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Tokenistic or transformative? An exploration of culturally safe care in Australian mental health nursing

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ABSTRACT

Given the harmful impacts culturally unsafe practices can have, there is a need to ensure mental health nurses (MHNs) provide care which respects and is affirming of Aboriginal and Torres Strait Islander peoples and their cultures. The aim of this qualitative study was to explore non-Indigenous MHNs' preparedness and experiences in providing care to Aboriginal and Torres Strait Islander peoples. Eight in-depth. semi-structured interviews were conducted with non-Indigenous MHNs. These interviews were thematically analyzed. The findings indicate that non-Indigenous MHNs have a limited understanding of cultural safety. In addition, supports for non-Indigenous MHNs to develop cultural safety skills and abilities are fragmented and any efforts to implement culturally safe practices are constricted by the dominance of the biomedical model in public mental health. The findings support the need for targeted reforms within public mental health services. Without sustained efforts to change, non-Indigenous MHNs will continue to work in ways that are culturally unsafe and harmful for Aboriginal and Torres Strait Islander peoples.

KEYWORDS

Cultural safety; mental health nurses; Aboriginal and Torres Strait Islander peoples

Introduction

State-provided public mental health services are often the only mental health services available to Aboriginal and Torres Strait Islander peoples in Australia (Isaacs et al., 2010). Within these services, MHNs represent the largest professional group providing care (Molloy et al., 2019). However, research (McGough et al., 2018) has indicated that despite acknowledgment of the importance of training in cultural safety and an increased emphasis on the inclusion of Aboriginal and Torres Strait Islander peoples'

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knowledges in the nursing curriculum (Australian Nursing and Midwifery Accreditation Council, ANMAC, 2019), many MNHs may still not have the knowledge, skills or confidence to support Aboriginal and Torres Strait Islander service users with their mental health care needs. This study explored MHNs' preparedness and experiences in providing culturally safe mental health care for Aboriginal and Torres Strait Islander peoples.

Background

Aboriginal and Torres Strait Islander people continue to experience significant health disadvantages and risk factors compared to non–Indigenous Australians (AIHW, 2018a; Parker, 2010). These health disadvantages are complex and embedded in Australia's history of colonization, racism, and oppression (Paradies et al., 2008). Displacement from traditional lands, loss of language, law, leadership, and traditions continue to have ongoing, adverse impacts on Aboriginal and Torres Strait Islander peoples' health and wellbeing (Mills et al., 2018). This has resulted in fear, mistrust and uncertainty toward health services which persists today for many Aboriginal and Torres Strait Islander peoples (Australian Health Ministers' Advisory Council [AHMAC], 2016; Dudgeon et al., 2014).

These health disparities are particularly prominent regarding mental health and wellbeing (McGough et al., 2018). At any given time, one-third of Aboriginal and Torres Strait Islander peoples report high or very high rates of psychological distress (Australian Bureau of Statistics (ABS), 2014). Moreover, Aboriginal and Torres Strait Islander peoples die by suicide more than twice as often as non-Indigenous Australians (ABS, 2018). The disparity between and non-Indigenous Australians' mental health outcomes is increasing and has been labeled by the Australian Medical Association (AMA) (2017, p. 9) as "a growing mental health crisis that must be addressed".

A factor that is likely to be contributing to this disparity, is that Aboriginal and Torres Strait Islander peoples' perspectives on health including social and emotional wellbeing have been repeatedly disregarded (Shepherd & Phillips, 2016). As the National Aboriginal Health Strategy Working Party (NAHSWP, 1989, p.172) describe, Australian public mental health services have been traditionally "designed and controlled by the dominant society for the dominant society" and have largely "failed to recognise or adapt programs to Aboriginal beliefs or law." Over the years, several National and State policies have attempted to promote service change in response to the call for more culturally appropriate mental health programs (Sayers et al. 2017). National reports such as the *Royal Commission into Aboriginal Deaths in Custody* (Johnston, 1991) and the *Ways Forward* report (Swan & Raphael, 1995) identified significant problems in existing

mental health services. These reports found that mental health professionals had little understanding of Aboriginal and Torres Strait Islander peoples' culture, which often resulted in misdiagnosis and inappropriate treatment. The *Burkendin Report* also highlighted how the denial of human rights combined with a discriminatory mental health system placed an unbearable burden on many Aboriginal and Torres Strait Islander peoples (Calma et al., 2017). Despite the findings of these landmark reports, successive policy reviews have concluded that their implementation has been largely ineffective with services continuing to work in exclusionary ways (McGough et al. 2018; Walker & Sonn, 2010). The continued ineffectiveness of these approaches has highlighted the critical need for culturally competent practitioners and culturally responsive mental health services (Dudgeon et al., 2020).

