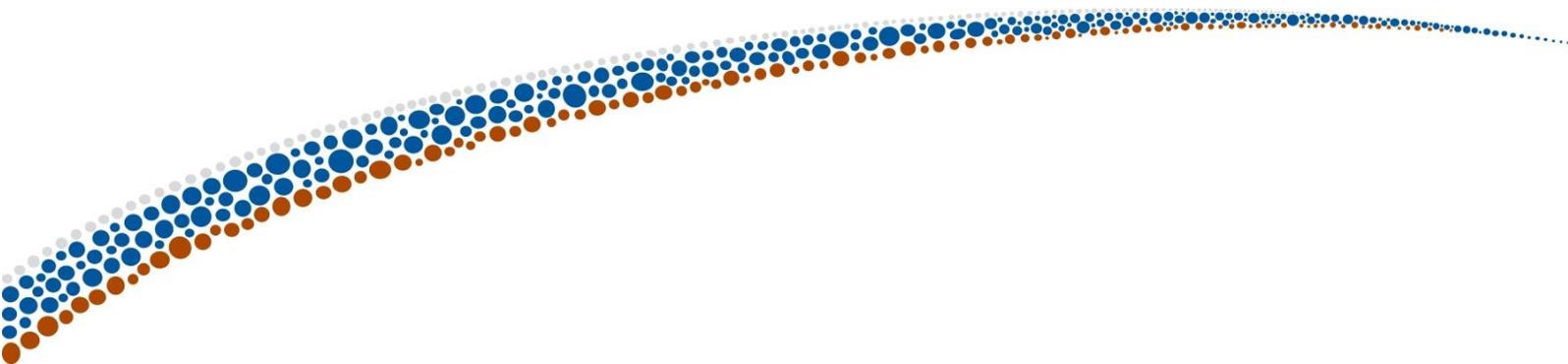


A culturally respectful and non-discriminatory health system

Aboriginal Patient Take Own Leave

Review and recommendations for
improvement



Suggested citation

Aboriginal Health Policy Directorate, 2018, *Aboriginal Patient Take Own Leave. Review and recommendations for improvement*, Department of Health of Western Australia, Perth.

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1. Background

Take Own Leave (TOL) describes the circumstances where a patient chooses to leave prior to commencing or completing treatment¹. 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).

TOL events disrupt medical treatment, are associated with increased readmission, and pose significant problems for patient continuity of care. TOL is strongly associated with post-operative complications, increased morbidity and mortality, and increased healthcare expenditure².

Aboriginal patients are significantly more likely to TOL and DAMA than non-Aboriginal patients. Nationally, Aboriginal people self-discharge between 6 and 19 times the rate of non-Aboriginal people². In WA from 2013-2015, rates of DAMA for Aboriginal patients were 11 times the rate for non-Aboriginal patients³. Aboriginal status has been found to be the single most significant contributing factor to a patient's DAMA risk². Aboriginal people who TOL are more likely to return to the ED and DAMA has been found to cost the health system more than 50 per cent the cost of patients who are discharged by physicians⁴.

DAMA is considered one of the measures of the extent to which hospital services are responsive to the needs of Aboriginal patients and therefore an indirect measure of cultural competence⁵.

The WA health system is committed to improving the health outcomes of Aboriginal people and ensuring that it is providing a culturally competent health service to Aboriginal people. Reducing the rates of TOL for Aboriginal people is an important step towards achieving this.

2. Purpose

This paper is intended as a guide/resource for Health Service Providers (HSP) and other stakeholders to assist them in addressing TOL for Aboriginal patients, specifically it will:

- review the relevant and current policies and recording processes within the WA health systems
- outline TOL recording and coding pathways
- examine the current rates of DAMA (TOL currently not tracked) in the WA health system
- summarise the information received through the consultation process (see section 2.1 Consultation Process), and additional research into contributing factors and impacts of TOL for Aboriginal people

¹ National Take Own Leave Working Group 2017, *Draft National Take Own Leave Framework*, Unpublished

² Australian Health Ministers' Advisory Council (AHMAC) 2017, *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Canberra.

³ Australian Institute of Health and Welfare 2017, *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report: Western Australia*. Cat. No. IHW 185. Canberra: AIHW

⁴ Aliyu, ZY 2002, 'Discharge against medical advice: sociodemographic, clinical and financial perspectives', *International journal of clinical practice*, vol.56, no.5, pp. 325-327.

⁵ Shaw, C 2016, *An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients*, College of Medicine and Dentistry, James Cook University, Deeble Institute Issues Brief no: 14.

- provide strategies for improving TOL rates for Aboriginal people.

