Cultural responsiveness: a conceptual model for mental health professionals engaging with Aboriginal and Torres Strait Islander people.

Thesis by publication submitted by

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For the award of Doctor of Philosophy
University of New England
2023

This research has been conducted with the support of the University of New England Aboriginal and Torres Strait Islander Higher Degree by Research scholarship under the Australian Government Research Training Program (RTP).

Abstract

Cultural responsiveness is a term that has become more commonly used by a wide range of organisations and disciplines when referring to the ways in which mental health practitioners work and interact with Aboriginal and Torres Strait Islander people. Within the discipline of psychology cultural responsiveness is seen as a fundamental learning and skill area for all practitioners and has become an essential feature of the psychology curriculum taught in universities. However, the concept has lacked clear definition, understanding and measurement.

Through a series of peer-reviewed journal articles, this thesis comprises four components focussed on cultural responsiveness when working with Aboriginal and Torres Strait Islander clients. Initially, the literature is reviewed using a concept analysis, which then formed a foundation for a conceptual model of cultural responsiveness which the author has called Foucault's Oscillation. Following this a qualitative study involving 12 participants who identified as Indigenous Australians and who were former clients of mental health practitioners were interviewed using a semi-structured format based on the conceptual model. Adopting an Indigenous Standpoint Theory approach, and listening to their stories, it was crucial both culturally and from the perspective of fuller understanding to afford these people a voice in shaping a sense of meaning of cultural responsiveness.

The fourth and final part of this study sets out the process of designing and validating an instrument to assess cultural responsiveness, which the author has called the Cultural Responsiveness Assessment Measure (CRAM). A Qualtrics survey assisted in the gathering of data from a sample of 400 respondents whose contributions led to a nine-factor instrument that can help mental health practitioners to evaluate and to improve their interventions with Indigenous clients.

This study has shown that cultural responsiveness is a multi-faceted concept that is recursive and non-linear and reminds practitioners to constantly reflect on who they are and what values they bring into the therapeutic environment. The findings from the qualitative study were a powerful testimony to the fact that mental health services for Indigenous people need to be much better.

Certification

I certify that the ideas, experimental work, results, analyses, software and conclusions reported in this thesis are entirely my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

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Peter Smith

10 October 2023_____

Date

Acknowledgements

Walking the journey of Higher Degree by Research is never done in isolation, and it is fitting and appropriate to acknowledge the many people who have walked this journey with me, all of whom I now call friends.

My first acknowledgement is to Elders past, present and emerging of the Gamilaroi and Anaiwan Nations where the work of this research took place. I feel blessed to have been able to undertake this project on the land of my ancestors, and every day I sensed their presence around me encouraging me and inspiring me to keep going to give voice to our people.

When I first approached my primary supervisor, Dr. Kylie Rice, in School of Psychology at UNE, I wasn't sure what response I would get. We had already been delivering cultural competence workshops at UNE for at least a couple of years for undergraduates and postgraduates, and I knew that we could work well together. However, I braced myself for her reaction to my proposed research, because I understood that supervision is no small task to take on amidst the busy life of an academic. Her enthusiasm and support from that moment never faltered throughout my candidature, and I am deeply grateful for her wise guidance and her genuine commitment to cultural responsiveness and its importance for all psychologists.

I have known Professor Kim Usher in School of Health at UNE for a number of years, as a person who has had a long involvement working with local Aboriginal communities in the New England northwest region. Her wealth of experience and her skill in mentoring many HDR students over the years made her someone whom I wanted as my secondary supervisor from the outset. I have truly valued her wise counsel and her Monday student support groups were for me an absolute standout.

Statistics is a word that often strikes terror into the hearts of those of us who work within mental health, and I really appreciate the hard work and gentle guidance offered by my secondary supervisor Associate Professor Nicola Schutte, in School of Psychology. She helped to make stats an enjoyable experience and, in those moments, when I felt overwhelmed and I needed to go back and read Statistics for Dummies, her quiet and gentle reassurance kept me on task helping to renew my resolve.

An essential part of research involving First Nations people is to maintain frequent contact with an Aboriginal Advisory Group, to ensure that cultural protocols are maintained, and that research is conducted not only ethically but also respectfully and in a manner that is culturally safe. I want to take this opportunity to thank all of the members of the AAG, especially Gamilaroi Elder Uncle Neville Sampson and local Elder Uncle Tommy Taylor. This thesis features the use of terms from traditional Gamilaroi language, and I am grateful for the advice of local Gamilaroi Traditional Owner Jason Allan who reviewed my work to ensure that these terms are being used accurately.

To my wife Sharyn, a proud New Zealand Māori *wahine* of the Ngati Porou tribe, who gave unwavering support for my PhD from the very beginning when I first suggested the possibility, I offer loving thanks, because without her support I know that this journey could not have happened.

I want to also acknowledge my mother, Dolly Smith, now deceased, whose own education was limited to just a few years in high school, but who passed on to me her passionate belief in the power of knowledge and education. Her own voice as a Gamilaroi *yinarr,* and child of the Stolen Generations, was kept silent by the prejudice and discrimination of her own time, and this was in some measure what drove my determination throughout this project to enable the voices of our people to be heard.

I offer my heartfelt thanks, to those wonderful people who agreed to be interviewed for the qualitative component of this thesis. Their stories, sometimes shared through tears, conveyed messages that there is so much that we need to be doing better as mental health practitioners, when working with Aboriginal and Torres Strait Islander clients.

My thanks also go out to family friend, Dr. Angel Mok from UNE School of Education who first asked me why I wanted to do this research, and who then listened patiently to my story. She taught me the importance of understanding that sometimes the best learning takes place when not seated at the work desk, and her wonderful advice to keep a reflective journal of this time helped to provide me with deeper knowledge and understanding that could only have come through my own self-reflection.

In conclusion, I also acknowledge the support of the University of New England which provided an Aboriginal and Torres Strait Islander Higher Degree by Research scholarship and enabled this project to proceed.

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Prologue:Origins (Yilaambiyal)

"I am conscious of the spirits of ancestors around me, supporting and encouraging me, that what I am doing is important and matters to our people. I am hopeful that in some way, what I do helps to close the gap in mental health."

(Peter Smith, Reflective Journal, 22/7/2021)

Impetus for the Research

At the outset (yilaambiyal) it is important to reflect on the journey both personal and professional that has brought me to see the importance of this topic and my place within it. The topic for this research has come about as a long process that has included my ten years of involvement presenting cultural competence workshops to mental health professionals for the Australian Indigenous Psychologists Association (AIPA) at a variety of locations across eastern Australia. This research is also about my personal journey, as an Aboriginal Australian of the Gamilaroi Nation, seeking to find an identity that for generations in my family was denied or concealed. It has also been about finding "home" among my people and on the Country of my ancestors.

My experience delivering workshops meant for me that any attempt at initiating this research prior to the present time would, in my opinion, have been premature and lacking in foundation. The cultural competence workshops grounded me in not only the content and its meaning but also the importance of ensuring that Aboriginal and Torres Strait Islander people receive the quality of mental health care that they need and deserve. Mainstream services have often not been culturally safe (Kendall & Barnett, 2015), and as an Aboriginal psychologist I understood that closing the gap is also about closing the mental health gap between Indigenous and non-Indigenous Australians.

This also involved my own personal journey. As the son of an Aboriginal mother of the Stolen Generations, growing up in the city away from Country with minimal connection to both Country and people as well as culture, it would mean that much learning and experience would need to happen before this project could commence. Childhood and young

adulthood was a time when there was no acknowledgement of our Aboriginality that might have resolved some of my identity confusion. The post-colonial era had ensured that previous generations had been taught to despise and deny their Aboriginality, especially if light skin colour could aid the deception. It has been arguably the post-Modernist movements of the 1960s, 1970s and 1980s such as the Women's Movement, the LGBTQI+ Movement, the Civil Rights Movement and the emergence of diverse opinions and theories brought about by Critical theory, Liberation Theology and Liberation Psychology and the New Age Movement, that have facilitated a safer environment for people to declare and own their Indigenous heritage.

My journey takes me back to my twenties and a time when it was not uncommon for young Australians to set out on their own overseas odysseys. I recall a time in Israel, when as a tourist and briefly as a "kibbutznik" working on a farming collective, I was with a cluster of other tourists looking from a vantage point onto the old city of Jerusalem and marvelling at its antiquity, beauty, and history. There was a young American in this group, and we engaged in brief conversation, curious about each other and our purpose in being there. He said to me that as a Jewish person, it was good to be back in Jerusalem. I responded asking about his last visit to the holy city and he replied that he had never been here before. His reply initially took me by surprise, but I was reminded from biblical history about the fall of Jerusalem and the exile into Babylon and how these events had brought about the Jewish diaspora. This young man was returning to Country, to a place where he had never previously visited or lived, but to a place that reflected the aspirations and yearning of his people. I could not have known it at the time, but this chance meeting would many years later resonate strongly with me when I returned to the Country of my ancestors, to a place where I too had never previously lived.

Apology by the Australian Psychological Society

In 2016 Professor Tim Carey, on behalf of the Australian Psychological Society (APS), at the society's inaugural congress in Melbourne, issued a formal apology to Aboriginal and Torres Strait Islander people for the profession's past mistreatment and failures which contributed to social disadvantage and even systemic abuse. I was present on this momentous occasion and together with a small number of my colleagues from the Australian Indigenous Psychologists Association, I was invited onto the stage in the main auditorium to receive the apology. Standing in full view of approximately 1,500 assembled APS members I became quite conscious of those who were not there to receive this apology, and those who had more right

to be there than me. But as with so many moments in history the protagonists are often the accidental participants in what unfolds, and I resolved to see this moment as something for our people that needed to be said but also needed to be received, no matter how unworthy I considered myself to be.

The apology was described as a "profoundly emotional moment and resulted in a standing ovation by the delegates after the apology was read" (Carey, et al., 2017, p.265). According to reports the apology received coverage in mainstream media in Australia and the media releases were picked up in the U.S., U.K., Europe, Africa, and China, where responses were positive and supportive. My own response was that this historical moment needed to move beyond the apology and propel our profession forward into improving the ways that we work with Aboriginal and Torres Strait Islander people, because past ways had clearly failed.

How this research came about (Gaga-li)

There is a saying among our people that "Country calls us" (gaga-li). I probably thought that by returning to the northwest for a tree-change in 2012, Country had already called me, but there was more to come. In 2019 I was asked to assist in my capacity as a psychologist with clinics that were being run for the small community which continues to reside at the old Mission about 30 kilometres out of town. "The Mish", set up in 1895 on part of what had been Dr. Nowland's pastoral landholding, "Walhallow", is very typical of many Aboriginal reserves set up during the time of the Protection Era; set up at some distance from the town, separated from town by a river (the Mooki) and located in an area of rich, sprawling farmland on the Liverpool Plains (Quirindi Historical Society, 2021). Generations of our people were sequestered here by the government ostensibly to protect them from those who might seek to harm them or even to eliminate them, because massacres were not unknown in this part of the district. However, under paternalistic government administration such places became a mechanism of oppression, control, and social division.

Our people believe that the spirits (dhuwi) of our forebears remain in this place, and on Country we are given vitality, renewal, and inspiration. It was here while assisting at the clinic that the inspiration to pursue further study came to me. I had spent some time introducing myself to the local Elders and a few weeks later, I dutifully attended this clinic expecting to offer some assistance to local people, but not one person turned up. I had much time for reflection about what this might mean, and thoughts of culturally competent mental

health practice kept resonating in my head. There were memories of past workshops and my exhortations to participants and now I found myself wondering what is missing from my own practice as I sat in an empty room in the clinic waiting for people who would never arrive. From this moment I resolved to do something about determining what it is that continues to deter our people from taking part in therapy. These thoughts then developed into what I have undertaken in this program of research, and I became convinced that I needed to hear the voices of our people in a way that can help us all to be better mental health practitioners. I can never know why those scheduled clients failed to show up. Perhaps there was fear and suspicion in a place where there had been a long history of the whitefella's scrutiny and scorn, but this research, I believe, gives our people the chance to tell us what we need to know and what we need to do better.

My Position as Researcher

Aboriginal and Torres Strait Islander people have also experienced their own diaspora or scattering, through the time of the Stolen Generations with disconnection from Country and culture as central features. So, to be able to embark on this research I could see that I needed to be living on Country, so that I would be able to position myself in a way that could enable me to better understand the people with whom and for whom I was conducting this research. Positioning myself also meant that my community needed to see and identify me as one of their own and not just another researcher peering into their lives for the benefit of just the researcher and not the community. This was going to take a bit of time because most of my life had been away from Country (walaaybaa) and my ancestral connections in the Gamilaroi nation were not with the local clan who call themselves Gamilaraay, but with people further to the northwest who are known as Yuwaalaraay. So, I had to first overcome feelings of inadequacy and even fear that I might not be accepted by my own people and could be seen as an interloper, an impostor, or a fraud.

My initial attempts to contact the local community were hesitant and tentative, and it took almost three years living in the local community before I summoned the courage to approach the local Aboriginal Medical Service (AMS) to secure a base from which to work. I was surprised at how readily I was accepted. No-one questioned or challenged my claim to Aboriginality and there was no demand for me to produce my Confirmation of Aboriginal Status, which I had ready in case of any push back, and so with this simple gesture of acceptance I felt a sense that I had come home (walaaybaa). Also, since undertaking this

research project staff at the AMS, including its CEO, are now part of my Aboriginal Advisory Group, to whom I regularly report. Additionally, I could now understand in a deeper more personal way what that young man in Jerusalem had meant, all those years ago, when he said that it was good to be back.

Choosing the area of research

As already noted, I had the benefit of ten years' experience presenting AIPA's cultural competence workshops, and I had also been working within School of Health at University of New England with Professor Kim Usher in designing and presenting a more localised version of cultural competence for both UNE students and Indigenous mental health workers in the community. Accordingly, in undertaking this research, I wanted to discover more about this topic for two specific reasons. The first reason is the material that I had been presenting prior to UNE had not undergone a major revision since the first workshops in 2010 and it was in my opinion, beginning to show its age in its references, audio-visual material, and some of its statistical information.

The second reason that I have been drawn to this topic is the fact that people participating in workshops were frequently asking about a manualised format to work with Aboriginal and Torres Strait Islander people. Perhaps it is something within the culture of psychology where we are trained to use instruments to assess and measure and evaluate, but workshop participants often wanted to know how to behave in ways that were culturally competent, and they wanted some structure or system to guide them in their interventions. There was clearly less enthusiasm for other elements of the workshop such as learning about the importance of social and emotional wellbeing, and the social, political, and historical determinants of wellbeing. There was also not a positive response to reminders that setting out cultural competence in a manualised, one size fits all format was not going to be of much value. Aboriginal and Torres Strait Islander people comprise approximately 250 separate nations or language groups as well as clans within these nations often with their own regional dialects and customs. There is no single Indigenous identity and the diversity among nations is as vast as the Australian continent itself, so a 'rule book' approach is not going to work.

A third reason that brought me to this topic is that prior to moving back to Country I had spent more than 20 years working in state government departments responsible for child protection, out of home care and juvenile justice. Throughout this time, working as a

forensically trained psychologist, I came to see how disproportionately Aboriginal and Torres Strait Islander people were being represented among those who were being brought before the courts for care and criminal matters. It was clear that something was seriously wrong because in Australia where Indigenous people comprise approximately 3% of the total population (ABS, 2019), Indigenous youth were making up 51% of juvenile offenders in custody and in adult jurisdictions Indigenous people comprised 35% of the adult custodial population (Hovane, et al., 2014). Such numbers were a stark reminder to me that the system has been failing Aboriginal and Torres Strait Islander people, and something urgently needed to change, at systemic, and organisational levels, which appeared to be culturally unsafe. (Kendall & Barnett, 2015).

These experiences as well as participant responses from the workshops have given me much to reflect on in recent years and two things have stood out for me as a result. The concept of cultural competence may be misleading for people suggesting that the attainment of certain proficiencies makes one competent. Of equal concern is the possibility that a practitioner may believe that competence means competence in all settings with Aboriginal and Torres Strait Islander people, conferring a kind of cultural passport to work with all groups.

The other focus of my reflections was that current models of cultural competence and the workshops paid little attention to the position of the practitioner in working with Aboriginal and Torres Strait Islander people. Kilcullen (2018) has said that although learning content is important and even straightforward, learning who we are personally in relation to that content is a more important though complex process. This self-knowledge that Kilcullen refers to is a key element that has been mostly missing from past models and I came to realise that this needs to be given greater prominence in any future model of this concept, allowing a more constructivist rather than a didactic learning paradigm to emerge.

Change of Direction (Gaya-y)

When Columbus crossed the Atlantic in 1492 in search of the New World, he wasn't sure where he was going; wasn't sure if he would get there at all because some said he would sail off the edge of the earth; and when he got there, he thought he was somewhere else, and called the local Indigenous people Indians in the belief that he had reached the East Indies. In my research journey I have often thought about Columbus and the many terrifying unknowns,

the self-doubt, and challenges that he faced. If we can put aside for a moment the fact that he was an agent of Spanish expansionism and colonialism that exploited Indigenous people, and just look at the interior journey of the individual, I found parallels in my own journey. What I have discovered is that research can often take us to places that we least expect, and which provide experiences beyond anything we might have ever anticipated.

When I first set out to research cultural competence, I had no idea that in the ocean vastness of this topic, I could end up steering a new course. This happened for me in 2020 following my participation in a webinar on decolonising psychology. For me, it was a superb presentation, and I emailed the presenter to thank her and to tell her how much I got from what she shared. She very kindly replied and thanked me, but it was what she described next that changed my whole research direction. She said that cultural responsiveness is what we need to aim for because it is more dynamic than cultural competence, which she considered was too static. That was a lightbulb moment, but her next comment convinced me that my research needed something more and needed a major paradigm shift. She said via email that she had just received in the chat function on Zoom, a comment that was critical of her presentation. However, instead of looking to defend herself and justify her position, she replied that she now needed to have some reflexivity concerning the critical comment. In other words, her first response was to seek to understand the meaning behind the comment and the perspective of the person who made the comment. From my exchange of these emails with the presenter I came to see just how important reflexivity is when viewed within the cultural responsiveness dynamic and I realised that it has been the missing ingredient for which I had been searching.

This chance encounter also introduced me to the concept of "decolonisation", a term that will be found in several places throughout this thesis. It is defined as a process that dismantles the social hierarchies of power and inequality that were established by colonial authorities as a way of maintaining places of superiority (Fanon, 1968), and these have been continued throughout the post-colonial period up until the present day. Decolonising adopts an Indigenous Standpoint (Nakata, 2007), to be discussed in more detail in Chapter 3, that privileges Indigenous wisdom, traditions and knowledges, and it is the aim of this thesis to contribute in ways that decolonise our thinking. However, the process of decolonisation is not only about changing structures and organisations and ways of doing research, but it also operates at an individual level. I too, have had to decolonise my own thinking and my mental

health practice, from some of the colonial conditionings of my own education, both formal and informal (Dudgeon & Walker, 2015) that have come about from growing up away from Country and culture.

Summary

The direction and the title of my research evolved to include an important element that had been neglected in past models: reflexivity. Reflexivity became the centre of my new conceptual model and research which would set it apart from past models and elucidate the cultural responsiveness dynamic. Reflexivity is about understanding at a deeper level; higher order thinking that genuinely seeks meaning about values, choices, and behaviours. According to Etherington (2004) reflexivity means being aware of how the personal, social, and cultural contexts in which we live, and work can influence our interpretation of the world and so this knowledge needs to inform our actions, communications, and understandings. I could see that it is the essential element needed by practitioners to work with our people, that is experiential, perhaps challenging, and goes beyond didactic models based on simply learning information. At this point I also began to see that an assessment instrument to evaluate reflexivity would be a significant step forward. To understand this model, it also involves my own reflexivity about where I have come from and who I am in relation to this research.

> It is an ongoing process for me as a psychologist to question not only my competence, but also what I do and how I go about my interventions. It means that as a researcher, I must question who benefits or who might be disadvantaged by my research. It means that as a teacher, I must be mindful of what I communicate to students and question ways that I may be able to help give voice to Aboriginal and Torres Strait Islander clients (Smith, 2021, p.30).

This new model is setting out into uncharted waters, but I believe that it explores new territory that strengthens the quality and value of our work as mental health professionals. As a process of decolonisation, it liberates not only the colonised but also the colonisers.

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Chapter 1: Introduction (Yaama)

"My intention is not to lay blame or promote feelings of guilt – these are negative emotions that achieve little – but to invite you to share the challenge of finding better ways that have better outcomes for all of us".

Rob Riley, Aboriginal leader and activist (1995)

"Yaama" is a traditional Gamilaroi greeting that can mean simply g'day or it could be asking as to one's wellbeing. It is used here as a formal introduction which invites the reader to discover the details concerning the steps that were taken throughout the project, how each study contributed to the way in which meaning evolved, how overall relevance and place, sit within wider scholarship.

In the previous section the reader was informed about the author's motivation and choice of the topic for this research. There was brief mention of new directions which extend our understanding with a new conceptual model which stands apart from previous models. In this section the meaning of the research construct, cultural responsiveness, its background and history and the way the project moved forward are described. The author has taken as a starting point to this thesis the apology to Aboriginal and Torres Strait Islander people by the Australian Psychological Society (APS) at its congress in Melbourne in 2016 (Dudgeon, et al., 2020). The apology, at which the author was present, was for past failures and to seek "to achieve significant change, (whereby) the discipline and profession must modify the psychology curriculum by including Indigenous knowledges and relevant history, ensuring the psychology workforce develops and maintains competencies and the ability to work in a culturally responsive and safe manner." (p.560).

1.1 Aim and research questions

The aim of the work that comprises this thesis has been threefold: to clearly define what is meant by the concept Cultural Responsiveness, because there has currently been no clear definition. The second part of the aim was to hear from Indigenous clients of mental health practitioners as to what they considered to be culturally responsive practice, and then to see where client responses triangulated with literature definitions. The third and final part of the aim of this work was to design and validate an assessment instrument to guide students and practitioners towards more culturally responsive mental health practice.

The research questions were:

- What is meant by the term Cultural Responsiveness and how can it be defined?
- What are Indigenous clients telling us about Cultural Responsiveness that is going to better inform our understanding of this concept?
- What do mental health practitioners need to be doing to be culturally responsive and how can they assess their work in ways that are self-reflexive?

1.2 Structure of the thesis

The thesis consists of a series of five articles submitted for publication in peer reviewed journals, and these articles represent the chapters which are listed below and set out in Table 1.1. A diagrammatic representation of the thesis is depicted in Figure 1.1, and this shows the interconnected aspects of the various components of the project. The process begins at the bottom of the figure where the literature review branches out to the conceptual model and the two qualitative studies referred to as Indigenous Voices and Spirituality. These then in turn informed the structure of the Cultural Responsiveness Assessment Measure (CRAM) which arose out of the conceptual model and the qualitative study, linked by a larger bidirectional arrow. The CRAM is depicted as the summit or end point of the project representing where research moves into practice, and where the work of cultural responsiveness (action phase) produces what this thesis in chapter seven calls cultural capital (outcomes phase). Spirituality was an additional chapter and an additional qualitative study that relied upon a portion of the data that was collected in the larger qualitative study described in chapter four. It is depicted as an offshoot of the figure because the data did not contribute anything additional towards the CRAM.

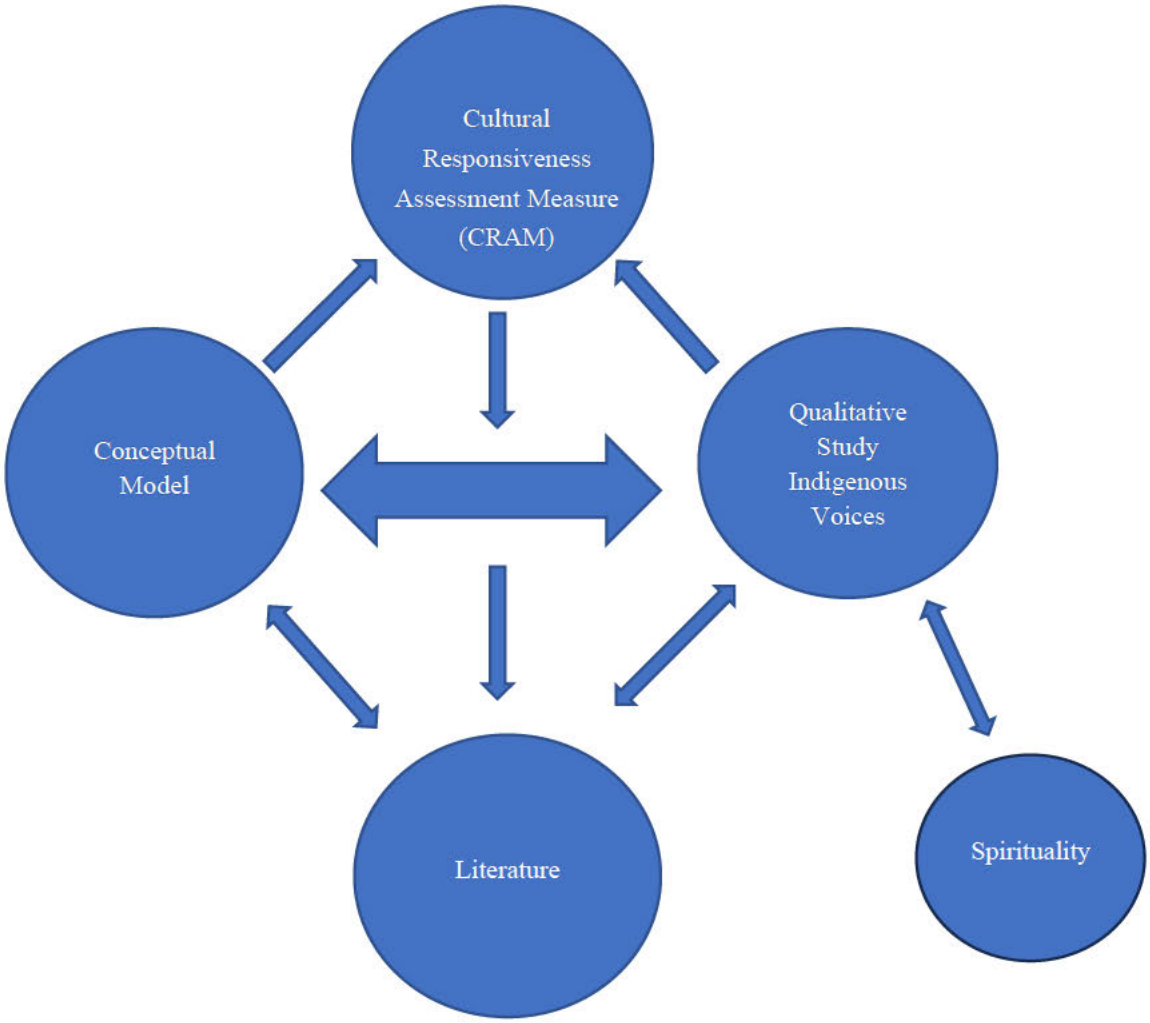


Figure 1.1 Thesis Diagram

Prologue: origins

The Prologue introduces the topic to the reader and introduces the author of this thesis. It describes how this project first took shape, its conceptual origins and why it became a work of importance to the author. It offers to the reader an understanding of where the author derived ongoing internal motivation for this challenging journey.

Chapter 1: Introduction

This chapter outlines the subject of this project, its importance, its purpose, structure, and context. It describes for the reader what this project adds to our understanding of cultural responsiveness, and sets the scene for the following chapter, which is the literature review, which develops the conceptual model of cultural responsiveness.

Chapter 2: Literature review

This describes a systematic review of the literature which comprises a concept analysis to determine what is already known and understood about cultural responsiveness and to assist in clearer understanding and definition of its meaning. This review was published in *Australian Psychologist* in 2021.

Chapter 3: A conceptual model

Out of the findings of the concept analysis a new conceptual model provides an important tool for practitioners to navigate their way through the cultural responsiveness dynamic. This new model, called Foucault's Oscillation by the author was published in *Australian Psychologist* in 2022.

Chapter 4: Qualitative study

This chapter involves the collection of qualitative data through interviews with Aboriginal and Torres Strait Islander clients of mental health professionals and the analysis of the collected data. It is also an introduction to Indigenous Standpoint Theory and the importance of prioritising Indigenous Knowledge Systems and allowing the voices of participants to be heard. The work of this chapter was submitted for publication in *Ethnicity and Health* in 2023

Chapter 5: Spirituality for Indigenous Australians

This chapter focuses on Indigenous spirituality as it is important to have some understanding of the place of spirituality in the lives of Indigenous Australians in order for practitioners to be culturally responsive. Spirituality within this context, stands as quite distinct from what many would identify as mainstream religion and this chapter sets out to understand this important component of social and emotional wellbeing for Indigenous Australians. This chapter was published in *AlterNative* in 2023.

Chapter 6: Assessment instrument

Based on the data collected in Studies 2 and 3, this chapter describes the process of constructing an assessment instrument, the Cultural Responsiveness Assessment Measure (CRAM), that assists in measuring and assessing cultural responsiveness. The instrument's validity and reliability are discussed as well as its applicability in use with mental health

professionals working with Aboriginal and Torres Strait Islander clients. This chapter was published in the *International Journal of Social Psychiatry* in 2023.

Chapter 7: Discussion and Conclusion

This chapter describes how the four studies of this thesis combine to answer the research questions of this project and what conclusions and recommendations as well as limitations have emerged in this process.

Epilogue: Reflexivity

This reflective piece on the part of the author is an opportunity to share the experience of the research journey and what it has meant. Because it is a personal account, it is written in the first person and serves as a bookend to the Prologue: Origins.

Table 1.1 Structure of the Thesis

Prologue	Origins	How this research came about and why it is important to the author.
Chapter 1.	Introduction	Aim and Research Questions; Significance of the study and what it adds.
Chapter 2.	Literature Review	A concept analysis to determine literature definition.
Chapter 3.	Conceptual Model	A new model of cultural responsiveness: Foucault's Oscillation
Chapter 4.	Qualitative Study	The meaning of cultural responsiveness from listening to Indigenous voices.

Chapter 5.	Spirituality for Indigenous Australians	Its meaning and importance.
Chapter 6.	Assessment Instrument	Development and validation of the Cultural Responsiveness Assessment Measure (CRAM).
Chapter 7.	Discussion and Conclusion	A synthesis of the overall project with future directions
Epilogue	Reflexivity	The author's final personal reflections.

1.3 Background

There has been considerable evidence for some time that the burden of mental health has been falling disproportionately on Aboriginal and Torres Strait Islander people across Australia. The Australian Bureau of Statistics (2019) reported that suicide now is the fifth leading cause of death among Indigenous Australians and has occurred at a rate that in most states is twice that of the non-Indigenous population. Between 2008 and 2018 there has been a 22% increase in Indigenous suicide which does not appear to be accounted for by increase of population, but rather underlying intergenerational trauma stemming from colonisation and the disadvantaged conditions and challenges being faced by many communities (Dudgeon, Holland and Walker, 2019).

Locally, Hunter New England and Central Coast Primary Health Network (HNECCPHN) in its report on Mental Health and Suicide Prevention (2018) found that in New South Wales the prevalence of psychological distress was nearly three times higher for Aboriginal people than for the non-Indigenous population. Contributing factors to these high needs were the impact of intergenerational trauma for Aboriginal and Torres Strait Islander people which in turn had affected family function, leading to increased family violence, as well as drug and alcohol use (HNECCPHN, 2018). The report also noted that Indigenous people were accessing mental health services at a higher rate than non-Indigenous people and called for "trauma informed care by culturally appropriate services (p.90). The HNECCPHN

report also noted that for Indigenous persons the hospitalisation rate for mental health conditions was 23 per 1,000 while the rate for non-Indigenous persons was 11 per 1,000, possibly indicating that Aboriginal and Torres Strait Islander people are not accessing early intervention mental health services and subsequently present to services only when they are in absolute need (Fredericks, 2010). Another factor in these figures is the lack of availability of services in rural and regional areas, leading to travel which may be at considerable distance and cost, and which also removes people from Country and the support of family and community.

