OVERVIEW

This chapter explores what is involved in being a professional practitioner working in the area of Aboriginal and Torres Strait Islander mental health. It does this with regard to the principles, standards and practice frameworks that contribute to the capacity and empowerment of mental health practitioners and Aboriginal and Torres Strait Islander clients, families and communities.

This chapter covers workforce issues such as working as part of a multidisciplinary team and social health teams—their ethical practice and professional responsibilities. The National Practice Standards for the Mental Health Workforce (2002) identify five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. This chapter discusses the core competencies, knowledges, skills, understandings and attributes regarded as essential for these practitioners and extends these to include Aboriginal and Torres Strait Islander health workers. We provide an overview of the historical context, highlighting some of the relations between the disciplines and professions and between those professions and Aboriginal and Torres Strait Islander people. This is part of the context that has given rise to new ways of working that are empowering, respectful and ethical.

There are consistent and complementary themes identified in the literature to working effectively as Mental Health practitioners with Aboriginal and Torres Strait Islander people, such as adopting a community development approach and using primary care models, and the crucial role of cultural competence. A case is made for the importance of practitioners providing cultural safety and care (as well as culturally responsive and appropriate services) for Aboriginal and Torres Strait Islander clients, their families and communities. Equally important is the need to develop strategies for self-care and support such as mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

This chapter provides a range of tools and strategies and a Critical Reflective Framework for Analysis to assist students or practitioners from various disciplines to develop these key competencies in their practice in Aboriginal and Torres Strait Islander mental health. The Framework aims ‘to enhance professional competence as practitioners’ through reflection upon self, others, the discipline and professional codes of conduct, and the broader contemporary and historical contexts in which practitioners and their clients, and their families and communities are situated.
THE MENTAL HEALTH PRACTITIONER/PROFESSIONAL

Under the COAG mental health reform to improve Indigenous health and wellbeing, Aboriginal and Torres Strait Islander health workers, counsellors and clinical staff in Indigenous-specific health services require the capacity and competence to identify and address mental illnesses and associated substance use issues in Indigenous communities, to recognise the signs of mental illness and to make referrals.

THE CONTEXTS OF WORKING

Traditionally, the roles of professionals in the mental health services, therapies and associated disciplines have been underpinned by implicit values and assumptions that reflect the norms of the dominant majority groups in Western culture. Several reviews of Australian Indigenous mental health policy implementation suggest that much of the work being done in this area has been ineffective. This is attributed to the silos within government agencies and services, to the boundaries between different health professionals, and to services and organisations that are unresponsive and inappropriate to the needs of Indigenous individuals, families and communities. Individual factors can be the assumptions and attitudes of practitioners, particularly non-Indigenous practitioners. These assumptions can be influenced by colour or cultural blindness as well as overt racism. They can blind the practitioner’s ability to understand and appreciate the pervasive, transgenerational impact of colonisation upon Indigenous individual, family and community health, and mental health and wellbeing described in Chapter 3.

Further, the impacts of monoculturalism have proved particularly challenging for practitioners aiming to implement the reforms of successive National Mental Health Plans. This has highlighted the importance of ensuring that staff can acquire and maintain the skills to deliver service reform in new ways. The Second National Mental Health Plan 1998–2003 pointed out the need for education and training initiatives to ensure an appropriately skilled workforce to work effectively with culturally diverse client groups. The National Practice Standards for the Mental Health Workforce (CDHA, 2002) identify five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. Each of these is governed by codes of professional conduct and ethical guidelines.

Guidelines, protocols and principles of practice

There are a number of national and community-based ethical guidelines, protocols and principles of practice available for practitioners working with Aboriginal and Torres Strait Islander peoples and communities. These guidelines encourage practitioners to familiarise themselves with local history, customs and ways of working, as well as the local mental health issues.

In addition to its code of ethical conduct, the Australian Psychological Society (1996) has also produced a set of guidelines for engaging in an empowering manner when researching within or delivering health services to Indigenous peoples. These guidelines and codes of ethical conduct are invaluable resources for practitioners to engage in intercultural relations that are empowering, safe and respectful. These values and principles are not only about guiding individual behaviour of professional practitioners, but also guide the actions of mental health and other service systems. See for example the Australian and New Zealand College of Psychiatrists, Australian Indigenous Mental Health Ethics, Protocols and Guidelines.

NATIONAL COMPETENCY STANDARDS IN MENTAL HEALTH

The National Standards for Mental Health Service and the National Practice Standards for the Mental Health Workforce (NPSMHW) form the basis of the key competencies expected of individuals upon graduation from their higher education training, and this is linked to the
provision of mental health services. These standards are geared to graduates of psychology and other mental health professions.

The NPSMHW outline the knowledge, skills and attitudes required when individual members of these five professions work in a mental health service. Others involved in providing services for people with a mental illness—general practitioners, home and community care service providers, hospital staff providing acute care, and family and other carers—may also find these national practice standards useful. The standards also provide a strategic national framework for the education and training of the future mental health workforce and it is expected that they could be used to:

- promote clinical best practice
- identify appropriate skill levels and workplace training and education needs
- guide clinical supervision, mentoring and continuing education
- influence the development of relevant undergraduate and postgraduate curricula.

The NPSMHW are expected to inform the curriculum guidelines and training in each of these professions to develop a quality Aboriginal mental health workforce in primary, secondary and tertiary health care sectors across the three tiers of government. It is expected that this process will help to achieve the outcomes of the Emotional and Social Wellbeing Action Plan and the Social Wellbeing Key Result Area in the National Strategic Framework for Aboriginal and Torres Strait Islander Health.

The 12 practice standards are listed below, but only the first three National Practice Standards have been identified as key focus areas to be introduced in all training and postgraduate courses for practitioners in mental health services. These three standards have particular value for all groups including professional groups and mental health services, key policy-makers in each of the states and territories, and universities and Vocational Education and Training sectors that offer undergraduate and postgraduate services in mental health.

