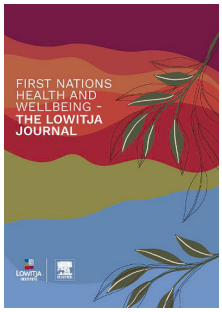

Review

Principles and practices of communicating with Aboriginal and Torres Strait Islander peoples accessing mental health services: A systematic review

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Abstract

Purpose Communication between mental health professionals and Aboriginal and Torres Strait Islander peoples is critical for culturally safe care. Although the importance of communication is well recognised, genuinely supporting culturally safe communication necessitates moving beyond challenges to identify

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solutions. Using a strengths-based approach, this study aimed to identify principles and practices for communicating with Aboriginal and Torres Strait Islander peoples accessing mental health services.

Methods This study was conducted at the interface of Indigenous and Western knowledge using theories and tools developed by Aboriginal and Torres Strait Islander scholars and integrating these with systematic review methods. A systematic search for qualitative and quantitative evidence was conducted across databases including peer-reviewed and other ('grey') literature. Search results were independently screened by an Aboriginal researcher and a non-Indigenous clinician researcher. Following screening, additional searches were conducted (e.g. of reference lists in systematic reviews). The quality of literature sources meeting inclusion criteria was appraised by the same researchers using Aboriginal and Torres Strait Islander and Western tools. Informed by Indigenous research methodology, thematic synthesis was used to identify principles and practices for communication.

Main findings The search strategies identified 2,504 unique literature sources. Following screening, 57 sources were deemed to meet inclusion criteria. Critical appraisal identified that most sources were produced by reputable organisations and authors, who provided accurate information based on evidence, although fewer sources incorporated Aboriginal or Torres Strait Islander leadership, governance and authorship. Thematic synthesis identified three high-level principles for communication that could be understood from the standpoints of Aboriginal and Torres Strait Islander Peoples and other people living in Australia: 1) *Knowing Our Stories*: Professional requirements of knowledge and understanding to support culturally safe communication; 2) *Being With Us*: Preparing for culturally safe communication; and 3) *Doing Things Our Way*: Practices for culturally safe communication.

Principal conclusions The sizable body of literature synthesised in this review identifies both high-level and detailed principles and practices that mental health professionals should employ to promote culturally safe communication with Aboriginal and Torres Strait Islander peoples accessing mental health services.

Keywords: First Nations Peoples; Communication principles; Communication practices; Communication strategies; Mental health; Cultural safety

Highlights

- Communication is a foundational component of culturally safe mental healthcare.
- This review identifies core communication principles and practices for this setting.
- These principles and practices should be employed to support decolonising care.

Introduction

'Cultural safety is about issues of access to service and communication, rather than technical skills' (Ramsden 2002, p.179).

In Australia, both research evidence and Government policy recognise the importance of communication in providing safe and effective care (Australian Commission on Safety and Quality in Health Care 2021; De Zilva et al. 2021; Jennings et al. 2018). For Aboriginal and Torres Strait Islander Peoples[1], safety is not limited to *what* care is provided but also *how* that care is provided (Dudgeon et al. 2018; Gayaa Dhuwi (Proud Spirit) Australia 2024). The latter is increasingly conceptualised as cultural safety, which requires health systems and professionals to be aware of cultural differences, decolonise services, consider power relationships, implement reflective practice, and allow consumers to determine what is safe for them (Curtis et al. 2019). For the provision of health services to Aboriginal and Torres Strait Islander Peoples, communication is a critical component of designing and delivering safe and effective services (De Zilva et al. 2021; Jennings et al. 2018). Communication is especially critical for mental healthcare, where it is routinely the primary medium for diagnosis, monitoring and treatment (Cruz and Pincus 2022; Maguire and Pitceathly 2002; Michaelson and Rahim 2023; Norris et al., 2016; Stone et al. 2020).

Recognition of the importance of communication in mental healthcare dates at least to the 'Ways Forward' report (Swan and Raphael 1995), the first national analysis of the mental health of Aboriginal and Torres Strait Islander Peoples. This report recommended enhancing communication by involving professionals such as interpreters and Aboriginal liaison officers. Following this report and building on holistic understandings of health promoted by Aboriginal community-controlled health organisations from the 1970s, a model of social and emotional wellbeing (SEWB) for Aboriginal and Torres Strait Islander Peoples was progressively developed (Dudgeon et al. 2025; Gee et al. 2014). As the SEWB model has increasingly become integrated into the design and delivery of health services, the importance of safe ways of communicating with Aboriginal and Torres Strait Islander Peoples has become increasingly prominent (Gibson et al. 2020; Gupta et al. 2020; Murrup-Stewart et al. 2020).

The SEWB model conceptualises holistic understanding of wellbeing that is not restricted to the absence of mental illness (Gee et al. 2014). Moving beyond a deficit focus of illness to holistic understanding of wellbeing has facilitated increased recognition of the importance of strengths-based approaches (Kilcullen et al. 2020). This article aligns with strengths-based approaches to identify principles and practices for communication with Aboriginal and Torres Strait Islander peoples accessing mental health services. This strengths-based approach can enhance culturally safe communication, thereby facilitating meaningful relationships and outcomes for Aboriginal and Torres Strait Islander Peoples (Hart et al. 2009; Kerrigan et al. 2025).

Consistent with recommendations from the 'Ways Forward' report (Swan and Raphael 1995), one approach for optimising communication involves services delivered by Aboriginal and Torres Strait Islander professionals. Outside Australia, there have

[1]Aboriginal and Torres Strait Islander Peoples is the term most commonly used throughout this paper to refer to the Indigenous Peoples of Australia. Alternative terms, such as Indigenous Peoples, are occasionally used for consistency with source materials.

been calls to consider matching consumers of mental health services with professionals on the basis of language, ethnicity or cultural identity (Meyer and Zane 2013; Sue et al. 2009). If adopted with Aboriginal and Torres Strait Islander perspectives, this may enhance therapeutic relationships and outcomes due to increased trust and cultural safety (Upton et al. 2021). Notwithstanding this potential, challenges for realising this in Australia include higher rates of mental illness diagnoses among Aboriginal and Torres Strait Islander Peoples (Page et al. 2022) and a small number of Aboriginal and Torres Strait Islander professionals working in mental health settings (The Australian Health Practitioner Regulation Agency and the National Boards 2023; Transforming Indigenous Mental Health and Wellbeing Project 2022). For these reasons, developing capacity among non-Indigenous professionals to effectively communicate with Aboriginal and Torres Strait Islander peoples will remain essential for the foreseeable future. As this increases the risk that care will not be culturally safe (Chakanyuka et al. 2022; Hole et al. 2015; Kelaher et al. 2014; Miller et al. 2024; Wilkinson et al. 2022), guidelines for non-Indigenous mental health professionals are essential.

This article is a response to recognising: 1) the importance of communication for culturally safe mental healthcare for Aboriginal and Torres Strait Islander Peoples; 2) the importance of including non-Indigenous mental health professionals in efforts to improve culturally safe mental healthcare; and 3) using strengths-based approaches to enhance practice. Working from this recognition, this article reports a systematic review designed to answer the following question: What are the principles and practices of communicating with Aboriginal and Torres Strait Islander peoples accessing mental health services?

Methods

Aim and scope

To answer the research question developed for this study, a mixed methods approach was used to systematically search for relevant literature and synthesise sources using thematic synthesis (Lizarondo et al. 2022; Stern et al. 2020). Following methodological guidance for conducting mixed methods systematic reviews, a convergent synthesis approach was used to facilitate integration of quantitative and qualitative evidence (Aromataris et al. 2024). Moreover, this review utilised a 'research at the interface' methodology that spans Indigenous and Western knowledge systems (Ryder et al. 2020). This approach aims to foreground Indigenous ways of knowing, being and doing (Martin 2003) to be practical for non-Indigenous mental health professionals and beneficial to Aboriginal and Torres Strait Islander Peoples. As described further below, the interface methodology for this review used theories and tools developed by Aboriginal and Torres Strait Islander scholars and integrated these with systematic review methods from the Western intellectual tradition.

This review addresses certain themes and challenges that may be common across Aboriginal and Torres Strait Islander communities collectively. The authors would also like to acknowledge the rich diversity among Aboriginal and Torres Strait Islander communities whose experiences, distinct traditions and practices must be considered to fully understand and respect all unique cultural backgrounds. For this reason, the findings of this review may not necessarily apply to individual Aboriginal or Torres Strait Islander peoples.

