ORIGINAL ARTICLE

Lip service: Public mental health services and the care of Aboriginal and Torres Strait Islander peoples

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ABSTRACT: *The failure of public mental services in Australia to provide care deemed culturally safe for Aboriginal and Torres Strait Islander people has persisted despite several national reports and policies that have attempted to promote positive service change. Nurses represent the largest professional group practising within these services. This article reports on a multisited ethnography of mental health nursing practice as it relates to this group of mental health service users. It explores the beliefs and ideas that nurses identified about public mental health services and the services they provided to Aboriginal and Torres Strait Islander people. During the fieldwork, mental health nurses described the constricting effect of the biomedical paradigm of mental illness on their abilities to provide authentic holistic care focused on social and emotional well-being. Despite being the most numerous professional group in mental health services, the speciality of mental health nursing appears unable to change this situation and in many cases maintain this status quo to the potential detriment of their Aboriginal and Torres Strait Islander service users.*

KEY WORDS: *Aboriginal Australians, culture, Indigenous peoples, mental health, nursing.*

INTRODUCTION

Mental disorders are reported to be the leading cause of disease burden among Aboriginal and Torres Strait Islander peoples after cardiovascular disorders (AIHW 2016). Indigenous Australians are also dying from suicide at 2.1 times the rate for non-Indigenous Australians (AHMAC 2017). In the context of public mental health service provision, specialized community mental health service contacts for Indigenous Australians were four times the rate for non-Indigenous Australians in 2014–2015 (AHMAC 2017). Between 2011 and 2013, the hospitalization rate for Indigenous women with mental health issues was 1.5 times the rate for non-Indigenous women, and the hospitalization rate for Indigenous men with mental health issues was 2.1 times the rate for non-Indigenous men (AHMAC 2017).

Since the 1990s, significant problems with the public mental health services provided to Aboriginal and Torres Strait Islander peoples have been identified (Human Rights and Equal Opportunity Commission 1993, Royal Commission into Aboriginal Deaths in Custody 1991, Swan & Raphael 1995). Both the Royal Commission report and the Burdekin report found that mental health professionals had little understanding of Indigenous Australian culture, and this often resulted

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in inappropriate treatment. Despite these reports and later attempts at change through the National Strategic Framework (Commonwealth of Australia 2004) and the National Mental Health Plan (Commonwealth of Australia 2009), inflexible models of service delivery and inadequate cultural awareness have continued to present barriers for Indigenous Australian service users (Isaacs *et al.* 2010; Walker *et al.* 2014).

Since the 1995 *Ways Forward* report, Australian health policy and planning have increasingly recognized that mental health and well-being are intrinsically connected to the 'whole of life' for most Aboriginal and Torres Strait Islander peoples (Swan & Raphael 1995, p. 20). After the publication of *Ways Forward*, policy related to mental health has focused on Aboriginal and Torres Strait Islander social and emotional well-being, described as 'a multidimensional concept of health that includes mental health, but which also encompasses domains of health and well-being such as connection to land or 'country', culture, spirituality, ancestry, family, and community' (Gee *et al.* 2014, p. 55). Such policy recognizes that factors pertaining to Indigenous Australians' social and emotional well-being extend beyond the mental health system to encompass education, law and justice, human rights, and native title (Zubrick *et al.* 2014). The concept of mental illness as physiological disease within the biomedical paradigm, therefore, fails to address Aboriginal and Torres Strait Islander health perspectives. Furthermore, this paradigm is based on an approach to illness and disease that is both inappropriate and irrelevant to the beliefs of most Aboriginal and Torres Strait Islander peoples (Westerman 2004).

While Indigenous Australian communities have continued to advocate for culturally appropriate mental health programs (Zubrick *et al.* 2014), several national and state policies have attempted to promote the development of positive service change in response (Sayers *et al.* 2017). However, successive reviews of Aboriginal and Torres Strait Islander mental health policy have concluded that its implementation has been largely ineffective (Zubrick *et al.* 2014).

State-provided public mental health services include crisis management, crisis support, continuing care, inpatient services, primary care, and early intervention, and these are often the only mental health services available to Aboriginal and Torres Strait Islander peoples (Isaacs *et al.* 2010). However, valid understanding of Aboriginal culture has rarely shaped service provision or guided care of Aboriginal and Torres Strait Islander peoples who require these services (Haswell-

Elkins *et al.* 2007). Nurses represent the largest professional group practising in these services (Government of Australia 2013).