**Twelve practice standards for the mental health workforce**

1. Rights, Responsibilities, Safety and Privacy—of family members, carers, rights of clients, privacy, confidentiality and safety guidelines.
2. Consumer and carer participation—mental health professionals are supposed to know about supporting bodies and consumers.
3. Awareness of diversity—this is explored in this chapter.
4. Knowledge of mental health problems, mental disorders and applying this to our practice.
5. Promotion and prevention—adopting a preventive approach and educating others in order to promote optimal wellbeing.
6. Early detection and intervention—looking for early signs and symptoms of mental health problems; assessment, treatment, relapse prevention and support.
7. Evidence-based assessment, treatment, and support services that could prevent relapse.
8. Integration and partnership—mental health professionals to provide continuity of care by working with other organisations and services.
9. Service planning, development and management—developing skills for the planning, development, implementation and evaluation of management of mental health services.
10. Documentation and information systems.
11. Evaluation and research.
12. Ethical practice and professional responsibilities.
There are a range of core competencies, knowledge, skills, understandings and attributes regarded as essential for all mental health practitioners, including Indigenous Health Workers, to be a competent health professional in accordance with these Practice Standards. Competence is gained through education and training supervision and experience and demonstrated through the acquisition or existence of specified knowledge, skills, values and attitudes. For example, all mental health practitioners are required to demonstrate knowledge in:

- the assessment of people who may have mental illness; the treatment and management of people with a mental illness
- issues to do with medication
- the management of aggression, particularly in community settings
- particular population groups vulnerable to self-harming behaviours
- issues of cultural difference and ways to access assistance when dealing with people from a cultural or linguistically diverse background
- referrals to and from other agencies which require a comprehensive knowledge of community resources.

Mental health practitioners are also required to have comprehensive knowledge of the Mental Health Act and Mental Health Regulations, including their intent, the use of forms, the referral process, the use of police and community treatment orders, and the ability to give advice under Section 63 of the Act. The Act focuses on the generic competencies that recognise that although people bring specific knowledge and understandings to their disciplines they need cross-cultural skills and understandings for working in Indigenous contexts. This chapter touches on rights, responsibilities, safety and privacy, and consumer and carer participation; it explores in depth the issues associated with awareness of cultural diversity since this is fundamental to the purpose of the text.

Rationale for developing cultural competence

The rationale for developing cultural competence in the health services is documented in a raft of policy guidelines and frameworks that aim to address the health inequities experienced by Aboriginal and Torres Strait people. It is based on the recognition that existing services and approaches to improving the health and wellbeing of Aboriginal Australians have not been successful (AHMAC, 2004). There is increasing recognition of the need for health practitioners and those responsible for delivering health services to take account of the historical, cultural, and environmental experiences and contemporary circumstances of Aboriginal people.

In 2005, the National Health and Medical Research Council (NHMRC) produced a document, *Cultural competency in health: A guide for policy, partnerships and participation in cross-cultural contexts*. This describes a model with national application and is aimed at high-level policy-makers. Stewart suggests that this guide has the potential ‘to lead the way forward for the development of cultural competence in Australian healthcare—if it can galvanise action to make cultural issues “core business at every level of the health system”’ (NHMRC, 2005, p. 1).

In addition, the Australian Health Ministers Advisory Council has also developed the national *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*, which sets out a number of principles and examples of practice to guide services and practitioners when working with Aboriginal and Torres Strait Islander peoples. The Framework consists of building blocks aimed to improve knowledge and awareness, skilled practice and behaviour, to develop strong relationships and create equity of health outcomes. For example, the NHMRC has produced a document about values and ethics in Aboriginal
and Torres Strait Islander health research. These values—reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity—provide the basis of guidelines for conducting health research.

**Cultural competence**

Cultural competence is a commitment to engage respectfully with people from other cultures. A commitment to cultural competence is the beginning of an ongoing process that requires motivation and a willingness to improve cross-cultural communication and practice in both individuals and organisations. Cultural competence encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety. Cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations (Cross et al., 1989). Importantly, for individuals, cultural competence requires more than becoming culturally aware or practising tolerance. It can be defined as the ability to identify and challenge one's own cultural assumptions, one's values and beliefs. It is about developing empathy and connected knowledge, the ability to see the world through another's eyes, or at the very least to recognise that others may view the world through a different cultural lens (Fitzgerald, 2000 cited in Stewart, 2006).

**Cultural respect**

Cultural respect is a fundamental element of cultural competence which involves the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples.

Cultural respect is about shared respect. Cultural respect is when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples, where cultural differences are respected and where the health care system and services respect the legitimate cultural rights, practices, values and expectations of Indigenous peoples. The goal of cultural respect is to uphold the rights of Indigenous peoples to maintain, protect and develop their culture and achieve equitable health outcomes (AHMAC, 2004).

The national Cultural Respect Framework endorsed by AHMAC aims to provide a nationally consistent approach to building a culturally competent health system that will improve access to and responsiveness of mainstream services for Aboriginal and Torres Strait Islander peoples. It builds on the recommendations put forward in several milestone reports designed to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples:

- Royal Commission into Aboriginal Deaths in Custody: National Report
- Ways Forward: The Report on the National Consultancy on Aboriginal and Torres Strait Islander Mental Health
- Bringing Them Home: A Report on the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families
- Health Is Life: Report on Inquiry into Aboriginal and Torres Strait Islander Health.

It is recognised that despite the imperative for government policy-makers and planners to take account of the specific needs and expectations of Aboriginal and Torres Strait Islander peoples, the planning and delivery of culturally secure and appropriate health and mental health services remains an ongoing challenge. It requires commitment and the recognition that cultural respect needs to be embedded across all sectors of the system and at the corporate, organisational and care delivery levels to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes (AHMAC, 2004). The Cultural Respect Framework outlines strategies across a number of dimensions (system, organisational, professional and individual) to systematically lift the cultural competency of mainstream health services (AHMAC, 2004).
CULTURAL SAFETY AND COMPETENCE IN INDIGENOUS CONTEXTS

In recent years, a focus on developing cultural competence has arisen from recognising the importance of culture, ethnicity, racism, histories of oppression and other contextual factors in the experiences of individuals and communities. To this end, considerable attention has been paid to the development of models and guidelines for delivering culturally competent and safe health services.