Mental health systems have failed Aboriginal and Torres Strait Islander people, and there is widespread recognition and evidence that practitioners and service providers need to be mindful of the impact of colonialism, diverse cultural and environmental experiences, and contemporary social and economic circumstances of Australia's First Nations people (Walker et al. 2014; Kendall & Barnett, 2015). Mental health and wellbeing for Indigenous Australians may be enhanced by better therapist understanding of the importance of acceptance, respect, forgiveness and integrity, honesty, courage, empathy, mindfulness, and spirituality (Kilcullen et al. 2018). Additionally, the importance of Country (walaaybaa) as both a focus of connection and a source of mental and physical health is emphasised by Trzepacz, Guerin and Thomas (2014). However, Kendall and Barnett (2015) found that mainstream health services are frequently avoided by Aboriginal and Torres Strait Islander people because they often find that many services are deemed to be culturally unsafe, and this avoidance is influenced by negative historical experiences, poor cultural understanding, and inappropriate communication. Fredericks (2010) has noted that the health services themselves often determine how Indigenous clients connect, and whether they feel comfortable, secure, culturally safe, and happy to access the service or whether this access is related to effort, angst, and energy. It becomes the challenge for services and individual service providers, therefore, to seek ways that can enable these services to become more culturally inclusive.

1.4 Significance of the study for Practitioners, Students and Universities

More broadly, cultural responsiveness model can inform the quality of Indigenous-content courses delivered by universities for graduates working with Indigenous clients. For the discipline of psychology, for example, course content should follow the recommendations of the Australian Indigenous Psychology Education Project (AIPEP) that seeks to embed and

integrate Indigenous studies in psychology for all students, and for staff to teach relevant material that will prepare students to work within a culturally responsive framework.

The Australian Psychology Accreditation Council (APAC) is responsible for developing standards for the education and training of psychologists within Australia. In its Accreditation Standards for Psychology Programs, APAC (2019), recognises that cultural responsiveness is a core competency for all four levels of qualification, from undergraduate studies through to postgraduate courses. Additionally, all Specialised Areas of Practice (APAC, 2019) specify that culturally responsive assessment and culturally responsive interventions must inform professional practice. However, within the Glossary of Accreditation Standards of this document (APAC, 2019), the term cultural responsiveness is not defined, so the findings of this study are timely. Additionally, the Psychology Board of Australia (PsyBA), the national registration authority, defines cultural responsiveness as "strengths-based, action oriented and culturally capable approaches that facilitate increased access to affordable, available, appropriate and acceptable healthcare" (PsyBA, 2020, p.15). Curriculum reform is also a process of decolonisation reducing the dominance of western epistemologies and methodologies, or as De La Rey and Thompson (2020) have described, this is a process of giving up constructions of privileged status, disassembling the mantle of oppression and constructing new paradigms. Ultimately it could be argued that decolonisation at this level is also a process of nation-building that is transformative and liberating.

It is envisaged that all universities will consequently need to include within their respective Reconciliation Action Plans (RAPs) cultural responsiveness training as a core competency for all students and staff (Reconciliation Australia, 2021). The new conceptual model described in this thesis makes clearer what is required of mental health practitioners for best outcomes for Aboriginal and Torres Strait Islander Australians. Accordingly, it becomes crucial, within this context that there is clarity around the definition of cultural responsiveness, and in part this has been the task of this research.

Many Aboriginal and Torres Strait Islander people have identified what they need and want to heal themselves and their communities. These include preventative and holistic healing processes that promote strong, resilient communities focusing on restoring social and emotional wellbeing (SEWB) (Gee et al., 2014). Frankland et al. (2011) describe cultural safety as consisting of those services that are culturally sanctioned so that everyone has the right to feel good about themselves and about their identities. Therefore, a focal element of

this research was to give, in the first instance, a voice to Indigenous clients to describe what they consider to be culturally safe and culturally responsive practice, and from that position to move toward a process that will guide practitioners in the right direction. Accordingly, it was the intention throughout this project from the very start that Indigenous voices would guide the direction and be a primary source of input for what is learned. Additionally, a primary consideration was that this research would have direct benefits to Indigenous individuals and Indigenous communities, respecting Indigenous knowledge, culture, and traditions.

1.5 What does the study add?

As noted above, cultural responsiveness needs more elucidation, both at a theoretical level and within the context of clinical practice. Dudgeon et al., (2020a) found uncertainty among both practitioners and those teaching in higher education about how to engage, build and maintain positive working relationships with Indigenous clients, as well as how to provide culturally responsive psychology services. This uncertainty may be related to lack of relevant knowledge of Indigenous history, key concepts, strengths, and concerns of Indigenous peoples (AIPEP, 2019). Accordingly, this project aimed to 1) determine a clear concept definition of cultural responsiveness, 2) present a new conceptual model of cultural responsiveness, 3) identify components of cultural responsiveness, and 4) develop a self-assessment tool that will assist a reflexive approach to professional development of cultural responsiveness.

There is no clear definition of the concept of cultural responsiveness and most written sources, such as journal articles as well as grey literature which includes reports, policy papers and discussion papers, use the term in a manner that presumes the meaning to be self-evident (Smith et al., 2021). The literature search in Chapter Two was the initial means of determining a clear definition of cultural responsiveness for this program of research, through a concept analysis, and findings from this literature search provided the foundation for a new conceptual model of cultural responsiveness described in Chapter Three. This model is iterative and recursive and differs markedly from previous linear models in the literature depicting cultural competence. This model serves to identify the personal and professional skills needed to work with Indigenous clients and facilitates ongoing self-reflection of culturally responsive practice.

There has been a paucity of research where researchers have listened to the voices of Aboriginal and Torres Strait Islander people sharing from their perspective what is in fact culturally responsive mental health practice. Most previous research has been focused on therapist self-evaluation and such a practitioner-based perspective risks perpetuating an ethnocentric approach to research that fails to acknowledge Indigenous epistemologies and lived experience (Smith et al., 2021a). Accordingly, the qualitative study outlined in Chapter Three seeks to provide further data which will then triangulate with the data from the literature search giving strength to the emergent definition.

A new self-reflective instrument for assessment of cultural responsiveness is presented in Chapter Six which builds on and applies the previous chapters. It is anticipated that this instrument will assist practitioners and students to assess their strengths and struggles towards culturally responsive practice.

1.6 Methodology

In order that priority is given to Indigenous epistemologies and worldviews, this research has adopted an Aboriginal Participatory Action Research (APAR) methodology, which according to Dudgeon, et al., (2020b) recognises the sovereign knowledge of Indigenous people. It is a transformative and critically self-reflective research method consisting of the following core elements:

1. The involvement of Aboriginal co-researchers in supporting communities to collectively identify risk and protective factors.
2. The enactment of a research process that respects Indigenous people as experts-by-experience of their own mental health, their families, and communities.
3. Indigenous leadership and governance and the establishment of local Indigenous community reference groups.
4. Localised knowledge generation.
5. Community level feedback and dissemination.
6. The enactment of the National Health and Medical Research Council (NHMRC) Indigenous core values.

7. The implementation of the Nine Guiding Principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.

APAR is also informed by Indigenous Standpoint Theory (IST) which prioritises Indigenous epistemologies and Indigenous voices (Dudgeon et al., 2020) and decolonises research, rebalancing power and providing healing (Drawson, et al., 2017). Western knowledge systems have predominated in the past with grand narratives of the colonial culture (Dudgeon et al., 2020) which have for example, classified Indigenous people within binary systems that have disenfranchised them and erased their cultural heritage. IST dismantles the structures of power and social hierarchy that have marginalised Indigenous knowledge systems and gives voice to these systems in ways that shift the narrative towards a balance that is healing and restores social and emotional wellbeing. To this end, it was important throughout the entire work of this thesis, that consultation with a local Aboriginal Advisory Group (AAG) and local Aboriginal Elders was essential. The author, who is a proud Gamilaroi man, had regular contact with Aboriginal Medical Services in rural New South Wales towns, and consulted with a local Gamilaroi Elder when the COVID pandemic put limits on meetings of the AAG. These advisory meetings were important to ensure that cultural protocols were always maintained and that Gamilaroi language terms, that are featured throughout this thesis, have been used with accuracy and appropriateness. Furthermore, the research project within Chapter Four, where Aboriginal and Torres Strait Islander participants were interviewed, approved by university Human Research Ethics Committee and the Aboriginal Health and Medical Research Council (AH&MRC), strengthening the APAR methodology.

Additionally, the qualitative study in Chapter Four seeks to give voice to Indigenous people in a manner that sets out to understand their individual experiences, with mental health services. This search for meaning has applied inductive and deductive analysis methodology that incorporates the structure or hypothesis of predetermined a priori themes from the literature (deductive) and any new themes which emerged from the interview data, a posteriori (inductive) (Azungah, 2018).

1.7 From Cultural Competence to Cultural Responsiveness: An Overview

This chapter draws upon more than ten years of experience for the author of co-producing and co-presenting cultural competence workshops at a variety of locations around Australia on behalf of the Australian Indigenous Psychologists Association (AIPA). The workshops were a collective effort on the part of members, and feedback from more than 1,000 participants, most of whom were mental health professionals, was overwhelmingly positive (Hart, 2014). Participants frequently commented on the value of listening to invited Elders and Traditional Owners and hearing the stories and anecdotes from the Indigenous psychologist presenters. However, a frequent response was that attendees were looking for something more: a step by step, directive, even manualised guide to working with Aboriginal and Torres Strait Islander clients. These comments have prompted much reflection over the years, and it has become clear that something more is needed; a fresh approach that better equips mental health professionals to maintain and embed the skills that are so crucial in this work. The movement from cultural competence to cultural responsiveness is one way of advancing this pedagogy and this chapter, which has been submitted as part of an edited book, introduces a new model for this new approach.

There has been a growing awareness in Australia of cultural diversity and the complex human interplay of numerous cultures lived by people who have come to this country for reasons as diverse as the people themselves. Multiculturalism has also shed a light on the oldest continuously surviving culture on the face of the Earth, that of Australia's own Aboriginal and Torres Strait Islander people. This deepening cultural awareness has been reflected in a growing sense of the importance of cultural competence for psychologists and other mental health professionals when working in Indigenous contexts (Wells, 2000). The Federal Government's National Practice Standards for the Mental Health Workforce (2013) are clear in their direction that "mental health practitioners actively and respectfully reduce barriers to access, provide culturally secure systems of care, and improve social and emotional wellbeing" (National Practice Standards, 2013, p.14). These practice standards have relevance for practitioners, students and graduates, and training institutions to ensure that appropriate content is included in their programs. Standard 4 (National Practice Standards, 2013) specifically refers to working with Aboriginal and Torres Strait Islander people and according to Walker (2014), practitioners must actively reduce barriers to service

access, providing culturally secure systems of care, which improve social and emotional wellbeing.

Cross et al. (1989) described cultural competence as a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. This implicates individual practitioners, systems, and agencies. However, Walker et al. (2014) have noted that systems have failed Aboriginal and Torres Strait Islander people, and there is widespread recognition and evidence that practitioners and service providers need to be mindful of the impact of colonialism, diverse cultural and environmental experiences, and contemporary social and economic circumstances of Australia's First Nations people (Dudgeon et al., 2020). Mental health and wellbeing for Indigenous Australians are enhanced by better therapist understanding of the importance of acceptance, respect, forgiveness and integrity, honesty, courage, empathy, mindfulness, and spirituality (Kilcullen et al. 2018). Additionally, the importance of Country not only as a focus of connection but also as a source of mental and physical health is emphasised by Trzepacz et al. (2014).

Past ethnocentric practices and policies, the products of a colonial history, with its inherited legacy of privilege, have contributed to a gap in health and particularly mental health outcomes for this group. Hook et al. (2013) suggested that mental health professionals must develop a capacity to move away from using their own cultural values as a benchmark for measuring and judging the behaviour of people from other cultural backgrounds. This is a concept described as cultural humility. Cultural humility also involves the understanding that cultural responsiveness is a continuous and dynamic process, not just an event to be achieved (Hook et al., 2013). Furthermore, according to Kuo (2011) collectivist cultures like those in Aboriginal and Torres Strait Islander communities emphasise group cohesion, interdependence, connection, harmony and conforming to group norms. Individualist cultures, in comparison, such as that found within mainstream non-Indigenous Australia, value independence and autonomy (Clark et al., 2017).

Aboriginal and Torres Strait Islander people have identified the need for preventative and holistic healing processes that promote strong, resilient communities focusing on restoring social and emotional wellbeing (SEWB) (Gee et al., 2014). The success of therapeutic services depends on cultural safety and relationship building. Frankland et al. (2010) define cultural safety as consisting of those services that are culturally sanctioned so

that everyone has the right to feel good about themselves and about their identities. In 2016, the Australian Psychological Society formally apologised to Aboriginal and Torres Strait Islander people for past failures in its dealings and treatment that have disadvantaged and caused distress to First Nations Australians. The apology, received by a gathering of Indigenous psychologists, including the author, resolved to pursue a different way of working with Indigenous Australians by "listening more and talking less; following more and steering less; advocating more and complying less; including more and ignoring less; collaborating more and commanding less" (Carey et al. 2017, p.265). Accordingly, in the spirit of this apology, the research aimed to listen more to what Indigenous clients had to say about culturally responsive practice.

According to Bhui et al. (2007) and Hernandez et al. (2009) there has been scant evidence to support any one concept of cultural competence. Overseas research (Betancourt et al., 2003; Majumdar et al., 2004) has mostly involved examination of cultural competence with clients from culturally and linguistically diverse populations. When research has involved overseas First Nations people (Brach & Fraserirector, 2000) this research may not inform Australian contexts as these communities have quite different histories, and social, cultural, and political determinants that have been formative for them but distinct from the determinants for Indigenous Australians.

Lie, et al. (2011) observed that there is limited research showing a positive relationship between cultural competency training and positive patient outcomes, and added that there is a need for more high-quality research in this area with better designs, large sample sizes, and validated standardised tools. Switzer et al. (1998) found that mental health care can be considered culturally competent when it is delivered in ways that respect the patient/client's cultural beliefs and attitudes. According to Flaskerud (1982) there are nine principal components of culturally competent care that are empirically based and associated with positive client outcomes: 1. Therapists who share the culture of clients. 2. Therapists who share the language or language style of clients. 3. Location of the agency in the client's community. 4. Flexible hours and appointments. 5. Provision of or referral to services for social, economic, legal, and medical problems. 6. Use of family members in the therapy process. 7. Use of a brief therapy approach. 8. Use of or referral to clergy and/or traditional healers. 9. Involvement of consumers in determining, evaluating, and publicising services. These can be grouped into three broad areas: Respect for ethnic differences; easy access to

care; involvement of community and family (Switzer et al. 1998). An additional definition from working with Culturally and Linguistically Diverse populations is that cultural competence requires four factors: community context; cultural characteristics of local populations; organizational infrastructure; direct service support (Hernandez et al., 2009).

The Australian Indigenous Psychologists Association (AIPA) adopted a model of cultural competence, centred on social and emotional wellbeing, including the determinants of mental health for Indigenous people (see Figure 1.2.). This became a central feature of the cultural competence workshops for non-Indigenous mental health professionals, and it is a model which describes health from a holistic and collectivist perspective, and recognises the self as being embedded within family and community (Gee, et al., 2014). The model identifies seven distinct domains of social and emotional wellbeing (SEWB) which make people strong and which guide practitioners to work with Indigenous clients in a culturally competent manner. These domains (not in any order of priority) are: 1. Connection to body; 2. Connection to mind and emotions; 3. Connection to family and kinship; 4. Connection to community; 5. Connection to culture; 6. Connection to country; 7. Connection to spirit, spirituality and ancestors. The model also includes social, historical, and political determinants that have often had a detrimental impact on Aboriginal and Torres Strait Islander people but can also have a positive impact when they are directed in a manner that is collaborative, strategic and seeking best outcomes. Placing mental health within this broader Social and Emotional Wellbeing framework emphasises that for many Indigenous Australians mental health issues are still entwined with the past injustices of colonisation (Gee et al., 2014) and the importance of a more holistic approach to formulation and therapy.

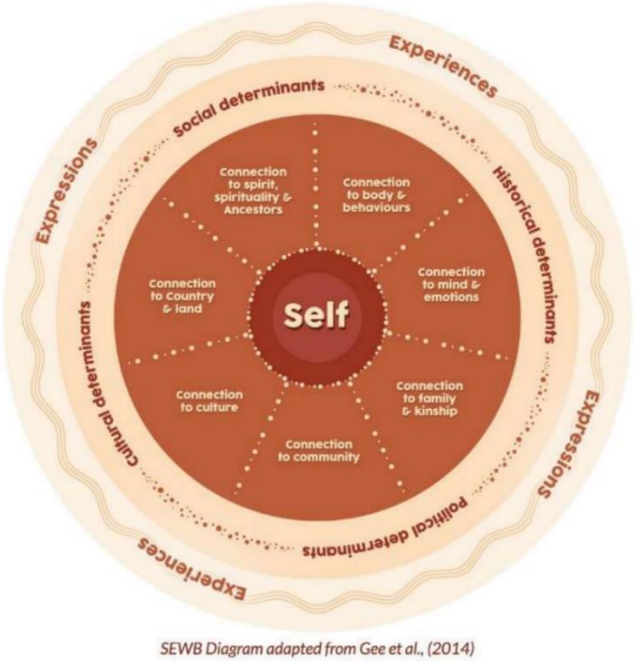


Figure 1.2. Model of Social and Emotional Wellbeing

1.8 The mental health landscape for Indigenous Australians

Although mental illness was present in Aboriginal and Torres Strait Islander society prior to European colonisation, according to Parker and Milroy (2014), it was rare, and the greater prevalence of mental illness in the contemporary setting reflects disruption of that society in a strong context of social and emotional deprivation.

As noted by Silburn et al. (2014) suicide is believed to have been a rare occurrence among the Aboriginal and Torres Strait Islander people of pre-colonial times, however, Australian Bureau of Statistics (2019) reported that suicide now is the fifth leading cause of death among Indigenous Australians, and has occurred at a rate that in most states is twice that of the non-Indigenous population. Between 2008 and 2018 there has been a 22% increase in Indigenous suicide which does not appear to be accounted for by increase of population, but rather underlying intergenerational trauma stemming from colonisation and the disadvantaged conditions and challenges being faced by many communities (Dudgeon et al., 2019). A report by Australian Institute for Health and Welfare (AIHW, 2015) has also noted that Indigenous suicide is a growing issue with one quarter of all child suicide deaths being Indigenous.

Hunter New England and Central Coast Primary Health Network (HNECCPHN) in its report on Mental Health and Suicide Prevention (2018) found that in New South Wales the prevalence of psychological distress was nearly three times higher for Aboriginal people than for the non-Indigenous population. The report identified contributing factors of the impact of intergenerational trauma, for Aboriginal and Torres Strait Islander people which in turn had affected family function, leading to increased family violence, as well as drug and alcohol use. The report also noted that Indigenous people were accessing mental health services at a higher rate than non-Indigenous people, and that for Indigenous persons the hospitalisation rate for mental health conditions was 23 per 1,000 while the rate for non-Indigenous persons was 11 per 1,000. This might suggest that Aboriginal and Torres Strait Islander people are not accessing early intervention mental health services and subsequently present to services only when they are in absolute need (Fredericks, 2010). Furthermore, it was likely that many more were not accessing these services because of service cultural inappropriateness.

Cultural inappropriateness has led to avoidance of mainstream health services by many Aboriginal and Torres Strait Islander people (Kendall & Barnett, 2015), and Fredericks (2010) has commented that the health services themselves often determine how Indigenous clients connect and whether they feel comfortable, secure, culturally safe and happy to access the service or whether this access is only with a great deal of effort, angst and energy. It becomes the challenge for services and individual service providers, therefore, to seek ways that can enable these services to become more culturally inclusive, prompting questions as to how they can become culturally competent and more localised and specialised rather than working from evidence drawn from the general population (Kendall and Barnett, 2015).

According to Australian Bureau of Statistics (2019) Indigenous Australians make up approximately 3% of the national population; about 750,000 persons within a total population of more than 25 million. The Psychology Board of Australia (2020) in its annual report has noted that there are 38,906 registered and provisionally registered psychologists across Australia, however, only about 290 of them identify as Aboriginal or Torres Strait Islander, representing 0.5 percent of the total psychologist workforce. In order to gain some parity using the population percentage of 3% as a benchmark, there is a need for a further 1,000 Indigenous psychologists to be able to deliver mental health services to the Indigenous community at the same level of service as the general population. Indigenous psychologists or other Indigenous mental health practitioners cannot meet this need without the assistance of

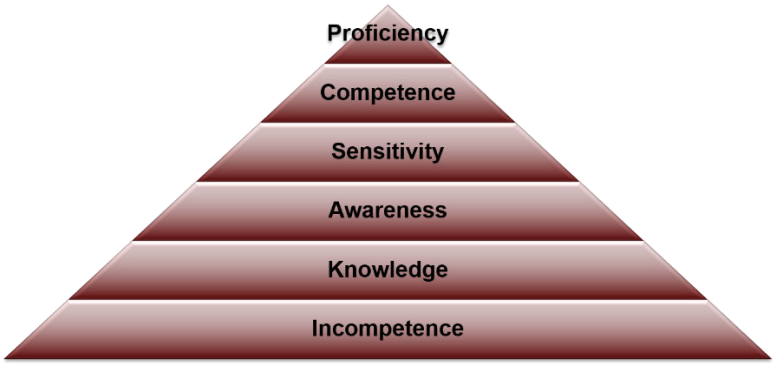
others, so the need to grow a culturally competent non-Indigenous mental health workforce by supporting students at all levels of study and, for a culturally competent and aware workforce is crucial.

Cultural Competence

The term and concept of cultural competence appears to have been in use since about the late 1980s (Wells, 2000) with the six stage Cultural Competence Continuum model of Cross et al (1989), and then followed by Orlandi (1992) with the Cultural Sophistication Framework which depicted a three-stage progression from cultural incompetence through cultural sensitivity to cultural competence. Campinha-Bacote et al. (1996) offered the Cultural Competence Model of Care, which like the two previous models is process orientated and moves through the stages of cultural awareness, cultural knowledge and cultural encounter. Wells (2000) built on the work of her predecessors with her own Cultural Development Model which also comprised six stages along a continuum, with the first three stages called the cognitive stage and the second three the affective stage. The Wells (2000) model was further developed by Ranzijn et al. (2010) as a guide for developing and teaching programs for undergraduate psychology students and introduced the notion of critical reflection and the nature and significance of culture for the individual practitioner. It is worthy to note that these models were developed overseas as generic models and were not constructed for specific work in either mental health or for Indigenous Australians.

The Australian Indigenous Psychologists Association (AIPA), in 2010 designed what became known as Journey Towards Cultural Competence workshops. Using the model of Social and Emotional Wellbeing (SEWB) in Figure 1.2; it also adopted the Wells (2000) model of the cultural competence continuum (Figure 1.3), which like the others already described, is a linear model, conveying the idea that levels of competence, once achieved, are immutable and transferable when working with other groups, nations, clans or in other regions. The linear nature of this model risks conveying the message that culture is somehow a static, and not a dynamic phenomenon, and a ‘one size fits all’ approach. These reasons exemplify the need for a more flexible model that is less rigid in structure, and non-linear in its progress, that takes account of the heterogeneous nature of Aboriginal and Torres Strait Islander culture with the many differences between communities across Australia. Such a model must also take account of the wide variety of experience and skills on the part of individual practitioners and organisations, and allow for dynamism and fluctuations.

Accordingly, a new approach and new terminology is needed when describing and teaching what continues to commonly be called cultural competence.



(Wells, 2000)

Figure 1.3. The Cultural Competence Continuum

As can be seen from Figure 1.3, in the Wells (2000) model Competence and Proficiency are attained by 'climbing the pyramid' through the various stages to a point that appears to be the summit or high point, and hence the journey aspect of cultural competence as promoted by AIPA in its workshops is understandable. Table 1.2 describes the AIPA (2010) model adopted from the Wells (2000) progression model, which is a later development of earlier linear models already described, and which propels practitioners in one direction in the same unchanging sequence of stages. Although this model acknowledges that individuals may have different starting points on the continuum and may even regress the model doesn't allow for internal variability in specific competence skills This suggests that competence in one skill or in one setting means global competence in all skills and all settings. The Wells (2000) model also does not appear to acknowledge that competence is a set of skills, not just a single skill to be accomplished and that for the practitioner these skills may present areas of both strength and weakness. Furthermore, the model could convey the impression that an individual or an organisation irrevocably remains at a particular level when for various reasons competence skills could diminish, so any bidirectionality might be overlooked, failing to see the need for continuing professional development. Practitioners also must remember that competence is specific to one setting and does not necessarily generalise to other cultural settings.

Table 1.2. Definitions of the Six Stages of Cultural Competence

Incompetence This stage is **characterised** by a lack of knowledge of the cultural implications of health behaviours. A system or agency that is culturally blind believes that the helpful approaches used by the dominant culture are universally acceptable. **Knowledge** Cultural incompetence gives way to cultural knowledge when the learning process begins. This level involves learning about the elements of culture and their role in shaping and defining health behaviour. **Awareness** Cultural knowledge leads to cultural awareness when practitioners start to recognise and understand the cultural implications of their own behaviour and that of others. **Sensitivity** Cultural awareness prepares one to become culturally sensitive, where practitioners start to integrate cultural knowledge and awareness into their practice. **Competence** To reach a level of cultural competence, a practitioner needs to be routinely applying culturally appropriate interventions and practices. There is an acceptance and respect for cultural diversity and service delivery is reviewed and adjusted to meet the needs of different cultural groups. **Proficiency** Those who are culturally proficient are competent and confident practitioners with a practised and well-developed set of skills. Cultural diversity is valued, and self-determination is promoted and supported. (AIPA, 2010)

Beyond this Wells (2000) model, the literature has also shown further definitions that are of importance in understanding the construct of cultural competence. As a concept it is broad and contested, (Hollinsworth 2017), lacking definitional clarity and overlooking the diversity of Indigenous communities as well as focal issues such as power, racism, white privilege, and so some closer consideration is warranted.

Cultural Safety

In Australia, it has been commonly reported that Aboriginal patients find health services culturally unsafe—they are unwelcoming and alienating due mainly to the attitudes staff in these centres bring to their care. The concept of cultural safety is particularly relevant to mental health professionals as it seeks to promote cultural integrity and the promotion of social justice, equity, and respect (McGough, Wynaden, & Wright, 2018). The term cultural safety was first termed by Dr. Irihapeti Ramsden and was adopted by the Nursing Council of New Zealand in 1992 and consists of a process of self-reflection by practitioners about power relationships and patients' rights (Curtis et al., 2019). It requires a response from practitioners to examine how their own culture impacts on their clinical interventions and then to make necessary changes. Dr. Ramsden also saw cultural safety as the end point of a stepwise linear

progression from awareness through sensitivity to safety, in a similar fashion to the models already described (Curtis et al., 2019). It is a process of critical analysis through a decolonising lens that allows the practitioner or the student to recognise the impact of colonisation on the health and wellbeing of Indigenous people and to see where new forms of colonisation could be emerging within systems. It must be more than a reflection on clinical practice but must encompass a true reflection on one's own identity, often with its legacy of inherited privilege and power, described in critical thinking theory as a reflexive approach (Ryder et al., 2017).

Cultural Humility

A term that is closely related to cultural safety is cultural humility, which was described by Hook (2013) as being an interpersonal stance that is other-oriented rather than self-focused, characterised by respect and lack of superiority toward an individual's cultural background and experience. This interpersonal aspect is complemented by an intrapersonal attitude of genuine humility with an accurate view of the self. Cultural humility is a necessary and fundamental element for therapists working with people from other cultures and the task for the therapist is to suspend any notion of personal superiority of worldview, values, and beliefs. Hook also noted that the therapist who is culturally humble has a deeper awareness of deficits in knowledge leading to greater efforts to build that knowledge, in a manner that becomes more attuned to the client.

Cultural Responsiveness

Cultural responsiveness has become a more common term in recent years, in preference to cultural competence. It is, considered to be a more dynamic term that requires therapists to continually respond, as opposed to being competent, in a finite sense and in a sense of having achieved and completed something. This ongoing and dynamic aspect of responsiveness is reflected in the description by Indigenous Allied Health Australia's (2019) report on cultural responsiveness as being transformative, incorporating knowledge, especially self-knowledge, behaviour and action. It also involves how therapists engage with people in genuine dialogue ensuring the cultural safety of clients, and it has been adopted as the preferred term in the title of this chapter, because it best represents a decolonising approach to working with Indigenous people.

Cultural responsiveness is also the descriptor of the Australian Psychology Accreditation Council in its Accreditation Standards for Psychology Programs (2019), where it specifies that cultural responsiveness is a necessary learning outcome for all levels of graduate competency: Foundational, Pre-Professional, Professional, and Professional with Specialised Areas of Practice.

Reflexivity

As an element of cultural safety and cultural responsiveness, reflexivity is the essential part that facilitates the therapeutic process and facilitates learning and discovery. The French philosopher, Michel Foucault, was among the first to identify the importance of reflexivity, in epistemology, and as an essential part of ethnology research, and cautioned that the researcher must resist the urge to superimpose the self upon the other. Researchers, observers, and practitioners must step out of their own cultures in order to understand the culture of another. There must be what Foucault called a "perpetual oscillation" between the culture of the self and the culture of the other (Foucault, 2001).

Holland (1999) identified reflexivity as being applied to that which turns back on or takes account of itself or of the personal self and considering the effect of the personality or presence of the researcher on that which is being investigated. Reflexivity is a dynamic similar to that described by Foucault which moves outward in experience and then back into reflexivity – Foucault's perpetual oscillation.

In order to become reflexive, the challenge for the therapist is to develop an ability to become contemplative. This is more than thinking or even reflecting. Reflexivity is a process of higher order thinking that extends beyond the purely cognitive (Coulson & Homewood, 2016). It is a space of deep empathy and understanding that seeks genuine truth and suspends all judgement. Indigenous Australians call it Deep Listening; eastern spirituality calls it Mindfulness; western spirituality, Contemplative practice, but learning this skill requires an inner peace and stillness. Australian Cistercian monk and monastic scholar, Michael Casey (2014), describes this in terms of "in a world where communication is huge, it takes a fair amount of resolution to create for oneself a sphere of silence, in which urgencies are put on hold and words are weighed" (p.76). This sphere of silence is the reflexive or contemplative self, and for the therapist, discovering it is fundamental to understanding the following model.

1.9 Summary

This chapter has introduced the reader to the importance of clearly articulating the concept of cultural responsiveness and the need to position this concept within mainstream learning and practice. Mental health services for Aboriginal and Torres Strait Islander people have not always been inclusive and there is a mental health gap that must urgently be addressed.

As noted in this chapter there is a need to clearly define what is meant by cultural responsiveness, as most of the literature presumes a definition that is self-evident, and the following chapter sets about reviewing what the literature tells us about this concept. It relates how there has been a movement in meaning and terminology that extends back several decades, and how the term cultural responsiveness gained its pre-eminence. The chapter will also introduce to the reader a new conceptual model of cultural responsiveness that offers a clear guide to practitioners working with Aboriginal and Torres Strait Islander people, and for students and teachers to learn and to impart knowledge that will ultimately lead to best outcomes and which will help to close the gap in mental health.

At the end of this chapter there is a list of the author's publications, conferences at which the author has presented, and consultancies that have been included because they relate to the author's ongoing work in cultural responsiveness. A Higher Degree by Research (HDR) project inevitably includes a work component that comprises dissemination and sharing of research findings and outcomes both within and outside one's university. It is also deemed important that the message of cultural responsiveness and what needs to be done better in mental health gets delivered to those who work in this area and those who aspire to this work. This project, in its earliest form, began for the author long before it was formally commenced, and the 2014 and 2016 conferences included in the list are indicative of a journey now embracing cultural responsiveness that began before that time and has been decades in its preparation.

