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Building readiness for inclusive practice in mainstream health services: A pre-inclusion framework to deconstruct exclusion¹

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ABSTRACT

Across the globe, people are not equitably included or respected by health services. This results in some people being 'hardly reached' and having less access to safe and appropriate care. While some health services have adopted specific agendas to increase inclusion, these services can struggle to implement such strategies because the underlying reasons for exclusion have not been addressed. This calls for preparation prior to implementation of inclusion approaches that deconstruct discourses and practices of exclusion. This paper presents a pre-inclusion framework that seeks to deconstruct exclusion in health services. Authors developed this framework from action research in four 'mainstream' regional health services in southeast Australia over five years. Research identified dominant discourses of exclusion among staff in these services. The study also identified common experiences of residents hardly reached by these services. Following, a range of change activities were undertaken within these services to deconstruct exclusion. Researchers also kept journals, reflected on their impact, and identified lessons learned from trying to deconstruct exclusion. Triangulating these analyses, researchers developed an interdisciplinary framework that weaves together Foucauldian theory on power/discourse with continuous quality improvement processes to embed cultural humility and voices of the hardly reached in health care. The framework outlines five foundational concepts (power as productive, deconstruction, use of continuous quality improvement processes, cultural humility and voices of service users), followed by six principles (a journey, expect resistance, whole of service approach, make visible the reasons for change, we are all cultural beings and people centred care) and six actions undertaken within health services (commitment, assessment of exclusion, action plans, structural change, reflective discussions and engagement). Until such approaches to deconstruct exclusion are implemented, inclusive agendas are likely to be ineffective.

1. Introduction

Internationally, not all people are equitably included or respected by health services. This lack of inclusion places the health and wellbeing of some people at risk (Bastos et al., 2018; Bond et al., 2019; Bourke et al., 2019; Helman, 2007; Hole et al., 2015; Luchenski et al., 2018; Malatzky et al., 2018a; Marmot, 2018; Sokol and Fisher, 2016; Wallace et al.,

2020). Evidence is clear that when health services are not inclusive and safe, those experiencing exclusion are less likely to use them (Durey et al., 2013; Helman, 2007; Hole et al., 2015; Levesque and Li, 2014). These residents are then 'hardly reached' by health services due to dominant practices that work to 'gatekeep' access to health care (Sokol et al., 2015, 2016).

Thus, there is clear need for inclusion of the 'hardly reached' whose

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circumstances prevent access to health care (Wallace et al., 2020). Internationally, governments have developed frameworks, audit tools and other strategies to increase the inclusiveness of health services (McIntosh et al., 2019; O'Hara, 2006; Victorian Government, 2017, 2019). However, to date there is no one framework acknowledged to achieve this (Luchenski et al., 2017). Most frameworks focus on inclusion for specific groups, placing awareness on differing cultural beliefs and practices as well as health needs and outcomes of the 'other' (Downing and Lowal, 2011; Malatzky et al., 2018a). These approaches are also problematic because there is little acknowledgment of the intersectionality of these groups (Luchenski et al., 2018). Further, inclusion frameworks have challenges within health services because little attention is given to the cultures of health professionals and health services, and it is assumed that health services are capable of implementing frameworks across the whole organisation. Most importantly, these frameworks do not challenge the reasons for exclusion, and so the barriers to inclusion continue. Trying to implement inclusion frameworks in organisations that are not informed about, ready for, or understanding of why exclusion exists is often unsuccessful (Downing and Kowal, 2011; Kumaş-Tan et al., 2007; Newman et al., 2013). Engaging the hardly reached with such services can again place them in unsafe situations (Sokol et al., 2016).

While inclusion is often the focus of strategies to engage the hardly reached, addressing exclusion in health care is less interrogated. Adopting Peace's (2001, p. 34) perspective, exclusion is understood as "ways of naming" the collective processes that work to deprive people of access to opportunities and means, material or otherwise, to achieve well-being and security in the terms that are important to them". Exclusion is multi-dimensional, dynamic, relational and underpinned by unequal power relations, where the hardly reached are repeatedly disempowered in diverse ways when seeking, negotiating and utilising health care (Freeman et al., 2019; McIntosh et al., 2019; Mor-ton-Robinson, 2014; Popay et al., 2008). Therefore, before inclusion can progress, exclusive practices need to be challenged. This calls for change by health services to rupture power relations that maintain exclusive practices (Bastos et al., 2018; Bond et al., 2019; Malatzky et al., 2018a).

This study proposes a pre-inclusion framework that prepares 'mainstream' health services for the implementation of specific inclusion frameworks. This pre-inclusion framework challenges thinking of the dominant group and gently deconstructs dominant discourses to embed cultural humility and voices of the 'hardly reached' into health services (see Malatzky et al., 2018a). Drawing on the works of Malatzky et al. (2018a) and Mitchell et al. (2018), this pre-inclusion framework was constructed from action research in four mainstream health services over five years. The aim of this paper is to present this new framework that prepares mainstream health services for implementing other inclusion approaches. Before presenting the empirical work, the paper begins by outlining the conceptual thinking underpinning the framework.

