Charles Darwin University

Finding ways together

Researching with Aboriginal women in a mental health setting

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Finding ways together: researching with Aboriginal women in a mental health setting

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Key words

Aboriginal, women, inpatient, mental health, ethics, methods.

Abstract

Introduction

This paper describes the collaborative development of a method and process for transcultural qualitative enquiry, undertaken as the second phase of a mixed method PhD research project.

Aim

To develop an ethical, sensitive and culturally secure research method and process with which to explore the experiences of Aboriginal women in an acute mental health inpatient unit, a potentially vulnerable research population. To invite Aboriginal women to share their stories and their experiences as current inpatients, or as carers, visitors and health service providers.

Method

A local Aboriginal Reference Group (ARG) was constituted and collaborated with the first author in developing working strategies and tools. Members of the ARG guided all aspects of the research process, acted as primary agents for information-giving, informed consent and interview processes, and were co-authors of relevant publications.

Results

The method described here fostered trust and cultural respect, and embedded informed consent as an ongoing process. Eleven Aboriginal women inpatients undertook a single semi-structured interview prior to discharge from the inpatient unit. Five ARG members also gave interviews, adding insights from their 'insider-outsider' perspectives. A rich dataset of personal experience was made available for analysis.

Conclusions

The process devised for this study integrated principles of cultural respect and collaboration with an ongoing process of informed consent. By integrating these principles into research initiatives and evidence-based practice, and by ensuring familiarity with local Aboriginal and Torres Strait Island cultures, non-Aboriginal mental health nurses can enhance transcultural mental health service delivery in an acute setting.

Summary of relevance

Issue

The experiences of Aboriginal women in tertiary mental health services are largely unexplored or subsumed under the categories of 'women' or 'Aboriginal'. There is little detail to guide culturally sensitive process development for collaborative research in an acute setting.

What is already known

National guidelines and journal articles describing practical methods for transcultural research generally focus on larger scale community studies. No studies have been found which describe processes suitable for acute inpatient settings.

What this paper adds

Detailed description of respectful collaboration to develop an ethical, culturally secure process with which to engage Aboriginal women in an acute mental health inpatient unit as potential research participants.

Introduction

This study arose from the first author's experiences during 12 years in clinical and management roles in the Northern Territory of Australia, mainly in the Top End Mental Health Service (TEMHS) Inpatient Service. This unit serves a high proportion of Aboriginal clients from urban, rural, and remote communities in the Northern Territory (NT) and beyond. Aboriginal people constitute approximately 30% of the NT population, and approximately 50% of annual total separations from the inpatient unit. There are no other acute mental health inpatient units within 1500 kilometres (Bradley et al., 2017). Over the years, steps have been taken to introduce culturally secure practices to improve service delivery for Aboriginal clients (Hinton, Bradley, Trauer and Nagel, 2014).

As a feminist and a believer in person-centred care delivery I (first author) questioned whether policies and care pathways based on ethnicity alone as a reference point for cultural interventions could deliver best quality outcomes for Aboriginal women (Bradley, Dunn, Lowell, & Nagel, 2015). This initial 'gut feeling', based on familiarity with the setting and local service data, was strongly backed up by the female Aboriginal Mental Health Workers (AMHWs) who formed the basis of the foundational Aboriginal Reference Group (ARG) and who encouraged me to pursue the project.

Support from TEMHS management allowed research access to datasets, ARG members' time and collaboration, and permission to recruit potential participants.

Aboriginal women in Australia

Australian Aboriginal women take a central role in maintaining family and community cohesion, and in ensuring that children are brought up 'strong in culture' as a core constituent of ongoing wellbeing (Wright, 2012). Strength and resilience endure, despite disempowerment and oppressions resulting from colonisation, including patriarchal authority conferred by white men on Aboriginal men with consequent loss of Aboriginal women's authority and ownership of country (Moreton-Robinson, 2005).

Physical disability, employment insecurity, financial instability, inadequate housing and inequity in access to basic services are a daily reality, especially for those in remote communities (Burns et al., 2013). Successive policies of removal, the *Stolen Generations*, have given rise to kinship disruption, societal turmoil and alienation from land and culture which continue to undermine physical and mental health and wellbeing (Anderson & Tilton, 2017). Women often remain understandably wary of authority figures, including health personnel, since the fear of losing their children endures as a reality today (Anderson & Tilton, 2017).