Cultural safety

The notion of cultural safety has its roots in nursing research in Aotearoa, New Zealand, and derives from a Maori reality. Ramsden (1993) states that cultural safety is in part about Maori asserting the legitimacy and diversity of Maori realities in New Zealand as well as a response to the difficulties experienced by Maori with Western-based models of nursing. In her view, ‘cultural safety developed from the experience of colonisation and recognises that the social, historical, political diversity of a culture impacts on their contemporary health experience’ (Ramsden, 2002, p. 112).

Since then the concept of cultural safety has further been refined and extended to the concept of cultural appropriateness in health practices. Clear (2008) makes the crucial point that while culturally safe practice focuses on ‘effective clinical practice for a person from another culture’, ‘unsafe cultural’ practice ‘diminishes, demeanes or disempowers the cultural identity and wellbeing of an individual.’ This is a critical area of practice, and Parker (2008, citing Morgan, 2006, p. 203) points out that ‘serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions’, particularly in remote communities. It is important to recognise that failure to instil culturally safe practices is a diminution and erosion of fundamental cultural and human rights for Indigenous peoples. There is a need to establish processes and protocols to ensure culturally safe practices that are appropriate for diverse Indigenous community contexts in Australia. Cultural safety is about acting in ways that enhance rather than diminish individual and communal cultural identities and empower and promote individual and community wellbeing. To create a culturally safe space involves a high level of critical reflexivity (a concept that will be explored in detail later in this chapter), as practitioners may not always be aware of how their behaviour and method of interaction could make people from different cultures feel unsafe, with negative consequences for client access and continuity of care.

Definition of cultural competence

Cultural competence is defined as the knowledge, awareness and skills aimed at providing a service that promotes and advances cultural diversity and recognises the uniqueness of self and others in communities (American Psychiatric Association, 2002; Betancourt et al., 2003; Richardson & Molinari, 1996; Sue, 1998, 2006; Whitbeck, 2006). The focus on cultural competence is a response to ongoing health inequalities and related disparities in access to health services and experiences in health for different communities. The purpose of cultural competence is to foster constructive interactions between people of different cultures. However, it is now generally recognised that cultural competence for one population may not necessarily translate to another (Kim et al., 2006; Sue, 1999, 2003), so cultural competence needs to be regarded as an ongoing process developed in a particular intercultural context. Sue and Sue (1990) suggest that cultural awareness requires that mental health professionals are cognisant of, and take responsibility for, their own biases, stereotypes, values and assumptions about human behaviour generally, and recognise that these may differ from those held by other cultural groups. Importantly, therefore, they need to develop appropriate practices and intervention strategies that take into account their client's historical, cultural and environmental context.
Cultural competence involves the knowledge, skills, attitudes and values necessary for effective intercultural transactions within diverse social, cultural and organisational contexts (Sue, 1998, 2006). Cultural competence is a dynamic process that is constructed by and in the context of human relations, including the processes of crossing cultural boundaries. Here, context can be understood using the notion of social ecology, where people and their environments are seen as interdependent. The issues that arise for people in developing cultural competence can be understood within the context of the individual, the family and peers, the school and social or sporting clubs, ethnicity, class, race, gender and the broader policy, social, cultural and historical context. These are different levels of analysis that are interdependent. Cultural competence needs to be considered within a broader system-wide social, historical, political and economic context as well as at the level of individual professional practice. By connecting cultural competence with the notion of social ecology, we recognise the need to consider different levels of a system that must be considered in promoting culturally competent practice and service delivery. At a system level, all health sector and organisational staff members need to develop significant aspects of cultural competence; and organisations need to respect and cater for cultural diversity, through their physical layout and presentation and the implementation of policies, procedures and practices that promote culturally safe, responsive environments. As Kessaris (2006) argues: “cultural awareness” and “anti-racism” type training can no longer focus primarily on seeking to “understand” the “other”. Emphasis must be placed on understanding the self in the midst of unbalanced power relationships’ (p. 358). Many of these unequal power relations operate within and between the various service delivery and policy sectors.

In a national study to incorporate Australian Indigenous content into the undergraduate psychology curriculum, Ranzijn et al. (2007) conducted focus groups on cultural competence in mental health professions and organisations. They identified some key issues:

- lack of awareness among professionals about Indigenous clients, cultures and contexts
- lack of specific skills and strategies for working in Indigenous contexts
- lack of engagement in broader issues of justice and human rights
- the need for understanding of, and strategies for, challenging prejudice, ethnocentrism and racism.

The conclusions reached in the focus group workshops regarding the need to examine the nature of the mental health professions confirm the need and value of the Critical Reflection Framework of Analysis for students and practitioners (Walker, 1999, 2004) which frames the discussion. The findings also inform the further development of culturally competent framework(s) that encapsulate the various multidimensional elements of cultural competence to inform curriculum and teaching across all social service and health professions (Ranzijn et al., 2008).

**ELEMENTS OF CULTURAL COMPETENCE**

Sue (2006) outlined a model of cultural competence that encompasses the knowledge, values and beliefs, and skills considered necessary to be culturally competent. These have been further articulated by different authors, including by such as Ranzijn et al. (2008) and McConnochie et al. (2008) in the context of education and training in the Australian context. The different dimensions need to be understood within a nested system that operates simultaneously at both individual and system levels, recognising that a culturally incompetent system can undermine culturally competent practitioners. Cultural competence encompasses a dynamic interaction between interconnected ‘elements’ identified in the critical reflection framework for analysis and action, and developing and maintaining cultural competence through critical reflection. The list below captures some of the aspects of the different dimensions of cultural competence, and we have included the notion of reflexivity, which we discuss later in the chapter.
Working Together

**Knowledge**
- broad or generic understanding of the nature of worldviews and culture, and the implications of culture for understanding human behaviour
- an understanding of the specific cultural and historical patterns that have structured Indigenous lives in the past and the ways in which these patterns continue to be expressed in contemporary Australia.

