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An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients

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HESTA is proud to have sponsored this Deeble Scholar.

Contents

Key messages

- Aboriginal and Torres Strait Islander peoples are overrepresented in rates of discharge against medical advice (DAMA), especially in the rural and remote context
- DAMA rates are considered a measure of the responsiveness of hospitals to the needs of their Aboriginal and Torres Strait Islander patients
- Currently high levels of DAMA suggest that acute care settings are not effectively addressing the concerns of Aboriginal and Torres Strait Islander patients in order to keep them engaged in care for the full duration of their treatment
- The causal factors associated with DAMA are diverse and complex, and include institutionalised racism, a lack of cultural safety, a distrust of the health system, miscommunication, family and social obligations, and isolation and loneliness
- Aboriginal and Torres Strait Islander patients should not be considered the sole responsibility of Aboriginal and Torres Strait Islander healthcare staff. All members of the health workforce, in collaboration with Aboriginal Health Workers (AHWs) and Aboriginal Liaison Officers (ALOs) need to be accountable for the wellbeing of Aboriginal patients in acute care.
- The following recommendations are made to address rates of DAMA in the Aboriginal and Torres Strait Islander population:

1. Improvement of current cultural competency training in acute care.
2. Improvement of cultural safety frameworks in hospitals.
3. Development of a nationally recognised scope of practice for AHWs and ALOs.
4. Increased recruitment and retention of AHWs/ALOs in acute care, especially in rural hospitals.
5. Development of more flexible community-based care models to provide culturally appropriate care for Aboriginal and Torres Strait Islander patients.
6. Continued research into DAMA in the Aboriginal and Torres Strait Islander population.

Executive summary

Discharge against medical advice (DAMA), also referred to as self-discharge, occurs when an in-patient leaves a hospital or healthcare setting before discharge is advised by the treating provider. DAMA causes interruption of treatment therapies and is strongly associated with post-operative complications, increased morbidity and mortality, readmission, and increased healthcare expenditure. It is widely known that Aboriginal and Torres Strait Islander peoples suffer from increased rates of chronic disease and have poorer health outcomes than the non-Indigenous population. It is now understood that Aboriginal and Torres Strait Islander peoples are also overrepresented in self-discharge rates, especially in the rural and remote context (Wright 2009b, Katzenellenbogen et al. 2013, AIHW 2013).

DAMA rates are considered a measure of the responsiveness of hospitals to the needs of their Aboriginal and Torres Strait Islander patients. Currently high levels suggest that acute care settings are not effectively addressing the concerns of Aboriginal and Torres Strait Islander patients in order to keep them engaged in care for the duration of their treatment. The literature review identified that there are a number of contributory factors associated with DAMA among Aboriginal and Torres Strait Islander peoples. Several significant factors are: institutionalised racism, a lack of cultural safety, a distrust of the health system, miscommunication, family and social obligations, and isolation and loneliness.

Evidence suggests that enhancing cultural safety in hospitals is instrumental in reducing self-discharge. Cultural safety is based on partnership between provider and patient, in which shared respect underpins improved communication, treatment decisions and health outcomes (Wright 2009b). For the Aboriginal and Torres Strait Islander population, the presence of Aboriginal Health Workers (AHWs) and Aboriginal Liaison Officers (ALOs) has been demonstrated to enhance cultural safety, improve patient care, and in certain cases, significantly reduce self-discharge (Einsiedel et al. 2012, Katzenellenbogen et al. 2013).

AHWs and ALOs are well placed to help reduce DAMA in the Aboriginal and Torres Strait Islander population. However, institutional changes are needed to optimise this role. Greater employment and utilisation of AHWs/ALOs in hospitals, underpinned by a nationally recognised scope of practice, can enhance their ability to provide culturally appropriate care to Aboriginal and Torres Strait Islander patients. Coordination between acute and community-based care providers can aid in offering healthcare services that are more accessible and culturally acceptable. Improved community care and health education may encourage Aboriginal and Torres Strait Islander patients to remain in care for the duration of their treatment.

Acknowledgements

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1. Introduction

Discharge against medical advice (DAMA)[1] is defined as the occurrence of an in-patient leaving a hospital or healthcare setting before discharge is advised by the treating provider (Clark et al. 2014, Yong et al. 2013). This occurs when the patient either officially 'self-discharges' by completing the appropriate documentation, or simply leaves before their hospital stay is complete (Clark et al. 2014). DAMA disrupts medical treatment, is associated with increased readmission, morbidity and mortality, and poses significant problems for patient continuity of care (Einsiedel et al. 2012, Katzenellenbogen et al. 2013). DAMA is more prevalent in the Aboriginal and Torres Strait Islander population (AIHW 2013), especially for those living in rural and remote areas (Katzenellenbogen et al. 2013). In light of recent policy developments, there is a renewed determination to substantively address disadvantage in Aboriginal and Torres Strait Islander health. Examining underlying factors for, and possible solutions to, self-discharge in the Aboriginal and Torres Strait Islander population is essential to reducing the gap in health equality.

This issues brief considers the following questions:

1. What is the prevalence of self-discharge in the Aboriginal and Torres Strait Islander population?
2. Why is it occurring?
3. What role do Aboriginal Health Workers (AHWs) and Aboriginal Liaison Officers (ALOs) play in providing healthcare for Aboriginal and Torres Strait Islander patients?