1.10 Publications

Smith, P. (2021) Cultural safety: Moving beyond cultural competence. *InPsych, The bulletin of the Australian Psychological Society Limited.* 43(1). Flinders Lane, Melbourne. https://www.psychology.org.au/inpsych.

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Smith, P., Rice, K., Schutte, N., & Usher, K. (2023). Healing through meaning as an aspect of Spirituality for Indigenous Australians: A qualitative study. *AlterNative: An International Journal of Indigenous Peoples.* 16(3), 626-634. https://doi.org/10.1177/11771801231193169

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Dudgeon, P., Carey, T., Hammond, S., Hirvonen, T., Kyrios, M., Roufeil, L., **Smith, P.** (2020). The Australian Psychological Society's apology to Aboriginal and Torres Strait Islander people: Going beyond the apology in the teaching and training of psychologists. In N. Rubin and R. Flores (eds). *The Cambridge Handbook of Psychology and Human Rights.* 553-567. Cambridge University Press. https://doi.org/10.1017/9781108348607.

1.11 Conference Presentations

Smith P. (2022) *From cultural competence to cultural responsiveness: A conceptual model for mental health practitioners*. Presented at Hunter New England Local Health District Psychology Conference, 25 November, University House, Newcastle.

Smith, P. (2021) *From cultural competence to cultural responsiveness: A conceptual model for mental health practitioners*. Presented at Australian Psychology Learning and Teaching (AusPLAT) Conference, 17-19 September, Newcastle University.

Smith, P. & Dalton, T. (2016) *Engaging with Aboriginal and Torres Strait Islander people.* Presented at Australian Psychological Society Congress, Melbourne Victoria.

Smith, P., Hovane, V. & Ryan, K. (2014) *The Transformative Effects of Cultural Competence workshops for the Australian Indigenous Psychologists Association (AIPA).* Presented at International Conference of Applied Psychology, Paris, France.

Smith, P. Webinar series and face to face presentations on Cultural Responsiveness to undergraduate and postgraduate students at University of New England, University of New South Wales, and University of Newcastle. 2021 to present.

Smith, P. (2022) Webinar Presentation on Cultural Responsiveness to members of the Australian Association of Psychologists Incorporated (AAPi).

Smith, P. (2023) Three Minute Thesis: *Cultural Responsiveness from journey to dance.* University of New England, Graduate Research School.

1.12 Consultancies

Psychology Board of Australia (PsyBA). Consultant to the Board regarding updates to the competencies for general registration, specifically concerning cultural responsiveness. Representing Australian Indigenous Psychologists Association. 2022 to present.

Psychology Board of Australia (PsyBA). Member of the National Psychology Examination Committee, tasked with reviewing the content of the national examination and with aspects concerning cultural safety for entry level practitioner registration. 2023.

Australian Indigenous Psychology Education Project (AIPEP). Member of the Community of Practice representing Australian Indigenous Psychologists Association, with a task of reviewing Indigenous curriculum content in university psychology programs. 2021 to present.

Australian Association of Psychologists Incorporated (AAPi) Member of Indigenous Panel of Advisors to the association on matters concerning cultural responsiveness of practitioners and Indigenous issues in general. 2021 to present.

1.13 References

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Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF ORIGINALITY

(to appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate, and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	**Page number(s)**
All, aside from contributions by other authors listed in the form below	
Figure 1.2 Model of Social and Emotional Wellbeing	Page 34
Figure 1.3 The Cultural Competence Continuum	Page 37

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Higher Degree Research Thesis by Publication

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STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

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Chapter 2: Literature Review (Gayarra-gi)

"Following reflections, what steps will we take to change our work practices, engage as psychologists with Indigenous peoples in a culturally safe manner and ensure that our awareness translates into attitudes and actions that are characterised by cultural responsiveness, and into positive outcomes for Indigenous Australians?"

(Dudgeon et al., 2020a, p.564)

As noted in Chapter One, there are gaps in the literature concerning cultural responsiveness, and some sources use the term without defining it, in a manner that appears to presume that there is some universally accepted meaning of the concept. Therefore, it was determined that a systematic search (*gayarra-gi*) of the literature needed to clarify and define meaning to enable this project to advance, and this literature review was published in *Australian Psychologist* in 2021.

This chapter also introduces the reader to the author's conceptual model of cultural responsiveness that not only provides a visual definition of this construct but also sets out a framework for learning and teaching as well as for professional practice which is aligned to the latest national requirements for course content and professional registration. This work was published as:

Smith, P., Rice, K, Schutte, N., Usher, K. (2021). Cultural responsiveness for mental health professionals working with Aboriginal and Torres Strait Islander clients: A concept analysis. *Australian Psychologist 56:6,* 446-457. https://doi.org/10.1080/00050067.2021.1974281. (1st Quartile, Impact Factor 1.8)

2.1 Abstract

An analysis of the literature was conducted to clearly define the meaning of cultural responsiveness as it applies to the work of mental health practitioners who engage with Aboriginal and Torres Strait Islander clients. This concept analysis utilised Rogers' (2000) protocol, seeking to understand the key terms defining cultural responsiveness. A search of databases yielded a sample of 13 articles for analysis after screening and quality assessment. Five major themes emerged, which were considered definitive of cultural responsiveness: Knowledge, Inclusive Relationships, Cultural Respect, Social Justice/ Human Rights, and

Self-Reflection. These themes are presented as core values or components of culturally responsive mental health services with Aboriginal and Torres Strait Islander clients. The implications for practitioner professional development and the education of students within mental health disciplines are also discussed (Smith et al., 2021).

Keywords

Australian; Aboriginal and Torres Strait Islander; cultural competence; cultural responsiveness; cultural safety

2.2 Introduction

This concept analysis examines the literature concerning cultural responsiveness as it relates to interventions of mental health practitioners whose clients are Aboriginal and Torres Strait Islander people of Australia. The term Indigenous is respectfully used to encompass both of these groups of First Nations people within Australia and it is a term that has been favoured by some peak representative groups in this country for similar reasons. The term Aboriginal is used where this refers to a specific person or persons. This work seeks to provide a clearer understanding of cultural responsiveness and how this understanding contributes to best practice for a range of mental health professionals including psychologists, psychiatrists, counsellors, social workers, and mental health nurses.

For more than three decades, cultural competence has been the concept of choice to describe working with diverse populations (Cross et al., 1989), however Wells (2000) noted that cultural competence was not sufficient to attain a level of cultural development that met the health care needs of these populations. Considered to be too static it needed both practitioners and organisations to move from what was called a cognitive phase of acquiring knowledge, to an affective phase of internalising the knowledge and making it a routine part of professional practice. Additionally, the first author's ten years of experience delivering cultural competence workshops brought him to the conclusion that more was needed beyond instructivist learning paradigms and that practitioners needed to be taking away from workshops more than information and a set of guidelines directing them what to do or not to do. Hart (2014), while using the old terminology with a new concept proposed that clinicians needed to become culturally competent only with the support and/or encouragement of the health systems in which they participate, and that self-awareness of one's personal and professional culture is only a part of the development of cultural competence. The slow move

forward in this country may partly explain why Walker, Schultz and Sonn (2014) noted that current systems have failed Indigenous people and Kendall and Barnett (2015) found that mainstream health services are often avoided by them. They found that many services are deemed to be culturally incompetent, and this avoidance is influenced by negative historical experiences, poor cultural understanding and inappropriate communication. Accessibility was found to be enhanced by a collective and holistic approach to health. Additionally, acceptance, respect, forgiveness, integrity, honesty, courage, empathy, mindfulness, and spirituality are important qualities for a strength-based approach supporting good mental health for all therapists working with Aboriginal and Torres Strait Islander people (Kilcullen et al. 2017).

Mental health professionals must develop a capacity to step out of their own cultural values in order to understand people from other cultural backgrounds; a concept described as cultural humility (Hook, 2013). This concept also involves the understanding that cultural competence is an ongoing and dynamic process, not just an event to be achieved. This process must be engaged in by practitioners and by undergraduate and postgraduate students. The final report of the Australian Indigenous Psychology Education Project (2019, p.iv) makes it clear that for institutions of higher education "an appropriate curriculum content and pedagogical approach is fundamental to the training of culturally competent psychologists."

The 2016 apology by the Australian Psychological Society, to the Indigenous people of Australia has already been introduced in this work. This apology made resolution to pursue a different and better way of working with Indigenous people. The apology resolved that psychologists would be "listening more and talking less; following more and steering less; advocating more and complying less; including more and ignoring less; collaborating more and commanding less" (Carey et al. 2017, p.265). This resolve was a clear acknowledgement that past practices in mental health have failed Indigenous people. The way forward must be one of culturally responsive practice, that decolonises the mental health disciplines away from past ethnocentrism and hegemony that have served the structures and processes of colonialism with their inherent forms of racism that have prevailed in Australia and globally (Dudgeon & Walker, 2015).

The Australian Indigenous Psychologists Association (AIPA), the peak organisation in Australia for Indigenous psychologists designed a model of cultural competence which has featured since 2010 in its cultural competence workshops for non-Indigenous mental health

professionals. It presents health as holistic and from a collectivist perspective with the self being centred within family and community (Gee, et al., 2015). The model features seven domains of social and emotional wellbeing making people strong and guiding practitioners to work with Indigenous clients in ways which are culturally competent. Connections to body, mind and emotions, family and kinship, community, culture, Country, spirit, spirituality and ancestors, all guide practitioners toward best outcomes for clients (AIPA, 2010).

Revised in 2013, the National Practice Standards for the Mental Health Workforce (2013, p.11) make it clear that mental health practitioners must "actively and respectfully reduce barriers to access, provide culturally secure systems of care and improve social and emotional wellbeing". Hart (2014) in her review of the AIPA model, noted that mental health services should recognise the right to self-determination and form meaningful partnerships based on cultural respect and culturally responsive and safe practice. It was further noted by Hart that the AIPA model of cultural competence had highlighted a difference in world views between Indigenous and non-Indigenous Australians. She added that the elements of cultural respect and cultural responsiveness, where Indigenous understandings and knowledge systems are honoured, are fundamental, and these will feature in this review.

Concept analysis has been adopted as the most appropriate form of review of the literature as it can provide some guidance when the concept under review lacks sufficient literature, is vaguely or not clearly defined, or when research and literature do not match (Foley & Davis, 2017). These authors define formal concept analysis as "a process whereby concepts are logically and systematically investigated to form clear and rigorously constructed conceptual definitions" (p.5). In respect of cultural responsiveness, it is a concept that has emerged in recent times out of several previous models and concepts that are frequently used interchangeably without clear distinction or definition. The present literature review aims to make the definition clearer and less ambiguous.

2.3 Method

A literature search sought to analyse the concept of cultural responsiveness, as it applies to Indigenous people within a mental health context, asking the question: "What is cultural responsiveness and what are its core components?" The literature obtained this information

across several discipline areas where Indigenous and non-Indigenous practitioners work in a mental health capacity.

This concept analysis utilised Rogers' (2000) protocol which involves six primary steps:

1. Identifying the concept and any related terms.
2. Identifying and selecting an appropriate method of data collection.
3. Collecting the data and identifying the specific attributes, and contextual basis, including interdisciplinary, cultural, and temporal variations.
4. Analysing the data.
5. Using an example of the concept, if appropriate.
6. Identifying hypotheses and implications for further development of the concept.

Step 1. Identifying the Concept and any related terms

Cultural Responsiveness

The literature focusing on cultural responsiveness demonstrates an evolving definition. In the last decade, the meaning has evolved to encompass more than just competence in practice but also what is an ongoing process of collaborative and respectful relationships and critical reflection (Green, 2016). These aspects of critical reflection and respect set cultural responsiveness apart from other concepts such as cultural competence, and it is clear that here is where we need to advance our understanding. Indigenous Allied Health Australia's (2019) report on cultural responsiveness describes it as being transformative, incorporating knowledge, especially self-knowledge, behaviour and action. However, some sources define it, as though its meaning is self-evident. For example, the Victorian Health Services Cultural Responsiveness Framework (2009, p.4) defines cultural responsiveness as simply "the capacity to respond to the healthcare issues of diverse communities", without further elucidation or detailed description.

Cultural Competence

In the 1970's cultural awareness and then cultural sensitivity were the adopted terms which were about recognition and acceptance of cultural diversity (Havelka, 2017) but these tended to overlook professional practice. The term cultural competence emerged in the 1980s (Cross et al., 1989) when it was described as a congruent set of values, attitudes and policies. A

decade later Switzer (1998) considered cultural competence to be centred on respect for cultural beliefs and attitudes. However, Wells (2000) described it more within the terms of professional practice, as "the routine application of culturally appropriate health care interventions and practices" (p.193).

Cultural competence, according to Campinha-Bacote (1996), could only come about through awareness, knowledge and encounter and this model was built upon by Wells (2000) who added the elements of sensitivity and a point beyond competence called proficiency in what is a linear model that marks progression from one point to another. To facilitate progression, self-reflection and self-critique are essential elements in cultural competence, which also includes cultural humility, which requires that the practitioner step out of the culture of the self in order to understand the culture of the other (Hook et al., 2013; Curtis et al., 2019).

Sue (2001) defined the culturally competent practitioner as one who progresses in awareness, knowledge and skills needed to "function effectively in a pluralistic democratic society, with the ability to communicate, negotiate, interact and intervene on behalf of clients from diverse cultural backgrounds" (p.802).

Cultural Safety

Another related term that appears in the literature as a component within definitions of cultural competence and cultural responsiveness is cultural safety. According to Curtis et al. (2019) cultural safety involves acknowledging the barriers to effective clinical practice that arise as the result of the power imbalance between the practitioner and the client. Cultural safety requires that practitioners come to understand and acknowledge the impact of their own culture on interactions and interventions with clients of another culture. It involves genuinely questioning biases, attitudes and entrenched opinions and stereotypes and prejudices that could influence the quality of care.

Step 2. Identifying and selecting an appropriate method of data collection

Studies that met the following criteria were initially considered for inclusion in this analysis: full text, peer-reviewed journal articles that address practitioners working with Indigenous people within a culturally responsive framework. However, the paucity of relevant journal articles even when the term "Indigenous" was used revealed nothing further and this

necessitated a search that included grey literature which comprised a variety of reports, project documents, position papers and one doctoral thesis. Searches were conducted in October 2020, with a university librarian assisting in selection of databases and search terms, using EBSCO, Informit, ProQuest, PsychInfo, Pubmed as well as Australian Indigenous HealthInfoNet. In all searches publications were limited to articles, documents, and full text studies in English between the years 2010 and 2020 and the search terms were: "cultural responsiveness"; and Australian; and Aboriginal. Torres Strait Islander was not included in the search terms as most of the literature includes this term together with Aboriginal and it is rare to see articles about Torres Strait Islander people on their own. The term Indigenous was not used as a search term, as the initial search revealed no additional sources. This is a broadly used term internationally and studies not focused on Australia were not included. Searches of databases continued systematically until it had become clear that no new data was appearing. The year 2010 was selected as a baseline year because there was little evidence of the use of the term prior to that year.

Data was organised according to definitions of cultural responsiveness in the literature, which were then used to generate categories, and in turn make up the component parts of the concept being analysed. Only literature explicitly using the term cultural responsiveness were accepted for the review, despite some sources being more implicit or calling this concept by another name. These definitions are set out in a table format that assists an overall view for comparison and a clearer appreciation of the breadth and variety of the sources (see Table 2.1).

The data set comprised the literature that in some way sought to describe cultural responsiveness beyond mere mention of the term. The definitions were then divided into components which were coded and grouped accordingly. These became the components of the concept of this study: cultural responsiveness.

Step 3. Collecting the data and identifying the specific attributes, and contextual basis, including interdisciplinary, cultural, and temporal variations

Data sources, as listed in Table 2.1, were of a wide variety of publications, even though *peer reviewed journal article* was the intended initial search criterion. Grey literature was included together with peer reviewed journal articles, because to exclude them would have diminished the sample for this review. It was also considered that this literature, which ranges across

several disciplines, such as nursing and social work as well as psychology, made an important contribution in terms of elucidating the concept in question. The inclusion of grey literature, which is publicly available and is often produced by government agencies, business and industry but not subject to academic peer review processes, has been a contested issue within reviews of literature. However, as Adams, Smart and Huff (2017) have noted grey literature has a place within dynamic and applied areas where scholarship is lagging and where novel fields of enquiry are being explored. It is included here for these reasons and to help give a fuller picture to this concept (Adams et al., 2016). Additionally, Rosewarne (2009) found that researchers need to exercise some caution in accessing only peer reviewed sources as most Indigenous authorship is within grey literature leading to what he describes as a cultural bias in mainstream collections.

From ontological and epistemological perspectives, Rodgers (2000) and Hupcey and Penrod (2005) held that concepts are contextual in the same way that language is contextual, so in the collection of data, a degree of caution is needed in interpretation of any concept and how it is described within cultures. If language and analysis is colloquial as well as scientific (Risjord, 2006), there will be some fluidity in meaning, and accordingly it has been important in this analysis to restrict the concept to Australian contexts.

Step 4. Analysing the Data

Definitions of cultural responsiveness within the thirteen literature sources in Table 2.1, were listed and coded within each source, according to categories, taking note of surrogate terms and related sub-categories. This is an inductive process of observing the data for emergent parts of the concept, which contrasts with deductive forms of hypothesis testing. An inductive process of analysis codes data without trying to fit it into some pre-existing format or definition. It is essentially data driven, or "grounded" in the data rather than researcher driven, and the importance is not determined by frequency in the literature but by whether it captures something in terms of the overall research question (Braun & Clarke, 2006; Clarke & Braun, 2016).

It is also important to bear in mind when analysing the data that when one is grounded in the data it is not possible to enter a theoretical vacuum (Braun & Clarke, 2020) because all researchers maintain their own theoretical assumptions which inform analysis, and so a purely inductive analysis is often not possible.

2.4 Results

The data collection process is set out in a flow chart (Figure 2.1) that describes selection and screening of information and aligns with the purpose of this concept analysis. Database searches indicated 121 sources, while 4 sources of grey literature were found using Google Scholar. After duplicates were removed, this number was reduced to 113. Screening by title and abstract further reduced the number to 53, which then reduced to 13 after examination of these sources eliminated 40 in which cultural responsiveness was not defined. This final screening confirmed what had been noted in the general perusal of literature content, whereby the term "cultural responsiveness" is frequently used without being defined. This suggests that there is a need to clarify the meaning of the term, especially as it is already a term defining an area of professional skill (APAC, 2019).

The final sample of the literature, shown in Table 2.1 provides information regarding this literature, including author, title, definition and definition source. Because this study was conducted for the purpose of a concept analysis focus was on definitions and the emergent components in the definitions as they are described below. Five separate parts or components of cultural responsiveness were identified within the literature definitions: Knowledge, Inclusive Relationships, Cultural Respect, Social Justice/Human Rights, and Self-Reflection/Reflexivity. These components are defined in more detail:

Knowledge

The concept of knowledge within the literature described both extrinsic knowledge and self-knowledge, or insight, in the sense of understanding oneself better and developing new ways of knowing. It was also a descriptor for knowledge of self and how one impacts others in terms of one's own values. This concept additionally extended to sub-themes of understanding or awareness of power and privilege, and their roles in maintaining hegemony (Bennett & Gates, 2019).

A surrogate term for knowledge in the reviewed data was *learning.* This encompassed many forms such as formal learning and informal versions such as cultural immersion and developing the skill of listening.

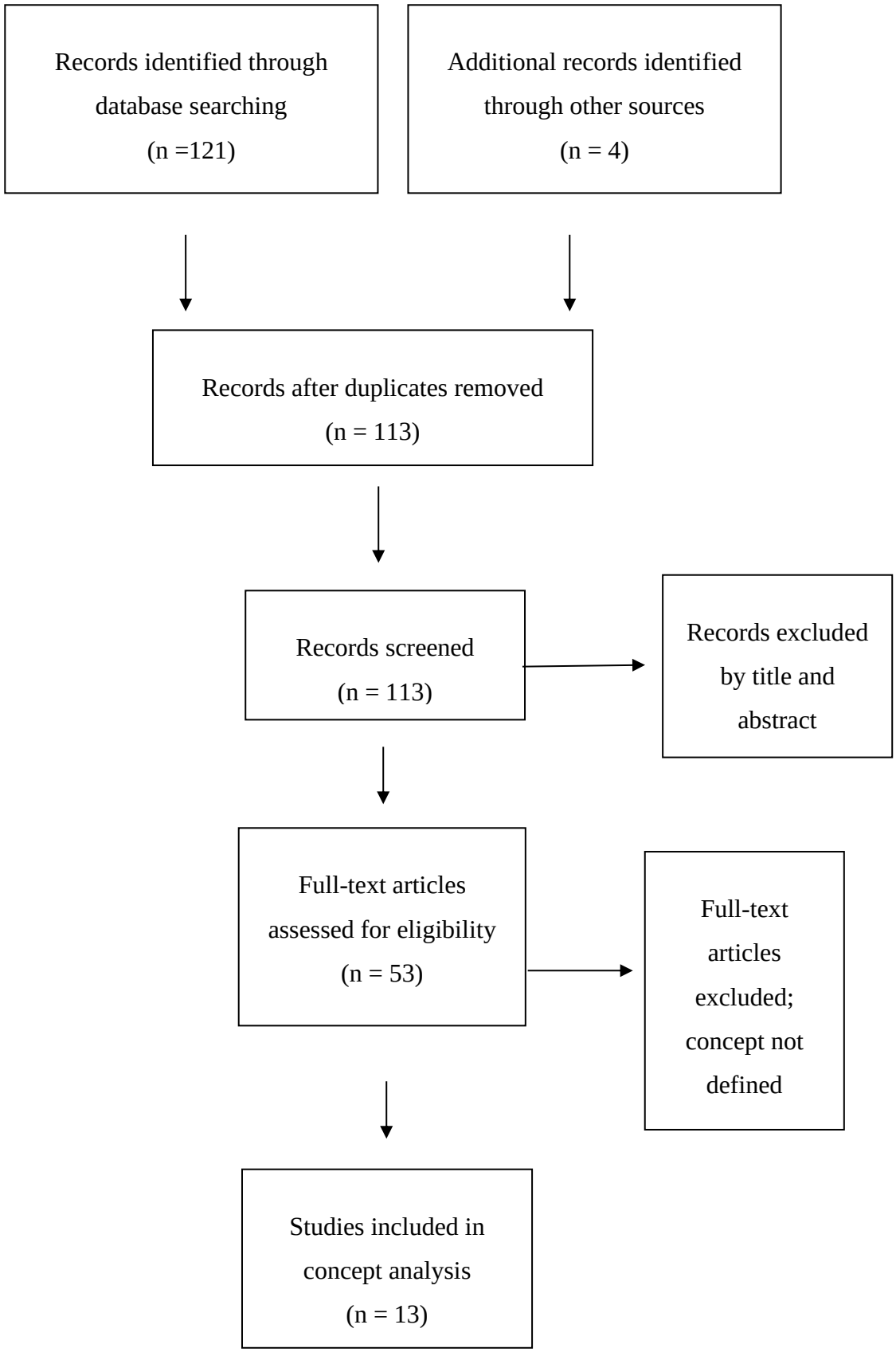

Figure 2.1. Flow Chart of Literature Search

Table 2.1. Literature Definitions of Cultural Responsiveness

Authors	Title	Definition	Definition Source
Indigenous Allied Health Australia (2019)	Cultural Responsiveness in action: An IAHA Framework	Cultural Responsiveness has cultural safety at its core. It is innately transformative and must incorporate knowledge (knowing), self-knowledge and behaviour (being) and action (doing) (p.5). It is a negotiated process of what constitutes culturally safe health care, as decided by the recipient. It works in partnership and supports Indigenous leadership.	Report 2019
Carey et al. (2017)	The Australian Psychological Society's Apology to Aboriginal and Torres Strait Islander people	Change that has been brought about by decolonising psychology, particularly concerning assessment, research and intervention. A foundation for working with Aboriginal and Torres Strait Islander people.	Peer reviewed journal article.
Bennett and Gates (2019)	Teaching cultural humility for social workers serving LGBTQI Aboriginal communities in Australia	Reflection, examining experiences of power and privilege, embracing uncertainty, and interrogating previously held assumptions. An ongoing process that requires awareness of the relationship between ourselves and others and the systems in which we interact.	Position paper for curriculum development.
O'Keefe, et al. (2018)	Getting started: exploring pre-service teachers' confidence and knowledge of culturally responsive pedagogy in teaching mathematics and science	Affirming cultural identities and nurtures sense-making through inclusive relationships and interactions.	Case Study with undergraduate student teachers as participants.

Table 2.1. (Continued)

Authors	Title	Definition	Definition Source
Parmenter et al. (2020)	Chronic disease self-management programs for Aboriginal and Torres Strait Islander people: Factors influencing participation in an urban setting.	Cultural responsiveness is about easy access to program, flexibility in attendance, group environment, relationship building, personalised and integrated approach to care, communicating results regularly; community ownership of the program.	Program focus groups with responses from Indigenous participants.
Minnican and O'Toole (2020)	Exploring the incidence of culturally responsive communication in Australian healthcare: the first rapid review on this concept	Reflexivity, flexibility, self/other- awareness, respectful, trustworthy, honest and transparent, non-judgemental, willing to learn, ability to listen, including and/or acknowledging family	Literature Review
Bennett et al. (2018)	Incorporating Aboriginal and Torres Strait Islander curriculum frameworks into practice and implications for employment	Cultural responsiveness is not ethnocentric; self-reflection; critically evaluates practice	Position Paper
Genat et al. (2016)	Sectoral system capacity development in health promotion: evaluation of an Aboriginal nutrition program	Respect Aboriginal governance; engage in equal partnerships; transparent accountability to local leaders; respect Aboriginal values and perspectives; respect Aboriginal collective identity; Aboriginal cultural diversity; promote inter-generational healing; engage in compensatory capacity development.	Qualitative design; semi-structured interviews with Aboriginal and non-Aboriginal participants.
Bennett et al. (2018)	Cultural responsiveness in action: Co-constructing social work curriculum resources with Aboriginal communities.	Capacity to develop collaborative and respectful relationships with Aboriginal and Torres Strait Islander peoples in order to respond to the issues and needs of communities in ways that promote social justice and human rights.	Case studies with Aboriginal participants used as a teaching aid for tertiary students.

Table 2.1. (Continued)

Authors	Title	Definition	Definition Source
Young et al. (2013)	Getting it right: Creating partnerships for change": Developing a framework for integrating Aboriginal and Torres Strait Islander knowledges in Australian social work education	Learning new and different approaches of becoming not of being.	Project: "Getting it right: Creating partnerships for change. Integrating Aboriginal and Torres Strait Islander knowledge in social work education and practice.
Dudgeon et al. (2020)	Wellbeing and healing through connection and culture	Essential practices and policies which make Aboriginal and Torres Strait Islander peoples feel culturally safe and which are informed by Indigenous ways of doing, knowing and being. Driven by culture and gives back to culture, to reconnect at risk individuals, families and communities to their core cultural values and healing systems (p.42)	Project Position Paper
Green et al. (2016)	Cultural responsiveness and social work - a discussion	Collaborative and respectful relationships with Aboriginal and Torres Strait Islander peoples in order to respond to the issues and needs of communities in ways that promote social justice and uphold human rights. (p.67)	Critical framework discussion paper.

Inclusive Relationships

Inclusive relationships were described in the extracted literature as working co-operatively, mutual respect, collaboration, working with families and communities, and equality (O'Keefe et al., 2018). Inclusive relationships engage in an equal and open dialogue, and they take note of the systems within which we all function and interact, and how those systems shape our personal points of view and core values (Bennett & Gates, 2019). The overall implication is that empowerment of Indigenous individuals and communities and working more

collaboratively are core elements and a distinct departure from traditional mental health treatment models.

Cultural Respect

This theme focused on the need for practitioners to step out of their own personal culture and understanding and to value the culture of the client. Cultural respect also involves respect for beliefs and cultural heritage and requires the practitioner to practise reflexivity to understand the dynamics of cultural respect and what needs to change (Havelka, 2017) or what needs to be learned (Minnican and O'Toole, 2020). Cultural respect was presented as respect for Indigenous values and structures such as the place of elders, the meaning of a collectivist culture and Indigenous governance (Genat et al., 2016). It is also informed by an aspect of cultural safety which puts at its centre Indigenous ways of knowing, doing and being (Dudgeon et al., 2020).

Social Justice/ Human Rights

Social Justice/ Human Rights emerged as a theme fundamental to the definition of cultural responsiveness. This theme involves responding in appropriate ways to the issues and needs of communities and families (Bennett et al., 2018), which in turn promotes intergenerational healing (Genat et al., 2016). It also involves the process of decolonising mental health and understanding how research, intervention and assessment in the past have disadvantaged Indigenous people and only served the purposes of the non-Indigenous society (Carey et al., 2017).

Self-Reflection/Reflexivity

Self-reflection has already received mention in this review, under the definition of cultural safety. It also represented a major theme in the literature, where it refers to a genuine self/other awareness that is honest, transparent and non-judgemental (Minnican & O'Toole, 2020) and involves critical evaluation of one's practice (Bennett et al., 2018). It involves awareness of power and privilege and the ways that these have disadvantaged Indigenous people in the past and present (Bennett and Gates, 2019).

It is important to bear in mind that self-reflection or the preferred term reflexivity is more than just reflection, which is defined as some purposeful thinking about a topic or

experience. Reflexivity is a process of analysis or critical thinking, which includes reflecting from different perspectives, and it is this element of otherness that is the transformative aspect of reflexivity (Coulson & Holmwood, 2016). Reflexivity and the Reflexive Self are described further in this chapter and form what have become central elements of the conceptual model of Cultural Responsiveness, providing a new approach to this important area of work.

Step 5. Using an example of the concept

According to Foley and Davis (2017) the use of an example in concept analysis provides a concrete operationalisation of the concept. It is used here to demonstrate the importance of the emergent themes in this concept analysis and what they mean in practical terms for cultural responsiveness.

> The author, an Aboriginal psychologist, about two years ago had been asked to speak to a group of people in a small local community about self-care and maintaining emotional wellbeing. Mathew, a local Aboriginal Elder, was in this group and after he had decided from his observations, that the presenter was approachable and culturally safe, arranged to meet for a yarn. He was a deeply troubled man, because his traditional land, located on the black soil plains of northwest New South Wales, was about to be turned into an open cut coal mine, by an overseas mining corporation. He, along with many of his neighbours in this tiny rural community had battled for years against a well-resourced corporate giant and a series of governments that appeared to be not listening to their voices. He was now mentally and emotionally exhausted and the struggle had also impacted his physical health. As an Elder of his people, his role of custodian of traditional land, and the stories and customs of his people, would matter little once the bulldozers and excavators moved in. Time with Uncle Mathew was more a case of walking with, rather than working with a client, because clearly there were powerful external forces in play which were social and political determinants of his overall wellbeing. He spoke of many things and shared many stories about living on the Country of his ancestors. He brought photographs of sacred sites, known only to a select few, where there were grinding grooves and rock carvings and caves where ancient artifacts had been uncovered. It was the task of the author to listen with respect and to allow him to have a voice, but also to understand the impact of what had been happening in his life, especially with recent events. [1]

This factual, de-identified example demonstrates how mental health practitioners can engage in a culturally responsive manner, even when there are prevailing and persistent external stressors. **Knowledge** and **Cultural Respect** were important here in understanding the role of Elders and the sometimes-burdensome responsibilities that they carry. It was also important to understand the central place of community, land and ancestors and the preservation of culture. Additionally, knowledge of current events was also crucial to understanding the client's disposition and presentation.

Inclusive Relationships featured in the first approach to the little group at the information day. Clients will often look for authenticity about who a therapist is rather than what they are. These relationships were also essential in maintaining engagement through our time together, where there was a preparedness to listen respectfully and to genuinely put oneself into the place of the client in order to understand.