Challenged by the above critique, the authors undertook a social analysis of mental health nursing practice as it relates to Aboriginal and Torres Strait Islander mental health service users. This study explores the beliefs and ideas that nurses identified about public mental health services and about the services provided to Aboriginal and Torres Strait Islander peoples.

METHODS

The aim of this study was to explore the culture of mental health nursing in relation to the care of Aboriginal and Torres Strait Islander service users of public mental health services. The study aimed to contribute to our understanding of current practices and attitudes and describe in-depth current systems and processes within the Australian mental health services. Two additional papers will present findings focused on specialist mental health nursing practice and Aboriginal and Torres Strait Islander service users. This decision was informed by the amount of data generated by the research process, and the belief that these papers will strengthen the reporting of our study.

Ethnography enables research on the beliefs and social interactions of groups (Naidoo 2012). The object of this ethnographic inquiry, a professional group of mental health nurses, works across many different clinical areas within multiple health services that constitute the public mental health system in Australia. Using a traditional approach to ethnography would have required this study to focus on a single site of clinical practice. Viewing the issue through the lens of multisited ethnography, however, has allowed the research to explore mental health nursing culture across Australia (Molloy *et al.* 2017).

The primary author collected ethnographical materials between October 2014 and December 2016. Fieldwork included participant observation at two Australian College of Mental Health Nurses conferences and non-participant observation in two state health services: (i) a regional mental health service; and (ii) an inner-city mental health service. The conferences offered a space to hear from presenters about current practice and engage with attendees about their ideas on practice in the public mental health service setting. In relation to the two mental health services, the sites where

practice were observed involved community mental health teams, inpatient wards and mental health teams working in emergency departments. In-depth interviews were also conducted with 17 mental health nurses from across the country, recruited through the Australian College of Mental Health Nurses' 'Aboriginal & Torres Strait Islander Special Interest Group' e-list and from the fieldwork sites. These interviews lasted between 30 and 70 min and were recorded and transcribed for data analysis. A further 28 mental health nurses were informally interviewed. These conversations took place in practice settings. Fieldnotes were recorded at the end of each interaction. All nurses interviewed were registered nurses who had experience practising in the public mental health services.

During the period of the research, the authors undertook a review of relevant documents, including scholarly literature, professional and health service documents, government publications, and historical documents related to the speciality. Throughout the research, the primary author took fieldnotes, which served as both a written record of the ethnography and as a method for practising reflexivity throughout the research process.

The analytic strategy used for interview transcriptions and fieldnotes followed what Corbin and Strauss (2008) describe as open coding, axial coding, and selective coding. This inductive process derived the themes of the ethnography explored in this article, namely 'biomedical creep', and 'lip service'; the additional themes of 'respecting the difference', 'a specialist practice?', and 'mental health nursing and the other' will be explored in additional papers. Data analysis revealed the interrelationships between practice experiences and ideas about practice and provided us with a means of focusing observations on mental health nursing and its practice in relation to Indigenous Australians in public mental health services. The names used for all interviewees are pseudonyms. The study received ethical approval through the HREC (Tasmania) network (H0014330).

FINDINGS

Biomedical creep

Fieldnotes
The Psychiatric Intensive Care Unit is a daunting place. There is a dim indoor area and a large bright enclosed outdoor space. It's hot. A soft smell of body odor carries in the breeze that enters from outside. The service users walk around with only a handful engaging with each other or staff. The nurse manager tells me the majority are Indigenous Australians. The interactions I see between them are tense. The whole atmosphere seems tense, or at least I'm tense because I haven't been in such a confined space with this many unwell people for a number of years. There are arguments. One of the men roars at an older man and then at the staff who intervene. Someone starts shouting about a phone call. Another person beside me is talking loudly to himself, agitated by whatever is going on for him.

The four staff working all seem relaxed in this environment. They are spread out and observe the scene and involve themselves in it when required. They try to dampen down the escalating agitation and respond to requests. I position myself on a couch to talk with a nurse. As I begin to talk one of the service users begins to sing a song in an Indigenous language and starts a dance. He is soon joined by another Indigenous Australian man, who mirrors him in tune and step. It ends after about a minute and they walk off from each other.