**Values**
- an awareness by professionals of their personal values and beliefs
- a capacity and willingness to move away from using their own cultural values as a benchmark for measuring and judging the behaviour of people from other cultural backgrounds
- an awareness of the values, biases and beliefs built into the practitioner’s profession and an understanding of how these characteristics impact on people from different cultures.

**Skills**
The mental health practitioner requires a mix of generic skills to carry out their role; they also need to develop a repertoire of skills that build on their knowledge and values to work effectively as a professional in intercultural contexts. These skills include:
- all aspects of triage/intake practice including mental status examination
- risk assessment, crisis assessment and management
- investigative and history-taking skills
- analysis of information
- decision-making
- problem-solving skills
- determining priorities
- ability to work as a team member
- working collaboratively with a broad range of health services and providers
- written and verbal communication
- ability to incorporate the principles of culturally sensitive practice in mental health care
- conflict resolution
- debriefing skills
- ability to self-monitor.

**Attributes**
Reflecting on our individual values and attitudes involves the skill of critical reflexivity, which includes, among other things, developing an understanding of:
- the nature and dynamics of power as it operates in many levels from practitioner–client interactions to organisational and political systems
- the nature and impacts (on both Indigenous and non-Indigenous people) of unearned or ascribed privilege
- the nature and effects of racism at individual, institutional and ideological and discipline levels
- the history of relationships between Indigenous Australians and systems and professions
- the effects of this history on Indigenous perspectives about the professions and the extent to which each profession is constrained by the culturally constructed models and disciplinary knowledges/theories used by the profession.
HUMAN RIGHTS

Mental health practitioners need to show a commitment to natural justice and the fundamental rights of the individual. They need to be able to show respect and empathy and demonstrate discretion and the ability to uphold confidentiality. This requires balancing the rights of the individual with the rights and needs of the community. It requires sensitivity, tolerance, and importantly, the ability to request assistance if necessary. Finally, mental health practitioners are expected to demonstrate good practice standards by adhering to the ethical codes and policies of the Department of Health in their state, as well as National Codes of Practice. Mental health practitioners have a professional responsibility and require skills to work as part of a larger multidisciplinary mental health team and to be willing and able to share relevant information.

Mental health practitioners are also expected to comply with language services policy; they have an obligation to determine the need for and provide a qualified interpreter where required. They must use professional interpreter services rather than family or unqualified personnel when conducting a mental health assessment.

WORKING IN PARTNERSHIP

There is broad agreement from both Indigenous clients and Indigenous and non-Indigenous practitioners that practitioners need to work in genuine partnership with Indigenous Australians to be effective. Working in true partnership is a very different model from the conventional individualistic Western way of working. This has a number of important implications for practice, and a growing literature is now available, including detailed protocols for working with Indigenous Australians, to guide the practitioner in this area:

- Recognise that the individual ‘client’ (in the case of individually oriented practice), their family and community, Indigenous co-workers and other professionals are equally ‘experts’ in the process. Letting go of the ‘expert’ role can be very difficult and is likely to involve a lot of critical self-reflection on the unequal power inherent in the therapist–client relationship.
- Developing an effective partnership takes time, trust and personal relationship. For most Indigenous Australians, who you are is more important than what you are.
- Have regard for Indigenous protocols in community contexts. Often a process of vouching is required, in which one or some of the community members will attest to the person wishing to enter the community.
- Work in collaboration with cultural consultants, who will advise about cultural matters, provide guidance in appropriate behaviour, and mediate between the practitioner and the community.

STAGES TO CULTURAL COMPETENCE

There is widespread agreement within the literature that the development of cultural competence is a continuous process—the process of becoming, not a state of being (Campinha-Bacote, 2008). Wells (2000) elaborates on the continuum provided by Cross et al. (1989), who offer a model that links the elements of cultural competence (knowledge, attitudes and skills) to a developmental framework. They identify a sequence of stages along a continuum:

- Cultural incompetence: lack of knowledge of the cultural implications of health behaviour
- Cultural knowledge: learning the elements of culture and their role in shaping and defining health behaviour
- Cultural awareness: recognising and understanding the cultural implications of behaviour
- Cultural sensitivity: the integration of cultural knowledge and awareness into individual and institutional behaviour
- Cultural competence: the routine application of culturally appropriate health care interventions and practices
• **Cultural proficiency:** the integration of cultural competence into one’s repertoire for scholarship (e.g. practice, teaching, and research; Cross et al., 1989). At the organisational level, cultural proficiency is an extension of cultural competence into the organisational culture. For the individual and the institution, it is mastery of the [five preceding] phases of cultural competence development.

Both Cross et al. and Wells suggest, however, that this is a constant state of learning dependent on our willingness to remain forever vigilant and reflective.

**EXTENDING COMPETENCE THROUGH CRITICAL PRAXIS**

Letting go of the ‘expert’ role can be very difficult and involves a lot of critical self-reflection, as well as recognition of the unequal power inherent in the practitioner–client relationship.

What are some resources for extending the dynamics of cultural competence? In this section, we consider the concepts of whiteness studies, Indigenous knowledge, power, anti-colonialism and multidisciplinarity.

**Indigenous knowledge and whiteness studies**

The work done by Indigenous authors can be important in showing how mainstream services and practices work in exclusionary ways to the detriment and disadvantage of Indigenous populations. Several authors (e.g. Oxenham, 2000; Rigney, 1997) highlight the importance of incorporating and applying Aboriginal terms of reference (which means values, aspirations and ways of being and doing) into policies, practices and processes that impact on Aboriginal people. This work is important in showing how health service systems can be made more responsive and sensitive to Indigenous people and their particular needs. The work of ethnic minorities, women’s studies and whiteness studies can also show how mainstream systems and practices produce normativity—that is, the standards, regulations and protocols intended to provide uniformity of service and best practice can also undermine cultural competence. In combination, this interdisciplinary work offers resources, standpoints and frames of reference that can be used to ask pertinent questions about race relations, histories of oppression, and constructions of health and mental health and wellbeing, which ultimately are crucial understandings and activities that affect health and mental health service delivery.