Researcher standpoints

To work at the interface of Indigenous and Western knowledge systems (Ryder et al. 2020), a research

team working from diverse standpoints was brought together to undertake this systematic review. The major dimensions of the review were undertaken by the first three authors, with contributions from the remaining co-authors. The review was led by Stuart Ekberg, who is descended from Western Arrernte people and migrant settlers from Britain, Germany and Sweden. Originally trained in the academic discipline of psychology, Stuart has pursued a career as a social science researcher specialising in communication in healthcare. Two research assistants undertook many aspects of the review process. Johannah Roman, a Larrakia woman and descendant of the Roman family from Garramilla (Darwin, Northern Territory), is qualified with an Honours of psychological science and continues to pursue advocacy for Aboriginal and Torres Strait Islander Peoples' rights to access quality education and healthcare. Hana Li Na Hoberg, who has Danish and Chinese heritage, works as a mental health nurse and has research experience. Hana has spent part of her life living as a migrant in Indonesia, North America, Kuwait and Scotland. Hana continues to advocate for improving human rights, equity and access to healthcare for Aboriginal and Torres Strait Islander Peoples and culturally and linguistically diverse individuals. Diverse standpoints enabled these researchers – in collaboration with other co-authors of this review – to collaboratively work at the interface of Indigenous and Western knowledge systems, including understanding of mental health practice. Further details about all co-authors are available in the Author biographies section.

Selection criteria

The following inclusion criteria were used for this review:

- Used a strengths-based approach to identify communication principles or practices;
- Examined communication between mental health professionals and consumers;
- Considered consumers who were accessing mental health services;
- Considered consumers who were Aboriginal and/or Torres Strait Islander peoples;
- Considered consumers who were adults.

In addition to the above inclusion criteria, the following exclusion criteria were used:

- Focused on Indigenous Peoples outside Australia;
- Focused on non-Indigenous Peoples;
- Not focused on a mental health context (not involving mental health professionals, not focused on consumers with mental health concerns/mental illness, not a mental health care service/setting);
- Focused on participants who were younger than 18 years old;
- Publications of literature reviews;
- Publications of conference abstracts.

Populations younger than 18 years were excluded due to the triadic dynamic of paediatric care, and the associated conflicting tensions that can arise from health professionals, caregivers and child patients, who each have their own rights and responsibilities (Jenkins et al. 2024).

Search strategy

This mixed methods systematic review assessed a combination of peer-reviewed academic and grey literature databases that were searched between 3 November 2025 and 5 November 2025. All literature sources produced prior to 3 November 2025 were eligible for inclusion in the review. Searches of peer-reviewed academic literature were conducted through PsycINFO, Medline, CINAHL, Embase and Web of Science. A grey literature search was also undertaken to

identify any relevant clinical guidelines, government reports, policies, books or theses not identified through databases of peer-reviewed literature. These databases included Google Advanced Search, ProQuest, Informit, Policy Commons and Overton. The search strategy for this review was developed with customised search terms according to individual databases using thesaurus terms (e.g. Medical Subject Headings [MeSH] terms in PubMed) and keywords. Thesaurus terms and keywords were paired with field codes, parentheses and Boolean operators to further define their results. A copy of the search strategy used for academic literature is available as Supplementary Material S1 and the strategy for grey literature as Supplementary Material S2.

The reference lists of all relevant literature reviews were manually searched after screening (described below) to identify any additional literature sources. Additionally, a snowballing approach was employed to identify relevant sources published by authors of included literature sources. All first and last authors of included sources were identified using a simple Google Scholar search: "author first and last name" AND "Aboriginal". The sources retained past the title and abstract screening phase underwent full-text screening by reviewers in Rayyan (https://www.rayyan.ai/). All additional identified sources were then subject to the same screening procedures as undertaken for literature sources identified through the original literature search.

Screening

Literature sources identified using the search strategy described above were screened using Rayyan (Ouzzani et al. 2016). Once duplicate sources were identified and removed, two reviewers (JR and HH) independently performed a double-blind title and abstract screen according to the inclusion and exclusion criteria. Discrepancies were then resolved through a discussion, and the two reviewers (JR and HH) then repeated the screening process for a full-text review of the remaining sources, with discrepancies again resolved through a discussion, and sources that met the inclusion criteria included.

Quality appraisal

Methods used for critical appraisal of the included studies were two adapted quality appraisal tools. Consistent with principles of interface methodology (Ryder et al. 2020), critical appraisal tools from both Aboriginal and Torres Strait Islander and Western intellectual traditions were utilised. For this study, the Aboriginal and Torres Strait Islander Quality Appraisal Tool (QAT) (Harfield et al. 2020) was adapted for use alongside an adapted version of the quality appraisal called the Authority, Accuracy, Coverage, Objectivity, Date, and Significance (AACODS) checklist (Tyndall 2010). Using two tools created a large amount of critical appraisal questions with some overlap. Overlapping items were adapted to only include questions most relevant to the research question (and included literature sources). This resulted in a 12-item quality appraisal checklist (Table 1). This assessment aimed to evaluate the authority, accuracy, coverage, objectivity, date and significance of both academic and grey literature. It also assessed the cultural appropriateness of the included literature by appraising the quality of included literature from Aboriginal and Torres Strait Islander perspectives, values and cultural input.

Data extraction

Two reviewers (JR and HH) independently performed data extraction from included sources. Extraction involved copying all sections of text within a source that were relevant to the systematic review question and inclusion criteria from included sources. At the

Quality appraisal item	Sources meeting criteria
Authority: A) Is the author identifiable? B) Is the author's reputability clear (e.g. reputable organisation, professional qualifications, experience, other reputable work)? [If yes to both, then 'yes'; if unclear to both or no to one, then 'unclear'; if no to both, then 'no'] (AACODS)	55 (96.5%)
Accuracy: A) Is there a clearly stated aim or approach that is adhered to throughout? B) Are claims based on appropriate information or evidence? [If yes to both, then 'yes'; if unclear to both or no to one, then 'unclear'; if no to both, then 'no'] (AACODS)	54 (94.7%)
Coverage: Are limits to relevant populations and types of information or evidence clearly stated? [If yes to both, then 'yes'; if unclear to both or no to one, then 'unclear'; if no to both, then 'no'] (AACODS)	57 (100%)
Objectivity: A) Is the author's standpoint clear? B) Does the work seem to be balanced in presentation (e.g. moving beyond a deficit discourse; and discussing limitations)? [If yes to both, then 'yes'; if unclear to both or no to one, then 'unclear'; if no to both, then 'no'] (AACODS)	53 (93.0%)
Date: A) Unless there is a valid reason otherwise, does the document have a clearly stated date? B) Is information presented current, up to the date of publication? [If yes to both, then 'yes'; if unclear to both or no to one, then 'unclear'; if no to both, then 'no'] (AACODS)	53 (93.0%)
Significance: Did the literature source consider the implementation of findings to ensure sustainable and meaningful change? (AACODS/QAT)	49 (86.0%)
Did the literature source respond to a need or priority determined by the community? (QAT)	10 (17.5%)
Was community consultation and engagement to produce the literature source described? (QAT)	30 (52.6%)
Was the literature source produced with Aboriginal and Torres Strait Islander leadership and/or governance? (QAT)	30 (52.6%)
Was the literature source produced involving Aboriginal and Torres Strait Islander people as co-authors? (QAT)	13 (22.8%)
Was the literature source guided by an Indigenous knowledge paradigm? (QAT)	36 (63.2%)
Did the literature source adopt a strengths-based approach, acknowledging and moving beyond practices that have harmed Aboriginal and Torres Strait Islander peoples in the past? (QAT)	52 (91.2%)

AACODS, Authority, Accuracy, Coverage, Objectivity, Date, and Significance checklist; QAT-A, Aboriginal and Torres Strait Islander Quality Appraisal Tool.

Table 1: Proportion of included sources successfully meeting each quality appraisal criterion

same time the two reviewers conducted a quality appraisal of each source against the 12-item quality appraisal checklist described above.