2. Conceptual approach to the study

Prior to specific inclusion work, exclusive practices warrant deconstruction (Malatzky et al., 2018a). Therefore, the project embedded a Foucauldian perspective where power is viewed as productive rather than repressive (see Foucault, 1995; Foucault and Gordon, 1980). As effects of power/knowledge, discourses from within and outside a health service guide and normalise particular understandings, forming certain truths that are reproduced into normative ideas and standardised health care practices not necessarily intended to exclude (Carabine, 2001; Foucault, 1995; Foucault and Gordon, 1980). It is these normalised knowledges and actions leading to exclusive practices that require reframing (Sjoberg and McDermott, 2016) to avoid new practices of inclusion being subjugated by normalised knowledges of exclusion.

It is only those experiencing exclusion, disengagement or lacking access that can identify exclusionary discourses (Gatwiri et al., 2021;

Paradies, 2016). To avoid assumptions about all individuals of a specific cultural or demographic group, this research follows Sokol et al.'s (2015, p. 520) focus on the "circumstances" of the hardly reached that denies their access to services rather than their identity. Ways to hear, empower and give voice to the hardly reached identifies not only practices of exclusion but also the discourses underpinning them. Further, given the diversity and intersectionality of the hardly reached, in conjunction with the multi-dimensional, dynamic and relational forms of exclusion, identification of dominant discourses underpinning exclusion is what can drive change. Deconstruction of these discourses within health services can prepare health practices for engagement with the hardly reached.

While it is the excluded that identify exclusion, change is needed from drivers of these practices. This places the cultural position of staff and the culture of the organisation as relevant to how exclusive discourses manifest (Fredericks, 2010; Rix et al., 2014). A cultural humility approach encourages health professionals to reflect on their own cultural assumptions and position of power (Dudgeon et al., 2014; Foronda, 2020). As (Tervalon and Murray-Garcia, 1998, p. 117):

Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

As established understandings of health care practice are not easily challenged, it is expected that some staff will resist destabilising these previously accepted truths (Foucault, 2002; Foucault and Gordon, 1980; Malatzky et al., 2018a). Hence, change initiatives are well served to align with accepted health service change processes. Continuous Quality Improvement (CQI) processes have been found to be effective in achieving observable, actionable and longterm inclusion change in health services (Durey et al., 2012; Larkins et al., 2019; Mitchell et al., 2018). The CQI process complements an action research approach and can be aligned with perspectives that view power as exercised by all to both resist and conform to dominant discourses (Mitchell et al., 2018; see also Durey et al., 2012). CQI provides health care workers with a mechanism through which to identify areas of exclusion, openly discuss their concerns and develop actions to address the exclusion. As CQI methods are now routine in health care, they can be easily understood, incorporated into planning, and divide change into smaller steps (Durey et al., 2012; Gardner et al., 2010; Mitchell et al., 2018; Renzaho, 2008). Research in Australian Aboriginal settings suggests that CQI processes can embed change in health service systems, enhance collaboration and teamwork, embed local history and culture into health service practices, enable two-way learning between the community and health professionals, and involve community in the design and implementation of change, although these require trust and workforce stability (Larkins et al., 2019; Redman-MacLaren et al., 2021).

With an interdisciplinary weaving of a Foucauldian lens, voices of the hardly reached, cultural humility and CQI processes, action research was undertaken in four 'mainstream' health services and their local communities. Learnings from these processes along with researcher reflections were used to construct a pre-inclusion framework. This paper presents this pre-inclusion framework that deconstructs exclusive practices in health services to prepare services for specific inclusion approaches.

3. Methods

3.1. Setting

The study was undertaken in a rural region where inclusion is necessary due to fewer services, less choice of services and greater health needs (McIntosh et al., 2019; Wakerman et al., 2008). Action research

was undertaken in four ‘mainstream’ health services in this region of southeast Australia. The four health services differ in size, health focus and engagement with particular service user groups. Health service 1 is a medium sized health service in a regional centre that focuses on primary health care and wellbeing services. Health service 2 is a small mental health and wellbeing service in the same regional centre. Health service 3 works with families to support child health while health service 4 is a small hospital based in a rural town 35 km from the regional centre. The four services differ in their understandings and practices relating to cultural humility and inclusion.

The relationships between researchers and the services developed differently. Researchers approached health service 1 as a local leader in cultural inclusion. Researchers also approached health service 3 because it is a health service working with all families across the entire community. Health service 2 wanted a partnership in research, while health service 4 approached the researchers to improve First Nation Australians’ experience of their service. While the relationships began differently, researchers gained support from the executives of the four services for action research and then joined working groups, committees and attended staff and/or management meetings to jointly design activities related to deconstructing exclusion.

