AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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Understanding leave events for Aboriginal and Torres Strait Islander peoples and other Australians from health service organisations:

A Systematic Literature Review

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Background

Understanding leave events from health services is a key element in improving health outcomes and cost effectiveness for our health care systems.

In Australia, the term ‘Take Own Leave’ (TOL) is used broadly to indicate when a person has left the health service prior to being seeing by a health professional or has left against medical advice. This report specifically uses the term ‘leave events’ in order to not stigmatise a patient who may leave a health service due to factors that are currently not understood or acknowledged by the health system. This systematic review of current literature seeks to identify these factors.

Objective

The primary objective of this literature review was to identify evidence relating to the causes contributing to Aboriginal and Torres Strait Islander peoples and other Australian peoples leave events from health services. The second objective was to identify evidence based preventative measures that have been effective in reducing leave events, and recommendations that could be implemented.

Method

A systematic literature review was conducted in June 2020, which included Australian studies published from 2013. Publications were considered and included if they reported on primary research which focused on Aboriginal and Torres Strait Islander peoples and other Australians who leave health services including acute health services, Aboriginal community-controlled health and medical services, community services or primary care health services prior to being seen by a health professional or have left against medical advice. Additionally, any other possible definitions in relation to “leave events” used by Australian health and medical services were included while conducting the search. A list of terms is at Appendix 1 of the review.

Results

The electronic database search returned 30 relevant records and 9 additional records were identified by a manual search in Google Scholar. Reference lists of the included articles were searched. From these articles, 11 met the inclusion criteria for the review. Of the 11 included studies, 5 were based in New South Wales, 2 in Western Australia, 1 from Queensland, 1 from Northern Territory and 2 were conducted nationally.

This literature review was reported in accordance with the PRISMA (preferred reporting items for systematic reviews and meta-analysis) reporting guidelines provided for systematic reviews and meta-analyses

Summary of Causes of "leave events" found in this review

Personal factors that contributed to a leave event	System factors that contributed to a leave event
• Past negative experiences • Distrust of health services • Impact of intergenerational trauma • Association of hospitals with death • Feelings of isolation and loneliness, • Feeling unwelcome and misunderstood • Feeling better, or sufficiently well to leave • Distrust of doctors • Limited understanding of illness and expected length of stay • English as a second language • Not being able to smoke on the hospital campus • Family, cultural and social obligations • Financial responsibilities • Pressure from partners and family to return home • Taken by family • Remoteness of hospital • Socio economic disadvantage • Transport cost and availability	Workforce factors • Staff speaking 'roughly', mistreating patients • Inappropriate and insensitive behaviour by staff • Medical staff lacking appropriate cultural training • Staff stereotyping patients • Absence of Aboriginal Liaison Officers and Aboriginal Health Workers and other Aboriginal workforce • Language barriers • Conflicting understanding of the reason for admission between provider and patient Systems factors • Long waits • Complicated admission and discharge procedures • Institutions not culturally safe • Personal and institutionalised racism • Hospital policies reinforcing racist systems and barriers • Miscommunication and misunderstandings • Limited access to Aboriginal support while in hospital • The 'impersonal nature' of Western medicine

Recommendations

The review identified a number of recommendations from the literature. These recommendations could be applied to:

- Individuals working in the health system
- Health service organisations
- Community controlled health organisations

The recommendations in the report align closely with the actions in the National Safety and Quality Health Service (NSQHS) Standards and the suggested strategies for improvement in the *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health* published by the Commission in 2017.

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The George Institute for Global Health

June 2020

Understanding Leave Events for Aboriginal and Torres Strait Islander People and other Australians from Health Service Organisations

Systematic Literature Review

Contents

Summary

This systematic literature review was conducted in June 2020 by The Aboriginal and Torres Strait Islander Health Team of The George Institute for Global Health on behalf of the Australian Commission on Safety and Quality in Health Care (the Commission). The Commission is leading a project to consider options for a national strategy to reduce the rate of Aboriginal and Torres Strait Islander people who leave health service organisations before treatment is completed. The national strategy will also strengthen the safety and quality of healthcare systems supporting Aboriginal and Torres Strait Islander people. In Australia, a leave event indicates when a person has left the health service prior to being seeing by a health professional or has left against medical advice.

This report reviewed literature post 2013 to identify the causes of prevalence and incidence rate of “Leave Events”, or any similar terms for Aboriginal and Torres Strait Islander peoples and other Australian people who present to acute health service organisations, Aboriginal community-controlled health services, Aboriginal medical services, community services and primary care services. This review identified evidence based preventative measures that have been or could be implemented to reduce “Leave Events” and describes any additional terms and definitions used for ‘Leave Events” by states and territories not already listed.

Introduction

Australian Commission on Safety and Quality in Health Care (the Commission) is a government agency that leads and coordinates national improvements in safety and quality in health care across Australia. The Commission is funded jointly by all state and territory governments and the Commonwealth government. It is established under the *National Health and Hospitals Network Act 2011* and its role codified in the *National Health Reform Act 2011.*

The Commission works in partnership with the Australian, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

Background and Context

Understanding leave events from the health system for all Australian people is vital in improving health outcomes and improving cost effectiveness for our health care systems. All Australians should receive safe and quality healthcare and there is a need to understand why leave events continue to occur and how these can be addressed. This report explores leave events from the healthcare system through a systematic search of literature between 2013 to 2020.

In Australia, the term ‘Take Own Leave’ (TOL) is used broadly to indicate when a person has left the health service prior to being seeing by a health professional or has left against medical advice. This report specifically uses the term ‘leave events’ in order to not stigmatise a patient who may leave a health service due to factors that are currently not understood or acknowledged by the health system. This review seeks to identify these factors.

Leave events include ‘Take Own Leave’ (TOL) and mean that a patient decides to leave before the commencement or completion of medical treatment. If a patient absconded or goes missing before medical treatment it is documented as did not wait (DNW). Leave events also include self-discharge or leave at their own risk (LOR) and if a patient leaves against medical advice they are documented as discharge against medical advice (DAMA).[1]

Leave events interrupt a person receiving the correct medical treatment and are associated with increased readmissions,[2] which impact ongoing medical care associated with increased morbidity and mortality. The report found a variety factors associated with and reasons for leave events including but not limited to loneliness, waiting too long, experiences of racism, distrust of the health system, a lack of culturally safe institutions, miscommunication and misunderstandings, feelings of isolation and loneliness, family and social obligations as well as sex, age group, remoteness of hospital, state/territory of hospital and remoteness of usual residence.[2]

Aboriginal and Torres Strait Islander people are at higher risks of leave events than other Australians. Although this report focuses on all Australians it is especially important for Aboriginal and Torres Strait Islander peoples due to ongoing impacts from colonisation, systemic racism and issues surrounding trust and power which other Australian people do

not experience.[2] It is well documented that disparities in health outcomes for Aboriginal and Torres Strait Islander peoples compared to other Australians exist. There is a life expectancy gap of 11.5 years for men and 9.7 years for women, as well as higher rates of chronic disease.[3,4] This is reflected by the ongoing impacts of colonisation, oppression and racism.[5]

Objective

The primary objective of this systematic literature review was to identify the causes that contribute to Aboriginal and Torres Strait Islander peoples and other Australian peoples' leave events from health services. The second objective was to identify the evidence based preventative measures that have been effective in reducing leave events and recommendations that could be implemented in the future.