Synthesis

Although a mixed methods design enabled the review to incorporate both quantitative and qualitative evidence, the data extraction process identified that only qualitative data met the inclusion criteria. This resulted in no extraction of quantitative data and did not require a convergent integrated approach (Aromataris et al. 2024). Due to the information contained within including literature sources, thematic analysis was determined to be the most suitable approach for synthesising the findings of included sources. Included data were imported into the qualitative data analysis software NVivo (version 14) for synthesis. Analysis followed established processes for thematic synthesis (Thomas and Harden 2008). This resulted in three independent rounds of coding undertaken by two reviewers (JR and HH). The first two rounds began with 'line by line' coding to generate detailed insights about the included information. The second round of coding developed descriptive themes that were agreed upon by discussion between the two reviewers and another author (SE). The third round of coding confirmed the suitability of identified themes. The reviewers and another author (SE) examined discrepancies between codes after the third round of coding to ensure accurate reporting of the data and interpretation of the themes. Following the third round of coding, one author (SE) in consultation with the reviewers (JR and HH) identified main themes and subthemes that could be organised within them.

Sensitivity analyses were performed to evaluate the robustness of the synthesised results by examining the location characteristics of the data sources. Reviewers attempted to identify whether a source's information related to a particular jurisdiction (i.e. state or territory), region, city, community, tribe or language group. Such information was specified in NVivo for synthesis. As this information was not consistently reported across included studies, it was not ultimately utilised in the final synthesis.

Results

Literature search and screening

The search included literature sources produced prior to 3 November 2025, yielding 2,814 sources from academic and grey literature databases. After removing duplicates, 2,438 sources were screened by title and, if necessary, abstract. This resulted in identification of 245 retrievable sources that potentially met inclusion criteria for the review. Following the full-text screening of these sources, 47 were deemed to meet inclusion criteria. An additional snowballing approach was employed to identify relevant sources published by authors of included studies and the reference lists of any relevant literature reviews. A final search using these strategies was completed on 13 January 2026, resulting in an additional 66 sources being screened, of which 10 met inclusion criteria for the review. This resulted in a total of 57 sources included in the review (Figure). Two literature sources were posthumously edited versions of a dissertation (Sheldon 2000; 2001). Although some information was duplicated, there were sufficient differences to warrant including both sources.

The most common reasons for the exclusion of sources were: i) focusing on populations younger than 18 years old; ii) examining clinical health settings that did not focus on providing mental healthcare; iii) focusing on populations other than Aboriginal or Torres Strait Islander Peoples; and iv) identifying the need for culturally safe communication but without providing strategies, principles or examples that could be applied in practice. The characteristics of included studies are available in Supplementary Material S3.

Quality appraisal

Using the 12-item critical appraisal tool described earlier, seven literature sources (10.4% of included sources) were deemed to meet all quality indicators (Chamberlain et al. 2020; Dudgeon et al. 2016; Dudgeon and Ugle 2014; Milroy et al. 2024; Tujague and Ryan 2023; Vicary and Westerman 2004; Westerman 2004). Most literature sources addressed most or all the items on the Authority, Accuracy, Coverage, Objectivity, Date and Significance (AACODS) checklist, demonstrating that they were produced by reputable organisations and authors, and provided accurate information based on evidence. In contrast, fewer sources met many or all the items on the Aboriginal and Torres Strait Islander QAT. For many sources, this reflected a lack of Aboriginal and Torres Strait Islander leadership, governance and authorship.

Synthesis of information from included sources

Informed by an Indigenist research framework (Martin 2003), three high-level principles for communication were identified. Each high-level principle was comprised of more specific principles or practices for communicating with Aboriginal and Torres Strait Islander peoples accessing mental health services. Each of the high-level principles can be described from both Aboriginal and Torres Strait Islander and non-Indigenous perspectives:

1. *Knowing Our Stories:* Professional requirements for culturally safe communication

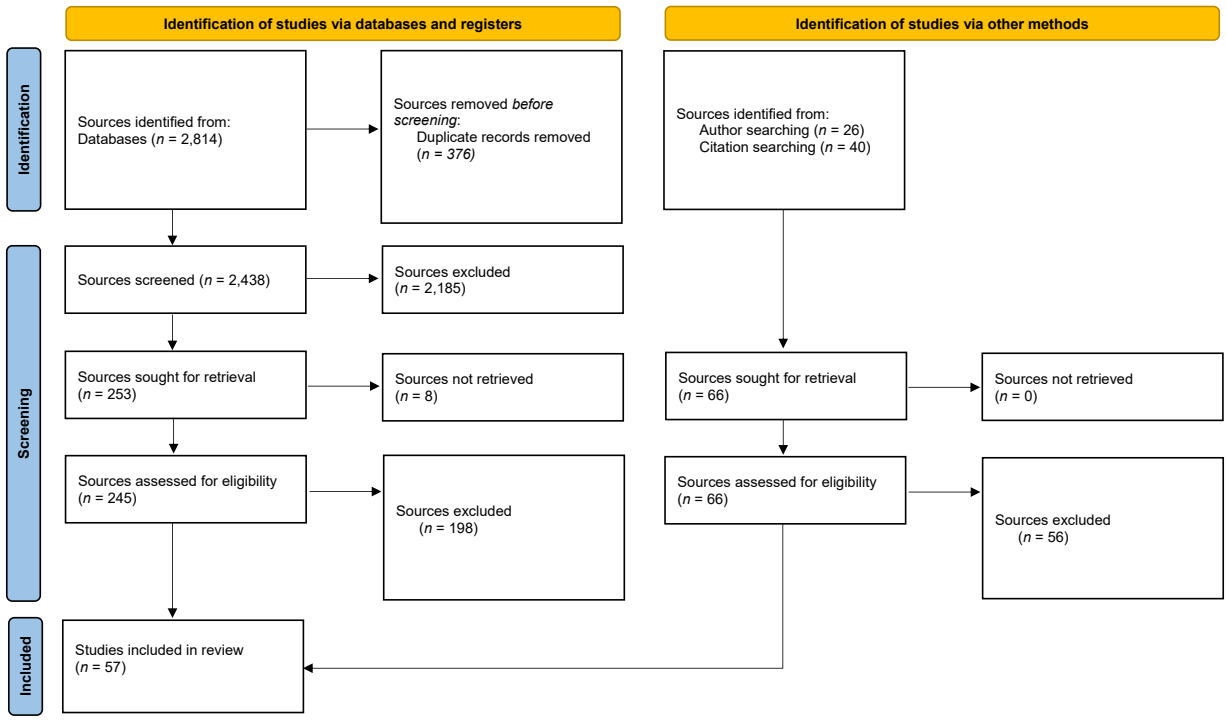

Figure: Flowchart showing the results of screening process.

2. *Being With Us*: Preparing for culturally safe communication
3. *Doing Things Our Way*: Practices for culturally safe communication

Each of these high-level principles, along with specific principles and practices that comprise each main principle, are now considered in turn.

Knowing Our Stories

Professional requirements for culturally safe communication

To provide culturally safe care to Aboriginal and Torres Strait Islander Peoples, mental health professionals must first develop meaningful understandings of Aboriginal and Torres Strait Islander cultures, history before and after colonisation, and the impacts of colonisation on Aboriginal and Torres Strait Islander communities (Aboriginal Mental Health First Aid Training and Research Program 2008; Cameron 2010; Drew et al. 2014; Dudgeon and Ugle 2014; Eley et al. 2006; Esler et al. 2007; Gibson et al. 2020; Isaacs et al. 2020; McGough 2015; Milroy et al. 2024; Nagel et al. 2012; Ralph 2000; Raphael et al. 2007; Rolfe et al. 2015; Sevar 2010; Sheldon 2001; Tujague and Ryan 2023; WA Department of Health 2024; Walker et al. 2014; Westerman 2008). These meaningful understandings should recognise diversity between Aboriginal culture and Torres Strait Islander culture, as well as diversity within Aboriginal cultures (Burdekin 1993; Cameron 2010; Dudgeon et al. 2016; Isaacs et al. 2020; Ralph 2000; Raphael et al. 2007; Vicary and Westerman 2004; Westerman 2008). Because of this diversity, mental health professionals need to develop understandings of the communities, cultures and languages of Aboriginal and Torres Strait Islander Peoples they routinely work with (Drew et al. 2014; Isaacs et al. 2020; McGough 2015; Milroy et al. 2024; Rolfe et al. 2015; Tujague and Ryan

2023; Vicary and Bishop 2005). Meaningful understanding of culture also requires mental health professionals to critically reflect upon their own culture, beliefs and values, to understand how these influence the care they provide to others (Dudgeon et al. 2016; McGough 2015; Raphael et al. 2007).