In 2006, Sonn and Green reviewed a series of articles that consider some of the challenges of engaging in transformative practice across intercultural boundaries. The articles present examples of how **subjectivity and reflexivity** are used to promote empowering interactions in the context of research and practice relationships between Indigenous and non-Indigenous people. Central to this work is the requirement that we understand histories of colonialism and the role racism has played in the oppression of indigenous peoples. The authors engage with the writing of Australian Indigenous and Maori scholars, taking up the challenges set out by those scholars for working towards liberation and decolonisation. This work is important because it offers a way in which cultural competence can specifically engage with issues of power and privilege, and the power that we are afforded because of our different group memberships, including our professions.

For example, Smith (1999) in Aotearoa, New Zealand, and Gilbert (1977), Martin (2003), Moreton-Robinson (2003) and Nakata (2002) in Australia argue that the colonising ways of Western research and practice need to be disrupted. They reveal how different disciplines have participated in the construction of knowledge about Indigenous and ethnic groups that extends into psychology, health practice and policy and service provision. For example, some colonising practices are reflected in how ethnic and racial minorities are constructed as an inferior or exotic ‘other’. These constructions have implications for how individuals and communities are treated in different social settings, including health contexts. A shared feature of anti-colonial writing is the focus on decolonisation (among other projects), which in part engages with examining
various ways in which ethnic and racial minority communities are presented as problematic and often blamed for their own misfortunes. At one level, this deconstructive work is aimed at understanding the assumptions, ideologies, motives and values that inform research and practice (Smith, 1999). At another level, it is about developing and promoting ways of knowing, being and doing that are anchored in the lived social and historical realities of indigenous peoples (McPhee & Walker, 2001). Among other things, this work demands that we ask critical questions about what we know of different groups of people. Whose standards have we accepted as the key standard for comparison? Whose ways of living are privileged? What are the implications of imposing understandings on people?

A related area of work is concerned with understanding how dominance and privilege is constructed and maintained (e.g. Frankenberg, 1993; Green et al., 2007). At a broad level, whiteness studies are concerned with examining the production of dominance and understanding the complex interplay of privilege and power afforded by whiteness in the context of race relations—and how to undo it (Hurtardo & Stewart, 1997). Green et al. (2007) identified three mechanisms by which whiteness is produced and maintained, including the production of privilege through the construction of knowledge and history, national identity construction and belonging, and in racist practice. In terms of knowledge and history construction, it has been argued that Western views and ways of knowing and doing have been privileged at the expense of other ways of knowing and doing (Riggs, 2004). For example, Sarra (2005) and Dudgeon, Mallard and Oxenham (2000) have discussed the powerful and oppressive effects on Indigenous people of externally imposed definitions of self and community. Sarra noted that many white people speak about Indigenous people in terms of negative representations generated by non-Indigenous people, thereby reproducing racism. McKinney (2005) theorised that anti-racism practice for white people will require a shift in focus from prejudice reduction to an awareness of systemic and inherited privilege and a commitment to challenge racist behaviour.

This important area of work allows us to examine at a deeper level the basic assumptions that inform disciplinary research and practice, including those we hold about notions of personhood. As Riggs (2004) and others have noted, some of the assumptions about universality of human psychological processes may benefit those who share this view, but they exclude other cultural understandings of self and can be detrimental and harming. To this end, whiteness studies also afford a set of resources that may enable researchers and practitioners to make visible their normative assumptions, thereby opening up spaces for negotiation and interrogation (Roberts et al. 2001; Walker 2004). Green and Sonn (2005), for example, identified several narratives that informed non-Indigenous people's engagement in reconciliation. Among them were those that viewed Australian Indigenous culture as deficient, those that viewed other white people as racist, and those that blamed the system and history for Indigenous people's disadvantage. These narratives are not mutually exclusive but have different implications for intervention, and they also work to reproduce the privilege of non-Indigenous people (Roberts et al., 2001).

However, engaging in critically reflective practice and crossing intercultural boundaries involves different challenges: it often means letting go of certainties and being prepared to negotiate with clients and communities. Letting go of certainties and foreclosing recipes for action can be emotionally challenging and leave one feeling vulnerable, powerless and out of place, so having the ability to work outside one's own comfort zone is crucial. In addition, being able to negotiate and bring together and work with different knowledges and expertise within specific contexts are also important skills.

**Safety, self-care and support**

Mental health practitioners wanting to work competently in Indigenous contexts may find themselves confronted by the potentially challenging nature of engaging in decolonising practice at the individual level, as well as supporting complex and traumatic circumstances that clients and communities may be experiencing. This can be fraught with uncertainty. It is
therefore important to have strategies for self-care and support. These would include mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

**BRINGING IT TOGETHER: CRITICALLY REFLECTIVE PRACTICE**

This section explores the range of reflective activities and learning processes that can give mental health practitioners skills and techniques and understandings to enhance their work. These activities and processes assist practitioners to develop a clearer understanding of their roles, the power relations operating within their work, and the range of strategies to address the issues and concerns they are facing. The transformative potential of critical reflexivity resides in students or practitioners interrogating the political, social and cultural positioning of Indigenous people in temporal terms (historical and contemporary) and geographic contexts (including community contexts), to affirm and validate Indigenous identity and difference. The intersection of these different elements is reminiscent of Sue's multidimensional elements of cultural competence (Sue, 2001). These are explicit competencies that will enable students or practitioners to make a commitment and to navigate the cultural interface in a way that makes a genuine difference to Indigenous mental health and wellbeing.