3.2. Researchers

The subjectivities of the researchers are also important. The research was initiated by three White female researchers (authors 1, 2 and 4) who, upon hearing the message from a First Nations colleague, adopted the position that inclusion was the responsibility of the privileged and requires rupturing power relations within ‘mainstream’ (see [Malatzky et al., 2018a](#)). They embarked on a journey of learning and action to assist health service partners deconstruct exclusion to become more inclusive. They partnered with author 6, another White female researcher who resided in a metropolitan region in southeast Australia. Receiving research funding, they employed a woman of colour (author 3) as a researcher to work with them. In addition, community co-researchers were employed to assist with interviews and Aboriginal researchers from their department also conducted interviews. Later in the project, a male researcher of colour (author 5) joined the team who brought experience from Bangladesh and insights into exclusion. The research team acknowledge their non/Whiteness, genders, own experiences of exclusion, diverse professional backgrounds (sociology, anthropology, language, health services research and pharmacology) and residence in/outside the rural region of study as some of the

Table 1
Data collection in each of the four health services.

Project Phase	Type of Data Collection	Health Service 1 (90 staff)	Health Service 2 (25 staff)	Health Service 3 (16 staff)	Health Service 4 (300 staff)
Phase 1 Assessment of discourses	<i>Initial Interviews (2016–2017)</i>	20 interview with staff and board members	15 interviews with staff	6 interviews with staff	4 focus groups with 28 participants
Phase 2 Consumer discourses of health services	<i>Consumer interviews (2018–2019)</i>	119 participants • 76 individual interviews • 7 small group interviews with 15 participants (2–3 in each interview) • 5 focus groups with 28 participants • 21 First Nation • 63 from non-English speaking backgrounds (including 12 refugee or asylum seeker participants) • 37 under 25 years • 15 members of the LGBTQIA + community • 43 parents • 79 identified as female • 40 identified as male			9 interviews with First Nation participants
Phase 3 Action research to increase inclusion	<i>Participation on health service committees (2016–2020)</i>	Meetings with CEO Meetings with senior manager Regular meetings with staff advisory group	Community advisory group Quality and risk committee Meetings with Manager	Meetings with manager	Cultural responsiveness working party Community and cultural governance committee Member of the Board for 12 months
Phase of Project	Type of Data Collection	Health Service 1	Health Service 2	Health Service 3	Health Service 4
Phase 3 Cont’d	<i>Discussion groups and reflective learning activities (2016–2019)</i>	3 discussion groups on access & equity, sameness, and culture & privilege with 33 participants 4 discussion groups on engagement, communication, health & wellbeing, and culture with 29 participants	1 discussion group on approaches to health and health care with 8 participants 1 discussion group on engagement with 7 participants 1 discussion group on complex case studies care with 8 participants	1 discussion group on culture and cultural norms with 17 participants 1 activity group on othering and stereotypes with 14 participants 1 discussion group on clinical challenges with 8 participants	Regular meetings with staff advisory group Meetings with each team 5 discussion groups on White privilege, sameness and diversity in the local community 13 activity groups on access, equity and diversity with 65 participants 10 discussion groups on asking the question’ with 50 participants
	<i>Other activities (2017–2018)</i>				Review of 14 different types of Admission and discharge documentation Flyers on walls and regular information in newsletters on inclusion
Phase 4 Reflective learning of researchers	<i>Journal entries (2017–2020)</i> <i>Team meetings</i>	Fieldworker 1: 40 entries Fieldworker 2: 89 entries Notes from discussion at 47 research team meetings			

subjectivities underpinning construction of this interprofessional pre-inclusion framework (Dieleman et al., 2017).

3.3. Research design

The research adopted a multi-stage, mixed methods, decolonising methodology to develop a framework to deconstruct discourses of exclusion (Malatzky et al., 2018a; Mitchell et al., 2018). This was undertaken through five interwoven phases, each outlined here.

Phase 1: The first phase sought to make visible the *dominant discourses reproducing exclusion* within each health service. Ethics approval was gained from The University of Melbourne (Ethics ID 1546059 and 1750926) to conduct initial interviews and focus groups with staff in each service. In health service 1, 20 staff and leaders were randomly selected for interview while in services 2 and 3, all staff were asked to participate in an interview, and in service 4 all staff were invited to attend focus groups (see Table 1). In these initial interviews, staff were asked about their work, their clients, diversity and what would increase use of the service by the hardly reached. Interviews and focus groups were audio recorded as well as by notes. Analysis of transcripts was informed by a critical discourse approach to identify the dominant discourses underpinning cultural practices and exclusion in these services (Nielsen and Glasdam, 2013). Given that place and setting are important, analysis was conducted separately for data from each service. To begin, all transcripts and notes were coded to identify “statements which cohere in some way to produce both meanings and effects” (Carabine, 2001, p. 268) about exclusion as identified by previous literature, themes of service users arising in phase 2 and identification of exclusion by non-White researchers. Where there were common codes within the same service, these were identified as normative meanings and practices relating to exclusion which were then integrated to identify dominant discourses (Edley, 2001). Because of the large amount of data, only the major dominant discourses common to each service are summarised here. More detailed analysis of the discourses and language reproduced by health professionals are presented elsewhere (Malatzky et al., 2018b, 2020a, 2020b, 2020a; Mohamed Shaburidin et al., 2020a).

