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Creating "a Safe Place to Go": Yarning With Health Workers About Stroke Recovery Care for Aboriginal Stroke Survivors—A Qualitative Study

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Abstract

Stroke affects Aboriginal people at disproportionate rates compared to other populations in Australia. Aboriginal peoples are less likely to receive a timely stroke diagnosis, or timely culturally responsive treatment, as there are very few stroke resources and recovery plans that have been developed by Aboriginal peoples for Aboriginal peoples. Understanding how to develop and implement culturally responsive stroke care requires research approaches that are informed by and with Aboriginal people. A qualitative Indigenous research methodology including "yarning" was undertaken to understand the experiences of both Aboriginal and non-Aboriginal health workers from nine health services providing stroke rehabilitation and recovery support to Aboriginal people living within the participating communities. Data were analyzed using an inductive approach driven by an Indigenous research approach. Yarns revealed three themes: (i) the role of culturally safe health environments to support stroke survivors, their family, and health workers; and how (ii) complicated, under-resourced systems impede the capacity to support stroke survivors; and (iii) collaborative and adaptive practices prevent people "falling through the cracks." This study highlights the need to scrutinize the cultural safety of health care, current health systems, workforce, and culture and how these influence the capacity of health workers to provide care that is responsive to the individual needs of Aboriginal stroke survivors and their families. These learnings will inform the co-design of a culturally responsive stroke recovery care strategy to improve the recovery experience and health and well-being of Aboriginal people and their families living with stroke.

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Introduction

Stroke has a significant impact on the health of Australians: stroke accounted for 1 in 20 deaths in 2019, and over 100 stroke events occurred in Australia every day in 2020 (AIHW, 2023b). Stroke care requires acute inpatient treatment typically followed by rehabilitation, which can occur in the hospital and/or the community (AIHW, 2023a). This study aims to explore the impact stroke places on Aboriginal peoples through research that is generated with and by Aboriginal researchers, clinicians, and community members. Acknowledging the social, cultural, political, and historical contexts that continue to impact Aboriginal peoples' health and well-being (Fogarty et al., 2018), we note that a gap in the health of Aboriginal and non-Aboriginal people in Australia exists (Smallwood et al., 2023). As a group of Aboriginal and non-Aboriginal researchers, we re-position this study with the Aboriginal people of Australia who have an incidence of stroke that is higher than non-Aboriginal Australians (1.7 times as high; death 1.6 as high) (AIHW, 2023b).

Aboriginal survivors of stroke are less likely to have access to the required treatment and recovery services than non-Aboriginal peoples (Armstrong et al., 2015). Whilst the use of culturally appropriate resources and receipt of culturally safe health care is associated with better health outcomes for Aboriginal people (Blacker & Armstrong, 2019), access to both is unfortunately limited. Culturally appropriate health resources in this study refer to educational and recovery tools that have been developed in consultation with a community and reflect the wants and needs of this said community to maximize their access to culturally safe health care. Cultural safety as described by Ramsden (2002) refers to "… the mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. Safety is a subjective word deliberatively chosen to give the power to the consumer" (p. 6). Within a health care setting, culturally safe health care is about how health care is experienced rather than what health care is provided. It requires the health care to be safe, accessible, and responsive care, free from racism, and ensured when a health worker recognizes and responds to the power imbalance between them and the patient. It requires the health worker continually reflect on their knowledge, skills, attitudes, practising behaviors, and conscious and unconscious biases (Department of Health, 2021).

The study presented here is the first in a program of research from the Yarning Up After Stroke project which is a Medical Research Future Fund–sponsored trial seeking to co-design and evaluate a culturally appropriate stroke recovery self-management tool. The project commenced with studies seeking to provide an in-depth understanding of the current issues experienced by Aboriginal stroke survivors, their families, and carers and by health workers supporting stroke rehabilitation and recovery of Aboriginal stroke survivors living on Gamilaraay/Gomeroi Country. The aim of this study is to amplify the experiences of health workers providing stroke care, rehabilitation, and recovery support to Aboriginal people living in the study sites.

Methods

Methodology

The research methodology was driven by an approach that respects Indigenous knowledges and worldviews; it also recognizes that previous research has tended to be done *to* rather than *with* Indigenous people (Smith, 2002). To ensure the methodology was respectful of Indigenous knowledges and worldviews, the study was guided by a local Indigenous cultural advisory group that includes elders, community members, and local service providers. Our study has acknowledged and embedded the principles of the Australian Institute of Aboriginal and Torres Strait Islander Studies Code of Ethics for Aboriginal and Torres Strait Islander research, with an emphasis on recognizing Aboriginal and Torres Strait Islander peoples' right to self-determination as fundamental to all research conducted in Australia (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2020). This includes upholding of Aboriginal peoples' right to be informed about this project's aims and intent. The researchers and community worked together throughout the study. The use of Indigenous knowledge within the study was guided by the community and community members within the research team. The authors, made up of seven Aboriginal and six non-Aboriginal members, worked with the Aboriginal Cultural Advisory Group to co-design the study, conduct the data collection, and undertake the data analysis. As Indigenous research is a shared story negotiated at every step (Kovach, 2009), a yarning approach (Geia et al., 2013) was chosen to ensure participants' voices were privileged. The yarning approach, which adopts a respectful and safe relationship between Aboriginal participants and researcher(s) (Lin et al., 2016), allowed the participants to lead the research conversation and share the experiences and perceptions they felt were most important.