[1] DAMA is also referred to as self-discharge, absconding, taking own leave (TOL) and away without leave (AWOL).

4. How can hospitals and the healthcare system be more responsive to the concerns of Aboriginal patients in order to keep them engaged in care for the full duration of their treatment?
5. Can AHWs/ALOs be an effective instrument in facilitating this change?

2. Understanding the problem

What is the prevalence of self-discharge in the Aboriginal and Torres Strait Islander population, and why is it occurring? What role do AHWs and ALOs play in providing healthcare for Aboriginal and Torres Strait Islander patients?

2.1 Discharge against medical advice

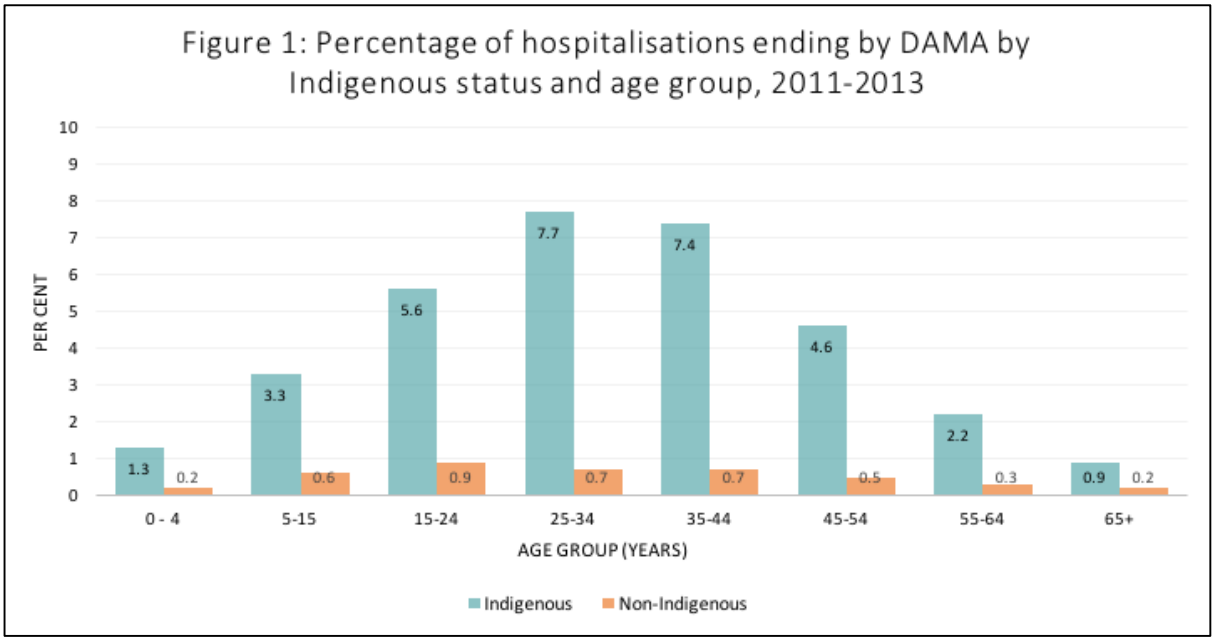
DAMA represents a problematic issue in healthcare for patients and healthcare providers alike. It causes interruption of treatment therapies and is strongly associated with post-operative complications, increased morbidity and mortality, re-admission and increased healthcare expenditure (Einsiedel et al. 2012, Katzenellenbogen et al. 2013). Results from two studies conducted in the United States (US) have shown that patients who self-discharge are more likely to be readmitted to hospital, usually within 14 to 30 days (Aliyu 2002, Southern et al. 2012). Southern et al. (2012) also found that patients who DAMA generally have shorter hospital stays than those who do not, which is independently associated with increased rates of readmission (Collier 2012). Premature discharge and subsequent readmission to hospital significantly disrupts patient continuity of care, which is crucial for effective treatment and improved health outcomes.

Understanding patient motivation to self-discharge has been under-represented in the literature in Australia and internationally (Henry et al. 2007, Moyse & Osmun 2004). Hence, making useful predictions about *who* is at risk of DAMA is problematic. However, there are some consistencies across the literature as to the characteristics of patients who self-discharge. Violent and non-compliant behaviour, alcohol and/or drug abuse and male gender have been associated with DAMA in a number of studies (Henry et al. 2007, Moyse & Osmun 2004). Research conducted by Bowers et al. (1999) on psychiatric care found that there are a plethora of reasons why patients self-discharge, including isolation, fear, miscommunication, breakdown of the patient-doctor relationship, stigma, family responsibility, boredom and worries about housing and property. Many of these issues are out of the healthcare provider's control. However, there are areas in which hospitals and healthcare providers can make significant changes in order to reduce self-discharge. Evaluating institutionalised practices, improving provider training and creating a more welcoming hospital environment have been recognised as such factors.

