Review

Acute mental health service delivery to Indigenous women: What is known?

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ABSTRACT: The Australian College of Mental Health Nurses directs that mental health nurses must ‘enable cultural safety in practice, taking into account age, gender, spirituality, ethnicity and health values’. The present study is a review of the existing literature undertaken in order to identify current knowledge and knowledge gaps regarding the experience of Indigenous women in acute mental health inpatient facilities. In particular, studies that identified environments and practices promoting the development of culturally-safe healing spaces for Indigenous women, and studies that identified women’s experience of seclusion, were sought. The results showed that there is little literature directly relevant to Indigenous women’s experiences of inpatient mental health units in Australia. The present study consolidates existing knowledge and knowledge gaps, and advances the argument for gender-disaggregated future research. Implications for professional practice and service development are also noted.

KEY WORDS: acute mental health, Indigenous, inpatient, seclusion, women.

INTRODUCTION

The delivery of culturally-secure, non-discriminatory practice is a gold standard for current mental health services (National Mental Health Strategy Workgroup 2010) and the mental health workforce (Australian Health Ministers’ Advisory Council (AHMAC) 2002). For mental health nurses, the Standards of Practice published by the Australian College of Mental Health Nurses directs that mental health nurses must ‘enable cultural safety in practice, taking into account age, gender, spirituality, ethnicity and health values’ (Australian College of Mental Health Nurses (ACMHN) 2010, p. 5). In order to fulfil these standards, mental health nurses must turn to the professional and clinical literature to obtain an evidence base for practice. Where evidence is limited, it is incumbent on the nurse to identify gaps and to participate in or conduct research to promote quality practice (AHMAC 2002).

It is the aim of mental health services in Australia to deliver effective care in the least restrictive possible environment, and inpatient services remain a last port of call when clients are deemed to pose a risk to self or others (Muir-Cochrane et al. 2012). Within inpatient services, the principle of the least restrictive treatment is maintained. Seclusion events (confining a person at any time of the day or night alone in a room or area when it is not within their control to leave) are regarded as critical or signpost events within the acute clinical setting, indicating heightened levels of client distress, breakdown in the collaborative therapeutic relationship central to recovery (ACMHN 2010; Grigg 2006), and/or a failure of the clinical environment to deliver therapeutic outcomes (Substance Abuse and Mental Health Services Administration (SAMHSA) 2006). The Australian Human Rights and Equal Opportunity Commission has, since 1993, been critical of the experience of seclusion described by many consumers, concluding that the practice is a ‘humiliating breach of their human rights’ (Human Rights and Equal Opportunity Commission (HREOC) 1993, p. 271).
The Top End Mental Health Service acute inpatient unit serves a high proportion of clients of Indigenous background from all regions of the Top End of the Northern Territory (Australia) and beyond, and from urban, rural, and remote Australian communities. Attempts have been made to introduce a culturally secure mental health nursing model and to find an evidence basis for high-quality service delivery for Indigenous clients (Bradley 2008). Mental health nurses working in the acute inpatient setting in the Top End of the Northern Territory must have access to evidence in order to deliver culturally secure practice and service development to meet the needs of Indigenous women.

The present study describes the literature search undertaken as part of a research project to identify current knowledge and knowledge gaps regarding the experience of Indigenous women in acute mental health inpatient facilities. Ultimately, the project will provide both quantitative and qualitative evidence to assist service and policy development in acute mental health services for Indigenous women in the Top End of the Northern Territory and beyond. The research has full ethics approval from the Human Research Ethics Committee of the Northern Territory Department of Health and Families and the Menzies School of Health Research.

**Terminology**

Aboriginal and Torres Strait Islander people have diverse languages, cultures, and communities. In recognition of diversity, this article uses the term ‘Indigenous’ to acknowledge women from all Australian Aboriginal and Torres Strait Islander groups. The term ‘community’ is used to describe a group of Indigenous people with a common language, culture, religion, and land or shared identity. Indigenous community is not based solely on geographical location (Dunbar 2011).

The terms ‘mental health’ and ‘social and emotional well-being’ are still used almost interchangeably, despite calls for greater clarity (Garvey 2008), and are used in this article as they occur in any reference quoted.

**METHOD**

A literature search was undertaken, searching in particular for studies examining the understandings and experiences of Indigenous Australian women in acute mental health inpatient settings, and identifying environments and practices which might provide culturally-safe healing spaces for Indigenous women admitted to such units. Search facilities of the Charles Darwin University Library and library website (Darwin, NT, Australia) were used.