Uncle and his little community were clearly standing in the face of a political storm where vested interests were forcing the agenda and **Social Justice/Human Rights** were sometimes lost in the struggle. He would have been deeply aware of how much these events had already become a form of dispossession for his people who remain deeply scarred by past history of dispossession and marginalisation (Dudgeon & Walker, 2015). The task for the practitioner here is in **Self-Reflection**, and to understand how the dynamics of power and privilege have disadvantaged Indigenous people and how they can be helped to heal.

2.5 Discussion

Step 6. Identifying hypotheses and implications for further development of the concept

The concept of cultural responsiveness is a starting point of evolving best practice, rather than the end point, and as Foley and Davis (2017) noted, a concept is the building block of a greater structure. This structure which encompasses the work of mental health professionals with Indigenous people has been a work in progress for more than 30 years and will continue to evolve into the future. The concept of cultural competence (Cross et al., 1989) provided a foundation for cultural awareness and cultural sensitivity (Wells, 2000), and more recently, cultural humility (Hook, 2013) and cultural safety (Curtis et al., 2019). There has been a steady movement forward to what is now termed cultural responsiveness and it is likely that this term will continue to evolve in the future, as research continues.

Cultural responsiveness is proposed as a developmental and recursive process. Prior to this review cultural responsiveness had already been identified as being inclusive of cultural safety and cultural humility and this review found that it may consist of overlapping features, including knowledge, inclusive relationships, cultural respect, social justice and self-reflection. These features may build on each other and develop and grow with changing circumstances and experiences. Cultural responsiveness within this review, was found to be a more embracing concept than those concepts which have preceded it. Cultural responsiveness is now the overarching goal for mental health practitioners, and the component parts form the strategy through which to achieve that goal. Unlike models of stepwise progression, cultural responsiveness challenges practitioners to constantly extend and to deepen their skills and experience, adapting to fluctuations brought by time and changing contexts.

The initial search of the literature revealed a limited number of texts (125) which mentioned cultural responsiveness, many not defining it, and indicated both some recency for the concept and potential for further research. Indigenous people have demonstrated that they are reluctant to access mainstream health and mental health services, and so further research will need to determine the nature of these barriers and what can facilitate better access. Within this cultural milieu literature can only be one part of what defines this concept, which remains incomplete without hearing the voices of Indigenous clients, the people most directly impacted.

Five themes emerged from the extracted literature: 1. Knowledge; 2. Inclusive Relationships; 3. Cultural Respect; 4. Social Justice/ Human Rights; 5. Self-Reflection. These themes are not new to mental health work with Indigenous people, but as they merge together in this concept analysis, they present a model that is more dynamic and more interactive than previous conceptual models such as cultural competence and cultural safety. This list of themes comprising cultural responsiveness is not exhaustive, and it is likely that in the future, as the body of literature grows so will the concept of cultural responsiveness, adding to existing themes. However, the current literature suggests that the themes emerging from the conceptual analysis are important for mental health practitioners working within a culturally responsive framework. The themes recurred throughout the literature and were described in a variety of terms with essentially the same meaning. Construct validity requires a future development of this concept which will utilise the responses of Indigenous clients of mental health professionals.

Past literature and previous models of cultural competence have for the most part focused on the first four of the five themes listed above. Although they mention the fifth theme, Self-Reflection or Reflexivity as part of cultural competence, cultural humility and cultural safety, these models arguably fail to give this core component more than just a brief mention. They opt rather to give priority to the acquisition of skills, awareness and knowledge while sometimes putting reflexivity as a function within each element. Reflexivity is a stand-alone component of cultural responsiveness. It is more than just thinking, it is a process of higher order thinking that extends beyond the purely cognitive to a space of deep empathy and understanding that seeks genuine truth and suspends all judgement (Coulson & Holmwood, 2016). Instead of asking what is this information and how can I acquire it, reflexivity asks who am I in response to this information and what is it asking of me (Kilcullen et al., 2018). Reflexivity, therefore, makes cultural responsiveness more dynamic, in that it elicits a personal response that goes beyond the acquisition of knowledge. The literature has found this to be a core element and it therefore must feature in any future conceptual models of cultural responsiveness and must form a foundation for future learning paradigms. Linear models, which are more defined by progression in knowledge and information have served an important role in the past but a future non-linear model where reflexivity becomes the guiding element will change the dynamic and advance our understanding in ways that improve both teaching and practice.

Previous literature has shone some light on the importance of developing more inclusive health services to promote better access by Indigenous people that is more in line with the wider community (Kendall & Barnett, 2015). It is imperative therefore that there must be an understanding of cultural responsiveness leading to professional practice within a clear and relevant model in order to show the way forward and to close the gap in mental health services.

Walter (2016) has noted that Indigenous people "are rarely asked their views on Australian values, Australian society and their own place within it……they occupy different social worlds, with most social interaction being transactional rather than relational" (p.93). This call for inclusive relationships appeared as a theme within most of the reviewed literature indicating that it is a significant factor within the concept of cultural responsiveness, so further work is needed to elucidate the meaning of this theme. The literature is only part of the development of enhanced understanding of cultural responsiveness. A fuller

understanding will require that Indigenous clients be asked their views as to what it means for them in their lives, and what they perceive as barriers to culturally safe and culturally responsive treatment.

2.6 Limitations of the study

This study was limited to an Australian context, and therefore there were fewer articles than if there had been a more widespread search. However, the findings remain important for the Australian context, but the themes would also be relevant for mental health practitioners working with Indigenous populations in other parts of the world, especially where those populations continue to be impacted by colonialism. Comparison of the concept between Australian and overseas cultural contexts was not a feature of this review, for the specific reasons already stated, but it could provide a rich source for future study. Despite the limitations cultural responsiveness is still an emerging concept and this study is an early step in its development, but it only tells us how the literature sees it.

2.7 Summary of the study

This concept analysis has sought and generated, from literature sources, new knowledge, to answer the question: "What is cultural responsiveness and what are its components?" The literature revealed that in addition to cultural safety and cultural humility, cultural responsiveness must also be considered to consist of five major elements: Knowledge, Inclusive Relationships, Cultural Respect, Social Justice/Human Rights, and Self-Reflection. It is the position of this paper that these definitive elements are crucial when considerations of content are made in terms of training, curricula and proficiency for practitioners who work with and are preparing to work with Indigenous people. Additionally, this concept analysis has shown a way forward for mental health practitioners in a range of mental health disciplines to adopt a culturally responsive approach to their work that promises better outcomes for clients.

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Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF ORIGINALITY

(to appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate, and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	**Page number(s)**
All, aside from contributions by other authors listed in the form below	

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[redacted] 10/10/2023

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[redacted] 11/10/2023

Principal Supervisor Date

Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

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Chapter 3: A New Model of Cultural Responsiveness: Foucault's Oscillation (Yulu-gi)

"A reflexive relationship is bidirectional with both the cause and the effect affecting one another in a relationship in which neither can be assigned as causes or effects."

(Michel Foucault)

Based on previous models, the literature and the themes which emerged in the literature search, the author hereby proposes a new model for better conceptualising cultural responsiveness. The literature has presented several models of cultural responsiveness, cultural competence and cultural safety. These models tend to be linear models, and it is the author's contention that such models are incomplete because they present cultural responsiveness as a static end point or some place of achievement, rather than a continuous process. It is the position of this paper that cultural responsiveness is ongoing and continuously dynamic, not always making progress, but constant, and what French philosopher and political theorist, Michel Foucault (2001) called being in "perpetual oscillation".

Perpetual oscillation for Foucault (2001) is that which suspends long chronological (linear) discourse in the human sciences for the purpose of reflection. To reflect on culture so as to understand it, this process studies the "structural invariables" of cultures rather than the succession of events. So, to better understand Foucault's terminology of perpetual oscillation in relation to cultural responsiveness, it is useful to look at the current prevailing analogy of cultural competence as journey. The analogy and conceptualisation envision a start and finish point, and competency moves inexorably in a positive direction, but this analogy takes little account of circumstances in which competence does not progress or may even regress. Competence in one community makes one competent in one community (AIPA, 2010) and there is a risk of self-identifying as being responsive or competent across all communities, nations, tribes, clans.

The proposed new model of cultural responsiveness is the author's conceptualisation, and it serves as a new development in our understanding of cultural responsiveness. It is a departure from linear models, and it is arguably more dynamic and iterative, and is multi-directional unlike past models. It represents a novel approach to cultural responsiveness

because it places reflexivity at the centre with the various movements (depicted as bi-directional arrows) radiating outwards and inwards. In defining reflexivity, Dudgeon (2020) said that the ability to provide culturally responsive services is preceded by an understanding of one's own identity as a cultural being, and so as depicted in the model, the Reflexive Self becomes the driving force which moves the individual in an outward direction along one or more directions at the same time. This non-binary model is multidirectional enabling practitioners to be in more than one domain at a time and unlike previous models it is dimensional not categorical, allowing for practitioners to attain degrees of achievement. The domains represent no hierarchy of importance allowing individuals to commence at any position around the circle after moving outwards from the Reflexive Self, where reflexivity determines the starting point. Movement back to the Reflexive Self along one of these domains may take place while the practitioner remains at some point or points along one or more of the other domains. Each domain was identified from the concept analysis, and they each represent a fundamental component of cultural responsiveness.

This dynamic model of cultural responsiveness represents what the author calls Foucault's Oscillation, and it changes the analogy of journey of cultural competence to the dance (yulu-gi) of cultural responsiveness. As dance it consists of repetitive forward and backward movements towards and away from the reflexive self, assisting the practitioner to venture forth where and when need arises, to best respond to the issues and needs of clients.

This work was published as:

Smith, P., Rice, K., Schutte, N., & Usher, K. (2022) Reflexivity: A model for teaching and learning cultural responsiveness in mental health. *Australian Psychologist.* 57(4), 209-214. https://doi.org/10.1080/00050067.2022.2078648 (1st Quartile, Impact Factor 1.8)

3.1 Abstract

Cultural responsiveness is a term accepted by many as the best descriptor for professionals working with Indigenous clients in cross cultural situations. This article sets out a guideline and a model of cultural responsiveness that can be adopted by mental health professionals worldwide.

This model positions reflexivity at the centre and as the source and force that drives the cultural responsiveness dynamic.

Domains of this model were previously identified from the literature and provide a guideline for students and practitioners to learn and to work in ways that are culturally responsive. Implications for the use of this model within teaching and learning contexts as well as within professional practice are discussed.

Keywords

Aboriginal and Torres Strait Islander; reflexivity; cultural responsiveness; Indigenous; conceptual model; teaching and learning.

Key Points

What is already known about this topic

1. Cultural responsiveness is a fundamental requirement for mental health practitioners working with Aboriginal and Torres Strait Islander people.
2. Cultural responsiveness is a core learning component for students of psychology aspiring to work as mental health practitioners.
3. Reflexivity is an important aspect of the cultural responsiveness dynamic.

What this topic adds

1. A new model of cultural responsiveness that is dimensional and iterative.
2. A model that centres reflexivity as the source and impetus for developing cultural responsiveness.
3. A more defined guideline of cultural responsiveness that assists teaching and learning for institutions, students, and practitioners.

3.2 Introduction

In 2016 the Australian Psychological Society (APS) formally apologised to the Aboriginal and Torres Strait Islander people of Australia (hereafter referred to respectfully as Indigenous) for the profession's past mistreatment and failings that led to disadvantage and systemic abuse. The APS, in demonstrating its commitment and to show a way forward, resolved in this apology that psychologists would be "listening more and talking less; following more and steering less; advocating more and complying less; including more and ignoring less; collaborating more and commanding less" (Carey et al., 2017, p.265).

In a response to the apology Carey, et al. (2017), three of whom are Indigenous psychologists, noted that between Indigenous and non-Indigenous Australians there has been a gap in health, education, mental health, and in social and emotional wellbeing, with higher rates of psychological distress, chronic disease and incarceration. Additionally, beyond psychology, Kendall and Barnett (2015) and Fredericks (2010) found that mainstream health services are not culturally safe, or culturally competent (to use their term) and must share some responsibility for the fact that many Indigenous people tend to avoid them or only access them when their condition has become chronic. This group suffers mental illness at higher rates than the wider community and has a suicide rate that is double that of the rest of the Australian population (Silburn et al., 2014). Between 2008 and 2018 there has been a 22% increase in Indigenous suicide in Australia which does not appear to be accounted for by increase of population. This figure may suggest intergenerational trauma stemming from colonisation and the disadvantaged conditions and challenges being faced by many communities (Dudgeon, et al., 2019).

Culturally responsive practice decolonises mental health away from past ethnocentrism and hegemony that have served the structures and processes of colonialism with their inherent forms of racism that have prevailed in Australia and globally.

> Decolonisation recognises Indigenous cultural views, conceptual frameworks and practices based on holistic conceptions of health and wellbeing and incorporates them into research, practices, and services. Ethnocentrism in science, as in everyday life, includes the tendency to view one's own group's standards as the right standards. The hegemony of western colonisers resides in their undefeated (but not unchallenged) political domination and their power to elevate ethnocentric

> perspectives to the level of supposedly universal standards (Dudgeon & Walker, 2015, p. 282).

Walker, et al., (2014) have noted both psychology curricula and policy implementation have failed through a "lack of awareness among professionals about Indigenous clients, cultures and contexts, lack of specific skills and strategies, lack of engagement in broader issues of justice and human rights, and a lack of understanding of prejudice, ethnocentrism and racism (p.198)." It is now the responsibility of current mental health professionals, as well as educators, employers and those responsible for professional registration, to ensure that this is done better and that services are inclusive and culturally responsive. Accordingly, this paper presents a model of cultural responsiveness that can assist practitioners to work with Indigenous mental health clients that is respectful, inclusive and seeking better outcomes. The model serves as a blueprint to guide and direct practice. More importantly it will hopefully ensure through reflexivity that there is ongoing understanding of where the practitioner is positioned in respect of the cultural responsiveness dynamic.

The purpose of a model is to go one step further than a definition of the concept, and models "originate from a realist perspective. The outcome of their analysis is fixed truth; concepts as measurable variables that ideally are knowable outside of context functional within a realist research world for which, in part, they are created" (Duncan et al., 2007, p.297). From an ontological perspective realism is that which seeks objective truths or universal beliefs, as opposed to relativism where meaning is contextually bound, and so a model within a realist context may have wider applicability than that which was initially intended. The purpose of presenting cultural responsiveness as a model is to offer practitioners an instrument to guide and assess their work, that is dynamic and visual and although there have been previous models of cultural responsiveness from overseas, such as the Multicultural SuperVISION model (Garrett et al., 2001) and the Family Partnership model (Tipa, et al., 2015) there has been to date no evidence of a cultural responsiveness model for working with Indigenous people within the Australian context.

In Australia cultural responsiveness has been included as a core competency for psychology students at all levels of university study from undergraduate to postgraduate and it is now a component of what is expected of candidates for national professional registration (Australian Psychology Accreditation Council, 2019; Psychology Board of Australia, 2018). It is crucial that we all share a common understanding of what we mean by cultural

responsiveness so that we remain clear about what is now required of students and practitioners. Additionally, the dimensional aspect of the model provides a foundation for the future design of a screening instrument completed by both students and practitioners to guide them towards culturally responsive practice.

3.3 Cultural Responsiveness

Cultural responsiveness is conceptually non-linear and moves away from past ideas of achieving skills and attaining a level where one size fits all for all time. Indigenous Allied Health Australia (2019) has described cultural responsiveness as being transformative, incorporating knowledge, especially self-knowledge, behaviour, and action which requires practitioners to continually respond rather than simply being competent. It also involves therapists engaging with people in genuine ever-changing dialogue ensuring the cultural safety of clients. It has been adopted as the preferred term in the title of this paper, because it best represents a decolonising approach to working with Indigenous people (Smith et al., 2021a, in press). Cultural responsiveness, within the spirit of the apology is about listening more and talking less and working collaboratively with clients.

3.4 Reflexivity

To understand cultural responsiveness, it is important to understand the place of reflexivity within the model. Reflexivity is more than just being reflective or mentally dwelling on something. It is a process of higher order thinking that extends beyond the purely cognitive (Coulson & Holmwood, 2016). It critically examines one's own attitudes, values, and biases, with a view to engaging with people in a manner that is culturally safe, meaning free of racism and attitudes of superiority (Wilson, 2014). For mental health professionals, reflexivity is about looking closely at one's own practice (Bennett, et al., 2018) and becoming aware of power and privilege and how they have impacted Indigenous people in the past and present (Bennett & Gates, 2019). Instead of asking what is this information and how can I acquire it, reflexivity asks who am I in response to this information and what is it asking of me (Kilcullen et al., 2018).

This paper sets out a model of cultural responsiveness that centres reflexivity and emphasises its importance for mental health professionals. Previous models (Wells, 2000; Sue, 2001) have identified reflexivity as an implicit feature of each step along the way, but this model features it explicitly as a fundamental step before, during and after each movement

in the cultural responsiveness dynamic. In contrast to past models, reflexivity in this model, is a process that positions the mental health practitioner within the model as the initiator, the recipient, and the beneficiary of the process.

3.5 A New Model of Cultural Responsiveness - Foucault's Oscillation

French philosopher and political theorist Michel Foucault (2001) used the term perpetual oscillation to describe that which suspends long linear discourses in the human sciences for the purpose of reflection, and so the authors have called this model Foucault's Oscillation. Reflexivity (see Figure 3.1) means that linear progression is dispensed with and, in contrast to a uni-directional journey of acquired competence, reflexivity is iterative and becomes an interactive dance between the reflexive self and experience. Foucault (2001) described this in terms of a movement or oscillation between the realm of the self and the realm of the other where there is an authentic search for understanding and knowledge, and similarly this model, created by the authors, sees a bidirectional movement between the reflexive self and experience. Previous models have mostly featured a hierarchy of importance or achievement or competence. This model depicts no point at which the individual has arrived at the endpoint or summit. The model is not binary and an individual in this model can be in more than one of the domains or experiences (depicted as bi-directional arrows) at the same time.

The model also makes clear the central role of the reflexive self that is the driving force behind what takes place. The domains or experiences (Table 3.1) were derived from a search of the literature, in the form of a concept analysis (Rodgers, 2000), which sought to define the components of what comprise cultural responsiveness (Smith et al., 2021b). Although this list cannot claim to be exhaustive it nonetheless reflects current research and authorship, within the Australian context. The domains in Table 3.1 are unlike most other models, in that they are dimensional not categorical, enabling practitioners to self-assess, and to understand where they have strengths or struggles and reminding them that skill levels are subject to change and are not fixed. This aspect of the model is crucial to understanding that when working with Indigenous people the social and emotional needs will vary from one context to another. There is no single definition of what it means to be Indigenous in Australia and cultural respect is about understanding and respecting diversity of Indigenous peoples and communities (IAHA, 2019).

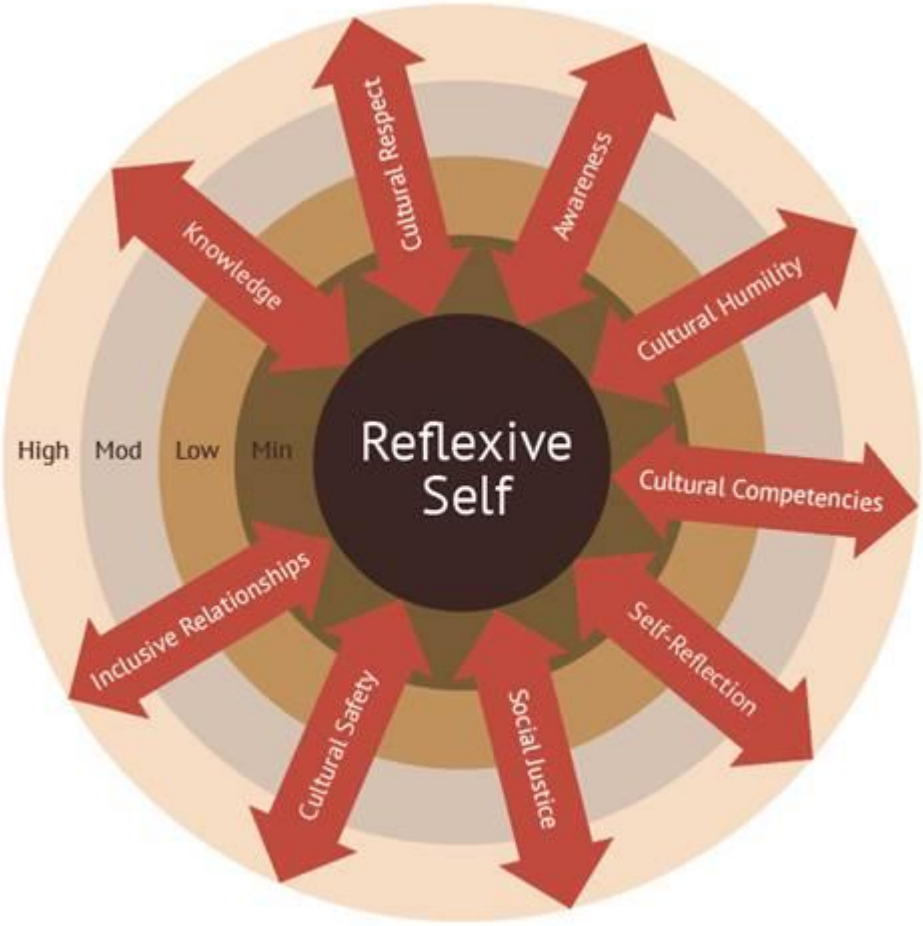

Figure 3.1. Foucault's Oscillation (Smith, Rice, Schutte & Usher, 2021a)

Table 3.1. Domains of Cultural Responsiveness

Awareness:
Awareness describes a process where one comes to an understanding and knowledge of how personal and wider societal beliefs, attitudes and behaviours can impact on others.

Cultural Competencies:
These are the skills and interventions of the culturally responsive practitioner. They may include use of culturally appropriate assessment instruments, tests, culturally based programs, or therapeutic modalities. Competencies could also include skills in engaging a cultural mentor or a traditional healer.

Cultural Humility:
Cultural Humility describes the capacity to step out of one's own cultural perspective to understand the cultural background of others. It is other-oriented rather than self-focused and suspends any notion of personal superiority of worldview, values, and beliefs. The therapist who is culturally humble has a deeper awareness of deficits in knowledge leading to greater efforts to build that knowledge, in ways that become more attuned to the client. (Hook et al., 2013)

Cultural Respect:
Cultural respect involves respect for beliefs and cultural heritage. It requires the practitioner to practise reflexivity to understand the dynamics of cultural respect and what needs to change. It includes respect for Indigenous values and structures such as the place of Elders, the meaning of a collectivist culture and Indigenous governance as well as Indigenous ways of knowing, doing and being. (Minnican & O'Toole, 2020; Genat et al., 2016)

Cultural Safety:
Consists of a process of self-reflection by practitioners about power relationships and clients' rights. It must be more than a reflection on clinical practice but must encompass a true reflection on one's own identity, often with its legacy of inherited privilege and power.

Inclusive Relationships:
Inclusive relationships engage in an equal and open dialogue. They take note of the systems within which we all function and interact, and how those systems shape our personal points of view and core values. The overall implication is that empowerment of Indigenous individuals and communities and working more collaboratively are core elements. (Bennett & Gates, 2019)

Knowledge:
The concept of knowledge describes formal and informal learning and self-knowledge, or insight, in the sense of understanding oneself better and developing new ways of knowing. It is a descriptor for knowledge of self and how one impacts others in terms of one's own values. (Bennett & Gates, 2019)

Self-Reflection:
This refers to a genuine self/other awareness that is honest, transparent, and non-judgemental and involves critical evaluation of one's practice. It involves awareness of power and privilege and the ways that these have disadvantaged Indigenous people in the past and present. (Bennett and Gates, 2019; Minnican & O'Toole, 2020; Bennett et al., 2018)

Social Justice/Human Rights:
This involves responding in appropriate ways to the issues and needs of communities and families which in turn promotes intergenerational healing. It also involves the process of decolonising mental health and understanding how research, intervention and assessment in the past have disadvantaged Indigenous people and only served the purposes of the non-Indigenous society. (Bennett et al., 2018; Genat et al., 2016; Carey et al., 2017).

(Smith, Rice, Schutte & Usher, 2021a)

3.6 Importance of a model of Cultural Responsiveness

The model presents the dynamic of cultural responsiveness, and the domains provide the roadmap of how one can become more culturally responsive. From a teaching and learning perspective it presents epistemological, axiological, and ontological frameworks to inform course content for students and to develop professional practice that can lead to better outcomes. For example, the domain of Inclusive Relationships could offer both students and practitioners the opportunity of working with Indigenous practitioners or within Indigenous communities or Indigenous services. This could lead to improved collaboration as well as to providing valuable learning. The domain of Social Justice/Human Rights could be the challenge needed for institutions to include within curricula new subject areas such as Indigenous Psychology, Critical Theory or Liberation Psychology. The domains of Cultural Respect and Cultural Humility offer a range of possibilities for institutions to utilise local Indigenous knowledge and to learn from Elders and Traditional Owners within programmes of study. For individuals these two domains are about "listening more and talking less; following more and steering less; collaborating more and commanding less" as promised in the APS apology (Carey, et al., 2017). Cultural safety is related to both respect and humility, but it ensures that practitioners are working with Indigenous clients in ways of effective, quality care that suit clients' needs and are free of racism and any of the values that support power and superiority. (IAHA, 2019). Reflexivity, at the centre of this model, enables practitioners to position themselves within the model in order to genuinely face what personal challenges and questions the domains present and to avoid an *attainment* mentality of having arrived at some end point where nothing more is required. Reflexivity also removes practitioners from being the experts with the power, and it positions them in a space to learn with genuine humility (Wilson, 2014).

The cultural responsiveness model provides the opportunity to inform the content and curricula of what universities offer at undergraduate and postgraduate levels. The model promises to be a useful tool and if successfully adopted in Australia could assist mental health professionals who are working with local Indigenous people in other countries especially where these people have been impacted by colonial cultures. Such a move would require further exploration as to local suitability. However, a strength in this model is that it is less about the acquisition of local specific skills and knowledge to be acquired than it is about

who the professional is within the context of the work that is undertaken, and this offers new perspectives for mental health professionals working within a wide variety of contexts. As a learning paradigm it favours a constructivist experiential model where Eurocentric epistemologies are put on hold and the practitioner becomes open to learn from the richness of Indigenous Knowledge Systems.

3.7 Conclusion

The apology by the Australian Psychological Society in 2016 was a watershed moment in the history of this country, the mental health profession, and Indigenous people. It was not only an acknowledgement of the wrongs of the past, but it also forged a commitment for the future. Cultural responsiveness and the model described in this paper offer a way to now move forward into that future and to close the gap in mental health. The model of cultural responsiveness enables practitioners to adopt a dynamic process that can assist in working with Indigenous clients and that also offers ongoing assessment for both students and practitioners. Culturally responsive mental health practices will lead to better access by Indigenous people which must in turn reduce the mental health burden for Indigenous people and for Indigenous communities.

Importance of Cultural Responsiveness

The new model has significance for cultural responsiveness training designed to assist therapists to deliver best practice and, culturally informed treatment of Aboriginal and Torres Strait Islander people. Many of these clients in the past have rarely accessed Western therapy services, which are for the most part focussed on treatment of presenting symptoms within a medical model and are most often not holistic. This group suffers mental illness at higher rates than the wider community and has a suicide rate that is double that of the rest of the Australian population (Silburn et al., 2014). Developing culturally responsive practice prepares therapists who will work with Indigenous clients to help reduce elevations of psychopathology that have proven to be a gap in the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people when compared to the wider population.

More broadly, the cultural responsiveness model will also inform the content and quality of Indigenous-content courses delivered by universities whose graduates will be working with Indigenous clients. For schools of psychology, for example, course content

would follow the recommendations of the Australian Indigenous Psychology Education Project (AIPEP, 2019). These seek to embed and integrate Indigenous studies in psychology for all students, and for staff to teach relevant material that will prepare students to work within a culturally responsive framework. The Australian Psychology Accreditation Council is responsible for developing standards for the education and training of psychologists within Australia. In its Accreditation Standards for Psychology Programs (APAC, 2019), it states that cultural responsiveness must be included as a core competency for all four levels of qualification for students and practitioners. Additionally, within all Specialised Areas of Practice it has clearly stated that culturally responsive assessment and culturally responsive interventions must inform professional practice. However, within the Glossary of Accreditation Standards of this document, the term cultural responsiveness is not included and is therefore not defined so clarity of definition becomes an urgent priority. The Psychology Board of Australia is responsible for the professional registration of psychologists and its National Psychology Examination includes as one of the eight competencies for examination: Working in cross-cultural contexts, including Aboriginal and Torres Strait Islander issues (APS, 2011).

This now turns the focus onto all Australian universities which will need to include within their respective Reconciliation Action Plans (RAPs) cultural responsiveness training as a core competency for all students and staff. This new conceptual model makes clearer what is required of mental health practitioners for best outcomes for Aboriginal and Torres Strait Islander Australians, by placing reflexivity at the centre of all action.

A Definition of Cultural Responsiveness

Cultural responsiveness for practitioners is a recursive process that sets reflexivity at the centre of a dynamic and ongoing movement where the reflexive self, initiates exploration into the domains of learning, experience, and discovery for best outcomes for Indigenous people.

3.8 Summary

A culturally responsive mental health workforce will help to decolonise psychology by giving a place to Indigenous epistemologies and worldviews as well as to Indigenous Australians who for generations have not had a voice in determining the circumstances of their own lives. Within this model, mental health practitioners step outside of their own cultural perspectives, by entering the space of the reflexive self, viewing the culture of others through Indigenous

knowledge systems, and genuinely understanding how power has brought about disadvantage and how Eurocentric narratives have dominated and have determined people's lives.

The apology by the Australian Psychological Society in 2016 was a watershed moment in the history of our country, its Indigenous people, and our profession. It was not only an acknowledgement of the wrongs of the past, but it also forged a commitment for the future. Cultural responsiveness and the model described in this paper offer a way to now move forward into that future and to close the gap in mental health. This chapter has provided a clearer definition of cultural responsiveness and gives a means to achieve that for those wishing to work with Aboriginal and Torres Strait Islander mental health clients.

In the following chapter a qualitative study is described in which Aboriginal and Torres Strait Islander clients are given the opportunity to share their experiences of treatment by mental health professionals and to state in their own words what cultural responsiveness means for them.

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Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF ORIGINALITY

(to appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate, and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	**Page number(s)**
All, aside from contributions by other authors listed in the form below	

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10/10/2023

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11/10/2023

Principal Supervisor Date

Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

	Author's Name (please print clearly)	**% of contribution**
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11/10/2023

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Chapter 4. A Qualitative Study: Listening to People's Voices (Winanga-Li)

"We would like people in Australia to take time to listen to us. We are hoping people will come closer. We keep on longing for the things that we have always hoped for - respect and understanding…"

(Dadirri, by Miriam-Rose Ungunmerr-Baumann, Daly River, NT)

Chapter two introduced the reader to the concept of cultural responsiveness and the meaning as defined within the literature. A conceptual model was presented in chapter three to assist practitioners in their understanding to better inform their interventions. Chapter four is about listening to Indigenous people and what they consider to be culturally responsive mental health practice and whether their experiences match what has been found in the literature. The following was submitted for publication as:

Smith, P., Rice, K., Schutte, N., & Usher, K. (2023). Cultural responsiveness in mental health care; listening to the voices of Australian Indigenous people: a qualitative study. *Qualitative Health Research* (Submitted manuscript; 1st Quartile, Impact Factor 3.2)

4.1 Abstract

This qualitative study, set out to understand the meaning and construct of cultural responsiveness from the perspective of Indigenous Australians. Based on a previously derived literature review and conceptual model, cultural responsiveness comprised nine domains of Knowledge, Awareness, Cultural Humility, Cultural Safety, Cultural Competencies, Inclusive Relationships, Cultural Respect, Social Justice/Human Rights, and Reflexivity. This study adopted an Aboriginal Participatory Action Research strategy, which took the unique approach of interviewing Aboriginal and/or Torres Strait Islander former clients of mental health practitioners. Using a semi-structured interview based on the domains of a conceptual model of cultural responsiveness, data was collected and reviewed to determine whether these domains were supported by the participants and/or whether any new themes/domains emerged. Participants were interviewed using an online platform (N=11) and face-to-face

(*N*=1) and their responses supported the construct of cultural responsiveness derived from the literature, in some cases extending the meaning of domains. Participants frequently described their experiences in mental health as culturally unsafe, alienating and distressing, and reported that therapist cultural awareness and knowledge, especially self-knowledge were often lacking. Based on deductive analysis of participant perspectives and experiences, all domains of the model were retained. This study extends and clarifies the description and meaning of domains of cultural responsiveness. Implications for mental health practice involving Indigenous clients are also discussed.

