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Nursing care and indigenous Australians: An autoethnography

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ABSTRACT

Background: Public mental services in Australia have failed to provide culturally appropriate care for Indigenous Australians despite several national reports and policies that have attempted to promote service improvement in this area.

Purpose: This research focused on the experiences of working as a mental health nurse in an Australian public mental health service as the focal point for an autoethnography.

Method: The research used written journal reflections to critically explore culture within a public mental health service as it related to the care of Aboriginal and Torres Strait Islander Australians.

Findings: The mental health service was a place where white privilege was maintained through the dominance of the biomedical model of mental illness. Standardised approaches to nursing care further strengthened white privilege within the mental health service, and produced care practices that were unable to respond appropriately to the mental health needs of Indigenous Australians.

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1. Introduction

Said (1993) observes that society is still influenced by imperialism, through history and the new forms it has taken in the 'postcolonial' world. To understand the contemporary experiences of Aboriginal and Torres Strait Islander Australians, a historical background is essential (Dudgeon, 2014). Archaeologists have identified that people lived in Australia for at least 50,000 years before the decision to colonise it into the British Empire (Broome, 2002). Numerous Aboriginal historical and religious concepts regarding their long habitation of Australia pre date this period to creation of land and people in the Dreamtime (Eckermann et al., 2006).

During the period of colonisation, colonists subjected Aboriginal people to an unremitting invasion (Broome, 2002). This undeclared war that saw colonist's claims to the land overriding the Aboriginal people's right to life (Rowley, 1970). Aboriginal people were victims of rape, shootings, and poisoning as colonisation spread throughout the country (Eckermann et al., 2006; Kidd 2005). Furthermore, the introduction of diseases, such as smallpox, measles, and influenza, led to the massive depopulation of Aboriginal communities (Broome, 2002). Colonisation also introduced agricultural processes that excluded people from their traditional food sources, which led to widespread hunger and associated illnesses (Eckermann et al., 2006).

Colonialist policies led to the loss of traditional lands, relegation of the people to reserves and missions, separation, death, and the erosion of cultural traditions (Eckermann et al., 2006). The catastrophic consequences of colonisation continue to affect Aboriginal and Torres Strait Islander Australians to the present day (Dudgeon, 2014).

Mental disorders are reported to be the leading cause of disease burden among Indigenous Australians after cardiovascular disease, with Indigenous Australians being more than twice as likely to be hospitalised for mental disorder as non-Indigenous Australians (AIHW, 2011). However, Indigenous Australians have identified a lack of respect for their culture and the dominance of a Western-centric perspective on mental health as causing negative health care experiences in public mental health services (Walker, Schultz, & Sonn, 2014).

2. Methodology

Autoethnography has become an increasingly popular method in qualitative research (Anderson, 2006). In this form of ethnographic research, the researcher's awareness is focused on the Self while remaining concerned with the broader context in which their experiences have occurred (Denzin, 1997). This refocusing provides an approach to research and writing that seeks to both describe and analyse personal experience in order to understand cultural experience (Ellis, Adams, & Bochner, 2010). The ethnography is usually written in the first person and can feature stories affected by social structure (Holt, 2003). Foster, McAllister and

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O'Brien, (2006) believe that autoethnography can benefit mental health nursing practice through exploring local practices in a way that may resonate as meaningful for nurses and so be educative and insight-raising for the discipline. While Wright (2008) suggests that by focusing on Self in research, nurses can learn how their values, attitudes and beliefs about health, illness and care have been constructed. In undertaking this work, I was guided by Adams and Holman Jones (2011, p. 111) who suggest that the concept of the *autoethnographic* is "sharing politicized, practical, and cultural stories that resonate with others and motivating these others to share theirs".

Despite literature that raises concerns about practices within Australia's public mental health services (Walker et al., 2014), there has been little literature focused on mental health nursing and its practices related to the care of Indigenous Australian people within them. I have used my own experiences of working as a mental health nurse in public mental health services as the focal point of this autoethnography. This has been explored through written journal reflections that focused on my experience within a public mental health service. Some of these journal reflections, carried out over the last three years, are synthesised in this paper into story. This story is related to my experience around caring for my first Aboriginal consumer, that I hope resonate with others and bring them to share their own. Ethics approval was granted by the Human Research Ethics Committee (Tasmania) Network.