Ethics

Ethical approval to conduct the study was received from the Hunter New England Local Health District Human Research Ethics Committee (2020/ETH02782) and the Aboriginal Health and Medical Research Committee (#1773/21). Written informed consent was obtained from all participants in the study.

Participants

Participants (n = 9) in the study were health workers (Aboriginal health workers, registered nurses, community care providers, and general practitioners) engaged in service delivery to local Aboriginal people recovering from a stroke in the Tamworth (regional) and Quirindi (rural) area of New South Wales, Australia. This area, Gamilaraay/Gomeroi Country, New South Wales, is the location of a high Aboriginal population compared to other areas of Australia (local 10.1%—all of Australia 3%) (Australian Bureau of Statistics, 2022). Recruitment occurred through direct invitation from the research team to local service providers. Potential participants were provided with a participant information sheet that outlined the aims and objectives of the study and the requirements of them if they chose to participate. Table 1 provides participants' unique identifiers together with relevant background information. Some information is not provided to ensure anonymity is maintained.

Table 1. Participant Information.

Identifier	Role	Aboriginal
HW01	Community care provider	Y
HW02	Registered nurse	Y
HW03	Registered nurse	Y
HW04	Aboriginal health practitioner	Y
HW05	Aboriginal health practitioner	Y
HW06	General practitioner	N
HW07	Registered nurse	N
HW08	Registered nurse	N
HW09	Registered nurse	N

Note. Self-identified Indigenous status.

Data Collection

Yarning is a method of data collection commonly employed in research with and by Aboriginal people (Bessarab & Ng'andu, 2010). Given we yarned with both Aboriginal and non-Aboriginal people, the research team and advisory group agreed that this method of collection was an appropriate approach for all our participants given yarning emphasizes sharing information holistically (Bessarab & Ng'andu, 2010; Hughes & Barlo, 2021). Yarns were conducted between September 2022 and December 2022. Most yarns were individual, but two were group yarns consisting of two (n = 2) and three (n = 3) health workers, respectively, working within two different teams. Participants were advised prior to the yarns who would be yarning with them, which for individual yarns (n = 5) were conducted by both Aboriginal and non-Aboriginal researchers, with one yarn conducted by only an Aboriginal researcher. Prior to the yarn commencing, the interviewer spent time setting the scene and developing rapport with the participants to then yarn (see Table 2 for an overview of the foci of the yarns) with participants where yarns lasted between 38 and 56 min. Yarns were audio-recorded and transcribed verbatim by a professional transcription service with whom a confidentiality agreement had been initiated.

Data Analysis

The transcriptions were loaded onto the NVivo 12 platform (QSR International). Jackson Newberry-Dupe led the data analysis with input from Simone Owen, Vicki Brandy, and Amy Thompson. Prior to inductive analysis, Jackson Newberry-Dupe listened to all yarns and read all transcripts and interviewer field notes. Each transcript was analyzed individually; afterwards, initial descriptive coding was performed across transcripts, and related themes were grouped to create superordinate and subordinate themes (Bond et al., 2015). Thematic analyses were refined with input from all members of the research team. This included five Aboriginal research team members from the participating Aboriginal communities and members of the participating Aboriginal community during established community group gatherings. This process ensured our analysis was reflective of the yarns shared in the data collection process (Campbell-Jackson et al., 2014). Importantly, Kovach (2021) emphasizes when working with Indigenous research approaches, value must be placed on the subjective and interpretive nature of research to ensure knowledge is not decontextualized but rather remains reflective of the lived experiences of the participants within the study. Thus, our approach has required frequent member-checking within our team and community in conducting the analysis. The analyses were discussed with the Aboriginal Cultural Advisory Group on several occasions during the process via video link or telephone to ensure inclusivity for all members of the Aboriginal Cultural Advisory Group.

Table 2. Health Worker Yarn Guide.

What services do you currently provide to Aboriginal and/or Torres Strait Islander people and/or their families living with stroke within the Tamworth community and surrounding areas?
Do you think it's important for Aboriginal/Torres Strait Islander people who work for your organization to provide support to Aboriginal/Torres Strait Islander people living with stroke and their families?
What proportion of your staff are Aboriginal/Torres Strait Islander?
How do you think your organization is addressing the cultural safety of your clients?
What strategies are in place within your organization to recruit Aboriginal and Torres Strait Islander peoples into the professional health workforce?
Do you think these services are working well?
Can you describe any unmet needs or areas of service provision for Aboriginal and Torres Strait Islander people living with stroke in the community that could be improved within your organization?
What are the services you currently provide to Aboriginal/Torres Strait Islander people living with stroke?
Do you think the current needs of Aboriginal and Torres Strait Islander people living with stroke in the community are being appropriately met?
How can the needs of Aboriginal and Torres Strait Islander people living with stroke in the community be better met?
How and by whom are referrals made to your service?
How could your knowledge of the potential effects of stroke be improved?
How could your knowledge of the services that may be needed following a stroke be improved?
What are the current barriers for Aboriginal/Torres Strait Islander people living with stroke and their families accessing/using your service?
Who are the important stakeholders (groups or people) that you think should be involved in a project which aims to improve access to culturally appropriate stroke recovery services and rehabilitation tools?