Phase 2: The second phase sought out the *experiences of those who are hardly reached* by health services. The four health services identified particular groups they felt they hardly reached, specifically, First Nations, Culturally and Linguistically Diverse (CALD), Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, A-sexual and non-gender binary (LGBTQIA+), new parents and young people, particularly those under 25 years with mental illness and/or identifying as male. Ethics approval was gained (Ethics ID, 1852528 and 1648254) to conduct interviews and focus groups with these groups about their experiences of access to and use of health services. Community co-researchers with these same identities were employed to assist with recruitment and interviewing. Participants were recruited through researcher networks and relationships and also at community groups, hubs and public places. Some interviews were not conducted in English and were later translated and transcribed. Interviews were conducted with individuals, as small groups, or as focus groups, at the choice of the interviewee/s. Participants had diverse sociocultural identities and many could be grouped into more than one of the above identities (see Table 1). All were asked about their use of and access to health services, what makes a safe and welcoming service, and experiences with any of the four specific health services. Transcripts were coded by two researchers to identify perspectives and experiences of participants. From these codes, three major themes were identified that represented the overall experiences of these diverse residents in relation to exclusion at local health services (Miles et al., 2019). While detailed analysis of this data is presented elsewhere (Mohamed Shaburidin et al., 2020b), here the analysis integrates voices of the hardly reached into the framework.

Phase 3: The third phase worked with health services through *CQI processes of change*. Activities were jointly designed by researchers and

relevant committees and managers at each health service in response to findings from phases 1 and 2. While health services wanted to co-design activities with the hardly reached, early engagement attempts highlighted the need to first deconstruct exclusionary practices to prepare a safe environment for co-design in the future. The change activities were developed as part of a CQI process, where some were undertaken by the researchers, some by staff and others involved external facilitators or training. Activities, and staff response to them, led to new activities, also designed by both researchers and health service staff. Here, only activities involving the researchers are included.

These action research activities were approved by the university ethics committee using an opt out ethics application (Ethics ID 1749789). A few staff members did opt out. Between 2017 and 2019, researchers hosted discussion groups and activities, aimed at instilling reflective thinking and the tenets of cultural humility, that were scheduled in the service when staff were able to attend (see Table 1) (see Sue, 2013). The activities were initially recorded but to encourage engagement and honesty, later activities were only recorded via notes. While team activities could be run with all staff simultaneously in health services 2 and 3, multiple sessions were needed in the larger health services (1 and 4). All audio recorded data were transcribed and notes from health service activities were written up as a short transcript documenting the activity and general response. Using content analysis, all transcripts were coded to identify responses to the activities, in/exclusion and the meanings, processes and contexts underpinning these discussions (Miles et al., 2019).

Phase 4: The fourth phase identified key *learnings and reflections among the researchers*. Two of the researchers active throughout phases 1–3 kept individual reflective journals of the process, interviews, focus groups, activities, discussion groups and meetings at the health service over four years. These journals were coded by the author to identify learnings, reflections, meanings and changes (including resistance to change) in the health services. In addition, there were regular research team meetings that discussed the challenges of inclusion work and what seemed to achieve change. Notes from these team discussions were also recorded and coded. Content analysis of these journals, meeting notes and team discussions contribute to highlighting what was important to the process, what was observed to produce change and what was necessary in deconstructing exclusion (see Findlay, 2002).

Phase 5: The final phase *triangulated findings to construct the pre-inclusion framework*. Following Carter et al. (2014) and Morse (2009), data from each phase were analysed separately. Data analysed from the differing methods used in phases 1–4 were then triangulated to integrate knowledge for practical implementation (see Patton, 1990). Triangulation was careful to situate different findings based on differing data collection methods, levels of knowledge, contexts and change/resistance over time (see Carter et al., 2014), but also recognised that all phases had theoretical similarities (Morse, 2009) based on Foucauldian perspectives of power/knowledge, decolonisation and reflective learning (Foucault and Gordon, 1980; Gatwiri et al., 2021; Rix et al., 2014). Triangulation was undertaken throughout three workshops involving authors 1–4 (see Fielding and Fielding, 1986; Patton, 1990).