Oppression is compounded when these factors are accompanied by a mental health diagnosis; stigma and marginalisation contribute further to disempowerment and silencing (Van Den Tillaart, Kurtz & Cash, 2009).

Ways of knowing

As a non-Aboriginal researcher, I was cognisant that acknowledgement of and reflection on one's own research standpoint is essential to authentic implementation of Aboriginal research methodologies. This applies to both Aboriginal and non-Aboriginal researchers (Moreton-Robinson & Walter, 2010). A culturally responsive methodology privileges Aboriginal knowledge and understanding equally with

Western knowledge-generation and frames research as addressing benefit to participants and communities rather than seeking 'problems' (Moreton-Robinson & Walter, 2010). Non-Aboriginal researchers adopting a de-colonising stance must be prepared to reflect on their own cultural constructs, to learn from their Aboriginal colleagues and to apply Aboriginal ways of knowing into their research and/ or practice (Laycock, Walker, Harrison, & Brands, 2011; Reid & Taylor, 2011).

Moreton-Robinson (2003) identified feminism to be the only theoretical space in academe to take 'difference' seriously. Her Indigenous Women's Standpoint is centred on Indigenous women's knowledges and informed by feminist and de-colonising Indigenous models (Moreton-Robinson, 2013).

In this study, feminist intersectionality provided a framework to guide my beginning exploration of stories outside my experience, stories of Australian Aboriginal women whose experiences are, like those of Indigenous women worldwide *' . . .*shaped by the intersecting forces of colonization, confiscation of traditional land bases, forced assimilation, residential schools, patriarchy, and the ongoing removal of Aboriginal children from their homes' (van Herk, Smith, & Andrew, 2011, p. 62).

The non-Aboriginal researcher - standpoint

> Our understanding of reality and its meaningfulness exists because of our ability as subjects to assign meaning that has been produced historically and socio-culturally. Feminist standpoint theory accepts that political interests and moral values are part of knowledge production and they shape our research; as such all researchers' beliefs are inextricably a constitutive part of their standpoints (Moreton-Robinson, 2013, p.335).

As a researcher my standpoint is that of feminism influenced by my white, English working-class background, my professional nursing acculturation and my clinical history as senior nurse on the mental health inpatient unit. I acknowledge the

privileges, complexities and limitations inherent in my situation as a white woman of professional power and academic status attempting to present the voiced experiences of Aboriginal women.

Members of the inaugural ARG had known me for many years and expressed confidence in my good intentions and ethical approach to cultural security (Kovach, 2010; Laycock, 2011). The ARG supported and guided me throughout to ensure that the research promoted the ethical advancement of knowledge and respect for the diversity and integrity of Aboriginal cultures. ARG members were Aboriginal women from diverse backgrounds who had knowledge and experience of the inpatient unit as mental health professionals, family caregivers and visitors. All had professional qualifications and clinical experience, and some had research experience.

Engagement and thoughtful collaboration with the members of the ARG gave the opportunity to interrogate my own perceptions and misperceptions of culturally secure research practice, and to develop a method which, as far as possible, honoured the primacy of Aboriginal women's preferences and perspectives in the research process (Dunbar, 2011).

Research design and method

This study explored the question "How do Aboriginal women experience the acute mental health inpatient unit?" It aimed to develop an ethical, sensitive and culturally secure method and process to explore the experiences of Aboriginal women with multiple vulnerabilities. We wanted to ask Aboriginal women to share their stories and their experiences as inpatients, or as carers, visitors and health service providers. Our mixed method approach combined a quantitative examination of pre-existing local datasets with a qualitative exploration of women's own stories. The quantitative phase of the research was described in an earlier article (Bradley et al., 2017). This article describes the collaborative development of a method and process

for the second, qualitative, phase undertaken to add personal meaning to the quantitative findings.

