack of practical knowledge i.e., (don't know how); fear of practice i.e. (too scared); working in Aboriginal health is "too hard"; to learning to practice regardless (barrier-breaker). Participants described not knowing how to work in Aboriginal health and lacked strategies to do so resulting in an

inability and uncertainty about how to progress. Fear included a fear of being racist and of making assumptions or doing or saying the wrong things (Wilson et al., 2015, p. 4). Those participants reporting the experience as too hard had worked in Aboriginal health for longer and were more aware of the barriers to practice, including external barriers and the wider socio-determinants of health. Participants in the group ‘learning to practice regardless’, were aware of both the external and personal factors, such as their own beliefs, influencing their practice (Wilson et al., 2015, p. 4).

Wilson et al. (2015) reported that participants demonstrated differences in; the willingness to work in Aboriginal health; understanding of the Australian Aboriginal history; degree of awareness of their own cultural identity and influence on working with Aboriginal people; and levels of (dis)comfort about the social, political and intercultural issues that influence the interactions in health care. Not knowing how to work in Aboriginal health and lacking the resources and ability to do so was also expressed by participants (Wilson et al., 2015). In the context the substantive theory, not knowing or *lacking in knowledge and understanding of Aboriginal culture* and being *unprepared by the system* were two aspects of phase one of *disruption to self-awareness* as part of the basic social psychological problem *being unprepared*. The components of fear, anxiety and shame featured in Wilson et al. (2015) and as part of the substantive theory of *seeking solutions to navigate the labyrinth* to overcome *being unprepared*.

7.3.7. A comparison of the substantive theory with Harrison and Turner (2011) “Being a ‘culturally competent’ social worker: Making sense of a murky concept in practice”

The research explored the experience of providing culturally safe care by health professionals. This included the understanding of the concept of cultural safety and influences to working within this framework. An exploratory study of Australian social workers by Harrison and Turner (2011) investigated the understandings of cultural competence in the provision of care. Harrison and Turner (2011) posited that despite the recognition of the importance of cultural competence in providing appropriate care, the term conjures up multiple descriptions and interpretations with understandings of the concept influenced by context and conditions, thus describing cultural competence as a “murky concept” (2011, p. 333). Focus groups were used to collect the data with prompt questions

developed to elicit data regarding the understanding of the term cultural competence, examples from clinical practice and how the organisation impacted professional practice.

Harrison and Turner (2011, p. 341) revealed that participants implied that cultural competence refers to policies, attitudes and behaviours and the term signifies valuing diversity, and a willingness to understand other cultures and the ability to work with culturally diverse patients. Further that cultural competence is associated with explicit organisational mandates as well as abstract attributes that health professionals need to develop. As one participant in their study described “cultural competence is about being aware of what you don’t know” (2011, p. 341). Additionally, comfort in being uncertain, challenging assumptions and acknowledging personal shortcomings were all connected with cultural competence.

General themes such as human values and respecting the individual being more important than cultural competence emerged in Harrison and Turner (2011). In learning to become culturally competent, participants discussed the ability to empathise with others, self-awareness and the ability to self-reflect. However, while there was confidence in the ability to learn to be culturally competent, there was less certainty in the impact of formal education and training (Harrison & Turner, 2011). There was also the concern that cultural competence training was frequently treated as a token exercise by agencies with the organisation being a major influence to the reality and application of cultural competency (2011, p. 344).

In the context of the substantive theory, there were similarities to the components of the findings from Harrison and Turner (2011). As part of the experience of *being unprepared*, participants moved through the two phases; *disruption to self-awareness* and *fluctuating emotions*, both periods of self-awareness, self-reflection, emerging empathy with others. Movement through these phases of being unprepared provide the impetus for the participants in this study to engage in *seeking solutions to navigate the labyrinth* to overcome the experience of *being unprepared*.

7.4 Comparison of the substantive theory with other theories

The following section details similarities between the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* with other relevant theories. No substantive theory related to mental health professionals’ experience in providing culturally

safe care was identified. However, several theories were identified within the literature which reflected important components and similarities to the features of the developed substantive theory. This section begins with some founding theories contributing to the conceptualising of clinical practice and care and concludes with the contemporary recovery orientated approach to care employed within the mental health setting, thus reflecting an evolutionary approach and shifting paradigms care delivery. These theories presented here include: A five-stage model of mental activities involved in direct skill acquisition (Dreyfus & Dreyfus, 1980) and Novice to Expert (Benner, 1982); Bandura's Theory of Self-efficacy (Bandura, 1995); Theory of Reasoned Action (Fishbein & Ajzen, 1975); Theory of Human Caring (Watson, 1979); Theory of Nursing: Cultural Care Diversity and Universality (Leininger, 1988); and Intercultural Sensitivity Model (M. J. Bennett, 1986); and Recovery-orientated frameworks.

7.4.1. A comparison of the substantive theory with Dreyfus and Dreyfus (1980) A five-stage model of mental activities involved in direct skill acquisition

A major feature of the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* was participants' use of cognitive responses. Participants employed reasoning and perceptive skills to protect them from the experience of *being unprepared*. Skill acquisition refers to the learning process used to develop new skills, habits or qualities. This process can be conceptually and physically challenging and requires mental and emotional knowledge and understanding as a prerequisite to practice and improvement (Boyd & Yin, 1999). A model of skill acquisition was described Dreyfus and Dreyfus (1980) in the five-stage model of mental activities involved in direct skill acquisition. This model provided an understanding of the stages involved in the process of skill acquisition. Dreyfus and Dreyfus (1980) proposed that skill acquisition develops via instruction and experience with the learner passing through five developmental stages: novice, competence, proficiency, expertise and mastery. In the novice stage, the learner accepts instruction and follows rules without responsibility other than to conform to these rules. Competence develops after substantial experience. Proficiency is demonstrated through the use of intuition in decision making and formulation of plans. Expertise no longer requires precise knowledge and happens unconsciously and automatically as effortless performance is demonstrated. At the highest stage of mastery, the experts' intense immersion in their work performance surpasses even higher levels of expertise. Thus, the stages in this process describes a gradual transition from strict adherence to the imparted knowledge and rules, to a mainly intuitive method of

performance that relies on implicit knowledge, but also acknowledges the need to engage analytical approaches at times (Peña, 2010). The implications of this model support a guided framework which considers issues at each stage of the process and facilitating skill development. Training and educational support must consider the developmental stage of the learner and avoid presenting complex concepts prematurely, and thus allowing the movement through the process at the learners' pace and to avoid regression to an earlier stage (Dreyfus & Dreyfus, 1980). Benner (1982) found that this model could be generalised to the nursing context as it considers incremental development of skill based on education and experience and adapted the model to explain the development of nursing skills in the stages of clinical competence. Benner (2004) states that the key to effective judgement and clinical insight lies in experiential learning from particular clinical situations and that poor judgement must be improved, with the distinctions noted. Therefore, the Dreyfus model of skill acquisition addresses this kind of experiential learning in a complex setting over time (Benner, 2004, p. 189). Benner (1982) refined the levels of proficiency to nursing as novice; advanced beginner; competent; proficient; and expert. Contained in this adaptation was the recognition that nurses utilise experience, not just education to develop competencies to navigate a range of complex situations. Benner (1982) proposes that the proficient nurse no longer ascribes to rules and formulas to direct their practice, but is guided by past experiences as they incorporate new paradigms and exemplars. Further, that a deeper understanding of the situation is needed before one acquires a mastery of ways of dealing with a particular experience (Benner, 1982, p. 406). Accordingly, good practice requires the practitioner to develop ethical insight and demonstrate effective clinical judgement informed by relevant scientific domains (Benner, 2004, p. 189). The capacity to respond as an ethical agent is also linked with the development of higher level skills and difficulties in understanding the complexity of practice and with interpersonal encounters and with problem engagement, precludes the nurse from progressing to the next level of competence (Benner, 2004). The experienced nurse attains an understanding of a patient's illness and their response to it, through an intricate understanding of the patient and their context and through advanced practice which has come from experience with many comparable situations. This acquired clinical knowledge, alerts the nurse to potential issues in subsequent clinical encounters (Benner, 2009). Although Benner's model is based on expertise in the nursing profession, it is applicable to many fields, particularly in clinical practice disciplines.

In summary, Dreyfus & Dreyfus's (1980) five stage model of skill acquisition and Benner's (1982) levels of nursing proficiency reflected aspects of the *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. As participants engaged in each phase of the process of *seeking solutions by navigating the labyrinth*, they developed mastery to overcome *being unprepared*.