Results

Three themes emerged from the analysis of the health worker (HW) yarns (see Figure 1), and these were (i) Culturally safe health environments to support stroke survivors, their family, and health workers; (ii) Complicated, under-resourced systems impede the capacity to support stroke survivors; and (iii) Collaborative and adaptive practices prevent people "falling through the cracks." These themes and sub-themes are described below with relevant participant quotes.

Culturally Safe Health Environments to Support Stroke Survivors, Their Family, and Health Workers

"A Safe Place to Go". Participants highlighted the importance of considering individual, family, and community factors to achieve the best outcomes for Aboriginal stroke survivors. Participants all spoke about the need to be mindful of cultural considerations and cultural safety when providing care, particularly the importance of fostering culturally safe environments. An important element of this was providing "a safe place to go":

> It's a scary time and an unpredictable time already, you know, so you just need that safe, trusting environment from the very early day, don't you? (HW02)

One participant spoke about adapting their clinical spaces into a hub for informal supports around non-health issues for the stroke survivor and their family:

> … I always make sure that this corner, this clinic is your second home, and if they don't have food, they come to us … they come to me and say, "We are in trouble, this happened, this happened, I've got nothing to eat," and they know they can get it … these are all non-clinical things, but it's a safe place, and I have created that safe place …. (HW06)

Some participants reported situations in which Aboriginal people did not feel comfortable receiving care from health professionals of the opposite sex, and times when people disliked the hospital environment or felt unsafe, contributing to people wanting to urgently leave the hospital:

> … the outpatient sort of stuff is a bit hit and miss …, ideally everything is put in place before people go home and get discharged, but I think from a patient's perspective, they just want to get home, and they'll say whatever they need to …. (HW03)

These rushed discharges would often cause further issues around follow-up care and support for Aboriginal stroke survivors when returning home: "… [creating] a bit of a drama when they get home, and then the struggle is then you've got to try and get services [for them] …" (HW03).