The first workshop synthesised the findings from phases 1–4 over multiple years, identified similarities and differences across the four sites and different phases, and mapped the process of change/resistance in each service. This resulted in records of enablers and barriers of change, place-based factors, a set of principles underpinning change processes, a long list of researcher learnings and a set of actions to deconstruct exclusion. The second workshop condensed the outcomes of workshop 1 through focused discussion of ‘what led to change’ in all four health services. Critical discussion of context, power and relationships considered the interrelationships between the principles, places, change processes, researcher learnings and actions. This workshop articulated the foundational concepts based on what the researchers brought to the framework. Discussion then distinguished 13 principles underpinning change from six action processes; all were derived from the research

design, dominant staff discourses, voices of the hardly reached, CQI processes, researcher reflections and discussions of power and context. The third workshop refined the framework by condensing to six principles and six actions, challenging earlier linear change processes, and confirming the foundational concepts. This was then described in diagrammatic and written form which was circulated to authors 5 and 6. Further changes in language were made by all authors throughout multiple iterations. This paper first provides an overview of findings from phases 1–4 and then presents a new pre-inclusion framework for health services.

4. Findings

4.1. Phase 1: discourses of exclusion among health professionals

While discussions with health professionals were varied and complex, there were some common understandings that reflected dominant discourses of exclusion. These discourses reinforced that (a) staff assume the service is accessible for all, (b) that all clients are thought to be treated the same, (c) that the biomedical approach is best for everyone and (d) that White privilege is normalised (see Table 2). Consequently, these discourses enabled genuine knowledge gaps in how exclusion manifested, why inclusion was important and how to engage health consumers from backgrounds different to their own (see Malatzky et al., 2020a, 2020b; Mohamed Shaburidin et al., 2020a). Examples of resistance and challenge to the dominant discourses emerged but clearly as alternative discourses. Further, dominant discourses continued to re-emerge and required repeated deconstruction as they were reinforced in settings outside the health service.

Table 2

Dominant discourses of exclusion identified in the four health services.

Dominant Discourse	Examples of how expressed by health professionals	Effects of the discourse
Health Services are accessible for all	“We are here, available and open” “If they need to [use this service], they will” “They can come to us” “They have a car and can drive, but they want home visits” “We have a ramp and self-opening doors ... everyone can come here”	Barriers to access were invisible It was assumed sick people know how to access health services Access is the users responsibility Inflexible service delivery times/places Lack of recognition of exclusion beyond physical disability
Sameness	“I treat everyone the same” “Everyone gets this” “We can’t cater to everybody’s individual whims”	Homogenisation of all service users Care is rigid, inflexible Catering for difference would be too demanding/unrealistic
Biomedical is best	“This is the service provided” “I have always done it this way” “We have more important priorities than thinking about culture or inclusion”	Western approaches were best for all Health professional is the expert White privilege is not questioned; difference is not a priority
White privilege is accepted	“We don’t see many Aboriginal people here” “We just send them to ...” “We are inclusive”	White privilege is not questioned; Aboriginality is observable Homogenisation of local community service user choice not considered Assumption that all experiences are like the norm

4.2. Phase 2: experiences of inclusion and exclusion among the hardly reached

Discussions with 128 local residents also identified some common experiences of exclusion (see Table 3). While many provided examples of inclusive practices and positive experiences with health services, many also talked about their identity being assumed, communication problems, and/or not understanding health systems. Service users were left to negotiate the health system as well as the judgements and assumptions of themselves, their health needs and both their families and communities. These insights informed how the CQI activities were developed in phase 3.

4.3. Phase 3: CQI activities to deconstruct exclusion in health services

A range of CQI activities, designed by researchers and staff for each health service, were facilitated by the researchers (see Table 1). During these activities, researchers identified common responses that provided insights of exclusion in these services (see Table 4). Developing plans, identifying change activities, and “getting started” were found to be overwhelming and embedded with resistance. Key to change was an openness to learning. Embedding voices of the hardly reached from phase 2 in these activities was found to be key for legitimacy and gained responsiveness from staff. The concepts of access and equity were tangible issues that could be used to engage staff in a process of reflection while the concepts of cultural humility, reflexivity and privilege (Dudgeon et al., 2014) were often labelled as “too difficult” or “irrelevant and unnecessary.” Researchers also observed that changes were more likely to result where activities were obviously clinically relevant. Throughout these CQI processes, the same discourses identified in phase 1 re-emerged, indicating they are entrenched and need to be continually challenged.

Table 3

Experiences identified by the hardly reached.