We needed to demonstrate respect for cultural sensitivities, avoid coercion and ensure that informed consent was embedded as a continuous affirmative process within the research method:

> Such an approach also requires restructuring the methodology to focus on relationship building and the research process, rather than the usual emphasis solely on outcomes (Dudgeon et al., 2010, p.84).

As planning progressed it became clear that all collaborators on this research project were entering on a new journey. Context-specific difficulties were encountered which at times threatened to derail the project; discussing and agreeing process modifications extended the project timeframe substantially (McGrath, Rawson, & Adidi, 2013; Weston et al., 2009). Table 1 outlines steps taken to address context-specific barriers. We found little in the published literature which directly addressed method or process for eliciting experiences of Australian Aboriginal women within an acute inpatient mental health setting (Bradley et al., 2015). ARG members collaborated with and guided me as a non-Aboriginal first author to fashion an ethically grounded trans-cultural method of inquiry which both satisfied academic requirements and was responsive to cultural terms of reference within the context of this research. As identified by Minkler (2004), where communities of potential participants are characterised by flux ‘our notions of participation similarly must be flexible enough to take into account the culture and social environment of the community members with whom we work’ (p.692). Working in this way, the *process of inquiry* itself is integral to the validity of the research project (Dudgeon et al., 2010)..

Table 1 Barriers and research approaches

Identified barrier	Addressed by
Inpatient population (potential participants) in rapid transit	• Early introduction of the research information, undertaken by AMHWs • Modification of requirements for follow up and knowledge sharing.
Language barriers: difficulty in accessing Interpreter services	• Modification of interview requirements • ARG judgment on primary researcher's competent understanding of Aboriginal English • AMHW judgment on potential participant fluency in Aboriginal English / Standard English
Gendered cultural norms	• All female research group

Potential perceived coercion to participate	• AMHWs undertake initial approach, information and consent process
	• ARG members undertake all interviews
	• Non-Aboriginal primary researcher introduced but remains in background:
	    o Culturally appropriate introduction by PLS, with 'vouching' by AMHW
	    o Personal introduction by Aboriginal interviewer before final consent.

Method

Ethics

Ethical guidelines require specific attention to the protection and needs of vulnerable populations (NHMRC, ARC & AVCC, 2015). This study addressed the ethical issues inherent in gaining informed consent from participants with multiple intersecting vulnerabilities: Aboriginal women, diagnosed with mental illness, incarcerated in an environment of legislated power imbalance, and often speaking an Aboriginal language as their primary language with limited English language proficiency.

Our original literature review was described in Bradley et al. (2015). In preparation for this qualitative study, a further search was undertaken with specific reference to ethics and consent and extending the timeframe to 2018. Key words were: *Aboriginal, Indigenous, women, female, girls, inpatient, acute, mental, psychiatry, research, ethics, consent.* Insights gained from this supplementary search underpinned the development of a culturally responsive method and process.

Ethics approval for this research was received from the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health.

Research Group

The research group comprised myself as first author, my supervisory panel and my ARG members, whose support and guidance in cultural processes and protocols complemented and strengthened the research project. All members of the research group were women, reflecting the living Aboriginal cultural reality of a 'two-gendered approach to life' in both traditional and urban settings (Dudgeon & Bray, 2017).

Aboriginal Reference Group

Ethical and academic guidelines emphasise the need for an ARG as an essential component of the research process (AIATSIS, 2012; Australian Indigenous Health InfoNet, 2015; Laycock et al., 2011; NHMRC, ARC & AVCC, 2015) but there was little practical description of how this was to be achieved or maintained within the non-academic setting of a working mental health unit. We learnt together as the project progressed.

Reference Group members were Aboriginal women who had knowledge and experience of the inpatient unit as mental health professionals, family caregivers and visitors – and sometimes with a mix of these experiences. All had professional qualifications and clinical experience, and some had research experience. ARG members were instrumental in devising culturally appropriate processes for identifying potential participants, recruitment and consent. Plain language information and interview tools were collaboratively developed, and knowledge sharing strategies and future research directions identified (Marshall, Kendall, Catalano, & Barnett, 2008).