2.2. Why is discharge against medical advice an important issue in Aboriginal and Torres Strait Islander health?

It is widely acknowledged that Aboriginal and Torres Strait Islander peoples have poorer healthcare access and health outcomes than the non-Indigenous population. The causes of this significant health gap are multifactorial and complex, and are underpinned by cultural, social, political and economic factors (Durey 2012, Nguyen 2008). The Aboriginal and Torres Strait Islander population suffer from higher rates of chronic disease (such as diabetes, cancer and kidney disease) and injury, and are hospitalised at a rate 1.8 times higher than that of the non-Indigenous population (AHMAC 2015, Vos 2007). It is now understood that Aboriginal and Torres Strait Islander people are also overrepresented in DAMA rates. Indeed, it is estimated that Aboriginal and Torres Strait Islander people self-discharge between 6-19 times the rate of non-Indigenous Australians (Wright 2009b, Katzenellenbogen et al. 2013, AIHW 2013). Aboriginal and Torres Strait Islander males aged between 25 and 44, in particular, have been found to self-discharge at 20-30 times the rate of non-Indigenous patients (Wright 2009a). While a number of factors influence the likelihood of a patient self-discharging, such as gender and socio-economic status, identifying as an Aboriginal or Torres Straight Islander person has been found to be the single most significant contributing factor to a patient's DAMA risk (AHMAC 2015).

Figure 1: Percentage of hospitalisations ending by DAMA by Indigenous status and age group, 2011-2013

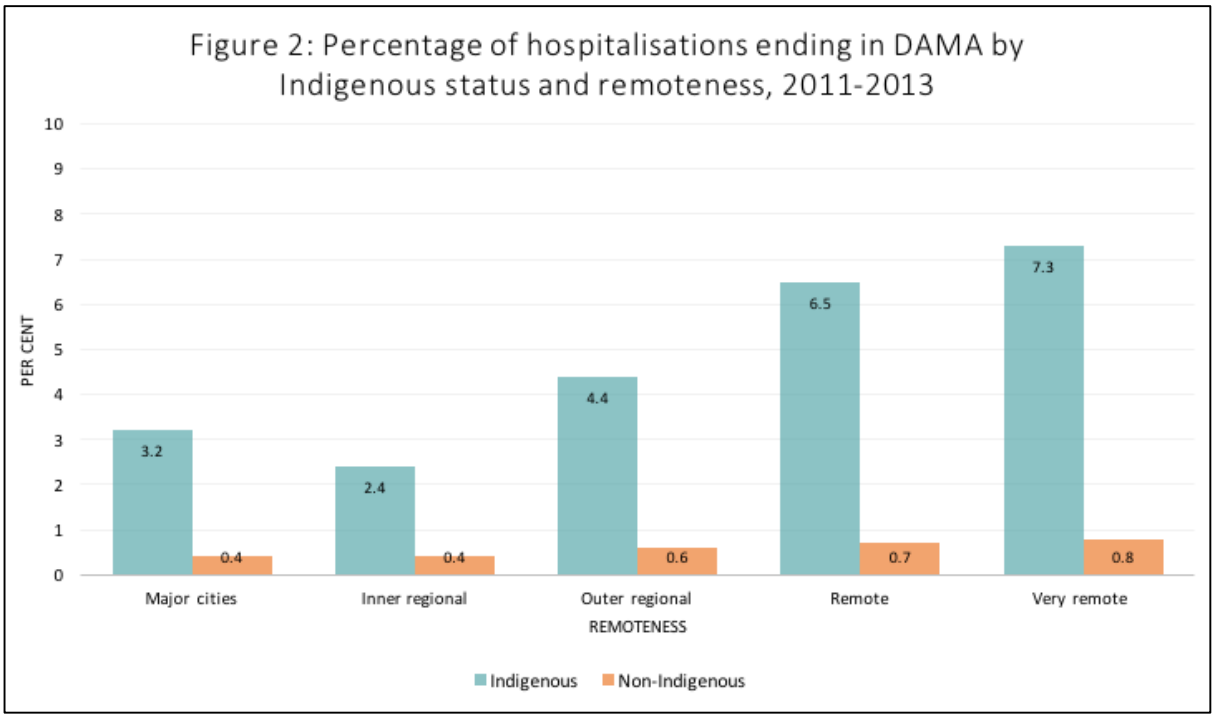


Source: AIHW National Hospital Morbidity Database

Access to healthcare services is particularly problematic for both non-Indigenous and Aboriginal and Torres Strait Islander people living in rural and remote areas. However, as of 2011, Aboriginal and Torres Strait Islander people are more likely to live in remote areas as compared to their non-Indigenous counterparts[2] (ABS 2013). A study of 1000 Aboriginal and

[2] 21.4% of Aboriginal people live in remote areas, compared to 1.7% of non-Aboriginal people.

Torres Strait Islander communities has shown that 69% are located more than 100km from the closest hospital, and hence have more limited access to services (Thomas & Anderson 2006). Katzenellenbogen et al. (2013) found that Aboriginal and Torres Strait Islander people living in a rural area are significantly less likely to attend a metropolitan hospital. Further, data shows that DAMA rates tend to increase with increasing remoteness of Aboriginal and Torres Strait Islander patients. Katzenellenbogen et al. (2013) also found that rural Aboriginal and Torres Strait Islander patients admitted to a non-metropolitan hospital were 50% more likely to self-discharge compared to metropolitan patients admitted to a metropolitan hospital. Data presented in Figure 2 show that rates of DAMA in the Aboriginal and Torres Strait Islander population are highest in regional and remote localities. However, this data also shows that, irrelevant of location, rates of DAMA are higher in the Aboriginal and Torres Strait Islander compared to non-Indigenous population.