When I explain the focus of my study to the nurse, he tells me that an Indigenous Australian nurse works in the unit but he thinks the nurse doesn't 'do anything different' when compared to the practice of non-Indigenous nurses. 'You could staff this place with all Indigenous staff and it wouldn't change. It's the model. Medical'.

Across different clinical areas and across the country, mental health nurses repeatedly discussed the concept of a constricting medical/biomedical 'model'. The National Standards for Mental Health Services (2010, p 2), first introduced by the Australian Government in 1996 'to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services', do not clearly identify the presence of a medical model as something that exists in the services they seek to shape. Yet for nurses, this model has a power that they discussed encountering every day and that they view as having ultimate control over many of their workplaces. It envelops their practice settings and creates situations that alienate the nurses from their expectations of good mental health care. They described the 'medical model' as constricting the possibilities of holism within services and killing off other approaches to treatment, leaving nothing but pharmaceuticals.

Fieldnotes
Georgina tells me the mental health services are 'shit'. 'We talk about being holistic but we're not. It's still, take the tablets'.

Interview

Eve: Just putting them on medication is not enough either and sometimes that's all they get really … When I first started in [a regional city] 20 years ago it was much more holistic health.

The mental health nurses discussed how the circumstances created by this medical model are used by psychiatrists to maintain their privileged position within the services. It emboldens them to dictate the conditions service users find themselves in, even when there seems no clear reason for these situations beyond psychiatrists' own individual opinions. It allows them to discredit the ideas of other health professionals, empowering the doctors with a belief that they know best.

Interview

Chris: What you're saying [as a nurse] doesn't really count.

However, this is not simply an issue of medicine dominating nursing in their shared sites of clinical practice. A paradox for mental health nursing is that at a time when governmental discourse captured in the policies and standards focuses on the ideology of holism, social and emotional well-being, and recovery (Commonwealth of Australia 2009, The National Standards for Mental Health Services 2010), many mental health nurses encountered during the research believe their own specialty is moving further away from the possibilities of care that could be described in such terms. The care they see being delivered most consistently by mental health nurses in mental health services is characterized as biomedically biased.

Many mental health nurses described this creeping influence of the biomedical paradigm within mental health nursing practice. This idea appears to be based on the belief that mental health nursing in Australia had once been more balanced in its approaches to care, taking influences from disciplines other than medicine, such as psychotherapeutic approaches. At a time when policy urges holistic care, mental health nurses mourn the loss of more holistic approaches to care; they talked about an increasing reliance on biomedical treatments only, particularly in inpatient environments.

Interview

Patrick: All we've become now is the nurse at the drug trolley or the food trolley. And I think nurses are to blame for that themselves. They haven't been good enough at doing the psychological stuff to make themselves invaluable. They're invaluable at handing out medications, but even that role, because of the changing dynamic of the

workforce, more and more less trained types of nurses are able to give medications now.

Nurses saw different reasons for this development. A clinical environment that is increasingly focused on getting people out of inpatient beds is seen to have had a significant impact. The same government that pushed change in mental health services also put pressure on that system. This resulted from policies such as the *National Emergency Access Target,* which is aimed at producing Australian emergency departments (EDs) in which 90% of all patients will leave the ED within 4 hours, after being either discharged, admitted to hospital or transferred to another hospital for treatment (AIHW 2013). These policies have created expectations on inpatient bed management that have impacted on all areas of the services, both in the hospital setting and community mental health teams. A nurse unit manager working in an acute inpatient ward described the influence of this expectation to 'churn' people through the service:

Interview

Coco: [The inpatient unit] for example would be churning people out so quickly that there's so much potential there in terms of what nurses could be doing with their patients, but they're so caught up in just doing tasks and managing, you know, sort of administering tasks for people and following through on instructions from doctors, and giving out tablets and doing the admin sort of side of nursing that's ever-growing, and there's little time to actually be there engaging with the person. And they do the best they can, they're fantastic but I think the medical model up there is if we're getting people in, we're treating them quickly, well how do we do that? Largely with medication whether it's to sedate them and just get them through till they're calmer, or whether it's to start them again on something, but there's not a lot of other therapies going on.

The other issue that was noted to be a factor of the biomedical focus for mental health nursing practice was related to undergraduate nursing education. Many nurses working in mental health view the move to 'comprehensive nursing' as something that had led to the crumbling of the speciality, causing a default to biomedical approaches to nursing care. This was identified in particular by those who had undertaken specialist mental health nursing training prior to the instigation of comprehensive training and by those who had completed direct entry specialist mental health training in other countries before migrating to Australia.