Viewing cultural competence as a dynamic-in-interaction requires us to consider critical reflection/reflexivity as central to culturally competent practice. It involves both interrogating and integrating Indigenous and Western knowledge systems and critically reflective practice at the cultural interface (Walker et al., 2000). Critical reflection/reflexivity is an essential skill for all professional practitioners working at the highly politicised, complex and dynamic Indigenous and non-Indigenous interface (McPhee & Walker, 2001). This is in line with the idea of knowledge as 'knowing how to act'. 'To act is to contextualize behaviour, and being able to act skilfully implies that actions are appropriate to a given context' (Greenwood & Levin, 2005, p. 51). Here, new knowledge and ways of being are produced in the act of reflection-on-action in the real world. Critical reflection is a key principle for ethical practice, as Walker et al. (2000) state:

> All practitioners, both Indigenous and non-Indigenous, tend to operate according to a complex interaction of their own values, beliefs and experience and the values, assumptions and paradigms of their professional discipline or field. The way individual practitioners carry out their roles, and the way they act with clients and other professionals depends largely on their interpretation of that discipline which is largely influenced by their own beliefs and values, knowledge and experience. (p. 322)

This suggests that as practitioners or action researchers we need to consider how our own social, cultural and professional positioning will influence the relations we have with different people who seek our assistance in any context—but in this instance in the mental health setting. Thus, reflexivity in one sense is about recognising and critically engaging our own subjectivities in the context of relating across cultural boundaries. It means examining our own social and cultural identities and the power and privilege we are afforded because of these identities. It also requires that we engage with the political and ideological nature of practice and knowledge production and consider the implications of these for those we aspire to work with. Therefore, as Parker (2005) suggests, 'Reflexivity should not be a self indulgent and reductive exercise that psychologizes phenomena and psychologizes your own part in producing them. Instead, the reflexive work is part of action, and in action research much of that reflexive work is undertaken alongside and in collaboration with co-researchers' (p. 35).

The process of critical reflection is a powerful tool for producing new knowledge and processes, and contributes to improving fundamental social justice outcomes for Indigenous people (Walker et al., 2000). In doing so we become more conscious of the power that inheres in our own practice in order to democratise relationships, interactions and processes and to promote a culturally secure process and environment that will improve their health and wellbeing outcomes. As Walker et al. state, our desire and commitment to be ethical, effective, culturally competent practitioners therefore requires that we:
• analyse and understand the broader cultural, social, political and economic environment and how it impacts on or influences our professional and personal practice and the lives of the people we are working with

• make our own disciplinary and professional practice the subject of our inquiry in order to analyse and where necessary change it, so that our actions are more culturally responsive, relevant and effective for the specific individuals and groups with whom we are working

• draw information from a broader social and historical context as well as our professional context to better inform and interpret our own and our clients’ actions and responses. While the focus is about our professional practice in context, explanations need to extend beyond our taken-for-granted practice to look at how relations of power in the broader social and political context impact on issues of race, culture, gender and class, and in turn, how they may influence their own and [others’] beliefs, values and behaviour (Walker et al., 2000, p. 18).

Figure 12.1 below depicts the multidimensional and iterative nature of critical reflection and illustrates how our understandings of self, others and the particular profession interact with the broader cultural, social, historical, political and economic context; our understandings and the formal and informal theories underpinning our professional practice are informed by a complex interaction of values, beliefs, assumptions, experiences and contextual factors.

This figure also depicts the tensions and interacting elements that occur at an individual level and that are experienced by those people who recognise and acknowledge that they are working within the cultural interface and attempt to understand their own relationship with the various elements within it.

**Figure 12.1:** Critical Reflection Framework of Analysis (R. Walker, 1999)
The tools and techniques developed to facilitate the process of critical reflection enable practitioners to make more conscious decisions in their work to support the interests of the groups with whom they are working. Many of these tools and techniques of critical reflection have been developed, refined and applied over several years by staff and students or practitioners in the Indigenous Management and Community Development (ICMD) program as part of the transformative and decolonising project to improve the overall circumstances of Indigenous Australians (Walker, 2004). These same tools and techniques were used by students and practitioners as they attempted to identify, develop and apply Indigenous terms of reference (Oxenham, 2000) in their work with a range of professions in community management, policy-making and social services and community health and mental health areas.

TOOLS AND TECHNIQUES FOR CRITICAL REFLECTION

The main tools and techniques developed for the ICMD course materials were summarised in Working with Indigenous Australians: A handbook for psychologists (Dudgeon et al., 2000) as follows:

**Questioning**—helps us to generate new knowledge about ourselves, others, the context and their interconnecting influences. Questions should uncover: reasons, factors, links, possibilities, intentions consequences, feelings (*how* others feel and *why*).

**Analysing**—requires looking behind what’s happening for underlying issues, causes and effects, identifying own/others’ assumptions, and deconstructing complex situations into specific issues. Analysis helps make meaning of situations, events, issues and practices, both at a personal and professional level, privately and publicly.

**Defining the issue**—means identifying issues that cause concern or require further exploration and/or evaluation. The issues may be related to our own practice, someone else’s response, or feelings of uneasiness or uncertainty with respect to an interaction or intervention.

**Seeking other perspectives**—involves reading widely, talking with relevant people, and ‘stepping into the shoes’ of clients/others to see how situations and ideas appear for them.

**Mapping**—helps to draw links between different perspectives and ideas to reveal how taken-for-granted things fit together. It can help to clarify the problem and situate it within the bigger picture.

**Critical reflection through dialogue**—takes place formally or informally between the practitioner’s personal experience and the shared understandings, discipline knowledge and professional rules and practices that inform their experience. These different perspectives are underpinned by values and assumptions that may differ substantially from, and challenge, those of the practitioner. Approaching critical reflection as a kind of dialogue helps us to work through our own mental processes and to see other perspectives we might not come up with on our own. As such, critical dialogue can assist practitioners to use tools and discourses to challenge the accepted boundaries of traditional or dominant theories and practices. It helps practitioners to identify, critically assess and articulate how their own informal theories about working at the Indigenous/non-Indigenous interface contribute to and have the potential to transform their understandings about their own practice (Freire & Shor, 1987) as well as assist in their self-care and support.

