

'You have to feel safe to be unsafe and to be able to express feelings is unsafe': Aboriginal Peoples' Experiences Engaging with Mental Health Practitioners and Services

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Abstract

Background

Access to culturally responsive mental health care is a critical health equity issue for Aboriginal and Torres Strait Islander peoples. Inequities in access and engagement with services, and outcomes are not attributable to individual factors but are produced through mental health systems shaped by ongoing colonial histories, western epistemological dominance, and systemic racism. While culturally responsive practices are increasingly advocated, First Nations lived experience remains an under-represented primary evidence-base within mental health equity scholarship. This study aimed to hear the stories of First Nations people, exploring their individual and kinship experiences related to engaging with mental health practitioners and services.

Methods

This study employed a qualitative Indigenous yarning methodology to centre Aboriginal peoples' lived experiences of engaging with mental health practitioners and services. Twenty-three Aboriginal participants from across Australia shared stories through individual yarns. Data were analysed using inductive thematic analysis within a relational and decolonising research paradigm, with participant feedback incorporated into analysis procedures to ensure cultural and interpretive integrity.

Results

Three interconnected themes emerged from participants' accounts, illustrating how Aboriginal peoples' experiences of mental health care are often shaped by unsafe practices and structural inequities. Participants emphasised that cultural safety within therapeutic relationships and environments was essential to feeling able to engage with care, while its absence led to withdrawal and harm. Broader systemic, structural, organisational, and logistical barriers further limited access and continuity of care. Participants also identified culturally grounded mental health and wellbeing practices, situated within social and emotional wellbeing frameworks, as critical to healing and engagement, particularly where mainstream biomedical approaches had proven inadequate.

Conclusions

These findings demonstrate how inequities in mental health care are produced through everyday clinical interactions, institutional norms, and service structures that marginalise First Nations ways of knowing, being, and healing. Cultural safety functions as an ethical imperative as well as a structural determinant of mental health equity. By foregrounding Aboriginal lived experience, this study contributes critical

evidence to inform culturally grounded, system-level reforms within Australia and may inform other settler-colonial health systems seeking to advance mental health equity for Indigenous peoples globally.

Introduction

Psychology as a discipline has played a historical role in perpetuating harm toward Aboriginal and Torres Strait Islander (hereafter 'First Nations') peoples through the application of oppressive, culturally biased, and western-centric models of care(1, 2). By privileging western epistemologies, professional norms, and biomedical frameworks, psychology has routinely marginalised First Nations ways of knowing, being, and healing, contributing to inequities in access and engagement with systems, and outcomes rather than individual treatment failures. These dynamics have positioned mental health care as a site of exclusion and distrust for many First Nations peoples, a reality acknowledged in the Australian Psychological Society's apology and its commitments to change(3). In response, decolonising psychology has emerged as a critical approach that seeks to disrupt colonial hierarchies within the discipline by reclaiming self-determination, centring First Nations knowledges, and engaging in truth-telling about the enduring impacts of colonisation(4–6). Together, these critiques position psychology as a professional in need of improved cultural responsiveness, but also as a structurally implicated discipline that continues to produce mental health inequities for First Nations peoples.

One First Nations-led response to these structural inequities is the Social and Emotional Wellbeing (SEWB) framework, which offers a holistic, relational understanding of wellbeing grounded in First Nations worldviews(7). SEWB situates mental health within relationships, culture, community, Country, and broader structural conditions(7). This holistic framing has been substantiated through First Nations-led research that centres First Nations lived experience of mental health that demonstrate how the structural and relational disruptions identified within the SEWB framework are experienced in everyday life, shaping both distress and pathways to healing(8, 9).

A report compiled by the Seedling Group and the Lived Experience Centre in collaboration with the Black Dog Institute(9) explored First Nations peoples' lived experience of mental ill health, in particular suicide. Using Indigenous methodologies, including virtual yarning groups and creative activities, the 13 participants (12 Aboriginal, 1 Torres Strait Islander) from across the country identified a combination of contributing factors that impact mental health experiences and SEWB(9). These factors included the intergenerational impacts of the Stolen Generations, child removal, substance use, and disconnection from family, community, culture, and Country, which resulted in threats to identity and belonging(9). The participants acknowledged that these factors can often lead to experiences of grief, trauma, self-harm, and suicidality within communities(9).

The failure of mainstream services to adequately address SEWB in culturally appropriate ways, often due to a lack of understanding of holistic First Nations worldviews, was further identified as compounding distress, particularly for those who had negative prior experiences when seeking help(9). Instead, participants described family, kin, and community as the most trusted and vital sources of support,

underscoring the central role of culture and connection in healing and recovery for First Nations peoples(9). These findings reinforce the importance of using holistic wellbeing frameworks, incorporating First Nations worldviews, and the protection, strengths, and healing that can come from cultural connections. Documented gaps in psychologists' cultural knowledge, practices, and training make strengthening culturally responsive practice essential to safeguarding First Nations clients' SEWB(10, 11).

The Psychology Board of Australia's(12) recently revised professional competencies to reflect a significant shift in how competence is defined within psychological practice. These updates foreground cultural safety and responsiveness as essential components of ethical and effective care, particularly when working with First Nations peoples. In this context, the Psychology Board of Australia(12) defines clinical competency as part of the threshold professional competencies required for registration, whereas cultural competency encompasses two dimensions, cultural safety and cultural responsiveness. Cultural safety refers to environments where individuals feel spiritually, socially, emotionally, and physically safe, with their identity affirmed and respected and importantly, can only be determined by the client, not the practitioner or service(12). Cultural responsiveness complements this by emphasising the psychologist's ability to engage with and adapt to clients' cultural contexts(12). By integrating culturally relevant knowledge into practice, psychologists are empowered to foster mutually respectful environments and co-create therapeutic approaches that are meaningful and effective.

Murrup-Stewart and colleagues'(8) systematic review of 33 Aboriginal SEWB programs highlights the centrality of holistic, culturally grounded approaches to healing. Participants consistently valued yarning, creative expression, capacity building, and practices embedded in cultural safety, community reciprocity, and trusting, non-judgemental relationships with staff. Reflections further underscored how intergenerational trauma, grief, and structural disadvantage compound distress, while healing was associated with strengthened identity, resilience, and empowerment(8). Although focused on SEWB programs rather than clinical settings, these findings offer important insights for psychologists and mental health services seeking to engage in culturally responsive practice with First Nations clients.