Scope

Research Scope	
Purpose of the study	Exploration of leave events for health services
The population	Aboriginal and Torres Strait Islander peoples and other Australians
Timeframe	Post 2013 (inclusive)
Methodology	Systematic literature review
Geographical location	Australia

This systematic literature review sought to answer the following questions:

1. What are the causes that contribute to leave events?
2. What evidence-based preventative measures have been or could be implemented to reduce leave events?
3. Describe any additional terms and definitions used for Leave Events by States and Territories in Australia.

Method

A systematic literature review was conducted from May 27th until June 30th, 2020 which included Australian studies published from 2013. Publications were considered and included if they reported on primary research which focused on Aboriginal and Torres Strait Islander peoples and other Australians who leave health services including acute health services, Aboriginal community-controlled health and medical services, community services or primary care health services prior to being seen by a medical professional or have left against medical advice. Additionally, any other possible definitions in relation to "leave events" used by Australian health and medical services that may not be already outlined in Appendix 1 were included when found while conducting the search.

Search terms also included the many different terms that can be used to refer to Aboriginal and Torres Strait Islander peoples including but not limited to Aboriginal, Torres Strait Islander, Indigenous, First Australian, Murri, Koori, Noongar. Data was obtained from post 2013 on the prevalence and incidence rate of "leave events", or any similar terms for Aboriginal and Torres Strait Islander peoples and other Australians who present to acute health service organisations, Aboriginal community-controlled health services, Aboriginal medical services, community services and primary care services. Causes that contribute to "leave events" for Aboriginal and/or Torres Strait Islander peoples and other Australians was identified. This included "leave events" causes for Aboriginal and/or Torres Strait Islander children (≤18 years of age). Any additional terms and definitions used for "leave events" by states and territories not already listed was also searched.

Inclusion Criteria:

- Aboriginal and/or Torres Strait Islander people
- Australian population focus
- Present findings from primary research (both quantitative and qualitative)
- Data sources clearly outlined e.g. (interview, survey, focus group, hospital databases
- English language
- Data post 2013 (inclusive of 2013, from 01/01/2013)
- Prevalence and incidence rate of "Take Own Leave" events (using the 'leave terms in Table 1) for Aboriginal and Torres Strait Islander peoples and non-Indigenous people
- Include "leave events" causes for Aboriginal and/or Torres Strait Islander children (≤18 years of age)
- Acute health service organisations, Aboriginal community-controlled health services, Aboriginal medical services, Community services and primary care services
- Investigated any aspect of Aboriginal and Torres Strait Islander people and/or other Australian people who have left a health or medical service prior to being seen by a medical professional or has left against medical advice
- Any intervention-based studies that have been implemented to reduce Aboriginal and/or Torres Strait Islander people and other Australian's who leave the health or medical service or has left against medical advice.

Exclusion Criteria:

- Does not focus on Australian or Aboriginal and Torres Strait Islander populations.
- Papers will be excluded where they include routine discharge or negotiated/agreed discharge; discharge for the day programs and instances of 'did not attend'.
- Papers will be excluded if search terms are not included in Title or Abstract.

Both quantitative and qualitative research designs were included within the search. Two methods were used to locate relevant studies: (a) a search of databases for primary papers using the platforms including OVID Medline (b) A hand search of references from identified studies. Once the search had been conducted, duplicates were removed and the title and abstract of the remaining articles were screened for inclusion. EndNote software was used to manage references.

Search terms for the systematic literature review are found in Appendix 1 and search syntax in Appendix 2

Papers were assessed for potential inclusion if they met each of the following criteria:

- presented findings from primary research (both quantitative and qualitative)
- investigated any aspect of Aboriginal and Torres Strait Islander people and/or other Australian people who have left a health or medical service prior to being seen by a medical professional or has left against medical advice
- involved Aboriginal and Torres Strait islander people across all age groups
- any intervention-based studies that have been implemented to reduce Aboriginal and/or Torres Strait Islander people and other Australian's who leave the health or medical service or has left against medical advice
- papers were excluded where they included routine discharge or negotiated/agreed discharge; discharge for the day programs and instances of 'did not attend'

Assessment of included papers

Included papers were assessed using the Mixed Methods Appraisal Tool (MMAT).[6] The MMAT has previously been shown to be a comprehensive tool for assessing mixed method studies and meets the accepted standards for validity and reliability. Where possible, we conducted a qualitative synthesis that was dependant on the assessment of individual qualitative based articles and a quantitative meta analyses for quantitative studies.

Quality of studies

The quality of included studies varied. Of the 11 studies, one had a MMAT score of * (25%),[7] six studies were scored at **(50%),[1,2,4,8-10] three scored ***(75%)[11-13] and one paper that included patient interviews and scored ****(100%)[14] Using the MMAT tool resulted in an overall methodology score which was then calculated into a percentage.

Scoring metrics

For each retained study, an overall quality score may be not informative (in comparison to a descriptive summary using MMAT criteria) but might be calculated using the MMAT. Since there are only a few criteria for each domain, the score can be presented using descriptors such as *, **, ***, and ****. For qualitative and quantitative studies, this score can be the number of criteria met divided by four (scores varying from 25% (*) -one criterion met- to 100% (****) -all criteria met-). For mixed methods research studies, the premise is that the overall quality of a combination cannot exceed the quality of its weakest component. Thus, the overall quality score is the lowest score of the study components. The score is 25% (*) when QUAL=1 or QUAN=1 or MM=0; it is 50% (**) when QUAL=2 or QUAN=2 or MM=1; it is 75% (***) when QUAL=3 or QUAN=3 or MM=2; and it is 100% (****) when QUAL=4 and QUAN=4 and MM=3 (QUAL being the score of the qualitative component; QUAN the score of the quantitative component; and MM the score of the mixed methods component).[6]

Refer to Appendix 3 for the MMAT summary.

Results

Search Results

The electronic database search returned 30 relevant records and 9 additional records were identified by a manual search in Google Scholar. Reference lists of the included articles were searched. After assessing the records for relevance 29 references were saved and full texts were obtained and reviewed for relevance to the research questions. Duplications were removed, and titles and abstracts were reviewed to select studies. Full-text screening of preselected studies was performed by two reviewers independently, to select studies according to inclusion criteria. Included studies were appraised for quality using appropriate tool MMAT.

Data was extracted, and study findings and characteristics synthesised in a narrative summary. From these articles, 11 met the inclusion criteria for the review. Of the 11 included studies, 5 were based in New South Wales, 2 in Western Australia, 1 from Queensland, 1 from Northern Territory and 2 were conducted nationally. This systematic literature review was reported in accordance with the PRISMA (preferred reporting items for systematic reviews and meta-analysis) reporting guidelines provided for systematic reviews and meta-analyses.[7] (See Appendix 4 for results).