Theme	Examples	Processes of exclusion
Assumptions of identity	“They assumed my partner was female and the mother of my daughter” They assumed “I don’t understand English” “They asked for my health care card as if every Aboriginal person is on a health care card”	Subscription to stereotypes; assumptions of heterosexuality Judgements of non-normative identities
Communication	“Rude” or “unfriendly” “They didn’t listen” “It just felt like they didn’t care” “They seemed rushed so I didn’t ask” “It wasn’t that I didn’t understand; I understood what she said, I just didn’t agree with it” “They yelled from corridor. I have asked them not to do that as I’m deaf” “It was so difficult last time that I couldn’t be bothered going back again”	Unwelcoming Concerns of not being heard Concerns not taken seriously Health issues were dismissed Not feeling respected Everyone treated the same Leads to not using services
Unaware of how health services work	“I don’t know where to go or who to ask” “I didn’t know how much it would cost so I put it off” “I didn’t know who to see and how I got to see them”	Unaware of how to access the service, the cost of the service or referral processes

Table 4

Change activities and outcome in the four health services.

Goal of change	Activities	Response to activity
Deconstruct White privilege	Discussions of access, equity and/or diversity Discussion group on White privilege and exclusion	Open and honest discussion, knowledge building, improved understanding, reflection Participants struggled with the diversity conversations and what “diverse” includes (ie old, young, gay, illiterate, etc.) Did not understand “White privilege” and was unable to relate to practice
Cultural humility	Activities to make visible our own identities Activities of our own cultural assumptions Discussions of practice challenges	Struggled to link to practice Struggled with concept and practice of honest self-reflection Seeking a protocol on how to ... Could identify but unsure what to change
Structural exclusion	Identification of information gaps Review of documents (wording and question order)	Staff engaged well More inclusive, consumer friendly forms
Rates of recording of Aboriginal and/or Torres Strait Islander identity	Asking the question of Aboriginal and/or Torres Strait Islander Identity	Understanding of why asking the question is important Understanding of asking the question appropriately Identified areas of resistance, lack of cultural knowledge, lack of understanding of social determinants of health, and the presence of racism Identified further training needs

4.4. Phase 4: reflective learnings among researchers

Table 5 presents key learnings from the researcher journals and meeting notes that stress the importance of staff understanding why inclusion is important, that change takes time, that openness to pluralism is important and that staff are engaged through specific and practice-based changes. These learnings also highlight the importance of health service leaders being committed, challenging resistance and implementing change across the whole service. Similarly, researchers learned to expect resistance, strengthen emotional intelligence and that the use of Whiteness could facilitate honest discussions of exclusion.

Table 5

Research reflections and learnings.

Learnings and reflections	Reasons
Address <i>why</i> inclusion is important	Cannot assume practitioners understand their privilege; need to re-state
Inclusive practice is a journey	Journey is longterm term change, encouraged trust, sought out hard to reach, and addressed staff expectations
Leadership must be committed	Leaders set expectations; need to challenge resistance
Expect resistance	Enhanced project
Emotional intelligence	Key to facilitating and challenging staff
Whole of health service issue	Inconsistency at health service deprioritised inclusion
Specific and practice-based	Relate to staff practice
Use of Whiteness	White facilitators effective at challenging exclusion and privilege
Pluralism	Openness to different practices and perspectives key to all involved

4.5. Pre-inclusion framework to create readiness

A series of workshops triangulated the research findings from phases 1–4 to develop a pre-inclusion framework for health services (see Fig. 1). While most cultural inclusion frameworks assume services are ready for inclusion, this framework challenges exclusion to prepare health services for other inclusion approaches. The framework recognised the five foundational concepts, outlined earlier in this paper, as underpinning its approach and being assumed at the outset, namely power as productive, deconstruction, CQI processes, cultural humility and voices of the hardly reached. The framework also articulates six processes of change which are preceded by six principles.

4.6. Principles

From the triangulation of data in phases 1–4, six principles were identified that assist to challenge exclusion if adopted by a health service prior to implementation of the framework. These principles make clear the expectations of, and necessary commitments from, the health service. In the research, where these were agreed on or expected, they enabled progress to challenge exclusion, and the opposite was also found. The first principle is that the deconstruction of exclusion processes in a health service is a **journey** of change. It is a long-term commitment that takes time, persistence and learning. Driving this journey is leadership of the organisation committed to long-term change, to challenging resistance and to pursuing an agenda of inclusiveness over time. This process requires openness to alternative understandings from the hardly reached and avoiding assumptions of identity, ensuring respectful communication and making clear service availability and accessibility (see Table 3). This requires two-way learning and pluralistic approaches. The journey of change also

**Fig. 1.** Pre-inclusion framework to deconstruct exclusion in health services.

requires space and time where cultural orientations are considered and re-visited as exclusive discourses re-appear. For this reason, change needs to occur at the pace of the health service.

The second principle is to adopt a **whole of organisation approach**; the journey is institutional as well as individual. Engagement of all parts of the health service is important to achieve whole-of-organisation change. It requires a whole organisation to re-learn, re-think and re-create their systems of health practice from the perspective of cultural humility. While some areas of each service and some staff were more interested/resistant, teams choosing not to participate allowed exclusion to continue and suggested to others that exclusion was permitted. Interestingly, some of the teams most resistant initially became strong advocates for inclusion over time.