7.4.2. A comparison of the substantive theory with Bandura's (1977) Theory of Self-efficacy

A major feature of the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* was the movement through a process of developing awareness and abilities in providing culturally safe influenced by personal, professional and systematic conditions. Participants in this study deployed a range of intellectual, self-assessment and self-management to mobilise behaviours and protect them from the experience of *being unprepared*. Social learning theories offer some insights in explaining influences of human behaviour with (Bandura & Walters, 1963) postulating that learning and behaviour is a cognitive process occurring in a social context. Bandura (1986) later pursued the social cognitive theory of human functioning offering that presents the behaviour as a manifestation on cognitive, vicarious, self-regulatory and self-reflective process in human adaption and change. Arising from this work was the theory of self-efficacy (Bandura, 1977) which viewed humans as self-organising, self-regulating, pro-active, self-reflective agents and not merely driven by the environment or internal impulses. Bandura's (1977) theory of self-efficacy provides a framework for understanding factors influencing performance and behaviour, asserting there is a direct relationship between an individual's perceived self-efficacy and behavioural change. Bandura (1977, p. 84) states that self-efficacy comes from four sources of information: "personal accomplishments; vicarious experience; verbal persuasion; and physiological states". Self-efficacy was described by Bandura (1995) as the belief in one's capabilities to organise and implement a solution to manage situations.. It was proposed that an individual's belief about their ability to exercise control over their level of functioning and factors influencing their lives, is central to the mechanism of self-regulation (Bandura, 1986). Additionally, change in the individual is dependent on a set of psychological factors that must be either developed or mobilised (Bandura, 1986). Self-regulation as explained by Bandura (1991) is a complex phenomenon functioning through a number of cognitive processes including self-monitoring, standards, evaluation, judgement, self-appraisal and emotion. Further, rational regulation of motivation and behaviour relies significantly on an

“anticipatory proactive system rather than simply on a reactive negative feedback system” (Bandura, 1991, p. 282).

Perceived self-efficacy reveals an individual’s belief in their ability to manage and control difficult or challenging situations and over their performance and relates to confidence in the ability to exert control over one’s own motivation, behaviour and social environment (Bandura, 1997). It encompasses the adjustment of thoughts, emotions, motivation and changing environmental factors (Luszczynska, Schwarzer, Lippke, & Mazurkiewicz, 2011). Bandura (1977) offered the hypothesis that the individual’s expectation of personal efficacy determined whether coping behaviours will be instigated, how much effort will be exerted and when confronted with barriers, challenges and negative experiences, how long the behaviour persists. Self-belief is vital in overcoming a new or challenging situation or adopting new behaviours and is significant in how an individual approaches goals and challenges. Self-efficacy influences human functioning including behaviour, motivation, and thought patterns and responses. In positions where self-efficacy is low, tasks and situations tend to be avoided (Bandura, 1977). Further, high self-efficacy promotes movement towards mastery of challenging situations rather than avoidance behaviours (Bandura, 1997).

While social learning theory has clinical application in the treatment and conceptualisation of phobic anxiety disorders and in understanding the principles of social learning to enhance knowledge acquisition and retention, the theory of self-efficacy has also been implemented as a theoretical framework for research into employees’ behaviour and performance. Salanova, Lorente, Chambel, and Martínez (2011, p. 2257) used social cognitive theory and self-efficacy to guide the study to investigate the self-efficacy as the key personal resource influencing nurses “extra-role” performance through work engagement and to examine whether transformational leadership is an influential contextual resource that influences self-efficacy. Findings also revealed a mediation model in which transformational leadership explains nurses “extra-role” performance through self-efficacy and engagement Salanova et al. (2011, p. 2264). Recommendations are made by Salanova et al. (2011) for future research to design and evaluate strategies for developing transformational leadership in clinical areas, especially amongst nurses.

In the context of this current study, participants developed and mobilised psychological factors to reduce the impact of *being unprepared* and to use in *seeking solutions by navigating the labyrinth*. Anticipatory and proactive strategies were utilised in phase two,

taking the next step and phase three, *seeking new solutions*. Participants also identified the significance of self-belief and perceived self-efficacy in the experience of *seeking solutions by navigating the labyrinth*.

7.4.3. A comparison of the substantive theory with Fishbein and Ajzen (1975)

Theory of Reasoned Action

Participants in this current study sought to overcome the experience of *being unprepared* by considering their personal strengths and limitations and intention to manage the experience. The theory of reasoned action (TRA), developed by Fishbein and Ajzen (1975) offers insight into attitude and behaviour. Components of TRA include behavioural intention, attitude and subjective norm. The theory proposes that an individual's behavioural intention depends on the individual's attitudes and subjective norms. Behavioural intent refers to the measure of strength in the intention to perform behaviours, with attitudes consisting of beliefs about consequences of the behaviour and the perception and evaluation of these consequences. Finally, subjective norm considers the perceived expectations of others along with intentions to conform to this behaviour (Fishbein & Ajzen, 1975). Therefore, the TRA postulates that an individual's behaviour is predicted by their attitude toward the behaviour and their perception of how they will be viewed by others by performing that behaviour. According to this theory, there are two main determinants of behaviour: personal responses and social influences (Ajzen & Fishbein, 1980). Further, Ajzen, Albarracin, and Hornik (2012) proposed that behaviour can be influenced by changing the notional antecedents and that interventions aimed at behavioural beliefs can consequently influence attitudes by changing attitudes intentions and actions. TRA offers an opportunity to explore reasons why an individual or group is motivated to behave in a certain way. Application TRA includes the framework for evaluation whether a particular behavior is more significantly influenced by an individual attitude, perceived subjective norms or both. In implementing inventions for change, specific interventions can be developed to target the key influencing factors.

In the newly developed substantive theory, participants reported that *feeling part of the solution* assisted their movement *towards seeking solutions by navigating the labyrinth to overcome being unprepared*. However, several participants in this study reported they did not believe they had a sense of control and this increased their experience of *being unprepared*.

7.4.4. A comparison of the substantive theory with Watson's (1988) "Human Caring Theory"

Central to the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* was the experience of providing meaningful interpersonal interactions and care to patients. Watson's (1988) theory of caring in nursing emerged as an attempt to give new meaning to the process of nurse-patient interactions and a move away from the biomedical dominated models. Watson's original model centred around ten carative factors which provided the framework for nursing care and were embedded in the philosophy and value system which was humanistic and spiritually based (Watson, 1988). These factors attempted to respect the human dimensions of nursing and the subjective experiences of recipients of care (Watson, 1979). The major conceptual features of the original theory centre around (1) carative factors; (b) a transpersonal care relationship; and (3) the caring occasion (Watson, 1979). With a contemporary lens, Watson described the theory's application as a philosophy, ethic, paradigm or worldview (Watson, 1997). Watson proposed that humans cannot be separated from self, others, the environment or cosmic interactions and advocated a deep respect and reverence for human beings and the transpersonal caring relationship. The term transpersonal refers to the "value of deep connectedness, shared relationship, subjective meaning and shared humanity" (Watson, 2002, p. 13). The transpersonal relationship calls for an authentic and genuine use of self, the ability to be reflective and with focused intentions on caring, healing, wholeness and health rather than disease states, illness and technological cures (Watson, 1997). According to Watson (2002), nursing is focused on helping the patient achieve an enhanced degree of harmony within the mind body and soul and this is attained through the process of a transpersonal caring relationship. Transpersonal caring, therefore promotes intentionality in caring-healing as an explicit process and conveys a connectedness beyond the ego and capturing spiritual dimensions all humans share with the deeper self, others, the environment and the universe (Watson, 2002, p. 13). Watson proposed the contribution of caring science offered a distinct disciplinary foundation to the profession of nursing and an opportunity to incorporate both the metaphysical and material-physical dimensions of science and healing (Watson, 2008, p. 15). The theory of human caring asserts that the transpersonal caring competencies are linked to the ontological development of the nurse's human competencies and ways of *being and becoming* (Watson Caring Science Institute, 2015).

The evolution of the Watson's theory of caring (1988) led to the shift from the *carative factors* to the *caritas process* offering new terminology and phenomena to the area of inquiry, theorising and knowledge development to the nursing discipline and caring science. Watson

(2008, p. 34) suggests the shift in focus allowed a deeper understanding and guidance on how to “enter into, interpret, sustain and inquire about the intention and consciousness of the original carative factors”. Although Watson’s original theory focused on nursing, it has relevance to the ethic and foundation for any health professional (Fawcett, 2002) and the theory of care continues to make direct and indirect contributions and influences on nursing and health discipline curricula, research and practice.

From the perspective of this study, Watson’s Human Caring Theory (1988), reflected important elements of providing care that were central to the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. In this study, participants’ experience of working with Aboriginal patients in a mental health setting promoted their understanding of transpersonal caring. During the transpersonal caring interactions, participants attempted to find a level of connectedness through a genuine use of self and critical reflection while focusing on holistic meanings of health and wellbeing. In exploring the personal experience of health and wellness for recipients of care, participants ensured patients were provided with respectful and meaningful care that was not purely focused on the western bio-medical model of treatment

Watson’s (1988) theory of human caring reflected important components of caring central to the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. In this study, participants’ experience *being unprepared* was increased as they acknowledge they failed to understand the human experience for the Aboriginal patient. Participants’ experience of *being unprepared* was further increased by the inability to establish the connectedness required for the transpersonal relationship. Participants in this study reduced their experience of *being unprepared* through the deployment of humanistic values in their interactions with patients. The substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* expands on Watson’s (1988) theory by extending the breadth of knowledge on how health professionals provide cultural safe care for Aboriginal patients. Additionally, the substantiate theory also emphasises the complexities of providing culturally safe care in a mental health setting including the limitations, challenges and opportunities, which has not been explored previously in the literature.