The cultural, historical, spiritual and social belief systems of Aboriginal and Torres Strait Islander Peoples can have important differences to the cultures of other people who live in Australia (Burdekin 1993; Cameron 2010; McGough et al. 2018; Nagel et al. 2012). Because of this, certain beliefs or practices that may be interpreted as a sign of a mental illness within Western biomedicine may not necessarily indicate mental illness for Aboriginal and Torres Strait Islander Peoples (Drew et al. 2014; McGough et al. 2018; Sevar 2010). For example, seeing spirits or hearing voices of loved ones who have died or focusing on entities such as malign spirits can be a shared experience among Aboriginal and Torres Strait Islander Peoples and not considered a sign of individual mental illness (Aboriginal Mental Health First Aid Training and Research Program 2008; Drew et al. 2014; McGough et al. 2018; Rolfe et al. 2015; Sevar 2010; Westerman 2008). For this reason, mental health professionals should ensure that they develop an understanding of a person's connection to culture and tailor their communication to the cultural context of the person with whom they are working (Aboriginal Mental Health First Aid Training and Research Program 2008; Burdekin 1993; Chamberlain et al. 2020; Drew et al. 2014; Haswell et al. 2009; McGough 2015; Morgan et al. 1997; Raphael et al. 2007; Rio 2021; Sevar 2010; Sheldon 2000; 2001).

Being With Us

Preparing for culturally safe communication

The literature sources included in this review describe a range of considerations that mental health professionals should make before working with individual Aboriginal and Torres Strait Islander consumers and their families.

Determining a suitable location

Several sources recommended considering the location where a clinical encounter might occur prior to meeting with Aboriginal and Torres Strait Islander peoples. This is because the environment of a conversation may be meaningful for some people. For instance, some may feel uncomfortable in confined spaces and instead prefer less formal meeting spaces, such as meeting outside or in a person's home (Aboriginal Mental Health First Aid Training and Research Program 2008; Bates and Hurley 2022; Cameron 2010; Drew et al. 2014; Eley et al. 2007; Haswell et al. 2009; Lavrencic et al. 2021; McGough et al. 2018; NSW Health 2019; Ralph 2000; Sheldon 2000; 2001; Tujague and Ryan 2023; Wright et al. 2021). Where a formal clinical space must be used, this environment can be made less alienating by incorporating cultural elements such as art (Morgan et al. 1997; Tujague and Ryan 2023), or through social practices such as offering a cup of tea to reduce formality (Hunter 2008). Gender protocols may also mean that some Aboriginal and Torres Strait Islander peoples will be more comfortable meeting in a gender-specific environment where members of the opposite gender are not present (Bates and Hurley 2022) or are seated separately (Ralph 2000).

Determining whether to involve family and community

Multiple sources highlighted that working with a consumer's family and community network will enhance culturally safe care in many cases (Bates and Hurley 2022; Dudgeon 2000; Haswell et al. 2009; Milroy et al. 2024; O'Brien 2006; Raphael et al. 2007; Rolfe et al. 2015; Sevar 2010; Sheldon 2000; 2001; Vicary and Bishop 2005). Prior to a clinical encounter,

consideration should therefore be given to who might be involved in that encounter. Some consumers may prefer a meeting environment where family members or friends are present (Esler et al. 2007; Sheldon 2000; 2001). Other consumers may prefer to meet individually with a professional (Aboriginal Mental Health First Aid Training and Research Program, 2008; Esler et al. 2007), especially when discussing matters that may embarrass them in front of their family (Aboriginal Mental Health First Aid Training and Research Program, 2008; Vicary and Bishop 2005). Consideration could be given to involving important community members who can provide cultural guidance and practices, such as Elders and traditional healers (Lavrencic et al. 2021; Milroy et al. 2024; WA Country Health Service, 2023). Mental health professionals should check to determine whether and who a consumer would like to be present and involved (Bates and Hurley 2022). There may also be reasons that particular people should not be involved, which is discussed in further detail below.

Determining whether to involve Aboriginal and Torres Strait Islander mental health professionals

Some sources referred to Aboriginal and Torres Strait Islander peoples working as mental health professionals. This could include clinical roles (e.g. as a psychologist), or as an Aboriginal and/or Torres Strait Islander mental health worker. The importance of Aboriginal and Torres Strait Islander health professionals was often described in relation to diverse benefits: working with consumers to facilitate culturally safe care and effective engagement with health services (Bradley 2019; Haswell et al. 2009; Isaacs et al. 2020; WA Country Health Service, 2023); working with other healthcare professionals who require cultural advice (Haswell et al. 2009; Isaacs et al. 2020; McGough et al. 2018; McKenna et al. 2015; Sevar 2010; Sheldon 2000; 2001; Tosson et al. 2022; WA Country Health Service, 2023); vouching for health professionals who are not an Aboriginal or Torres Strait Islander person (Cameron 2010; Westerman 2004); and brokering understanding between consumers and professionals (McKenna et al. 2015). On occasions where Aboriginal or Torres Strait Islander health professionals are not available, alternative arrangements should be explicitly identified (Trueman 2013). When such professionals are available, checks should be made to ensure that their involvement is culturally appropriate. Some Aboriginal or Torres Strait Islander health professionals may be unsuitable for certain consumers for reasons such as being the opposite gender or being in an avoidance relationship (Bradley 2019; WA Country Health Service, 2023; Westerman 2004). Checking with an Aboriginal or Torres Strait Islander health professional about whether there are any cultural reasons why they cannot be involved with a particular consumer is one way to manage this risk (Westerman 2004).

Identifying whether there are people who should not be involved

For some Aboriginal and Torres Strait Islander peoples, gender can relevantly determine what can be said to whom. Areas of distinct men's business and women's business can relate to aspects of life, such as ceremonies, sexuality and health (Haswell et al. 2009). Protocols generally require that discussions of such matters are not undertaken with, or in the presence of, people of the opposite gender (Bates and Hurley 2022; Isaacs et al. 2020; Morgan et al. 1997; Sheldon 2001). These restrictions generally extend beyond Aboriginal and Torres Strait Islander peoples to all people who live in Australia who are of the opposite gender, including mental health professionals (Isaacs et al. 2020; Morgan et al. 1997; Ralph 2000; Sheldon 2001; Trueman 2013;

Westerman 2004). In addition to gender, Aboriginal and Torres Strait Islander cultures can foreground important obligations and entitlements within kinship and community networks. This can include avoidance relationships, such as between a mother-in-law and son-in-law, which can influence the nature and extent of interaction between different family and kin members (Bradley 2019). In some circumstances, the dual role of being a professional and also a member of a consumer's family or community may warrant excluding that professional from working with a consumer or the need for additional support (WA Country Health Service, 2023). Situations that violate gender or kinship protocols can have tangible consequences (Westerman 2004). For these reasons, mental health professionals should check whether there are people who should not be involved in conversations about mental health and SEWB.

Accommodating different priorities about time

Priorities about time within Aboriginal and Torres Strait Islander cultures can differ from those within the cultures of other people who live in Australia (Crawford et al. 2000; Drew et al. 2014; Gibson et al. 2020; Haswell et al. 2009; Morgan et al. 1997; Ralph 2000; Raphael et al. 2007; Rio 2021; Trueman 2013). For instance, certain commitments that arise among family and community can take precedence over an appointment that has previously been scheduled (Dudgeon et al. 2016; Haswell et al. 2009; Morgan et al. 1997; Rio 2021; Trueman 2013). For these reasons, arrangements should not be considered as conclusively determined until they occur. Re-confirming an arrangement on the day of an appointment is one way to ensure that it is still appropriate (Morgan et al. 1997; Rio 2021). Moreover, differences in priorities about time between Aboriginal and Torres Strait Islander Peoples and other people who live in Australia can mean that mental health professionals should be prepared for activities taking longer than they are accustomed to when working with others (Chamberlain et al. 2020; Dudgeon et al. 2016; Gibson et al. 2020; Ralph 2000; Rio 2021).

Doing Things Our Way

Practices for culturally safe communication

When meeting, working and caring for Aboriginal and Torres Strait Islander consumers and their families, the included sources identify a range of communication practices that mental health professionals could consider that may be suitable for individual Aboriginal and Torres Strait Islander peoples.