The primary databases searched were EBSCOhost, incorporating CINAHL Plus with Full Text, Medline with Full Text, PsycARTICLES, PsycINFO, SociINDEX with Full Text, and the Psychology and Behavioral Sciences Collection. As the primary repository of Australian mental health nursing literature over three decades, the database archive of the *International Journal of Mental Health Nurses* was searched separately. Secondary databases included e-Journals and Humanities International Complete. Citations from relevant articles and texts were accessed. Google Scholar was also used as a baseline search aid.

Databases were systematically searched (Higgins & Green 2011; Joanna Briggs Institute 2011) for articles, book chapters, policies, reports, and other relevant literature, which directly addressed the major theme of Indigenous women in acute mental health inpatient units. The date was limited from 2000 to present. Key words used in various combinations included: *Indigenous, Aboriginal, women, female, girls, inpatient, acute, hospital, mental, psychiatry, incarceration, and institution*. When this initial search yielded little result, the criteria (key words) were widened to include literature which made direct reference in various permutations to *gender, institutions, mental health, healing, social and emotional well-being, coercion, and seclusion*. The date range was extended to 1970 up to the present. Searches were not confined to nursing sources, but included sources from allied health, medicine, psychology, social sciences, education, and anthropology. Grey literature was also systematically searched (Joanna Briggs Institute 2011).

**FINDINGS**

Very little literature examining the experience of Indigenous women in the acute mental health system was found. Indigenous mental health issues are noted in primary care and public health literature, with particular focus on social and emotional well-being. However, while severe and continuing mental illness among Indigenous groups in the community is given attention in the medical literature (e.g. Hunter *et al.* 2012), inpatient experience for Indigenous people is rarely studied. Furthermore, discussion of Indigenous mental health issues, with the exception of perinatal mental health, is rarely disaggregated by gender. The majority of literature found described small-scale, qualitative, or mixed-method studies.

In their comparative survey of the health of Aboriginal populations in Australia, Canada, the USA, and New Zealand, Freemantle *et al.* (2007) emphasized the paucity
of data in all jurisdictions due to multiple factors, including, until recently, the non-collection of census information on ethnicity, and the complexities inherent in self-reporting such information due to histories of colonial neglect, disparagement, discrimination, and overt violence:

Aboriginal populations in New World nations share the common experience of having their cultures profoundly affected by contact with outsiders. They are also linked by their history of deeply held spiritual beliefs and practices; prolonged exploitation, prejudice and discrimination; attempts at forced assimilation; large scale neglect of human rights; health problems and social disadvantage; and efforts to obtain international recognition and protection for their peoples and cultures. (Freemantle et al. 2007, p. 4)

Ypinazar et al. (2007) attempted to consolidate documented understandings of Indigenous mental health beliefs by means of a meta-synthesis of peer-reviewed qualitative empirical research. Their extensive searching revealed five articles based on four studies. Five major themes were identified as having ‘dynamic interconnectedness’:

(i) culture and spirituality; (ii) family and community kinships; (iii) historical, social and economic factors; (iv) fear and education; and (v) loss (p. 473).

While culture, kinship, and intergenerational trauma were noted as important to Indigenous understanding of mental health issues, only one study was noted to report age ranges; none reported on gender lines. Only one article provided any definition or clarity around the meaning of mental illness for Indigenous people, and only one examined the perspectives of those with mental illness or disorder. None provided any insight into the importance or otherwise of gender and experiences in the cultural explanation of mental health or illness.

De Donatis (2011) noted that without an understanding of Indigenous mental illness aetiologies there can be no real change in basic assumptions guiding mental health service delivery. Her ethnographic investigation among the Yolŋu people of north-east Arnhem Land remains the only in depth investigation found of Indigenous Australian mental health and illness concepts. No attempt was made to explicate distinctions (if any) between male and female experiences of mental health or illness.

Studies of Indigenous women’s health in Australia and attention to female narrative are found mainly in terms of women’s business (reproductive and perinatal health) or of women’s role in children’s health. Studies into the mental health of Indigenous women similarly cluster around these themes, for instance Austin et al. (2007), who concluded that perinatal psychiatric illness was a leading indirect cause of perinatal deaths and that Indigenous women were overrepresented in the data they analysed. Burns et al. (2013) gave an overview of women’s health in the community with some reference to hospitalization, including high rates of hospitalization for mental health issues and self-harm, but not to the human experience of being in hospital. In their exploratory study of Indigenous women birthing in hospital, Dietsch et al. (2010) showed that the experience can be frightening and disempowering for families as well as patients, when cultural and emotional safety are ignored and power differentials are used to intimidate or even bully vulnerable women.