Finding a way - consultation

The ARG was constituted formally, in agreement with TEMHS management. Formal meetings during the planning phase took place over 12 months. Terms of Reference were established, and meetings were minuted to ensure that decisions were fully integrated into the research establishment process. Members consented to meetings being recorded either in written notes or in sound recording. These meetings confirmed research aims, reviewed and developed key documents and formalised processes for recruitment, interviews and ongoing collaboration. From commencement of interviews until final draft of results, consultations continued through informal small group or individual discussion.

ARG members reviewed the proposed Plain Language Statement and Consent Form, making it clear that academic Plain Language was not plain enough, and endorsing improvements in language clarity and accessibility. Together ARG and I developed sampling and recruitment methods, drew up interview guidelines and prompts, and prepared a distress protocol.

Our central commitment was to ensure ongoing informed consent from participants, and to eliminate as far as possible any coercion – real or perceived – from the recruitment and interview process. The resulting multi-staged informed consent process relied on interpersonal interaction and trust between AMHWs and potential participants.

Participants and setting

Inpatient participants were recruited through convenience sampling. Inclusion criteria were women age 18 years and over, who self-identified as Aboriginal, were currently admitted to the TEMHS Inpatient Unit, and were assessed by themselves and their treating team as competent to consent and to tolerate interview.

Interviews were often postponed or cancelled at short notice as family visits and family leave took priority, and medico-legal events on the ward sometimes required AMHW presence elsewhere as a matter of urgency. Some potential participants withdrew during the consent process due to unavoidable factors, such as transfer to general hospitals for treatment of underlying physical conditions or unexpected availability of return flights to remote communities offering timely discharge.

Managing unequal relationships

I was employed in senior nursing and management positions in the Top End until 2011. While this employment ended well before interviewing commenced, it was possible that some potential participants might remember and feel coerced or fearful about participation. The ARG considered this potential risk and established a robust process to minimise potential constraints, ensuring I had no contact with potential participants in the process of giving information about the research and in obtaining consent. In their capacity as cultural advocates and direct care workers, AMHWs assumed this role to ensure a fully informed and voluntary consent process. Members of the ARG conducted inpatient interviews in order to minimise perceptions of power imbalance in eliciting stories and to enhance participant comfort (De Crespigny, Emden, Kowanko, & Murray, 2004).

Language considerations

We wanted to capture the women's descriptions of their interaction with an acute mental health service in their own language, which could be any of nine major Top End Aboriginal language groupings, or one of many other languages and dialects. We initially planned to use interpreters as required at all stages of the research process (McGrath et al. 2013) but this proved impracticable. Interpreter service availability was often limited (Ralph et al., 2017), medical assessments and legal issues such as Mental Health Review Tribunal were prioritised, and interpreters might

be called away at any time to emergencies elsewhere. Occasionally a participant might refuse an interpreter due to a culturally proscribed avoidance relationship restricting communication between certain relatives, or due to community tensions (McGrath et al. 2013). Interviews were therefore confined to potential participants assessed by AMHWs as having sufficient fluency in Aboriginal English or Standard English. This allowed for accurate interview transcription by the first author, with clarification by members of the ARG as necessary.

Recruitment and consent

Potential inpatient participants were women aged 18 and over who identified as Aboriginal. AMHWs confirmed with the treating team the individual's capacity to consent and to tolerate interview, focusing on the woman's susceptibility to anxiety and specific cognitive factors of thought disorder and attention (Howe et al., 2003). Emotional risk was managed by developing a Distress Protocol based on the work of Draucker et al. (2009), to be followed if the participant showed signs of emotional distress.

AMHWs and ARG members introduced and explained the project in order to maximise a fully informed and voluntary consent process (Figure 1). Understanding and consent were verified at every stage of the recruitment process and before each interview, embedding informed consent as a continuous affirmative process within the research method (NHMRC et al., 2015).

Whenever possible, AMHWs discussed participation in the research project with the potential participant and family, with time given for ongoing discussion within the family group. Any indication of refusal or reluctance to participate in the project was respected. The AMHW then discussed the Plain Language Statement and Consent Form in detail and left a copy of each with the woman. The AMHW remained

available in person and via telephone for further discussion with the woman and with family or community representatives as desired.