For the purposes of this paper many of the statistics and strategies will refer directly to DAMA as it is currently a performance indicator in the WA Health Performance Framework. Although TOL is not currently tracked it can be assumed that DAMA rates are reflective of overarching TOL rates.

2.1 Consultation process

In early 2017 the Aboriginal Health Policy Directorate (AHPD) at the WA Department of Health (DOH) undertook targeted TOL consultation on behalf of the National TOL Working Group (Working Group). A consultation template was developed by the Working Group and AHPD coordinated input from WA stakeholders to contribute to the national consultation process. Stakeholders received a template to provide a written response that was collated and sent to the Working Group for further consideration.

Stakeholders consulted as part of this process included 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. Presentations were also given to the AHCWA Board, Aboriginal Health Executive Group, Strategic Aboriginal Health Group, Statewide Aboriginal Health Network and WA Aboriginal Health Partnership Forum.

Although collected for the Working Group, the findings of this consultation have contributed to the development of this document.

3. Policy Context

3.1 WA Aboriginal Health and Wellbeing Framework 2015-2030

The *WA Aboriginal Health and Wellbeing Framework 2015-2030* (the Framework) and its associated *Implementation Guide* (Implementation Guide) recognise Aboriginal people who DAMA as a priority for the WA health system.

DAMA is a headline measure for the Implementation Guide under Strategic Direction 3 – A culturally respectful and non-discriminatory health system. The Strategic Outcome for this direction is that; *WA Health recognises racism as a key social determinant of health for Aboriginal people. Health care, whether government or community provided is to be free of racism and discrimination*⁶. In order to achieve this outcome the Implementation Guide outlines three main focus areas:

- **Workforce development and training**
 - Improved access to cultural education and training for non-Aboriginal staff including opportunities for ongoing professional development.
- **Engagement and partnerships**
 - Aboriginal consumers, carers and communities are effectively engaged in the design, planning and evaluation of programs and services to improve patient satisfaction and quality care.

⁶ Aboriginal Health Policy Directorate 2015, *WA Aboriginal Health and Wellbeing Framework 2015-2030*, Western Australian Department of Health, Perth.

- Collaborative partnerships with Aboriginal community controlled health services support systematic and ongoing two-way communication.
- **Organisational and systemic approach**
 - Governance arrangements reflect and demonstrate a whole-of-organisation approach to improving cultural competency and responsiveness.
 - Flexible and responsive services that identify and respond to barriers to access.
 - Systemic racism and discrimination is better understood, addressed and prevented⁷.

3.2 Health Services Performance Report

The WA health system has acknowledged the importance of DAMA and the impact that it has on Aboriginal people by including it as a measure in the Health Services Performance Report (HSPR) under Performance Indicator (PI) P4-2a since 2017-18. This indicator defines DAMA as the percentage of admitted Aboriginal and non-Aboriginal patients who left against medical advice⁸. The 2017-18 target rate for the DAMA indicator is under 0.77 per cent for both Aboriginal and non-Aboriginal patients⁸.

It is acknowledged that 0.77 per cent is an ambitious target for HSPs to reach for Aboriginal patients and will take some time to achieve, however all improvements are important and encouraged. In relation to Aboriginal patients HSPs are considered to be:

- 'performing' if the rate is under 0.77 per cent
- 'under performing' if the rate is between 0.77 – 5.00 per cent
- 'not performing' if that rate is above 5.00 per cent⁸.

3.3 Definitions and HSP policies

The following TOL-related definitions and policies have been sourced from policy documents from DOH, WA Country Health Service (WACHS), South Metropolitan Health Service (SMHS), North Metropolitan Health Service (NMHS), East Metropolitan Health Service (EMHS) and Child and Adolescent Health Service (CAHS).

3.3.1 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.

Recorded: All three DNW episodes are to be recorded on the MR1 form. Following the third DNW the DNW is recorded on the patient database, i.e. Patient Administration System (PAS).

Policies: [DNW WACHS](#)

⁷ Aboriginal Health Policy Directorate 2017, *Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015-2030*, Western Australian Department of Health, Perth.

⁸ Department of Health 2017, *Health Service Performance Report: Performance Indicator Definitions Manual 2017-18, P4-2: Percentage of admitted patients who discharged against medical advice: a) Aboriginal, b) Non-Aboriginal, Version 1.1*, Western Australian Department of Health, Perth.

3.3.2 Discharge Against Medical Advice

Definition: Where a patient leaves against medical advice⁸.

Recorded: DAMA form completed and recorded in the Hospital Morbidity Data System (HMDS) under the Mode of Separation (MOS) section as a code 6.