Overseas and in Australia, studies of the experiences of (mostly non-Indigenous) women in inpatient units have shown that women may feel fearful of experiencing or witnessing aggression, sexual harassment, and other serious incidents in the institutional setting, and may feel disempowered or disregarded in reporting their experiences (State of Victoria 2008). In international literature, some indication of the personal experiences of women in inpatient units in the UK was given by Copperman and Knowles (2006) in a small-scale series of interviews with staff members and service users; however, the authors noted that the experience of women from minority ethnic backgrounds is not clearly described or explored in the literature. Hagen and Nixon (2011) used qualitative interviews to explicate the experiences of women in Canada who had been hospitalized during a psychotic episode. They did not specify the ethnicity of participants, but excluded non-English speakers. In New Zealand, cultural security within health services has been embedded for decades. Nevertheless, in New Zealand the experience of women is also poorly studied (Wilson 2008). There is evidence that differences in the experience of coercive practices between Maori and non-Maori are reduced by the integration of Maori mental health workers within inpatient services (Durie 2011; Kumar et al. 2008).

A lack of cultural security, including poor understanding of communication styles and use of language interpreters in service delivery, can lead to emotional and physical distress for Indigenous people, which results in reduced service use and poor health outcomes (Coffin 2007; Lowell et al. 2012; Nagel & Thompson 2006). Dunbar (2011) noted that any change in services must involve representatives from Aboriginal communities as champions for the change and as arbiters of what strategies are successful.

In multiple articles examining Indigenous women’s engagement with, and use of, community health agencies,
Fredericks (2009; 2010) argued that services need to look for ways to empower Indigenous women in a culturally sensitive manner, rather than act as ‘sites where the dominant culture controls all within the environment and re-inscribes colonial stereotypes’ (Fredericks 2010, p. 21). She argued that by consulting the views and needs of Indigenous women, policy makers and service providers can enhance access to health services and health spaces, and generate improved health outcomes, noting that:

Places and space are neither innocent nor neutral . . . they can work to marginalise and oppress or to include and engage. They are instruments of the political: they are embedded with power and unwritten laws informing women whether they belong or they don’t. (Fredericks 2009, p. 41)

A qualitative study by Kelly et al. (2011) described the acute experience of rural and remote Aboriginal people attending a general hospital. They addressed the needs of Indigenous women in a cultural context, advocating such measures as gender-segregated wards and bathrooms. Acknowledging the complexity of the remote Indigenous journey, they included understanding of the need for support from family and community, but did not explore how this need might differ between men and women and different age groups.

Nagel’s (2005) review of remote mental health in the Top End of the Northern Territory is one of very few which directly referred to Indigenous women within the acute mental hospital setting. As part of a project introducing aspects of an integrated mental health care package in remote communities, it was noted that Indigenous women’s hospitalization rates for depression (twice the rate of that for non-Indigenous women), psychotic disorder, and substance use probably represented only the tip of the iceberg of mental distress within communities. Without further focused studies, this distress remains unheard. A unique, direct narrative by an Indigenous woman described her experience of an acute psychotic episode in an ‘abusive mainstream system’ in contrast with an Aboriginal Mental Health Service, but did not give specific detail to guide the development of non-abusive services, beyond the observance of basic human rights (Sherwood 2005).

The hospitalization of Indigenous people is characterized by several researchers and commentators as an extension of historical solutions to ‘the Aboriginal problem’; that is, of segregation in reserves, missions, and penal institutions (Broadhurst 2002; Cox 2007; Gray & Sagger 2005; Struthers & Lowe 2003). The rates of hospitalization in acute mental health, like rates of imprisonment, are higher for Indigenous than non-Indigenous women. A fear of hospitals influences health-seeking behaviours for Indigenous people, and may lead to unnecessary ‘crisis’ admissions:

Fear of admission, especially involuntary admission, has been a factor in patients and family being reticent to give a frank history. Fearing incarceration, and a loved one being removed from the family, understandably brings out strong emotions in Aboriginal communities given their history of removal and institutionalisation. (Sheldon 2010, p. 215)

The multiple inheritance of racism, sexism, and indigence suffered by Indigenous women has been characterized as ‘a Prison of Disempowerment . . . built out of the lies of colonisation’ (Lucashenko 2002, p. 143). Institutionalization is seen as pervading all aspects of Indigenous life, reducing the individual’s expectation of self-determination and health choices, as argued by Edwards and Sherwood (2006), who write from their experiences as Aboriginal registered nurses and speak to their own experience of silencing within the mainstream. Institutionalization mirrors a historical precedent for the use of prisons and mental hospitals as a socially-approved method of managing individual behaviours, which are characterized by the dominant sector of society as deviant (Roach Anleu 2005). This pervasive, disempowering conflation of hospitalization with incarceration may influence the expectations and experiences of Indigenous women whose behaviour is brought under scrutiny by health and social agencies.