7.4.5. A comparison of the substantive theory with Leininger’s (1988) “Theory of Nursing: Cultural Care Diversity and Universality”

A major feature of the newly developed substantive theory was the experience of providing care to a patient from a different culture from ones' own, specifically in the context of this study, Australian Aboriginals. The concept of transcultural care emerged several decades ago as an area of inquiry into research and practice. Leininger's (1988) theory of nursing: cultural care diversity and universality, which emerged from the concept of transcultural nursing, focused on cultural dynamics that influence the nurse-client relationship. The theory of cultural care provides a framework for understanding the process of providing care to culturally diverse patients. Leininger refined the theory over several decades, which grew from two major foundations: care or caring, as the central unifying and dominant premise of nursing; and culture, as the totality of human lived experiences, beliefs and values (Leininger, 1991, 1993, 1995). The theory of cultural care as proposed by Leininger, aimed to provide nursing care that is culturally fitting, through health care delivery that is congruent with patients' cultural values and beliefs (Leininger, 1998). Leininger believed that care and culture were invisible and undetermined phenomena which had been ignored as crucial knowledge and skills need to promote the nursing profession (King & Averis, 2000).

This theory has enhanced knowledge of diversity and commonalties amongst cultures in relative to human caring, health and wellbeing, illness and beliefs and values. Leininger hypothesised that there are three modes for guiding nursing care judgements, actions for culturally congruent care including (a) preservation and or maintenance: referring to activities that assist individuals of a particular culture to maintain some essential cultural values relating to health and wellbeing (b) accommodating and or negotiation: referring to creative actions that help individuals adapt and cooperate with the aim of meeting the health care goals of the patient of a particular culture; and (c) re-patterning and or restructuring; referring to supportive professional actions that facilitate the patient to modify or adjust health behaviours to promote positive health outcomes, while respecting the patient's cultural values (Leininger, 1988). These modes have had significant influences over the understanding of providing culturally appropriate care and also in the development of cultural competence (P. N. Clarke, McFarland, Andrews, & Leininger, 2009, p. 234).

In developing the theory, Leininger (1991) predicted there were diverse and sometimes commonalties of expressions and patterns of health existing between people of different cultures, which was not always obvious. Another major principle was that the worldview, social structure, religion, gender, socio-economics, political environment, context and language and professional health care beliefs influences these expressions of care, beliefs and

value. Leininger later developed the Sunrise model (1991) as a visual aid in understanding the complex and multiple dimensions of the theoretical tenets of Theory of Cultural Care. Leininger (1997) asserts that the Sunrise model is a helpful framework for considering the multiple factors that influence health care beliefs and values. The analogue of the sunrise was used to represent the rising of the sun or “care” and to signify the opening of the mind to facilitate the discovery of the many different influences to care and the health and wellbeing of patients. The Sunrise model represents components of social structure and world views which influence health through language and the environment. Secondly, these factors influence traditional, specialised and professional nursing systems. Together, the two components embody the multifactorial aspects that must be considered in order to appreciate the complexity of human health and caring. The Sunrise model depicts the basic tenet of Leininger’s theory; that humans are inseparable from their cultural background and social structure (Leininger, 1991). The use of the Sunrise model can be influential in guiding therapeutic and culturally congruent care (King & Averis, 2000).

Expanding on Leininger’s original work, J. S. Boyle and Andrews (1989) summarised transcultural nursing as having four main concepts: environment/culture, health, people and nursing. Boyle and Andrews described the obstacles to cultural care including: (1) lack of understanding of cultural and ethnic groups other than one’s own; (2) stereotyping members of cultural or ethnic groups without consideration for individual differences; (3) judgement of other groups according to one’s own standards and values; (4) assigning negative attributes to members of other cultural or ethnic groups; and (5) viewing the experiences of others as inferior to those of one’s own group (J. S. Boyle & Andrews, 1989, p. 52). Further, that the culturally sensitive practitioner will endeavour to modify their care to include traditional and cultural perspectives to health and wellbeing and act as an advocate for those from culturally diverse groups. Central to Leininger’s Theory of Cultural Care Diversity and Universality theory (1988) in caring for a patient of another culture, was the need to understand how the person viewed the world and factors influencing these worldviews. Consequently, the theory has been used globally in the pursuit to improve the delivery of health care in a diverse and multicultural context, including Australia in improving the standard of Aboriginal health care (King & Averis, 2000, p. 182).

The Theory of Nursing: Cultural Care Diversity and Universality (Leininger, 1988) echoes central elements of cultural care central to the theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. In the context of this current study, participants

sought to overcome the basic social psychological problem being *unprepared* through the process of *seeking the solutions by navigating the labyrinth*. Participants moved through phases of this process entitled *neutralising the differences*; *taking the next step*; *seeking new solutions*; and *becoming a culturally safe practitioner*. These phases are comparable to the three core modes of Leininger's theory guiding nursing care judgements and actions for culturally congruent care including entitled preservation and or maintenance; accommodating and or negotiation; and re-patterning and or restructuring. Participants' experience of *being unprepared* was reduced when participants were able to overcome some of the obstacles to providing culturally congruent care as outlined by J. S. Boyle and Andrews (1989) including the lack of knowledge and understanding of cultural differences; stereotyping; judgement of an individual from one's cultural perspective; and assigning negative attributes of members of a cultural group. In order to move through the basic social psychological process, mental health professionals must seek to navigate the transcultural nurse-patient relationship by focusing on the cultural dynamics influencing the relationship and accept that cultural care values are entrenched in traditional, socio-economic, cultural and historical dimensions factors.

7.4.6. A comparison of the substantive theory with Bennett's (1986) "Intercultural Sensitivity Model"

Arising from transcultural nursing models of the era, M. J. Bennett (1986) proposed a model to explain the maturation of cultural understanding on a six-stage continuum called the Intercultural Sensitivity Model. This model identifies the underlying cognitive adjustments individuals employ to understand cultural difference. The continuum moves from ethnocentrism, (the tendency to view other cultures from one's own perspective) to ethnorelativism (the ability to see values and beliefs as cultural rather than universal). M. J. Bennett (1986) proposed that the earlier stages are characterised by denial of differences and defenses against difference with the later stages representing acceptance, adaptation, and integration of different world views. Specifically, the six stages include (1) denial of cultural differences; (2) defense of one's own culture; (3) minimisation of other cultures in order to protect one's own cultural identity; (4) cultural acceptance; (5) adaptation to cultural differences; and (6) integration of full cultural awareness into everyday interactions. Positioning along the continuum of cultural understanding is dependent on life experiences. Ethnorelative stages are characterised by a positive attitude towards cultural differences and tend to be indicative of individuals who work towards inclusion and understanding diversity

(M. J. Bennett, 1993). Changes occur as the individuals progress through each step along the continuum. The progress through each step are summarised as the following: from denial to defense, where the individual develops an awareness of the differences between cultures: from defense to minimisation, where negative judgements are reduced and the individual is introduced to similarities between cultures: from minimisation to acceptance, where the individual begins to accept the significance of intercultural differences; from acceptance to adaptation, when the individual commences assessment and investigation into other cultures; and from adaptation to integration, where the individual develops empathy towards the other culture (M. J. Bennett, 2004). This model provides a framework for exploring attitudes towards differences and how this corresponds to values and beliefs about other cultures, with the aim of developing higher levels of cultural competency.

Hammer, Bennett, and Wiseman (2003, p. 422) use the term intercultural sensitivity to refer to ability to discriminate and experience different cultures and the term intercultural competence to refer to the ability to think and behave in intercultural appropriate ways. They argue that broader intercultural sensitivity correlates with an increased capacity for demonstrating intercultural competence. Hammer et al. (2003) applied the framework for cultural sensitivity (M. J. Bennett, 2004) in developing the Intercultural Development Inventory to measure the orientation towards cultural differences. They proposed this measure has significance for assessment of training needs of personnel, guiding interventions for development of cultural competence and evaluating cultural training programs. The Developmental Model of Intercultural Sensitivity proposes that cultural sensitivity and cultural differences have the potential to facilitate or inhibit developing relationships and effective communication with others, with M. J. Bennett (1993) suggesting this is vital to productivity, innovation and creativity in partnerships. Dougherty (2004) proposed that intercultural competence training was essential to reduce the cultural inequalities in mental health. Several authors have applied this model to the development of cultural training programs in health care including Munoz, Dobroka, and Mohammad (2009) and Pernell-Arnold, Finley, Sands, Bourjolly, and Stanhope (2012). Munoz et al. (2009) applied the developmental stages in the formulation of a multidisciplinary course in cultural competence for nursing and other health care professionals, with participant's critical reflections indicating progress in acquiring cultural knowledge, skills and desire. Pernell-Arnold et al. (2012) applied the model to the evaluation of a multi-cultural, recovery-focused training program delivered to a multi-disciplinary mental health team. The study reported a nonlinear

process of transformation from ethnocentric to ethnorelative in the team members and the changes appeared to reflect changes in worldviews held by participants. Pernell-Arnold et al. (2012) recommended that training must explore the complexities of the world views held by mental health professionals and that entrenched racial inequalities cannot be addressed by brief presentations of cultural awareness. Pernell-Arnold et al. (2012) claim that cultural training that is limited to increasing knowledge or information at a cognitive level only, will significantly affect how individuals learn to modify, adapt and develop culturally safe interventions in their professional practice.