Rather than seeing patients/clients as culturally 'other,' acknowledging that **both health professionals and clients bring cultures to health care** is the third principle. Acknowledgment that we are all cultural beings and reflecting on the cultural assumptions that practitioners bring to health care (Malatzky et al., 2018a) can lead to more pluralistic understandings. Whiteness was also found to have a role in the change process; the use of Whiteness assisted in deconstruction by creating honest discussion, challenge and resistance. For example, White facilitation allowed White staff to ask "why do they need more?" or "why can't they come in to the service?" and for these to be discussed. However, when using Whiteness, it is key that the voices of the hardly reached are prioritised to avoid the dominant group speaking for the hardly reached.

It cannot be assumed that staff understand why inclusion is important and so the fourth principle is that **reasons for change are visible**. This makes clear why change is necessary and how change can be undertaken. Staff identified that hearing about cultural inclusion was not the same as understanding "how it is relevant to my work" and "what I need to do differently". Making tasks specific, small and ensuring that the process begins with an understanding of the need for change were found to be important. Without this understanding, staff were reluctant to engage.

The fifth principle is to **expect resistance**. This is not easy work, not always accepted, and in this study some staff worked to protect discourses of sameness, reproduce current models of care, and reject pluralism as too complex. Health service personnel are not homogenous and diverse thinking and practice makes deconstruction an inconsistent process. The journey is not linear but will involve steps towards and away from exclusion. The responses and actions of leaders and power brokers were found to challenge or allow resistance in the service. Therefore, services, researchers and service users need to expect discomfort as power relations and normalised ways of practising are interrogated and ruptured.

The final principle is adoption of a **people-centred care** approach, where the person and their support network is at the centre of their healthcare decision-making and considered an expert in their own lives, including their culturally-based perspectives of health. This includes being "responsive to a person's holistic needs (and goals) that emerge from their own personal social determinants of health" as well as addressing "the holistic needs and aims of the community" (Goodwin, 2014, p. e026). This extends focus beyond patients/clients to community health literacy, health service governance and working with the hardly reached to ensure their ability to and support in pursuing health and well-being.

4.7. Actions within the health services

Following commitment to the six principles above, the pre-inclusion framework identifies six actions to prepare a health service for inclusion (see Fig. 1). These actions are observed by staff, recognised to contribute to change, and embedded in health service action plans, protocols and policies. The six actions identify a process, not necessarily linear, cyclical or in any order, and actions may be advanced simultaneously,

allowing for periods of progression, regression and inaction. None are markers of change but rather processes as part of the journey. These actions are underpinned by CQI where small actions are identified, planned, implemented, reviewed and embedded into longterm change.

Whole of health service commitment to the journey: Actions to address exclusion need to begin with a recognised, public and/or documented commitment, including in strategic plans, action plans, statement of priorities and other formal documentation that acknowledges the commitment and subsequent actions. This is a whole-of-organisation public commitment by health service managers and leaders to embark on a journey of inclusion by embracing the six principles above. The commitment affirms the process of change and signals to staff and the hardly reached that practices of exclusion will change.

Assessment of exclusion: The service needs to honestly assess where the service sits in its journey of inclusion, identifying practices and dominant discourses that lead to and maintain exclusion. It does not serve the interests of services to over/under-state their place on this journey. This assessment requires an external lens, including the hardly reached. Dominant discourses are likely to include assumptions of sameness and health professional as expert. Further, the focus on discourse enables a service to identify and challenge the understandings underlying exclusive practices.

Action plan: The development of an organisation-wide action plan to deconstruct exclusion across the entire health service needs to report to the highest levels (e.g., executive and board levels) and include long-term, mid-term and shorter-term goals. The plan needs to engage teams across the whole service and identify major changes required in order to reframe discourses of exclusion through small and specific steps. Some short-term 'easy wins' enable change to be witnessed in order to strengthen the commitment of staff (e.g., email signatures). In addition, actions around communication encourage open and genuine dialogue that seeks to avoid assumption and judgement. In time, these changes need to privilege the voices of the hardly reached.

Structural changes: In addition, structural changes are also needed to address barriers to inclusion. Addressing these structural barriers reaffirms the commitment of leadership across the health service and maintains engagement of staff. These structural changes may include: changes to policies, protocols and environments; employment targets and new roles; consumer advisory groups; traditional owner recognition; reviewing food choices, forms, signage and access to interpreters; and ensuring space is available in services for specific needs.

Reflective discussions: An important action throughout the change process is peer learning through reflective discussions that will gently challenge current thinking and dominant discourses of exclusion. Major challenges tend to disengage practitioners but gentle change and ongoing learning adapts the approach, thinking and practices of health staff. Strengths-based approaches serve to encourage the actions of staff who seek to rupture exclusionary practices while not blaming those who struggle to shed long-held beliefs. Dominant exclusionary discourses require deconstruction over time to enable concepts of pluralism, people-centred care and learning to move to the fore. Further, consideration of assumptions, language and whose voices are privileged is important learning for practitioners that can be honed over time.