Promoting self-determination

There were two approaches in the included sources that were congruent with culturally safe practice by promoting self-determination: 1) person-centred approaches; and 2) strengths-based approaches. Person-centred approaches could include promoting ways for conversations to be led by a consumer and (if present) their family, such as by asking what they would like to get out of a particular meeting or their care more generally (Dudgeon 2000; Elliott et al. 2020; Emerging Minds 2023; Gibson et al. 2020; Leckning et al. 2019; Nagel et al. 2012; Nagel and Thompson 2007; WA Department of Health 2024). Empowering consumers and their families through a person-centred approach can be enhanced through a strengths-based approach (Chamberlain et al. 2020). This involves ensuring that conversations foreground a focus on strengths that can promote resilience and recovery (Chamberlain et al. 2020; Elliott et al. 2020; Raphael et al. 2007; Trueman 2013; Tujague and Ryan 2023). Some sources described how promoting self-determination is particularly

important for adopting a trauma-informed approach to practice and is often advocated for when working with Aboriginal and Torres Strait Islander Peoples (Chamberlain et al. 2020; Tujague and Ryan 2023).

Building rapport

Aboriginal and Torres Strait Islander peoples may not feel comfortable discussing personal information with someone until they have developed a trusting relationship (Bates and Hurley 2022; Dudgeon 2000; Dudgeon and Ugle 2014; Trueman 2013; Vicary and Bishop 2005; Wright et al. 2021). Building rapport is thus an important precursor to other clinical activities (Dudgeon et al. 2016; Emerging Minds 2023; Sheldon 2000; 2001). As noted earlier, priorities about time within Aboriginal and Torres Strait Islander cultures can differ from those within the cultures of other people who live in Australia. Mental health professionals should therefore be prepared for the possibility that activities could take longer than they are accustomed to when working with other people who live in Australia; this extends to building rapport. Taking time to ensure rapport is a practical way of demonstrating respect for a person and making a good impression (Emerging Minds 2023; Raphael et al. 2007).

The initial moments of an encounter, especially when a mental health professional is meeting a consumer – and perhaps also their family – for the first time, can be a particularly important moment for building rapport (Bates and Hurley 2022; Dudgeon et al. 2016; Emerging Minds 2023). Unless a consumer displays a clear preference to commence with talking about their illness (Haswell et al. 2009), initial moments should focus on the mental health professional introducing themselves and making a connection with the consumer and any family present (Cameron 2010; Emerging Minds 2023; Gibson et al. 2020; Haswell et al. 2009; Rio 2021; Sheldon 2000; 2001). In making a connection, topics that can be particularly important for Aboriginal and Torres Strait Islander Peoples include Country and kin. Providing space for consumers, family members and mental health professionals to share information about where they are from, their family relations, their connection to Elders and other significant community members provides an opportunity for the parties involved to understand where they stand in relation to one another (Cameron 2010; Rio 2021; Sheldon 2000; 2001; Westerman 2004). An important part of this process includes mental health professionals being willing to share information about themselves, such as where they are from, who is part of their family and their connection to the local area (Adams et al. 2014; Bates and Hurley 2022; Cameron 2010; Dudgeon 2000; Elliott et al. 2020; Morgan et al. 1997; Sevar 2010; Westerman 2008; Wright et al. 2021).

Vouching

An introduction or endorsement by someone already known to the consumer – a process often referred to as vouching – can progress the building of rapport (Cameron 2010; Trueman 2013; Vicary and Bishop 2005; Vicary and Westerman 2004; Westerman 2004; 2008). Alternatively, a mental health professional can mention other people they are acquainted with in the consumer's community, so a consumer might recognise existing trust for the professional within their community (Sheldon 2001). Engaging in other relational activities during the initial moment of a clinical encounter, such as offering to make a cup of tea, can provide space for rapport to be developed before proceeding to clinical activities (Hunter 2008). As rapport is progressively developed, this initial phase should include an

explanation of the purpose of the clinical encounter (Gibson et al. 2020; Sheldon 2000; 2001).

Yarning and deep listening

In contrast to the highly structured communication characteristic of clinical activities such as assessments, sources often recommend that mental health professionals use more open-ended conversational practices when working with Aboriginal and Torres Strait Islander Peoples – an approach often referred to as yarning (Aboriginal Mental Health First Aid Training and Research Program 2008; Adams et al. 2014; Bradley 2019; Chamberlain et al. 2020; Drew et al. 2014; Elliott et al. 2020; Emerging Minds 2023; Milroy et al. 2024; O'Shea et al. 2024; Ralph 2000; Raphael et al. 2007; Sheldon 2000; 2001; Trueman 2013; Vicary and Westerman 2004). This approach is often characterised by asking fewer questions, providing fewer summaries, allowing more opportunities for extended narratives as the primary way for information to be conveyed, finding out about the broader context of a person's life before asking about their presenting problem, and listening deeply to what is being said – a practice sometimes described in relation to the contemplative process known as *Dadirri* in Ngan'gikurrungur language (Bates and Hurley 2022; Cameron 2010; Chamberlain et al. 2020; Dudgeon et al. 2016; Elliott et al. 2020; Haswell et al. 2009; Nagel et al. 2012; Ralph 2000; Sheldon 2000, 2001; Vicary and Westerman 2004).

Intersecting with practices for developing rapport described earlier, initial conversations may not necessarily focus on a person's mental health but rather are used to develop a trusting relationship within which such conversations can subsequently occur (Chamberlain et al. 2020). Yarning might also be used as an alternative to asking Aboriginal and Torres Strait Islander Peoples to complete forms, if such an activity is not a usual way a person would provide information about themselves (Elliott et al. 2020). Where forms are essential, consideration should be given to making these as accessible as possible (Bates and Hurley 2022; Eley et al. 2006; Emerging Minds 2023; Nagel et al. 2012; Nagel et al. 2009; Rolfe et al. 2015). On occasions where mental health professionals feel it important to ask questions, phrasing these as open-ended or holistic questions can keep a focus on yarning and avoid turning the conversation into an interview (Bates and Hurley 2022; Cameron 2010; Elliott et al. 2020; Leckning et al. 2019; Morgan et al. 1997; O'Brien 2006; Raphael et al. 2007; Rio 2021; Sheldon 2001; Trueman 2013; Westerman 2004).

Seeking clarification

Multiple sources recommend seeking clarification so a mental health professional can ensure that they have developed appropriate understanding. This can be particularly important in relation to matters such as culture, community, kinship, language, connection to Country, and SEWB (Cameron 2010; Gibson et al. 2020; Haswell et al. 2009; Leckning et al. 2019; McGough et al. 2018; Sheldon 2000; Trueman 2013; Vicary and Westerman 2004; Wright et al. 2021). In addition to seeking clarification to ensure a mental health professional's own understanding, it is also important to seek clarification to determine whether a consumer's understanding of what a mental health professional has said aligns with what was intended (Bates and Hurley 2022; Drew et al. 2014; Southern NSW Local Health District, 2020).

Recognising language differences

Differences in ways that language is used are potential sources of misunderstanding. Differences are possible even when both the consumer and mental health professional speak English. Aboriginal and Torres Strait Islander consumers may, for instance, attach

cultural meanings to terms such as 'depression' that are distinct from meanings associated with such terms by mental health professionals who are part of cultures of other people who live in Australia (Aboriginal Mental Health First Aid Training and Research Program 2008; Bradley 2019; Vicary and Bishop 2005). Avoiding technical expressions and professional jargon can minimise risks of misunderstanding (Adams et al. 2014; Bates and Hurley 2022; Drew et al. 2014; Elliott et al. 2020; Haswell et al. 2009; Lavrencic et al. 2021; Milroy et al. 2024; Morgan et al. 1997; Nagel and Thompson 2007; O'Brien 2006; Sheldon 2000; Vicary and Bishop 2005; WA Department of Health 2024). As well as avoiding technical expressions, other approaches may be required to align with concepts that are meaningful for consumers (Drew et al. 2014; Esler et al. 2007; Lavrencic et al. 2021; Nagel et al. 2009; Raphael et al. 2007; Sevar 2010; Sheldon 2001; Southern NSW Local Health District, 2020; Trueman 2013). For example, expressions such as feeling 'slack' or 'weak' may be suitable alternatives to terms with negative connotations such as 'depression' (Sevar 2010; Sheldon 2001).