Cultural competence and cultural safety

The term cultural competence has been adapted and used widely among mental health practitioners across the world in recent decades (Kirmayer, 2012). Cross et al. (1989, p. 13) defined cultural competence as a "set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enables the system, agency or those professionals to work effectively in cross-cultural situations". Cultural competence approaches have been criticized for "essentializing, commodifying and appropriating culture" ultimately leading to stereotyping and further disempowerment (Kirmayer, 2012, p.160). In response to the criticisms, various alternative concepts have been proposed such as cultural safety.

The concept of cultural safety is said to have originated through the work of scholar and Māori nurse Irihapeti Ramsden (Ramsden, 1990). As defined by the New Zealand Nursing Council initially in 1992 and again in 2011 (2011, p. 7), cultural safety is:

> The effective nursing practice of a person or family from another culture…. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact of his or her culture on his or her professional practice.

Importantly, culturally unsafe practice is "any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual." (New Zealand Nursing Council, 1992, p. 7).

In the Australian context, the concept of cultural safety has been adapted to include the experiences, knowledges and aspirations of Aboriginal and Torres Strait Islander peoples. Rather than simply being an extension of concepts such as cultural competency, cultural safety requires the

practitioner to critique power structures and "challenge their own culture, biases, privilege and power" (Curtis et al., 2019, p.14). Furthermore, when working with Aboriginal and Torres Strait Islander peoples, it is only the Aboriginal and Torres Strait Islander person who can determine whether a clinical encounter is safe.

Promoting cultural safety – Education and practice

The importance of cultural safety education has been acknowledged by the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2019). This body requires nursing educational programs to "embed principles of diversity, culture, inclusion and cultural safety for all people" and that Aboriginal and Torres Strait peoples' knowledges are incorporated in nursing courses (ANMAC, 2019. p16). However, to date there is little evidence that mandating Aboriginal and Torres Strait Islander content in the curriculum translates to improvements in the provision of culturally safe care in graduates (Power et al., 2016). On the contrary, research shows university students often display opposition and hostility in relation to Aboriginal and Torres Strait Islander cultural content, particularly when asked to reflect on white privilege, power and equality (Chiodo et al., 2014; Dudgeon & Fielder, 2006).

In addition, there is limited evidence that mandatory workplace cultural training leads to any change in service delivery (Shepherd, 2019). Molloy et al. (2021) found that mental health nurses were largely unaware of amendments to the *Code of Conduct for Nurses* (NMBA, 2018*)* which explicitly outlined expectations for culturally safe and respectful practice. Moreover, research suggests that MHNs complete Aboriginal and Torres Strait Islander cultural training only to return to clinical settings which do not encourage the use of these practices (Bradley et al., 2015; Westerman, 2004). This can lead to the perpetuation of culturally unsafe nursing practices.

Rationale

Given the adverse impacts culturally unsafe practices can have on Aboriginal and Torres Strait Islander peoples, it is critical that MHNs provide health services in a way which respects Aboriginal and Torres Strait Islander peoples (Mills et al., 2018). However, there is relatively limited research which has explored MHNs' preparedness for providing mental health care to Aboriginal and Torres Strait Islander peoples. The limited research that has explored this topic suggests that many MHNs may not have the knowledge, skills or confidence to support Aboriginal and Torres Strait Islander service users with their mental health care needs (McGough et al., 2018). Therefore, the aim of this study was to further explore

non-Indigenous MHNs' preparedness and experiences in providing mental health care for Aboriginal and Torres Strait Islander peoples.

Methodology

This study adopted an interpretive qualitative design. The premise underlying this design is that it is important to undertake research that connects theory with practice (Kahlke, 2014). This is consistent with the aim of this study, which was to gain an in-depth understanding of non-Indigenous MHNs' experiences and knowledge, skills and abilities in providing mental health care for Aboriginal and Torres Strait Islander peoples.

Participants

Participants were eight, purposefully selected, non-Indigenous MHNs who had experience in providing care for Aboriginal and Torres Strait Islander peoples. Participation was voluntary and all participants gave informed consent. Participants ranged in age from 33 to 66 years old and had between 4 and 45 years' experience working as a MHN. (see Table 1 for participant demographics).