Source: AIHW National Hospital Morbidity Database

2.3. Why Aboriginal and Torres Strait Islander patients discharge against medical advice – what does the research say?

To date, a limited number of qualitative studies have been conducted that examine the causal factors associated with DAMA in the Aboriginal and Torres Strait Islander population. A review of the available literature found five research papers that specifically address this issue. Although this is a small data set, it will provide the basis of the evidence for this issues brief.

a. *A qualitative analysis of patients taking their own leave from Alice Springs Hospital in 1998 – Franks and Beckmann 2002*

The findings of this study were based on interviews with 19 patients (16 Aboriginal and Torres Strait Islander) and 38 health professionals (7 Aboriginal and Torres Strait Islander). Interviews were semi-structured and guided by questions about reasons for hospital admission, beliefs about the hospital system, and reasons for leaving the hospital. Responses from patients and health professionals highlighted a common set of factors associated with DAMA:

- Issues and miscommunication with hospital staff, such as being spoken to 'roughly;'
- Language and cultural barriers;
- Loneliness and social isolation;
- Family obligations;
- Wanting to die on country; and
- Perception that it is 'okay to go.'

b. *Self-discharge against medical advice from Northern Territory hospitals – Henry et al. 2007*

This comprehensive report analysed responses from 48 interviews and 8 focus groups conducted with patients and providers across five regional hospitals from 2005-2006. An economic analysis estimated that preventing the majority of DAMA events would produce a saving of $4.7 million over five years in Northern Territory public hospitals. The report determined four key areas that impact on self-discharge: patients' response to hospitalisation; social and cultural issues; health system failures; and cultural security. Within these areas, specific factors associated with self-discharge were identified as:

- Linguistic and cultural communication issues;
- Financial responsibilities, especially on payday;
- Pressure from partners and family to return home;
- Distrust of the health system;
- Transport cost and availability (patients from remote communities may self-discharge when transport to go home becomes available);
- Perceived racist, inappropriate and insensitive behaviour by hospital staff; and
- Absence of Aboriginal and Torres Strait Islander staff, especially Aboriginal Liaison Officers (ALOs) and Aboriginal Health Workers (AHWs).

c. *'They just don't like to wait' – a comparative study of Aboriginal and Torres Strait Islander and non-Indigenous people who did not wait for treatment or discharged against medical advice from rural emergency departments: Part 1 and Part 2 – Wright 2009*

This two-part study examined the characteristics of patients who either 'did not wait' or self-discharged from the emergency departments of four rural New South Wales hospitals[3] between January and December of 2006. Consistent with other studies, it found that Aboriginal and Torres Strait Islander patients were 2.5 times more likely to self-discharge than their non-Indigenous counterparts. One key conclusion was that this trend provides strong indirect evidence of service dissatisfaction, suggesting that hospitals are not currently responsive to the unique needs of Aboriginal and Torres Strait Islander patients. This study identified causal factors for DAMA as:

- Cultural differences;
- Real or perceived racism;
- Lack of cultural safety;
- Unfamiliar routines; and
- Isolation and loneliness.

d. *Self-discharge by adult Aboriginal and Torres Strait Islander patients at Alice Springs Hospital, Central Australia: insights from a prospective cohort study – Einsiedel et al. 2012*

This study, conducted at the Alice Springs Hospital, described its considerable Aboriginal and Torres Strait Islander patient base as living in remote and economically disadvantaged communities. Between July 2006 and August 2007, DAMA rates were recorded and weekly patient interviews were conducted. During this time period, 300 Aboriginal and Torres Strait Islander patients discharged during 489 admissions. Many of these self-discharge events involved young adult patients with treatable conditions. Importantly, it was found that over 90% of patients who self-discharged were completely reliant on social welfare, suggesting a relationship between socioeconomic disadvantage and self-discharge. The key factors found to be associated with DAMA were:

- Conflicting understanding of the reason for admission between provider and patient;
- Use of English as a second language;
- The 'impersonal nature' of Western medicine;
- Distrust of doctors;
- Association of hospitals with death; and
- Experience of miscommunication and alienation.

e. *Voting with their feet – predictors of discharge against medical advice in Aboriginal and Torres Strait Islander and non-Indigenous ischaemic heart disease inpatients in*

[3] 1. Kempsey District Hospital
2. Grafton Hospital
3. Port Macquarie Base Hospital
4. Coffs Harbour Base Hospital

Western Australia: an analytic study using data linkage – Katzenellenbogen et al. 2013

This study examined DAMA rates in patients admitted with their first ischaemic heart disease (IHD) event in Western Australian hospitals from 2000-2008. Consistent with other data, this study found that young, male, Aboriginal and Torres Strait Islander and rural patients were more likely to self-discharge. Possible causes of self-discharge in the Aboriginal and Torres Strait Islander patient population were identified as:

- Family and social obligations;
- Medical staff lacking appropriate cultural training;
- Aboriginal and Torres Strait Islander patients feeling unwelcome and misunderstood;
- Anxiety and anger; and
- Negative associations with hospitals.