3. My story

I migrated to Australia from Ireland in 2004. I was a Registered Psychiatric Nurse with five years' experience and had been sponsored for migration by an Australian mental health service. My job was in an inpatient admissions unit that served a multicultural population in a bustling urban environment. The unit's catchment area was residence to some of Australia's richest and poorest people, with areas where multi-million dollar apartments overlook homeless shelters. The majority of the people admitted to the unit were there against their will, with an admission criteria being that focused on risk, be it to themselves or others, due to mental illness.

Violence occurred with unnerving regularity and the atmosphere in the corridors was often tense and at times frightening. The unit had been opened in the 1960s and looked like that was the last time it had been decorated. There was scribbled graffiti on the yellowed walls and the few pieces of furniture were old and dirty. The corridor was often malodorous with a mix of body odour, pungent smells from the busy toilets and cigarette smoke wafting in from a garden area. This was a space regularly filled with laughter, where you could see wonderful expressions of creativity, peer support and staff camaraderie. It was a space often filled with screaming, where people had killed themselves and others were badly injured following assaults. I viewed it as the antithesis of a "therapeutic environment".

When I cared for my first Aboriginal consumer, I found myself questioning my nursing practice and psychiatric understandings. The woman maintained a constant dialogue with herself and appeared distressed when not distracted. In conversation, she was not obviously thought disordered or hallucinating. She had recently lost her children to Social Services, and then her public housing. The medical team treating her tried various "anti-psychotic" medications and different combinations of "anti-psychotic" medications without any obvious effect, bar "side-effects" and the label "treatment resistant" started to become attached to her name in the office conversations.

In one afternoon handover, an experienced nurse wondered if it was "an Aboriginal thing" when it was pointed out again that "there was still no change in behaviour or mental state". She'd been there

for about three months. The comment confused me. What was "an Aboriginal thing"? What did it mean for me as a nurse who regularly had this person allocated to me for her nursing care? Why didn't I know about "Aboriginal thing[s]"? And what did I need to know about them?

We didn't have access to an Aboriginal Mental Health Worker and I hadn't received any education about the nursing care for Aboriginal people, although I did it with some regularity. When I reflect back on my nurse training, I think my education prepared me to care for Irish people across their life span. It recognised that people came from different socioeconomic backgrounds, had differing religious beliefs and sexual orientations, but perspectives on mental health outside the Western perspective were not a focus. The biomedical perspectives on mental illness were challenged and critiqued by my educators but with concepts that sat comfortably within the Western culture.

Before I came to Australia, my understanding of Aboriginal people was miniscule. I saw Aboriginal people in the background of the history I had learnt in school about the settlement of Australia. They seemed to me to be there initially to observe the arrival of the British but then disappeared from the pictures that followed. The focus of the teaching I got was wholly focused on the Europeans in Australia.

Challenged by the idea of an "Aboriginal thing", I looked in the direction of my Australian colleagues, who I would label "caring" and who seemed to have a good knowledge about care for mental health inpatients. The biomedical model of mental health was dominant in the care delivered in the unit and it produced a generic approach to nursing. We tried to nurture helping relationships, we gave out tablets, we observed behaviour and we reported back to "treating teams" of psychiatrists who guided interventions with "treatment" plans. Aboriginal people, Vietnamese people, Australian people, Sudanese people, etc. There was no difference in the approach taken. We claimed to be "consumer-focused" without any real choices around treatment and care.

We were guided by the ideas of the Mental State Exam and the American Psychiatric Association through DSM IV. I never heard discussions about differing health beliefs. There was one-size that was presumed to fit all. When I started to read about Aboriginal mental health to support my practice, I found literature that made me feel uncomfortable.

In the 1990s, three national reports included issues related to Indigenous Australian mental health services. These were the report of the [Royal Commission into Aboriginal Deaths in Custody \(1991\)](#), the Burdekin Report on Human rights ([Human Rights and Equal Opportunity Commission, 1993](#)) and the 'Ways Forward' report ([Swan & Raphael, 1995](#)). These documents acknowledged Indigenous Australians need for improved mental health services and identified significant problems with the contemporary services. Both the Royal Commission report and the Burdekin report identified that mental health professionals had little understanding of Indigenous Australian culture, often resulting in misdiagnosis and inappropriate treatment ([Royal Commission into Aboriginal Deaths in Custody, 1991](#); HREOC, 1993).

Since the Ways Forward report in 1995, there has been an increasing recognition within Australian health policy and planning, that mental health and well-being are intrinsically connected to the "whole of life" for most Aboriginal people ([Swan & Raphael, 1995](#)). According to the report,

The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural, and spiritual health. Land is central to well-being. The holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations, which constitute cultural well-being. These interrelating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it

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