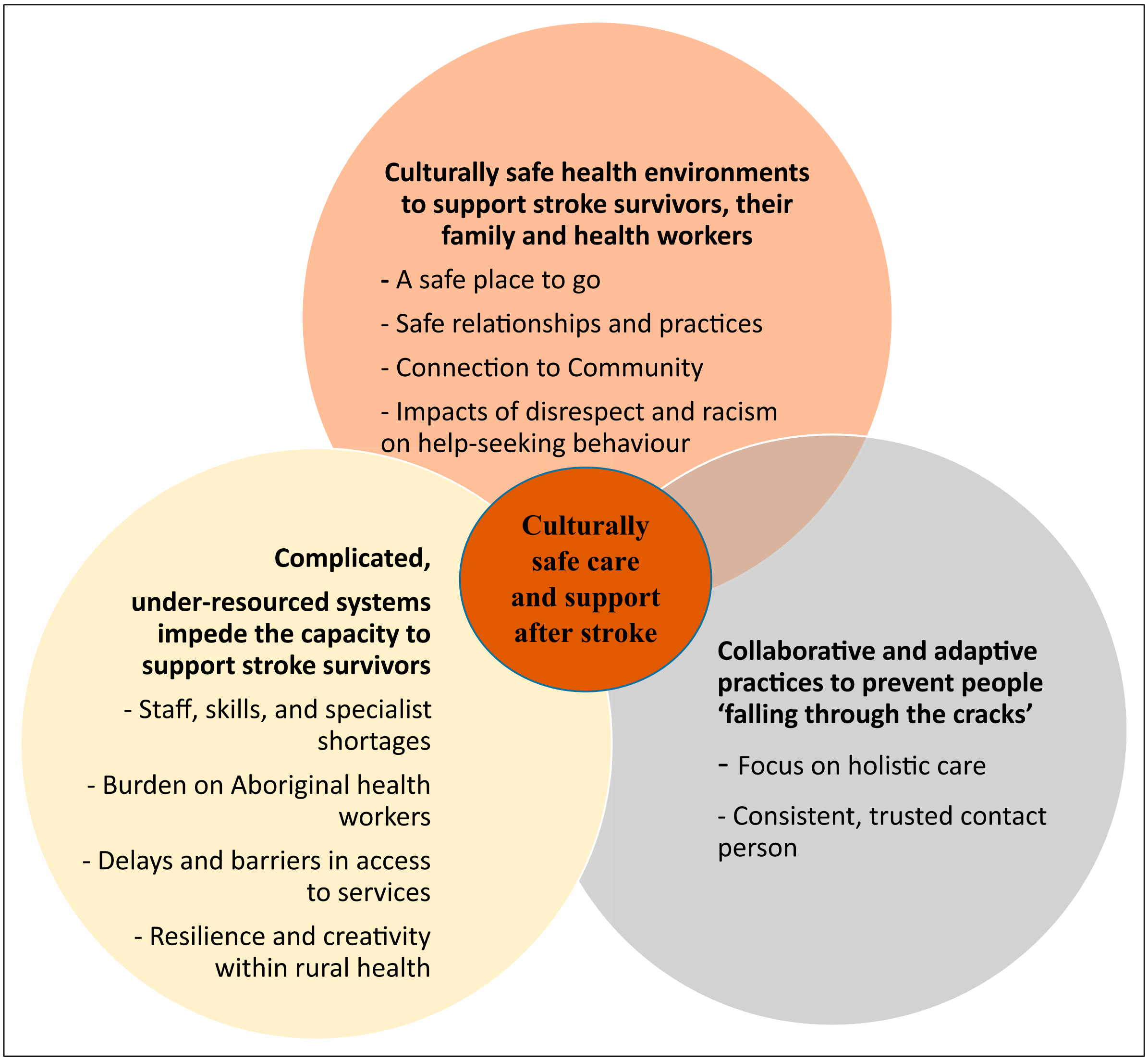

Figure 1. Culturally safe care and support after stroke: Thematic Analysis Framework.

The importance of creating safe places that can cater for family and extended kin was highlighted. One participant described the need for health workers to accept that some Aboriginal people may have many visitors during their hospital stay:

> … sometimes the clinicians don't understand that that's their culture. There are so many people … like, sometimes ten, twenty sitting outside. So, yeah, [there needs to be] somebody who can understand, explain that to the family, and organize all those things; I think we need to do that …. (HW06)

Safe Relationships and Practices. Including family in health and care conversations with the stroke survivor was seen as vital in achieving culturally safe relationships and practices. In describing what their experience had taught them about communicating big news to Aboriginal stroke survivors, participants emphasized the need to carefully consider who needed to be present, how much family input the stroke survivor desired, and who should be the one to deliver the news:

> I think, if he [the doctor] wanted to have those conversations, he should've waited with the daughter, and just had a bit more delicate approach … it's finding a point of where you should and shouldn't have those conversations as well …. (HW02)

Respondents noted that it was important for health workers to recognize that stroke survivors' decisions may not always align with health recommendations, either due to personal or family considerations (e.g., HW08, "… saw the need to support his family more, than what he needed to be in rehab"), and that health workers should aim to respect their choice. They advocated for a realistic rather than rigid approach, aiming to meet stroke survivors halfway to encourage healthy choices and behaviors where possible. One participant suggested that if services helped with family responsibilities and difficulties where appropriate, this may in turn support better engagement and adherence to stroke rehabilitation and recovery-related activities.

Acknowledging the impact that stroke could have on a person's confidence and relationships was also identified as important. One participant noted that "… it's very difficult [for stroke survivors], there's all sorts of problems in their shame and being embarrassed and going out in public [within community]" (HW09), making it hard for them to talk about the issues they were facing. The benefits of open, authentic, and trusting relationships were described, with participants feeling that this led to improved engagement and sharing of important issues. Taking time to establish relationships was seen as critical to achieving the benefits of a trusting relationship between health workers and Aboriginal people living with stroke and their families:

> … put the time in to have that yarn with that patient, that you build that trusting relationship, so then your care later down the track will probably be much easier …. (HW08)

Connection to Community. The role of meaningful engagement between Aboriginal people from their community working in health roles and Aboriginal stroke survivors and their family was seen as central to building trust:

> I think for us [Aboriginal health team based in community], we're pretty well validated [within the community], which is really helpful, … we have good, open conversations with community about what we can and can't offer, and I think that that's, for me, I think that's really important …. (HW03)

Aboriginal people are employed in many health service roles in this community. There are roles identified exclusively for Aboriginal people to support engagement in health services within this community, these being an Aboriginal liaison officer, a role based within the hospital setting to support Aboriginal and/or Torres Strait Islander people during their emergency presentation and/or inpatient admission, and an Aboriginal health worker, a community-based role to support engagement with health care in the community. Participants raised the complexities of engaging Aboriginal people working in health service roles, as they were often described as being stretched beyond their capacity, sometimes having to assist in facilitating a connection between the community (not just the stroke survivor) and health services. This unofficial role was attributed to the fact that "… there are not many Aboriginal Liaison Officers" (HW06) and they are "… stretched so thin" (HW08).

Employment of Aboriginal people in health worker roles was perceived as advantageous for creating a safe environment for stroke survivors, given their ability "to develop a bit of a connection where you've got some common ground …" could mean that "… the conversations [about sensitive health topics] are probably a little bit easier to navigate" (HW03). This was perceived as beneficial and valuable in improving the relationship between health services and workers and the Aboriginal community. However, some noted that health workers who were well connected to the community may not always be the person of preference for the stroke survivor and it was important to balance the need to build rapport with the need to respect a stroke survivor's preference: "… some may not want a culture person because that culture person knows the family, and they worry about the privacy …" (HW01), this being a limitation that was described in the context of an under-resourced system. For example, having one Aboriginal person in a liaison role for an entire health service team may limit options for a stroke survivor who may have a personal or family relationship with the health worker.