Differences in language can become more pronounced when mental health professionals and consumers speak different languages. For consumers, differences in language from mental health professionals can include speaking Aboriginal and Torres Strait Islander languages, Aboriginal English or Kriol. Where this is the case, the importance of accommodating language differences is increased (Aboriginal Mental Health First Aid Training and Research Program 2008; Australian Institute of Health and Welfare 2022; Bates and Hurley 2022; Bradley 2019; Drew et al. 2014; Dudgeon et al. 2016; Eley et al. 2006; Esler et al. 2007; Haswell et al. 2009; Isaacs et al. 2020; Lavrencic et al. 2021; Leckning et al. 2019; Morgan et al. 1997; Nagel et al. 2012; Puszka et al. 2016; Ralph 2000; Rolfe et al. 2015; Sheldon 2001; Trueman 2013; Vicary and Bishop 2005). Where warranted, interpreters may need to be used to ensure that clinical tasks are conducted accurately or to allow consumers to receive treatment in their preferred language (Bates and Hurley 2022; Bradley 2019; Emerging Minds 2023; Leckning et al. 2019; Milroy et al. 2024; Rolfe et al. 2015; Sheldon 2000; Southern NSW Local Health District, 2020; Tosson et al. 2022; Vicary and Bishop 2005; Walker et al. 2014). If an interpreter would be beneficial, it may be important to check whether there are any cultural reasons why a particular interpreter may be unsuitable for a specific consumer (Bradley 2019). Differences in language can also relate to the languages that mental health professionals speak. For instance, where mental health professionals speak English as a second language, it may be important to consider whether and how this could create scope for misunderstanding (Bradley 2019; Puszka et al. 2016).

Recognising non-verbal and paralinguistic communication

Several sources note differences in use of silence, suggesting that Aboriginal and Torres Strait Islander Peoples have greater tolerance of longer periods of silence than other people who live in Australia (Bates and Hurley 2022; Morgan et al. 1997; Sevar 2010). The uses and meanings of silence may differ between individuals, communities and settings (Bates and Hurley 2017), but can include contemplation and reflection (Aboriginal Mental Health First Aid Training and Research Program 2008; Bates and Hurley 2022; Cameron 2010; Crawford et al. 2000; Haswell et al. 2009; Morgan et al. 1997; Sheldon 2000), disagreement (Bates and Hurley 2022; Crawford et al. 2000), waiting (Ralph 2000), reluctance to answer (Haswell et al. 2009; Sheldon 2000), and not feeling obligated to

respond (Bates and Hurley 2022). Mental health professionals can observe when and how silence is used and mirror these practices in their own communication (Bates and Hurley 2022; Elliott et al. 2020). Silence can also be used by mental health professionals to demonstrate listening to what they are being progressively told, rather than interrupting with questions (Cameron 2010; Drew et al. 2014; Elliott et al. 2020; Gibson et al. 2020; Vicary and Westerman 2004).

Some sources also note that eye gaze practices can differ between Aboriginal and Torres Strait Islander Peoples and other people who live in Australia (Bates and Hurley 2022). For some Aboriginal and Torres Strait Islander peoples, sustained direct eye gaze towards a person can convey judgement (Aboriginal Mental Health First Aid Training and Research Program 2008; Haswell et al. 2009; Sheldon 2000; 2001), disrespect (Bates and Hurley 2022; Haswell et al. 2009) or aggression (Bates and Hurley 2022). Also similar to recommendations about silence, mental health professionals can observe how a person uses gaze and mirror this with their own gaze (Bates and Hurley 2022; Trueman 2013). If a person seems to prefer sitting side by side with others rather than facing towards them, this could also be accommodated and will reduce direct gaze (Bates and Hurley 2022; Rio 2021; Sheldon 2000; 2001).

Although not considered in detail, other forms of non-verbal and paraverbal communication can differ between Aboriginal and Torres Strait Islander Peoples and other people who live in Australia. These include tone of voice (Bates and Hurley 2022; Bradley 2019; Gibson et al. 2020; Trueman 2013), gesture (Australian Institute of Health and Welfare 2022; Bates and Hurley 2022; Drew et al. 2014; Ralph 2000), posture (Drew et al. 2014), nodding (Adams et al. 2014) and facial expression (Bates and Hurley 2022).

Recognising and responding to shame

Among many Aboriginal and Torres Strait Islander communities, the concept of shame can be a relevant consideration (Aboriginal Mental Health First Aid Training and Research Program 2008; Bates and Hurley 2022; Chamberlain et al. 2020; Haswell et al. 2009; Leckning et al 2019; Raphael et al. 2007; Sheldon 2001; Westerman 2004). Feelings of shame can be attributed to the topic of mental illness or the sharing of personal information with strangers, both of which can be routinely required in discussions about mental health (Aboriginal Mental Health First Aid Training and Research Program 2008; Bates and Hurley 2022; Leckning et al. 2019; Milroy et al. 2024; Raphael et al. 2007; Sheldon 2001). In instances where shame may be relevant, a mental health professional might address this by prefacing what they need to talk about with explanations such as 'I'm not trying to shame you but it will help me to understand your illness if you can tell me…' (Sheldon 2001, p.440). It may also be appropriate to delay discussion of potentially shameful topics until rapport has been developed (Trueman 2013) or to enquire about these matters indirectly (Westerman 2004).

Asking permission

Discussing potentially sensitive matters is a routine activity in mental healthcare, but some matters can be especially sensitive for Aboriginal and Torres Strait Islander Peoples. Before discussing potentially sensitive matters, multiple sources recommend that mental health professionals seek permission to do so (Aboriginal Mental Health First Aid Training and Research Program 2008; Chamberlain et al. 2020; Elliott et al. 2020; Haswell et al. 2009; Sheldon 2001). Whether and how sensitive matters are discussed can depend on who is present (e.g. the involvement of family members), so asking permission to discuss a matter should incorporate seeking permission for who

should or should not be involved (Aboriginal Mental Health First Aid Training and Research Program 2008; Bates and Hurley 2022). Under some circumstances, such as when a mental health professional and consumer are of different genders, permission seeking should incorporate checking whether the mental health professional is the right person to discuss these matters with the consumer (Haswell et al. 2009; Sheldon 2001). Permission seeking may also be important to negotiate a suitable place and time for a clinical encounter (Sheldon 2001; Vicary and Bishop 2005). Overall, asking permission should be approached as an ongoing process rather than a one-off event; for instance, if strong emotions emerge during a clinical activity, permission should be sought to continue that activity (Raphael et al. 2007).

Indirectness

In some Aboriginal and Torres Strait Islander communities it is bad manners to be too inquisitive, so asking too many direct questions can be understood as impolite, disrespectful, intimidating or authoritarian (Haswell et al. 2009; Trueman 2013), especially in relation to sensitive matters (Morgan et al. 1997). Direct questioning can be followed by confirmatory responses that may or may not be factual or correct but are produced to be polite or to stop questioning as quickly as possible (Bradley 2019; Leckning et al. 2019; Morgan et al. 1997; Rio 2021; Rolfe et al. 2015; Sheldon 2000; 2001; Trueman 2013; Westerman 2004). Sometimes referred to as 'gratuitous concurrence', this practice can become a source of misunderstanding (Bradley 2019; Morgan et al. 1997). Other times, direct questions can be responded to with silence, disavowing an ability to respond (e.g. by shrugging), or walking away abruptly (Trueman 2013). Alternatives to direct questioning are more narrative or conversational in their organisation, such as through use of stories or yarning (Bates and Hurley 2022; Chamberlain et al. 2020; Drew et al. 2014; Elliott et al. 2020; Haswell et al. 2009; Vicary and Westerman 2004). This can be facilitated using the versatile communication approaches described below. Although narrative approaches are more open-ended than direct questions, they nonetheless often result in relevant information being progressively produced (Chamberlain et al. 2020). Where questions need to be asked, indirect or open-ended questions (e.g. 'I'm wondering about…') can be preferable (Bates and Hurley 2022; Cameron 2010; Leckning et al. 2019; Morgan et al. 1997; O'Brien 2006; Ralph 2000; Rio 2021; Trueman 2013; Westerman 2004). This increases scope for a consumer to talk more freely about a matter than might be possible if asked direct and constrained questions (Ralph 2000). Notwithstanding the above, there may be circumstances where direct questioning remains important, such as during discussions about physical safety or emotional welfare (Bradley 2019).