Given the physical, social and emotional health status of the Aboriginal population and essential cultural protocols regarding death it was necessary to formulate a process to be followed in the case of the death of a participant. Families were assured that they would be consulted, and their wishes followed regarding use or withdrawal of the participant's information.

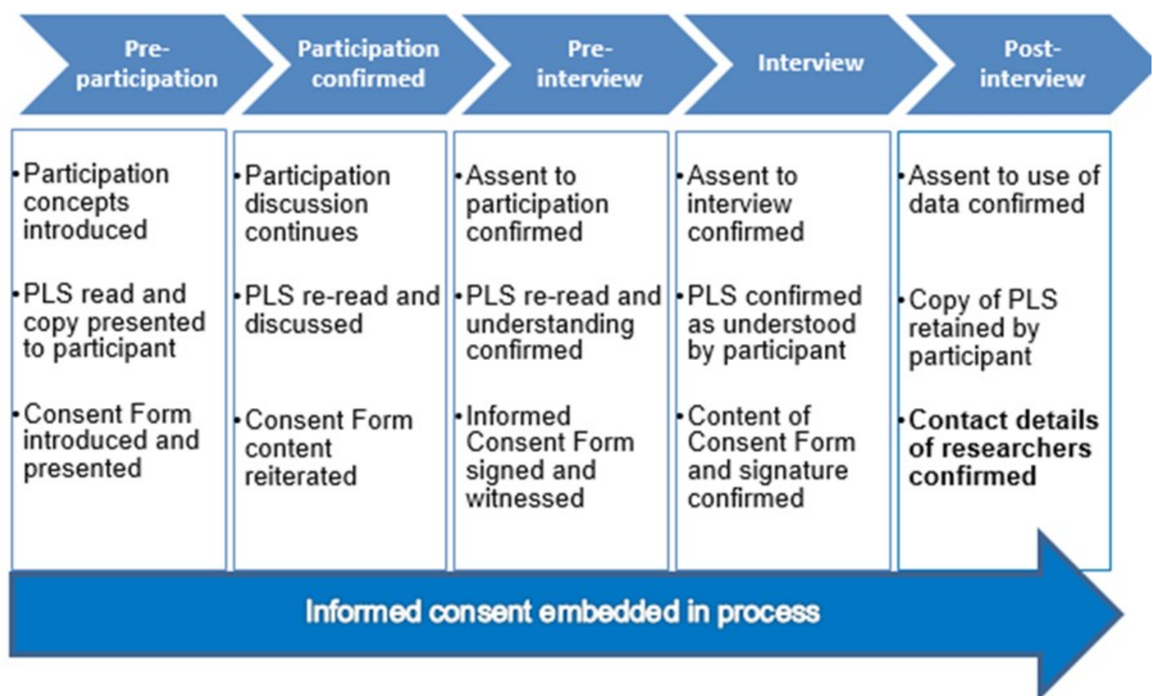

Figure 1 Inpatient Participant Informed Consent process using Plain Language Statement (PLS) and assent

Interview process and data management

Semi-structured interviews took place informally in a quiet area of the ward. All interviews were captured using a small recording device, most lasted 30 minutes or less, and all were ended when the interviewee indicated that they had no further information they wished to convey.

My role was to stay in the background and monitor the sound recorder. I was introduced before the interview commenced, and my presence explained. After

confirming that my presence was acceptable, I positioned myself out of the participant's line of sight and did not interact verbally or nonverbally during the interview unless directly addressed. Recordings were transcribed by me and transferred to NVivo software for coding and analysis. Wherever possible, the transcript was confirmed with the participant to check for accuracy. This was not possible where the participant was on leave or discharged after interview. In these cases, points of language or culture which were unfamiliar to me were noted at time of interview and discussed with the interviewer as soon as possible after interview, to confirm accuracy. Participants could request a follow up interview, if desired. All were given contact numbers, should they wish to follow up after discharge.

As first author, I transcribed all interviews and coded all data to ensure consistency of coding. Using elements of a constructivist grounded theory approach, data were organised and coded into categories (Charmaz, 2014). Sampling continued, with continuous evaluation during the interview and analysis process in collaboration with the ARG and Supervisory Panel, until no further new information was forthcoming relevant to the experiences of Aboriginal women in the inpatient unit (Charmaz, 2014; Malterud, 2016). Members of the initial ARG discussed and agreed the coding process and later member checking with the ARG and Supervisory Panel confirmed my understanding of the data and analysis of the themes. The findings from the interview analysis will be reported in a later article.