In discussing why Aboriginal people tended to confide more in Aboriginal staff, respondents articulated the differences between yarning and typical clinical interviews. The fluidity and informality of a yarn was suggested to mean that "… they open up more, and they just tell you everything, and then you just find these little gems of things that you need to go, 'Okay … that could be looked at'" (HW02), with a focus on conversation, rapport, and relationship building. Respondents acknowledged that non-Aboriginal people were sometimes necessary to ensure coverage of services required. Educating non-Aboriginal health workers was suggested as an important strategy to ensure that care being delivered was culturally safe. Some felt that whilst services were making efforts towards creating a culturally safe environment (e.g., spaces to go with family), there was much more potential to improve cultural safety through health worker practices: for example, non-Aboriginal health workers gaining knowledge and skills in (i) delivering culturally safe care and (ii) developing better therapeutic relationships with stroke survivors, by connecting to Aboriginal stroke survivors and their families on a deeper level:

> … we do a lot of um Aboriginal education around respecting the difference and stuff, … but when you get down to the

> nitty gritty, you want to actually develop those relationships and knowing how to talk to Aboriginal people and how to connect to their families, I don't think that's done very well …. (HW08)

However, knowledge and use of appropriate and safe individual cultural practices was not always enough. Providers acknowledged important considerations when engaging non-Aboriginal health workers to deliver care and highlighted how some of the limitations could be managed. For example, the value of, wherever possible, delivering care to stroke survivors in cooperation with Aboriginal health workers was raised:

> … I can't do what I do without [my Aboriginal health worker colleagues], and any of the Aboriginal staff that I work with because of that, you know … there might some clinical stuff that I can kind of bring to the table, but I rely on these guys to really bring the cultural sort of expertise to the table in the interacting with community …. (HW03)

Although overstretching Aboriginal people within health worker roles was identified as a concern, the value of Aboriginal staff with a holistic picture of patients' trajectory through their work in different services was noted. Aboriginal staff working across multiple services was considered a great asset, enabling a service team to anticipate and mitigate difficulties; the worker described as being able to give [the team] "… a little bit of a heads-up on what kind of might be happening with somebody as they've just got home from hospital …" [HW03].

Participants reported the importance of having knowledge of culturally safe, flexible, and trusted services that they could recommend when having to refer stroke survivors onto other services. Some participants reported difficulty in ascertaining how culturally safe services were:

> … bad experiences they have experienced with other clinicians where they have shown, like, discrimination …. So, what I normally do is, I change my pathway … and try and make them feel less stressed when they go there … sometimes the main issue is the connection with the clinician; which jeopardizes the outcome. (HW06)

Impacts of Disrespect and Racism on Help-Seeking Behavior. Participants highlighted the consequences of bad experiences as well as dismissive and racist behaviors experienced by Aboriginal stroke survivors in this community, on their willingness to engage with health services. Participants noted that disrespectful behavior by service providers not only reduces stroke survivors' help-seeking behavior and engagement with health services but also influences others within their family and community, as negative experiences are talked about and shared:

> … it can do damage … and that goes onto other family members, too, and it's a vicious circle where the rest of the family then won't trust in that service, and it continues on …. (HW02)

Service providers may underestimate the flow-on effect of these dismissive behaviors, particularly in how they are communicating to stroke survivors non-verbally, for example, through dismissive body language: "It's not just the language, the communication, it's how you communicate it to the person sitting in front of you …" (HW06).

Participants also suggested that historical mistreatment and bad experiences contributed to low trust, with Aboriginal stroke survivors having low engagement with health care generally. This at times resulted in people disengaging with rehabilitation and some people being completely lost to follow-up. One participant identified instances where Aboriginal people were being dismissed by health care professionals at important time points, such as when they have sought help during acute events such as stroke:

> … this is what I've heard from people, okay? Going to Emergency Department, going … getting things done, sometimes they say, "Yes, just because we are Aboriginal, this is … we don't get listened. We don't get a good deal. We are not heard." … They keep saying this to me …. (HW06)

Complicated, Under-Resourced Systems Impede the Capacity to Support Stroke Survivors

Staff, Skills, and Specialist Shortages. To improve a service's capacity to provide adequate and respectful care, participants noted that "… it's always about educating all of the hospital staff" (HW02) and other service providers around respectful dialogue, the services, and programs available to Aboriginal stroke survivors, and stroke information. However, participants also noted that many of the obstacles faced by Aboriginal people navigating the health care system following a stroke were a result of structural, system-wide issues. For instance, participants commonly identified staff, skills, and specialist shortages as a barrier to provision of care:

> … we lost four [GP's] … when you are short of staff, you try and find shortcuts. It should never happen, right,. So, they don't go ahead, take a history, examine, do investigate, listen to the person why this is happening … and this happens …. (HW06)

This included a lack of appropriately skilled health workers in community-based services specifically designed to support Aboriginal people living with stroke and the impact this had on their ability to support people during recovery in community:

> … we have a position here for a social worker but that hasn't been filled for probably six months … I don't know if at the moment here, we have the capacity, know what I mean? I don't know if we are able to do that [support stroke survivors in recovery well] but it's a sad thing to say. (HW09)