Complementing this program-level evidence, practitioner-focused research has examined how psychologists seek to enact culturally responsive care when working with First Nations peoples. Mullins and Khawaja(13), drawing on interviews with non-Indigenous psychologists, emphasised adaptability, relational and trauma-informed practice, openness to working beyond traditional psychological formality, and viewing cultural competence as an ongoing journey, though the absence of First Nations psychologists was a key limitation. Addressing this gap, Darnett and colleagues(10) found that both Aboriginal and non-Indigenous psychologists identified culturally responsive practice as strengths-based, relational, holistic, and grounded in SEWB frameworks, with particular emphasis on deep listening, trust-building, collaboration with family and community, and working beyond diagnostic and biomedical lenses, alongside persistent systemic and workforce challenges. Taken together, these findings align with Aboriginal practitioner accounts that conceptualise effective healing as inherently grounded in Aboriginal ways of knowing, being, and doing, with western models engaged selectively and

only where appropriate, and where cultural safety, long-term relationships, and practitioner accountability are central(14).

Taken together, existing research highlights that culturally responsive mental health practices for First Nations peoples must be grounded in First Nations worldviews, holistic frameworks, and relational approaches, and must prioritise cultural safety, humility, and accountability(8, 10, 13, 14). However, much of this literature centres the perspectives of psychologists, practitioners, or service providers(10, 13, 14), or relies on secondary synthesis(8), rather than direct testimony from First Nations peoples themselves. As a result, First Nations lived experience remains underrepresented as primary evidence within mental health equity literature, despite being central to understanding how inequitable access, engagement, and outcomes are produced. Responding to this gap, the present study reports findings from a First Nations yarning methodology to centre Aboriginal peoples' lived experiences of engaging with mental health practitioners and services, identifying barriers, enablers, and possibilities for culturally safe and responsive care. While situated in the Australian context, the findings have relevance for broader settler-colonial health systems where Indigenous mental health inequities persist due to colonial histories, systemic racism, and epistemic injustice(6, 15).

Method

Research Design, Questions, and Framework

The method undertaken in this exploration has been published in a detailed methodology paper elsewhere(16). Briefly, this research applied a qualitative First Nations yarning methodology to explore Aboriginal peoples' lived experiences of engaging with mental health practitioners and services. In this study, lived experience was defined as Aboriginal peoples' personal and/or kinship experiences of engaging with mental health practitioners and services, rather than practitioner or service-provider perspectives. This definition shaped participant eligibility and guided the focus of the yarning conversations. Due to restrictions of publication guidelines, this paper partially addresses two of the five research questions that guided this exploration. They include,

1. What do Aboriginal and Torres Strait Islander people perceive as barriers and enablers to psychologists and mental health services?
2. What suggestions do Aboriginal and Torres Strait Islander people have to improve the mental health industry?

The methodology was grounded in a relational First Nations research paradigm, which recognises knowledge, being, and doing as inherently relational and governed by accountability to people, Country, and context(17). This approach informed all stages of the research, including recruitment, data generation, analysis, and interpretation. This manuscript was formatted in alignment with the Qualitative Journal Article Reporting Standards (JARS-Qual)(18) and align with the Standards for Reporting Qualitative Research (SRQR)(19)

Team Positionality

The first author, Emily Darnett, is a Palawa, early-career academic and clinical psychology registrar with a background in mixed-methods research spanning First Nations wellbeing, psychology, education, and public health. Madelyne Hudson-Buhagiar is a Wiradjuri person, researcher, clinical psychologist with expertise in developing a culturally safe workforce driven by a passion for providing culturally grounded therapy, Indigenising mental health support and reducing barriers to accessing high quality mental health support. Justyce Pengilly is a Gamilaraay woman, clinical psychologist and research assistant whose work centers on transforming mental health systems through decolonising methodologies and community-led co-design. Associate Professor Graham Gee is an Aboriginal-Chinese-Celtic clinical psychologist and Senior Research Fellow, with extensive experience in Aboriginal community-controlled health settings. His research expertise spans healing child sexual abuse, complex trauma, resilience, and the development of trauma-informed healing responses for Aboriginal and Torres Strait Islander peoples across the lifespan. Professor Monica Thielking is a non-Indigenous researcher and leader in higher education who is committed to working with, and learning from, First Nations staff, students and leaders to improve pathways and outcomes for First Nations students, and ensuring that psychological training at the university-level includes and promotes culturally safe knowledges and practices. Finally, Associate Professor Clinton Schultz is a Gamilaraay man, psychologist, and Director of First Nations Strategy and Partnerships at the Black Dog Institute. His academic and clinical work focuses on the intersection of lore, culture, and holistic wellbeing, and he is a recognised leader in First Nations workforce development and systemic. As a collective, the team's diverse positionalities informed a reflexive, relational approach to analysis and translation that was attentive to power, accountability, and the ethical responsibilities of working with Aboriginal lived experience.

Participants

Twenty-three Aboriginal people (17 females, 4 males, and 2 non-binary people) contributed to this project by sharing stories about psychologists and mental health services. Table 1 displays the participants' demographics. To enhance anonymity, the participants' age decade was recorded (age range = 20s-60s). A more detailed demographic description can be found in the associated methodology paper(16).

Table 1
Participant Demographic Information

Pseudonym	Gender	Age (Decade)	Job Role
Janggul	Female	50s	University student
Gawarn	Female	40s	University student engagement officer
Whale	Female	20s	Mental health worker
Bessie	Female	40s	Academic
Jarrah	Non-binary	30s	Nurse
Bubba	Female	30s	Public servant
Wiran	Female	40s	Health management
Gimuru	Female	30s	SEWB lived experience worker
Kukaki	Female	20s	Mental health worker
Roo	Female	40s	Health management
Googgar	Male	30s	Family case worker
Pelican	Female	30s	Mental health worker
Djidi Djidi	Non-binary	20s	University student
Yolla	Male	50s	Researcher
Turtle	Female	20s	Researcher
Walluamara	Female	20s	SEWB worker
Callie	Female	30s	Artist
Alkere	Female	30s	University student
Crow	Female	30s	Youth worker
Black Cockatoo	Male	30s	Social services industry
Palana	Male	50s	Hospitality management
Jirnkirdji	Female	60s	Consultant
Dhiyaan	Female	40s	SEWB worker

Participants' Country and current geographical locations are important contextual information, as this signifies the ancestral knowledge that they hold, as well as the local Aboriginal community perspectives and/or knowledge that they currently reside in, and which have been woven into their stories and contributed to the findings in this paper. The project balanced demographic representation with ethical

confidentiality due to its relational recruitment method, which is why Table 1 omits connections between participants' demographics and their ancestral Country or current locations.