**Recording activities/observations**—keeping a diary or journal or using tape-recordings can be a useful way to record activities or observations or pose questions relating to specific differences between cultural values, beliefs and those of discipline and self. These observations can form a basis for self-reflections, further discussions or assessment, although issues of confidentiality need to be acknowledged (excerpt from Walker et al., 2000, p. 319, in Dudgeon et al., 2000a).
NEGOTIATING THE CULTURAL INTERFACE

Walker (2004) suggests practitioners employ the theoretical construct of the Indigenous/non-Indigenous interface as part of a practice framework that is both decolonising and transformative. The framework can also be used to position interactions within the university and VET sector curriculum for mental health practitioners, and to inform policy process at a state and national level. For example, Walker claims that Working with Indigenous Australians: A handbook for psychologists, edited by Dudgeon et al., inserts Indigenous ways of knowing, being and doing firmly into the discipline of psychology. It has been recommended by the Australian Psychological Society as a compulsory text for all psychology courses and crucial reading for all practitioners working with Indigenous clients (Dudgeon et al., 2000, p. ix). As such, ‘the Handbook exemplifies how the incorporation of Indigenous and non-Indigenous knowledges and practices can decolonise and transform disciplinary practices that have traditionally oppressed, marginalised and otherwise harmed Indigenous interests (and legitimised the process) in the name of Anthropology and Psychology’ (Walker, 2004, p. 187). The Handbook is an example of transdisciplinarity—drawing on and sharing understandings, methods and experiences across a range of disciplines to interrupt, inform and transform the disciplines and knowledges.

Multidisciplinarity: Working with multiple discourses

Practitioners need to interrogate and integrate reflective processes on Indigenous terms of reference. It is important to acknowledge and maintain the tensions between the different standpoints and discourses underpinning critical, ethical, socially just practice in Indigenous mental health contexts. These include the various critical positions available to the mental health practitioner as a consequence of the interactivity between the different disciplines, standpoints (Indigenous, feminist and post-structuralist) as well as the multiple and competing discourses of community psychology, social psychology, psychiatry and primary health care ‘which are critiqued through the discourse of Indigenous cultural values and protocols’ for mental health practice in diverse contexts (Walker, 2004, p. 188).

These multiple critical positions embrace the diverse and complex politics operating across the intersections of race, class and gender within both Indigenous and non-Indigenous domains, enabling the mental health practitioner to identify the level of complexities at the intersection of Indigenous and non-Indigenous ideas and practices and their own potentially ambiguous location within them (Walker, 2004). In other words it is possible to interrogate the potential positive and negative effects of different disciplinary discourses from different subject positions. These dialectics avoid simple, uncomplicated notions of cultural difference, subsuming some of the broader and general imperatives of social transformations. Practitioners need to acknowledge the complexity of the cultural politics of difference, and incorporate processes to problematise, dialogue and negotiate around this difference within their professional practice in order to initiate a more inclusive and effective practice (Greville, 2000; McPhee & Walker, 2001; Oxenham, 2000).

All practitioners working in the mental health area need to be aware of and take into account the complex nuances of cultural politics operating within the Indigenous and non-Indigenous interface in order to address the relations of power and issues of social justice and fundamental human rights (Walker, 2004). Negotiating the interface is underpinned by the idea that a decolonising and transformative potential resides in that space (Dudgeon & Fielder, 2006; McPhee & Walker, 2001; Walker, 2004). Incorporating human rights principles to inform our work at the Indigenous/non-Indigenous interface enables new ways of working that recognise equal power relations and partnerships (Walker, 2004).
**Power, knowledge, culture and politics**

Chapters 3 and 6 of this book confirm that Australia’s colonial history, Indigenous contemporary circumstance, lack of access to services and resources and lack of control over the most fundamental aspects of their lives are key determinants of Indigenous health and mental health and wellbeing issues. The conceptual frameworks of critical reflection and cultural interface are frameworks of analysis which enable mental health students or practitioners to identify, understand and critique the historical and political factors and existing power relations operating in their interactions with clients, their families and communities. The enduring realities of colonial domination require students and practitioners to operate in an ethical, conscious and critically reflective manner and with regard to the power, responsibilities and expectations inscribed within their professional and personal (and community) roles.

The application of these analytical and reflective tools will enable students and practitioners to recognise the relations of power operating within the political structures and the way they influence policies, standards and resources and services in the sectors that affect how people’s needs are attended to. The deconstruction of knowledge and power entails looking at how the various discourses (including public policy discourses and paradigms around quality assurance and best practice) and the disciplines that support mental health and wellbeing can operate to serve both positive and negative ends; and how and why they operate in ways that do not always serve interests and achieve positive outcomes for Indigenous clients, families and communities (see Kowal & Paradies, 2005). This understanding and competence developed through critical reflection allows practitioners to reach a level of proficiency over time to identify strategies to change and/or reinterpret institutional and social policies, practices and processes that impact negatively on Indigenous people.

**CONCLUSION**

Many of the ways of thinking about mental health in the various chapters in this book are examples of interrupting previously held theories about mental health that can result in blaming the victim, with negative outcomes for Indigenous clients, families and communities. This chapter outlines the National Practice Standards for the Mental Health Workforce (2002) and explores issues such as the professional responsibilities of working as part of a multidisciplinary team, engaging in ethical practice, understanding notions of cultural safety, and acquiring cultural competence. We argued that practitioners must provide cultural safety and care (as well as culturally appropriate services) for Indigenous clients, their families and communities, and they also need to develop strategies for self-care and support as they question some of their ways of thinking and doing while engaging in self-reflective, transformative practice.

Central to the chapter is the Critical Reflective Framework for Analysis, which aims to enhance professional competence as practitioners through reflection upon self, others, the discipline and professional codes of conduct. The broader contemporary and historical contexts in which work is situated should be included here. The relations between the disciplines and professions and between those professions and Indigenous people are part of the context that has given rise to new ways of working in ways that are empowering, respectful and ethical. In our view, cultural competency is a dynamic that is contingent and contextual—it is not an end state, but it is processual and about ensuring sensitive, democratic, just and transformative practice.