The available literature identifies a number of consistent factors that are associated with self-discharge in the Aboriginal and Torres Strait Islander population. These are: a lack of cultural safety and culturally appropriate care, institutionalised racism, miscommunication, family and social obligations, and isolation and loneliness.

Further, differing understanding between patient and provider of diagnosis, aetiology and required treatment can diminish the quality of patient care. 'Health' from an Aboriginal and Torres Strait Islander perspective may encompass not only physical wellbeing, but social, emotional and cultural wellbeing of the individual and their community (NACCHO 2014). This holistic understanding can be at odds with the biomedical model of health adopted in hospital settings, which focuses predominately on the management of disease. In the context of self-discharge, this belief system may manifest in a patient leaving the hospital before their treatment is complete for reasons such as attending to cultural obligations, or because they are homesick for country. Healthcare providers may not readily appreciate a patient's decision to self-discharge, or the social determinants of health that underpin that decision, which can lead to misunderstandings and a breakdown in communication. As such, 'negotiating shared concepts of illness' between non-Indigenous providers and Aboriginal and Torres Strait Islander patients is a significant challenge for the healthcare sector (Einsiedel et al. 2012: 240).

2.4 The role of Aboriginal Health Workers and Aboriginal Liaison Officers

The Aboriginal Health Worker (AHW) workforce has been a part of Australian healthcare provision since the 1950s, and developed in response to the need to provide culturally safe healthcare services to Aboriginal and Torres Strait Islander people (HWA 2014, Abbott et al. 2008). Cultural safety is defined by Williams (1999: 213) as 'an environment which is safe for people, where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning (and) shared knowledge.' Cultural safety recognises the imbalanced power relationship between Aboriginal and

Torres Strait Islander patients and the health system, the impact of differing understandings of health on healthcare, and advocates for partnership between provider and patient (Wright 2009b). The presence of Aboriginal and Torres Strait Islander people themselves in the health workforce is an important contributor to cultural safety.

Currently, there is no consistent, nationally recognised definition of an AHW. The Health Workforce Australia report *Growing our Future: the Aboriginal and Torres Strait Islander Health Workforce Final Report* (HWA 2011) recommends an AHW be defined as an individual who:

- Identifies as an Aboriginal and/or Torres Strait Islander and is recognised as such by their community; and
- Is the holder of the minimum qualification in Aboriginal and Torres Strait Islander primary health care; and
- Has a culturally safe and holistic approach to health care.

While the minimum qualification is identified as a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care, there is considerable variation in the educational attainment and scope of practice of AHWs (HWA 2014). This variation is not only due to differing skill sets and workplace demands, but the degree of recognition and integration of the role in mainstream healthcare settings. As described by Abbott et al. (2008), AHWs can be responsible for clinical care (such as health checks and immunisations), patient health education and health promotion, chronic disease management, community advocacy and cultural mentorship for non-Indigenous health professionals.

Aboriginal Liaison Officers (ALOs) do not perform clinical duties. Rather, they provide social, emotional and cultural support to Aboriginal and Torres Strait Islander patients, liaise between patients and providers, and work collaboratively with social workers to provide a link between the acute and community healthcare setting. However, the primary role of both AHWs and ALOs is 'cultural brokerage' between Aboriginal and Torres Strait Islander patients and the mainstream healthcare setting (Williams 2001).

Data presented by Health Workforce Australia (HWA) (2014) indicates that as of 2011 there were 1,256 AHWs (inclusive of ALOs) employed in the healthcare sector nationwide. Of these, only 27% (337) worked in hospitals (318 in public hospitals, and 19 in private). The majority of AHWs (64%) worked in the private or community sector. Considering the 1,356 hospitals (747 public, 612 private) across Australia (AIHW 2015), there would appear to be large gaps in the employment of AHWs in acute settings. Although the distribution of AHWs cannot be inferred from this data, clearly there is not an AHW employed at each Australian hospital. This assessment is supported by the National Rural Health Alliance (2006), which states that there is an insufficient number of Aboriginal and Torres Strait Islander health professionals to ensure access to a health worker for all Aboriginal and Torres Strait Islander patients.

3. The policy context

3.1 Why is this relevant for policy makers?

Addressing the inequalities in Aboriginal and Torres Strait Islander health is an important national health policy issue. In 2010-2011, the total health expenditure for Aboriginal and Torres Strait Islander people was approximately $4.6 billion, which is 3.7% of Australia's total recurrent health expenditure (AIHW 2013). Contemporary policy frameworks have been developed to address the Aboriginal and Torres Strait Islander health gap with a focus on understanding the unique needs of Aboriginal and Torres Strait Islander patients, the social determinants of health that shape their access to healthcare, and creating a healthcare system that is responsive to those needs.

The *Closing the Gap* program, endorsed in 2008, aims 'to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Aboriginal Australians by the year 2030' (Human Right and Equal Opportunity Commission 2008). Although there have been some improvements, according to Prime Minister Malcolm Turnbull's Closing the Gap 2016 Report Card (Department of Prime Minster and Cabinet 2016), slow progress has been made against life expectancy targets, indicating that there is significant room for improvement before the target date of 2030.