Four included studies used a retrospective cohort method, one of these included patient interviews by Lloyd J.et al.,[14] Four cohort studies and two systematic reviews were included. Included in this review was two government reports and one health policy document. All studies were from Australia and included qualitative and quantitative methods.

Terminology

Terminology for leave events in Australia are used generally to specify when a person has left a health service prior to being seen by a health professional or have left against medical advice. However, there are many inconsistencies in the terminology as each state and territory define leave events differently. Terminology for leave events can also vary depending on the context of where a person presents, for example to an emergency department compared to being admitted as a patient.

Leave events are noted by the national organisation, Australian Institute of Health & Welfare (AIHW) as ‘take own leave’ (TOL), ‘incomplete emergency attendances’, ‘discharge from hospital against medical advice’. In Western Australia leave events are termed as ‘take own leave’, (TOL), ‘did not wait to receive treatment’ (DNW), ‘abscond’ or ‘go missing’, ‘self-discharge’, ‘leave at their own risk’ (LOR), ‘away without leave’ (AWOL) or ‘discharge against medical advice’ (DAMA). NSW record leave events as ‘take own leave’ (TOL), ‘did not wait’ (DNW), ‘discharge against medical advice’ (DAMA) and ‘left at own risk’ (LOR).

The Northern Territory use ‘discharge/leave against medical advice within 48 hours’ (DAMA/LAMA), ‘discharge against medical advice’ (DAMA), ‘self-discharge’, ‘absconding’, ‘taking own leave’ (TOL) and ‘away without leave’ (AWOL) for leave events. Tasmania and Victoria are the only states that use CODE Z which means left against medical advice. South Australia document leave events as ‘inpatient discharge against medical advice’ and ‘left emergency department at own risk’. Queensland use a code for leave events but is different to TAS and VIC which is Code 07 ‘discharged at own risk’. Finally, Australian Capital Territory use ‘patient who did not wait to be seen’. See Appendix 5 for the definitions of terminology.

Prevalence of ‘leave events’

The rates of leave events for Aboriginal and Torres Strait Islander people are two and a half times more than that of other Australians. There are several contributing issues associated with leave events that cause Aboriginal and Torres Strait Islander peoples to leave a healthcare facility before treatment or during treatment. Several recommendations from evidenced based studies could be implemented across Australian healthcare services to address this.[2,11,12,14,15]

The Australian Institute of Health and Welfare (AIHW) collected national data using the National Hospital Morbidity Database for years 1998–99 to 2012–13 and found that leave events for Aboriginal and Torres Strait Islander patients have increased. Hospitalisation for injury and poisoning had the highest rates of leave events for Aboriginal and Torres Strait Islander peoples compared to other Australians.[8] The greatest difference between Aboriginal and Torres Strait Islander peoples and other Australians was in endocrine, nutritional and metabolic disorders. Other contributing factors identified were Indigenous status and remoteness of hospitals.[8]

While it is established that the prevalence and rate of leave events is higher among underserved communities such as culturally and linguistically diverse (CALD) children 0-16 yrs[12], similar patterns are also seen in Aboriginal and Torres Strait Islander children. A retrospective cohort study by Gardner in 2016 indicated that urban Aboriginal children 0-16yrs were more likely to be reported as discharging against medical advice than other Australian children. [9]

Routinely collected medical data between January 2007 and December 2012 were analysed and the findings showed that patients’ medical records were incomplete and not being recorded by clinical staff. Although comprehensive quality routine data can help to identify service gaps experienced by patients and families, this was not possible due to the incomplete records. This study was unable to inform the reasons for leave events for children and families. Further reasons why Aboriginal and Torres Strait Islander children refused to continue treatment were not explored in the study.[9]

Remote rehabilitation service uptake by male Aboriginal patients was studied by Munro in 2018. It is noted that 47% Aboriginal patients at a remote NSW drug and alcohol rehabilitation centre self-discharged without completing the program.[10] This finding is aligned with the study by Katzenellenbogen et al. (2013) that revealed leave events are more common among Aboriginal and Torres Strait Islander peoples in rural and remote areas. Munro’s analysis of the patients’ admissions from 2011 to 2016 showed that patients referred from the criminal justice system were more likely to self-discharge. It is known that discharge against medical advice in adult general population leads to increased risks of re-admission[2], but Munro could not establish the same pattern in remote Aboriginal male patients due to unavailability of follow-up data.[10]

Causes of ‘leave events’

In a study conducted by Lloyd J several significant factors that predicted leave events included: loneliness, taken by family, payday, attending court, the football, feeling better, staff mistreatment; staff speaking ‘roughly’ and waiting too long.[14] Lloyd J also found that in the Northern Territory, Aboriginal and Torres Strait Islander people with medical conditions that appeared to “get better” before completing treatment and left the healthcare facility were documented to have been discharged against medical advice or recorded as ‘non-compliant’. However, most had little understanding of their illness and there was a lack of clear and culturally appropriate communication from health providers explaining the potential consequences of leaving before treatment is completed.[14] Aboriginal people who live in the

Central Dessert continue to fear hospital settings and believe they are connected to death. Another issue identified was not being able to go back on Country so patients who have a terminal illness prefer to leave the hospital in order to be able to die on Country.[14]

A systematic review by Shaw revealed that experiences of racism, distrust of the health system, a lack of culturally safe institutions, miscommunication and misunderstandings, feelings of isolation and loneliness, family and social obligations as well as remoteness of hospital from usual residence all contributed to leave events.[2] Shaw's review included a study by Katzenellenbogen that indicated acute healthcare settings are not effective in addressing the apprehensions of Aboriginal and Torres Strait Islander patients in order to maintain patient's engagement in their follow up treatment.[4]

The cross-sectional analytical study undertaken by Katzenellenbogen in Western Australia showed the risks associated with leave events were unique to Aboriginal and Torres Strait Islander patients compared with other Australians, although, the study also identified that drug and alcohol dependency associated with leave events was a strong predictor for Aboriginal and Torres Strait Islander patients and other Australians. The study found that Aboriginal and Torres Strait Islander patients leave events were unique due to culturally distinct personal and systemic factors associated with negative experiences from hospital and mainstream institutions. The study had consistent findings with other studies in this review of leave events for Aboriginal and Torres Strait Islander patients that were associated with a lack of cultural safety and culturally appropriate care, personal and institutionalised racism, miscommunication, family and social commitments, isolation and loneliness.