Keywords

Australian, Cultural Responsiveness, Aboriginal and Torres Strait Islander, Indigenous, Qualitative Research

4.2 Background

This study enabled the voices of Indigenous people to be heard through a series of interviews within a qualitative methodology undertaken to explore cultural responsiveness from the perspective of the mental health client. It set out to work collaboratively with Aboriginal and Torres Strait Islander people in ways that honour and respect their traditions and knowledges to bring about genuine partnerships and self-determination (Dudgeon et al., 2020). The importance of this study, which also produced published work on the meaning and healing aspects of Indigenous spirituality (Smith et al., 2023), is grounded in the understanding that there has been a dearth of work that has given voice to Indigenous Australian clients concerning their experiences within mental health services (Bhui et al., 2007; Bennett & Gates, 2019). The term Indigenous is used respectfully within this article as a term to identify both Aboriginal and Torres Strait Islander people who are Australia's First Nations people.

A previous literature review (Smith et al. 2021), found limited sources within published literature that provide a definition of cultural responsiveness, suggesting an assumption that meaning is self-evident not requiring elucidation. Indigenous Allied Health Australia (IAHA, 2019) defines cultural responsiveness as cultural safety that is determined by the recipient and based on practitioner knowledge, and a process of negotiation that works

in partnership with Indigenous leadership. Other scholars have incorporatd reflection of the power and privilege of settler culture, while challenging previously held assumptions, and the systems in which we all live and interact (Bennett & Gates, 2019). Cultural responsiveness affirms cultural identities that are determined through inclusive relationships (O'Keefe et al., 2019) and through reflexivity (Havelka, 2017; Bennett, Coghlan et al., 2018) develops a sense of the other in terms of awareness, knowledge, trust, respect, and honesty that suspends judgement of the other's culture (Minnican & O'Toole, 2020). Dudgeon, Bray et al., (2020) consider that cultural responsiveness is about reconnecting at-risk individuals to their core values and systems of healing, promoting cultural safety as being informed by Indigenous ways of knowing, doing and being that eliminate racism and prejudiced stereotypical thinking.

Based on the concept analysis by Smith et al. (2021), a conceptual model of cultural responsiveness was developed from the literature. This model, called Foucault's Oscillation (Smith et al., 2022, p.3,) is set out in Figure 4.1 and is comprised of the following:

- Knowledge of Indigenous people and of oneself.
- Collaborative or Inclusive Relationships.
- Cultural Respect.
- Social Justice/Human Rights.
- Reflexivity.
- Awareness
- Cultural Safety
- Cultural Humility
- Cultural Competencies

The present study sought to interrogate and validate the elements of this model through the perspective of Indigenous Australians and hear the voices and stories of those for whom culturally responsive mental health practice is a priority.

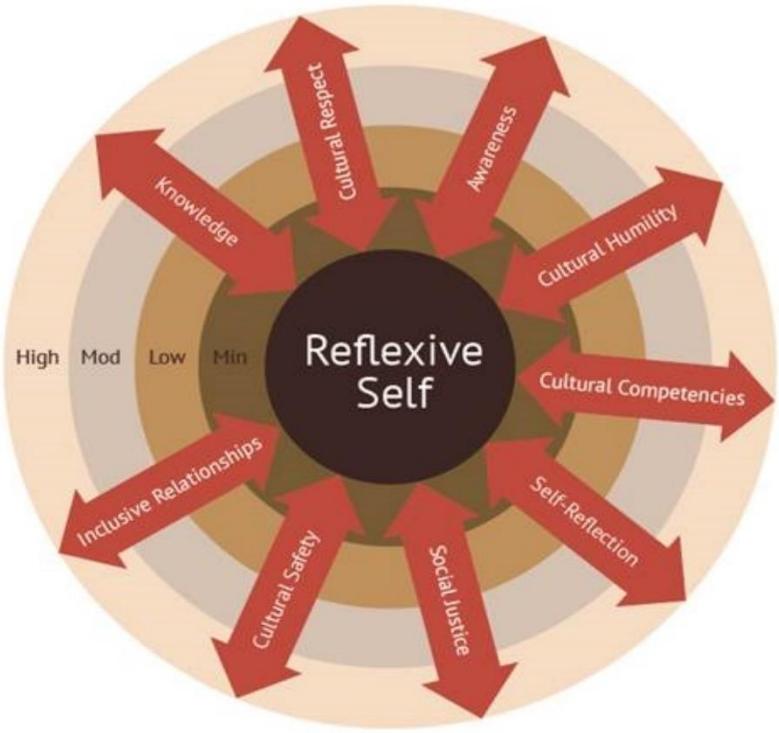

Figure 4.1. Cultural Responsiveness – Foucault's Oscillation (Smith et al., 2022)

Indigenous Standpoint Theory

Indigenous Standpoint Theory (IST) (Dudgeon et al., 2020) adopts a critical approach in respect of research and methodologies that are undertaken by, with and for Indigenous people. It requires a process of reflexivity on the part of the researcher to understand the perspectives of Indigenous people and to understand how power can determine outcomes and influence how people with less power behave and respond. The role of IST is to transform that power into ways that prioritise and change the prevailing narrative into one which listens to the voices of Indigenous people and empowers them to come forward and to speak with openness and candour (Dudgeon, et al., 2022). IST facilitates the expression and learning of Indigenous knowledge systems by allowing Indigenous people to speak for and of themselves (Evans, et al., 2014) through the historical, geographical, and spiritual lenses of culture (Latulippe, 2015). Indigenous knowledge has traditionally been transmitted orally so the spoken word is of prime importance and the first role of the researcher is to listen.

Aboriginal Participatory Action Research

Aboriginal Participatory Action Research (APAR) (Dudgeon et al., 2020b) is critically self-reflexive, transformative, and aligns with Indigenous guidelines of self-determination as set out in the Ways Forward Report (Swan & Raphael, 1995). It is informed by Indigenous Standpoint Theory which has been shaped by at least two decades of consultation between researchers and Elders and community members (Moreton-Robinson, 2004).

The importance of Indigenous voices in this study has been at the forefront of considerations since the development of this research, and this is fundamental to Indigenous Standpoint Theory and Aboriginal Participatory Action Research. There has been a long history across several disciplines of research done with Indigenous people that have produced little or no outcomes for them, leading to disempowerment and further alienation (Nicholls, 2009; Walter, 2016). APAR is a research strategy that aims to benefit the researched as well as being a decolonising, strength-based, action-oriented approach that is informed by the participants so that those being helped determine the outcome of their own research (Dudgeon et al., 2020b). Such measures of empowerment for Indigenous people also benefit the non-Indigenous population who can learn from ancient wisdom and be liberated from their previous roles of asserting authority and control by reappraising and moving away from dehumanizing modes of action (Freire, 1971). A process of consultation with a local Aboriginal Advisory Group (AAG) and local Aboriginal Elders was essential throughout this research, to respect and be guided by Indigenous wisdom. The first author, who is an Aboriginal psychologist and a descendant of the Gamilaroi Nation, also had regular contact with key Indigenous health services and personnel throughout the research process. He also consulted with Gamilaroi Elders when the COVID pandemic put limits on meetings of the AAG. These advisory meetings were important to ensure that appropriate cultural protocols were always maintained and that participants were interviewed within a culturally safe environment. Furthermore, this research, was approved by both the university Human Research Ethics Committee and the Aboriginal Health and Medical Research Council.

4.3 Method

A hypothetico-deductive approach (Sprenger, 2011; Nola, 2007) was adopted in this research as it makes use of extant literature as a base and a point of departure, producing testable

research propositions that more easily enable findings to be replicated compared to those produced with inductive methods (Pearse, 2021). It is a deductive *a priori* qualitative approach that is more explanatory and confirmatory rather than exploratory and descriptive (Yin, 2014), and in this research, was used to confirm the elements of cultural responsiveness found in the literature. It was selected as the preferred methodology as it enabled the researchers to delve deeper into cultural responsiveness by interviewing clients and seeking their understanding of the proposed constructs. Ethics approval for this study was granted by Aboriginal Health and Medical Research Council (AH&MRC) to facilitate the voice of Indigenous people in what they consider is culturally responsive mental health care. The questions and themes in the semi-structured interview were assembled *a priori* based on the pre-existing conceptual model of cultural responsiveness derived from the literature (Smith et al., 2022). The responses from participant interviews (*N*=12) were a means of testing the hypothetical literature definition and the proposed conceptual model for their rigour and consistency and to test the literature's predictive power (Sprenger, 2011).

In addition, at the beginning of the interview, *a posteriori,* participants were given the opportunity to express in general, what the therapy experience meant for them and at the end what therapists could do to be more culturally responsive (results specified in Final Comments below).

Participants and recruitment

The first author is a practitioner and researcher, so it was important at the outset to confirm that participants had not been clients of the first author, to avoid any conflicts of interest. Consent forms were signed by participants prior to each interview (Appendix V). Semi-structured interviews were conducted, and participants had the choice of face-to-face or an electronic platform with visual capability on computer, or telephone. In addition to these twelve participants, a further six people initially indicated that they were prepared to be interviewed but withdrew prior to interview. Of those who withdrew, one was recovering from COVID, another changed his mind, and another cited unspecified personal reasons for deciding not to proceed. The remaining three failed to attend and gave no reason. Ultimately the challenges of acquiring a qualitative study sample must be met pragmatically whereby sample size will often be determined by who wishes to be included (Smith, 2011).

Participants were informed of the study through flyers (Appendix IV) which were distributed through local healthcare services, university Aboriginal student centres, and professional networks of the first author. Prior to interview interested persons were contacted by email to provide opportunity for questions and to distribute more detailed information (Appendix III) and consent forms for the study. A richness of experience was sought through this qualitative study, to expand understanding of this concept, rather than quantity of data. As such, representative random sampling of a population was not appropriate or feasible (Polkinghorne, 2005), and purposive sampling was selected (Black, 2010; Malterud et al., 2016). Twelve participants who identified as Aboriginal and/or Torres Strait Islander were interviewed, who were at least 18 years of age and had previously participated in at least one session of therapy with a mental health professional

Data Collection

Of the twelve participants interviewed (Table 4.1), one participant chose to be interviewed face-to-face in the researcher's workplace, while the eleven remaining participants were interviewed through the online platform. The first author also personally transcribed the interviews on the same day, as a way of becoming more familiar with and immersed in the data. This provided an opportunity for further analysis of content as well as to learn whether any non-verbal data had been overlooked (Smith & Sparkes, 2016). Interviews lasted approximately thirty minutes, and participants were subsequently contacted to ensure that issues had not arisen that might be a source of ongoing distress, and they were sent a copy of the transcript to seek confirmation that it was an accurate record of the interview. No participants requested any amendments.

Table 4.1. Participant Demographics (*N*=12)

Pseudonym (Nation/Tribe)	Age	Gender	Treating Mental Health Professional
Emma (Bundjalung)	18-29	Female	School Counsellor (non-Indigenous)
Euphemia (Gamilaraay)	70+	Female	Psychologist (non-Indigenous)
Jill (Kooma)	30-49	Female	Clinical Psychologist (non-Indigenous)
Julie (Darug)	50-69	Female	Psychiatrist (non-Indigenous)
Mary (Kamilaroi/Darkinjung)	50-69	Female	Psychologist (non-Indigenous)
Nanna (Kabi Kabi)	50-69	Female	Psychologist (non-Indigenous)
PJ (Kija)	30-49	Female	Clinical Psychologist (non-Indigenous)
Ray (Bundjalung)	30-49	Male	Psychologist (non-Indigenous)
Renee (unspecified)	30-49	Female	Psychologist (non-Indigenous)
Rose (Trawlwoolway)	30-49	Female	Psychologist (non-Indigenous)
Sarah (Anaiwan)	30-49	Female	Psychologist (non-Indigenous)
Vicki (Gamilaroi/Wiradjuri)	30-49	Female	Psychologist (non-Indigenous)

The semi-structured interview guide for data collection (Appendix II) consisted of three sections. Part A was an introductory section which sought confirmation from the participants that they understood the purpose of the study and what was being asked of them. It also confirmed that they understood the terms of consent, had read and signed the consent form, and were willing to proceed with the interview. At this point they also were asked to choose a pseudonym for themselves which was described as an interview name. Part B was the demographics section which sought to confirm that they identified as Aboriginal and/or Torres Strait Islander, whether they had nation, tribe, or clan affiliation, which is sometimes referred to colloquially as mob, whether they had been clients of a mental health practitioner and whether the practitioner had identified to them any Indigenous status. Age cohort and gender identity was also asked within this section.

Part C represented the main body of the interview and began with an open-ended question inviting participants to describe their overall personal experience with sessions with a mental health practitioner and their general impressions. Questions following from this were

based on the nine domains of the conceptual model of cultural responsiveness (Smith et al., 2022) and sought to elicit responses to explore the domains of the model in an *a priori* hypothesis, and as to whether this hypothesis, derived from the literature, was supported (Sprenger, 2011; Pearse, 2021; Yin, 2014).

At the conclusion of the interviews, each participant was asked whether there was anything further that they would like to add or that they could think of that a clinician could do to be more culturally responsive. Interview questions are included in Appendix II and responses to this open-ended question are presented below in the 'Final Comments' section.

Data Analysis

It was important to become familiar with the data, and repeated immersion in both the audio recordings and the written transcripts was an important first step in the analysis process. This immersion enables the researcher to become familiar with the data in its entirety and helps to reveal concepts in their contexts (Bradley et al., 2007).

The twelve participants who took part in this study were interviewed based on the themes of the definition of cultural responsiveness which emerged from the literature. Accordingly, thematic analysis (Braun & Clarke, 2006), which is often employed in qualitative methodology, was not a primary strategy, because the main aim in analysing the interview content was to see whether responses from participants confirmed what had already been found in the literature; thus, in respect of taxonomy, the conceptual domains were already coded as themes from the literature review (Smith et al., 2021). This is also referred to as thematically driven coding which uses theory as its foundation and departure point (Boyatzis, 1998). The fourth author also undertook the analysis separately from the first author to ensure the trustworthiness of the data.

In addition, detailed and repeated analysis of both audio recordings and printed transcripts sought to uncover any additional themes beyond those which guided the semi-structured interviews. Such analyses also provided the opportunity to observe any additional themes that were not identified in the literature. This approach ensured that participant experience was given primary importance and served as a triangulation for meaning of the concepts being explored. It also served to minimise any researcher bias such as looking only for a predetermined outcome (Braun & Clarke, 2006).

Participants were initially invited to answer a general question about their experience:

> *You have indicated that you attended session(s) with a mental health practitioner. Can you describe for me that experience in your own words?*

4.4 Results

Participants' responses demonstrated a broad range of experiences and responses that are presented in Table 4.2. A synthesis of responses indicated that Knowledge, Awareness, Cultural Safety and Cultural Humility domains were rated as highly important by all participants. Further detailed description, including the voices of participants and analyses are presented in the Discussion section.

Table 4.2. Participant Brief Descriptions of sessions with therapist

Pseudonym	Description
Emma	I found it a bit tense. Maybe because it was at school, I didn't get too much from it.
Euphemia	Initially I was a bit scared having to go and talk about my personal issues.
Jill	I felt that I often had to explain a lot of cultural and family elements and how they impacted on the presenting concern that I had.
Julie	To sum up in one word would've been traumatic. It caused me actually more harm than good.
Mary	I think to sum it up, it was traumatic.
Nanna	I can't say it wasn't helpful, it was specific. I mean the problem was overwhelming for her.
PJ	In respect of my Aboriginality she encouraged me, and she encouraged me to go to Country.
Ray	It was daunting. I was very scared. I guess a fear of judgement.
Renee	It was helpful. Yeah, it was helpful. That's probably the best way to describe it.
Rose	I did get some stuff out of it which was positive but not an outcome I would've liked.
Sarah	It was a bit intimidating but after a few sessions I relaxed a lot more.
Vicki	It wasn't very helpful, quite judgemental.

Table 4.3 lists the domains of the model, and the percent of the participants who identified each domain as comprising culturally responsive mental health practice. The purpose here was not to determine whether individual practitioners had practised or

demonstrated evidence of each domain, but instead whether these domains were of importance to participants, and how they identified and defined them.

Table 4.3. The Domains of Cultural Responsiveness

Domain	Participants identifying importance
Knowledge	100%
Awareness	100%
Inclusive Relationships	64%
Cultural Respect	91%
Cultural Safety	100%
Social Justice & Human Rights	64%
Self-Reflection	91%
Cultural Humility	100%
Cultural Competencies	55%

As presented in Table 4.3, Knowledge, Awareness, Cultural Safety and Cultural Humility were identified by all participants, followed by Cultural Respect and Self-Reflection. Inclusive Relationships and Social Justice & Human Rights were identified by fewer participants, while Cultural Competencies, which relates to specific interventions and skills, was identified by the least number. However, most participants rated all the domains of the model as important. The following sections present the voices of participants through quotes relevant to the domains.

Knowledge

The domain of knowledge refers to formal and informal learning, and includes self-knowledge, or insight, in the sense of understanding oneself better and developing new ways of knowing (Bennett & Gates, 2019). Every participant (N=12) identified knowledge as an essential component of cultural responsiveness, but knowledge for them concerned an expectation that therapists would understand them better on a personal level and be better informed about specific needs related to culture and the impact of historical events.

He did ask me a little bit about my background, and I told him that I was Aboriginal and that my family was part of the Stolen Generation, and he told me I just needed to get over it. That that's what it was, and you can't change that so move on. That's not an excuse. But he did also reiterate that that was probably why I was an addict because you're more susceptible to being an addict if you're Aboriginal. (Julie)

There was no, "Well tell me about that. Explain that to me." There was no desire to understand so she could be of better service to me. There was just "Nup, don't know anything about that. Let's just get on with the bit that I do know about". (Nanna)

For Ray, the need for practitioner knowledge manifest through not having an opportunity to disclose his Indigenous identity that would have been a more holistic approach.

The lack of asking, you know, that focus on what caused me to be there rather than on asking who I am, what makes me me, what's my culture, what's my history, you know, what's my family, what's my mob. That was completely missing. It might make the process a little bit more drawn out, but I'd rather give the person that context so that then I feel as though they know me better. (Ray)

Renee considered that a part of knowledge was for practitioners to recognise the gaps in their own understanding and to allow themselves to learn from their clients.

She was open to the fact that she might not necessarily have access to any cultural insights that might inform our sessions. So, by telling me that she's not Indigenous she was not only making sure that I knew but also having me understand that she is aware that there may be a need for me to have cultural insights that she might not be aware of, or a cultural element of our sessions that she may not be able to participate. (Renee)

Jill noticed that when her therapist sought out further knowledge it made a significant difference to what she was able to get out of sessions.

I think it was just the lack of knowledge that frustrated me….I can't recall if he mentioned how he got that knowledge, but I remember feeling quite supported that he actually did make the effort to go and get that knowledge. (Jill)

Awareness

Awareness was also recognised as an important part of cultural responsiveness by all participants, where knowledge comes to an understanding of how personal beliefs and attitudes can impact on others. Awareness for participants was about empathy, and from Julie's perspective awareness is about listening and having the empathy to understand.

> *I think that therapy and the fact that even though you don't know anything about someone's culture you can still be empathetic to their situation, and you can be willing to listen. You don't have to understand it, but you can listen to it. (Julie)*

Mary and Nanna were brief and to the point.

> *No, I don't think she had any awareness at all. (Mary)*
>
> *No, she tried to dismiss my culture as being irrelevant to what we're doing. (Nanna)*

For Vicki the lack of awareness shown by her mental health practitioner was more overt and was perhaps even a disenfranchising experience.

> *I just thought that her comments were probably like just seemed to be either completely ignorant or not know anything, you know what I mean…… I identified as Aboriginal and like when you tick it or say it like she looks at me as if to say, "You're Aboriginal?" "Well, yeah, so what?" There was nothing. I don't know whether she was racist, or whether she just had no idea.*
>
> *P: Did you get a sense from her that your culture was being dismissed?*
>
> *V: Absolutely. (Vicki)*

Inclusive relationships

Inclusive relationships engage in an equal and open dialogue, and they acknowledge the systems within which we all function and interact, and how those systems shape our personal points of view and core values. Participants were asked if their mental health practitioner had worked co-operatively with family or community and whether that would have been helpful to them. This domain was endorsed by fewer participants and responses tended to reflect this, with some participants preferring not to have family and community support; but as Ray and Vicki expressed, there were other more important relationships than family relationships, such as relationships that are about connection to culture.

The thing that's helping me lately with my depression is that cultural connectedness. ……to me if it was addressed earlier on, I think it would have been more beneficial to my recovery. I think I would have recovered quicker…….. What would have helped me, I think this goes back to my respect for my Elders, would've been calling on my Elders to sort of sit me down, have a yarn and sort of, I think that would have definitely helped. I think they would've understood me more. (Ray)

I think if they had called on an Aboriginal Elder, a person who has an understanding, it would have been beneficial to me because of my history and stuff like that. (Vicki)

Cultural respect

Cultural respect involves respect for beliefs and cultural heritage, for Indigenous values and structures such as the place of Elders, the meaning of a collectivist culture and Indigenous governance as well as Indigenous ways of knowing, doing and being (Minnican & O'Toole, 2020; Genat et al., 2016). Most participants in this study considered that cultural respect was an important aspect of cultural responsiveness, but Rose saw this as understanding the client on a personal level.

I think if they understand you and understand how your mob works and all that kind of stuff, I think things will flow a lot nicer and you'll be a lot more comfortable. Being grounded and stuff like that is important. (Rose)

Cultural safety

Cultural safety evoked strong responses from participants, and it was identified as important by everyone who was interviewed. Within the literature (Curtis et al., 2019) cultural safety involves therapists understanding their place of privilege and power. Cultural safety from a consumer perspective can involve remaining guarded and careful, or measured and even having to walk in two worlds. For Renee being culturally safe is about being cautious and protecting herself from situations of racism.

Throughout my life I've learnt the skills to dance different dances in different worlds …..and while I'm always black, and while I'm always the way I am, in terms of my spiritual well-being and I'm always whole. What I present to others is always measured. (Renee)

For Vicki, from the outset it was clear to her that her therapist held beliefs that could lead to a culturally unsafe environment.

> *Comments like "Oh, you're Aboriginal", doesn't help the situation. To me, straightaway that shows that you either don't like us or you know nothing. You don't want to know, you know? (Vicki)*

Social justice and human rights

This domain is a reminder that therapeutic interventions involve holistic approaches to facilitate social and emotional wellbeing. Social justice and human rights can be viewed in the context of the literature focusing on the place of historical power and privilege and the process of decolonising mental health and understanding how mental health, and especially research, has in the past disadvantaged Indigenous people and only served the purposes of the dominant society (Hook et al., 2013; Genat et al., 2016). Participant responses tended to support this definition and their comments were very personal and reflected deep and long-lasting emotional impacts.

For Euphemia, a retired person who had grown up as a child on a local mission, the abuse of power was very personal and close to her family. She related the following story:

> *They had to get up early and the house was cleaned up by 9 o'clock in the morning every day because the mission manager and his wife would come around and inspect their homes, so I guess when mum and dad come along, and we all come along we always had to be up and be cleaned up because you don't want white fellas comin' and catchin' you dirty. And I still have that with me to this very day. (Laughs). That I've got to get up early and get my house cleaned up before they come around because as mum and dad used to say, "You don't want em sayin, 'ah what if they're dirty blacks'". (Euphemia)*

Julie experienced what appears to have been disadvantage first-hand within her sessions:

> *I think in my opinion, he had a great understanding of power that privileged white men hold, and I think the way he spoke, and he didn't match my words. He spoke from a power imbalance, from a top down using big medical words, and having to feel inferior about asking what he meant. So, to me that was horrendous. (Julie)*

Self-reflection

Self-reflection for mental health practitioners involves a critical evaluation of one's work that is aware and can put in place the changes that are needed to dismantle the structures of power and disadvantage. In working with Aboriginal and Torres Strait Islander people it means spending time over what has been shared in sessions and considering what could be achieved for better outcomes.

Most participants (91%) agreed with the literature that this was an important aspect of cultural responsiveness, but for most, except for three participants, this was something that was absent in their sessions with mental health practitioners.

Julie found that the absence of self-reflection on the part of her mental health practitioner was quite alienating and depersonalising:

> *What I heard him say before each session was: "I just need to read your notes again because I see so many people. I just have to remind myself what we spoke about". (Julie)*

Mary found that what got in the way of self-reflection for her mental health practitioner was a preoccupation with a particular technique that was inappropriate for Mary's situation and for working with Indigenous clients. She also identified a lack of preparedness to learn by listening to the client.

> *One of the things she did keep repeating throughout the session was, oh this is all very complicated. You've got a very complicated family. To you it might be complicated but to an Aboriginal family, not so much. I did not see any instances where she was trying to think through anything other than when she was standing in front of that whiteboard trying to work out the genogram. That was it. (Mary)*

Cultural humility

Cultural humility requires practitioners to step out of their own cultural perspectives to understand the cultural perspective of the client. It is other-oriented and is rid of any notion of cultural superiority. In practical terms it means that practitioners identify deficits in their own knowledge and seek to understand in ways that become more attuned to the client (Hook et al., 2013). In this study participants were asked if they experienced being listened to, if they

got a sense that their mental health practitioner was prepared to learn from them or whether they were spoken down to. Every participant identified cultural humility as an important element of cultural responsiveness, identified in the literature for therapists as a capacity to suspend any notion of superiority to understand the client.

> *I felt inferior, so inferior……He was an expert. He told me he was an expert in his field. (Julie)*

> *So yeah, I would say that I felt listened to for sure and not spoken down to. I think if I had felt that way, I just would have checked out and hopefully tried to find someone else. (PJ)*

> *I think she would've been prepared to learn from me. Yes. I think so. (Renee)*

> *I don't think I was listened to at all or again I did not feel comfortable in speaking because I just felt like I was shut down and I didn't have a say or a voice. (Vicki)*

Cultural competencies

Cultural competencies are the specific skills and interventions that practitioners use in their work with Indigenous clients. For the culturally responsive practitioner these may include culturally informed and validated assessment instruments, or programs and could also include seeking the assistance of a cultural mentor or Elder or healer. This domain of the model received the lowest rating from participants with only 55% identifying it as important, and their responses reflect the view that skills and interventions are more about cultural experiences and relationships, rather than doing therapeutic sessional work, so this domain may overlap with others such as cultural safety, interpersonal relationships and social justice/human rights.

> *Now I am at an Indigenous like health centre and I had like a session before with my counsellor and I found it really good because most of the staff is Indigenous, not that it matters, but it is very inclusive, and I feel like a lot safer. (Emma)*

> *It would have been lovely to have been taken out to a healing ceremony out in the bush with nature in itself. (Euphemia)*

> *But if I was encouraged to speak to my Elders beforehand, I think my recovery would have been much more expedited than it is now. (Ray)*

Nanna, who is also a mental health professional, brought a very different perspective to how she thought practitioners should work with Indigenous clients. She understood the importance of specific interventions, but from her experience as a practitioner she could appreciate that cultural understandings are also important.

> *And if she'd said something simple like: "Get yourself to the beach". I'm a 'saltwater woman'. "Get yourself to the beach. Stand on the beach. Be with friends, you know, connect. If she had any understanding of what makes me better…yeah, the EMDR would work because I love the EMDR and I use it all the time but it's not a fix-all. It's a tool. (Nanna)*

Jill sought out her own cultural guide at the same time as her mental health sessions. She sourced a ngangkari (traditional healer, pronounced *nun-kri*) to help her. This supports the understanding that cultural competencies or interventions for Indigenous people are more about adjunctive relationships rather than specific programs or Indigenous-specific assessments delivered by the practitioner.

> *I sought out some traditional healers through some other colleagues of mine and made that happen myself, and just didn't discuss it in my therapy sessions. It was amazing and then I spent some time at some very special spots, as well, but I've got some connections of local mob who knew of some particular spots that are quite healing themselves. Being able to go to these spots and see the ngangkaris created a lot more healing I think for me. (Jill)*

Final comments from participants

The opportunity for a final general comment elicited strong responses from participants because everyone gave an answer, and in some cases, at great length. This part of the interview was an opportunity to see if any additional themes might emerge that could extend the meaning of the conceptual model and it represented an inductive methodology in contrast to the deductive approach of the preceding part.

Emma emphasised the importance of giving people a voice and how cultural safety is also about the capacity of the practitioner to listen.

> *I think acknowledging that you can talk about it (culture) in this space if you want to. (Emma; Cultural Safety)*

Euphemia offered the reminder that therapy needs to acknowledge the importance and value of community support even in the therapy room.

> *I do know that there are people that like to be able to take others in (to the therapy room). I think that option should be made available right from the very start for those that maybe want to. (Euphemia; Inclusive Relationships)*

According to Julie culture needs to be discussed and not avoided from the outset.

> *I think it's really important when you start with a new client or patient or whatever they call them, to find out their cultural background because that can have barriers. (Julie; Awareness)*

Mary and Renee said that there are gaps in the training of mental health practitioners that will need to be attended to before interventions can be effective.

> *I think it is important that as part of their training that there is some education around Aboriginal and Torres Strait Islander communities and how people existed and the history of our people and their experiences and then to learn how to put that into practice. (Mary; Knowledge)*

> *I think there's so much potential for non-Indigenous practitioners to have Indigenous knowledge to inform their practice. And I don't think non-Indigenous practitioners understand how much it could really develop them as practitioners, and I think they don't even have the opportunity because they're deprived of that at the very start in terms of tertiary education because there's little Indigenous content in psychology programs, I think there's a general lack of understanding. (Renee; Knowledge)*

Nanna stated that practitioners need to be conscious of their strengths and weaknesses and to understand their personal and professional limits.

I think, look, you have to do your own work and I think that when you're comfortable with yourself, and I mean really comfortable, not just in your head comfortable, but comfortable with yourself, then you know that you don't know, and you know the importance of that and you're honest with that. I'm not asking you to be culturally aware. If you don't like it. If that doesn't sit with you, don't see us. It's that simple. But don't see us and still think that it's not important and try and fix us because that doesn't work. (Nanna; Cultural Respect; Self-Reflection; Cultural Humility)

PJ also spoke of professional limits and the responsibility of practitioners to ensure that they are suitably informed otherwise engagement can be impacted.

I feel like that there isn't enough education out there and if you're not educated in something you're not comfortable in something and if you're not comfortable in something you'll avoid it and unfortunately that just decreases engagement. (PJ; Knowledge)

Ray added that effective practice is more than just knowledge gathering; it is also about finding ways to incorporate knowledge into practice that accords with Indigenous ways.

Just goes back to that cultural awareness, that understanding I think if mental health practitioners took the time to understand Indigenous culture and not treat it as an afterthought and really incorporate Indigenous practices into their treatment, I think that would be amazing. (Ray; Awareness, Cultural Competencies)

Rose reminded us that Australian Indigenous people are not a single homogeneous group and practitioners need to be aware that there are many ways that Indigenous people conduct their lives and need to avoid any stereotyping.