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2011-2015)* (Australian Government 2013) recognised the importance of a culturally competent health workforce, aiming to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, develop a national Aboriginal and Torres Strait Islander health worker scope of practice, and build a workforce that has the requisite support and resources to provide high-quality care for Aboriginal and Torres Strait Islander patients. However, HWA (2014) identified that AHWs (inclusive of Aboriginal Health Practitioners and ALOs) have some of the longest average weekly working hours of all health professions, and have had the second largest increase in working hours since 2006.[4]

Building upon the *Closing the Gap* objectives, the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* was developed to provide an evidence-based framework to achieve equality in Aboriginal and Torres Strait Islander and non-Indigenous health. This plan outlines a number of priority areas for improving health outcomes, based on a best practice approach to enable Aboriginal and Torres Strait Islander patients to achieve better health outcomes. 'Health enablers' (presented in Table 1) are embedded in creating institutionalised cultural competence with the desired outcome of appropriate uptake of healthcare services by Aboriginal and Torres Strait Islander peoples.

[4] In 2011, AHWs worked an average of 36.4 hours per week, compared to an overall average of 31.9 hours per week for all health professionals.

Table 1: The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 Priorities

Health Enabler	Goal
a. A culturally respectful and non-discriminatory health system	All health care, whether government, community or private, is **free of racism**
b. Health system effectiveness and clinically appropriate care	The health system delivers clinically appropriate care that is **culturally safe**, high quality, **responsive and accessible for all Aboriginal and Torres Strait Islander people**
c. Evidence-based practice	Health policies and programs are clearly evidence-based and informed by robust health research and data systems
d. Mental health and emotional wellbeing	Aboriginal and Torres Strait Islander people have the best possible mental health and wellbeing. Social and emotional wellbeing strategies are integrated in all health care service delivery and health promotion strategies
e. Human and community capability	The capabilities, potential and aspirations of Aboriginal and Torres Strait Islander people are realised and **optimise their contribution as individuals to the health workforce and to strategies to achieve Aboriginal and Torres Strait Islander wellbeing**. Institutional and organisational structures and processes harness human and community capability and enhance its potential

Source: The National Aboriginal and Torres Strait Islander Health Plan 2013-2023

3.2 Hospital responsiveness to the needs of Aboriginal patients

Cultural competency of staff in the healthcare system significantly influences all aspects of Aboriginal and Torres Strait Islander patient care – willingness to access services, quality of care and health outcomes. Cultural competency training in hospitals is informed by policy, and according to the *Aboriginal and Torres Strait Islander Health Performance Framework 2014*, an accurate understanding of patient experiences in hospital and satisfaction with their care is key to shaping effective health policy. Therefore, examining how *responsive* a hospital is to its patients gives an important insight into how policy should be developed to meet these needs.

Rates of DAMA are considered an indicator of health system performance. How responsive a hospital is to the needs of Aboriginal and Torres Strait Islander patients, and consequently its cultural competency, can be evaluated by examining patient satisfaction with their care (AHMAC 2015, Katzenellenbogen at al. 2013, Durey et al. 2012). Although the reasons why

patients self-discharge are diverse and complex, current rates of self-discharge in Aboriginal and Torres Strait Islander patients imply ineffective cultural competency in acute care. Rather, as stated in the framework (AHMAC 2014), 'the elevated levels of discharge against medical advice suggest that there are significant issues in the responsiveness of hospitals to the needs and perceptions of Aboriginal and Torres Strait Islander peoples' (AHMAC 2015: 146).

4. Looking toward a solution

> *How can hospitals and the healthcare system be more responsive to the concerns of Aboriginal and Torres Strait Islander patients in order to keep them engaged in care for the full duration of their treatment? Can AHWs/ALOs be an effective instrument in making this change?*

Finding ways to reduce the rates of self-discharge in the Aboriginal and Torres Strait Islander population will require finding ways to become more responsive to their unique needs in order to keep them engaged in care. Given the many complex social and cultural factors associated with DAMA, this is a challenging task for the healthcare sector. However, there are opportunities for institutional change within acute care settings to address the problems that are within the control of the hospital.

From the available literature, it is apparent that there is a lack of research specifically addressing how to reduce rates of self-discharge, and further, the role of AHWs/ALOs in facilitating this change. Additional work to address this research gap could yield valuable insights into this issue. Of the research that is available, possible strategies to reduce DAMA are mostly based on recommendations of healthcare providers or the authors themselves, rather than statistical data. However, much of this evidence is consistent with contemporary understandings of best practice in improving health outcomes in Aboriginal and Torres Strait Islander people. It offers a valuable insight into the on-the-ground realities of managing self-discharge in hospitals.

4.1 Enhanced cultural safety

Increasing the cultural competence training of hospital staff and creating a culturally safe environment have been key recommendations in the research regarding self-discharge of Aboriginal and Torres Strait Islander patients. Greater awareness of cultural norms such as connection to country, family obligations and avoidance relationships[5] can equip staff in providing more appropriate care for their Aboriginal and Torres Strait Islander patients. Simple adaptations to the hospital environment, such as allowing extra space for family members to visit or providing bush tucker, can have a significant impact on an Aboriginal

[5] An avoidance relationship exists when communication between two individuals (usually extended family members) is limited or forbidden (Edwards 2005).

and Torres Strait Islander patient's comfort, wellbeing, and willingness to stay in hospital (Franks and Beckmann 2002, Henry et al. 2007).