Clark and Fileborn (2011) reviewed existing literature to examine issues of disempowerment and sexual violence in a range of institutional settings, including psychiatric wards, noting that Indigenous women are overrepresented in the correctional system, but did not address individual women’s subjective experiences. Sherwood (2005) described her personal experience of mental health inpatient care, but did not, except by inference, address the experience of other Indigenous women.

Seclusion – isolating a person within a room with no means of voluntary exit – is a coercive practice which Australian mental health services are seeking to reduce, and where possible, eliminate. At least one recent study based on local demographic data has shown that the risk of seclusion was increased for Indigenous Australians, although the demographic data were not disaggregated for gender, as well as Indigeneity (Happell & Koehn 2010). Outstanding within the literature, Sambrano and Cox (2013) presented the stories of three Indigenous inpatients – one a woman – using their own words to
describe their emotional and cognitive responses to the
experience of seclusion. For Indigenous clients, they con-
ccluded, seclusion is a ‘humiliating, degrading, and dehu-
manizing treatment (that) mirrors their experience in the
wider society’ (p. 7). They characterized Ani’s story of
singing in seclusion for 3 hours as an act of resistance,
reclaiming her humanity.

Gender-sensitive policy and process development are
necessary to ensure that the needs of women are not
overlooked in the inpatient environment (Copperman &
Knowles 2006). While women’s voices remain silent,
unsought, or unheard, the evidence base for culturally
safe, gender safe practice does not exist. Kurtz et al.
(2008) noted the act of ignoring or silencing to be an act
of structural violence that inhibits delivery and uptake of
effective service. Without awareness of the problems
which may affect Indigenous women, or the evidence on
which to base any action, policy makers and health agen-
cies cannot effectively address issues specific to Indig-
igenous women’s mental health.

For the mental health nurse, cultural sensitivity is a
vital element of therapeutic alliance. In attempting to
provide individualized, meaningful service to clients, it is
essential that nurses understand the cultural templates
that shape behavioural and emotional responses, beliefs,
and values about health, and what each person character-
izes as mental well-being (Bradley & DeSouza 2013).
Cross-cultural communication, including language issues,
as well as potentially conflicting interpretations of mental
health and well-being, must be examined in light of their
potential influence on diagnosis and on clinicians’ use of
coercive powers under mental health legislation (Nagel
2003):

Reflective practice and commitment to the understand-
ing of each individual as a person, taking into account and
respecting cultural diversity, will enable mental health
nurses to work with clients to establish supportive care
strategies and valid outcomes (Bradley & DeSouza 2013,
p. 105).

CONCLUSION

Evidence, rather than assumption, is needed to inform
service policy development, as well as therapeutic inter-
vention for individuals (Moerman & Van Mens-Verhulst
2004):

If Aboriginal and Torres Strait Islander women continue
to have their sense of identity marginalised and eroded,
they will continue to have the poorest health of any group
of women in Australian society. (Fredericks et al. 2010,
p. 7).

The literature provides few indications as to the way in
which Indigenous women may understand mental health
and illness, whether there is any conception within Indig-
enuous understandings of mental health that men’s and
women’s experiences might differ, or whether there are
ways in which Indigenous women believe that their
mental health and well-being might be supported or
hindered by specific attitudes and interventions. While
there is some discussion of Indigenous health seeking
and engagement within the Western paradigm, very few
studies relate to inpatient settings, and even fewer to the
experiences of Indigenous women.

Identified gaps in knowledge include Indigenous
women’s concepts of mental health in their life context,
their relationship with and experience of the acute mental
health system, and their experience of the inpatient unit
as both built milieu and existential event. Research is also
needed that examines the inpatient mental health unit as
a therapeutic modality in itself and as a culturally safe
healing space within the context of colonial history. The
role of Aboriginal mental health workers and interpreters
in inpatient care is also underresearched.

Focused research is needed to assist in the delivery of
culturally secure care in accordance with national and
professional standards, and to establish the mental health
unit as a culturally safe healing space. Above all, there is
need for research that is informed by and centred around
Indigenous women themselves, and which values their
own stories in their own words.

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