In describing resource shortages and oversubscription of health services, many noted that the burden was being felt by health care workers. In reference to possible strategies involving Aboriginal people working in health roles, some participants were quick to identify the lack of time already prevalent within these roles as a barrier to effectively delivering the care at the client's pace:

> … it's somebody who definitely that person who feels connected to … that has a trusted relationship with the patient, … you don't want to be rushing through this sort of stuff. You need to give people time, whether they've had a stroke or not, but I think, particularly if they've had a stroke, to be able to just kind of take it at that person's pace …. (HW03)

Burden on Aboriginal Health Workers. In line with the difficulties faced in recruiting people to health roles to support Aboriginal people, it was noted that the burden on Aboriginal health workers was particularly heavy, with too few positions within the hospital setting to meet the demand for liaison, advocacy, and general support for Aboriginal people with a stroke diagnosis in hospital settings:

> … the main support really, is through the [Aboriginal Liaison Officer]. … there has been lots of challenges … just getting access to [them] … [They] look after the whole [setting] and even though our rehab patients are here for quite a long time and often very complex, they still don't trump the needs of someone that is acute …. (HW08)

Similarly, respondents noted that community health providers may not have capacity to deliver the level of support required due to oversubscription and limited bridging services between hospital and community:

> … a person who's had a stroke, who's chosen not to do the rehab and gone home, and then everything's sort of fallen in a bit of a heap, and then it's kind of, "I'll go and see the GP and they'll sort it out," I just don't believe that they're that well-equipped to be able to put all of that sort of stuff together; they don't have time either …. (HW03)

Delays and Barriers in Access to Services. With under-resourcing leading to overworked staff, providers reported that they sometimes struggled to stay on top of changes in the funding schemes available to support stroke survivors. Similarly, many reported that the process of setting clients up with home care packages is overly complex, resulting in delays and barriers in access to services. This was raised as a difficulty experienced by some stroke survivors who were expected to progress their applications on their own that was seen as particularly arduous when applying for NDIS support:

> … takes, such a long time and we often they have to stay in [hospital] until we can get a plan and get equipment and funding and you know, all those sorts of things for them, which is hard again for them, you know, to stay in longer. (HW 08)

In line with this theme, one participant noted that stroke survivors did not have an independent advocate in the system. This places the onus on care providers to chase up stroke survivors and then to secure packages and advocate for their prospective clients, meaning people living with stroke must choose from those providers who approach them rather than seeking out providers themselves. Some providers noted that the time taken to prepare and process applications meant that packages were sometimes delayed, with bridging care plans from hospitals not always covering the entire waiting period. This could result in additional cost burdens for clients while they waited for their funding to be finalized:

> … with our home care service, there is client contribution, so people decline because of that reason … they've gotta pay …. They'll be like, "Oh, we'll wait to see if we can get our package" …. (HW01)

One respondent also suggested that while giving packages for self-management could empower stroke survivors and reduce nepotistic and unsatisfactory referrals noted in the previous tendering process, the current model did not provide them with enough support to manage the added responsibility.

Providers identified other factors contributing to access issues for Aboriginal stroke survivors, noting "… transport is a big barrier …" (HW09) and pointing to financial barriers due to lack of bulk-billing services. Similarly, respondents reported that clients' access to care was limited by service catchments and lack of local services for those living in regional or remote areas, who may be unable to access support without long commutes:

> I find the biggest, um, well the hardest thing is when, say for example, a patient wants to go back to Country …. Um, the lack of services that we can provide, compared to here … you

> can't sort of set them up like we've got here, because we've got Meals on Wheels, or community nursing …. And even GPs, like, there's very limited GPs. (HW02)

Resilience and Creativity Within Rural Health. Some participants provided examples of resilience and creativity within rural health *services* they felt were under-resourced to meet patient needs and identifying ways they partnered with other providers in the area to ensure stroke survivors' unique social and financial needs were met:

> … we don't have a lot of bulk billing people, but yes, there's one [physiotherapy] practice who has agreed to help me with bulk billing, so I send my patients to them. If they [the stroke survivor] don't want to do that, I teach them what to do. We give transport, get them to the clinic, explain what happened and try and explain the neuro plasticity … how you can, you know, even though sometimes you can't get where exactly you were before, but at least we need to try …. (HW06)

Collaborative and Adaptive Practices to Prevent People "Falling Through the Cracks"

Focus on Holistic Care. Service providers all felt that there was a need for stronger *focus on holistic care* in service delivery to facilitate successful transitions from hospital to home-based care. In describing how service providers could better support Aboriginal stroke survivors transitioning from hospital to community, respondents suggested that having good connection between hospitals and community support services was vital:

> … I think it has to start from the hospital, right? And so there has to be a handover process …. Maybe the Aboriginal Liaison Officer to handover to this side, and say, "Hey, you need to organize this visit, organize the transport, do this, do that," and hand it over so they will have a smooth journey … every Aboriginal Health …. AMS has Aboriginal Health Workers, that's what they do, but there is no … this connection, it doesn't happen … the communication. (HW06)