In the context of the newly developed substantive theory *seeking solutions by navigating the labyrinth to overcome being unprepared* similarity exists with the Intercultural sensitivity model (M. J. Bennett, 1986). The six steps along the continuum, from denial to defense; from defense to minimisation: from minimisation to acceptance; and from acceptance to adaptation correlate to the stages in the basic social psychological process. In *seeking solutions by navigating the labyrinth*, in the first phase, *neutralising the difference*, participants moved through the aspects of *avoidance*, *minimising the differences* and *denying the need to change*. In stage two in the basic social psychological process, taking the next step, participants moved through the aspects of *winging it* and *moving forward*. Acceptance and adaptation was seen in step three, *seeking new solutions* and the last phase, *becoming a culturally safe practitioner*. The participants in this study moved along a similar continuum from an ethnocentric to a more ethnorelative perspective as they sought to overcome being unprepared.

7.4.7. A comparison of the substantive theory with Recovery-orientated approaches to mental health care

Recovery is considered a process, a conceptual framework, a guiding principle and a framework for care (Anthony, 1993; Deegan, 1988). Emerging as an alternative to the biomedical treatment model for mental illness, a recovery-orientated approach has evolved to support mental health and wellbeing and reduce the impact of illness. This person-centred approach developed in response to global mental health reform, supported by the principles of social justice and equity (Muir-Cochrane et al., 2014). While there are many definitions of the term recovery, it has been described by Anthony (1993, p. 15) as a uniquely personal experience process of changing one's attitudes, values, feelings, goals, skills or roles and is a way of living a satisfying, meaningful and productive life, despite the constraints of mental

illness. Additionally, it involves creating new meaning and purpose as one seeks to progress beyond the negative impact of mental illness. The concept of recovery has become a focus of health care outcomes, recovery, personal narratives and service delivery (Jacobson & Greenley, 2001). Recovery is considered a philosophical and practical and pragmatic approach to mental health care with the emphasis placed on wellbeing, autonomy and empowerment. For mental health consumers and carers, the recovery approach refers to living optimally with mental illness, having hope and setting future goals, rather than just symptom management (Muir-Cochrane et al., 2014). Walsh, Stevenson, Cutcliffe, and Zinck (2008, p. 252) asserts that this recovery paradigm creates a space for services used to articulate their unique experiences of mental illness and health “without subservience to bio-psychiatry understandings, to oppose the paternalistic way in which mental health services are delivered”. In the recovery framework, the therapeutic relationship shifts towards patient driven goals and patient-centred care and is a significant shift away from the inequitable power relationship between patient and health care systems that has been entrenched in traditional psychiatric treatment approaches (Cutcliffe & Happell, 2009; Delaney, 2012)

As a framework to guide health care practice, the recovery-orientated approach is a shift toward achieving mental health, which encompasses more than merely the absence of systems. It includes the concept of hope and empowerment with person-centred care and collaborations and partnerships with patients, consumers and carers (Muir-Cochrane et al., 2014). Recovery from mental illness is considered an individualised experience with a person’s experience influenced by their cultural identify; their conceptualisation of health and illness; their experiences with loss, trauma, racism and discrimination; and their spirituality (Australian Health Ministers Advisory Council, 2013). Key factors such as social and economic factors are recognised as major influences to mental health in the recovery approach. Working as a mental health professional in a recovery framework includes collaborating with the individual to assist them in their pursuit of a meaningful life and satisfying life (O’Kane, 2013). Further, if it is accepted that there are many dimensions contributing to health, then the internal and external factors must be considered and supported in a person’s progression to recovery (O’Kane, 2013). The recovery-based model emphasises the significance of protective factors in reducing the destructive effects of mental illness. Protective factors serve as buffers or factors that inhibit the impact of risk factors. Social determinants of health, grouped according to the individual, family and peers; and

community are considered key protective factors as part of a recovery approach (Muir-Cochrane et al., 2014, p. 11).

The principles of recovery have been adopted by mental health services internationally including the United Kingdom and Ireland; Canada, United States of America, New Zealand and Australia. In Australia the *National recovery-oriented mental health practice framework* was developed to bring together a variety of recovery-orientated approaches developed from national and international literature. It provides a cohesive interpretation of recovery-orientated practice and service delivery for the Australian context and supplements the existing standards and competency standards. This framework describes the domains and capabilities required for the mental health services to operate in accord with the recovery-orientated principles and the guidance on responding to diversity in mental health issues and circumstances (AHMAC, 2013).

In this current study, participants moved through the stages of the basic psychological social process to overcome the experience of *being unprepared* in a framework and process that recognised the uniqueness of individual patients and moved beyond care that treats everyone the same, to care that meets the social, cultural and spiritual needs of patients and supports the recovery principles of person centred care.

7.5 Summary

This chapter commenced with a presentation of the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. Following this, the discussion focused on comparing the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* with other relevant theories and research. The literature discussed highlighted similarities to the findings of this study and the literature presented enhances the credibility, trustworthiness and transferability of the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. Common experiences were found by non-Aboriginal health professionals working with Aboriginal patients, and there appears to be similarities across other settings and therefore the findings presented are valuable to non-Aboriginal health professionals in other health care settings. Although this study has many similarities to the literature as presented in this chapter, the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* is unique in the specific details of the experience of mental health professionals.

The theory also provides a framework for health professionals, policy makers, consumers, and other stakeholders to prevent mental health professions *being unprepared* and to facilitate their movement in *seeking solutions by navigating the labyrinth* in providing culturally safe care to Aboriginal patients. The substantive theory encapsulates the complex experience of providing culturally safe care in mental health settings that has not been documented in the literature. The findings of this study not only show the challenges in the experience for mental health professionals, but also recognised the positive aspects of culturally safe care in the mental health setting. The substantive theory also demonstrates the need to review current practices in supporting mental health staff in providing appropriate care to Aboriginal patients. Chapter eight presents the concluding statements of the thesis, the implications and recommendations from research, education and clinical practice based on the findings of this study.

CHAPTER 8 IMPLICATIONS AND CONCLUSION

8.1 Introduction and overview

In the concluding chapter of this thesis, the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared* presented the unique experiences of how mental health professionals provide cultural safe care to Aboriginal patients. This area has not been fully explored within the Australian context and therefore the experiences highlighted in these findings provide a foundation for understanding this encounter. A discussion of the significance of the study findings, the implications for key stakeholders and pertinent recommendations are directed to mental health professionals, health services, educational providers, professional organisations and policy makers. The chapter concludes with a discussion of limitations of the study and suggestions for future research and a concluding statement.

8.2 Significance and implications of the findings

The significance of this study lies in the development of the substantive theory that explains mental health professionals' journey of development to enable them to provide culturally safe mental health care to Aboriginal people. The theory, developed in the Australian context, offers new insights and a unique perspective and contributes to the body of knowledge and understanding of issues salient to mental health professionals' experience of providing culturally safe care to Aboriginal patients.

The findings of this study suggest that:

1. The health care system, government organisations, education providers and policy makers do not understand or acknowledge the issues encountered by mental health professionals in providing cultural safe care to Aboriginal patients.
2. There is not a clear understanding of the concept of cultural safety amongst health professionals or its application to their role in care delivery to Aboriginal patients.
3. There is a lack of targeted professional development aimed specifically towards assisting health professionals in providing culturally safe care to Aboriginal patients.
4. There is a limited awareness by health professionals of the effects of racism and discrimination and the influence on health outcomes for Aboriginal people. The

experience of health professionals in providing cultural safe care has not been adequately addressed by organisations, health services, governments, educational providers and policy makers.

5. There is poor educational preparation of Australian citizens around Aboriginal history and culture and this impacts on their ability to work with first nation people in all employment settings including health. Improved educational preparation will also work towards; increasing efforts at reconciliation; and decreasing stigma and racism of Aboriginal people.
6. There is a need for all overseas trained health professionals to complete specific training in Aboriginal history and cultural safety prior to registration to practice.

The findings of this study go beyond the current body of knowledge and provide a greater level of understanding of the psychological, social processes, interactions and experiences of health professional when providing culturally safe care to Aboriginal patients. This study revealed that many mental health professionals felt unprepared to provided culturally safe care to Aboriginal patients and this is largely influenced by lack of understanding about Aboriginal people and history and support in providing this care. Attempts to address this were influenced by social and organisational support and feelings of empowerment. These experiences for participants occurred despite national agendas to reduce the gap in poor health outcomes for Aboriginal people and the national frameworks outlining cultural care requirements for health services and professionals. The issue of racism and discrimination that exists within society and that permeates the health care setting cannot be ignored. While participants acknowledged underlying racism in the broader community, few realised the levels of racism occurring within the health environment or the impact this had on Aboriginal people. The relationship between historical events, generational trauma, racism and current health care outcomes for Aboriginal people was not well recognised by participants. The findings suggest that is a need to continue to push towards improving health professionals' understanding of Aboriginal history and culture and recognising the relationship to mental health and wellbeing for Aboriginal people. Recognising the level of racism occurring and reflections on attitudes and positions of power and white privilege are also important in providing culturally safe care.

The study findings and recommendations are significant and are directed purposely at health professionals, professional organisations, health care environments, educational providers, organisations and policy makers to specifically consider the unique experience of working

with Aboriginal patients. Furthermore, strategies directed towards specific educational support, health policy, integration of cultural safety into clinical practice and explicit organisational support will ensure support for mental health professionals in providing cultural safe care is accomplished.