Results

Consultation and collaboration with the ARG members aimed to develop a research method and process sensitive to the needs of a culturally diverse and ethically vulnerable research population of Aboriginal women participants. Table 2 outlines the core steps taken to ensure research adherence to ethical principles. At every step of the research process ARG members confirmed that cultural values were appropriately observed.

Table 2 Adherence to ethical principles

NHMRC principles[1]	AIATSIS principles[2]	Research method compliance
1: Reciprocity . . . demonstrated willingness to modify research in accordance with participating community values and aspirations.	7: Responsibility for consultation and negotiation is ongoing.	• Principal researcher was guided by members of the ARG in selecting appropriate method and process.
2: Respect . . . the proposal responds to the diversity of Aboriginal and Torres Strait Islander Peoples . . .	5: Aboriginal knowledge, practices and innovations must be respected, protected and maintained.	• The ARG comprised Aboriginal women from diverse backgrounds. • Principal researcher was guided by the ARG in all decisions.
3: Equality . . . Researchers . . . ensure that the information that they provide is understood and usable in decision making . . .	6: Consultation, negotiation and free, prior and informed consent are the foundations for research with or about Aboriginal peoples.	• Principal researcher and ARG collaborated to produce a Plain Language Statement and Informed Consent Form • Ongoing confirmation of informed consent was embedded into the research method
4: Responsibility . . . transparency in the exchange of ideas and in negotiations about the purpose, methodology, conduct, dissemination of results and potential outcomes/benefits of research.	10: Aboriginal people have the right to full participation appropriate to their skills and experiences in research projects and processes.	• Members of the ARG discussed the proposed research with Aboriginal women in the inpatient unit, who supported development of the research project. • The project gave ARG members opportunity to use and further develop individual and group skills and capacities.
5: Survival and protection . . . safeguards are in place against the research project contributing to discrimination or derision of Aboriginal and Torres Strait Islander individuals or cultures	11: Aboriginal people involved in research, or who may be affected by research, should benefit from, and not be disadvantaged by, the research project	• The research process addressed comfort and cultural safety for Aboriginal participants • Outcomes will support improved service delivery for Aboriginal women. • Feedback to stakeholders includes recommendations for service enhancement as identified by Aboriginal women.
6: Spirit and integrity Does the proposal demonstrate a commitment to working within the spirit and integrity of Aboriginal and Torres Strait Islander Peoples?	1: Recognition of the diversity and uniqueness of peoples, as well as of individuals, is essential. 3: The rights of Aboriginal peoples to their intangible heritage must be recognised.	• Consultation and collaboration with ARG members demonstrated respect for Aboriginal culture and values • Research process enabled participants to express their views and experiences in their own voice, as far as was achievable in context.

1. National Health and Medical Research Council 2003, *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, Commonwealth of Australia, Canberra
2. Australian Institute of Aboriginal and Torres Strait Islander Studies 2012, *Guidelines for Ethical Research in Australian Indigenous Studies*, Revised 2nd edn, AIATSIS, Canberra.

Results indicated that potential participants perceived the embedded informed consent process and interview procedure as culturally secure and understood the culturage brokerage inherent in the research process: For instance, speaking with an AMHW interviewer one inpatient participant highlighted the need for cultural brokerage in the inpatient setting: '. . . more Aboriginal women . . . so we can speak

to them, like I’m speaking to you, and you explain, talking to that lady [points at primary author]’.

Eleven Aboriginal women inpatients gave informed consent and undertook a single semi-structured interview prior to discharge from the inpatient unit. None of the women who consented to interview withdrew from participation. They demonstrated confidence in the research aims and process, shared their personal stories with the research group and trusted us with evidence of their individual experiences.

Five Aboriginal women members of the ARG also gave informed consent and participated in informal interviews with the first author, adding insights from their ‘insider-outsider’ perspectives. In all, 16 Aboriginal women shared their stories and their experiences as current inpatients, or as carers, visitors and health service providers, adding generous information and new knowledge to a little-researched area.