Policies: [Hospital Morbidity Data System Manual-PartB](#)

[DOH Admission, Readmission, Discharge and Transfer Policy](#)

[DAMA SMHS](#) / [DAMA EMHS](#) / [DAMA WACHS](#) / [DAMA CAHS](#) / [DAMA NMHS \(Sir Charles Gairdner Hospital\)](#)

Other TOL events that are recorded as DAMA (see section 3.5 TOL recording and coding pathways), include:

- **Away Without Leave**

Definition: Where a patient takes leave but does not return.

- **Absconded; Lost or missing patient; and Suspected missing patient.**

Definition: Where a patient cannot be found, has been seen leaving or is suspected of leaving.

Recorded: If a patient absconds, goes missing or takes leave and does not return from a ward, a Clinical Incident begins and procedures are followed. The incident is recorded in the WA Health Clinical Incident Management System (CIMS) and the patient's medical record.

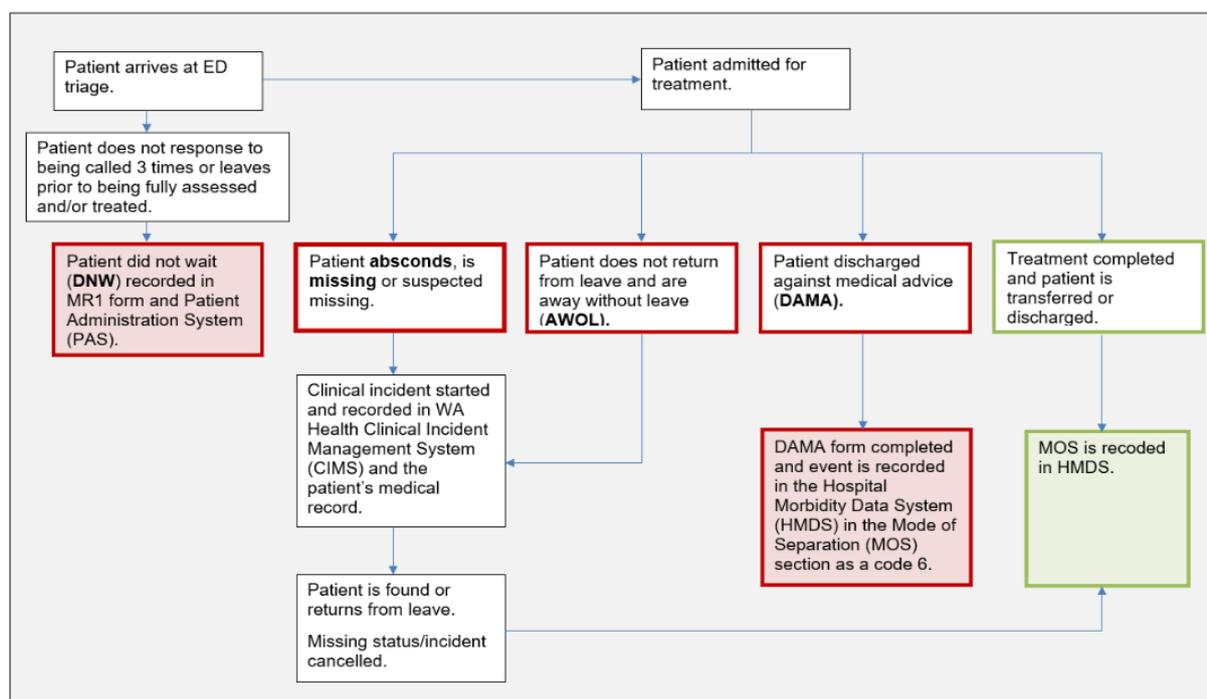
If the patient returns the incident is cancelled. If the patient cannot be found the incident is recorded as DAMA.

Policies: [WACHS](#) / [EMHS](#) / [CAHS](#) / [SMHS](#) / [NMHS - SCGH](#)

3.4 Other relevant policies documents

- WA Health Admission, Readmission and Discharge Procedures.
- Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023: Domain 1. Health System Effectiveness.
- National Indigenous Reform Agreement: Schedule D. Service delivery principles for programs and services for Indigenous Australians.
- National Safety and Quality Health Service Standards – User Guide for Aboriginal and Torres Strait Islander Health.
- Aboriginal and Torres Strait Islander Health Performance Framework: Tier 3 Health System Performance.
- WA Aboriginal Health and Wellbeing Framework 2015-2030 and Implementation Guide.
- Alcohol and Other Drug Withdrawal Management Policy.