Materials and procedure

This study was approved by the University's Human Research Ethics Committee (HREC). Prior to submitting the application, the researchers consulted with the University's Indigenous Academic Unit. The proposed project's aims and procedures were discussed with Director of the Unit in order to gain feedback on the project and to ensure that there was appropriate consultation prior to proceeding with the project.

Table 1. Participant demographics.

Pseudonym	Age Range	Education	Years as MHN
Tracey	50-60	• A Comprehensive Diploma-Based Nursing Program (New Zealand) • Postgraduate Diploma in Mental Health Nursing • Masters of Mental Health Nursing (Completing)	30 years
Belinda	50-60	• Bachelor of Science in Nursing • PhD in Mental Health	38 years
Nicole	50-60	• Bachelor of Nursing (Honours) • PhD (Completing)	7 years
Samantha	30-40	• Bachelor of Arts and Masters of Nursing (Combined) • Masters of Mental Health Nursing	11 years
Karen	30-40	• Bachelor of Nursing (Honours) • Post Graduate Diploma of Mental Health • PhD (Completing)	4 years
Christine	60-70	• Hospital-based training	47 years
Joe	60-70	• Hospital-based training • Certificate in Mental Health Psychiatric Nursing	45 years
Stephen	60-70	• Bachelor of Nursing	13 years

The semi-structured interview guide consisted of 15 questions: four demographic questions, nine open-ended questions. The development of the interview schedule was guided by the current study's research questions and previous research examining cultural safety in mental health nursing (see Molloy, 2018).

Interview transcripts were thematically analyzed (Braun & Clarke, 2006). This involved organizing, describing, and interpreting data by exploring underlying meaning and ideas. This inductive process derived several provisional key themes and subthemes. The authors cross checked the coding of themes and subthemes to ensure they accurately reflected the data. This process led to the final iteration of the themes and subthemes.

In order to uphold rigor and validity throughout the thematic analysis process, methodological principles recommended by Sundler et al. (2019) guided the research process. These principles included: (a) emphasizing openness, (b) questioning pre-understanding, and (c) adopting a reflective attitude. This included the asking of questions such as is it clear how themes were derived from the data? and are the findings meaningful and relevant?

It was also important as non-Indigenous researchers to engage in a process of ongoing reflexivity throughout the duration of the study. This reflexivity process included a review of the *ATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research* (Australian Institute of Aboriginal & Torres Strait Islander Studies, 2020), regular reflective discussions with coauthors, identifying any biases or preconceived views and being transparent with participants about these.

Findings and discussion

A number of key themes and subthemes were identified (see Table 2). The main themes included Treating the Individual, Culturally Unsafe, Mind the Gap and A Way Forward.

Table 2. Main themes and sub themes.

Themes	Sub Themes
Treating the Individual	Color Blindness
	Generic Therapeutic Skills
Culturally Unsafe	'They just get worse'
	Inappropriate Care
	Assumptions and Racism
Mind the Gap	Gaps in Knowledge
	Fragmented Supports
	Finding a Way
A Way Forward	A Desire for Change
	Being an Ally and Advocacy

Treating the individual

Many participants felt that 'treating the individual' and 'not seeing' racial or ethnic differences was a fundamental part of their role as a MHN. Not seeing or acknowledging how Aboriginal and Torres Strait Islander peoples' mental health care needs may be different to non-Indigenous patients led to the application of 'generic therapeutic skills'.

Color blindness

Some participants appeared to adopt a race-neutral or 'color-blind' attitude in their nursing practice. A color-blind attitude is an ideology that suggests racial and ethnic differences are unrelated to the provision of care (Neville et al., 2013). For example, Joe explained "I don't really categorise people in that way, so it's going to be a bit difficult for me." Similarly, Stephen found it hard to recall how many Aboriginal and Torres Strait Islander people he had worked as it "it may not always be obvious what their ethnic background is, their cultural background" and it was "not always the primary topic of conversation."

According to McGough (2016), non-Indigenous people may adopt a color-blind attitude in order to deny or minimize any cultural differences and avoid uncomfortable emotions with regard to these differences. While a color-blind approach may initially seem like a valuable position to reduce discrimination by treating everyone equally, it also encourages the use of a framework that minimizes the impact of racial inequalities, denies historical traumas and diminishes the importance of culture for Aboriginal and Torres Strait Islander peoples (McGough, 2016; Neville et al., 2000).