The Department of Health of Western Australia conducted a review in 2018 of relevant and current policies on leave events. The Aboriginal Health Policy Directorate (AHPD) held consultations with Health Service Providers, Aboriginal Health Council WA (AHCWA), Health Consumers' Council (HCC), WA Primary Health Alliance (WAPHA), Mental Health Commission (MHC) and key senior WA Health staff. Through these consultations many common themes were identified as causes for leave events for Aboriginal and Torres Strait Islander patients. Common themes included systemic racism and stereotyping, distrust of health services, not enough Aboriginal workforce, lack of appropriate communication and language barriers, family, cultural and social commitments, alcohol and other drugs, mental health issues, admission and discharge procedures.[1]

In a retrospective cross-sectional study by Sealy et al in 2019, leave events among Aboriginal and Torres Strait Islander children compared with other Australian children 0-14 were clearly established from an analysis of a 5-year inpatient admissions dataset. The Bayesian multivariable logistic regression analysis was used to determine the predictors of leave events in admissions. Aboriginality has been identified as one of the strong predictors of leave events among paediatric patients. This study was unable to assess the reasons of leave events for Aboriginal children but drew on other studies that stated it could be due to distrust in the health system, lack of cultural safety, staff attitudes, hospital policies and racism.

The study also highlighted the probable under-documentation of Aboriginal or Torres Strait Islander status which may be due to fear of racist treatment and the historical practice of removal of children during hospital stays.[13] While many authors tried to discover predictors for leave events within Australian hospitals from medical datasets[2,4,12,13], little evidence is available from robust qualitative exploration of Aboriginal patients' experience. A summary of causes is represented in Table 1.

Table 1: Summary of Causes of "leave events" found in this review:

Personal factors

- Negative experiences
- Distrust of health services
- Loneliness
- Taken by family
- Feeling better
- Feelings of isolation and loneliness,
- Family, cultural and social obligations
- Remoteness of hospital
- Intergenerational trauma
- Socio economic disadvantage
- Association of hospitals with death
- Financial responsibilities
- Pressure from partners and family to return home
- Transport cost and availability
- Not being able to smoke on the hospital campus
- Feeling unwelcome and misunderstood
- Distrust of doctors
- Association of hospitals with death

System factors

- Staff mistreatment
- Staff speaking 'roughly'
- Waiting too long
- Lack of culturally safe institutions
- Miscommunication and misunderstandings
- Personal and institutionalised racism
- Stereotyping
- Lack of Aboriginal workforce
- Language barriers
- Complicated admission and discharge procedures
- Staff attitudes
- Hospital policies
- Inappropriate and insensitive behaviour by hospital staff
- Absence of Aboriginal Liaison Officers and Aboriginal Health Workers
- Medical staff lack appropriate cultural training
- Conflicting understanding of the reason for admission between provider and patient
- English as a second language
- The 'impersonal nature' of Western medicine
- Patients limited understanding of illness and expected length of stay
- Poor access to Aboriginal support while in hospital

Preventative Measures

The Aboriginal Health Policy Directorate 2018, Department of Health WA found a number of preventative measures to reducing 'leave events' outlined within this section.[1] These included the need for health systems be responsiveness through effective cultural competency including increased cultural training of hospital staff on connection to country, kinship and family obligations. It was found that to be effective this training must be mandatory and ongoing. Cultural training models that are developed should be translated to individual settings according to locally identified priorities.

Other preventative measures that were explored in the paper found that the implementation of a living document such as a 'Cultural Security/Safety Policy/Framework', developed in collaboration with Aboriginal and Torres Strait Islander stakeholders, policy makers and communities can improve provision of appropriate and safe healthcare. Improvement of the hospital environment through policy changes to accommodate for family members to stay with the patient during their stay was also discussed.

Consideration for a culturally appropriate holistic model of healthcare was discussed. Pathways between hospital and community care providers need to be developed in collaboration with Aboriginal and Torres Strait Islander communities to enable appropriate healthcare within their community. Culturally safe and appropriate environments during pre-admission processes for Aboriginal and Torres Strait Islander patients were also found to be important for patients to feel welcome and comfortable. The availability of an Aboriginal health Worker/Liaison Officer to address the concerns of culture early in their admission was also found to build a trusting environment.

Another preventative measure outlined Aboriginal community-controlled health services involvement in equipping patients with information about hospital processes and what to expect when they attend the healthcare service. Establishing partnerships and protocols with Aboriginal stakeholders to improve coordination and continuity of care between health services and community-controlled health services was deemed important. Two -way communication between Aboriginal community-controlled health services healthcare services and effective engaging patients and carers in the design and plan of programs and services can improve patient's quality of care.

Discussion

The purpose of this systematic literature review was to examine the causes that contribute to leave events from health care services and understand the current recommendations that may reduce rates of leave events for Aboriginal and Torres Strait Islander people and other Australians. This study established that there are numerous causes that contribute to Aboriginal and Torres Strait Islander patient leave events that are well documented.[1,2,12] Many of the studies and reports repeated themes such as systematic and personal racism, distrust of hospitals and patients feeling misunderstood and unwelcome. Other themes such as the lack of cultural competency, cultural safety in hospital and cultural training among the health workforce were recurrent. Systemic and personal racism needs to be addressed if equity is to be achieved within the healthcare system.[16] Improving the cultural competence of health services and creating culturally safe environments will help address racism, and feelings of being unwelcome.[1]

Health service organisation policies are developed within a western biomedical framework that continue to reinforce colonial power structures in Australia which marginalises Aboriginal and Torres Strait Islander people.[16] A change in institutional policies to balance the inequitable power structures is needed. Genuine engagement of Aboriginal and Torres Strait Islander stakeholders is needed to improve the policy structures that support systematic change.[1]

As an example, Western Australia have implemented a preventative program to address leave events for Aboriginal and Torres Strait Islander people who have experienced a cardiac episode. Another Western Australia support system “Friends of RPH” assist with washing, shopping, banking and connecting with families/phone calls, ensures that patients stay in hospital until the completion of their treatment.[1] More programs developed in partnership with Aboriginal and Torres Strait Islander communities would improve the incidence rates of leave events.

Conclusions

Higher prevalence and incidence rate of leave events among Aboriginal and Torres Islander patients in comparison to non-Aboriginal Australians indicate that there are unique individual and system factors driving the problematic issue. While attempts are made to understand the causes, most research efforts are focused on quantitative studies and a lack of robust qualitative exploration of the patients' experiences exists. Further research to address this gap could better inform health service organisations on how to improve treatment completion rates for Aboriginal and Torres Strait Islander patients. The causes and preventative measures from the literature highlight the needs of effective cultural competency, culturally appropriate holistic models of healthcare and Aboriginal community-controlled health services involvement. Consistent terminology and appropriate terms to define ‘leave events’ across all states within Australia will also ensure better data capture.

Recommendations

Key recommendations

The are several clear recommendations that can be implemented at the individual, community, organisation and system level in order to better understand and reduce leave events from the health system. Many of these recommendations are specific to improving cultural safety of the system that is currently leading to a higher proportion of leave events amongst Aboriginal and Torres Strait Islander patients compared to other Australian patients. Key recommendations are summarised below:

Individual:

- Increased capability of individual self-reflective practice on their values and beliefs, whiteness and privilege, and how these can impact on health service delivery and work practices
- Attend mandatory cultural safety and awareness courses throughout the year
- Consider the language you use (written, verbal and non-verbal) when communicating
- Work alongside and learn from Aboriginal Health Workers.