8.3 Implications of findings

The developed substantive theory has implications for health professionals working with Aboriginal people, health services, organisations and education providers. Several implications and recommendations can be made which originate from the findings and include four specific areas: (1) implications for mental health professionals; (2) implications for health services; (3) implications for organisations; (4) implications for educational providers; and (5) implications for governments.

8.3.1. Implications for health professionals

The first implication and recommendation is focused on health professionals and initiatives to assist them to be more prepared when engaged in providing culturally safe care. While this study was conducted in a mental health setting, there are broader implications for all health professionals. The initiatives for health professionals include professional practice, professional support and education in cultural safety.

8.3.1.1. Professional practice

The findings from this research have significant and specific implications for the professional practice of mental health professionals. Participants in this study spoke of the limited previous exposure to Aboriginal people and their restricted knowledge of Aboriginal history and culture exacerbated their experience of *being unprepared*. These findings recognised the psychological, social processes and shared concerns of mental health professionals in the complex and difficult issues arising in providing culturally safe care.

The research findings emphasise the need to examine issues of racism and discrimination in the health care environment. Experiences with racism and discrimination directed at participants were reported in the study and incidents exacerbated negative experiences and the ability of participants to work towards providing culturally safe care. However, participants failed to see the effects of racism on Aboriginal people and how this influenced

their health outcomes. While participants noted society's influence of racism and discrimination, personal strategies such as avoidance, minimisation and denial were more covert forms of biases. While these protective strategies served to assist the participants in managing the process, they also impeded the movement toward *becoming a culturally safe practitioner*. Frequently, these strategies were manifestations of limited knowledge and understanding of Aboriginal history and culture and reduced understanding of the enduring impact of colonisation and the resulting trauma on the health and wellbeing outcomes for Aboriginal people. The level of competency and cultural awareness of non-Aboriginal health professionals remains problematic (O'Brien, Boddy, & Hardy, 2007). As Henry, Houston, and Mooney (2004) acknowledged over a decade ago, health professionals compromise quality care by discriminating against others, however unintentionally, based on race or culture. While it may not be comfortable to suggest that discrimination is pervasive within the health care environment, it is recommended that individual clinicians reflect on their own attitudes and practices in order to lead a system change for more caring and receptive health care setting (Durey, Thompson, & Wood, 2012).

Motivating influences to improve cultural care practices include attitudes, knowledge and skills. Individuals need to be informed, motivated and trained in cultural safety in order to incorporate this knowledge and skill into their daily practice. It is imperative that clinicians' increase their understanding of Aboriginal culture and history and its influences on the health and wellbeing outcomes for Aboriginal people. This recommendation applies to both Australian born and migrant health professionals. Opportunities for cultural awareness training and cultural safety programs must be explored as ongoing professional and personal development.

8.3.1.2. Cultural safety education

The deficit of knowledge and understanding of cultural safe care contributed to the participants' experiences of *being unprepared*. Many participants were unfamiliar with the concept of cultural safety and the implications for their clinical practice. The participants were unaware of the impact of colonisation for Aboriginal people and as Brascoupé and Waters (2009) state, oblivious to the resultant power differential between Aboriginal patients and clinicians that threatens to undermine positive health outcomes. The principles of cultural safety are to educate and facilitate self-examination and reflectivity of one's realities and attitudes they bring to clinical practice to foster open-mindedness towards difference and

diversity and to move away from blaming the victims of historical and social process for situation and to develop self-aware health professionals “who are culturally safe to practice as defined by the people they serve” (Crampton, Dowell, Parkin, & Thompson, 2003, p. 596). Cultural training programs must be specific to the needs of the local Aboriginal people, while respecting the diversity amongst Aboriginal people (Coffin, 2007), as programs that generalise are considered disrespectful and irrelevant to local Aboriginal needs. (Wright, Culbong, Jones, O'Connell, & Ford, 2013).

Mental health professionals working within a western biomedical model frequently fail to understand the cultural needs of Aboriginal people. Durey and Thompson (2012, p. 1) call for health providers to “critically reflect on whether policies and practices promote or compromise” Aboriginal health and wellbeing. While there have been several frameworks for providing care to culturally diverse groups, cultural safety steps beyond the concept of cultural insensitivities towards analysing power imbalances, institutional discrimination and colonial relationships as they relate to health care (National Aboriginal Health Organization, 2008, p. 3). Thus, cultural safety in the context of Aboriginal mental health promotes that the professional and institution “works to create a safe space for an encounter with patients that is sensitive and responsive to their social, political, linguistic, economic, and spiritual realities”(Kirmayer, 2012, p. 158). Drummond (2015, p. 186) stresses that “cultural safety remains the responsibility of all health professionals”. It is crucial that mental health professionals continue to pursue education in this area and that principles of cultural safety underpin any mental health education and professional development programs.

Participants stated there were limited opportunities for cultural training programs as part of their orientation to the health care setting or as part of continuing education programs. It is vital that mental health professionals lobby their employer for the provision of such programs and petition the importance of staff being able to be released to attend professional development. Strategies to provide education and training in cultural safety are vital to support mental health professionals in their clinical practice.

8.3.1.3. Professional support

The findings also provide important considerations for the need for professional support for mental health professionals in the workplace. Limited support from colleagues and peers intensified negative experiences and the movement toward *becoming a culturally safe practitioner*. As reported by participants, less support from others increased the experience of

being unprepared and conversely practical and collegial support in a nurturing environment reduced this experience. Supportive and reassuring professional relationships with an awareness of the personal and professional impact of providing culturally safe care will assist in the open dialogue into the complex conditions at play for the health professional.

Recommendations are made to promote the use of the framework of clinical supervision to foster collegial support and critical reflectivity on individual practice and on the practice within the disciplines of providing culturally safe care. Koivu, Hyrkas, and Saarinen (2011) state that clinical supervision not only provides peer support and an opportunity to destress, but also as a way of promoting professional accountability, skill and knowledge development. This is vital for clinicians who are committed to developing cultural competency.

Additionally, ongoing education and support from key stakeholders, including Aboriginal liaison officers, should be formally operationalised and be made available to clinicians.

Increased collaboration between these groups encourages the level of support and reduces the experience of *being unprepared* and promotes culturally meaningful care for Aboriginal patients.

Mental health professionals are key agents in meeting the objectives set out in Cultural Respect Framework (Department of Aboriginal Health, 2005) and the Aboriginal Health and Wellbeing Framework (Department of Health, 2015). Thus, collectively the professional disciplines must be encouraged to develop measures that ensure the provision of culturally safe care. There is a need for mental health professionals to work collaboratively with Aboriginal patients and families, engaging Aboriginal liaison officers to develop best-practice models for working with Aboriginal people in mainstream mental health care settings.

8.3.2. Implications for health services

The next implication and recommendations of the findings of this study is focused on the health service. Health care organisations need to take responsibility for the consequences of having staff who report *being unprepared*. Specific strategies directed towards the health service will ensure appropriate care and practices are operationalised within the hospital environment to support mental health professionals in the provision of cultural safety. Target implications are directed towards training, engagement of Aboriginal staff, collaboration with Aboriginal stakeholders, racism, leadership, guidelines and standards, and evaluation of outcomes.

8.3.2.1. Training

Generally, mainstream services are not well positioned to incorporate cultural presentations or provide a culturally safe admission experience (O'Brien et al., 2007). While it is imperative that non-Aboriginal mental health professionals acknowledge historical influences to social and cultural marginalisation, the health care organisations must provide this training in Aboriginal culture and history for its employees. Further caution is needed to ensure these offerings are not tokenistic, but are genuine attempts to introduce staff to Aboriginal beliefs and values, and examines power relations existing between the dominant 'white' cultural group and the Aboriginal populations (Durey, Wynaden, & O'Kane, 2014).

Participants noted the lack of timely access to professional support or assistance which was ad hoc. The need for mental health professionals to have well-timed professional support is imperative so that these negative experiences do not continue to influence the quality of care provided to Aboriginal patients. The health care organisation needs to ensure it is providing the level of educational, professional and systemic support in a timely manner that meets the needs of the mental health professional. Responsibility must be taken by the health care organisation to ensure employees feel prepared in carrying out their work and adequate resources are in place to support staff. Organisations need to maximise learning opportunities for staff by quarantining time away from the clinical area to attend training. Staff must feel encouraged and confident their requests for support will be forthcoming. It is through supportive organisational strategies that mental health professionals will gain confidence and *feeling part of the solution* in providing culturally safe care. As Durey et al., (2012) advocate, the health care setting must be a safe and empowering environment where non-Aboriginal health professionals become key agents of change.

8.3.2.2. Engagement of Aboriginal staff

Strategies must be considered to increase the number of Aboriginal liaison officers within the mental health setting. Multiple advantages exist in the employment of Aboriginal staff in non-Aboriginal specific health services including translation assistance, capacity building of non-Aboriginal staff, patient advocacy, health promotion, providing a welcoming presence with which the patient can identify and cultural sensitivity and competency training (both formal and informal) to non-Aboriginal staff (Baird, Harrison, Luhr, Noel, & Scott, 2006; Barwick, 2000; Stamp et al., 2008). The participants in this study were appreciative of support from Aboriginal liaison officers and frequently sought out their expertise and insight.