Participants' descended from lands across all Australian states and territories except the Australian Capital Territory. New South Wales was the most represented (6), followed by Queensland and Northern Territory (4 each), Tasmania (3), Western Australia and Victoria (2 each), South Australia (1), and one participant was unsure of their ancestral lands due to loss of family history from the Stolen Generations. Two participants contributed while on their Country. At the time of participation, 69.5% (16 people) were living in urban settings and 30.5% (7 people) in regional or rural areas. Victoria had the highest representation (9), followed by Queensland (5), South Australia (3) and Western Australia (2), and one participant each in the Australian Capital Territory, Northern Territory, New South Wales, and Tasmania.

Recruitment

Participants were recruited using relational methods consistent with the study's First Nations research framework(17). Email invitations were distributed through the research team's networks and included an invitation to register interest via Qualtrics or direct email contact with the first author. Ethics approval was granted by the Swinburne University Human Research Ethics Committee (SUHREC; 20236001-15567), and participants received a \$50 gift voucher in recognition of their time and contributions.

Research and Participant Relationships

The relational nature of the research process supported trust, reciprocity, and participant safety, particularly where pre-existing relationships existed. This was reflected in the authentic narratives, and optional reflective elements, which is published in the associated methodology paper(16). The relational research framework introduced ethical considerations, such as maintaining participants' confidentiality and addressing power dynamics between participants and the research team. To support participant self-determination, those with pre-existing relationships were offered the option to yarn with another unknown researcher on the team, though none chose to do so. The team navigated dual roles with care, respecting autonomy and cultural protocols, and no participants requested withdrawal from the study.

Participant Selection

Relational convenience sampling methods were used in the selection process. To be eligible to participate, individuals had to identify as Aboriginal and/or Torres Strait Islander, be over the age of 18, and have personal or kinship experiences engaging with mental health practitioners and services or higher education. Participant recruitment and data collection commenced from mid-2023 and were completed by December in the same year.

Data Collection

Participants shared their stories through individual online yarns conducted via Microsoft Teams. Yarns ranged from 50 to 180 minutes, with an average duration of approximately 90 minutes. All yarns were audio-recorded with participant consent, transcribed verbatim, and recordings were deleted once transcripts were reviewed for accuracy.

Yarning Procedure

Yarns were conducted in line with Indigenous yarning methodologies, including relational, family, and topic-based conversations that were flexibly guided by participants(20, 21). Conversations were audio-recorded, transcribed verbatim, and reflexively facilitated to support cultural safety and depth. To maintain the true nature of a yarn, questions were unplanned, although grounded in the topic being explored, reinforcing the project's reflexive nature. The first author, during the yarns, followed the participants' lead and, with a deep understanding of the research questions, linked the participants' stories and contributions to the project exploration. This was usually achieved through open-ended questions. With participants' consent, the yarns were hosted, recorded and transcribed using Teams software. The recordings facilitated the review of transcript accuracy and were securely deleted after they served that purpose.

Collaborative Data Analysis

This study employed a collaborative data analysis process, which is detailed elsewhere(16). In short, stories were analysed using an inductive thematic analysis (ITA) approach informed by Braun and Clarke's six-step framework(22). The first author engaged deeply with the stories through transcription and iterative reading, facilitating familiarity with participants' stories within their relational contexts. Initial codes were generated and organised into preliminary themes, which were refined through an iterative, collaborative process with the participant and research team to ensure cultural and interpretive integrity. Consistent with the study's relational paradigm, participant validation was incorporated into the analytic process. Participants were provided with summaries of their yarns(23) and emergent themes and invited to review, reflect on, and amend interpretations where necessary. This process supported both methodological rigour and participant agency. Analysis was further strengthened through reflexive consideration of researcher positionality and the broader socio-cultural context shaping participants' experiences(17). The analysis remained grounded in Indigenous ways of knowing by privileging participants' voices, relational context, and accountability to lived experience.

Translating and Disseminating Findings

The stories and yarns were unique to the participants and the place and space in which they occurred. The unstructured nature of the yarns, with diverse participants, revealed several stories and experiences on various topics beyond the research focus. To honour participants' stories, they are presented, where possible, in their sovereign context. Publishing guidelines limit this, and therefore, the findings from this

study have been planned for publication across a series of articles. This paper presents the findings relevant to psychology and mental health practices and services.

Findings

The findings show that inequities in mental health care are produced through everyday clinical interactions, service structures, and institutional norms that privilege mainstream models while marginalising First Nations knowledges and lived experiences. Unsafe experiences emerged as a key mechanism of exclusion, shaping differential treatment experiences, disrupted engagement, and avoidable harm. Three interconnected themes capture Aboriginal participants’ experiences of engaging with mental health practitioners and services (Table 2).

Table 2
Definition and Illustrative Quotes of the Studies’ Themes Relative to Mental Health.

Themes	Short Definitions	Illustrative Quotes
Creating Safety within Therapeutic Relationships and Environments	Relational practices and environments that foster client’s safety, and trust.	“It can take one thing that could just break that relationship.” (Black Cockatoo)
Barriers to Accessing Culturally Responsive Mental Health Care	Systemic, structural, organisational, and logistical constraints impeding equitable, culturally responsive mental health care.	“I end up taking her to a private provider and cost me a bomb. I had no money for ages” (Bessie)
Healing through Culturally Responsive Mental Health and Wellbeing Practices	Culturally grounded knowledge, strengths, and practices that facilitate healing and engagement.	“They need to be aware of the cultural intricacies.” (Janggul)

Theme 1: Creating Safety within Therapeutic Relationships and Environments

This theme demonstrates how cultural responsiveness and safety within therapeutic relationships and environments functions as a foundational condition for equitable engagement with mental health services for First Nations peoples. Participants’ accounts reveal that when mental health practitioners fail to establish relational trust, humility, and validation, mental health care becomes inaccessible or actively harmful, contributing to disengagement and inequitable outcomes. Conversely, culturally responsive, relational practices enabled sustained engagement, reinforced self-determination, and supported healing, underscoring the role of everyday clinical interactions in either reproducing or disrupting mental health inequities.