A mental health nurse working as an academic in a university shared her belief about the situation:

Interview
Emily: we're losing ground when it comes to the maintenance of a speciality in mental health nursing profession. So, we're dominated by nurses like generalist nurses or comprehensive, whatever word you want to use, who are totally uncritical of the biomedical model.

One of the clinical areas I visited during the research was a small inpatient mental health setting attached to an emergency department in an urban area. I talked to nurses who had trained in specialist mental health nursing programs in the United Kingdom and Ireland.

Fieldnotes
The Irish and English nurses said they had to de-skill to work in Australian mental health nursing. Their jobs also involved accepting a reduction in autonomy. They noted that practice was dominated by the medical model. They had recently tried to challenge the situation by attempting to wrestle control of initial assessments from the medical team. The medical team had agreed to do so, claiming that they did not in fact control the assessment procedures they controlled. They found nurses in their own team were resistant to undertaking the assessments of presentations to the unit. 'Australian nurses', one pointedly notes. He tells me he found this frustrating. Another nurse describes mental health nursing as 'shite' in Australia.

The reliance on biomedical approaches to nursing care has created a situation in some clinical areas where those who had control of the pharmaceutical treatments ultimately took control of the service user's care. With care and treatment controlled by psychiatrists, the services have become increasingly medically dominated, and nurses have become increasingly disempowered.

Interview
Joseph: you hear the nurses talking about their interventions in very biological terms, very medical terms. It's all about medication, PRN, getting the doctors to make a plan. They will often argue for hours about how crap the doctors are because this patient needs a plan. Well, what are you waiting on then? Write a plan. But it's always like, well, we can't do it, it's got to be the doctor that writes the plan.

For many nurses interviewed, this meant that the services that they worked in did not meet their expectations of adequate mental health services. A nurse speaking to me in a rural community mental health centre told me the following:

Interview
Eve: I find mental health service in general has gone down since I've been here dramatically especially in the model, it's just pure medical model. All they do is just medicate. Me and [a colleague] tried to do other things but we're limited as well but it's there, the medical model it's just medication, see you later, we'll review in three months.

Lip service
Amidst the struggles to attain holistic practice, many nurses were dubious about their service's ability to provide adequate care for Indigenous Australians. When I talked about the public mental services to a mental health nurse working within an Aboriginal community in a remote setting, she quickly told me the following:

Interview
Jane: It's just not something that I even consider or contemplate. I couldn't imagine referring someone to the public mental health system, an Aboriginal person.

A key barrier against Jane referring Aboriginal people was her experience of mental health services as *white* mental health services that were monopolized by the biomedical paradigm of mental illness and pharmaceutical treatments. These were places where the Aboriginal people she worked with would not do well.

Mental health nurses practising across the country expressed their belief that the public mental health services could not be effectively refocused on social and emotional well-being for Indigenous Australian service users. These services were challenged by embedding concepts into practice, such as cultural safety or cultural awareness for Indigenous Australians. Jessie, a mental health nurse working in South Australia, said he was pessimistic about how mental health services embedded approaches that could make the former effective or even welcoming for Indigenous Australians:

Interview
Jessie: I think we're deluding ourselves if we believe that we're fulfilling cultural responsibilities by doing what we do. I don't think we are in any way, shape or form. I think we're sadly lacking in our cultural awareness. To be honest I don't know how you would correct that. I don't know how you would make that work. I think it would be quite difficult to make it work.

The existing arrangements for services do not nurture the engagement of Indigenous Australians. While individual nurses and some teams focused their work

on trying to understand Indigenous Australians' fears of the system and understanding history and culture, the services in which these nurses were practising were often judged with cynicism. Chris, reflecting on her inner-city service, told me as follows:

> Interview
> Chris: I think we do the Band-Aid kind of what we need to. To look like we're meeting what may be policy requirements . . . – I can't think of the right word, it's kind of superficial and I think we could do it a lot better.

Facades of policies, posters, and mandatory training around delivering health services to Indigenous Australians hide services that are mostly medication-orientated. Policies are initiated, hospital executives launch Reconciliation Action Plans and mandatory training cycles persist, but service provision appears unmoved – or even unmovable. After a round of cultural awareness training in his service, one nurse questioned the impact of it at an organizational level:

> Interview
> Joseph: So has anything changed? I would say no.