However participants acknowledge difficulties in receiving timely support, due to the increasing demands placed on the Aboriginal liaison officers. Participants also noted that support from Aboriginal liaison officers within the organisation was limited to office hours. Organisations also have responsibility to evaluate the use of key professionals by mental health professionals and where needed, increase the capacity for opportunities these collaborations, including the access to support beyond standard hospital office hours. The introduction of more Aboriginal liaison officers itself will not necessarily lead to changes in the practice of mental health professionals, however closer working relationships, collaboration and alliances will work towards improving cultural awareness, empathic understanding and development of skills in culturally safe care. At a national level, strategies to increase the number of Aboriginal health professionals across all disciplines must also continue, with Durey et al. (2012) recommending an increase in Aboriginal participation in the workforce to increase the capacity of non-Aboriginal clinicians and foster collaboration between Aboriginal and non-Aboriginal people.

8.3.2.3. Collaboration with Aboriginal stakeholders

Support for changing practices are often primarily directed at supporting the individual clinician as the relationship between the mental health practitioner and the Aboriginal patient is central to cultural care experience. Research has shown that engagement with mainstream services is increased when Aboriginal people feel valued and respected (Aspin, Brown, Jowsey, Yen, & Leeder, 2012; Shahid, Finn, & Thompson, 2009). In evaluating and reflecting on cultural care in the mental health setting, it is imperative to the concept of cultural safety that care be judged by those receiving care. Failure to measure Aboriginal patients' and families perspectives of care fails to address the foundations of culturally safe care. Strategies must be initiated to evaluate the quality of culturally safe care. Donabedian (1988) proposed a framework for considering quality care that separates quality into structure (i.e. the characteristics of the setting and the impact on care), process (i.e. what is done to the patient) and outcome (i.e. the impact of the care on the patient). Health services must be committed to ensuring there is Aboriginal representation embedded in committees responsible for planning, monitoring and evaluating care and in creating working partnerships with community elders. More consultation with Aboriginal patients and families will provide insight into barriers and enablers to culturally safe care and provide opportunities to review current practices.

Opportunities for co-production in the mental health care delivery should be considered as part of a recovery-based and collaborative approach with Aboriginal people. Co-production is described in the recent literature as a new way of thinking about the provision of public health services, which has the potential to deliver a shift in the way health, education, and policy is delivered to make it more effective and efficient (D. Boyle & Harris, 2009). The underlying philosophy of co-production includes acknowledgement of both the health professional and the citizen as important contributors in the planning and delivery of services. Benefits to co-production in mental health services include: improved sense of belonging to local groups and networks; reduced stigma; increased skills and employability; reduced impact on emergency health care services; improved physical and mental well-being (Slay & Stevens, 2013). Co-production partnerships are effective when all parties believe in the vital value of the consumer perspective and require a high level of openness, trust, and honesty. Further, power in-equalities occurring between consumers and health professionals must be acknowledged and addressed to avoid perpetuating the cycle of inequality (Roper, Hopkins, & Houghton, 2014).

The six principles which are the foundation to co-production include; recognising the innate strengths and capabilities of consumers of services in an asset-based approach; building on existing capabilities; reciprocity and mutuality; peer support networks; blurring distinctions between health professionals and consumers, by reconfiguring the way services are developed and delivered; and facilitating rather than delivering and enabling public services to become facilitators of supporters of care, rather than be the sole providers (Slay & Stevens, 2013). Roper et al. (2014) assert that mental health professionals are ideally situated to advocate for co-production and partnerships with consumers, demonstrating its values to colleagues and policy makers. Co-production in mental health is gaining momentum in Australia as a transforming strategy in the delivery of health care (Gill, 2014) and potentially the next step in the preparation of mental health professionals (Cutler, Moxham, & Stephens, 2015). Therefore, these principles should be considered in supporting improved mental health outcomes for Aboriginal people.

Building trusting, mutually respectful relationships and effective collaborations with Aboriginal communities is an important preliminary step to providing culturally appropriate services (AIHW, 2013a). Partnerships and collaborations between the health service organisation and local Aboriginal groups will influence mental health professionals' exposure

and experiences with Aboriginal culture and people and aid in reducing the experience of *being unprepared*.

8.3.2.4. Guidelines and standards

In addition to the above mentioned strategies, health care organisations must provide relevant guidelines and practice standards for staff. These standards must feature high on organisational agendas, with a commitment to supporting staff in enacting within these requirements. The health care organisation must have available relevant and updated guidelines and policies that should be regularly reviewed to reflect best evidenced based practice. This will ensure that staff has appropriate and up to date information when they require it. Written resources must be available to staff with access available afterhours and opportunities for inclusion of culturally safe practices on hospital intranet sites should be considered. This will aid in the timely access of information as needed.

The findings highlight the significance of *feeling part of the solution*. Participants reported that at times they did not feel empowered to provide culturally safe care. Therefore, examinations of the role that mental health professionals play in the delivery of culturally safe health care services should be considered as several factors influenced these feelings of empowerment. Firstly, mental health professionals were frequently limited by their readiness and or ability and secondly by the barriers of inflexible work practices. Mental health professionals along with organisations, must identify these barriers and constraints that reduce the sense of empowerment in providing culturally safe care. Ongoing education is required to promote the importance of mental health professionals' understandings of the need for culturally safe care and the part they play in influencing health care outcomes for Aboriginal people. Consideration must be given to existing inflexible work practices when providing care for diverse cultural groups. Participants described the approach to care as a "set menu" or as 'one size fits all". Newman et al. (2013) also reported the reliance on familiar discourse of cultural diversity, has the potential to further marginalise minorities in a mainstream health care setting.

In addition to the need for critical reflectivity from the individual professional, is the need for the organisation to evaluate its assumptions about culturally safe care. The commitment to providing cultural safety in mental health services must be reflected in the organisation's policies, procedures and practice guidelines. Policy statements and practice guidelines

indicate the organisation's position and principles and in turn define the level of expectations for its employees.

8.3.2.5. Racism

Racism towards Aboriginal people continues to be a social problem in Australia (Redmond et al., 2014). However, many participants in this study were unaware of the forms of racism occurring within society or the clinical setting and were oblivious of the impact that racism and discrimination had on Aboriginal people or how it contributed to health outcomes. It is imperative that health professionals critically reflect and examine their own beliefs and values which form the foundations of their cultural positioning influencing health interactions and the delivery of care to Indigenous patients (Durey, Wynaden, & O'Kane, 2014, p. 296). As white health professionals gain insights into racism, their own racial identity and white privilege, they will develop empathy and skills in providing culturally appropriate care (Ancis & Szymanski, 2001; Utsey, Gernat, & Hammar, 2005). Without insight and changes into behaviour towards Aboriginal people, initiatives to improve health services may have limited impact on health inequalities (Larson et al., 2007).

Participants in this current study described incidents of institutional racism and discrimination occurring within the health care setting. Institutional racism is evident when societal systems impose oppressive or negative conditions against others based on race or ethnicity (Durey & Thompson, 2012). Health care organisations have a responsibility to identify areas of racism, discrimination and exclusion. Kelaher et al. (2014) reported that the experience of racism in health care settings was associated with increased psychological distress, which itself places the individual at increased risk of mental illness. These findings support the drive to improve cultural competency and reduce racism as a way of closing the health gap between Aboriginal and non-Aboriginal Australians (Kelaher et al., 2014, p. 3). Pedersen, Walker, Paradies, and Guerin (2011) identified fourteen mechanisms to reduce prejudice. These include the provision of information, the use of respect, careful choice of emotion, emphasis on commonality and difference, dissonance, evaluation, national identity, alternative talk, the length of interventions, and use of multiple voices from multiple disciplines, local needs, consensus, contact, whiteness and privilege, and the function of attitudes (2011, p. 61). Health care organisations have a responsibility to explicitly fight against racism at an individual and organisational level and to reduce the impact racism has on the mental health outcomes for Aboriginal people (Ziersch, Gallaher, Baum, & Bentley,

2011). Improving cultural competency of health care professionals and organisations will also tackle the negative health consequences of racism and discrimination (Awofeso, 2011). Strategies targeting racism and discrimination at an organisational level will contribute to supporting the mental health professional in *seeking new solutions by navigating the labyrinth* to overcome *being unprepared*.

8.3.2.6. Leadership

Support and direction from managers and leaders to participants was variable and they described the need for culturally safe practices to be on the “agenda” and more explicit. Health care managers and leaders are key agents in identifying areas of clinical care which are exemplary and requiring additional resources. Changes to experience of *being unprepared* are more likely to be effective when clinical leaders and senior staff promote and foster these changes (Hoffmann, Bennett, & Del Mar, 2013). Positive role models are also required as powerful motivators for changes in practice. Melnyk, Fineout-Overholt, Gallagher-Ford, and Stillwell (2011, p. 57) suggest it only takes one enthusiastic and committed individual to spearhead a team vision to improve care to patients and families. The move towards enabling mental health professionals will be more productive if the shift is driven by leaders committed to changing practice and improving mental health care for Aboriginal patients. Clear, unambiguous and explicit role modelling and direction from clinical and management leaders will encourage and promote cultural changes to practice. Further, a team of role models and mentors system-wide is vital to the implementation of strategies and sustainability in the organisation (Melnyk et al., 2011).