**Reflective exercises**

Throughout this chapter we have highlighted the importance of being critically self-reflective as well as engaging in more critical reflection on the disciplinary practice in which mental health practitioners are located. We have suggested that, among other things, this work demands that we ask a number of important questions. These exercises are designed to assist student/practitioners to do just that.
Working as a Culturally Competent Practitioner

1 Reflect on your own position of privilege

Tannoch-bland (1998) wrote that racism is dialectical: there are those who are disadvantaged by it and those who benefit from it. White race privilege is taken for granted and reproduced in everyday institutions. Privilege refers to a variety of situations which disproportionately benefit white people; it ranges from being in control of the economic and political system to more simple forms such as being able to buy band-aids and cosmetics suitable for white skin, and watching television programs that are representative of white people (MacIntosh, 1992; Tannoch-Bland, 1998). Tannoch-Bland provides 40 examples of the kinds of invisible privilege and unearned benefits associated with whiteness. We have selected 10 for illustrative purposes.

- I can be reasonably confident that in most workplaces my race will be in the majority, and in any case that I will not feel as isolated as the only, often token, member of my race.
- When I am told about Australian history or about ‘civilisation’, I am shown that people of my colour made it what it is.
- I can send my children to school in unironed uniforms without it reflecting on their race.
- I can dress down, or get drunk in public without reinforcing negative stereotypes about my race.
- When I speak in public my race is not on trial.
- When I’m late, my lateness isn’t seen as a reflection of my race.
- When I win a job or a scholarship, I am not suspected of doing so because of my race rather than my merit.
- When I need legal or medical help, my race doesn’t work against me.
- I expect that neighbours will be neutral or friendly to me.
- From among the people of my race, I can choose from a wide range of professional role models. (Tannoch-Bland, 1998, pp. 34–6)

Read the examples above and list three examples of benefits that you believe come from your race/gender/position/location.

2 Undertake individual cultural competence audit

According to Campinha-Bacote (2002), ‘As we begin, continue, or enhance our journey towards cultural competence, we must continuously address the following question, “Have I ASKED myself the right questions?”’ Campinha-Bacote (2002) has developed a mnemonic ‘ASKED’ which poses some critical reflective questions regarding one’s awareness, skill, knowledge, encounters and desire.

Awareness Am I aware of culturally appropriate and inappropriate actions and attitudes? Does my behaviour or attitudes reflect a prejudice, bias or stereotypical mindset?
Skill  
Do I have the skill to develop and assess my level of cultural competence?  
What practical experience do I have?  

Knowledge  
Do I have knowledge of cultural practices, protocols, beliefs, etc?  
Have I undertaken any cultural development programs?  

Encounters  
Do I interact with Aboriginal and Torres Strait Islander persons?  
Do I interact with culturally and linguistically diverse persons?  
Have I worked alongside Aboriginal and Torres Strait Islander persons?  
Have I worked alongside culturally and linguistically diverse persons?  
Have I consulted with Aboriginal and Torres Strait Islander persons or culturally and linguistically diverse groups?  

Desire  
Do I really want to become culturally competent?  
What is my motivation?  

2b  Consider these additional questions:  
What do we know about different groups of people?  

Whose standards have we accepted as the key standard for comparison?  

Whose ways of living are privileged?  

What are the implications of imposing understandings on people?  

3  Undertake organisational cultural competence audit  
Westerman’s (2007) research findings related to organisational cultural competence highlight the need for practitioners to reflect critically on the organisation in which they are working in terms of organisational competence. Westerman makes the point that ‘We’ve had organisations where 80% of their staff have had training in cultural knowledge or cultural awareness but that has had no relationship whatsoever to cultural competence and service delivery’.  

Westerman lists five key components of organisational competence:  
1  local Indigenous-specific knowledge  
2  skills and abilities for being able to adapt or utilise mainstream training in a way that will be effective with Indigenous clients
3 resources and linkages for the use of cultural consultants, cultural guides, having lots of links with the local community

4 organisational structures, ensuring that those are actually consistent with culturally appropriate practice

5 beliefs and attitudes—which is the most important?

Consider an organisation or service in the mental health service you work with or are familiar with. Do a cultural competence audit by identifying those issues that contribute to or diminish the sense of cultural safety and responsiveness for Indigenous clients and Indigenous families and staff that the organisation or service may or may not be aware of (Westerman, 2007). Taking into account the five components identified by Westerman, consider the following elements of organisational cultural competence suggested by Campinha-Bacote (2002):

**Context (organisational environment)**
In relation to the organisation:
- Does it promote and foster a culturally friendly environment?
- Is it located in an area where Aboriginal and Torres Strait Islander persons and culturally and linguistically diverse persons may wish to access services?
- Do the staff display attitudes and behaviours that demonstrate respect for all cultural groups?

**Practices (culturally inclusive)**
Does the organisation:
- involve or collaborate with Aboriginal and Torres Strait Islander persons or groups or culturally and linguistically diverse persons/groups when planning events, programs, service delivery and organisational development activities?
- develop policies and procedures that take cultural matters into consideration?
- provide programs that encourage participation by Aboriginal and Torres Strait Islander persons and culturally and linguistically diverse persons?
- use appropriate communication methods and language, e.g. appropriate and relevant information communicated through user and culturally-friendly mediums?

**Relationships (collaborative partnerships)**
Does the organisation:
- have knowledge of local Aboriginal and Torres Strait Islander groups?
- have knowledge of culturally and linguistically diverse groups in the community?
- have knowledge of local Aboriginal and Torres Strait Islander protocols?
- have knowledge of the protocols for communicating culturally and linguistically diverse groups in the community?
- actively involve Aboriginal and Torres Strait islander persons or groups and culturally and linguistically diverse persons or groups in the community?
- have a strategy for community engagement?

**Service delivery (outcomes)**
Does the organisation:
- develop and/or implement a collaborative service delivery model with other organisations relevant to the specific cultural needs of the clients?
- provide culturally responsive services that meet the cultural needs of clients?
4 Key concepts
Provide a brief definition for each of the following key concepts:

Social ecology

Subjectivity

Reflexivity

Power

Cultural interface

Whiteness

Privilege

References


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