Community:

- Aboriginal and Torres Strait Islander community- controlled health services to develop resources for information about hospital processes and what patients can expect when they attend the healthcare service.
- Healthcare services to establish partnerships and protocols with Aboriginal and Torres Strait Islander stakeholders to improve coordination and continuity of care between health services and community- controlled health services.
- Develop partnerships which support two -way communication between Aboriginal and Torres Strait Islander community-controlled health services and mainstream healthcare services.
- Effectively engage with Aboriginal and Torres Strait Islander community members, community-controlled health services, patients and carers to design and plan programs and services to improve patient's quality of care.
- Show respect for Elders and leaders in the community and involve them in decision-making processes.

Organisation:

- Display culturally appropriate art work in waiting areas and clinic rooms
- Install Acknowledgement of Country plaque
- Provide access to culturally safe health resources
- Conduct cultural audits
- Develop a Reconciliation Action Plan
- Provide accredited cultural safety and awareness courses for all levels of the healthcare system
- Participate in and recognise important community events such as NAIDOC
- Ensure that executive level staff/leadership have a substantial understanding of the purpose of cultural safety and its application within the healthcare setting

System:

- Increase cultural training of hospital staff at all levels on cultural issues
- Develop identified Aboriginal and Torres Strait Islander healthcare positions which are supported and managed with a clear professional career pathway
- Implement a living document such as a Cultural Safety Policy that has been developed in collaboration with Aboriginal and Torres Strait Islander stakeholders, policy makers and communities for all healthcare settings.
- Improve hospital environment through policy changes such as accommodation for family members to stay with the patient during their stay
- Develop a culturally appropriate discharge planning model of care for Aboriginal and Torres Strait Islander people developed in collaboration with Aboriginal and Torres Strait Islander communities to enable appropriate healthcare in their community.
- Create a culturally safe and appropriate environment during pre-admission processes for Aboriginal and Torres Strait Islander patients to feel welcome and comfortable.
- Recruit Aboriginal Health Workers/Liaison Officers in all healthcare services in Australia to connect to patients and to address the concerns of culture early in their admission to build a trusting environment.
- Develop programs and processes that promote the concept of holistic healthcare for Aboriginal and Torres Strait Islander patients
- Cultural safety awareness courses need to be accredited and embedded into standards that govern clinical professions such as The Royal Australian College of General Practice and the Australian Nursing and Midwifery Board.

Appendix 1

Search Terms

Health services	Population	Life course	Leave terms
1. Health care 2. Aboriginal health services 3. Community health services 4. Aboriginal medical services 5. Primary health care services 6. Tertiary care 7. Acute health service organisations 8. Aboriginal community-controlled health services 9. Hospital 10. Clinic* 11. Outpatient* 12. Local health network 13. Local health district 14. Primary Health Network 15. Emergency department	1. Indige* 2. Aborigin* 3. Torres Strait Islander 4. Nunga 5. Koori 6. Koorie 7. Murri 8. Nyoongar 9. Anangu 10. Bining 11. Yolngu 12. Palawah 13. Arrente 14. First Nation 15. First Australian 16. First People 17. Australia* 18. Patient* 19. Client* 20. Consumer*	1. Child* 2. Paediatric 3. Adolescents 4. Toddlers 5. Babies 6. Adults 7. People* 8. Parents	1. Discharged against medical advice (DAMA) 2. Take Own Leave (TOL) 3. Absent without leave (AWOL) 4. Did not wait (DNW) 5. Left at own risk (LOR) 6. Left against medical advice (LAMA) 7. Discharge at own risk (DOR) 8. Away without leave 9. Self-discharge 10. Treatment refusal 11. Patient dropouts 12. Refusal to participate 13. Treatment Adherence and Compliance 14. Health Services Accessibility 15. Separations from health services 16. Frequent presenters 17. Revolving door 18. Procedure not carried out because of patient's decision for reasons of belief and group pressure 19. Procedure not carried out because of patient's decision for other and unspecified reasons 20. Procedure not carried out for other reasons 21. Procedure not carried out, unspecified reason

Appendix 2

Search Syntax

1. (Abori* or indig* or leave* or health* or service* or without* or discharged*)
2. (Discharged against medical advice or left at own risk) and (Australia*) and (Health care)
3. (Abori* or indig*) and (leave* or discharged*) and (health* or service* or medical service or outpatient or health district)
4. (Discharged against medical advice or Leave or Absent or Did not wait or Left at own risk or Left against medical advice or Discharge at own risk or Did not wait or Away without leave or Discharged against medical advice or Take own leave or Against medical advice) and (health care and services or community or primary or tertiary or acute) and (Abori* or Indig* or Community) (Indige* or Aborigin* or Torres Strait Islander or Nunga or Koori* or Murri)
5. (Discharged against medical advice or Leave or Absent or Did not wait or Left at own risk or Left against medical advice or Discharge at own risk or Did not wait or Away without leave or Discharged against medical advice or Take own leave or Against medical advice) and (health care and services or community or primary or tertiary or acute)
6. (Discharged against medical advice or Take Own Leave or Absent without leave or Did not wait or Left at own risk or Left against medical advice or Discharge at own risk) and (Indige* or Aborigin* or Torres Strait Islander or Nunga or Koori* or Murri or Nyoongar or Anangu or Bining or Yolngu or Palawah or Arrente or First Nation or First Australian or First People or Australia* or Patient* or Client* or Consumer) and Primary health or tertiary or acute or outpatient or emergency)
7. (Discharge at own risk or Did not wait or Away without leave) and (Child* or Paediatric or Adolescents) and (Australia* or First Australian or First People)
8. (Discharged against medical advice and Australia*) and (Abori* or indig* or leave* or health* or service* or without* or discharged*) and (Patient* or Client* or Consumer*)
9. (Take own leave or Against medical advice or self-discharge) and (health care or services) and (child* or baby* or parent*) and (Australia*)
10. (Procedure not carried out or unspecified reason) and (Australia*)
11. Procedure not carried out because of patient's decision for reasons of belief and group pressure
12. (Procedure not carried out) and (patient's decision for other or unspecified reasons) and (Australia*)
13. (Separation* or treatment refusal) and (health services) and (Australia*)
14. (Frequent presenter*) and (emergency or hospital) and (Australia*)
15. (Revolving door) and (health care and services or community or primary or tertiary or acute or emergency) and (Australia*)

Appendix 3

Mixed method appraisal tool (MMAT) summary for eligible articles from 2013 to 2020.