3.5 TOL recording and coding pathways



4. Current situation

4.1 Australia

Nationally between 2013 and 2015, Aboriginal patients self-discharged at 7 times the rate of non-Aboriginal patients². Young Aboriginal adult males in particular have been found to DAMA at 20 to 30 times the rate of non-Aboriginal patients⁹.

DAMA rates among Aboriginal patients increase with residential remoteness. Aboriginal patients admitted to regional or remote hospitals were 50% more likely to DAMA compared to patients admitted to a metropolitan hospital². With 21 per cent of Aboriginal people living in remote areas this is a significant issue for the Aboriginal population².

Table 1 presents key factors that are associated with Aboriginal patients who DAMA.

Table 1 Aboriginal people who DAMA

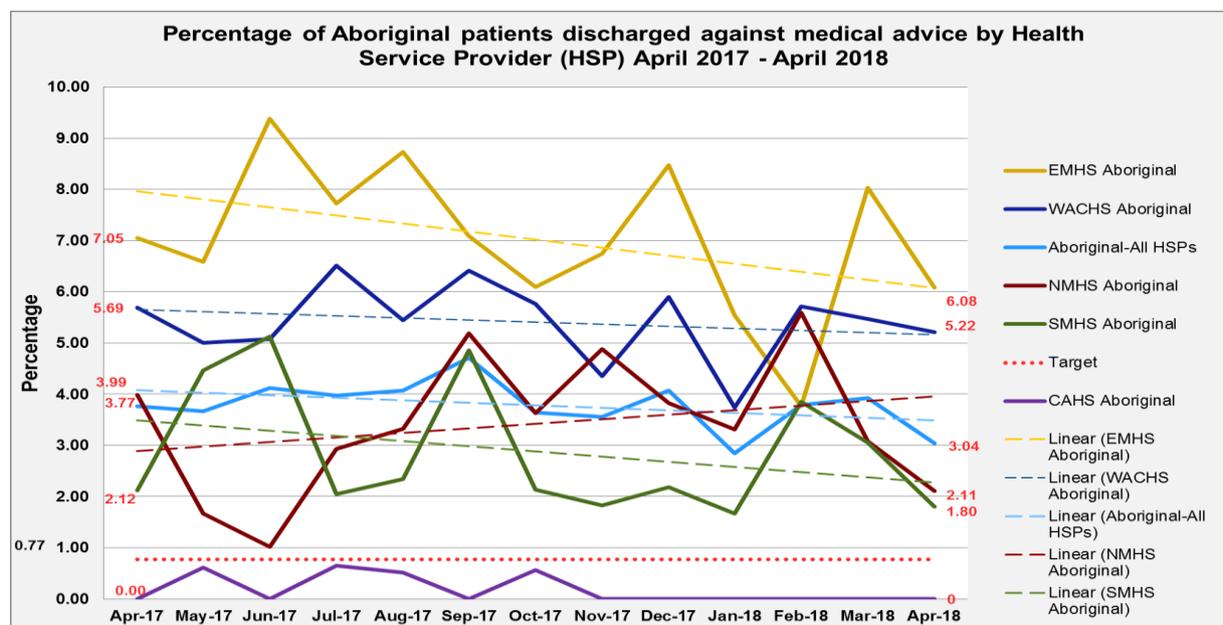
DAMA is most common for Aboriginal people aged 25-54 years ² .
DAMA is more common for Aboriginal people living in remote or very remote areas ² .
Men are more likely to DAMA than women ⁵ .
In 2015-16 Aboriginal patients were more likely than non-Aboriginal patients to not wait (5.2% of ED presentations compared with 3.5%) to receive treatment ² .
As a proportion of all hospitalisations of Aboriginal people for each specific diagnoses group, DAMA was highest for endocrine, nutritional and metabolic disorders (including diabetes) (7.4%), followed by injury and poisoning and external factors (7.0%) ⁵ .

⁹ Wright L 2009a, "They just don't like to wait"—A comparative study of Aboriginal and non-Aboriginal people who did not wait for treatment, or discharged themselves against medical advice from rural emergency departments: Part 1', *Australasian Emergency Nursing Journal*, vol. 12, no. 3, pp. 78-85.

4.2 Western Australia

In WA between 2013 and 2015, rates of DAMA for Aboriginal patients were 11 times the rate for non-Aboriginal patients (3.8% compared with 0.3%)³.

The HSPR Aboriginal specific DAMA performance indicator (PI P4-2a) has been measured in the WA health system from June 2017, the graph below shows the performance of HSPs over the past 12 months¹⁰.