Similarly, some respondents expressed a desire for greater inclusion of community care teams in the initial well-being planning meetings between the hospital team, family, and stroke survivor:

> … She's a coordinator, so she's the one that manages the clients …. She coordinates the care. So, she would do the well-being plans with the clients … a worker would go into the home to provide the services …. (HW01)

For others, the importance of providing mental health support to stroke survivors was seen to improve outcomes after hospital discharge:

> … the other thing is the stress, the anxiety, the mental health part … all of a sudden this has happened, and now they can't walk, or yeah, they can't do what they were doing before, so provide that support; that's very important. (HW06)

Flexible care and home visits were emphasized as an important component of holistic care, to reduce the need for repeated hospital visits after initial discharge:

> … that expectation that people get discharged from hospital, but then they've got to come back to hospital to receive treatment or therapy … doesn't kind of sit well with people, because they've just come out of there, you know … then they have to come back, you know? We see that with cardiac rehab, you know, "Oh, they want me to come back but they've told me I'm right to be at home, so …." (HW03)

Consistent, Trusted Contact Person. Many felt that having a consistent, trusted contact person for Aboriginal stroke survivors for the duration of their recovery journey would provide greater connection and engagement with services:

> … I think that there should be some sort of Aboriginal Health Worker or someone present … that can just sit there and, you know, just interpret the [jargon] …. Yeah, got a bit of a clinical background and can interpret for the family, and ask the questions that they might be too scared to ask, because it's not just Aboriginal people, but elderly people go, "Oh, yeah, yeah, I'll be okay. I'll be right. It's okay," but really, they're not, and they don't … yeah, they're too ashamed to ask those questions. (HW05)

Some participants felt that this service would be most important at the start, to help in building trusting relationships between stroke survivors and service providers. After these had been established, it was suggested that this contact person could step back and act on an "as-needed" basis:

> … if they're sort of set up with everything at home with the community nursing, an Aboriginal Health Worker, everything they need with the OT, and everything is set up, I feel as though then, I sort of say to them, "I'm still here," but I kind of … then, unless they come back sort of back into the hospital, that's sort of … that's me sort of done there … because there's obviously been that fear of institutions and going to appointments and GP's, so that is the biggest key, is building that trust. (HW02)

Discussion

The study was conducted to explore the experiences and perceptions of health workers who deliver stroke recovery services to Aboriginal people who have experienced a stroke in the Tamworth and Quirindi areas of New South

Wales, Australia, part of Gamilaraay/Gomeroi Country. Yarns with health workers within this regional community revealed the importance of ensuring culturally safe health environments for the stroke survivor and their family to enable equitable access and engagement in the rehabilitative care and the support needed during their stroke recovery. Health workers also identified the significant role they, other health workers, and collaborative practice, led by both Aboriginal and non-Aboriginal workers, play in creating these safe environments for Aboriginal stroke survivors. They also raised the impact that a person's previous experience of health systems and racism and disrespect has on an Aboriginal stroke survivor and their family's ability to determine their own stroke recovery journey.

The Importance of Cultural Safety

Cultural safety, a concept that emerged in New Zealand (Ramsden, 1992) and being increasingly utilized in Australia (Laverty et al., 2017), recognizes the impacts of colonization and power inequalities on Indigenous people globally and seeks to understand how these are manifested in health service delivery. It is essential for delivery of effective health care (Cairns et al., 2022). Determined by the consumer rather than the health care provider or service, culturally safe services lead to enhanced health outcomes for Aboriginal people (Aspin et al., 2012). It is very important to acknowledge that hospitals were, and in some places continue to be, unsafe places for Aboriginal people and their communities. The legacy of segregation, assimilation, and racist practices runs deep in histories of communities in rural areas, particularly in the hospital setting (Durey & Thompson, 2012; Durey et al., 2012, 2016). Acknowledging this history is important to contextualize the experiences reported by health workers in our study which revealed how past and present experiences of racism and disrespect when engaging with health services led to negative experiences for Aboriginal people living with stroke. This outcome has been reported previously (Shahid et al., 2011, 2013).

Perceptions of lack of cultural respect and sensitivity, such as lack of family space and poor cultural knowledge, lead to the experience of diminished cultural safety (Mbuzi et al., 2017). Participants in our study shared similar perceptions about the importance of the need to create "safe spaces" for and deliver culturally safe care to the Aboriginal stroke survivor and their family members and visitors. Health service providers must re-examine current practices and, where feasible and capacity enables, partner with Aboriginal peoples in their health service workforce, to ensure they are delivering stroke care that is respectful, culturally safe, and competent.

Given the diversity of Aboriginal and Torres Strait Islander cultures in Australia, it is not feasible to expect that cultural competence can be gained through a one-off course. To ensure cultural safety for stroke survivors, and as Ramsden (2002) suggested, health workers must continually self-reflect about their positions of power, attitudes, and assumptions so as to be better positioned to develop a therapeutic relationship that is free of racism and a power imbalance. Delivery of equitable health care outcomes requires both the people working within and the people managing health systems, to be aware of cultural issues, and undertake these ongoing reflections, to remain self-aware and able to make changes to practice as required (Smith et al., 2022).