Generic therapeutic skills

Consistent with a 'color blind' approach, participants repeatedly discussed generic practice skills in mental health nursing they felt were relevant and effective in working with Aboriginal and Torres Strait Islander peoples. Therapeutic skills included; unconditional positive regard, building rapport and active listening.

> Being able to listen I think is the most important skill for any sort of work. I think I was pretty lucky to be trained in Rogerian counselling techniques which are pretty much focused on being able to listen actively and respond non-judgmentally. (Joe)

> The same as working with everybody else. I work through a recovery patient centred approach … You've got to try and understand their experience of what's going on rather than what you've seen. (Christine)

The justifications for using generic therapeutic skills varied between participants and many did not identify any limitations to these approaches. In fact, many participants explained that they had been trying to provide the

best care they could for Aboriginal and Torres Strait Islander people. This finding is consistent with Molloy et al. (2019) who found that while many MHNs had good intentions, they were unsure of the most appropriate care for Aboriginal and Torres Strait Islander peoples.

Culturally unsafe

The theme Culturally Unsafe centered on participants' views of being part of a system which they considered was culturally unsafe and harmful for Aboriginal and Torres Strait Islander peoples. This theme included three subthemes; Inappropriate Care, 'They just get worse' and Assumptions and Racism.

Inappropriate care

Participants outlined public mental healthcare practices that they felt were inappropriate when working with Aboriginal and Torres Strait Islander peoples. Consistent with Molloy et al. (2018), participants discussed the limitations of the biomedical model of public mental health. These limitations included its emphasis on diagnoses and medication:

> Every time they get a new psychiatrist, they get a new diagnosis. Instead of working with the person, they work with a set of diagnostic labels. And Aboriginal people don't even, don't even ascribe to those diagnostic labels … You know, they could hear voices but it doesn't mean they're mad. (Belinda)

> It's called um 'tag, jab and release' that's the model they're actually working under. So, they come into the hospital and given loads of medication, they have a couple of sessions, long sessions, with a psychiatrist, the psychiatrist gives them a diagnosis, they're put on a depot injection and then they're discharged. (Christine)

In addition, participants spoke about other aspects of care that they felt were inappropriate such as the physical environment in psychiatric units. As Samantha shared:

> We had one person who wanted to have a smoking ceremony based on the experiences that they'd had that brought them to hospital. And that was just, it was way more difficult than it needed to be … A lot of our facilities are locked. I've had people say that they just want to go outside and connect to Country and be on ground that isn't cemented. And even that, like sometimes, you know, we aren't able to do that.

As highlighted by Samantha, policy frameworks aimed at closing the health gap have largely failed to consider architectural qualities of the healthcare settings which may impact on cultural safety (Haynes et al., 2019).

'They just get worse'

Many participants explained that Aboriginal and Torres Strait Islander people get worse, not better, when receiving care in psychiatric inpatient units. Christine shared:

> I think that Indigenous people get worse locked in a mental health unit. … They have the most extensive mental health period in hospital, in the psychiatric Intensive Care Unit. Because it doesn't take anything into account of where this person's come from.

Tragically the experience of being in a locked inpatient units had led to the death of a young Indigenous male who was locked in an inpatient unit for over three weeks. As Christine shared:

> He just completely attacked people, [they] gave him more and more medication. I don't know what the reason was or what the Coroner said, but he dropped dead … In the locked inpatient unit. And one of the big fears that he had was that 'you're gonna keep me locked up here and I'm gonna be dead.' And that's exactly what happened …

Christine highlighted how the use of culturally unsafe care can cause severe harm and result in tragic outcomes (Beckett et al., 2013). Nicole also expressed concerns regarding the impact of culturally unsafe practices. She was particularly concerned about the experiences of young Indigenous women in mental health settings:

> Being in a mental health unit you know under the Mental Health Act is a really scary and traumatic thing for, for most people anyway but for what we notice, young Indigenous women is really terrifying.

Nicole stated that young Aboriginal and Torres Strait Islander women were discharged earlier than men in order to connect with their supports "even though they might be still quite unwell" because "the longer they stay with us, the more traumatised they get so we don't want that." In support of Nicole's comments, research suggests practices involving seclusion may be re-traumatising for women who have experienced abuse or trauma (Bradley, 2019; Sambrano & Cox, 2013).