Further, almost all state and territory health departments have developed cultural competency frameworks for acute and primary care.[6] For example, the Queensland *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033* aims to 'provide culturally responsive health services, including the involvement and support of Aboriginal and Torres Strait Islander staff, and develop the cultural capability of all Queensland Health staff' (Queensland Health 2010: 10). Although these frameworks are employed, a lack of cultural safety persists as a well-documented causal factor associated with DAMA. The necessity to improve institutional practice has been recognised in the literature. For example, Henry et al. (2007: 58) states that 'the over representation of Aboriginal patients who discharge against medical advice in the Northern Territory suggests that the solutions for this problem can be found in large part through the implementation of a Departmental Cultural Security Policy.' As such, improvements need to be made at both an institutional and interpersonal level, including through translation of policy into practice, to provide culturally appropriate care for Aboriginal and Torres Strait Islander patients.

Enhanced cultural safety needs to be underpinned by meaningful and effective cultural training for all hospital staff. Although some form of cultural training is available at most hospitals, brief training sessions, a lack of appropriate funding and reluctance of staff to attend diminishes its efficacy (Westwood & Westwood 2010, Rix et al. 2013). Clinical staff themselves have expressed frustration at a lack of constructive cultural training. A participant in a study conducted by Rix et al (2013: 4) stated that 'I don't believe that you can do that as a one-off because…that's like saying 'tick I've done that' and that's useless. There's got to be some sort of ongoing mechanism, ongoing culture, within the organisation that supports that ethos constantly.' In addition, acknowledging the heterogeneity of the Aboriginal and Torres Strait Islander population, and the differing health needs of different communities, will assist providers in offering appropriate support and services. Flexible training models are needed that can be adapted to individual settings according to locally identified priorities.

4.2 Increased visibility and effective utilisation of Aboriginal Health Workers and Aboriginal Liaison Officers

[6] Queensland: Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033
New South Wales: New South Wales Aboriginal Health Plan 2013-2023
Western Australia: Aboriginal Health and Wellbeing Framework 2015-2016
Victoria: Koolin Balit – State-wide Action Plan 2013-2015
South Australia: Aboriginal Health Care Plan 2010-2016
Northern Territory: Aboriginal Cultural Security 2008
Australian Capital Territory: Aboriginal and Torres Strait Islander Workforce Action Plan 2013-2018
Tasmania does not currently have a policy document specific to Aboriginal health. The Primary Health Network is developing a needs assessment for Tasmanian Aboriginal health to be released March, 2016.

The importance of AHWs and ALOs in providing better care for Aboriginal and Torres Strait Islander patients is also evident in the literature. AHWs/ALOs, through their cultural brokerage role, are able to simultaneously help an Aboriginal and Torres Strait Islander patient interact with the hospital setting, and help non-Indigenous staff understand the needs of an Aboriginal or Torres Strait Islander patient. This multidimensional educational/advocacy/advisory role can be key to supporting patients to stay in hospital for the duration of their treatment. Indeed, the principal recommendation from staff interviewed by Franks and Beckmann (2002) was the need for more employment of specialised Aboriginal and Torres Strait Islander staff such as AWHs and ALOs to reduce DAMA. A study conducted by Taylor et al. (2009) showed a decrease in DAMA events of almost half during the six months an AHW was employed in a cardiology ward of a Western Australian hospital.[7] A particularly poignant account from a nurse describes the benefit of an AHW with DAMA at-risk patients:

> '*We nearly started a war one time. We had two people who were both the same sex, but the families were not friends and should not have been together…and the AHW told us "You need to move these patients straight away otherwise someone will walk." If she wasn't there we would have had a DAMA situation.'*

As concluded in the study, 'this reduction of DAMAs highlights an important impact of the AHW not only in improving patient comfort, but also in reducing the risks associated with premature discharge' (Taylor 2009: 552). Likewise, a study conducted by Einsiedel et al. (2012: 244) (see p 7) at the Alice Springs Hospital found that Aboriginal and Torres Strait Islander liaison led to 'significant reductions in self-discharge rates.' However, there is no data that identifies the ideal number of AHWs and ALOs needed to adequately address the needs of Aboriginal patients. Therefore, it is difficult to make recommendations about how many AHWs/ALOs should be employed in Australian hospitals.

The need for greater recruitment and retention of AHWs and ALOs in the healthcare sector is cited in a number of state health department policies (for example, see the *New South Wales Aboriginal Health Plan 2013-2023*, p 14). However, the mere presence of AHWs and ALOs in the healthcare workforce is not enough to ensure high-quality care for Aboriginal and Torres Strait Islander patients. A number of studies (Jackson et al. 1999, Franks & Beckmann 2002, Henry et al. 2007) report the need to address problems in the way the role is recognised and integrated into the hospital in order to be more effective in reducing self-discharge. Widespread systemic and organisational support is required to maximise this role. This may involve developing a nationally recognised definition and scope of practice for AHWs and ALOs, as recommended by HWA (2011). AHWs have expressed frustration with their role in acute care, stating they have not been able to fully use their clinical or cultural skills in the hospital (Henry 2007, Taylor 2009). Confusion as to the role of an AHW can

[7] 5 DAMA events occurred during the employment of the AHW, as opposed to 11 events that occurred in the preceding 5 months.

undermine its importance, inhibit effective collaborative care and lead to underutilisation (Taylor 2009). Further, better funding models would allow more AWHs/ALOs to be employed, and allow them to provide out-of-hours services when they are needed.[8] However, Aboriginal and Torres Strait Islander patients should not be considered the sole responsibility of Aboriginal and Torres Strait Islander healthcare staff (Durey 2012). All members of the health workforce, in collaboration with AHWs/ALOs, need to be accountable for the wellbeing of Aboriginal and Torres Strait Islander patients in acute care.