Participants emphasised the importance of mental health practitioners’ relationality as instrumental to building therapeutic rapport and fostering trust. Gawarn recalled an unsafe experience they had, saying,

I first went to a psych when I was 18. My sister had suicided, mum's like you need to do something. So I went to [a psychologist], and the person didn't create a safe space for a conversation. Straight away, they would just jump into it, they're like, what's the problem? Instead of trying to figure out who I was and what connection I had.

While Callie reported a similar experience,

I saw one other psychologist, but I didn't really feel like we gelled, it just felt like they were following a script. It was very much, 'why do you feel like that?', 'How does that make you feel?', 'Why do you think that was?', 'What in your past do you think brought that up for you?', and so that didn't work for me. Then (at the end), I'm going to write my notes, and I'm going to think about it and the next time you come back, he'll have some answers... It all felt a bit like, come on, let's go, hurry up kind of vibe...it felt like a cattle call almost.

Googgar also shared a similar experience when asked what seemed like a scripted question, stating, "my first ever psychologist, I told her a story about my mum, and she was like, 'how would you like to feel about that?' I'm like, well, obviously not fucking like shit like I do. So that didn't really work." Bubba noted the irony they found in psychologists not being relational, "It's funny, isn't psychology supposed to be about how to be social and build relationships and be approachable? But then I'm in a room that's very clinical... and I feel like I'm talking to someone who has no social skills."

Participants spoke about the importance of building trust. Jirnkirdji highlighted, "It's about consistency, and it takes time to build that trust with someone". This sentiment was echoed by Alkere saying "mob need reliability, especially outreach work because obviously people have that lack of trust in services...so if you don't show up for one thing, that's it, you're done, they will not trust you." While pelican suggested a lack of personal insights and humility from the mental health practitioner was problematic for developing rapport and building trust saying,

I don't understand why psychs are so defensive, like work on that...take things that people say and think about it without shooting back straight away and being defensive, because I find it embarrassing... don't blow up like that. Take a second to look at it because you're defensive for a reason.

Pelican went on to say,

You're in the wrong profession if you refuse to identify culture as something that you're working with, you are failing in your profession, which means you need to have the cultural humility to be curious about culture and the way it intersects with the individual experience.

Callie provided an example of how they demonstrate cultural responsiveness and humility in their therapeutic work with First Nations clients.

I found someone who listens, gives good advice and calls me on my shit. She took a genuine interest in me as a human, instead of, what are the issues that you're bringing to me or what has happened to you.

She let my identity come up organically over the sessions and, when I mentioned that I was Indigenous, she didn't really react to it at all. She just brought it up when she felt it was necessary. It wasn't a novelty for her, it was more one of the parts of my identity. Whereas other people would latch on to that and be like, that's important for us to talk about. She also gives me the choice to talk about things, asking, 'do you want to talk about that?', 'Do you feel comfortable talking about that?', and she didn't give generic advice or summaries... She established who I was and where I sit in the context of my family before we did anything else.

This example also reinforced the importance of transparent communication, and self-determination by providing clients' choices, as well as the need to identify, acknowledge, and integrate clients' cultural backgrounds and connections when working together. Garwarn reminds us that when practising humility, mental health clinicians need to be authentic; otherwise, it may result in client disengagement.

I would worry that if they come into the session with that humility, it could be taken as patronising. I possibly wouldn't overly engage, and wouldn't give anything deep or substantial. Then you're really saying, what you think they want to hear from you, and not being real. You're not sharing what you need to share, but what you think they think you should be sharing.

Participants commonly reported feelings of invalidation, for example, Pelican stated, "listen to us when we tell you things and don't fucking gaslight us and tell us that's not our reality." Pelican went to identify that the feelings of gaslighting can be soothed by mental health practitioners providing validation, "Validation is my fucking love language... to be understood by someone that's had similar lived experiences... that within itself makes such a difference to me." Janggul also made connections between feelings of being gaslit and echoed Pelican's desire for increased validation,

Validation is a recurring thing needed for mob...really validating more than you would with another client, because we haven't had that. The whole world is gaslighting us...validation doesn't come very often, so having that in session and really accentuating the validation I think is a really positive experience for us.

In a similar light, Palana also highlighted that accusations of lying can be invalidating, emphasising the need for mental health practitioners to acknowledge and unpack First Nations clients lived experiences to promote healing.

We need help to unpack [our history] to trigger any form of healing, it has to be spoken. It's not that we want people to say sorry, it just we want to be heard and not accused of lying. Just acknowledged it happened and validated that it wasn't right, it's not about blame. It's about recognition for healing, and that I am not going mad. I'm not the only one who's had this happen, and I'm not making this up. This is how I feel. This is how it's made me feel.

These experiences reiterate how validation can promote healing by acknowledging the harm caused by the internalised doubt, silencing, and the invalidation that is woven into colonial Australia.

Participants described how non-clinical, welcoming environments played a pivotal role in client's comfort. Many participants shared Bubba's sentiments that "when you're in a room that's very clinical, it's not my vibe." While Jirnkirdji ventured into more detail sharing, "the environment you walk into and how you're greeted matters. To be offered a tea, coffee or a water the minute you walk in... lowers your stress levels... for us mob it lowers our defence." Garwarn highlighted the importance of safety signalling within the environment offering,

It was a nice calming environment, but there was nothing that indicated a level of cultural competency in the conversations. So, I just didn't bring up culture, which... as a light-skinned person, it's not in the forefront. So, it wasn't a genuine interaction because she was only getting one part of me.

However, Jirnkirdji reminded us of the need for it to be authentic, saying,

Some of these organisations go to the other extreme, where they have lots of artwork and sometimes, I'll get a bit uncomfortable... I just think, what are you trying to do? What are you trying to prove? and maybe it's genuine, but I've asked a few of the staff members, do you know what this artwork means? Have you actually read the story, and none of them have. So, for me it's like why are they hanging up?

Theme: 2 Barriers to Accessing Culturally Responsive Mental Health Care

This theme identifies how systemic, structural, organisational, and logistical barriers function collectively to produce inequitable access to mental health care for First Nations peoples, limiting service availability, continuity, and cultural responsiveness irrespective of individual need. These include deficit discourses, workforce limitations, funding models, institutional processes, waitlists, and inflexible service models.

Systematic barriers are the deep-rooted societal or institutional norms that perpetuate inequality, inequity, or exclusion and disadvantage often already marginalised groups(6). Deficit discourses, the discipline of psychology, and psychologists' lack of cultural knowledge are discussed as systemic barriers because they reflect entrenched norms within mental health systems that pathologise First Nations ways of knowing, being, and doing, while ignoring cultural strengths, and reinforcing power imbalances. This continues the colonial project, sustaining First Nations exclusion and undermining the cultural safety and effectiveness of care for First Nations clients(2).