Using versatile communication methods

Art-based approaches, such as painting and singing, can be ways of fostering meaningful communication about mental health and social and emotional wellbeing (Cameron 2010; Chamberlain et al. 2020; Elliott et al. 2020; Milroy et al. 2024; Nagel and Thompson 2007). In addition to traditional arts, this can incorporate digital multimedia (Nagel and Thompson 2007; Nagel et al. 2009; Puszka et al. 2016). However, what constitutes appropriate and meaningful artforms may differ across Aboriginal and Torres Strait Islander communities (Cameron 2010). Other approaches, such as working on genograms, can help identify important people and supports within a consumer's kinship network (Chamberlain et al. 2020; Nagel and Thompson 2010). In some Aboriginal and Torres Strait Islander communities, it may be helpful to translate information into local languages (Nagel et al. 2012; Puszka et al. 2016; Rolfe et al. 2015), written in plain English (Nagel et al. 2012; Puszka et al. 2016) or conveyed using alternative

approaches such as visual methods (Bates and Hurley 2022; Cameron 2010; Eley et al. 2007; Nagel and Thompson 2007; 2010; Rolfe et al. 2015).

Discussion

Based on the synthesis of information contained in 57 literature sources, three high-level principles for communicating with Aboriginal and Torres Strait Islander peoples accessing mental health services were identified through this systematic review. Each principle can be described from the standpoints of Aboriginal and Torres Strait Islander Peoples and other people living in Australia: 1) *Knowing Our Stories:* Professional requirements for culturally safe communication; 2) *Being With Us*: Preparing for culturally safe communication; and 3) *Doing Things Our Way*: Practices for culturally safe communication. These high-level principles include more specific principles and practices that mental health professionals can use to enhance culturally safe communication with Aboriginal and Torres Strait Islander Peoples. Table 2 provides guidelines based on the findings of this review.

The findings from this review about communication with Aboriginal and Torres Strait Islander peoples accessing mental health services are consistent with key principles of cultural safety: awareness of cultural difference, finding ways to decolonise services, considering power relationships, implementing reflective practice, and allowing consumers to determine what is safe for them (Curtis et al. 2019). With ongoing integration of a SEWB model suitable for the design and delivery of health services for Aboriginal and Torres Strait Islander Peoples, communication has been recognised as critical for safe and effective care (Gibson et al. 2020; Gupta et al. 2020; Murrup-Stewart et al. 2020). The findings of this systematic review align with the core values articulated in a recent conceptual framework for enhancing communication with all consumers of healthcare in Australia and Aotearoa: being equitable, inclusive, evidence-based, collaborative and reflective (White et al. 2023). Although systematic reviews most strongly align with valuing evidence-based practice, the findings of this review are also consistent with the other core values. For example, valuing collaboration and reflection highlights the importance of using evidence to inform practice, while also using clinical expertise and experience to tailor communication to suit particular individuals and communities (Sackett et al. 1996; White et al. 2023). For health professionals seeking to optimise their communication, the principles and practices identified through this review (Table 2) are a guide, not a rule book. Evidence is only as useful as the people and contexts to which it can be appropriately applied.

This review focused on mental healthcare in recognition that communication is often the primary medium for diagnosing, monitoring and treating mental illness (Cruz and Pincus 2022; Maguire and Pitceathly 2002; Michaelson and Rahim 2023; Norris et al., 2016; Stone et al. 2020). Notwithstanding the importance of focusing on communication in mental health care specifically, communication is more widely recognised as fundamental for safety and quality in all healthcare (Australian Commission on Safety and Quality in Health Care 2021), including cultural safety (De Zilva et al. 2021; Jennings et al. 2018). Although many of the findings of this review are likely to be transferrable beyond the specific practice context of mental health, additional reviews are needed to confirm this and identify principles and practices that may be specific to particular healthcare practice settings.

Communication and interpersonal relationships are identified as a core capability for working with Aboriginal and Torres Strait Islander peoples in

Knowing Our Stories: Ensure you, your colleagues and your service understand what is needed for culturally safe communication

- Develop and demonstrate meaningful understanding of the impacts that colonisation, discrimination and disadvantage continue to have on Aboriginal and Torres Strait Islander Peoples and their distrust towards government and healthcare services.
- Critically reflect on your own culture, beliefs and values, to understand how your own culture influences how you behave, think, communicative with and provide care to others.
- Recognise diversity within Aboriginal and Torres Strait Island cultures and develop understandings of the communities, cultures and languages of specific Aboriginal and Torres Strait Islander Peoples you routinely work with.

Being With Us: Ensure you, your colleagues and your service have intentionally prepared for communication with Aboriginal and Torres Strait Islander peoples as early as possible before an encounter occurs

- Consider the environment and location of where a clinical encounter may occur (e.g. suitability of less formal spaces, such as outside).
- Identify which protocols should be followed (e.g. separation of genders).
- Determine if there are particular people a consumer would like to be present and involved (or not involved). Some may prefer a meeting with family or friends present, while others may prefer to meet away from others.
- Priorities about time can differ, so flexibility with appointment arrangements and length may be beneficial, as well as re-confirming appointments on the day they are scheduled to occur.

Doing Things Our Way: Ensure you and your colleagues practice culturally safe communication

Practice recommendation 1: Build rapport

- Create time to build rapport by introducing yourself to the consumer and anyone else present.
- Build connection by sharing common interests and stories. Ask where a consumer is from and be willing to share information about yourself.
- Consider whether an introduction or endorsement by someone already known to the consumer, their family or community could help build rapport.
- Where appropriate, delay discussion of potentially sensitive topics until later in an encounter, once rapport has been developed.

Practice recommendation 2: Promote self-determination

- Empower Aboriginal and Torres Strait Islander peoples accessing services by focusing on their strengths and recovery.
- Promote Aboriginal and Torres Strait Islander peoples to lead the conversation and ask what they would like to get out of a particular meeting or from their care.
- Provide choices and empower self-determination, without making promises you cannot keep.
- Before discussing potentially sensitive matters, seek permission to do so.

Practice recommendation 3: Recognise language differences

- Be aware that language differences may exist even if both Aboriginal and/or Torres Strait Islander consumers and mental health professionals speak English as their first or dominant language, such as cultural meanings attributed to particular terms.
- Consider if an interpreter is warranted, and if there are any cultural reasons why a specific interpreter may or may not be suitable for a particular person.
- Avoid using technical expressions and professional jargon.
- Take time to explain, allow for responses and do not rush consumers.
- Use open-ended or indirect questions that allow for opportunities for extended narratives and find out about the broader context.
- Be aware that consistently confirmatory responses (e.g. 'yes') may be used to be polite, or to stop questioning about something that makes a person feel uncomfortable.
- Seek clarification and check if the consumer understands what you are trying to convey.

Practice recommendation 4: Yarn and listen deeply

- Use an open-ended approach to conversations, rather than solely relying on direct questions.
- Allow opportunities for extended stories as the primary way for information to be conveyed, finding out about the broader context of a person's life before asking about the problem that has resulted in them seeking care.
- Show deep listening by being empathic, attentive, respecting silence and avoiding interruption.

Practice recommendation 5: Understand non-verbal, paralinguistic and versatile communication methods

- Be respectful of silence, using these moments to demonstrate listening, without rushing to interrupt with questions.
- Observe the gaze of others and modify your own gaze accordingly, as sustained and direct eye contact may cause discomfort or be considered as threatening.
- Be conscious of personal space, and consider whether someone might prefer an alternative arrangement to sitting 'face-to-face' (e.g. side-by-side).
- Consider art-based approaches, such as painting and singing, as a way of fostering meaningful communication about mental health and social and emotional wellbeing.

Table 2: Evidence-based guidelines for communicating with Aboriginal and Torres Strait Islander people accessing mental health services

training programs such as psychology (Dudgeon et al. 2016), comprising a broader program of decolonising approaches such as the Transforming Indigenous Mental Health and Wellbeing (TIMHWB) project (Selkirk et al. 2025). Communication skills can be effectively taught to both undergraduate students and postgraduate registered professionals across a range of clinical disciplines that work in mental healthcare (Furnes et al. 2018; Michaelson and Rahim 2023). For such training to be successful, curricula must be tailored to address specific areas of communication skills (Silverman et al. 2016), such as through recognition of cultural difference (Curtis et al. 2019). When appropriately tailored to recognise cultural difference, communication training has successfully improved clinicians' confidence and skills when communicating with Aboriginal and Torres Strait Islander consumers (Bernardes et al. 2022; Ekberg et al. 2025; Lin et al. 2023). The development of a continuing professional development training through research design and pilot testing, informed by the principles discussed in this review, will broaden clinicians' knowledge and competence in communicating with Aboriginal and Torres Strait Islander consumers (Lin et al. 2023; Main and Anderson 2023). The success of implementing the guidelines developed through this review (Table 2) for training new and existing mental health professionals would be maximised through alignment with existing initiatives, such as the TIMHWB project, which incorporate focus on transforming education, workforce and policy (Selkirk et al. 2025).