Assumptions and Racism

Participants discussed stereotypical assumptions and racist attitudes toward Aboriginal and Torres Strait Islander peoples that exist within the mental health sector. Stephen, even shared his own ethnocentric assumptions about the most appropriate type of care for Aboriginal and Torres Strait peoples. Stephen stated that it was "undoubtedly the case that whatever culture you come from the medical model has a positive influence on the cohort of people who are described as having schizophrenia". Stephen also felt that it

was his role to "manage" Aboriginal and Torres Strait Islander peoples' opposition to mental health treatment including the use of medications. Stephen's assertions support the use of the biomedical model as the 'gold" standard for care. Ryder et al. (2019, p.25), argues that this understanding is driven by a homogenous, monocultural framework in Australian health-care that is mostly "white, privileged, colonised and ethnocentric."

In addition to ethnocentric assumptions regarding the provision of health care for Aboriginal and Torres Strait Islander peoples, Tracey and Christine shared some examples of racist attitudes among some nursing staff:

> The staff have said stuff like, oh 'they're just a sixteenth Aboriginal', like, what does that mean? … I find that abhorrent myself. They're kind of not, not getting that if you identify as Aboriginal you identify as Aboriginal, story is over. (Tracey)

> There are some that are very racist. Oh, for God's sake. I mean you know they're saying, 'they get all this, they get everything, they get their medication on closing the gap then they won't bloody take it.' Well, you know, it's a bit more complicated than that. (Christine)

Joe also spoke about institutional or systemic racism he witnessed in a hospital setting.

> There was racism there that was pretty clear … These young guys usually, who may have been substance affected but they were caged really. It was pretty cruel to see. No one really taking any opportunity to debrief with them or engage with Indigenous support service.

Research suggests experiences of institutional racism such as what was described by Joe is a major contributor to psychological distress in Aboriginal and Torres Strait Islander peoples (Kelaher et al., 2014). Institutional racism also contributes to the continuing health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians (AIHW, 2018a).

Mind the gap

Participants repeatedly mentioned gaps in their knowledge, skills, and abilities to provide culturally safe and responsive care to Aboriginal and Torres Strait Islander peoples.

Gaps in knowledge

Consistent with the findings of Hellsten and Hineroa (2013), one of the main challenges faced by MHNs is a paucity of knowledge regarding mental health nursing and Aboriginal and Torres Strait Islander peoples. Participants openly reflected on the limits of their knowledge:

> I recognise that I have limited knowledge, you know…. I am very quite limited. And I've run off to my staff members who have that knowledge, and say come on, I need you. (Nicole)

> I think there are specific tools and recommendations that have been written in collaboration with Aboriginal and Torres Strait Islander peoples that are just not kind of used…. like there's a gap in my knowledge there. (Samantha)

In addition, most participants appeared to find it difficult to provide an explanation of what 'cultural safety' meant in relation to care for Aboriginal and Torres Strait Islander peoples. As some participants shared:

> To be honest with you I haven't heard that term before, but I imagine it's… is it that the person feels safe in the environment that they're being discharged to or that their culture is being respected? (Christine)

> I flagged that to my wife, and she started to answer it. And she was saying look you know, the importance of family groups. She said the overt descriptors you know, like having an Aboriginal flag outside the setting, could be welcoming. (Stephen)

Fragmented supports

In addition to stating that they lacked important knowledge when working with Aboriginal and Torres Strait Islander patients, participants also spoke about the fragmented support systems for MHNs. Belinda explained that 'a lot of clinical placements are negative experiences' with nursing students reporting 'bullying, judgmental attitudes, coercive treatment, and disrespect to clients.' Joe reflected on how fragmented supports, combined with a lack of professional development, can impair MHNs' ability to provide culturally responsive and safe care:

> They're traumatised by what they see and there's really no sophisticated approach to debriefing or facilitating their professional development. It's always, 'we don't have time for professional development' in nursing circles. Which to me is an absurd position to adopt. (Joe)

Research suggests that limited support from colleagues and peers exacerbated negative experiences for mental health professionals in the public mental health sector (McGough, 2016). This in turn can inhibit progression or development toward becoming a culturally safe practitioner (McGough, 2016).