Countries are so big and vast and different so if I was from certain areas men can't speak to women, certain skin groups can't mix, and stuff like that, so they need to understand a bit more in depth about those kinds of things as well. (Rose; Awareness)

Sarah and Vicki both emphasised the need for ongoing professional development for practitioners and Vicki recommended an immersive community experience to develop a sound knowledge base.

> *I guess doing a cultural safe training and like displaying that in your office and saying I have done this, that'll make the person feel just a little bit more comfortable going to a session. (Sarah; Knowledge; Cultural Safety)*

> *I think they all should have some kind of Aboriginal training if they're not Aboriginal and go out to some of our communities and work with our people. (Vicki; Knowledge)*

Jill provided the reminder that health and wellbeing are holistic, and the medical, diagnostic model can be quite inadequate for understanding client issues.

> *Health for us isn't about a diagnostic term or a very narrow formulation. It's about all these factors that impact on us. It's also if my family's well I'm more likely to be well but if they're not well that is going to impact. (Jill; Inclusive Relationships)*

The responses in this final, open-ended, unstructured section of the interviews thematically represented the domains of Knowledge, Awareness, Cultural Safety, Inclusive Relationships, Cultural Humility, Cultural Respect, Cultural Competencies, Self-Reflection, however Social Justice/Human Rights was not mentioned by any of the participants. Also, there were no new emerging overarching themes at this point of the interviews, although listening and giving people a voice was mentioned by several participants as being an important feature of Cultural Humility and/or perhaps Cultural Competencies.

4.5 Discussion

This study, as Aboriginal Participatory Action Research, set out to hear the voices of Indigenous Australians and to observe whether their responses provided confirmatory data for the definitions of the proposed model of cultural responsiveness set out in the literature (Smith et al., 2022). The purpose of this study was to seek from participants a clearer understanding of the overarching construct of cultural responsiveness, and from their

experiences as clients of mental health practitioners whether they also saw the importance of the elements or domains of the conceptual model.

Based on participant responses, some definitions of domains were extended beyond those definitions found in the literature. Knowledge, which was identified by every participant, was seen as more than simple acquisition of information, in a formal sense, but rather as understanding the client on a personal level. Participants agreed that therapist self-knowledge or insight was also essential. They expressed the need for genuine knowledge with a decolonising lens and an understanding of who clients are, and who therapists are in respect of their clients (Kilcullen, et al., 2018; Nakata, 2007). This was a key message, and it was frequently stated by participants that practitioners must take the time to ask their clients about their cultural connection, to learn, and to take the time also to listen.

Inclusive relationships were an outstanding feature of the participant responses, not just because they were identified as being important, but also because participants commented that this was noticeably absent from their sessions. Notably, participants reported that among the mental health practitioners they saw, there was not a clear understanding of either the meaning or the importance of inclusive relationships. Participants made it clear during interviews that many of their significant relationships were not familial, and in some cases were not even immediately communal. For example, Mary's experience of watching her therapist struggle with a whiteboard trying to create a genogram is a reminder that for Indigenous people the most significant relationships can be outside of family and community, and within what could best be described as cultural relationships. The message from this is that much care needs to be taken in how the domain of inclusive relationships is defined in this model and applied in practice.

Cultural safety, which previous research (Kendall & Barnett, 2015; Fredericks, 2010) has identified as an essential part of health services for Indigenous people and which provided a significant impetus to this study, emerged as an important theme mentioned by every participant. The place of power and privilege defined in the literature comes with the note of caution from participants that racism can lurk within and may explain why many Indigenous people are avoiding mental health services and perhaps health services in general.

The domain of cultural competencies was for participants not so much about interventions and skills as described in the literature, but about listening at a deeper level and

understanding that for some, the most important intervention may be for a practitioner to ask the client to identify cultural connections that may be meaningful for them, such as a return to Country or some special sacred place, as described by participants to provide healing and renewal. Cultural competencies include involvement of Elders and traditional healers, which could also possibly reflect the domain of inclusive relationships.

Additional issues are highlighted from these findings, beyond the immediate aim of this research. Many participants reported finding therapy culturally unsafe, to be an alienating and even distressing experience, and it would also appear that some of the participants experienced racism and discriminatory treatment where their culture was either ignored or dismissed. These findings demonstrate an urgent need for culturally responsive mental health practice with Aboriginal and Torres Strait Islander people and participants emphasised the need for cultural responsiveness training for practitioners and students, a suggestion that has also been represented in literature (e.g., Bennett et al., 2018). The alternative could be a failure of both duty of care and the responsibility to do no harm. An additional message from participants was that mental health practitioners need to be more aware of their limits of competence (also a professional and ethical obligation), and to adopt an approach responding to individual need.

The domains of the cultural responsiveness model (Smith et al., 2022) offer a foundation for research and mental health practice with Indigenous people in any part of the world. In other cultures, these domains could be contextualised with supplementary elements reflecting local cultural and situational contexts. Future research could also consider an ethnographic approach that is immersive, observational, localised, and reflective of individual communities (Strudwick, 2021).

Cultural responsiveness needs to be universally incorporated into training for mental health practitioners. Methods of assessing cultural responsiveness in practice are also needed to facilitate practitioner engagement in self-reflection and self-assessment to improve the effectiveness of their work with Indigenous clients.

4.6 Conclusion

This study was undertaken to determine whether the constructs of the model of cultural responsiveness would be supported by the responses from participants. Interviews confirmed

the domains, extended their meanings from those previously represented in the literature, and emphasised the importance of some domains more than others. The clear messages from participants were that mental health services need to be delivered in ways that better acknowledge culture, that practitioners are aware of the power that they possess in the therapeutic relationship, and that they must allow clients to have a voice that is listened to and understood.

The study has shown that Aboriginal Participatory Action Research is a transformative and necessary part of research with Aboriginal and Torres Strait Islander people. Their voices are needed to fully understand cultural responsiveness and to prevent disempowerment through imposing other models of healthcare. This study set out to listen and to understand, and mental health practitioners need to apply that perspective to ensure that their efforts are inclusive and aware with the knowledge to inform culturally responsive practice.

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Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF ORIGINALITY

(to appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate, and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	**Page number(s)**
All, aside from contributions by other authors listed in the form below	

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10/10/2023

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[redacted]

11/10/2023

Principal Supervisor Date

Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

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11/10/2023

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Chapter 5. Spirituality for Aboriginal and Torres Strait Islander Australians: (Dhuwi)

"The ancient spirits are all around us. They awaken from their slumber when someone is willing to listen. They have many messages. To hear them, the student must be quiet in mind, body and spirit, for profound truth does not need to be yelled. In this sacred space of quiet whispers, reflection can take place and the earth breathes more easily."

(Paul Callaghan, Worimi Nation)

Chapter 4 emphasised the importance of listening to the voices of Aboriginal and Torres Strait Islander people. Responses helped us to better understand this construct of cultural responsiveness and to inform us whether themes from the literature and the domains of the conceptual model were consistent with what people were telling us. An important message that emerged from the interviews was that spirituality forms a central place in the lives of people and as clients of mental health practitioners they are telling us that they want this acknowledged when they engage with therapists. The Gamilaroi word for spirit is *dhuwi* and it permeates every aspect of the lives of Indigenous people and forms a major part of their social and emotional wellbeing. This chapter which describes spirituality is included here because it is not only important to Indigenous clients it is also crucial that it is understood by mental health professionals and is not put aside as too difficult or too esoteric to be given any serious consideration. The following was published as:

Smith, P., Rice, K., Schutte, N., & Usher, K. (2023). Healing through meaning as an aspect of spirituality for Indigenous Australians: A qualitative study. *AlterNative: An International Journal of Indigenous Peoples.* 16(3), 626-634. https://doi.org/10.1177/11771801231193169 (1st Quartile, Impact Factor 1.9)

5.1 Abstract

The spirituality of Indigenous Australians is described in this study, showing its distinctness from mainstream religion, and its importance for social and emotional wellbeing. Connection and identity in the literature are defining elements in the spirituality of Indigenous people and this study set out to understand how connections contribute to meaning and healing. Guided by a semi-structured interview Indigenous spirituality was explored in terms of both meaning and importance. Four primary themes emerged from the interview data which described the

importance of connection: to ancestors, family, Country, and belief in God. There were also two sub-themes: nature and interior reality. Although spirituality was centred around these primary themes, for many Indigenous Australians there has been an amalgamation of traditional beliefs with mainstream religion that reflects the history of colonialism. Participants emphasised the importance for mental health practitioners to acknowledge clients' spirituality and to consider its importance within the therapeutic setting.

Keywords
Australian, healing, Indigenous, spirituality

5.2 Introduction

During the late eighteenth century Australia was colonised by the British based on the false notion that this Great South Land was terra nullius, a land of no people, and that it was simply there for the taking. As if to confirm this position, colonial diarist David Collins in 1798 wrote that the Indigenous people of this land when compared to the other colonies of the empire appeared to have no religion:

> It has been asserted that no country has been discovered where some traces of religion was not to be found. From every observation and enquiry that could be made among these people they appear to be an exception to this opinion. (as cited in Tripcony, 2007, p. 1)

There was also no understanding of the complexity of Aboriginal society and its structures or that there could be a system of authority based on physical and spiritual knowledge, experience, and values. The people were seen as members of a primitive, wretched, pagan, and immoral society that was in dire need of saving and civilising by Christian missionaries (Tripcony, 2007). Such missionary endeavour, following a pattern established in other parts of the British Empire, was to become a feature of colonisation and a means of pacifying and subjugating the Indigenous population to minimise any hindrance to colonial expansion. The terms Indigenous, Indigenous people, and Indigenous Australians have been used in this article respectfully to refer to Aboriginal and Torres Strait Islander people, who are the First Nations people of Australia. The term Aboriginal is used when referring to a specific person or it is the term used by another author.

From these beginnings which featured poor understanding of the Indigenous people and a paternalistic attitude towards them, a tone was set during the colonial period that would see tribal languages and cultural practices, including what might be called spirituality, banned (Broome, 2010). Such measures came about from the missionaries who considered traditional practices to be either pagan or forms of sorcery, and that tribal languages were not legitimate forms of communication (Tripcony, 2007). Responses to this new and imposed Christian religion varied greatly. Some accepted it enthusiastically, some rejected it completely, while others accepted the new and combined it with the traditional in a syncretising of beliefs (Calma, 2010). But more significantly, these early experiences indicated both an inability and an unwillingness on the part of the colonisers to understand the ways of the original people of Australia.

Hume (2000) has offered an explanation as to why missionary endeavour met with such mixed success. Aboriginal spirituality is something that Aboriginal people just have and don't need to acquire or work at. It is not something that can be compartmentalised and held separate from the rest of one's life (Edwards, 2002). In other words, it is not just something performed on one day of the week in locations set aside as places of worship, it is a constant ever-present component of daily living with the inter-connectedness of life's dimensions (McEwan et al., 2008). It possesses an immanence that is quite distinct from the transcendent and sometimes dualistic understandings of the monotheistic religions where the sacred and the profane have their respective places (Burns Coleman & White, 2006).

Additionally, as Broome (2010) has noted, paternalism and ethnocentrism were inherent in the Christian tradition, which spoke of father and children, shepherds and sheep, pastor and flock, and there was a prevailing attitude of superiority and denigration that pervaded some Christian missionary work. Nonetheless, mainstream religious adherence has continued for many Indigenous people until the present day, and more that seventy percent of Indigenous people in Australia self-identify as Christian (Grieves, 2009). However, it is important to understand what is meant by Indigenous spirituality and how it might differ from or be inclusive of religion.

Defining Indigenous spirituality

Spirituality within any context is always difficult to define (Greasley et al., 2001; Nolan & Crawford, 1997) because there will always be variations in how it is experienced and lived.

Also, within the Indigenous Australian context, it is not culturally respectful to presume, without permission of Elders, to set forth in any detail how a tribe or clan or group might practise its spirituality. Additionally, spirituality is a term used in English that seeks to explain a phenomenon in the Indigenous world with its origins in tribal language and a separate non-Western culture. The term has been appropriated into Indigenous culture as a later accretion describing Indigenous epistemologies and ontologies (Grieves, 2009), so it is important to keep in mind that any definition will be less than perfect because it will miss some of the nuances of language that do not translate easily into an English vocabulary. So, there will be a marked difference between the meaning of spirituality for Indigenous people and for non-Indigenous people who will neither fully understand nor decipher this concept (L. T. Smith, 1999).

Eckersley (2007, p. 54) has offered a general definition of spirituality with the following:

> In general terms, spirituality is known in Western contexts as coming from the Christian tradition, from the concept of non-material, invisible yet powerful and life-giving forces from God. Thus, spirituality is described as being a deeply intuitive, but not always consciously expressed sense of connectedness to the world in which we live.

Eckersley's description sees spirituality as something connected with religion, worship of a deity and a transcendent, separate phenomenon. For Indigenous Australians spirituality represents something quite distinctly different:

> Aboriginal spirituality derives from a philosophy that establishes the wholistic notion of the interconnectedness of the elements of the earth and the universe, animate and inanimate, whereby people, the plants and animals, landforms and celestial bodies are interrelated. These relations and the knowledge of how they are interconnected are expressed, and why it is important to keep all things in healthy interdependence is encoded, in sacred stories or myths. (Grieves, 2009, p. 7).

From this definition, Indigenous spirituality is seen as the basis of existence and a way of life from which values, ethics, protocols, behaviours, and all social, political, and economic organisation is developed (Grieves, 2009). It is therefore at the core of Aboriginal being and identity (Grant, 2004) and stands in contrast to the western concept. Catholic priest, biblical

scholar, and archaeologist Eugene Stockton who in 1986 established an Aboriginal Catholic Ministry in western Sydney makes this contrast between the two concepts clearer and endeavours to use the language of religion to describe Aboriginal spirituality:

> Aboriginal Australian spirituality has been described as embodying a reverence for life as it is—it does not promise a life after death, salvation, nirvana or similar that is offered by other religions. For Aboriginal people, this is as good as it gets. Life is as it is, a mixture of good and bad, of suffering and joy, and it is celebrated as sacred. Living itself is religion. The remarkable resilience of Aboriginal people is partly explained by the legacy of a spirituality that demonstrates an enthusiasm for living, a readiness to celebrate it as it is, a will to survive and to pass the baton of life to the next generation. (Stockton 1995, p. 77)

It becomes clear from the work of these authors that Indigenous spirituality and western religion are quite separate but parallel phenomena which have at times been accorded a closer relationship than they perhaps deserve. Stockton has noted that resilience has also been an element in Indigenous spirituality and Grieves (2009, p. 37) has identified this resilience in terms of "cultural resistance and persistence" in the face of dispossession and efforts to destroy beliefs and value systems by colonial powers. Spirituality is therefore an important aspect of social and emotional wellbeing by helping people to maintain a sense of identity and belonging as a buffer against racism and generational trauma (Poroch et al., 2009).

Spirituality and wellbeing

Indigenous artist Senimelia Kingsburra from Yarrabah community in Queensland conveys very powerfully the meaning of spirituality for her and its impact on wellbeing:

> Spirituality is about connecting with all living beings/ organisms in the world in harmonic ways and it is also about empowerment. Harmony is about perfect balance between all things. Spirituality is about tapping into the still places I go to when I'm on country and I feel like I'm part of all the things around me. In that still place, creativity and wisdom come from somewhere inside of you. When I'm on country I feel the stillness in the plants—can you imagine that you are a plant, swaying in the breeze as the breeze is flowing around and through the leaves? To me spirituality is

about finding the calmness in the busy spaces of my life. (as cited in McEwan et al., 2008 p. iv)

Much has been written in the past about Indigenous spirituality from the perspective of anthropology and religious studies but studies from the perspective of health benefits are not so plentiful (McEwan et al., 2008). Variables related to spirituality have indicated a positive and protective effect for wellbeing, suicidal behaviour, and substance abuse (Commonwealth of Australia, 2000; Hassed, 2000; Williams & Sternthal, 2007). Other researchers have found that religion and spiritual identity have been related to positive mental health, including responsibility, self-control, tolerance, and an internal locus of control (van Dierendonck & Mohan, 2006) supporting the notion that the more sense of control people have over their own lives the more likely it is that they will have better health outcomes.

Spirituality and the importance of meaning for wellbeing

As already noted, Indigenous spirituality finds its strength in connectedness to land and waters, to people and to culture. This in turn gives meaning to life for Indigenous people because belief provides the answers to the great universal questions of humankind and the purpose to existence (Edwards, 1994). It is also about finding or maintaining a harmony of interconnectedness and wellbeing where these relationships are interwoven with spirituality and culture (Alexander, 2008).

Social relationships are central to Indigenous spirituality and emotional wellbeing, which provide a shared belief system connecting the individual to community and a social support network that is a buffer against stressors and promote mental wellbeing (Tse, et al., 2005). Shared values of belief and practice strengthen individual bonds with community and bring an acceptance that gives purpose and meaning to life and increased self-esteem (Cattell, 2001). Connection to community and acceptance are the foundations for building a sense of hope, and for Indigenous people, hope is about renewing confidence for the future which brings about motivation, purpose and meaning towards achieving goals (Murphy, 1998) and develops a sense of personal agency that copes with the challenges of life and contributes to positive outcomes in mental health.

Spirituality and religion

It is important to acknowledge that for some Indigenous people mainstream religious affiliation, primarily through the Christian religions, remains important for them. This also represents strong community connection and a sense of belonging to a positive support network that is accepting and nurturing. Although the terms religion and spirituality are frequently used interchangeably, they are in fact quite distinct and not interdependent (Saad & de Medeiros, 2012). Where spirituality features meaning through connection and relationship, religion in comparison, finds meaning with adherence to a doctrine or set of principles with worship and petitioning of a deity through external/internal forms such as personal and communal forms of celebration and prayer. It most frequently manifests through an institutional structure, regular attendance at celebrations and/or rituals, and the reading and interpretation of sacred texts (Anandarajah, 2005). It has already been mentioned that some Indigenous people have embraced western religions, some have rejected them in favour of traditional spirituality, and some have been able to accommodate a hybrid of both (Calma, 2010). Locations of these respective groupings appear to reflect the work of various missionary endeavours in different regions, and their attitudes and degrees of tolerance towards the traditional values and cultures (Broome, 2010). For example, some missions were not in fact missions at all in the sense of being church run, but were government reserves administered by successive government agencies, and so there was less concern in these places about what people believed. In the contemporary context some Indigenous people have adopted the Christian theological concept of *reconciliation* with its meanings of restitution, forgiveness, change of heart and setting things right, to promote change in contested political areas such as makarrata, the Yolngu word for treaty, and formal recognition in the Australian Constitution 1901 (Deagon, 2021). So, political activism has become an unintended consequence of missionary activity, where Indigenous people are speaking the language and using the concepts of the dominant culture's religion to advance their causes. In other words, the colonised are decolonising the colonisers.

What emerges from the evidence presented by history and contemporary culture is that there is no single Indigenous spirituality just as there is no single identity of what it means to be Aboriginal or Torres Strait Islander. Spirituality reflects how Indigenous people experience the world, and Western conceptualisations are inadequate to describe what spirituality represents for many people. As evolving phenomena culture and spirituality, as

well as some mainstream religions, such as the evangelical Christian churches, have changed quite dramatically and they too have been reflective of a changing world (d'Abbs & Chenhall, 2013; Sutherland, 2011). Indigenous spirituality adapted and changed with the arrival of the Europeans with their Christian religion and so change has been an enduring and fundamental component of belief.

5.3 Method

Participants

The first author, a registered psychologist and a final year PhD student with previous experience in qualitative research at Masters level, interviewed twelve participants who identified as Aboriginal and/or Torres Strait Islander, who were at least 18 years of age and had previously participated in at least one session at any time in the past, with a mental health professional. In addition to these twelve participants, a further six people initially indicated that they were prepared to be interviewed but withdrew prior to interview. Of those who withdrew, one was recovering from COVID, another changed his mind, and another cited unspecified personal reasons for deciding not to proceed, and the remainder gave no reason.

Procedure

As part of a larger study participants (n = 12) (Table 5.1) took part in a hypothetico-deductive qualitative study (Nola, 2007) by the authors of this paper and were asked specific questions concerning spirituality within a semi-structured interview which was based on a search of the literature (P. Smith et al., 2021). The larger study sought to understand cultural responsiveness from the perspective of mental health practitioners working with Indigenous clients and acknowledging spirituality as a component of culturally responsive practice. Convenience sampling, in which participants were chosen based on their availability, formed part of this methodology (Malterud, et al., 2016). Ethics approval was received from the university's Human Research Ethics Committee and also the NSW Aboriginal Health and Medical Research Council. Additionally, this study benefitted from the advice of an Aboriginal Advisory Group whose role was to ensure that cultural protocols were maintained, and that the work of this study was undertaken in ways that were culturally safe and culturally respectful for all participants.

Table 5.1. **Participant demographics (*N* = 12).**

Participant (Nation/Tribe)	*Age*	*Gender*	*Treating Mental Health Professional*
Participant 1 (Bundjalung)	18-29	Female	School Counsellor (non-Indigenous)
*Participant 2 (Gamilaraay)	70+	Female	Psychologist (non-Indigenous)
Participant 3 (Darug)	50-69	Female	Psychiatrist (non-Indigenous)
*Participant 4 (Kamilaroi/Darkinjung)	50-69	Female	Psychologist (non-Indigenous)
Participant 5 (Kabi Kabi)	50-69	Female	Psychologist (non-Indigenous)
Participant 6 (Kija)	30-49	Female	Clinical Psychologist (non-Indigenous)
Participant 7 (Bundjalung)	30-49	Male	Psychologist (non-Indigenous)
Participant 8 (unspecified)	30-49	Female	Psychologist (non-Indigenous)
Participant 9 (Trawlwoolway)	30-49	Female	Psychologist (non-Indigenous)
Participant 10 (Anaiwan)	30-49	Female	Psychologist (non-Indigenous)
*Participant 11 (Gamilaroi/Wiradjuri)	30-49	Female	Psychologist (non-Indigenous)
Participant 12 (Kooma)	30-49	Female	Clinical Psychologist (non-Indigenous)

Bundjalung = a First Nations people of North Coast, New South Wales; Gamilaraay = a First Nations people of Northwest New South Wales; Darug = a First Nations people of Western Sydney, New South Wales; Kamilaroi = a First Nations people of Northwest New South Wales; Darkinjung = a First Nations people of Central Coast, New South Wales; Kabi Kabi = a First Nations people of Southeast Queensland; Kija = a First Nations people of East Kimberley, Western Australia; Trawlwoolway = a First Nations people of Northeast Tasmania; Anaiwan = a First Nations people of Northern Tablelands, New South Wales; Gamilaroi = a First Nations people of Northwest New South Wales; Wiradjuri = a First Nations people of Central West, New South Wales; Kooma = a First Nations people of Southern Queensland; *Gamilaroi, Kamilaroi and Gamilaraay are the same First Nation, named differently in different locations.

Each participant identified as Aboriginal and reported at least one session of therapy with a mental health professional at some time in their life. Participants were informed of the

study through flyers which were distributed to several local medical practices, to university Aboriginal student centres, and through a number of networks known to the first author, including the Australian Indigenous Psychologists Association. Prior to interview any persons who had responded to the flyer were contacted by email to provide opportunity for questions and to distribute more detailed information about the study. Those who expressed a willingness to proceed were sent information by email describing the study and introducing the researcher in more detail. Convenience sampling as a form of purposive sampling is common in qualitative research and it was adopted for this study because the primary aim was to explore aspects and relationships in the social world and not to determine representativeness to a wider population (Neuman, 2014).

Setting

Indigenous Australians are a diverse group within Australian society and come from over two hundred and fifty separate nations or language groups (Dudgeon & Walker, 2015) with their own expressions of culture, unique histories, and spirituality and for some, especially those in remote locations, tribal language as their first language. Seven participants identified with Indigenous nations within the state of New South Wales, three were from Queensland, and one each from Tasmania and Western Australia.

Data collection

All participants were fluent in spoken English language, the majority (n = 11) living in urban or inner regional locations, and two continued to reside on the traditional land of their respective nations. One interview was conducted face to face in the researcher's workplace and the remaining eleven interviews were conducted using Zoom. These are methods common in qualitative research and considered to be the best means to collect data (J. Smith & Osborn, 2003) because they open a dialogue between the researcher and the participant and often open areas that are pertinent and important to the research. For Indigenous people such dialogue is referred to colloquially as *yarning* and is a culturally appropriate way to engage with Indigenous Australians (Bessarab & Ng'andu, 2010) that respectfully allows the voices of participants to describe their lived experiences. Interviews which involved only the researcher and the participant took approximately thirty minutes, and the first author transcribed the audio recordings on the same day to achieve familiarity and immersion in the data and to ensure accuracy and that no non-verbal data was lost (B. Smith & Sparkes, 2016).

Following interviews participants were contacted to ensure that issues had not arisen that might be a source of ongoing distress and they were sent a copy of the transcript to seek confirmation that it was an accurate record of the interview.

In respect of the spirituality section of the interview participants were asked:

> Was your culture, including your beliefs, spirituality, and cultural heritage understood and respected in ways that helped you to feel at ease?
>
> What does spirituality mean to you?
>
> In what ways could mental health be more respectful of your spirituality?

Analysis

Thematic analysis (Clarke & Braun, 2017) which identifies and analyses patterns of meaning in qualitative data was used to extract themes in this study. Both the first author and the fourth author undertook this analysis separately to ensure accuracy, to resolve discrepancies and to minimise any researcher bias (Bradley, et al., 2007). Additionally, the Consolidated Criteria for Reporting Qualitative research Checklist (COREQ) (Tong, et al., 2007), guided the process to ensure systematic adherence and to support a clear rationale for the method.

5.4 Results

All participants readily responded to these questions and each expressed belief that spirituality for them was about connection. Some expressed pleasant surprise through smiles and even gasps and exclamations such as “wow” that indicated they were being asked about something that for them was clearly of importance. Participants often used the term connection, and this connection was expressed through four major themes:

- ancestors
- family
- Country, a term used to denote traditional tribal land
- belief in God, described also as the God of the Bible

There were also two sub-themes:

- Nature, denoting plants and animals, as well as earth and sky.

- Interior Reality, describing a personal spiritual consciousness.

Ancestors

One participant saw that spirituality was for her an awareness of the place of ancestors whom she always saw as close and involved in her life.

> It would have been lovely to say 'Oh, I've got my ancestors with me, and they walked in the door with me to sit in here,' that sort of thing. I would have loved that acknowledged because I have a strong belief that spirits are always with us. I don't think that gets acknowledged much. (Participant 2)

This comment also fits with the historical perspective already mentioned that such personal beliefs involving ancestral spirits were marginalised and even ridiculed by mainstream religious traditions and so such beliefs were not spoken about publicly. For another participant ancestors are connected with a particular place such as traditional lands:

> So, spirituality for me is a lot of things, so, it is going back to a place of belonging, for me it's going back to family, to my ancestors, like for when I pass. I know my family and my ancestors are around me constantly so that's something I experience. (Participant 4)

Family

The importance of family as a part of spirituality was mentioned by a number of participants. One description identified family and ancestors in an inclusive way:

> I guess like the connection to our families, loved ones, that have passed. Yeah. (Participant 10)

Another said:

> Culture, connection to Country; like kind of who I am; I guess like my family heritage. (Participant 1)

Country

Another person described this in more detail:

> It means a connection to land, a connection to my ancestors and it means a connection to the things that the physical eyes can't always see. It means new things. It means food. It means believing in things that just because you can't see them doesn't mean they're not there. (Participant 3)

Another participant in the study was quite forthright about the importance of connection to Country for his mental health:

> The thing that's helping me lately with my depression is that cultural connectedness… to me if it was addressed earlier on, I think it would have been more beneficial to my recovery. I think I would have recovered quicker. (Participant 7)

Belief in God

The connection to mainstream religion, that has already been identified with its historical link to past missionary endeavour, was reflected by these following comments:

> It's my relationship with God. It's the God of the Bible. (Participant 8)

And from another:

> Oh, spirituality! It means that there is a greater person, God, whatever. (Participant 2)

Nature

Nature represents part of what participants described when they spoke about connection to Country, so it represents a sub-theme within this study.

> So, for me it's nature, it's water. I mean I feel my most spiritual when I'm near water. So, for me it's a holistic thing. It's about all my five senses and my intuition. (Participant 3)

> But I was really disconnected. And if she'd said something simple like: "Get yourself to the beach." I'm a saltwater woman. "Get yourself to the beach. Stand on the beach. Be with friends, you know, connect." (Participant 5)

Interior reality

Interior reality was often described within the same context as Belief in God and because of its importance for participants this too has been included as a sub-theme.

> Spirit is what lives inside me and connects me with everything. So, yeah, that's interesting it's like my being. (Participant 5)

Another participant said:

> It is my inner being. It's who I am and what I am when nobody else is around… It's at the core of my being. That's what it is. (Participant 8)

One participant made the point that when practitioners fail to understand spirituality and interior reality this can lead to misunderstandings about mental health, diagnosis and what is culturally acceptable and even mentally healthy.

> I've certainly seen people say "Oh, they must have a diagnosis of this, or schizophrenia, et cetera", if they have spiritual visits or things like that. So, I think as a professional (they) could probably do better learning to have that sense of openness and understanding so that we're not reaching for diagnostic terms for things that fit within culture. (Participant 12).

5.5 Discussion

The findings of this study supported common themes through much of the literature describing the importance of connection and identity with Country, family and ancestors as well as belief in God (Edwards, 1994). Participants asserted that connection to these aspects of their lives brings not only meaning but also healing and social and emotional wellbeing, serving as a powerful message to mental health practitioners. The great variety in responses also confirmed what is already known, that there is no single Indigenous spirituality despite the existence of many common elements (Nolan & Crawford, 1997). Participant responses also indicated that there has historically been a syncretistic amalgamation of beliefs where the traditional has been woven into mainstream Christian belief systems, reflecting the impact of colonialism and the dominance of European culture (Calma, 2010).

What this study has added is that spirituality, however it is discerned, maintains a place of importance in most people's lives. Participants identified it as a means for them to achieve healing, and there were comments that they could have benefited from therapy quicker and more thoroughly if their mental health practitioners had at least either acknowledged their spirituality or shown some preparedness to work within a spirituality framework. Responses indicated that for many practitioners, knowledge of Indigenous spirituality is at best basic, and this appears to be a major factor in practitioner hesitancy to ask clients about their spirituality. Ongoing cultural responsiveness education, that includes Indigenous spirituality, for practitioners and students therefore emerged as an important and fundamental first step for working with Indigenous clients and it is the position of the authors that such education be a requirement for this work. Participants in this study indicated that practitioner knowledge in this area did not have to be comprehensive but needed to be sufficient to understand the place and the importance of spirituality for Indigenous people, so that the therapeutic environment can be respectful and culturally safe.

Limitations

This work which has identified the place and importance of spirituality was part of a larger qualitative study concerning cultural responsiveness for mental health practitioners working with Indigenous clients, and this limited the scope and the extent of the inquiry concerning Indigenous spirituality. Additionally, participants were limited to those who had been past clients of mental health practitioners, and this most likely limited the size of the sample. This study was also not able to benefit from a wider variety of participants living outside of urban and inner regional areas where access to communication technologies is more problematic especially for those living in remote locations and traditional communities.

5.6 Conclusion

The concept of spirituality remains a contested one within Indigenous culture because it continues to be defined and constrained by terms within English language and Eurocentric expressions, and these terms are inadequate to describe what is non-European.

The literature and the voices of Indigenous people heard in the context of interviews, clearly define it as something quite distinct from mainstream religious beliefs. Spirituality for Indigenous Australians is about the meaning of connection and belonging, belonging to

Country, to land and waters, to fish, birds, and animals and to family, kin, and ancestors. For many, it does not have the transcendent deity of most religions with their prayer forms, observances, and rituals, and it would therefore not be a religion by this definition. Nonetheless, spirituality and religious belief are both important to Indigenous people (d'Abbs & Chenhall, 2013) and are fundamental to mental health and social and emotional wellbeing. Therefore, it should not be overlooked by mental health professionals in their work with them, and the challenge now is for these professionals to make efforts to become informed, aware, and responsive to the cultural and spiritual needs of their clients to ensure best outcomes.