Discussion

> The resilience and perseverance demonstrated by many Aboriginal friends and colleagues are some of the greatest stories shared. The path of Aboriginal research requires relationships, time, continuous self-reflection, perseverance, openness to correction and re-education – and the journey is rarely black and white (Jalla & Hayden, 2014).

A demonstrated gap in the literature (Bradley et al., 2015; Dudgeon & Bray, 2017) is the failure to address the silencing suffered by Aboriginal women when their voices and experiences are subsumed in research under the wider categories of ‘Aboriginal people’ or ‘Women’. This exploratory research seeking the stories of Aboriginal women during their hospitalisation in an acute mental health unit constituted, to our knowledge, an undertaking unique to date in the Australian literature (Bradley et al., 2015). Developing a culturally sensitive method and process was complicated by the

numerous diverse Aboriginal cultural and language groups represented by potential participants in the inpatient unit. The establishment of an ARG was essential to underpin a research strategy which could effectively address these concerns and help fill the research gap (AIATSIS, 2012; Laycock et al., 2011).

Ethical guidelines laid down by the NHMRC (2003) and AIATSIS (2012) informed the development of a culturally responsive research method and process for this study. Input and direct feedback from ARG members and participants ensured that a painstaking, ongoing review of method and process underpinned adherence to cultural security in research, while maintaining research integrity and ethical security for potentially vulnerable participants.

Reid & Taylor (2011) state that non-Indigenous researchers can safely undertake Indigenous research 'if they are willing to step outside of their own cultural frameworks, to talk with their Indigenous colleagues, to learn from their Indigenous colleagues and to apply Indigenous ways of knowing, being, valuating and doing in their research' (p.6). Collaboration between ARG members, researcher and supervisory panel resulted in a carefully crafted method and process to balance the potential tensions between academic and cultural integrity. Such an approach also required restructuring the methodology to focus on relationship building and the research process, rather than emphasis on outcomes alone (Dudgeon et al., 2010).

The resulting process proved slower to implement than originally anticipated, but robust in maintaining ethical integrity. Due to the unpredictable nature of the acute unit milieu we took longer than anticipated to achieve our predicted number of inpatient interviews. Nevertheless, we retained the extended information and consent process to avoid any perception of coercion, in full knowledge that this would lead to forfeiture of several potential participant interviews. The difficulties encountered and solutions implemented during the project reflected the reality of undertaking research in challenging locations and on difficult topics (McGrath et al., 2013; Ralph et al.,

2017). Extra time and thought is required for planning and implementing a culturally secure process (Dudgeon et al., 2010), and this should be made clear and incorporated into project proposals (Weston et al., 2009).

Potential participants were subject to multiple vulnerabilities, including disadvantages of gender, culture, remoteness, language, and mental health status. By respectful collaboration the research team was able to develop an ethical, culturally secure research method and process with which to explore and document the experiences of Aboriginal women in an acute mental health inpatient unit. The professional and personal expertise, support and guidance of an ARG in such a setting is essential in developing and maintaining a respectful and meaningful research process.

Limitations

Lack of interpreter involvement constituted a limitation. Future research should prioritise availability of interpreters as required for participants for whom an Aboriginal language is the language spoken at home (McGrath et al., 2013; Ralph et al., 2017).

The research method described here is contextualised to the specific setting and participants, therefore some methods and issues may not be transferable beyond this context. However, the process proved successful in recruiting and engaging participants from diverse Aboriginal cultural backgrounds and may prove adaptable to other situations for non-Aboriginal researchers collaborating in research in acute inpatient settings.

Conclusion

Fundamental ethical principles of cultural sensitivity, collaboration and respect were demonstrated in developing this qualitative research method. The culturally respectful process and method developed for the project resulted in successful recruitment and safe interview participation for Aboriginal women in an acute mental health inpatient setting. By integrating these principles into relevant research and evidence-based practice and by ensuring familiarity with local Aboriginal and Torres Strait Island cultures, mental health nurses can enhance culturally secure mental health service delivery.

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