Engage with those hardly reached: When appropriate, health services need to engage safely with the hardly reached. Gaining the perspectives of people hardly reached and integrating their voices throughout service policy can inform plans for change in practices and service structures. It is important to ensure that feedback, engagement and relationships are constructively developed and inclusion in governance, planning and service design is eventually achieved.

These six actions need to be undertaken and reviewed, revised and implemented again, in the form of reflective practice using a CQI approach. The steps need to be adapted to the health service and local community context, based on history and current practices. Once begun, each step needs to be repeated and continued as well as connected to other steps. The six may not occur in sequence, may overlap and will

inform each other.

4.8. An example of the framework in action

To give an example of one process of change that led to development of the framework, the following case study describes a series of changes at health service 4. This case study was selected because it demonstrates all aspects of the framework, from identifying exclusive practices to CQI processes and resulting changes in the service. After the initial commitment by the Board of Directors, assessment of dominant discourses at the service were identified. A First Nations researcher interviewed nine members of the local Aboriginal community. While feedback from Aboriginal residents was often positive, community members identified that the question of Aboriginal and Torres Strait Islander identity was asked inconsistently and sometimes inappropriately. A CQI process was developed where discussion groups were facilitated by a White researcher with teams across the service about *why* asking the question of identity is important and *why* assumptions of Aboriginality can be inappropriate. At these discussion groups, staff questioned why they had to ask 'the question', who would ask, as well as ideas about safety. Discourses of sameness re-emerged along with a lack of understanding of inclusion and issues of workload, relevance and respect. These discussions paved the way for specific training on 'asking the question' by a First Nations trainer. Prior to this, staff needed to understand why asking the question is important, that the practice requires improvement and that it is a responsibility of all staff. After identifying an exclusive practice through engagement with service users, an action plan was developed at the health service to address the exclusive practice. Focusing on 'asking the question' made the change specific, relevant to practice, enabled discussion to deconstruct particular discursive practices, and justified the training to follow. Implementation of the above process and principles has contributed to an increase in service users identifying as Aboriginal and/or Torres Strait Islander.

5. Conclusion

'Mainstream' services must be able to provide quality and safe care to all, including those hardly reached (McIntosh et al., 2019). It is argued that new understandings, approaches and ways of thinking cannot replace existing exclusionary practices until the premise of exclusion is challenged. Bringing hardly reached people into unsafe services undermines any attempts at inclusion; exclusion must first be addressed. By challenging discourses embedding exclusion in everyday health care, more pluralistic approaches from a cultural humility perspective can begin. Of importance to this new framework is a Foucauldian understanding of power, deconstruction and change (Malatzky et al., 2018a) that interrogates exclusionary practices to promote cultural humility. This asks health professionals to reflect on their own cultures and practices and gives attention to the voices, experiences and cultures of those hardly reached (Dudgeon et al., 2014; Foronda, 2020). This is a shift towards privileging the discourses of health service users rather than providers, which some health professionals found threatening. In challenging these power relations, Whiteness, privilege and attention to long term change played important roles (Gatwiri et al., 2021; Morleton-Robinson, 2006) and warrant further investigation.

This study is limited by only being conducted in one region and the framework is yet to be implemented and evaluated. Despite this, the framework was constructed over five years, based on work in four different health services, and provides an innovative approach to inclusion. Challenges remain, including using CQI in less clinical activities, avoiding change-fatigue within health services, and balancing integration of the voices of the hardly reached with the safety of these individuals.

The marginalisation of non-biomedical knowledges has a colonial legacy and thus rupturing power relations to privilege the knowledges of

hardly reached service users is necessary (Malatzky et al., 2018a). This framework offers an approach to rupture these power relations to prepare specific health services for engagement and inclusion of those they hardly reach. Deconstruction of exclusion offers health services the opportunity to lead new models of inclusion that could address persisting inequities. In a world where racial divisions are prominent, addressing exclusion is an important step towards an inclusive society.

Credit author statement

Lisa Bourke: Conceptualisation, Methodology, Data collection, Data Formal analysis, Triangulation, Conceptualisation of framework, Drafting original and final draft. Olivia Mitchell: Conceptualisation, Methodology, Data collection, Data Formal analysis, Triangulation, Conceptualisation of framework, Reviewing and editing. Zubaidah Mohamed Shaburidin: Data collection, Data Formal analysis, Triangulation, Conceptualisation of framework, Reviewing and editing. Christina Malatzky: Conceptualisation of study, Methodology, Data collection, Data Formal analysis, Reviewing and editing. Mujibul Anam: Conceptualisation, Triangulation, Conceptualisation of framework, Reviewing and editing. Jane Farmer: Conceptualisation, Reviewing and editing.

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