Participants frequently spoke about the value of strengths-based approaches in therapy, rather than the common deficit-based language. They emphasised the importance of being seen for their strengths rather than their deficits, and how this shift fostered healing and self-determination. Yolla explain the problematic nature of deficit discourses,

When you sit in a deficit discourse, where the person in front of me is risky, unwell, or not capable...that establishes a deficit discourse from all the people who read that report. They stopped thinking about our mob as resilient and capable, and they started thinking about them as unable to look after their children... or unable to manage their health and health needs, which is fundamentally not true. But the stereotypes

become very prominent and super-reinforced. So, when we start to flip that narrative on its head as clinicians and we say, you are capable, you are empowered, you are the person who will lead us, with me walking alongside you... because you have the capacity, despite what the system keeps telling you. And in that process, we build support networks and wraparound services.

The discipline of psychology and Australian regulatory bodies are categorised in this paper as systemic barriers as they uphold western-centric frameworks, professional standards, and models of evidence that often fail to recognise or validate First Nations knowledge systems, cultural practices, and relational ways of healing. This entrenched dominance marginalises alternative approaches, restricts culturally responsive care, and places the burden of adaptation on First Nation clients and practitioners. Whale summed up this point stating, “in terms of psychology itself, it is a very white man's world”.

Participants shared stories that illustrated their intersections with these barriers. Djidi Djidi said that they “have a lot of concerns about the mental health system. I find it very annoying and a bit distressing how there's such a massive disconnect between services...The services don't really treat you as a person, there's no connection there.” Djidi Djidi then went on to note “all the therapies are from the white perspective, and we know immediately that most of the time it's probably not going to work for us just because it was made for white people.” Turtle's experiences demonstrated systemic barriers intersecting with mental health.

My experience when I was in a psychiatric ward, really turned me off mental health supports. I didn't find anything helpful, I felt completely disempowered, so disrespected and it felt like an extra kick in the guts when I was already struggling with mental health at that point... Being made to feel like I was a person, and I matter would have made a difference, actually listening to what I was saying and trying to understand it.

Many participants expressed their frustration about the lack of cultural understanding that they have experienced from the mental health workforce, services and systems because their training has been Eurocentric, and do not know how to talk about First Nations cultures, let alone, integrate it into their practice. Turtle demonstrated this when they said,

Just a genuine attempt to understand the world view of us... and maybe even ask questions like, what is your belief system? What is your worldview? It's not like we should have to educate them, but at the same time, need them to understand our normal.

Wiran supported this sentiment when reflecting on an engagement with their mental health practitioner saying,

There was absolutely no insight or cultural lens, that was not a factor... and that happens all the time. People either are able to relate to you with some sense of an understanding of your culture as an Aboriginal person, or they totally ignore it, and it was totally ignored.

Djidi Djidi highlighted the need for mental health practitioners to understand First Nations mental health, and be willing to learn to reduce the harm clients are experiencing,

Having an actual baseline understanding of how Indigenous mental health works is just the bare minimum...I think most psychs who aren't willing to put in the extra work will do more harm than good. I think a lot of Indigenous young people get a lot of trauma from dealing with white psychologists who don't give a fuck about learning about Indigenous people, or our specific cultural needs. It just invalidates us and stops us from wanting to engage with a service again, because if that's your first time engaging with a service and you are confronted with that, you're going to think every service is like this, and not want to engage with any service, and then you have another young person who's lost in the system again.

Alkere shared their appreciation for their psychologist positioning themselves, asking clarifying questions and willingness to educate themselves,

My psych would let me know when she didn't understand something very openly and would be like 'I haven't heard it described that way before would you mind sharing with me what that means to you', or 'in terms of the community context, what does that mean?' or 'how does that look?' Whereas other psychologists, they just felt awkward, and they didn't want to ask me a question about that. But then I could tell that they weren't understanding what I was saying. So, then I was overexplaining anyway, because they wouldn't tell me that they weren't understanding... So, I liked the fact that someone just acknowledged the elephant in the room, that she was not Aboriginal and I was, and there were things that she didn't understand, and she was open to learning but also didn't put the onus on me of educating her. There were a few times where she said, I'm going to file that one away and I'm going to go do my own research... I felt like a lot of other psychologists weren't willing to do that work...and you could see then getting increasingly uncomfortable, the longer the time went on.

Systems shape how care is defined, delivered, and evaluated, which perpetuates structural inequalities that disadvantage those already excluded from mainstream mental health systems. Structural barriers are considered the physical or institutional frameworks that hinder access, participation, or equity(1, 2). The structural barriers participants experienced included rigid hierarchies, policies, and procedures that prevent communication across levels and service models. Palana identified and navigated some of the structural barriers in their workplace by using,

a strategy of comorbidity treatments because with our community one person could go and get alcohol counselling, but they've got gambling addictions that are triggered by the alcohol or things that are triggered by other things and they have to go to a separate service to get gambling help and then they have some addiction support or even if somebody listened. But then they're telling the same story again and again and again but getting nowhere because they have to keep reliving it without processing it. Then they'll have a fumble with the alcohol, with the drugs, or with the gambling, and they will feel like they've gone back to square one and have to start all three all over again.

Jarrah spoke to a barrier caused by the rigidity within systems policies and procedures suggesting that “you need to have a little bit of flexibility to do things for people that you couldn’t otherwise” and provided an example, “a client needed to be driven somewhere at 7:30 in the morning. So, I said I would go and knock off early but imagine if you're doing that in the western system, they'll be pulling their hair out.”

Organisational barriers were considered the obstacles arising from the internal policies, culture, or practices of an organisation. It is essential to acknowledge that barriers discussed under specific headings could be relevant across all areas, especially when considering private mental health providers, as they are responsible for establishing their own policies and procedures. Therefore, in this section, we have focused on sharing suggestions that are more easily accommodated in the private organisational space. These suggestions include, flexible policies, traditional healing services, and the importance of administrative staff at mental health services to facilitate safety.