8.3.2.7. Evaluation of outcomes

There remains a need to develop outcome measures of quality and best practice in providing cultural safe mental health care. Measures of processes that influence patient outcomes, including cultural safe care, and identifies what is being done well and what needs to be improved must be included by the health care organisation (O'Brien et al., 2007). R. Walker (2011) outlined nine elements in an audit tool to assess cultural competence. These include leading and managing organisational change and continuous quality improvement; creating culturally welcoming environments for Aboriginal people and their families; developing the cultural competency of new and existing staff; providing culturally responsive care to improve Aboriginal access to services; facilitating culturally inclusive policies and practices; effective communication with Aboriginal people; building collaborative partnerships and

relationships with Aboriginal communities and organisations; improved service delivery in cultural competence; and monitoring and evaluation of the effectiveness of implemented strategies. Along with the implementation of cultural competency training, it is important to track and measure the level of cultural competency achieved.

The evaluation of the care provided is vital to defining why and how culturally safe care is achieved, something which O'Brien et al. (2007) criticises is lacking in the Australia's mental health treatment guidelines of Aboriginal patients. Competency in this area should be evaluated in a formal process, including clinical indicators and performance reviews (Hoffmann et al., 2013). In order to reflect on professional practice when working with Aboriginal patients, mental health professionals need access to guidelines and other forms of evidence in best practice and measures of current practices and identified practice gaps. Evaluating clinical practices and finding new ways of working within a culturally safe framework is dependent on the ability to change. Successful adoption of culturally safe practice requires an organisational philosophy and governance structure which is committed to the ongoing redesign of clinical care processes (Hoffmann et al., 2013) in response to the evidence provided by key indicators and the needs of Aboriginal patients and staff who provide care.

Strategies to support staff need to fit and mirror the organisational strategic aims and the existing organisational culture (Davies, Edwards, & Tremblay, 2010). Commitment to meeting the cultural competency and cultural respect frameworks as outlined by the Australian Health Ministers Council (2004) and in the Western Australian Health Aboriginal Cultural Respect Implementation Framework (Department of Aboriginal Health, 2005) must provide precise descriptions to staff the behaviour and practices that are expected. Without clear guidelines, individual and systemic barriers cannot be identified (Michie et al., 2005) in working within the cultural competency frameworks. Meeting the expectations of these guidelines and sustaining changes in practice also rely on a positive cultural attitude and individual, collective and organisational critical reflection, leadership and performance evaluation (Davies et al., 2010).

8.3.3. Implications for professional organisations

The third implication is directed at professional organisations. Most mental health professionals have a professional organisation to support and guide their professional development. Organisations such as the Australian College of Mental Health Nurses Inc.

(ACMHN), have established Standards of Practice (ACMHN 2010). These standards are focussed on the performance of mental health nurses and include professional knowledge, skills and attitudes. Several of these standards refer to cultural care, diversity and holistic care. Special interest groups under the umbrella of the ACMHN, like the Aboriginal and Torres Strait Islander Special Interest Group, play an important role in stimulating interest in and developing knowledge and skills in working with people from an Aboriginal background. Such organisations and special interest groups have an ongoing role in critically evaluating the educational and professional needs of their discipline and provide guidance and structure to reduce the experience of being unprepared. There is a need for professional organisations to collaborate and share their knowledge in this area to increase the capacity for all mental health professionals working with Aboriginal patients. It is vital these professional organisations act to raise the awareness of the mental health professionals' contribution to providing culturally safe care and address the needs of their members through the implementation of relevant standards.

8.3.4. Implications for education providers

The fourth implication is directed at educational providers. Racism and prejudice is experienced by many Indigenous people and operates on a number of levels to negatively influence health outcomes (Healey, 2014). Interventions to reduce racism need to target schools, universities, workplaces and health care organisations. Strategies such as Narragunnawali: Reconciliation in Schools and Early Learning program, assists schools to develop a higher level of knowledge of Aboriginal and Torres Strait Islander history and culture and increase respect, reduce prejudice and strengthen relationships between the wider community and Australian Indigenous people (Reconciliation Australia, n.d.-b). Part of the strategy in reducing the effects of racism towards Indigenous Australians in health care settings includes the preparation of undergraduate health professionals in providing culturally respectful health care (Durey, 2010, p. 87). McIntosh (2012) advocates for studies in white privilege to span the curriculums of health professionals, so they can enter the clinical setting with a greater awareness and skills in cultural competence (Mindrup et al., 2011). Confronting the effects of racism in health services towards Aboriginal Australians is a priority requiring a multi-tiered commitment to strategies linking policy to practice to reduce health disparities between Aboriginal and non- Aboriginal Australians. Part of this strategy includes preparing undergraduates and health professionals for culturally respectful health

care with education programs that are evaluated for long-term improvements to practice (Durey, 2010).

8.3.5 Implications for government

Strategies at improving mental health outcomes of Indigenous people must be considered a long term commitment from national and state government. Improving these outcomes is greater than the health care sector alone and requires a multi-level approach which addresses socio-determinants of health; accessibility of mental health services for Indigenous people; and racism and discrimination. It is vital governments continue to strive to combat racism and discrimination existing in society, particularly those attitudes and behaviours directed towards Indigenous people. Consideration must be given to the limited knowledge and understanding of Indigenous culture that exists in Australian society, particularly amongst new immigrants and value Indigenous culture must exist in our national identity.

It is imperative that Australian citizens receive robust educational instruction in the area of Aboriginal culture and history and the impact that colonisation of the British has had for Aboriginal people. Aboriginal perspectives need to be embedded across the educational curriculum with specific aspects of Aboriginal history address at each stage of the syllabus. The delivery of Aboriginal perspectives must be conducted by educators who have appropriate knowledge and in collaboration with Aboriginal cultural consultants and with input from local Aboriginal groups. The incorporation of Aboriginal perspectives into the core curriculum will strengthen the acknowledgement of Aboriginal identity, history and culture and promote reconciliation between Aboriginal and non-Aboriginal Australians.

Indigenous people comprise a small percentage of the Australian populations and therefore there is a risk the Indigenous voice will not be heard by those in positions of power and leadership. Governments are advised to consider strategies for strengthening the contribution Indigenous leaders and Elders provide in the development of policy and practice affecting Indigenous people, particularly in the area of mental health and wellbeing. Indigenous, culture and perspectives of health and wellbeing must remain high on the agenda of mental health reform and governments must continue to strive to work with Indigenous leaders, Elders and communities, in collaborative partnerships in providing culturally appropriate care. The sentiments of the 2008 National Apology must not become a distant memory, but provide the basis for continued efforts in reconciliation as the nation prepares for the Referendum to recognise and acknowledge Indigenous people in the Australian Constitution.

8.4 Recommendations for further research

Through the use of a grounded theory methodology, the substantive theory of *seeking solutions to navigate the labyrinth* to overcome *being unprepared* revealed complex and diverse experiences of the shared concern of mental health professionals when providing care to Aboriginal patients in mental health settings. The participants revealed several conditions influencing their experience of *being unprepared* and on the basic social psychological process of *seeking solutions to navigate the labyrinth*.

This is the first grounded theory study conducted into the experience of providing culturally safe care in a mental health setting and within an Australian context and adds new knowledge to issues identified within the national and international literature in providing culturally safe care to Aboriginal persons. There are several opportunities for further exploration and development as a result of the findings emerging from this study. This study presents several important elements influencing the experience of mental health professionals and the identified substantive theory should be further explored to confirm these findings. Further research could also utilise the substantive theory to compare and test the concepts identified in this study and to apply it as a theoretical model.

Further research which explores the experiences of mental health professionals in other states and the use of other methodologies may address some of the limitations identified in this study. The participants in this current study included several mental health disciplines. Additional studies may be warranted into the experiences of different mental health disciplines to determine if distinctions exist. Interventions suggested in this chapter could also form the basis for interventional studies aimed at improving the experience of providing culturally safe care for mental health professionals. Consideration could also be given to whether these interventions correlated to better mental health care outcomes for Aboriginal people.

Further research is also needed to evaluate the effectiveness of cultural awareness training currently implemented in the health care setting and the community in preparing staff to work with Aboriginal patients. This research should explore critical reflectivity of staff in their care of Aboriginal patients. Much more research is needed to understand the expectations of Aboriginal patients in mental health settings in receiving culturally safe care. Finally, future research should focus on the positive aspects of cultural safety and the impact of support on the experience of providing culturally safe care.

8.5 Concluding statement

Grounded theory methodology data has been used to identify the substantive theory of *seeking solutions by navigating the labyrinth* to overcome *being unprepared*. This study has raised the awareness of multifaceted issues that mental health professionals' experience in providing culturally safe care to Aboriginal patients in mainstream mental health services in a Western Australian context. This has been achieved through the study objectives which were to: (1) explore and describe mental health professionals' experiences of providing culturally safe mental health care to Aboriginal people in the Western Australian community; (2) Identify the factors that facilitate or inhibit that experience; (3) generate a substantive theory that explains the interactional and structural aspect of care provision for Aboriginal people; and to (4) evaluate the developed theory within the context of existing international literature.