A way forward

Desire for change

Most participants expressed their desire for changes to improve the quality of care provided to Aboriginal and Torres Strait Islander peoples. These

changes included increasing Aboriginal and Torres Strait Islander representation in the MHN workforce, increasing the number of Aboriginal Liaison Officers, making physical environments more culturally safe, implementing specialist post graduate training and having a more compassionate workforce. As some of the participants explained:

> We should have an Aboriginal Australian Liaison on the inpatient units … there's some large Indigenous communities down south … at the moment we don't even have an Aboriginal mental health worker on site. (Samantha)

> What I would like is mental health Aboriginal and Torres Strait Islander workers to work in the inpatient unit. And the patient to be 'specialled' rather than locked in the locked ward … specialled, that means one on one. We should be training more … (Christine)

> You know, to be working in mental health you should have or be working towards postgraduate qualifications. You cannot work in midwifery without being a midwife. Why are consumers of mental health services, any less deserving of a specialist workforce? (Belinda)

In support of Christine and Samantha's suggestions, research suggests the presence of Aboriginal Health Workers (AHWs) and Aboriginal Liaison Officers (ALOs) can enhance cultural safety and improve patient care (Einsiedel et al. 2013).

Being an ally and advocacy

Many participants mentioned that there are many MHNs who are passionate about improving care for Aboriginal and Torres Strait Islander patients. As participants highlighted:

> We've been really fighting to have an Aborginal Health Worker on the ward. And I think we've finally won it. And yeah, I'm really excited … (Tracey)

> There's definitely a core group of staff that are absolutely dedicated and passionate about the mental health wellbeing of all our population, and in particular Aboriginal people. (Nicole)

Nicole also spoke about how her colleagues "have a lot of respect for the Aboriginal community because we know it's definitely hard" and that they "tend to put in a little bit more energy, a little bit more of ourselves." Tracey felt advocacy was important in her role as a Nurse Unit Manager (NUM). During meetings "with those pop people" she "will always say, 'well where's the cultural stuff?' I've just, you just have to start saying it."

Conclusion

The current study's findings suggested that MHNs may have limited knowledge with regards to the provision of culturally responsive and safe care

for Aboriginal and Torres Strait Islander peoples. While some elements of culturally safe care were discussed, key factors such as recognizing inherent power imbalances and allowing the Aboriginal and Torres Strait Islander person to determine if care is culturally safe were rarely mentioned. The reasons behind this limited knowledge were multifaceted. However, the absence of Aboriginal and Torres Strait Islander cultural content throughout the participants' education and professional development are likely to have been major contributors. Some participants mentioned that any knowledge they had acquired was sought out in their own time. In addition to these knowledge gaps, participants' ability to implement culturally safe practice appeared restricted due to the dominance of the biomedical model. Participants appeared to rely greatly on generic therapeutic skills when working with Aboriginal and Torres Strait Islander peoples. By relying on their own generic therapeutic skills detached from cultural considerations, MHNs are potentially practicing in ways that are culturally unsafe for Aboriginal and Torres Strait Islander peoples (Geia et al., 2020; Neville et al., 2000).

It is important that future research includes the experiences and perspectives of Aboriginal and Torres Strait Islander people receiving care within public mental health care settings. This would provide a greater, in-depth understanding of how Aboriginal and Torres Strait Islander peoples' experience interactions with non-Indigenous MHNs in public mental health settings. Such research needs to adhere to the principles of ethical and responsible conduct according to the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATIS, 2020) Code of Ethics for Aboriginal and Torres Strait Islander Research.

Relevance for clinical practice

To date, there has been limited research on the experience of non-Indigenous health professionals providing culturally safe mental health care to Aboriginal and Torres Strait Islander peoples (McGough et al., 2018). This study highlights the importance of MHNs engaging in a process of ongoing learning and reflection. Rather than simply completing mandatory, generic 'cross cultural' training, MHNs need to engage in an ongoing journey toward becoming a culturally safe practitioner. This journey to cultural safety should not be seen as an end point, but rather as an ongoing process.

In addition, systemic change is needed to support MHNs to go beyond the biomedical model of care when working with Aboriginal and Torres Strait Islander peoples. For example, the Social and Emotional Wellbeing (SEWB) Model of care can support practitioners to work in a more effective and culturally safe way with Aboriginal and Torres Strait Islander peoples, families and communities. The SEWB Model is holistic and incorporates

mental, social, emotional, physical, cultural and spiritual wellbeing. It has been important in reclaiming and renewing Aboriginal and Torres Strait Islander understandings of health and wellbeing (Wilczynski et al., 2007).

As the largest professional group providing clinical care to Aboriginal and Torres Strait Islander peoples, there is a need to improve cultural safety within mental health nursing and the public mental health services at large (Hunter et al., 2013). Without urgent action and sustainable reforms, Australian mental health services will continue to provide care that is culturally unsafe and harmful for Aboriginal and Torres Strait Islander peoples.

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