Jarrah noted that their current Aboriginal counsellor “is pretty flexible, not like healthcare providers are....Last week I had to cancel last minute, and it was OK. Some places make you pay if it's not within 24 hours, but she's really understanding”. Djidi Djidi suggested a need for more “services that are not psychologist-based...services where we can go on Country and we can heal as Indigenous people traditionally heal. There should be options for more holistic care and not always in an office space, talking one on one.” Walluamara recognised some of the already mentioned barriers and then pointed out, “a big barrier I think is just the fucking admin staff at places”. They went on to explain that the reception staff at some psychological services and pathways they have navigated can be a barrier to accessing mental health care,

There's room to create a resource to show what it looks like when you're seeking mental health support. What your care might look like to give to people to show these are the kind of people who are responsible for supporting your mental health. You might be referred to a social worker, counsellor, and name all the different roles that people might see who would assist them, what they do, and what costs to expect. Because all of these things are real deterrents. Something as simple as someone's title is a deterrent to some people.

Logistic barriers were considered the practical or operational challenges that prevent smooth execution or access. The limited number of First Nations mental health providers was continually acknowledged by participants as an issue, as well as the logistical complexities within the referral pathways and accessibility barriers due to limited financial means. Callie shared,

Indigenous psychs are so hard to find, my friend made a list of First Nations women and people of colour who are also therapists, but no one could get in to see them because they were in such high demand, as so many people wanted someone who would understand them. But there weren't enough therapists from diverse backgrounds to go around...who don't make us feel like shit.

Janggul's insight reiterated the local gap in the First Nations workforce, stating “there's no one to do any (psychological) testing that's mob, no one...there's a huge gap and a huge bit missing.” Additionally,

Wiran reinforced “that would have been fantastic to have had an Aboriginal, either mental health, social worker or psychologist”.

Participants identified referral pathways as a critical point of breakdown in accessing appropriate mental health support. They described these pathways as unclear, inconsistent, and often disconnected from community needs, resulting in delays, miscommunication between services, and feelings of being lost or being placed in the ‘too-hard basket’. This lack of coordinated culturally responsive referral systems was seen to undermine trust and continuity of care. Djidi Djidi has experienced this saying, “constantly trying to find a service, finally getting in after whatever wait list and then depending on whatever person you're speaking with, you either get dropped, dismissed, or challenged in your life.” Walluamara suggested that more transparency and explanation are needed from doctors when referring people to a psychologist.

There's no clear pathway to say exactly how you would see a psychologist. If you go to the doctor, they don't explain the process to people. They leave people in the dark...Doctors say I'm doing a referral to this psychologist and that's it. They don't say, alright, I'm doing referral to this psychologist, and it might take a few weeks. They should call you to make the appointment so keep your phone on. This is the name of the person I'm referring you to. It might cost this much, and if they don't accept your referral, I might have to refer you somewhere else, which takes a few more weeks. Once you see them, they will send the paperwork back to me and you might have to come see me again. Just like explaining the process of what happens when you're, getting mental health support. It feels like you are just left in the dark.

Another commonly reported logistic barrier was the limited access to mental health practitioners due to the high financial means required to access mental health services. Crow shared that seeing a psychologist was “so expensive, I think the gap was \$90.00 or something each time. I was on maternity leave, so I wasn't working, and we just had (one income)”. Wiran shared their story, reminding us of the significant impacts financial barriers to accessing low-cost, culturally responsive mental health care services can have.

I think having access to low-cost, affordable, culturally informed mental healthcare would have accelerated my ability to leave the family violence situation like 10 years earlier at least... I look back now, and what was going on was acute, and I didn't know. I didn't realise that refusing to have sex with your husband and resulting in them swearing at you, calling you names, threatening to end the relationship, threatening to never see the kids again, slamming doors, being totally dysregulated, withdrawing their attention from their children for days, I didn't realise that that was coercion, but that was pretty acute...I think I would have come to the conclusion sooner if I had had access to low-cost mental healthcare, because I also had no access to money for years, I had no income, I had no access to my partner's money, and had to ask for money...I would definitely have wanted mental healthcare when my daughter was born because the coercion and coercive control side of him pretty much started as soon as she was born... It took me 12 years (to leave), although I certainly identified that what was going on was not okay, but I didn't have any money, I didn't have any support and didn't have any access to mental healthcare, and it's so shameful to have been such a capable woman.

Theme 3 Healing Through Culturally Responsive Mental Health and Wellbeing Practices

This theme demonstrates how culturally grounded mental health and wellbeing practices operate as equity-enabling responses within otherwise inequitable systems, supporting healing, engagement, and self-determination where mainstream biomedical approaches have failed. Culturally grounded and responsive practices were reported to involve acknowledging intergenerational trauma, respecting identity, using culturally grounded tools like yarning and art, and working holistically. Many participants acknowledged culturally grounded ways that promote healing for them. Bubba said “the way that I was able to express how I felt was when I was young was through art...I enjoyed doing like art classes at school and I guess I would speak about my emotions through art.” Wiran shared that her therapist, “brought weaving in for us, and we loved that because of the process, when I'm using my hands.” Finally, Gimuru shared,

The first couple of times, it's just getting to know what their connection is to culture and if that's something they want to explore and, how they want to explore it? If it's through painting or weaving or and just really being open to doing that, let's sit down for a coffee and have a yarn. If you just want to go out and talk in nature or, attend smoking ceremonies and, be a part of that and cleanse, thinking outside of the box. I quite often bring my Bush medicine or smudge sticks into work if someone's having a really fucked time...I'll sit out the front of the hospital and light it up and we'll cleanse ourselves because we're carrying too much bad juju and we need to get that shit away.

Participants commonly shared stories that embodied connections to all seven SEWB domains described by Gee and colleagues(7). These cultural connections were often discussed as strengths, or protective and healing factors in relation to participants' mental health and wellbeing. Jarrah shared the differences she saw in her family when engaging in holistic models of care,

My mum didn't have a SEWB worker till like three years before she passed. But the difference I saw in her in those three years after being engaged in this new model was amazing and changed my whole family... But it felt like it's a bit late now because she's palliative. So, I feel...if that was available in my childhood in the 90s, we just might not have had the exposure to the trauma.

Palana shared insights integrating community and family into practice to create motivation and build clients' capabilities,

Get clients into formal education or an apprenticeship or something like that where they could feel valued and refocus their attentions on something that they want for themselves and their families. So, it was a full lifestyle connectivity back to their roots. What do they need for their community? What do they need for themselves and how do they follow that journey through to better themselves, to be able to then share that with others, to help them on their journey.