The research findings detail the substantive theory of *seeking solutions to navigate the labyrinth* to overcome *being unprepared* and the conditions that influenced the experience. The findings are a testament to the generous contributions by the participants in speaking openly and honestly about their experiences. It is through their descriptions that a richer understanding of their experience has been uncovered which serves to increase the awareness of the important contribution mental health professionals make in providing culturally safe care. This knowledge and insight can provide the incentive to change practice, policy and to ensure mental health professionals do not continue to experience *being unprepared*. It is hoped through these findings, relevant initiatives and strategies will be instigated to facilitate mental health professionals in *seeking solutions by navigating the labyrinth*. Stakeholders such as government organisations, the health system and other key stakeholder organisations will have a better understanding of the needs of mental health professionals in providing culturally safe care to Aboriginal patients. Acknowledging the needs of mental health professionals in providing culturally safe care will ensure cultural safety continues to be placed high on professional and organisational agendas within a Western Australian context as we continue to strive to improve mental health care for Aboriginal Australians. The substantive theory will be significant for mental health professionals, health care organisations and government policy planners. The findings can be utilised in a range of ways to facilitate mental health professionals' movement from *being unprepared* through the process of *seeking solutions to navigate the labyrinth*.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

APPENDICES

Appendix A: Information sheet

Appendix B: Consent form

Appendix C: Semi-structured interview schedule

Appendix D: Curtin University's Human Research Ethics Committee approval

Appendix E: South Metropolitan Area Mental Health Service Hospital Ethics Committee approval



**INFORMATION SHEET
TO BE USED IN CONJUNCTION WITH THE CONSENT FORM**

Facilitating equity in mental health outcomes for Aboriginal people within mainstream mental health services in Western Australia

My name is Shirley McGough and I am a mental health nurse and a PhD student at Curtin University. I invite you to participate in a research study reviewing culturally safe mental health care for Aboriginal people in main stream health services. This study has been approved by the South Metropolitan Area Health Service Human Research Ethics Committee. This project is supported through a National Health Medical Research Council (NMHRC) capacity building grant; Mental Wealth: Improving Mental Health for Better Health Outcomes among Indigenous Australians (BMW). This study has been approved by the Ethics committee of Curtin University of Technology (Approval number: SON & M 35-2010).

If you decide to take part in this research study, it is important you understand the purpose of the study and your participation. Please read the following pages which will provide you with information about the study.

Nature and Purpose of the Study

The aim of this study is to investigate the provision of culturally respectful care and the impact on equity of mental health outcomes for Aboriginal Australians. This study will provide insights into policy and practice changes that will facilitate improved service delivery within a culturally respectful framework of care.

What the Study Will Involve?

If you agree to participate in this study, information about your experience of working with Aboriginal people in mainstream mental health services will be obtained through an interview lasting approximately 45 minutes. The interview will be audiotape-recorded and transcribed verbatim. There may be a need to re-interview you later to clarify issues discussed in the initial interview. If you agree to participate and sign the attached consent form, you are consenting to:

1. Be interviewed about your experience of working with Aboriginal Australians in the mental health setting.
2. Have the interview audiotape-recorded
3. Complete a demographic information sheet
4. If necessary be re-interviewed to clarify or discuss issues arising from the first

- interview.
5. Be interviewed in your own time
 6. Have the findings of the study published in the scientific literature.

Confidentiality

Information and data obtained in the course of this study will be stored in either a password protected computer file or locked metal filing cabinets. This information will only be made available to members of the team of researchers for the express purpose of performing the study. All of the collected information will be destroyed after 7 years. Furthermore, if publications arise from this research, the identity of participants will not be revealed in any of the published material.

Voluntary Participation and Withdrawal from Study

Your participation in this study is entirely voluntary. Your participation in this research is voluntary and you may withdraw at any time without penalty. If you have any questions or concerns about the study, please contact Shirley Mc Gough on 08 9266 7329 or at s.mcgough@curtin.edu.au

If you should have any complaints or concerns about the way in which the study is being conducted, you may contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929.

Thank you very much for taking the time to read this information sheet.

Shirley McGough
Faculty of Health Sciences
Curtin University
Phone (08) 9266 7329

Appendix B: Consent form



Government of **Western Australia**
Department of **Health**
South Metropolitan Area Health Service



Curtin University

CONSENT FORM
TO BE USED IN CONJUNCTION WITH THE INFORMATION SHEET

Facilitating equity in mental health outcomes for Aboriginal people within mainstream mental health services in Western Australia

Participants name: _____

1. I agree entirely voluntarily to take part in the study “Facilitating equity in mental health outcomes for Aboriginal people within mainstream mental health services in Western Australia” and I am 18 years of age or over.
2. I have been given a full explanation of the purpose of this study and of what will be expected of me.
3. I understand I am entirely free to withdraw from the study.
4. I agree to have the interview digitally recorded.
5. I understand the information obtained is primarily for the purpose of this study and this information will only be available to the researchers on the understanding it will be treated confidentially.
6. I understand I will not be referred to by name in any report concerning this study. In turn, I cannot restrict in any way the use of the results that arise from this study.
7. I have been given and read a copy of this Consent Form and Information Sheet.

Participant’s Signature:

Researcher’s signature

Date: _____

Date: _____



SEMI- STRUCTURED INTERVIEW GUIDE -

Facilitating equity in mental health outcomes for Aboriginal people within mainstream mental health services in Western Australia? A grounded theory study

The semi-structured interview will be used for data collection in this study. The researcher will meet with the participant approximately 15 minutes before the interview begins. During this time, the researcher will establish rapport with the participant and explain the purpose of the study.

The interview will commence by asking the participants the following questions:

Question 1

How long have you worked in the area of mental health?

Question 2

Tell me about your experiences of working with Aboriginal Australians

Question 3

What are the facilitators and barriers to the provision of culturally respectful care Aboriginal people?

Question 4

How can we improve equity in health outcomes for Aboriginal people?

Question 5

How do you reflect on your own practice when working with Aboriginal people?

Question 6

Do you think racism, discrimination and disadvantage impact on health outcomes for Aboriginal people?

The future direction of the interview will be directed by the responses obtained from the above questions however; the following prompts will be reflected in subsequent questions used in the interview to ensure that the objectives of the study are met.

Themes

1. Conceptualisation of mental illness for Aboriginal people
2. Cultural safety
3. Issues around Aboriginal people accessing services
4. Integration of traditional and Western models of care

Appendix D: Curtin University's Human Research Ethics Committee approval

memorandum



To	Ms Shirley McGough
From	Professor Gavin Leslie
Subject	Approval: SON&M 35-2010
Date	16 th August 2010
Copy	Professor Dianne Wynaden

Thank you for your "Form C application for your Research with Minimal Risk (Ethical Requirements)" project titled "**Facilitating equity in mental health outcomes for Aboriginal people within mainstream mental health services in Western Australia: A grounded theory study**". On behalf of the Human Research Ethics Committee I am authorised to inform you that the ethics for the project is approved.

Approval of this project is for a period of twelve months from 20th **August 2010** to 20th **August 2011**. If at any time during the twelve months you have any amendments or if a serious or unexpected adverse event occurs, please advise me immediately. The approval number for your project is **SON&M 35-2010**. *Please quote this number in any future correspondence.*

A handwritten signature in black ink, appearing to be "G. Leslie", written over a horizontal line.

Professor Gavin Leslie
Low Risk Assessor/ Director R&D
School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants: *This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.*

Appendix E: South Metropolitan Area Mental Health Service Hospital Ethics Committee approval



Government of Western Australia
Department of Health
South Metropolitan Area Health Service

Human Research Ethics Committee

wk

20 December 2010

Ms Shirley McGough
PhD Candidate
Faculty of Health Sciences
Curtin University of Technology
GPO Box U1987
Perth WA 6845

Dear Shirley,

Re: Facilitating equity in mental health outcomes for Aboriginal people within mainstream mental health services in Western Australia.

Thank you for your correspondence dated 13 October 2010, enclosing a research application form and relevant documents relating to the above study and seeking approval from the South Metropolitan Area Health Service (SMAHS) Human Research Ethics Committee (HREC).

The documentation has been considered by a sub-group of the SMAHS HREC and the issues raised have been addressed to the satisfaction of the group. I have, therefore, recommended to the Chief Executive that the study be approved at Fremantle Hospital as a low risk project.

I can confirm that the Chief Executive's delegate, on 16 December 2010 and under delegated authority from the Minister for Health, endorsed my recommendation to approve the study. You may, therefore, commence the study at Fremantle Hospital.

Please note that HREC approval is for a three year period from the date of final approval and the research should be commenced and completed within that period. If the study period is longer than three years, you are required to seek an extension to the approval before the end of this period. In the event that the study does not commence within 12 months from the date of final approval the study must be resubmitted to the HREC for approval.

The HREC is bound by NHMRC Guidelines to monitor the progress of all approved projects until completion, to ensure they continue to conform to approved ethical standards. In accordance with the *National Statement Chapter 5.5.3*, researchers also have a significant responsibility in monitoring their research activity and must submit the following to the HREC, in relation to this study:

- Annual reports on the progress (including compliance with any conditions of approval and maintenance and security of records).
- Final report on completion (including a copy of the results and any publications).
- Reports of adverse/serious adverse events, according to the Committee's SAE Reporting Guidelines and advise the Committee if the event has resulted in an amendment to the protocol and/or to the informed consent document.

Human Research Ethics Committee
c/- Fremantle Hospital and Health Service
Alma Street Fremantle Western Australia 6160
Postal Address: PO Box 480 Fremantle Western Australia 6959
Telephone: (08) 9431 2929 Fax: (08) 9431 3930

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