#	Author, Date, Country	Aims	Methods	Participants and setting	Analysis	Key findings	MMAT Scores
1	*Aboriginal Patient Take Own Leave. Review and recommendations for improvement* Department of Health Western Australia, Perth 2018	This paper is intended as a guide for Health Service Providers and other stakeholders to assist them in addressing TOL for Aboriginal patients	Health Policy	Aboriginal and Torres Strait Islander people	Consultation	Existing programs are being implemented across the WA health system that either directly aim to improve TOL rates for Aboriginal people or have an indirect positive flow on effect of the same.	**
2	*Aboriginal and Torres Strait Islander Health Performance Framework 2014 report: detailed analyses. Discharge against medical advice.* *Australia* Australian Institute of Health and Welfare	This report provides information on a range of measures of health status, determinants of health and the health system performance relating to Aboriginal and Torres Strait Islander people.	Government Report	All Aboriginal and non-Aboriginal people admitted in essentially all hospitals in Australia	Multivariate logistic regression analysis	Between 2011–13 There were 17,494 hospitalisations for Indigenous Australians where the patient left hospital against medical advice or was discharged at their own risk. This study has statistical data but no understanding of why the numbers are so high.	**
3	*An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients.* Caitlin Shaw 2016, Australia	Identifying what is the prevalence of self-discharge in the Aboriginal and Torres Strait	Systematic review on studies in or before 2015	Aboriginal and Torres Strait Islander people in Australia	A Brief for the Deeble Institute	Study found improvements are needed in these areas: -- Cultural safety frameworks in hospital -Cultural competency in acute care -Nationally recognised scope of practice for AHWs/ALOs -Increased recruitment and retention of AHWs/ALOs in acute care.	**

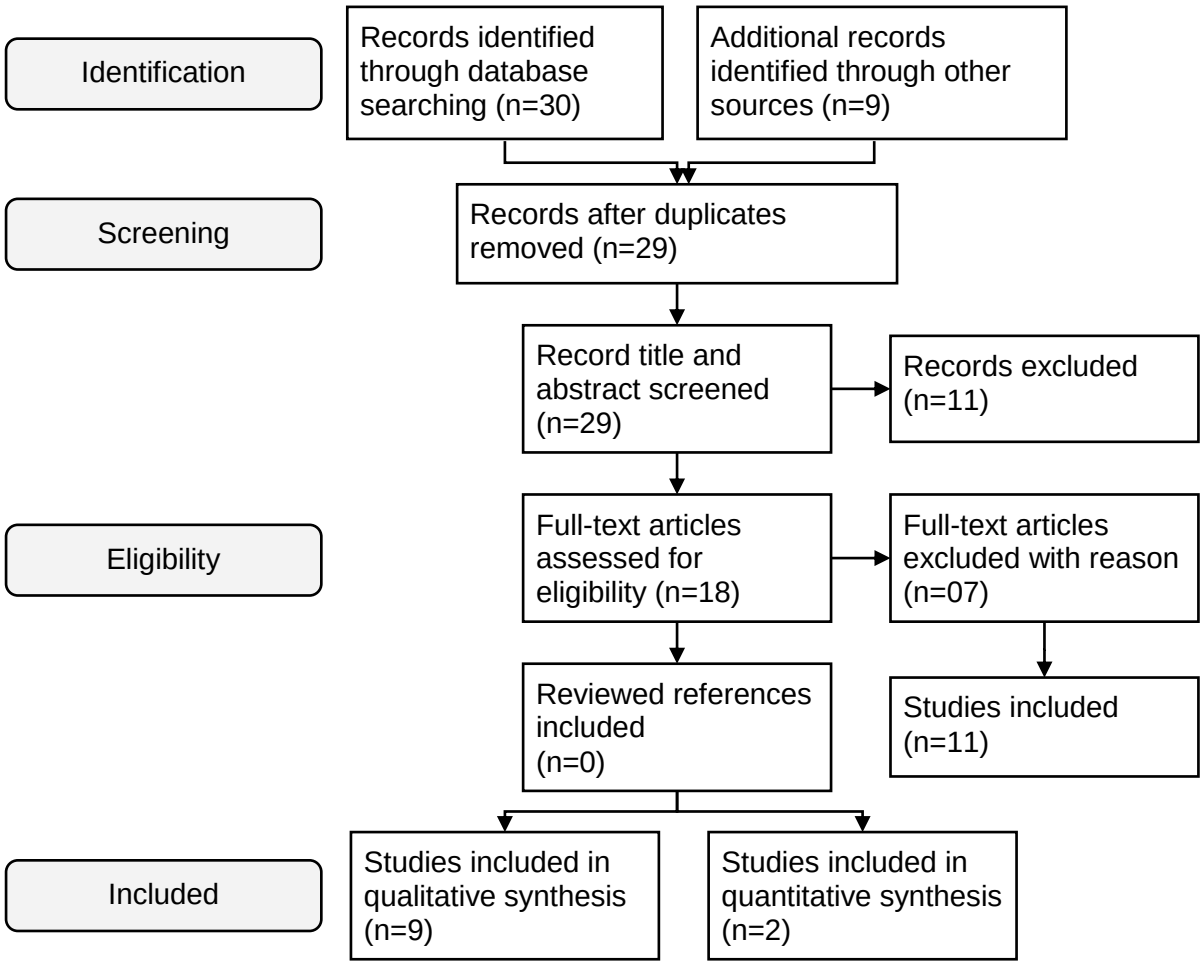
#	Author, Date, Country	Aims	Methods	Participants and setting	Analysis	Key findings	MMAT Scores
						-Development of more flexible community-based care models to provide culturally appropriate care for Aboriginal and Torres Strait Islander patients	
4	Diagnostic Report: Understanding contributing factors for Take-Own-Leave in NSW Health organisations Clinical Excellence Commission and NSW Centre for Aboriginal Health May 2020	Consultations focused on clinician and expert perspectives about the contributing factors for Take-Own-Leave and how they would like to improve the provision of care for Aboriginal peoples	Report	Aboriginal people in New South Wales	Interviews and extensive literature review	Through the consultation process and literature review ten main themes, for Take-Own-Leave, could provide a basis for further programs of work. Each theme links to all four levels of responsibility for action: the system, the organisation, the community and the individual.	***
5	*Discharge against medical advice in culturally and linguistically diverse Australian children* Xin Yue Guo, 2019 Sydney, NSW	The study measured the prevalence and rates of discharge against medical advice in culturally and linguistically diverse children in Sydney Children's Hospital Network.	Cross-sectional study	Culturally and linguistically diverse children (n=192 037), outpatients (n=268 904) and between2015 and 2018 for emergency department (ED) patients (n=158 903).	Prospectively collected data between 2010 and 2018 which was extracted from electronic medical records	Study found that being from a CALD background places children at increased risks to DAMA. Implementing appropriate health service responses may ensure equitable access and quality care for children from CALD backgrounds to reduce the rates of DAMA and its associated ramifications.	***
6	*Picture of the health status of Aboriginal children living in an urban setting of Sydney*	(1) Describe the health status and health indicators for urban Aboriginal children (age	Retrospective cohort study	Urban Aboriginal children 0-16 years Setting: south-east Sydney	Analysis of clinical records from Aboriginal maternal and child data from multiple databases,	Aboriginal children were more likely to be discharged from hospital against medical advice than non-Aboriginal	**