Limitations

Working at the interface of Indigenous and Western knowledge systems (Ryder et al. 2020), and foregrounding Indigenous ways of knowing, being and doing (Martin 2003), this review has identified and synthesised a burgeoning body of peer-reviewed and unpublished literature, identifying knowledge that can be practical for non-Indigenous professionals and beneficial to Aboriginal and Torres Strait Islander Peoples. Notwithstanding these strengths, the following limitations should be taken into consideration when interpreting the findings of this review.

Only six of the 57 included literature sources were deemed to meet all quality indicators adapted from the Aboriginal and Torres Strait Islander Quality Appraisal Tool (Harfield et al. 2020) and Authority, Accuracy, Coverage, Objectivity, Date, and Significance (AACODS) checklist (Tyndall 2010). In many sources there was scope for more meaningful involvement of Aboriginal and Torres Strait Islander people as cultural experts and knowledge holders. Failure to adequately incorporate this expertise may limit nuanced understanding of principles and practices of communicating with Aboriginal and Torres Strait Islander Peoples.

Nuanced understanding may have additionally been impeded because none of the included literature sources directly analysed communication between consumers and professionals. With few exceptions (Cass et al. 2002; Ekberg et al. 2025), a paucity of research directly observing communication in healthcare involving Aboriginal and Torres Strait Islander Peoples means that evidence is limited to indirect reports of what communication is like, gathered using methods such as reflecting on practice rather than directly observing practice. This creates the potential for a gap between what people report and the complexity of what actually happens (Catchpole et al. 2017). Following the protocols and practices of oral cultures, literature sources included in this review demonstrate how conversations between Indigenous mental health professionals can inform practice (Elliott et al. 2020). Building on this approach, future research could directly focus on conversations between mental health professionals

and Aboriginal and Torres Strait Islander peoples accessing mental health services.

Conclusion

Transforming mental health services to be safe for Aboriginal and Torres Strait Islander Peoples involves an ongoing process of decolonisation (Dudgeon and Walker 2015). This systematic review contributes to this process by synthesising available evidence into principles and practices for culturally safe communication with Aboriginal and Torres Strait Islander peoples accessing mental health services. Each principle can be described from the standpoints of Aboriginal and Torres Strait Islander Peoples and other people living in Australia: 1) *Know Our Stories*: Ensure you, your colleagues and your service understand what is needed for culturally safe communication; 2) *Be With Us*: Ensure you, your colleagues and your service has intentionally prepared for communication with Aboriginal and Torres Strait Islander peoples; and 3) *Do Things Our Way*: Ensure you and your colleagues practice culturally safe communication. Mental health professionals should employ these principles to promote culturally safe communication with Aboriginal and Torres Strait Islander people accessing mental health services. Future guidelines will be enhanced by generating the highest quality evidence that is based on meaningful involvement of Aboriginal and Torres Strait Islander peoples as cultural experts and knowledge holders.

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The authors have no relevant conflicts of interest to declare.

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Hana (Li Na) Hoberg is a non-Indigenous person who has Danish and Chinese heritage. She works as a mental health registered nurse with previous research experience. She has spent part of her life living as a migrant in Indonesia, North America, Kuwait and Scotland before returning to Turrbal and Yuggera Country (Brisbane, Queensland) and studying a Bachelor of Arts and Bachelor of Nursing. Hana continues to advocate for improving human rights, equity and access to mental healthcare for Aboriginal and Torres Strait Islander Peoples and culturally and linguistically diverse individuals.

Stuart Ekberg is descended from the Western Arrernte people of Central Australia and migrant settlers from Britain, Germany and Sweden. He was raised on Barngarla Country (Port Augusta, South Australia) and completed university on Kaurna Country (Adelaide, South Australia). Following a period living overseas, he lived and worked on Turrbal and Yuggera Country (Brisbane, Queensland), before returning to live and work on Kaurna Country. He is a social scientist specialising in the study of communication in healthcare, with programs of research focusing on the health and wellbeing of Aboriginal and Torres Strait Islander Peoples and other people accessing healthcare.

Julie Rogers is a Woppaburra woman whose ancestral lands include the Keppel Islands in Queensland. She grew up on the lands of the Turrbal and Yuggera Peoples. Julie has extensive experience in government positions, where she has been responsible for implementing initiatives designed to enhance the life experiences of First Nations Peoples in Queensland. She was recently awarded a PhD by the University of Central Queensland for research focusing on the cultural determinants of health and social-emotional wellbeing.

Michelle Combo is a Gamilaroi woman, born and raised on Country in north-west New South Wales, who has worked as a registered psychologist and manager within the public mental health sector in Queensland for the past two decades, primarily based in Yuggera and Turrbal lands. Michelle is also a racial equity educator and current PhD candidate, exploring the topic of antiracism training for health staff.

Christopher Henaway is the Indigenous mental health professional lead for one of the largest public mental health services in Australia. He is responsible for the supervision and professional development of the Aboriginal and Torres Strait Islander workforce. He is a senior occupational therapist with expertise in working with people with serious mental illness accessing tertiary mental healthcare. Christopher is a leader for the development and implementation of a whole of service health equity strategy. He regularly provides input into a strategic oversight committee for health equity at state level. He provides statewide leadership for the Aboriginal and Torres Strait Islander workforce on mental health and alcohol and other drugs service planning and implementation.

Ilana Mushin is a non-Indigenous person of European Jewish descent who grew up in Melbourne on the lands of the Wurundjeri People of the Kulin Nation. She now lives and works on the lands of the Turrbal and Yugara Peoples. Ilana's research focuses on turn management and knowledge management in conversational interactions, including those that occur in Aboriginal communities.

Renata Meuter was born and raised in the island country of Curaçao, and is of European, Indigenous Caribbean and West African descent. Since 1999 she has lived and worked on the lands of the Turrbal and the Yugara Peoples. Renata's research focuses on bilingual/multilingual language processing and on communication (specifically in healthcare) when speakers do not share the same first language.

Kylie Burke is a non-Indigenous person who grew up in Victoria, living and working on the lands of the Wurundjeri Woi-wurrung People before moving to Queensland 10 years ago. She has lived and worked on the lands of the Turrbal, Yugara and Kabi Kabi Peoples since 2013. She is a psychologist and researcher. Her research focuses on parenting and children experiencing adversity (e.g. adolescence, life-threatening illness, intergenerational effects of social

disadvantage) and mental health practice and systems. She has an Honorary position with the School of Psychology, The University of Queensland; and is an Associate Investigator of the ARC Centre of Excellence for Children and Families over the Life Course.

Jean Spinks is a non-Indigenous person, who grew up in Gunnedah, in north-west New South Wales, on the lands of the Kamilaroi Peoples. Jean has worked as a pharmacist, public health practitioner and health economist, and her research focuses on the provision of accessible and equitable healthcare to the whole community, which includes culturally safe care.

Christina M. Bernardes is a non-Indigenous person. Born and raised in Brazil, she is of European descent. She is a registered nurse specialising in public health. Since 2010 she has been based on the lands of the Turrbal and the Yugara Peoples and worked with Aboriginal and Torres Strait Islander people on the assessment of the supportive care needs and communication of cancer patients and patients managing chronic pain.

Danielle Alchin is a non-Indigenous person who grew up in Victoria before moving to Queensland. She has lived and worked on the lands of the Turrbal, Yugara, and Kabi Kabi Peoples since 2005. She is a psychologist and has worked with people in the public mental health setting, with a focus on supporting patients, families and staff in suicide prevention.

Edwin A Surijah, originally from Indonesia, is a guest on Aboriginal land. He has been graciously given the opportunity to contribute his skills in data analysis and project coordination to a research project focused on developing communication training for mental health professionals working with Aboriginal and Torres Strait Islander consumers. His research interests include quantitative data analysis, data visualisation, resilience, mental health, and the empowerment of minoritised communities, including refugees and people seeking safety in Australia.

Ireni Farag is a non-Indigenous person. She lives and works on the land of the Bidjigal and Darug Peoples. She is a counsellor, a lecturer in counselling and psychotherapy, and a PhD candidate. Her research interests include interactional practices within institutional settings, the nuances of therapeutic openings, collaborative learning frameworks and attachment-based teaching methods. She draws on her research, therapeutic practice and teaching experiences to develop training materials and presentations for a wide range of audiences.

Supplementary material

Supplementary material associated with this article can be found in the online version at 10.1016/j.fnhli.2026.100119.

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