Building Trust

A fundamental element in creating culturally safe health experiences after stroke was the formation of trusted relationships between health workers, the stroke survivor, and their family. One way to build these trusted health relationships is through the culturally safe practice of "clinical yarning"; an informal patient-centered conversational manner where over time and, through the sharing of stories and active listening between both the patient and health worker, trust is gained, learnings are shared, and information is exchanged (Lin et al., 2016). A health system in which health workers are better supported to understand the importance of clinical yarning and then are given time and encouraged to incorporate "clinical yarning" when working with Aboriginal people living with stroke would be a positive step towards addressing some of the negative experiences reported in this study.

Developing trust is important because distrust is often accompanied by experiences of discrimination and racism and has been found to contribute to a sense of disempowerment of Aboriginal patients, with some people believing that in order to engage with mainstream health, they had to abandon their cultural beliefs and practices (De Zilva et al., 2022). Creating a health service environment staffed with people who know how to build trust and respect Aboriginal people and acknowledge their cultural needs and the value of their contribution in delivering health care will support people living on Gamilaraay/Gomeroi Country and other surrounding communities, to achieve optimal recovery outcomes and quality of life after stroke.

Inclusion of Family

The importance of family inclusion in service delivery was also emphasized by the health workers in this study. Given the importance of family to Aboriginal people of Australia as a recognized feature of culture, this is not surprising (Artuso et al., 2013; De Zilva et al., 2022;

Green et al., 2018). The need to include family in all aspects of stroke service delivery must not be underestimated as it plays a major role in enhancing the individual's perception of the delivery of culturally safe practice and aids in the communication of health care and in important logistical support. However, it is also important to avoid blanket generalizations and listen to the needs of individual stroke survivors and their families. For example, although it is common for Aboriginal peoples to attend to their families and kin at the hospital, it should be noted that there are diverse practices regarding hospital attendance, where some Aboriginal families feel it is best not to "rush around the bedside" as it might cause undue stress on the person (i.e., they may think everyone has rushed there because they might be very unwell or dying).

Support to Navigate Stroke Recovery

The difficulties for stroke survivors and family navigating health services and the recovery process more broadly after stroke have previously been documented (Armstrong, McCoy, et al., 2021; Quigley et al., 2019). For example, Armstrong, Coffin et al. (2021) found individuals weren't consistently followed up after leaving hospital and were unsure who to contact if follow-up post discharge did not occur. Additionally, some participants reported that outpatient services were challenging to navigate, and they highlighted the need for support to deal with multiple issues, such as co-morbidities and financial and social changes after stroke (Armstrong, Coffin, et al., 2021). As was reported by health workers in this study, this post-stroke experience can be made even more challenging for people living in regional, rural, and remote areas where access to evidence-based care is suboptimal and, for Aboriginal people and communities, frequently not inclusive of their cultural needs and wants. Need for support to navigate this journey was proposed by many in this study, with the suggested model being a support role that helps people navigate their stroke recovery journey, and that is held by an Aboriginal person that is trusted within the community. The idea of an Aboriginal person within a health "navigator" role is an idea that has been trialled with Australian Aboriginal people in a range of contexts including recovery after brain injury, including stroke (Armstrong, McCoy, et al., 2021), within community-based mental health (McKenna et al., 2015), and within inpatient and outpatient cardiac care (Taylor et al., 2009).

Limitations and Future Research

The study included health workers from a specific location in Australia. Aboriginal people are not homogenous in their experiences or beliefs and so, given the specificity of the study, generalization of the findings to other Aboriginal people, communities, and health workers is not necessarily possible without considerable consultation and engagement in the local context. In addition, even though the number of participants is small, and generalizability may be limited, this study presents learnings consistent with those gained from similar work completed with health workers throughout Australia. It adds to the growing knowledge base concerning factors health workers perceive to be important for the delivery of culturally safe stroke recovery (Kelly et al., 2022; Quigley et al., 2019) and further strengthens the argument to design and implement models of care informed by community experience and proposed solutions.

Conclusion

This study, exploring the experiences and perceptions of health workers working with Aboriginal people living with stroke (and their families) on Gamilaraay/Gomeroi Country, provides important information on potential ways to improve the cultural safety of stroke recovery care. It highlights the importance of developing trusted and inclusive health relationships with both the person with stroke and their families, the potential value in providing support to navigate the stroke journey and the (under-resourced) health system, and the impact that the absence of such supports coupled with disrespectful and racist treatment can have on access to effective care throughout the various stages of the stroke recovery journey. These learnings will be used in future co-design work between this community and their research and health service partners to develop culturally responsive stroke recovery strategies and partnerships to optimize the health, spirit, and well-being of Aboriginal people living with stroke.

Author's Note

NB: Our research group works with Aboriginal people from Gamilaraay/Gomeroi Country located in the north-western plains of New South Wales Australia. "We recognize the diversity of Aboriginal and Torres Strait Islander people from across the many countries of this place we now call Australia. Recognizing this, throughout this text, we have used the preferred term 'Aboriginal people.'"

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