#	Author, Date, Country	Aims	Methods	Participants and setting	Analysis	Key findings	MMAT Scores
	Suzie Gardner, 2016, Sydney NSW.	0–16 years) in south-east Sydney (2) Compare state and national health indicators (3) Evaluate the quality of routinely collected clinical data and its usefulness in monitoring local progress of health outcomes.			between January 2007 and December 2012.	children. Routinely collected data did not include some information essential to monitor determinants of health and health outcomes.	
7	*Predictors of Discharge Against Medical Advice in a Tertiary Paediatric Hospital.* Louise Sealy 2019, Sydney, NSW.	To identify the demographic and clinical characteristics of DAMA patients from a paediatric hospital in Sydney	Retrospective cross-sectional	All Australian children	Data extracted retrospectively from electronic medical records over a 5-year period	This study found clear predictors of DAMA in this tertiary hospital admission cohort. Identifying these provides opportunities for intervention at a practice and policy level in order to prevent adverse outcomes. They found that Aboriginal children had a higher rate of DAMA for various reason.	***
8	*Self-discharge by Adult Aboriginal Patients at Alice Springs Hospital, Central Australia: Insights from a Prospective Cohort Study* Lloyd J. Einsiedel, 2013, Alice Springs, NT.	To determine rates and risk factors for self-discharge by Aboriginal medical inpatients at Alice Springs Hospital.	Prospective Cohort study. Patient interviews.	Participants: 202 Aboriginal adults in the General Medical Unit, Alice Springs Hospital	Statistical analyses of data between 2006 to August 2007.	Study found that there were many and varied reasons for self-discharged such as loneliness, taken by family, payday, attending court, the football, feeling better, staff mistreatment; staff speaking 'roughly' and waiting too long.	****
9	*Understanding remote Aboriginal drug and alcohol residential rehabilitation clients: Who attends, who*	To describe characteristics of clients at remote Aboriginal residential rehabilitation	Prospective Cohort study	All Aboriginal men aged over 18yrs in rehabilitation from 2011 to 2016 (N=329).	Retrospective analysis of 329 clients.	Nearly half (47%) of clients self-discharged from the program. Key recommendations include co-design model of care,	**

#	Author, Date, Country	Aims	Methods	Participants and setting	Analysis	Key findings	MMAT Scores
	leaves and who stays? Alice Munro, 2017, North West, NSW.	service through examining 5 years of data of a remote Aboriginal residential rehabilitation service for substance misuse patients.				standardise data collection and routine follow-up clients to monitor treatment effectiveness.	
10	*Unplanned readmission or death after discharge for Aboriginal and non-Aboriginal people with chronic disease in NSW Australia: a retrospective cohort study.* Amanda Jayakody 2018, NSW.	To examine whether rates of unplanned 28-day hospital readmission, or death, significantly differ between Aboriginal and non-Aboriginal patients in New South Wales, Australia, over a nine-year period.	Retrospective cohort	674, 365 hospital episodes of care for Aboriginal and non-Aboriginal patients	Sample of de-identified linked hospital administrative data. Analyses was retaining diagnosis codes and admission data from the first episode of each separation.	Aboriginal people admitted to an acute facility in NSW public hospital between 30th June 2005 and 1st July 2014	*
11	*Voting with their feet - predictors of discharge against medical advice in Aboriginal and non-Aboriginal ischaemic heart disease inpatients in Western Australia: an analytic study using data linkage* Judith M. Katzenellenbogen, 2013, Western Australia.	To investigate demographic and clinical factors that predict DAMA in patients experiencing their first-ever inpatient admission for ischaemic heart disease (IHD).	Cross sectional study	Participants were all first-ever IHD inpatients aged 25–79 years admitted between 2005 and 2009, selected after a 15-year clearance period and who were discharged alive. N=37,304 (Aboriginal 1602, non-Aboriginal 35702) from WA hospitals.	Analysis of linked hospital and mortality data	Study found the strongest predictors of DAMA are emergency admissions, history of alcohol admission and Aboriginality.	**

Appendix 4

Prisma Flow Chart.



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Appendix 5

National terms and definitions used in Australia:

Organization/ State	Source	Terminologies/Definition	Reference/ Policy	Effective Date (if policy)
National	*Cultural safety in health care for Indigenous Australians: monitoring framework.* Australian Institute of Health & Welfare, 2019.	**Take own leave (TOL)** refers to situations where hospital patients choose to leave prior to commencing or completing their treatment. **Incomplete emergency attendances** Definition: Patients left at their own risk or did not wait. **Discharge from hospital against medical advice** Definition: Patients left against medical advice or were discharged at own risk.	https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/patient-experience-of-health-care/take-own-leave	N/A
Western Australia	*Aboriginal Patient Take Own Leave. Review and recommendations for improvement* Department of Health Western Australia, Perth, 2018	**TOL** describes the circumstances where a patient chooses to leave prior to commencing or completing treatment. It includes instances where patients in Emergency Department (ED) **did not wait (DNW) to receive treatment, abscond or go missing, self-discharge, leave at their own risk (LOR), are away without leave (AWOL) or discharge against medical advice (DAMA).** **Did Not Wait** Definition: Patients who present to Emergency Services and did not wait to be treated after triage assessment. The patient is given three opportunities to be called at least 10 minutes apart. A DNW is different to DAMA. **Discharge Against Medical Advice** Definition: Where a patient leaves against medical advice. Other TOL events that are recorded as DAMA include: **Away Without Leave** Definition: Where a patient takes leave but does not return. **Absconded** Definition: Lost or missing patient; and **Suspected missing patient.** Definition: Where a patient cannot be found, has been seen leaving or is suspected of leaving. If a patient absconds, goes missing or takes leave and does not return from a ward, a Clinical Incident begins, and procedures	https://ww2.health.wa.gov.au//media/Files/Corporate/Policy-Frameworks/Information-management/Policy/Admission-Readmission-Dischargeand-Transfer-Policy/Supporting/Admission-Policy-Reference-Manual.pdf WACHS Management and Review of 'Did Not Wait' patients that present to Emergency Services Policy Hospital Morbidity Data System Manual-Part B DOH Admission, Readmission, Discharge and Transfer Policy	December 2017- September 2020 [i]2018- 2019 1 July 2017- 6 August 2019

Organization/ State	Source	Terminologies/Definition	Reference/ Policy	Effective Date (if policy)
		are followed. The incident is recorded in the WA Health Clinical Incident Management System (CIMS) and the patient's medical record. If the patient returns, the incident is cancelled. If the patient cannot be found, the incident is recorded as **Discharged Against Medical Advice.**		
	Admission Policy Reference Manual Department of Health Western Australia, Perth, 2019.	**Discharge Against Medical Advice** Definition: When the patient chooses to leave the hospital before the completion of treatment against the advice of the treating medical practitioners.	Admission Policy (superseded DOH Admission, Readmission, Discharge and Transfer Policy)	6 August 2019- 30 June 2020
New South Wales	*Diagnostic Report: Understanding contributing factors for Take-Own-Leave in NSW Centre for Aboriginal Health.* Clinical Excellence Commission and NSW Centre for Aboriginal Health, Sydney, 2020	**Take own leave** as an 'umbrella term' for describing the occurrence of incomplete medical treatment **Did not wait** Definition: Patients who decide not to wait for clinical care to commence or medical assessment following triage in the emergency department. **Discharge against medical advice** Definition: Patients who have been admitted to hospital who leave against the expressed advice of their treating physician. **Left at own risk** Definition: Any person who leaves against advice after treatment has commenced. A diagnosis is required. Includes those patients who were planned for admission but who did not physically leave the ED to another treatment location prior to their departure.	NSW Health Emergency Department Patients Awaiting Care policy NSW Aboriginal Health Plan 2013-2023: Mid-term Evaluation (2019) ED Mode of Separation Code Set Update 2017/18	16 March 2018 - 16 March 2023 2013- 2023 11 Sept 2017- 11 Sept 2022
	Mid-term evaluation of the NSW Aboriginal Health plan 2013-2023. NSW Health, 2019.	**Incomplete ED visits** Definition: visits for which the patient either left the ED before receiving a medical assessment or left the ED after a medical assessment but before completion of care or ED discharge.	Western Sydney ED Admission form	2013- 2023