4.3 Community-based care models

Considering the holistic nature of Aboriginal and Torres Strait Islander health and the cultural significance of community, appropriate and well-coordinated health services are required beyond the boundaries of hospital walls. Many Aboriginal and Torres Strait Islander people live in communities that are great distances from regional or urban centres, and rates of DAMA in the Aboriginal and Torres Strait Islander population are highest in regional and remote localities (see Figure 2) . Especially when considering patients with chronic disease, numerous and lengthy stays in hospital can be difficult to manage. In the Northern Territory, for example, public transport is difficult to access, and patients may self-discharge prematurely if there is a private vehicle returning to their community (Henry et al. 2007).

Responses from staff at a remote Northern Territory health service expressed concern that self-discharging patients were 'falling through the gaps' and that 'more formal arrangements could be made between hospital and local Aboriginal Medical Services, particularly in regional areas, to better manage self-discharging Indigenous patients' (Henry et al. 2007: 42). In particular, Aboriginal and Torres Strait Islander patients who frequently self-discharge require a model of care that better addresses their needs. Current service design and delivery modes can be too rigid to adequately address the diverse needs of Aboriginal and Torres Strait Islander patients (Rix et al. 2013). Greater flexibility in the provision of services, facilitated by coordination between the hospital and community-based health providers, could increase the utilisation of community-based treatment, shorten hospital stays, and potentially reduce DAMA events (Einsiedel et al. 2012).

Community healthcare is not just relevant for post-discharge care, but can also provide education about the hospital system before a patient is admitted. Community clinics can offer their patients information about hospital processes, what they can expect and, importantly, what support mechanisms (such as AHWs) are available to them (Henry et al. 2007). Improved patient understanding of the hospital and the services offered could ameliorate the hospital experience and encourage Aboriginal and Torres Strait Islander patients to stay for the length of their treatment.

5. Implications for policy-makers and providers

[8] Rehabilitation Services at the Royal Darwin Hospital reported that patients commonly self-discharged on the weekends when there was no ALO present (Henry 2007).

Improving health services available to Aboriginal and Torres Strait Islander people and ensuring their cultural appropriateness are policy imperatives for State and Commonwealth health departments, as well as an important priority for healthcare providers. If progress is to be made in reducing health inequalities and closing the gap with non-Indigenous people, effective steps to reduce DAMA must be taken that can be implemented at the system, institutional and provider level. Any policy initiative must recognise the heterogeneity of the Aboriginal and Torres Strait Islander population, and the diverse needs of Aboriginal and Torres Strait Islander patients in different cultural and geographical settings. Below are a number of recommendations based on the evidence provided in this issues brief.

5.1 *Recommendations*

1. *Improvement of current cultural competency training in acute care*

The cultural competency training currently offered in Australian hospitals should be reviewed and necessary improvements should be made to ensure training is comprehensive and effective. Training should be of an ongoing nature and be mandatory for all staff responsible for care of Aboriginal and Torres Strait Islander patients.

2. *Improvement of cultural safety frameworks in hospitals*

Hospitals should endeavour to provide a more welcoming and comfortable environment for their Aboriginal and Torres Strait Islander patients, and to address cultural concerns of Aboriginal and Torres Strait Islander patients early in their admission. This should be embedded in formal cultural safety frameworks that are understood and implemented by all staff.

3. *Development of a nationally recognised scope of practice for AHWs/ALOs*

State and Commonwealth health departments and relevant health bodies should devise a definition and scope of practice for AHWs and ALOs that is recognised nationally in order to support the uptake and integration of health workers in the hospital system.

4. *Increased recruitment and retention of AHWs/ALOs in acute care, especially in rural hospitals*

Hospitals should endeavour to employ more AHWs and ALOs, especially if they are rural or remote, and/or have a high proportion of Aboriginal and Torres Strait Islander patients. Appropriate support mechanisms should be in place to improve retention of health workers, and to ensure that their role in health delivery is respected and acknowledged.

5. *Development of more flexible community-based care models to provide culturally appropriate care for Aboriginal and Torres Strait Islander patients*

Better coordination between hospital and community care providers should be developed to allow more Aboriginal and Torres Strait Islander patients to receive care in their communities, including at discharge. Enhanced pre-admission processes and discharge plans are needed to improve Aboriginal and Torres Strait Islander patient care outside of hospital.

6. *Continued research into DAMA in the Aboriginal and Torres Strait Islander population*

Further work in this area should be undertaken to address the current research gap, and to allow development of evidence-based strategies. Research conducted needs to recognise the diversity of Aboriginal and Torres Strait Islander communities and contexts, and the impact of this on health.

6. Limitations

The literature available about this issue is limited, and many of the studies involve a small number of participants and/or are conducted at one hospital. This restricted the scope of the brief and the recommendations made.

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