5.7 Glossary

Yolngu language

makarrata	a name for the treaty to be formally recognised in the Australian Constitution 1901

Indigenous peoples

Anaiwan	Northern Tablelands, New South Wales, Australia
Bundjalung	North Coast, New South Wales, Australia
Darkinjung	Central Coast, New South Wales, Australia
Darug	Western Sydney, New South Wales, Australia
Gamilaraay; Gamilaroi; Kamilaroi	Northwest New South Wales, Australia
Kabi Kabi	Southeast Queensland, Australia
Kija	East Kimberley, Western Australia
Kooma	Southern Queensland, Australia
Trawlwoolway	Northeast Tasmania, Australia
Wiradjuri	Central West, New South Wales, Australia
Yolngu	East Arnhem Land, Northern Territory, Australia

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Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF ORIGINALITY

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We, the PhD candidate, and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	**Page number(s)**
All, aside from contributions by other authors listed in the form below	

Name of Candidate: **Peter Smith**

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10/10/2023

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11/10/2023

Principal Supervisor Date

Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

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11/10/2023

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Chapter 6: Assessment of Cultural Responsiveness (Wulanabi-li)

"Mental health practitioners are required to monitor their performance in regard to (knowledge, understanding, skills and attitudes) and to reflect on how their own practice is informed by knowledge. They recognise limitations in their knowledge and expertise and seek expert advice and supervision, as appropriate." (Assoc. Prof. Roz Walker, UWA)

The qualitative study in Chapter 4 gave Indigenous people an opportunity to speak for themselves in ways that described for them the meaning of cultural responsiveness. That study together with the meaning presented in the literature have brought us to the focus of this chapter which is to look at how cultural responsiveness can be assessed for the benefit of those mental health practitioners who are wanting to work with Aboriginal and Torres Strait Islander people. It could be said that Chapter 1, is for the reader, introducing the concept and setting forth the structure of this thesis. Chapter 3 is for the researcher, who has needed to form a clearer understanding of what is meant by the concept of cultural responsiveness. Chapter 4 has been for the clients, that their voices are heard, respected, and centred as a feature of this entire work. Chapter 5 is for students at all stages of their learning, that spirituality is understood within the wider context of social and emotional wellbeing. Finally, Chapter 6 is for the practitioners, that they may now be guided not only by a conceptual model but by an assessment instrument, that can evaluate their progress in the journey of cultural responsiveness, which will have its strengths and deficits.

The Gamilaroi term *Wulanabi-li* means to light a fire or to set aflame, and it is used in this context because an important use of fire for Indigenous people was for the renewal of the land and its vegetation (Taylor-Bragge et al., 2021). It is anticipated that this chapter, published in International Journal of Social Psychiatry, which presents the validation of an assessment instrument for practitioners and those aspiring to be practitioners, will ignite a flame that guides culturally responsive practice and brings a new and fresh approach to working with Indigenous clients.

Based on the literature review and the conceptual model set out in chapters 2 and 3 the Cultural Responsiveness Assessment Measure (CRAM), being presented to the reader in this chapter, was constructed to assist practitioners to evaluate their work with Aboriginal and

Torres Strait Islander clients. Chapter 4 and the qualitative study that sought responses from former clients offered further confirmation that the CRAM's structure was relevant and useful. Furthermore, to assess cultural responsiveness, the CRAM also needed capacity to evaluate reflexivity to assist practitioners to understand who they are in respect of their work with Aboriginal and Torres Strait Islander people. The CRAM is a comprehensive instrument that guides culturally responsive practice through assessment and self-reflection.

This chapter was published as:

Smith, P., Rice, K., Schutte, N., & Usher, K. (2023). Development and validation of the Cultural Responsiveness Assessment Measure (CRAM): A self-reflection tool for mental health practitioners when working with First Nations people. *International Journal of Social Psychiatry* (In Press) https://doi.org/10.1177/00207640231204211 (1st Quartile, Impact Factor 7.5)

6.1 Abstract

Background

The purpose of this study was to develop and to validate a measure of cultural responsiveness that would assist mental health practitioners across a range of disciplines, in Australia, to work with Indigenous clients.

Aim

The Cultural Responsiveness Assessment Measure (CRAM) was developed to provide a tool for practitioners and students to evaluate their own culturally responsive practice and professional development.

Method

Following expert review for face validity the psychometric properties of the measure were assessed quantitatively, from the responses of 400 mental health practitioners.

Results

Confirmatory Factor Analysis yielded a nine factor, thirty-six item instrument that demonstrated strong convergent and discriminant validity as well as test-retest reliability.

Conclusions

It is anticipated that the CRAM will have utility as both a learning tool and an assessment measure, for mental health practitioners to ensure that services are culturally responsive for Aboriginal and Torres Strait Islander people.

Keywords
Cultural responsiveness; Indigenous; self-reflection tool; Australian; Aboriginal and Torres Strait Islander

6.2 Introduction

Cultural responsiveness is recognised as a core competency for all psychology students and practitioners in Australia, as well as in other countries such as the United States and Canada (American Psychological Association, 2015; Canadian Psychological Association, 2021). The Australian Psychology Accreditation Council (APAC, 2019) has included cultural responsiveness as a requirement for all levels of psychology qualification and practice. Beyond psychology, the Australian Association of Social Workers (AASW) Practice Standards state that "social workers practice respectfully and inclusively with regard to culture and diversity" (AASW Practice Standards, 2023, p.10). Such requirements place importance on methods for both students and practitioners to monitor and assess their cultural responsiveness for working with Indigenous people. This group has found mainstream health and mental health services culturally unsafe (Kendall & Barnett, 2015) and its members suffer mental illness at higher rates than the wider community with a suicide rate that is double that of the rest of the Australian population (Silburn et al., 2014). Self-assessment measures can improve the accuracy of self-reflection across multifaceted competency domains and enable practitioners to identify and monitor gaps in practice, and facilitate professional development (Rice et al., 2022). To aid self-assessment of the core competency of cultural responsiveness, this research aimed to develop and validate a measure for mental health practitioners. Structured from the elements of cultural responsiveness found within the literature (Smith et al., 2021) and client interviews (Smith et al., 2023a; Smith et al., 2023b) the Cultural Responsiveness Assessment Measure (CRAM) provides a tool for systematic self-evaluation across nine domains of culturally responsive practice. It is anticipated that the CRAM will provide a tool for mental health practitioners in a range of disciplines, to work in ways that will help to close the gap in mental health, which has been found to be culturally unsafe for Indigenous people (Kendall & Barnett, 2015; McGough, et al., 2018).

Cultural responsiveness for practitioners is a recursive process that sets reflexivity at the centre of a dynamic and ongoing movement where the reflexive self, initiates exploration

into the domains of learning, experience, and discovery for best outcomes for Indigenous people (Smith et al., 2022). A culturally responsive mental health workforce will help to decolonise psychology by setting aside the ethnocentric practices of the dominant culture, giving a place to Indigenous epistemologies and worldviews (Dudgeon & Walker, 2015). As a dynamic and ongoing process cultural responsiveness requires that individuals continue to monitor their progress and consider areas of strength and deficit, and so the need for a self-assessment instrument is a matter of great importance to inform sound professional practice.

A measure or scale or assessment instrument can capture the depth and breadth of multifaceted constructs beyond the limits of a single item (Boateng et al., 2018). Cultural responsiveness is a complex and multifaceted construct that is an overarching term for multiple discrete domains that are also interrelated (Smith et al., 2021). This multifaceted construct requires an assessment instrument that is holistic and all-encompassing enabling systematic self-evaluation across all domains. Previous measures which have sought to evaluate practitioner capabilities in cross-cultural or multi-cultural contexts have been mostly designed for populations outside of Australia, and have largely focused on knowledge, attitudes and awareness of culture and health rather than practitioner responsiveness or capabilities in working with Indigenous people (West, et al., 2018). The CRAM is based on a framework that emerged from a concept analysis of cultural responsiveness found within the literature (Smith et al., 2021) and was subsequently developed into a model of reflexivity for teaching and learning (Smith et al., 2022). This model with nine domains centred on the reflexive self is recursive, non-binary and non-linear, prompting the need for ongoing practitioner self-evaluation. In a further study by the authors (Smith et al., 2023), which sought to test this model with Indigenous former clients of mental health practitioners, knowledge and awareness were clear themes. Further, culturally safe practice that is free of racism and includes practitioner reflexivity were also identified in the responses from participants, indicating that current concepts of cultural responsiveness need to now move forward to a more expansive definition and understanding of this construct.

The aim of the present study was to develop a psychometrically sound instrument to assist mental health professionals and students at a practical level, to work more effectively with Indigenous people. The study sets out to develop the CRAM and to assess the psychometric properties of the newly developed measure.

6.3 Method

The term Indigenous is used respectfully within this article as a term to identify both Aboriginal and Torres Strait Islander people who are the First Nations people of Australia, and the first author, a Gamilaroi First Nations researcher, was assisted with cultural advice and support from an Aboriginal advisory group that included Gamilaroi Elders.

There are three important steps to creating a scale that is valid and reliable: item development, scale development and scale evaluation (Boateng et al., 2018). Item development sets forth an initial set of items that are deemed to be representative of the construct that is to be measured. Scale development is the process of organising the items into a structure that is user friendly, clear, and logical, and scale evaluation seeks to ensure that the instrument is psychometrically rigorous, and tests validity and reliability and in respect of construct validity, assuring that it measures constructs as hypothesised (Churchill, 1979).

Item Development

Item development commenced from the conceptual model of cultural responsiveness (Smith et al. 2022), which is based on the literature review (Smith et al., 2021) and qualitative interviews (Smith et al., 2023), using both deductive and inductive methodologies (Morgado et al., 2017). This meant that items were initially deductively generated based on the following themes of cultural responsiveness (Smith et al., 2022): Awareness, Knowledge, Inclusive Relationships, Cultural Respect, Cultural Safety, Social Justice/ Human Rights, Self-Reflection, Cultural Humility, and Cultural Competencies. To strengthen the validity of the scale an inductive analysis of data from a qualitative study (Smith et al., 2023) were also considered with a view to discovering any additional emerging themes (Morgado et al., 2017). From these themes a pool of fifty items was generated to elicit responses for practitioners to evaluate their level of cultural responsiveness.

Scale Development

To evaluate face validity of the item pool, a panel of academics and practitioners, both Indigenous and non-Indigenous, were consulted to provide feedback on the suitability and appropriateness of the initial 51 items, and whether they would adequately measure changes to dimensional aspects of cultural responsiveness. Responses from the thirteen panel members focused on specific items, and there were no recommendations to remove any of the

domains, apart from a single comment that Knowledge and Awareness could be difficult for respondents to differentiate. Recommendations by each individual panel member for change of items and wording were incorporated after consensus by the research team and this process resulted in a reduced pool of 42 items, with six domains retaining five items and three domains with four items, shown in Table 6.1. All panel members were consulted a second time to review the latest version of the instrument which incorporated the panel's suggested amendments, and to provide opportunity for any additional comments or suggestions. Responses from this second round were integrated following review and consensus by the research team. These responses indicated that the items, fifteen of which would be reverse scored, and the nine domains of the CRAM were deemed to encapsulate the construct of cultural responsiveness. The panel also approved the response format of a 7-point Likert Scale, with choices ranging from "Strongly disagree" to "Strongly agree". Seven-point Likert scales possess greater sensitivity and accuracy than scales with less points, so the 7-point scale was adopted for this study (Finstad, 2010).

Table 6.1. Items and wording of the CRAM initially proposed by the expert panel

Awareness

1. ***1.*** Past history does not impact the mental health of Indigenous people today. ***(Deleted)***
2. There are many needs and issues affecting Indigenous communities, individuals, and families that differ from those in the wider community.
3. I can specifically name some of the causes that disadvantage the mental health of some Indigenous people in this country.
4. ***4.*** I believe that all Indigenous cultures are the same regardless of their location. ***(Deleted)***
5. I understand the types of strength and resilience that have enabled Indigenous people to resist colonisation.

Knowledge

6. I have actively sought information and knowledge about Indigenous people.
7. I have attempted to learn the history of Indigenous Australia.
8. Indigenous people are better off since colonisation.
9. I have made attempts to learn about local Indigenous culture.
10. Indigenous people need to take more responsibility for their own mental health. ***(Deleted)***

Inclusive Relationships

11. I would seek to work with family and/or community members of Indigenous clients including having them present during sessions.
12. In order to assist me and if appropriate I would seek the help of an Indigenous mentor.
13. Indigenous healers are important.
14. Accessing community members or Indigenous mentors is not important for successful outcomes.

Cultural Respect

15. I respect Indigenous culture and cultural values.
16. My own culture influences the way that I think and behave.
17. For some Indigenous people, spirituality has an important place within their culture.
18. Indigenous culture is not an important part of Indigenous people's social and emotional wellbeing.

Cultural Safety

19. I would make my practice more culturally safe, in ways such as seeking the guidance of Indigenous clients.
20. I take time with clients to explain therapeutic practice or to answer questions.
21. Changes to the workplace environment would not make it more culturally safe.
22. Asking an Indigenous client about their culture is not important for best outcomes in therapeutic practice.

Social Justice and Human Rights

23. I understand the meaning of my own position of power and privilege in relation to therapeutic practice.
24. I understand how the dominant culture has disadvantaged Indigenous people.
25. I understand how power and privilege and their psychological impacts have disadvantaged Indigenous people.
26. Decolonising mental health is not an important part of therapeutic practice.
27. Social justice means treating everybody the same. ***(Deleted)***

Self-Reflection

28. I frequently take the time to reflect on my thoughts, emotions, and behaviours in relation to therapeutic practice.
29. I use self-reflection to evaluate my values and my professional practice.
30. I have used self-reflection to make changes to professional practice or to further learn.
31. Self-reflection following a client session does not better inform subsequent sessions.
32. Reflecting on my own cultural values and their impact on others will not help me to work more effectively with my clients. ***(Deleted)***

Cultural Humility

33. Listening is an important first step in understanding a client's culture.
34. I am open to constructive criticism even if it causes me some discomfort.
35. I can learn from Indigenous clients who are knowledgeable of their own culture.
36. Understanding the cultural values of others does not contribute to better outcomes in therapeutic practice.
37. When working with Indigenous clients I strive to address deficits in my knowledge and ways of working.

Cultural Competencies

38. Deep listening is an important intervention when working with Indigenous people.
39. Working holistically with Indigenous clients is important.
40. I have used an Indigenous-specific therapeutic practice or an instrument that is validated by and for Indigenous people. ***(Deleted)***
41. Specific interventions for Indigenous people are not necessary for best outcomes in therapeutic practice.
42. The Western medical model of mental health is appropriate for all people.

Deleted denotes items omitted following confirmatory factor analysis. Final items of the scale are in Appendix A.

Scale Evaluation

The second aim of this study was to evaluate the psychometric properties of the newly developed CRAM. Following ethics approval from the university's Human Research Ethics Committee, this second stage of scale development consisted of a pilot study of the forty-two-item instrument, as an online survey. Participants were able to complete the survey anonymously or opt to provide an email address and complete the survey a second time, one month later for assessment of test-retest reliability.

Participants

Mental health practitioners and trainees across a variety of disciplines were invited to participate through electronic advertisements and printed flyers resulting in the participation of 400 mental health practitioners, with their demographics shown in Table 6.2.

Table 6.2. Participant Demographics (*N*=400)

Gender		
Female	322	(81%)
Male	68	(17%)
Non-binary	6	(1.5%)
Rather not say	2	(0.5%)
Current Role		
Psychologist	163	(37%)
Social Worker	19	(4%)
Mental Health Nurse	7	(2%)
Counsellor	13	(3%)
Student in a mental health discipline	180	(41%)
Other	56	(12%)
Years of experience	8.06 (mean)	10.05 (std. dev.)

Procedure

Participants were asked to complete the survey, hosted on Qualtrics™ (Provo, UT) and each participant provided online informed consent prior to undertaking the survey. Participants were also asked to provide their email address if they were willing to be contacted again to complete the survey once more a month later for the purposes of test-retest reliability

Materials

Cultural Responsiveness Assessment Measure (CRAM)

The psychometric qualities of the newly developed CRAM were the focus of the present study and as such are reported in the results section below.

Cultural Safety Training Questionnaire

The survey also asked participants as a measure of convergent validity, to respond to the items of the Cultural Safety Training Questionnaire (CSTQ; Ryder et al., 2017), which is a 15 item self-report scale. This instrument is a measure of cultural safety and evaluates attitude change across two factors: transformative unlearning and critical thinking for students and academic staff involved in Aboriginal Health. This instrument was reported as having overall adequate reliability for the two thematic areas with Cronbach's alpha > 0.70, (Boateng et al., 2018) and test-retest reliability with overall intraclass correlation (ICC) = 0.7 (Ryder et al., 2017). Reliability analysis for this sample indicated Cronbach's alpha of 0.82.

Riverside Life Satisfaction Scale

To assess divergent validity participants completed the Riverside Life Satisfaction Scale (RLSS; Margolis et al., 2019), a six-item one-factor self-report scale that assesses contentment with life, desire for change and absence or presence of envy. It is considered to possess strong correlation (r = 0.95) with another similar measure the Satisfaction with Life Scale (Diener et al., 1985) as well as high internal consistency (α = 0.75) and test-retest reliability (Margolis et al., 2019). Reliability for this sample was estimated with Cronbach's alpha = 0.86.

Analysis

Exploration of the dimensions and content of factors is a necessary first step before assessment of validity and reliability can be conducted (Boateng, et al., 2018). Confirmatory Factor Analysis (CFA) using Jamovi 2.3 (2022) statistical software explored both the content and the relationships between factors of the CRAM. CFA was selected as there was already an *a priori* hypothesis of the factor structure, and CFA is used where the purpose is to test theory that has already been established and where factors have been determined (Kääriäinen et al., 2011). CFA seeks to test whether the measures of a construct, in this case cultural responsiveness, are consistent with *a priori* understandings from literature and qualitative data of that construct (Awang, 2015). The measure in this study was derived from the theoretical model (Smith et al., 2022) developed from the published literature review (Smith

et al., 2021) and qualitative interviews (Smith et al., 2023). Thus, for this study which was hypothesis or theory driven rather than data driven, CFA was deemed to be the best method because it tests the structure of existing theory, unlike inductive methodologies (Maruyama, 1998; Kääriäinen et al., 2011). Exploratory Factor Analysis (EFA) was not deemed satisfactory for this study because it is data driven and it is adopted in research where there is no *a priori* assumption of the associations of variables (Kääriäinen et al., 2011).

The total sample of 400 survey responses were included in the CFA, and this number is deemed to be a suitable sample size for CFA (Cattell, 1978; Gorsuch, 1983). Based on a rating system convention for sample sizes in factor analysis by Comrey and Lee (1992) this study's sample would rate *good* (>300).

6.4 Results

Confirmatory Factor Analysis

All items demonstrated positive factor loadings (Table 6.3) and CFA where items with factor loadings with a standard estimate coefficient of <0.4 were deleted. This accords with the convention of Tabachnick and Fidell (2000) where 0.4 as a minimum, accounts for more than 10% of the item's variance and "as a rule of thumb, only variables with loadings of 0.32 and above are interpreted" (p. 625). This process resulted in reduction of the instrument to 36 items, with all factors possessing at least 3 items. The 36 items, together with the scale instructions, are shown in Appendix I and the final model structure of the CRAM is depicted in Figure 6.1

Table 6.3. Factor loadings with deleted items in bold

Factor	Item	Estimate	SE	Z	p	Standard Estimate	
Awareness	**A1**	**0.410**	**0.0892**	**4.59**	**< .001**	**0.302**	**Deleted**
	A2	0.738	0.0897	8.24	< .001	0.582	
	A3	0.994	0.0971	10.24	< .001	0.737	
	A4	0.401	0.0709	5.65	< .001	**0.331**	**Deleted**
	A5	0.722	0.0931	7.76	< .001	0.503	
Knowledge	K1	1.350	0.0566	23.88	< .001	0.929	
	K2	1.173	0.0508	23.10	< .001	0.911	
	K3	0.574	0.0721	7.96	< .001	0.397	
	K4	1.125	0.0681	16.53	< .001	0.731	
	K5	0.429	0.0834	5.14	< .001	**0.262**	**Deleted**
Incl. Relationships	IR1	0.734	0.0578	12.69	< .001	0.615	
	IR2	0.761	0.0475	16.01	< .001	0.738	
	IR3	0.879	0.0508	17.30	< .001	0.777	
	IR4	0.708	0.0746	9.49	< .001	0.479	
Respect	CR1	0.528	0.0348	15.18	< .001	0.700	
	CR2	0.484	0.0485	9.97	< .001	0.498	
	CR3	0.516	0.0334	15.42	< .001	0.724	
	CR4	0.526	0.0480	10.96	< .001	0.536	
Safety	CS1	0.628	0.0461	13.63	< .001	0.652	
	CS2	0.619	0.0522	11.87	< .001	0.582	
	CS3	0.560	0.0817	6.86	< .001	0.352	
	CS4	0.613	0.0674	9.09	< .001	0.456	
Justice	SJ1	0.704	0.0471	14.94	< .001	0.677	
	SJ2	0.935	0.0395	23.68	< .001	0.923	
	SJ3	0.985	0.0428	23.02	< .001	0.907	
	SJ4	0.766	0.0709	10.80	< .001	0.521	
	SJ5	0.316	0.1095	2.89	0.004	**0.149**	**Deleted**
Self-Reflection	SR1	0.984	0.0446	22.08	< .001	0.880	
	SR2	1.053	0.0422	24.94	< .001	0.946	
	SR3	0.982	0.0442	22.22	< .001	0.884	
	SR4	0.620	0.0704	8.82	< .001	0.432	
	SR5	0.550	0.0867	6.35	< .001	**0.318**	**Deleted**
Humility	CH1	0.454	0.0235	19.29	< .001	0.822	
	CH2	0.451	0.0359	12.56	< .001	0.595	
	CH3	0.589	0.0277	21.30	< .001	0.878	
	CH4	0.604	0.0622	9.72	< .001	0.478	
	CH5	0.705	0.0537	13.12	< .001	0.626	
Competencies	CC1	0.716	0.0369	19.42	< .001	0.835	
	CC2	0.750	0.0424	17.69	< .001	0.783	
	CC3	0.487	0.0971	5.02	< .001	**0.263**	**Deleted**
	CC4	0.718	0.0697	10.30	< .001	0.510	
	CC5	0.717	0.0609	11.77	< .001	0.574	

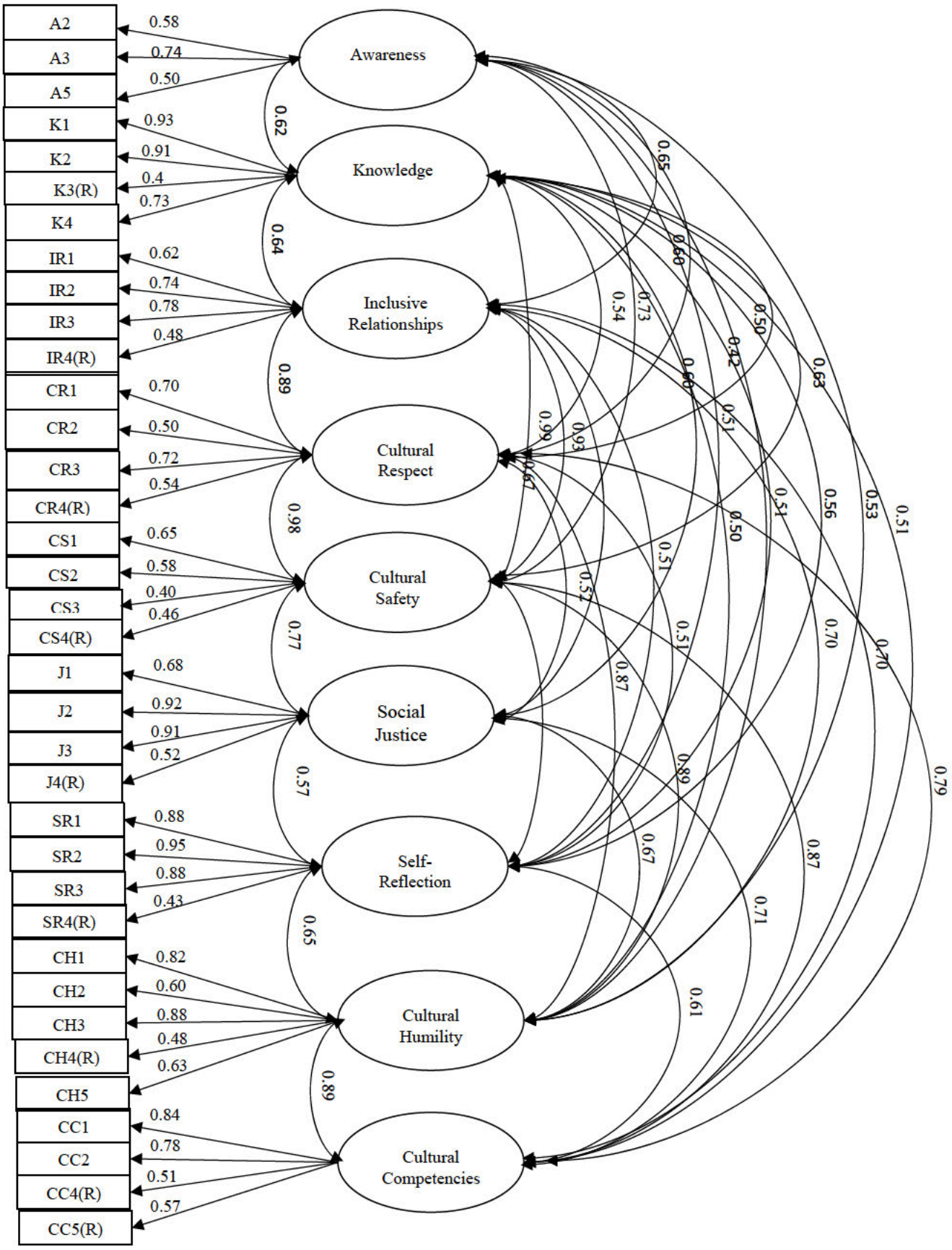

Figure 6.1. Final model structure of the CRAM. (R) denotes reverse scored items

With 400 responses in the CFA for a 36-item instrument, a response-to-item ratio of 11 to 1 was achieved, indicating a suitable sample size for validity and stability of factor loadings (Boateng, et al., 2018). CFA fitness indices which assist in understanding how the data support or fit the instrument, returned mixed results. The Root Mean Square Error of Approximation (RMSEA) showed satisfactory Absolute Fit (0.08) meeting the <0.09 threshold suggested by McNeish, et al. (2018) but the Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) as measures of Incremental Fit were slightly below acceptance levels of >0.90 at 0.79 and 0.77 respectively (Awang, 2015). However, these cannot be discounted as irrelevant (McNeish, et al., 2018) and rather than asking whether there is exact fit it can be more relevant to ask the degree of lack of fit and what meaning this then has for the instrument, which in this case may not affect its validity (Browne & Cudeck, 1992; McNeish, et al., 2018). Marsh et al. (2004) have cautioned against the universal application of cutoff values for fit indices in that these can be affected by sample size (under approximately 500) and model complexity, such as the nine-factor measure that comprises the CRAM. Nonetheless, the CFA fit indices indicated that the original *a priori* nine factor model performed well overall and that a more parsimonious model, with less factors, was not indicated, supporting the structure of the cultural responsiveness model.

Internal Reliability

The 36 items comprising the total CRAM demonstrated strong overall internal reliability ($\alpha = 0.94$), and reliability coefficients for all factors are presented in Table 6.4. The individual factors in general showed acceptable reliability with $\alpha \geq 0.7$ being acceptable (Boateng et al., 2018) apart from Awareness ($\alpha = 0.62$) and Cultural Safety ($\alpha = 0.58$) which were retained for reasons outlined in the discussion.

Table 6.4. Internal Reliability Coefficients

Factor	Cronbach's Alpha (N=400)
Awareness	0.62
Knowledge	0.81
Inclusive Relationships	0.72
Cultural Respect	0.68
Cultural Safety	0.58
Social Justice	0.81
Self-Reflection	0.83
Cultural Humility	0.73
Cultural Competencies	0.74
Total Scale	0.94

Test-Retest Reliability

In respect of test-retest reliability, which measures the temporal stability of the instrument, 150 participants responded to the invitation to complete the measure a second time and were emailed a link to complete the survey again. There were 50 responses received at timepoint 2 which is deemed a suitable sample size within the minimal acceptable error rates proposed by McMillan and Hanson (2014). Additionally, a sample of 50 involved in 2 timepoint responses delivers a correlation with power = 90%, $p< 0.05$ with the null hypothesis at 0 (Bujang & Baharum, 2017). Generally, a response rate of 32% to electronic surveys is deemed average (Shannon & Bradshaw, 2002), and the response rate to this survey at timepoint 2 was 33%. This is considered a good response rate when there are often diminishing returns for multiple surveys attributed to what has been called survey fatigue (Porter et al., 2004). The mean total score on the CRAM at timepoint 1 was 6.46 and at timepoint two was 6.44. The Pearson product-moment correlation coefficient was used in this instance, as a measure of reliability (Boateng, et al., 2018) and a correlation coefficient of 0.5, $p < .001$, indicated large effect size for test-retest reliability (Cohen, 1988) and suggesting that the scale assesses a stable construct that shows some changeability.

Construct Validity

For purposes of construct validity, measures of convergent and discriminant or divergent validity were used employing the total sample (N=400). In terms of convergent validity total scores on the CRAM were compared using the Pearson product-moment correlation with the total scores on the Cultural Safety Training Questionnaire (CSTQ; Ryder et al., 2017), an

instrument that was deemed to measure similar constructs as the CRAM. A correlation of 0.805, $p < .001$ indicated a large effect size (Cohen, 1988).

Evaluation of divergent validity was conducted by comparison with the Riverside Life Satisfaction Scale (Margolis et al., 2019) which measures constructs deemed to be fairly conceptually distinct from those measured by the CRAM, despite both measures similarly investigating personal beliefs and values, the foci of the two instruments are diverse. A result of 0.195, $p < .001$ indicated that there was small correlation between the scores on these two instruments (Cohen, 1988), supporting the position that the CRAM is a novel instrument that is not simply reflecting other measures (Boateng et al., 2018), in this case a measure of a generally positive view of one's life.

6.5 Discussion

The Cultural Responsiveness Assessment Measure (CRAM) has been developed as a tool for mental health practitioners to self-assess across all components of culturally responsive practice when working with Indigenous people. The CRAM is underpinned by a literature review (Smith et al., 2021), a conceptual model (Smith et al., 2022) and qualitative interviews with Indigenous clients of mental health practitioners (Smith et al., 2023). This paper detailed the development and initial psychometric evaluation of the CRAM, in accordance with recognised scale creation guidelines (e.g., Boateng et al., 2018). The initial results of psychometric testing, as presented above, suggest an instrument with strong face validity, strong internal reliability, and test-retest reliability. Item factor loadings were also considered suitable for the nine factors, supporting the *a priori* model of the instrument. Consideration was given to excluding the Awareness and Cultural Safety factors from the instrument, due to low reliability, but these factors were retained because they did not detract from the CRAM's overall reliability. These two factors in this instrument, also serve as a reminder to mental health professionals, in their self-assessment, that they are still important parts of culturally responsive practice, as identified in the related qualitative interview study of Indigenous clients of mental health practitioners (Smith et al., 2023). The CFA also indicated that there was some overlap between factors, and future psychometric evaluations may eventually indicate a reduced factor structure for the CRAM is warranted. However, the current evaluation justified all domains of the conceptual model and retained the nine-factor structure of the CRAM.