Wiran suggested for clinicians that “had a cultural lens...build in our accountability to our ancestors as part of our safety planning or strength planning rather than seeing it as an indicator of psychosis because it was honestly the thing that kept me going.” Additionally, Roo shared their thoughts on working holistically, and holding an understanding of how this impacts our presentation to mental health professionals and services,

I think that it's about being holistic, it's not just 'fixing' one thing. It's more than that, it's about community, it's about family, it's about past and present. I think each of us brings with us lived experience, both positive and negative about what it is to be an Aboriginal person, and we come to them with that experience, and it can take one thing that could just break that relationship. Whether it's language, whether it's assumptions, I think it's having that understanding and being able to use their skills to work through what is needed... My (Aboriginal) psychologist looks at me as a whole person, which you don't often get. I think that holistic approach where she knows the names of all of my kids, my sisters, my nieces and nephews who are like my children and she knows what they're all up to and remembered what they're all doing because that impacts on my life.

In one of Crow's experiences, they shared, although the psychologist was non-Indigenous, her proximity to the culture through working at an Aboriginal organisation gave her “the vernacular and understanding that an average psychologist didn't have it.” Therefore, Crow's experience was positive because, “when I was talking about spirit and ngangkari's and doing a smoking...I didn't have to explain it... which helped me develop a rapport with the psychologist... But my previous experiences weren't like that, and I felt like I was educating someone rather than actually getting therapy because I was just constantly explaining myself.”

Participants emphasised the importance of self-determination in regard to their experiences. Djidi Djidi shared a story of when they were denied the right to choose their intervention which they feel significantly impacted their healing.

I feel like if I was offered somatic therapy, EMDR, or any of those kinds of therapies, I would have been so much better off so early on. But I was forced into DBT and CBT. It didn't work for me because I already intellectualised everything, so they're like, you're a lost cause and that kind of thing. Even in studying they still say CBT works with almost everybody so this is the only therapy we're going to be talking about... But I have personal experience receiving that therapy and I know so many people who have tried that and it doesn't work. Then, if it doesn't work, then there was nothing we can do, and there's no other therapy apparently.

Bubba shared the negative impacts that can occur when being forced to engage in therapy, saying, from a young age, I was in the foster care system until 18. So, they were like you need to go see a counsellor. Then they put me in a room with a counsellor and said you need to talk. I was like, no, I don't. So that was probably the first thing I noticed being a young kid, like being forced to talk about stuff that you don't want to talk about... And I guess when you go through something traumatic like being in the

foster care system till 18 and I got split up from my brother as well and then they're like, you have to talk about this. It's like, but do I want to talk about it and bring it up, it's very traumatic.

Roo suggest to, "ask everybody what they prefer if it's not obvious...that puts the power back in our hands, self-determination you know."

Participants agreed on the need for mental health providers to provide First Nations clients with self-determination, increased validation, and culturally grounded practices, as well as holistic frameworks, strengths-based approaches, and cultural knowledge. They also emphasised the importance of demonstrating humility, relationality, reliability, and educating themselves. Differences have been shared in participants' stories above that at times contrast how they would like to receive these. These differences emphasise the importance for mental health practitioners to take a person-centred approach. Yolla explained it nicely, stating

When you are working with someone who is outside of your culture, outside of your ethnic group, outside of your suburb, you need to have some humility. Their experiences are different. That doesn't mean that they are so abnormally nonhuman that you can't apply the principles of psychology to them. That's ridiculous. Conceptually, what it means is you have to be tailoring your approach carefully and thoughtfully based on the things that they tell you, not the things that you assume. You know, and where's the harm in checking?

While participants' experiences largely aligned with the domains of the SEWB framework, many accounts also foregrounded institutional, organisational, and systemic factors, such as service design, funding structures, and professional power, that sit across, rather than within, individual SEWB domains, shaping the conditions under which wellbeing could be supported or undermined.

Discussion

First Nations peoples' experiences engaging with mental health practitioners and services are mostly unique and diverse; however, their experiences shared in the findings have common underlying enablers and barriers that should be considered to foster culturally responsive mental health practices and services. Healing can be enabled for First Nations clients by culturally grounding mental health and wellbeing practices and by creating safety within therapeutic relationships and environments, which are the overarching themes that enable cultural responsiveness. Conversely, barriers included systemic, structural, organisational, and logistical constraints that impeded equitable, culturally responsive mental health care. This work foregrounds the relational, systemic, and cultural dimensions of psychological practice that are often underrepresented in mainstream discourse(1, 4). Collectively, these findings advance psychology, underscoring the need to build a framework of cultural humility, responsiveness, and accountability as well as the importance of working from a broader holistic SEWB perspective when providing mental health services to First Nations people. In doing so, this work contributes to transforming psychology into a discipline that is inclusive in its pursuit of social and cultural justice.

The findings of this study make several important contributions to the existing literature and theoretical frameworks within psychology. First, they reinforce the decolonising psychology discourse(1, 2, 7) that challenges prevailing assumptions embedded in dominant psychological models that often universalise therapeutic processes without accounting for cultural specificity. The findings emphasised the importance of relationality to build trust with First Nations clients. Participants reported disengaging from practitioners when they felt they were robotic or scripted; however, they felt more connected after their experiences were validated. Validation promoting healing for First Nations people is unsurprising when considering our colonial lived experiences, as it recognises trauma and affirms our reality. This aligns with previous literature(7–10) that all emphasise the need to acknowledge the compounding impacts of intergenerational trauma, grief, and structural disadvantage on SEWB.

Furthermore, welcoming environments that authentically reflected First Nations cultures signalled safety to participants, fostered comfort, reduced stress, and lowered their defences. Participants' preference for more welcoming environments is less discussed in the literature. However, overlap is evident in Darnett and colleagues(10) study, where psychologists reported that conducting sessions outdoors in nature was a successful practice that facilitated ongoing engagement with First Nations clients. The harm that psychology has inflicted upon First Nations peoples, which has reinforced the mistrust of western systems and peoples developed in response to colonisation(1–3), may also partially explain these findings, as clinical settings are usually applied in mainstream services and often affiliated with hospitals. By foregrounding the relational and cultural dimensions of safety in therapeutic environments, this work contests the adequacy of standardised approaches and calls for a re-examination of what constitutes effective and ethical practice, particularly in cross-cultural contexts.