Chloe, who had worked in several management positions in mental health services over a twenty-year period, shared her reflections:

> Interview
> Chloe: I think that individuals within the services are trying to do better and are trying to understand. I don't think the services have got much appetite to restructure themselves to allow culturally appropriate activities to occur.

One of the interviewees working as a clinical nurse consultant described how not only were biomedical approaches dominant in approaches to care and treatment, but they had been mutated by a medical team, in a unit he had practised in, to treat an Aboriginal person differently from other service users. Joseph told me about this experience of care:

> Interview
> Joseph: I worked very closely with him but the doctors actually said he needed multiple antipsychotics, he was dangerous, he was very psychotic and he needed – he got really aggressive treatment. Which I didn't agree with but that view was discounted.

He was at one point on four antipsychotics including Clozapine. And I can remember trying to help this guy and feeling really conflicted because he was clearly suffering with extreme side effects. I mean the guy was rigid, his blood pressure was as high as a kite, and he was suffering all sorts of kind of increase and decrease in his body temperature. His jaw was rigid, his thought process was slowed down, and it was just disgusting to see. And when I tried to raise that with his consultant who was a specialist allegedly in Aboriginal care and ran a clinic out at the community where a lot of the clients came from, he just told me 'this is what you do, this is what you need when you're working with Indigenous people'. You know, they don't respond the same way as your typical Australian or other international kind of patients. They needed this more oppressive approach and I just thought 'Well, where's the evidence for that?' Because all I see is a guy – I didn't buy that at all.

I think I was always taught one antipsychotic only and if it was Clozapine, he was only on Clozapine because the others don't work anyway. So why bother putting an extra three in there when this poor… And this guy was in a real bad way. He eventually absconded and I didn't see him again after that – and I think rightly so. He probably couldn't wait to get away.

This use of biomedical interventions specifically for Aboriginal people was not something only carried out by medical staff.

> Fieldnotes
> I talk to a psychiatric registrar about her experiences working with mental health nurses as they have cared for Aboriginal and Torres Strait Islander people. She finds there is a big stigma towards Aboriginal and Torres Strait Islander people in the locality generally compared to other places that she has worked in within Australia. She thinks she sees this in how nurses use medication with Aboriginal and Torres Strait Islander people. In her experience, she has found that Aboriginal and Torres Strait Islander people are more likely to be given intramuscular medication than non-Indigenous people. She believes that Indigeneity also becomes a key issue in nurse's risk assessment. 'Young Aboriginal Male that is the worst to be'. She tells me a story about an Aboriginal woman who was being confined in a room and was shouting and cursing at the staff. The nurses wanted to medicate her to transfer her to another part of the service, but she could empathise with her sense of confinement and anger; so she sat and explained what was happening and she calmed down and was transferred without the need of sedating medication.

DISCUSSION

Nurses find themselves behind the scenes of their organizations' commitments to provide culturally safe

services to Indigenous Australians and do not see much progress in this area. Sherwood (2013) believes that appreciating the divergent ways of viewing health for Indigenous and non-Indigenous Australians is vital to these groups working together effectively and respectfully. Yet how this appreciation can be nurtured into respectful and meaningful change is a blockage in current public mental health services in Australia. These services train clinicians to recognize and respect the differences between Indigenous and non-Indigenous Australians, through programmes such as Respecting the Difference (NSW Ministry of Health, 2011). However, these same trained clinicians are then returned to clinical areas that continue to propagate models for professional practice that are not obviously respectful in regard to health beliefs or necessarily effective in engaging Indigenous Australian service users (Bradley *et al.* 2015; Shepherd & Phillips 2016; Westerman 2004).

The biomedically orientated thinking that has come to dominate psychiatry and its clinical settings in recent decades excludes alternative ways of thinking about clinical practice (Benning 2015). The exclusion of Indigenous Australian perspectives on social and emotional well-being from overarching models of practice continues inequitable power relations and blocks institutional ability to develop in ways that can effectively address Indigenous Australian service needs (Shepherd & Phillips 2016). The concepts of cultural awareness or cultural safety (Ramsden 2002) do not seem able to challenge this inertia. These ideas may have the potential to transform individuals (Doyle *et al.* 2016; McGough *et al.* 2017; Molloy & Grootjans 2014; Trueman 2017), but many of the nurses interviewed found their individual appreciation of these practice concepts was impotent in creating change in their wider organizations. The idea that biomedical interventions provide the tools to address mental illness is too deeply ingrained within the ideology, culture, and discourse of these services and is privileged within their hierarchical power structures (Lakeman 2013). This creates a clinical environment in which the only change is the development of mechanisms that create an illusion of appreciating divergence to address the mandated requirements of local and national policy (National Standards for Mental Health Services 2010, NSW Ministry of Health 2012, Queensland Health 2010). The National Aboriginal Health Strategy stated back in 1989 that mainstream health services were 'too far entrenched in the current system, based on the medical model, to promote or contemplate an alternative'