Organization/ State	Source	Terminologies/Definition	Reference/ Policy	Effective Date (if policy)
Northern Territories	*Key performance indicators 2017/18 – attribute sheets.* DOH Northern Territory Govt, 2017.	**Discharge/leave against medical advice within 48 hours (DAMA/LAMA)** Definition: patients who leave/discharge themselves from hospital against medical advice.	AIHW Episode of admitted patient care- separation mode	N/A
	An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients. Deeble Institute, 2016.	**Discharge against medical advice (DAMA)** is defined as the occurrence of an in-patient leaving a hospital or healthcare setting before discharge is advised by the treating provider. **DAMA** is also referred to as **self-discharge, absconding, taking own leave (TOL) and away without leave (AWOL).**	N/A	N/A
Tasmania	*Tasmanian Admitted Patient Dataset - 2019.* AIHW, 2019.	**CODE Z Left against medical advice** Definition: The code is used for patients who have discharged themselves against their doctor's advice.	Metadata online registry https://meteor.aihw.gov.au/content/index.phtml/itemId/441661	01/07/2019-30/06/2020
Victoria	*Section 3 – Data Definitions, Victorian Admitted Episodes Dataset (VAED) manual 2019-20.* Victoria State Government, 2019.	**Z Left against medical advice** Definition: Patient absconds or leaves against medical advice, at own risk. This includes newborns taken from the hospital against medical advice.	https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-Admitted-Episodes-Dataset-manual-2019-2020	2019- 2020
South Australia	*Aboriginal health in South Australia: 2017 case study.* Health Performance Council, Govt of South Australia, 2017.	**Inpatient discharge against medical advice** Definition: Public hospital inpatients who discharge themselves early against medical advice. **Left emergency department at own risk** Definition: persons who prematurely leave public hospital emergency departments (EDs) at their own risk after treatment has already commenced.	https://apo.org.au/node/106861	N/A

Organization/ State	Source	Terminologies/Definition	Reference/ Policy	Effective Date (if policy)
Queensland	*Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2019-2020.* Queensland State Government, 2019.	**Code 07 Discharged at own risk** Definition: Patients who abscond or leave hospital against medical advice.	https://www.health.qld.gov.au/__data/assets/pdf_file/0024/934413/Final_2019-20-QHAPDC-manual_v1.2.pdf	2019- 2020
Australian Capital Territory	*ACT Public Health Services Quarterly Performance Report – Technical and Supplementary Information Quarter 2 2019-20.* ACT Health, 2019.	**Patient who did not wait to be seen** Definition: Patient who did not wait to be seen by a health care professional.	https://health.act.gov.au/sites/default/files/2020-04/Att.%20A2%20-%20Technical%20and%20Supplementary%20Information%20-%20Quarter%202%2C%202019-20.pdf	2019- 2020

Appendix 6

Recommendations obtained from the systematic literature review

Title, Author, Date, Country	Recommendations
Aboriginal Patient Take Own Leave. Review and recommendations for improvement Department of Health Western Australia, Perth 2018	• Improve the cultural competence of health services and create culturally safe environments • Workforce development and training • Improved access to cultural education and training for non-Aboriginal staff including opportunities for ongoing professional development • Engagement and partnerships with Aboriginal consumers, carers and communities in the design, planning and evaluation of programs and services • Collaborative partnerships with Aboriginal community-controlled health services • Support systematic and ongoing two-way communication • Whole-of-organisation approach to improving cultural competency and responsiveness including governance arrangements that reflect this
An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients. Caitlin Shaw 2016, Australia	• Evaluate institutionalised practices • Improve provider training • Create a more welcoming hospital environment • Improve current cultural competency training in acute care • Improve cultural safety frameworks in hospitals • Develop a nationally recognised scope of practice for AHWs/ALOs • Increase recruitment and retention of AHWs/ALOs in acute care, especially in rural hospitals • Develop more flexible community-based care models to provide culturally appropriate care for Aboriginal and Torres Strait Islander patients. • Continue research into DAMA in the Aboriginal and Torres Strait Islander population
Self-discharge by Adult Aboriginal Patients at Alice Springs Hospital, Central Australia: Insights from a Prospective Cohort Study Lloyd J. Einsiedel, 2013, Alice Springs, NT.	• Improve cultural safety and modifying staff-associated risk factors

Title, Author, Date, Country	Recommendations
Understanding remote Aboriginal drug and alcohol residential rehabilitation clients: Who attends, who leaves and who stays? Alice Munro, 2017, North West, NSW.	• Tailor treatment to improve outcomes for high-risk clients • Aboriginal organisations to develop effective evidence-based programs aimed at minimising harms from substance misuse and criminal activity.
Voting with their feet - predictors of discharge against medical advice in Aboriginal and non-Aboriginal ischaemic heart disease inpatients in Western Australia: an analytic study using data linkage Judith M. Katzenellenbogen, 2013, Western Australia.	• Early recognition of patient discomfort (or lack of engagement) and identification of patients' concerns/issues • Screen for and deal with substance dependency proactively • Train staff in how to communicate and deal with situations in a culturally appropriate way • Appointment of an Aboriginal Health worker as patient advocate to help address patient's fears, complaints and concerns • Greater recruitment and retention of Aboriginal people in the health workforce, including interpreters for Aboriginal languages. • Cultural safety measures implemented at staff-level in the hospital system • Post-discharge interventions should form an integral part of the management of leave events for patients • Clear guidelines to contact primary care providers • Actively follow up patients and engage families • Recognise and address systemic racism • Reconfigure models of care to address the needs of Aboriginal and Torres Strait Islander people • Improve information systems • Facilitate communication across the health care sector and with Aboriginal and Torres Strait Islander communities

Abbreviations and Acronyms

TOL	Take on leave
DNW	Did not wait
LOR	Leave at own risk
MMAT	Mixed methods appraisal tool
QUAL	Qualitative
QUAN	Quantitative
MM	Mixed Methods
AIHW	Australian Institute of Health & Welfare
CALD	Culturally and linguistically-diverse
AHPD	Aboriginal Health Policy Directorate
AHCWA	Aboriginal Health Council of Western Australia
WA	Western Australia
HCC	Health Consumers Council
WAPHA	Western Australia Primary Health Alliance
MHC	Mental Health Commission
RPH	Royal Perth Hospital

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