The strong test-retest reliability calculated between the timepoint 1 and timepoint 2 data suggests stability of the instrument across two administrations, but unlike what would be found with a higher coefficient, it suggests that the measure also possesses elements of change and fluctuation. This would be expected with an instrument such as this, in that it assesses constructs for some people, particularly trainees, whose results from timepoint 1 to timepoint 2 may be influenced by a learning effect (Hart, 2014).

In relation to convergent validity the strong correlation between the CSTQ and the CRAM, suggests that the two measures partially assess a similar construct. In comparison, a small correlation with the RLSS which was considered to be discriminant or divergent from the CRAM, supports the position that the two measures deemed to be conceptually diverse are also sufficiently statistically distinct. These two results support the construct validity of the CRAM and provide evidence to support its ability to measure the dimensions of cultural responsiveness.

It was the intention of the authors from the outset that the CRAM would be an instrument that would assist both students and practitioners within mental health to monitor their cultural responsiveness, and it is noted that 41% of survey respondents identified as students and participants were from a range of disciplines and with varied experience levels. It is possible that results from a sample with a higher percentage of experienced practitioners could deliver different results. However, the results of this study indicate both the utility and relevance of the CRAM as a novel instrument across a range of mental health disciplines and for a variety of experience levels. Most similar instruments, including the CSTQ, measure single or a limited number of components of what is now proposed as being definitive of cultural responsiveness. The CRAM provides a holistic conceptualisation of cultural responsiveness, based on the broad and multi-factor model identified in research (e.g., Smith et al., 2021; Smith et al., 2023). This detailed model and measure provides a practical framework for practitioners, by identifying multiple factors and skills that can be specifically targeted in the development of cultural responsiveness. Thus, the CRAM provides a broad base for practitioners to assess relevant skills and attitudes when working with Indigenous peoples. This instrument moves mental health practice beyond competence models and the acquisition of knowledge and toward a more self-reflexive and collaborative approach.

This study was limited to mental health students and practitioners within the Australian context, and studies assessing the applicability of the CRAM for other locations is

needed. Future cross-cultural studies may find that some modifications for local culture may be necessary. For example, items specifically mentioning an Australian context could be modified to specify other cultural contexts for psychometric evaluation. Additionally, it is hoped that the CRAM could offer a foundation for an instrument to assist those who are involved in other disciplines beyond mental health. The scale and its factor structures may also offer a starting point that will have international applicability for practitioners whose work involves First Nations people. However, as to the suitability of the CRAM for use with non-Indigenous minority or marginalised groups such as refugees, immigrants, and ethnic minorities, this would require major structural changes. For example, specific items about Elders, spirituality, colonisation, and traditional healers, would need to be carefully reconsidered.

The results of the present study support the proposition that cultural responsiveness is a multi-faceted construct in terms of assessment and skill development. The CRAM total score demonstrated strong internal reliability and construct validity with acceptable test-retest reliability, and support for the nine-factor model of the instrument.

6.6 Conclusion

This study outlines the development of an instrument that may assist mental health students and practitioners to support Indigenous clients in ways that are culturally responsive. The CRAM, as a self-report instrument offers mental health practitioners a way to understand and assess their own areas of strength as well as those areas that need further attention when they are working with Indigenous clients.

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Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF ORIGINALITY

(to appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate, and the candidate's Principal Supervisor, certify that the following text, figures and diagrams are the candidate's original work.

Type of work	**Page number(s)**
All, aside from contributions by other authors listed in the form below	

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10/10/2023

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11/10/2023

Principal Supervisor Date

Higher Degree Research Thesis by Publication

University of New England

STATEMENT OF AUTHORS' CONTRIBUTION

(To appear at the end of each thesis chapter submitted as an article/paper)

We, the PhD candidate and the candidate's Principal Supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated in the *Statement of Originality*.

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Chapter 7. Discussion and Conclusion (Guwaa-li)

"Education is the most powerful weapon we can use to change the world."

(Nelson Mandela)

This chapter reviews and discusses (guwaa-li) how this thesis has answered the research questions and what has been proposed from the beginning. It stands as a synthesis of the chapters that make up this thesis and offers recommendations for future research as well as the limitations of this project.

The work of this entire project has been about a journey of discovery, of listening and finding better ways to go about what we do in mental health and to create environments that become inclusive and healing for Aboriginal and Torres Strait Islander people. Cultural responsiveness has emerged in this project as a multifaceted approach that enables mental health practitioners to go about their important work more effectively.

7.1 Research Questions

At the outset the aim of the project was to explore three specific research questions in relation to cultural responsiveness:

- What is meant by the term cultural responsiveness and how can it be defined?
- What are Indigenous clients telling us about cultural responsiveness that is going to better inform our understanding of this concept?
- What do mental health practitioners need to be doing to be culturally responsive and how can they assess their work in ways that are self-reflexive?

Within chapter one, the term, and the historical context of cultural responsiveness, as well as its importance for Aboriginal and Torres Strait Islander people is introduced to the reader. This chapter serves as a prelude to what follows in the remaining chapters where the research questions are addressed and explored in more detail.

The literature search in the form of a concept analysis in chapter two sought to define cultural responsiveness. The literature revealed that it is composed of the five principal elements of Knowledge, Inclusive Relationships, Cultural Respect, Social Justice/Human Rights, and Self-reflection. However, what appeared through this definition was also an understanding that cultural responsiveness is a recursive process, even a transformative one that is non-finite and is also non-binary, and this stood in contrast to previous understandings

under the cultural competence banner where models tend to be linear and binary. What began to appear in this part of the project was an understanding that what we are researching here is about practitioner change not just change of content or definition or even change for Indigenous clients. Self-reflection began to loom large, and this grew into the centrepiece for a conceptual model.

Chapter three presents this conceptual model, called Foucault's Oscillation, which was based on the literature review in the previous chapter, previous models and further understanding from additional literature sources as well as grey literature (Smith et al., 2022). The model increased the defining components of cultural responsiveness to nine factors or domains with the addition of Cultural Safety, Cultural Humility, Awareness, and Cultural Competencies. A conceptual model gives the definition of cultural responsiveness clarity and structure and enables further research to trace its path and even to extend what has been proposed. The following has been proposed by this author as a definition of cultural responsiveness:

> Cultural responsiveness for practitioners is a recursive process that sets reflexivity at the centre of a dynamic and ongoing movement where the reflexive self, initiates exploration into the domains of learning, experience, and discovery for best outcomes for Indigenous people.

Equipped with this definition and conceptual model the project was able to move into addressing the second research question which was to ask Indigenous former clients of mental health professionals what they considered to be culturally responsive practice. As set out in chapter four a semi-structured interview based on the conceptual model sought qualitatively to determine whether the working definition of cultural responsiveness was consistent with their experiences. As an *a priori* approach seeking confirmatory data, the responses from participants indicated support for all domains of the conceptual model although some were seen as more important than others. Perhaps more importantly the clear message from many of the participants was that mental health practitioners need to be doing much better in their interventions with Indigenous clients. These responses confirmed that there is a need for practitioners to regularly assess their cultural responsiveness and so the importance of the work in chapter six of validating an assessment instrument was reinforced.

The third and final research question asked what mental health practitioners need to be doing to be culturally responsive and this was addressed in the qualitative study described above but also in chapter six which was to design and validate an assessment instrument. Comments from an expert panel of mental health practitioners some of whom were Indigenous, assisted in the construction of the Cultural Responsiveness Assessment Measure (CRAM) which was designed to assist mental health professionals to evaluate their areas of strength and deficit in respect of cultural responsiveness. The CRAM effectively gets mental health practitioners answering their own questions in respect of what they need to be doing to be culturally responsive. True to the conceptual model it gets them to reflect on their place within the therapeutic relationship and the values that they bring to it.

The qualitative study, in chapter four, also highlighted the importance of spirituality for Indigenous people and chapter five sets out to assist practitioners to better understand what is meant by spirituality within the Indigenous context. This also is a further component to answering the third research question and what needs to be acknowledged and understood within the therapeutic environment if it is to be truly culturally responsive.

7.2 Recommendations and future directions

The prologue of this thesis made note of the 2016 apology of the Australian Psychological Society (Carey et al., 2017) to past Indigenous clients of mental health practitioners. Chapter two also mentioned this apology and its resolution to pursue a different and better way to work with Indigenous people. It would appear from the responses of participants who were interviewed in chapter four that in the years since the apology there has not been a great deal of progress.

Cultural responsiveness is now part of what is required by those seeking national registration by the Psychology Board of Australia (2020) and the Australian Psychology Accreditation Council (2019) has directed that it be a core feature of psychology curricula in Australian universities. These requirements place responsibility on individuals and institutions to ensure that there is sufficient opportunity for students and practitioners to learn about cultural responsiveness and its place within psychology professional practice. Accordingly, the need arises to produce and to deliver course content that will initially inform but also challenge people to adopt a culturally responsive approach to their work with Indigenous people.

The conceptual model of cultural responsiveness in chapter three is a good starting point for building course and workshop content and further development of the CRAM, will assist individuals to monitor their progress. It is also important to understand that cultural responsiveness and the application of findings from this project cannot be limited to First Nations people in Australia. As noted in chapter six the outcomes of this project could have applicability for work with First Nations populations in settler colonial countries internationally, and there is potential for use of the conceptual model and modified versions of the CRAM with non-Indigenous minority and marginalised groups in many locations.

This thesis also introduced to the reader in chapter four, the importance of Indigenous Standpoint Theory and Aboriginal Participatory Action Research (Dudgeon et al., 2020) which are respectful of Indigenous knowledges and cultural protocols and are a decolonising element, so it is recommended that courses and workshops are inclusive of Indigenous presenters and local Elders.

7.3 Limitations

It is anticipated that the work of this project will advance our understanding and application of cultural responsiveness, but it is acknowledged that this work is far from over. Conceptual models and assessment instruments are a starting point to continue this work. Qualitative research by its very nature does not deliver data from samples representative of a population in the same way as quantitative data with large sample sizes (Polkinghorne, 2005). The responses within the qualitative study give pause for reflection and provide a foundation for further investigation, but a secondary purpose of this study was to explore the structure of the conceptual model and whether it represented an accurate picture of cultural responsiveness. The sample of twelve in this study was considered by the author to be a minimum and it would have been ideal to have had a larger sample but recruitment in these situations is often challenging. Seeking Indigenous former clients of mental health practitioners was always going to be difficult, and this study might have produced a larger sample if it had not been limited to mental health but instead to health in general. Furthermore, a future comparative study including non-Indigenous former clients could also possibly yield important data and continue to extend our understanding of cultural responsiveness.

7.4 The realm of cultural responsiveness

To understand cultural responsiveness, it is also important to understand the context or realm in which it is situated, and Figure 7.1 is the author's conceptualisation of this realm. The starting point is cultural intelligence, which is the contemplative phase of understanding and internalising cultural values and knowledge, together with the awareness of gaps in that knowledge and understanding, that must come before the action phase of cultural responsiveness. This then leads to cultural responsiveness, the action phase of the realm where professionals put into practice the principles of cultural responsiveness, and which then leads to cultural capital, described by Bourdieu (1986) as the accumulation of labour and that which has been built up through the work of cultural responsiveness.

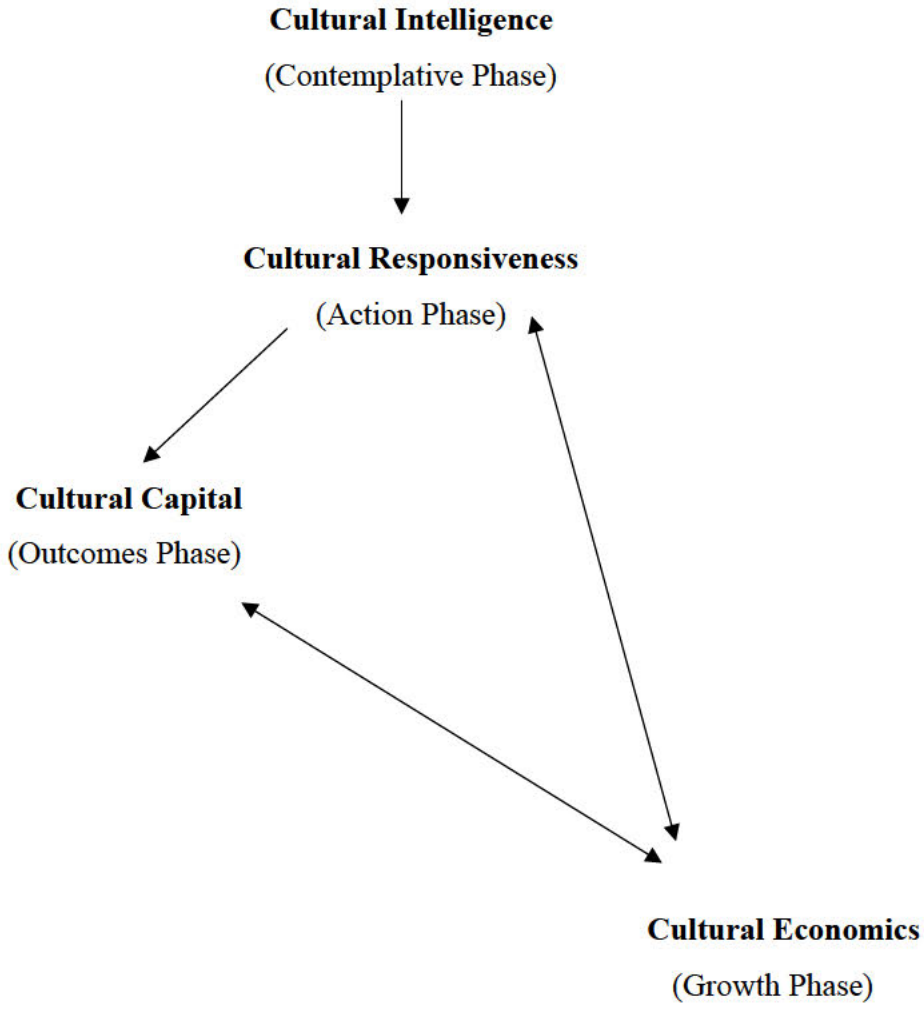

Figure 7.1: The Cultural Responsiveness Realm

Cultural capital is happening all around us. Acknowledgement of Country is now becoming more commonplace. There are notices of acknowledgement along main roads that the traveller is now in the land of an identified First Nations group. There are warnings on TV about images of those who have died and there are frequent references to Indigenous people and Elders. There is also a growing cultural intelligence happening in our society and it is placed in the conceptual model of the realm as a prerequisite to cultural responsiveness.

Cultural capital also produces cultural economics, where the work of cultural responsiveness produces an economy where work and services emerge, such as the important work of Aboriginal Medical Services, or where an Elder is brought in to present to a workshop group. Books are published and articles are written that continue to build the capacity of cultural capital. Cultural economics is also seen in projects such as land management practices that build further cultural and social capital.

The movements towards a Voice to Parliament, Treaty, Constitutional Recognition, Truth and Reconciliation are all manifestations of cultural capital that have developed a dynamism and vitality in and of themselves, where there is now vigorous debate across both sides of these complex issues. These debates have also featured cultural economics whereby the skills and intellect of Indigenous people have been featured in ways that have earned a deeper respect for voices that have long been silent.

7.5 References

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Epilogue (Yaluu)

"I sense that I am in so many ways changed for the better. I have remained fixed on the thought that this has been about improving mental health for a group for whom closing the gap is an urgent priority. Cultural responsiveness is transformative in many ways that are probably still emerging or are yet to emerge. And so, I wonder, how has it changed me?"

(Peter Smith, Reflective Journal, 21/2/2023)

Before I bid farewell (yaluu) to this work and to you the reader, it is important to spend a moment in reflection. This whole project has brought together theory and model development in a series of published articles that enable us to understand the meaning of cultural responsiveness and offer a way to implement this in working with Indigenous people. When as researchers we set out on this journey there is inevitably an element of naivete in what we plan to do. As noted earlier, I believed that I would be researching cultural competence, and this then became cultural responsiveness in line with the term adopted by both the Psychology Board of Australia and the Australian Psychology Accreditation Council, that encapsulates a dynamism that has been missing in earlier understandings. The conceptual model developed by the author, gives a new perspective on this construct that prompts constant evaluation and review in the understanding that skills are perpetually changing.

My overarching and primary concern in this work was that the voices of Indigenous people would be heard. My experience of interviewing participants in the qualitative study brought its own surprises and showed me just how important and relevant those voices were in my understanding of cultural responsiveness. It was at times disturbing and confronting to hear how badly mental health professionals are performing in their work with Indigenous clients. Hearing the stories of these wonderful and courageous people reinforced for me the importance of doing this much better by making mental health a safe and respectful place for all people.

The Cultural Responsiveness Assessment Measure (CRAM) is one way that I hope will enable practitioners to make whatever improvements they need to make in their work. It is just the beginning and there are a number of other measures that have emerged in recent times, and these are all positive moves at a time when cultural responsiveness needs to be understood and implemented.

As noted in the Prologue, memories of Christopher Columbus were my frequent companions in my research journey. He was a Genoese (Italian) working for the Spaniards and must at times have felt culturally out of step with his supporters and shipmates. Researchers, I have learned, often question their ability and their place within their research and even have moments of doubt and frustration, just like Columbus. However, I have learned the importance of remaining fixed on the horizon, the skill of waiting in patient silence, pointing in the right direction, in hope of landfall, knowing that in the end this journey will make a difference in the lives of others. My work is just one piece that may one day form a rich mosaic that others will finish. When Columbus planted the Spanish flag on Hispaniola, he would have had no idea that just a few days further journey across the water, was a place of immense natural resources and vast beyond anything that he would have known – North America. Research is often the realm of the surprising unknowns, and despite the storms and upheavals, it has taken me to places that I never anticipated. But there is always more that can be done and new horizons that beckon. I am so much richer for the experience and the mysteries of the interior journey, but more importantly, it is my fervent hope that my work in this project will enrich the lives of those whose voices for so long have been kept silent.

Yaluu, maaru yananga. Farewell and good wishes.

Appendices

Appendix I. Items of the Cultural Responsiveness Assessment Measure

Please read the following statements and choose a number between 1 and 7 where 1 means Strongly Disagree and 7 means Strongly Agree.

Awareness

1. There are many needs and issues affecting Indigenous communities, individuals, and families that differ from those in the wider community.
2. I can specifically name some of the causes that disadvantage the mental health of some Indigenous people in this country.
3. I understand the types of strength and resilience that have enabled Indigenous people to resist colonisation.

Knowledge

4. I have actively sought information and knowledge about Indigenous people.
5. I have attempted to learn the history of Indigenous Australia.
6. Indigenous people are better off since colonisation. (R)
7. I have made attempts to learn about local Indigenous culture.

Inclusive Relationships

8. I would seek to work with family and/or community members of Indigenous clients including having them present during sessions.
9. In order to assist me and if appropriate I would seek the help of an Indigenous mentor.
10. Indigenous healers are important.
11. Accessing community members or Indigenous mentors is not important for successful outcomes. (R)

Cultural Respect

12. I respect Indigenous culture and cultural values.
13. My own culture influences the way that I think and behave.
14. For some Indigenous people, spirituality has an important place within their culture.
15. Indigenous culture is not an important part of Indigenous people's social and emotional wellbeing. (R)

Cultural Safety

16. I would make my practice more culturally safe, in ways such as seeking the guidance of Indigenous clients.
17. I take time with clients to explain therapeutic practice or to answer questions.
18. Asking an Indigenous client about their culture is not important for best outcomes in therapeutic practice. (R)

Social Justice and Human Rights

19. I understand the meaning of my own position of power and privilege in relation to therapeutic practice.
20. I understand how the dominant culture has disadvantaged Indigenous people.
21. I understand how power and privilege and their psychological impacts have disadvantaged Indigenous people.
22. Decolonising mental health is not an important part of therapeutic practice. (R)

Self-Reflection

23. I frequently take the time to reflect on my thoughts, emotions, and behaviours in relation to therapeutic practice.
24. I use self-reflection to evaluate my values and my professional practice.
25. I have used self-reflection to make changes to professional practice or to further learn.
26. Self-reflection following a client session does not better inform subsequent sessions. (R)

Cultural Humility

27. Listening is an important first step in understanding a client's culture.
28. I am open to constructive criticism even if it causes me some discomfort.
29. I can learn from Indigenous clients who are knowledgeable of their own culture.
30. Understanding the cultural values of others does not contribute to better outcomes in therapeutic practice. (R)
31. When working with Indigenous clients I strive to address deficits in my knowledge and ways of working.

Cultural Competencies

32. Deep listening is an important intervention when working with Indigenous people.
33. Working holistically with Indigenous clients is important.
34. Specific interventions for Indigenous people are not necessary for best outcomes in therapeutic practice. (R)
35. The Western medical model of mental health is appropriate for all people. (R)

(R) denotes items that are reverse scored on a 7-point Likert scale

Appendix II. Interview Questions

Part A. Introduction: (To be completed by the interviewer)

You have been given the information sheet to read and to keep for yourself. Before we get started, do you have any questions about the study or what is being asked of you?

☐Yes ☐No

Details: _____

_____

You have also been given the consent form. Do you understand the terms of consent, and so do you agree to participate in this study?

☐Yes ☐No

Details: _____

_____

(Face-to-face participants will have the opportunity to sign a hard copy of the Consent form. Online participants will be sent the Consent form together with the Information form and will indicate consent by giving verbal acknowledgment, as above, on the recorded interview. This is known as Informed Recorded Consent).

What interview name, different from your real name, would you like to use for this interview?

Part B. General Questions: (To be completed by the interviewer)

Do you identify as:

☐Aboriginal

☐Torres Strait Islander

☐Aboriginal and Torres Strait Islander

***If you do not identify in any of these groups**, the purpose of the interview is to obtain responses only from Indigenous Australians, so we are unable to proceed any further.*

Do you identify with a specific group, tribe, clan, mob, nation, or region?

☐Yes ☐No

Details: _____

(Name of clan or tribe or mob)

Have you at any time been a client of a mental health practitioner, such as a psychologist, psychiatrist, counsellor, social worker, mental health nurse, occupational therapist?

☐Yes ☐No

Details: _____

(psychologist, psychiatrist counsellor, etc. No names.)

If you answered "No" *we cannot proceed any further as this study is only seeking responses from people who are former clients of mental health practitioners.*

Was this mental health practitioner:

☐Indigenous ☐non-Indigenous ☐Unknown

What is your age?

☐18-29 years

☐30-49 years

☐50-69 years

☐70+ years

☐Prefer not to say.

What is your gender?

☐Female

☐Male

☐Non-Binary

☐Prefer not to say.

You have indicated that you attended session(s) with a mental health practitioner. Can you describe for me that experience in your own words?

Probes: What did you think, feel, or see? What did you expect beforehand, and was it what you expected? If not, why not? What was good? What was not good?

What gave you the impression that it was or was not culturally responsive?

Probe: You might think about what happened or did not happen to give you this impression. Could anything have been done or said better? (Responsiveness)

Part C. Interview Questions; the model of Cultural Responsiveness:

Knowledge:

In what ways did your mental health practitioner demonstrate knowledge of your culture?

Probe: Could s/he acknowledge that there were gaps in this knowledge or even personal failures and that cultural knowledge is a continual process? What gave you that impression? How did this person go about getting that knowledge? (Knowledge)

Awareness:

Were there moments when your mental health practitioner understood the issues and needs of Indigenous communities and families? Describe these times. (Awareness)

Did you get the impression that your practitioner understood the breadth and diversity of Indigenous people and cultures in this country, or was there a sense of knowing about just a single culture that does not change from place to place? (Awareness)

Inclusive Relationships:

Describe ways that your mental health practitioner was able to work co-operatively with your family and community. (Inclusive Relationships)

Probes: *Did a friend or family member come to sessions with you? Was that helpful?*

Did you have a sense that you were working together as equals? (Inclusive Relationships)

Cultural Respect:

Was your culture, including your beliefs, spirituality, and cultural heritage understood and respected in ways that helped you to feel at ease? (Respect)

Probe: *Was anything said to you that indicated that your spirituality was or was not understood/respected?*

Probe: *What does spirituality mean to you?*

Probe: *In what ways could mental health be more respectful of your spirituality?*

In terms of culture (i.e., beliefs, spirituality, heritage) what could have been done to show more respect? (Respect)

Cultural Safety

Do you believe that the service provided by your mental health practitioner was culturally safe, respectful of your cultural values, and free of racism? If not, what was missing for you that could have helped you to feel culturally safe?

Probe: *What informed you that this service was culturally safe or unsafe? (Safety)*

Was there anything about the surroundings that made you feel more comfortable? What might have helped you to feel more comfortable?

Probe: *Were there any Indigenous images or posters or symbols such as flags? (Safety)*

Social Justice and Human Rights:

Were there indications that your mental health practitioner understood history and how power and privilege have disadvantaged Indigenous people?

Probe: *How was that conveyed to you? (Social Justice)*

Self-Reflection:

Do you believe that your mental health practitioner had reflected on what you had shared and had thought further about your issues between sessions?

Probes: Did you hear words like: "I have been thinking……", "Since last session, I was wondering……" or other similar expressions? If not, what words would have helped you? (Self-Reflection)

Cultural Humility

Did you experience being listened to or was your time with your practitioner one where you felt spoken down to and you had no chance to speak up for yourself? (Humility)

Was there a sense that s/he was prepared to learn from you? (Humility)

Cultural Competencies

Did your practitioner use any Indigenous-specific tests or assessments or ways of working that were specific to Indigenous people such as calling on the help of healers or Elders? If not, what would have helped you? (Competencies)

Is there anything further that you would like to add or anything else that you can think of that a clinician could do to be more culturally responsive?

Thank you for your participation today. You have contact numbers and email addresses if you are concerned about any matter, or if you would like a copy of your interview.

(Participants already have contact numbers and email addresses on the Information form)

Appendix III. Letter of Invitation to participants

Cultural Responsiveness:
A conceptual model for mental health professionals engaging with Aboriginal and Torres Strait Islander people.

University of New England

Information for Participants.

Dear Participant,

I am an Aboriginal psychologist researching Cultural Responsiveness and what this means for Aboriginal and Torres Strait Islander people.

What is this study about?

The aim of my study is to develop a better understanding of what can make services more responsive to the cultural needs of Aboriginal and Torres Strait Islander people. In this study, I am wanting Aboriginal and Torres Strait Islander people over the age of 18 years who have attended at least one session with a mental health professional to tell me what makes for good mental health practice, that is not only effective but also respectful, so your voice is important. This study will have benefits for Aboriginal and Torres Strait Islander people in terms of mental health care that understands and is shaped by culture, with mental health professionals who can respond appropriately.

How will the study be conducted?

I will be doing interviews, either by Zoom, Skype, Facetime or face-to-face and they will be recorded electronically. If you would rather be interviewed by another member of the team, such as a female research assistant, or another Aboriginal person, this can be arranged.

How can I participate and what if I have questions or concerns?

If you have any questions or concerns about the study, **please feel free to contact me on 0425 270 442 or by email on psmith90@myune.edu.au. My primary supervisor at University of New England is Dr. Kylie Rice who can be contacted by email on Kylie.Rice@une.edu.au; and by phone on (02) 6773 4259. Additionally, for any complaints please contact University of New England Human Research Ethics Committee on (02) 6773 3715. or by email on humanethics@une.edu.au.** This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE21-118, Valid to 30/11/2022 and the Aboriginal Health and Medical Research Council Ethics Committee (Approval No. 1846/21, Valid to 9/11/22) who can be contacted at 35 Harvey Street Little Bay NSW 2012 or by email at ethics@ahmrc.org.au.

Are there any risks?

This research should not raise upsetting issues for people but if at any time you experience any distress and need some support you can contact your GP or local health centre, or a counsellor at

Walhallow Aboriginal Corporation on 6746 2001 or Tamworth Aboriginal Medical Service on 6760 2500. The contact number for Lifeline is 131 114 and Beyondblue is 1300 22 46 36.

What about my privacy? Can I withdraw?

Your responses will be anonymous, because another name of your choosing, instead of your real name, will be used. However, researchers have a legal responsibility to report incidences where the participant poses a risk of harm to themselves or others and/or unlawful activity is identified. In such cases personal identity may have to be revealed.

Results from this study may be published in an academic journal or shared at a professional conference, but if any part of your responses are used, only your interview name will be included to distinguish from other responses.

It is your choice to take part in this interview and so you can also say "no", and you may withdraw from the study at any time, without any need of explanation, and your interview record will be deleted and destroyed. You may also change parts of your interview if inaccurate. All interview records and transcripts in this study will be maintained in a secure location, available only to the research team, and will be destroyed after approximately five years. However, general, de-identified data will be stored indefinitely to assist further research.

You will not be asked anything shared with your mental health professional, because what is being asked of you in the interview is for you to share your experiences and opinions regarding this time.

Can I get a copy of my interview?

You may request a copy of your interview, which will be stored for five years, and you are welcome to get a copy of the final report at any time. Please also feel free at any time to ask questions if there is anything that you are not sure of or if you have any concerns.

Thank you for taking part in this study. By way of thanks for your time and contribution, you will receive a $50 supermarket gift voucher.

Yours sincerely,

Peter Smith,

B.Soc.Sc., Grad.Dip.Counselling, M.Psych.(Forensic), PhD Candidate, MAPS, MAAPi.

Registered Psychologist (Registration No. PSY0001059063)

Member Australian Indigenous Psychologists Association

Appendix IV. [redacted]

Cultural Responsiveness: A conceptual model for mental health professionals engaging with Aboriginal and Torres Strait Islander people.

Contact Information

If you would like to participate in this study or you would like further information please contact:

Peter Smith at:
psmith90@myune.edu.au

Mobile: 0425 270 442

or Dr. Kylie Rice at University of New England at:
krice3@une.edu.au

Phone: 02 6773 3333

une
University of New England

Mental Health services for Aboriginal and Torres Strait Islander people need

If you are an Aboriginal or Torres Strait Islander person, over the age of 18 years, and you have at some time in the past been a client of a mental health professional, such as a psychiatrist, psychologist, social worker, counsellor or mental health nurse, you could help us to understand what has been working well and what needs to improve. This research is approved by the University of New England and Aboriginal Health and Medical Research Council, and its aim is to find out from people how mental health services can be more culturally responsive.

If you would like to assist in this study, you will be asked to participate in a one-on-one interview, either face to face or via a computer medium such as Zoom or Teams or Facetime. The interview will take about 45- 60 minutes and your identity will remain confidential. In appreciation of your time and your contribution you will be offered a $50 supermarket voucher.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HE21-118, Valid to 30/11/2022.). and the AH&MRC Ethics Committee (Approval No 1846/21, Valid to 9/11/2022.

Appendix V. Consent Form

Cultural Responsiveness: A conceptual model for mental health professionals engaging with Aboriginal and Torres Strait Islander people

PARTICIPANT CONSENT FORM

Completing this *Consent Form* is your choice. THIS MEANS YOU CAN SAY "NO".

By signing this *Consent Form,* it means that you agree to take part and understand the following:

□ Yes □ No	You understand why this project is being done, what is involved, and any risks, as described in the *Participant Information Sheet*?
□ Yes □ No	You are aged 18 years or over.
□ Yes □ No	You identify as Aboriginal and/or Torres Strait Islander
□ Yes □ No	You are a past client of a mental health practitioner.
□ Yes □ No	You will not benefit personally from taking part.
□ Yes □ No	Your participation is your choice and you can stop at any time.
□ Yes □ No	You have been given information and have been able to ask questions.
□ Yes □ No	You understand that any information collected about you will be safely stored for up to 5 years.
□ Yes □ No	That your information will not be given to anyone else.
□ Yes □ No	You have been given a copy of the *Participant Information Sheet* to keep.
□ Yes □ No	Any reports, conference presentations or journal articles about this project will not mention your name or reveal your identity.

Participant

I have read the *Participant Information Sheet* or had this read for me. I understand what is involved and I agree to take part.

PRINT NAME……

SIGNATURE…… DATE (DD/MM/YY) …./…./….

Researcher/Interviewer

I have explained the research project verbally, including what is involved and any risks and I believe that the participant has understood that explanation.