(NAHSWP 1989, p xvi). Nearly 30 years later, this entrenchment seems to thrive in public mental health services.

The impetus behind this is not simply an issue of medical professional control. Many nurses themselves have embraced a form of nursing practice that is dominated by biomedical constructions of mental illness (Barker 2001). In visits to practice sites, the absence of doctors was obvious. Where a medical presence was maintained, it was often a junior doctor surrounded by nursing staff. In the inpatient settings visited, medical teams visited for a round of conversations; few of these conversations with the nursing staff went beyond queries about bed availability or requests for chaperones. Nurses, however, were consistently in these sites, and any model could only have been maintained with the nurses' ongoing support. The roles that many nurses had chosen to perform were instrumental in maintaining biomedical dominance in these sites (Lakeman 2014).

Despite criticism that nurses voiced throughout the study, active, and material resistance to this dominance seemed limited. Nurses questioned incidences of treatment, but there was no evidence of overt revolt to the approaches that many believed led to service failings for the people they were nursing. The only obvious form of struggle seemed to be moving away from service centres such as hospital settings, with one community nurse noting, 'I think the closer you are to psychiatrists because they set the pace, the more influence of the biomedical model. The community workers, much less so. And certainly in rural remote areas, there is much bigger opportunities for mental health nurses to adopt the recovery approach.' One interviewee's resistance had led her to de-identify as a mental health nurse. Jane told me the following in relation to her work with remote Aboriginal communities:

Interview
Jane: I guess for myself I've kind of wanted to shake myself away from belonging to any culture of mental health nursing. I haven't liked that label, that identity and so I've gone [to do university studies] so I could be a counsellor not a mental health nurse. A mental health nurse just felt really limiting and I guess too much associated with a medical model for me to feel comfortable to have that as my title.

The research provided concerning insights into how health professionals could warp biomedical interventions in their management of Indigenous Australian inpatients. Interviewees described practices whereby Indigenous Australians were not simply experiencing

the dominance of biomedical reductionism and the restrictions on the range of care and practice that brings to all service users but also experiencing pharmacological practices guided by beliefs about Indigenous Australian ethnicity. There is a clear need for future research to examine if Indigenous Australian service users are at greater risk in public mental health services through the overuse of sedative medications.

CONCLUSION

Despite several national reports and policies that have promoted Aboriginal and Torres Strait Islander communities' calls for change regarding the development of positive service, public mental services in Australia still fail to provide culturally safe care for Aboriginal and Torres Strait Islander peoples. In this study, mental health nurses described the constricting effect of the biomedical paradigm of mental illness on their abilities to provide authentic holistic care focused on social and emotional well-being. The speciality of mental health nursing, although the largest professional group in mental health services, appears unable to change this situation; in many cases, it actually maintains this status quo to the potential detriment of its Indigenous Australian service users.

RELEVANCE FOR CLINICAL PRACTICE

For people who work in public mental health services, the challenge in ensuring reconciliation and recovery is to provide public mental health services that adequately meet the needs of Aboriginal and Torres Strait Islander peoples. Within these services, culturally valid understanding must not only shape individuals' practice but also provide the basis of all health services approaches for Indigenous Australian mental health care and treatment. To achieve this, there is a clear need for a more active engagement with Indigenous Australian communities, including Aboriginal and Torres Strait Islander mental health workers, Elders, traditional healers, and cultural healers. This inclusive approach should include an ongoing review of mental health nursing practices within services by Indigenous Australian community members and enable meaningful dialogue with communities about what approaches to care and treatment would best meet their needs. Such engagement should focus on whether valid understanding of Aboriginal culture is shaping care of Aboriginal and Torres Strait Islander peoples, moving mental health nursing practice beyond Western-centric approaches that reflect the dominant hegemony of the biomedical paradigm.

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