The findings of this study have significant implications for health equity. Participants' accounts demonstrate that inequities in mental health care are produced through systemic, structural, organisational, and logistical arrangements that constrain access to culturally safe care(1, 2, 15). Workforce shortages, rigid funding models, culturally uninformed referral pathways, and regulatory frameworks that privilege mainstream models of evidence collectively reproduce inequitable access and engagement for First Nations peoples(1, 2, 9). These inequities are compounded by epistemic injustice, whereby First Nations knowledge systems and lived experiences are routinely devalued within mental health services(4, 6, 24). As a result, cultural responsiveness becomes contingent on individual practitioners rather than embedded within systems, producing inconsistent and inequitable care experiences(10). Addressing these disparities requires structural reform that embeds First Nations governance, culturally grounded models of care, and accountability mechanisms across mental health systems.

The findings of this study extend existing theories and findings of cultural competence and trauma-informed care(13) by offering a more nuanced understanding of cultural responsiveness and relational healing. While prior research has acknowledged the value of holistic wellbeing frameworks and the integration of First Nations worldviews(8, 10, 14), this study reinforces and deepens those discussions by demonstrating the active role of culturally grounded practices (e.g., yarning, art, ceremony, and

connection to Country) in fostering trust, engagement, and healing. It highlights the limitations of models that treat culture as an optional add-on, advocating instead for First Nations ways of knowing, being, and doing to underpin all aspects of First Nations peoples' mental health care. Central to this is the provision of self-determination and person-centred care, which recognises the diversity of First Nations experiences and preferences.

Building on these practice-level insights, the findings also contribute to broader conversations about systemic reform and epistemic justice. They support and strengthen scholarship advocating for the integration of First Nations knowledges and community-based practices into mental health systems(4, 6, 25). The study aligns with decolonial and critical psychology perspectives that seek to disrupt Eurocentric paradigms and challenge the dominance of western mental health frameworks(5). Participants' experiences reveal the systematic disenfranchisement embedded in Australia's mental health systems and funding models(1, 2), which often marginalise culturally responsive care. By providing empirical evidence of the efficacy of culturally grounded healing practices and the limitations of current funding structures, the study lends weight to calls for systemic reform and the reconfiguration of service delivery models to better meet the needs of First Nations peoples.

In terms of utilisation, these findings can inform multiple domains of psychological practice and policy. Clinicians can draw on the insights to enhance cultural responsiveness and relational depth in therapeutic settings. Educators and supervisors can incorporate the findings into training programs to foster cultural humility and reflexivity among emerging practitioners. Policymakers and service designers can use the evidence to advocate for structural changes that support culturally safe environments and equitable access to care. The findings offer a roadmap for transforming psychology into a discipline that is more inclusive, relationally attuned, and responsive to the diverse cultural realities of the communities we serve. By identifying these points of convergence and divergence within the broader literature and areas for utilisation, the study contributes to a more inclusive and critically reflexive psychology discipline. It invites scholars and practitioners to reconsider foundational assumptions and to engage more deeply with culturally grounded knowledge systems in both theory and practice.

While this study offers rich insights into the experiences of First Nations peoples engaging with mental health protections and services, the limitations must be acknowledged. The relational recruitment strategy is situated within the Indigenous standpoint(26), though it simultaneously biases the sample toward communities and networks to which the research team is connected. Therefore, the findings are based on the voices of a specific group of Aboriginal participants. Notably, there was no Torres Strait Islander representation in the sample, a critical point for future research. Furthermore, some commonalities in the demographic information do not reflect the diversity within Aboriginal communities. As a qualitative study, the insights are contextually grounded and not intended to be generalised across all First Nations communities or mental health settings. The strength lies in depth, not breadth.

The study advocates for the need to develop a holistic conceptualisation of First Nations peoples' SEWB, while contradictorily focusing primarily on mental health services and not exploring intersections with other systems, such as justice, housing, and education, that also impact wellbeing and access to care. Moreover, the study critiques systemic and structural barriers while operating within those same systems, such as academic publishing and funding models. Operating within these systems constrains the scope of exploration and intersections, as well as the reform that the study can directly influence. Therefore, further critical reflection and cultural supervision should be engaged when considering and implementing the findings with Aboriginal clients.

The findings of this study have important implications for the future of mental health care for First Nations peoples. They highlight the urgent need to reconfigure service design to embed First Nations ways of knowing, being, and doing as foundational to care. This includes co-designing services with First Nations communities, expanding access to culturally grounded practices, and ensuring that care is holistic, relational, and strengths based. The study also underscores the importance of workforce development, including increasing the number of First Nations mental health professionals and equipping non-Indigenous practitioners with cultural humility and trauma-informed training. Additionally, the findings call for reform of funding and policy models to support long-term, flexible, and community-led approaches. Improving referral pathways, enhancing transparency in service navigation, and prioritising self-determination in therapeutic decision-making are also critical steps toward culturally safe and effective care. Future research should continue to centre First Nations voices, explore diverse healing practices, and evaluate culturally responsive models across varied contexts.

Conclusion

This study adds to the growing body of research centring First Nations voices in mental health reform. It highlights the systemic, structural, and relational barriers that undermine culturally safe care, while also demonstrating the healing potential of culturally grounded practices and holistic frameworks rooted in First Nations ways of knowing, being, and doing. The findings call for mental health systems to move beyond tokenistic inclusion of culture and toward genuine integration, with person-centred care and self-determination at the core. They also support policy reform, workforce development, and further research. By evidencing both the harms of culturally unresponsive practices and the transformative impact of culturally grounded care, this study offers a clear direction for systemic change, one that empowers, respects, and affirms First Nations peoples, knowledges, culture, and lived experiences.

Abbreviations

CBT

Cognitive Behavioural Therapy

DBT

Dialectical Behaviour Therapy

EMDR

Eye Movement Desensitisation and Reprocessing
ITA
Inductive Thematic Analysis
JARS
Qual-Qualitative Journal Article Reporting Standards
SEWB
Social and Emotional Wellbeing
SRQR
Standards for Reporting Qualitative Research

Declarations

Ethics approval and consent to participate:

Ethics approval was granted by the Swinburne University Human Research Ethics Committee (SUHREC; 20236001-15567). All participants provided informed consent prior to participation.

Consent for publication:

Consent for publication was obtained as part of the informed consent processes embedded within the study and collected prior to participation in the yarning process.

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The authors declare that they have no competing interests.

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Author Contribution

All author's made substantial contributions to this work. ED, under the supervision of MT lead the conception, and design of the work. ED led the data collection, and analysis and drafted this manuscript under CS supervision. All authors (ED, MH-B, JP, GG, MT, & CS) substantively revised the manuscript and continue to contribute in significant ways to the translation and dissemination of the work.

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Data Availability

The datasets generated and analysed during the current study is not publicly available as individual privacy could be compromised.

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