Communication for Mental Health Practitioners

A total of **17 Yarning Circles** were facilitated across four Queensland Hospital and Health sites.

Metro North HHS – Chermside, Caboolture, Fortitude valley, City

Metro South HHS – Inal, Browns Plains

Central Queensland – Rockhampton and Gladstone

There were also two yarning circles held for Aboriginal and Torres Strait Islander Mental Health Professional.

A total of 136 attended.

**PARTICIPANTS**

|  |  |  |  |
| --- | --- | --- | --- |
| **HHS** | **Number of Yarning Circle** | **Number of Participants** | **IDENTIFIED**  **(A&TSI)** |
| **Metro North** | 6 | 39 | 10 |
| **Metro South** | 5 | 44 | 7 |
| **Central Qld** | 6 | 47 |  |
| **Cairns** | tbc | tbc | tbc |
| **Total** | **17** | 136 |  |

Yarning Circles – Project Overview, team, partnerships, stakeholders, yarning circles, cultural capability, mental health services, support planning, building rapport and effective communication with Aboriginal and Torres Strait Islander patients and families, training content, modes of delivery etc.

Yarning circles were recorded and transcribed by Community based research assistants.

Codes

Initial coding – familiarisation, grouping, patterns of meaning, stories expressed by practitioners

| Name | Description | Files | References |
| --- | --- | --- | --- |
| clinical practice and behaviour | Practitioners describing their interactions with patients | 8 | 77 |
| biases | Practitioners self-identifying personal biases | 4 | 15 |
| knowledge of history | Practitioners expressing their lack of knowledge of Aboriginal historical and culture | 3 | 6 |
| communication challenges | Practitioners’ description communication challenges that occur within specific interactions with patients | 7 | 33 |
| cultural challenges | Practitioners’ description cultural challenges that occur within specific interactions with patients | 8 | 35 |
| Cultural communication norms | Examples of Aboriginal cultural communication norms | 6 | 16 |
| communication barriers | Examples of interactions where challenges arises due to misunderstandings or lack of knowledge of Aboriginal cultural communication norms | 3 | 4 |
| cultural needs | Examples of Aboriginal cultural needs/beliefs/values | 5 | 14 |
| beliefs and values | Examples of Aboriginal cultural beliefs and values | 2 | 5 |
| traditional healers | Mentions of traditional healing/healers | 1 | 1 |
| MH system | Information related to the mental health system | 0 | 0 |
| positive examples | Strength based/positive examples of effective communication or relationship building/rapport/interactions | 1 | 4 |
| statistical representation | Information related to statistical data | 2 | 4 |
| system or service response | Information related to how the mental health system responds including processes | 5 | 17 |
| barriers | Examples of barriers identified by practitioners | 5 | 24 |
| stereotypes and racism | Examples of stereotypes and racism identified by practitioners | 1 | 1 |
| cultural impact |  | 3 | 3 |
| culturally responsive action | Examples of culturally responsive actions by individual staff members or by the mental health system | 4 | 20 |
| Indigenous workforce | Information related to Aboriginal and Torres Strait Islander Workforce - reliance, cultural load, barriers, understaffed, roles and responsibilities, cultural barriers, discrimination | 5 | 14 |
| training content | Information related to content identified by practitioners | 7 | 52 |
| mode of delivery | Modes of delivery suggested by practitioners | 4 | 19 |

## **Emerging Themes**

Applying Braun and Clarks Reflexive Thematic Analysis (2023), several themes have emerged from the initial yarning circles. Within these themes there were several sub themes.

|  |  |  |
| --- | --- | --- |
| **Key Theme** | **Sub themes** |  |
| **Clinical Practice and Behaviours**   * Self-identified and reported practices and behaviour. * Unidentified practices and behaviour | **Culture** | Practitioners identified that was a need to improve.   * Traditional/ cultural beliefs and values, protocols, and practices – including spirituality and gender. * Historical socio-political significance of contemporary health inequity * Holistic perspective of health * Concept of “healing” vs “Treatment” * Cultural communication norms |
| **Communication Challenges** | * ***Interpersonal communication*** - communicating with family, building rapport, trusting relationships, use of time. * ***Verbal and Written Communication (including the use of language)*** – Terminology, health jargon, silent language/ non-verbal, body language, health literacy, medical tools, and resources. * ***Cultural Disconnect*** - Privilege, Bias, Discrimination, Cognitive Dissonance, * ***Cultural Humility -*** applying cultural knowledge within interactions to provide culturally safe and responsive care. |
| **System or Service Response** | **Aboriginal and**  **Torres Strait Islander Workforce** | * Overworked/over utilised workforce. * Inadequate numbers * Discrepancies in roles and responsibilities * Retrofitting practice to suit “process” * Culturally safe and appropriate assessment and screening tools * Invalidation of cultural expertise within clinical space |
| **Training Mode of Delivery** | * Off-site * Mixed delivery | * Skills development/Practical * Face to Face and online * Yarning Circles * Experiential / Scenario based * impactful |

**Reflexive Thematic Analysis**

**Phase 1: Familiaring oneself with the data** -This phase involves which involves being intimately acquainted with the data by reading and re-reading the data, noting initial analysis and observations of individual data sets and the data in its entirety.

**Phase 2: Systematic Data Coding -** This phase is an exploratory process that involves the development of broad patterns of meaning based on the collated data. This is followed by further analysis and engagement in related data to create potential themes.

**Phase 3: Developing and reviewing themes. -** This phase involves identifying conceptual patterns or shared meanings of data to produce initial codes or ideas that can be clusters around a central concept. This is not a passive process, instead researchers are to intentionally apply their position, knowledge, and intellect to drive this process.

**Phase 4: Developing & reviewing themes.** This phase involves reviewing, checking, and adjusting themes by reviewing the data set as a whole. Researchers must ensure that the themes are evidentially robust, convey a story that is connect to the data set and applicability to the research question.

**Phase 5: Refining, defining and naming themes.** This phase involves presenting comprehensive ’story’ for each theme. This synopsis includes a detailed description, the scope and definitive name for each theme. It is during this phase that some themes will not be relevant and go altogether.

**Phase 6: Writing up.** This final phase involves the refining and re-conceptualising of your research journey or ‘story telling’. It involves being descriptive about your research choice, approaches and position including how you as a researcher embedded yourself into the production of knowledge. In addition, the ‘story’ needs to clearly and concisely support analytical claims.