Source: WA Health Service Performance Report June 2018

5. Understanding why Aboriginal patients TOL

The reasons Aboriginal people TOL can vary significantly and reflect a complex combination of historical, cultural, social, political and economic factors¹¹. Through consultation and research some common themes that have been recognised as contributing factors. Many of these common factors are interrelated and should be considered in conjunction with one another to develop a full understanding of why an Aboriginal person may TOL. The common themes include:

- Racism and stereotyping
- Distrust of health services
- Hospital environments
- Aboriginal workforce
- Communication and language
- Family, cultural and social obligations
- Social determinants of health
- Alcohol and other drugs
- Mental health and social wellbeing
- Admission and discharge procedures.

¹⁰ Department of Health 2018, *The WA Health Service Performance Report June 2018*, Western Australian Department of Health, Perth.

¹¹ Durey A 2012, 'Owning solutions: a collaborative model to improve quality in hospital care for Aboriginal Australians', *Nursing Enquiry*, vol. 19, no. 2, pp. 144-152.

Cultural competency is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals to enable that system, agency or those professionals to work effectively in cross-cultural situations¹². Health professional and health services apply the knowledge and understanding to improve the delivery of safe and quality health care.

Encompassed within the cultural competency of a health service is the cultural safety of its patients. Patients are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes¹². Cultural safety is not defined by the health professional, but is defined by the health consumer's experience, including the individual's experience of care they are given, ability to access services and to raise concerns¹².

The common themes for why Aboriginal patients are significantly more likely to TOL than non-Aboriginal patient can all be linked to the overall cultural competency of a health service.

5.1 Institutional and inter-personal racism and stereotyping

Racism and stereotyping can lead to poor health outcomes and reduce trust in the health system for Aboriginal people and has been identified as a significant contributing factor for Aboriginal patients to TOL.

The National Aboriginal and Torres Strait Islander Social Survey 2014-15 reported the following findings for Aboriginal Australians aged 15 years or over:

- 35 per cent experienced unfair treatment due to their race in the previous 12 months
- 14 per cent avoided situations due to past unfair treatment, and of those 13 per cent had avoided seeking health care due to past unfair treatment
- 6 per cent disagreed or strongly disagreed with the statement 'Your doctor can be trusted'
- for those living in non-remote areas, their General Practitioner rarely or never showed respect for what was said (15%), listened to them (20%) or spent enough time with them (21%)¹³.

Some examples of racial bias and stereotyping with respect to Aboriginal patients that were raised in the consultation process include:

- Aboriginal patients won't comply with treatment instructions, and therefore not all treatment options are investigated or made available
- Aboriginal patients are under the influence of alcohol and/or other drugs
- Aboriginal patients have mental health issues¹.

Institutionalised racism is the embedding of practices, policies or procedures within systems or institutions that maintain and reproduce avoidable and unfair inequalities. It follows the assumption that the dominant group represents the normative culture, assimilating the

¹² Aboriginal and Torres Strait Islander Standing Committee 2016, *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health*, Australian Health Ministers' Advisory Council, Canberra.

¹³ Australian Bureau of Statistics 2016, *National Aboriginal and Torres Strait Islander Social Survey 2014-15*, Australian Bureau of Statistics, Canberra.

needs of minority groups into that of the dominant¹⁴. Institutionalised racism does not allow for the needs of minority groups to be appropriately recognised or met and can therefore contribute to Aboriginal patients to TOL.

Aside from acts of overt and deliberate racism, racial bias is also a significant factor that affects the treatment of Aboriginal people in the health setting. Racial bias is often an implicit bias in which a health professional's attitudes, feelings or stereotyping based on characteristics such as race, age and appearance, affect their understanding, decisions, actions and behaviours towards other people in an unconscious manner¹⁵. These associations develop over a long time beginning at a very early age through exposure to direct and indirect messages. In addition to life experiences, the media are often the origins of implicit associations¹⁵.

5.2 Distrust of the health system

Aboriginal people's prior experience with government agencies and the health system, personally and of their family and friends, can significantly influence the decision of the person to stay in hospital and complete treatment. Historical factors such as segregation and previous negative engagement with the health system has led to a distrust of the health system and may contribute to greater instances of TOL².

5.3 Hospital environment and design

An unwelcoming and unfamiliar environment can lead to Aboriginal patients to feel fear and anxiety in the hospital environment and increase the likelihood the patient will DAMA^{5,16}. Environmental factors that can contribute to an Aboriginal person to DAMA include:

- distance and social isolation from the patient's community and country
- unfamiliar routines
- sterile and unwelcoming surroundings
- lack of outdoor space (including waiting areas)
- lack of larger meeting areas for family to gather
- the 'impersonal nature' of Western medicine
- a belief that hospitals are associated with death^{5,16}.

5.4 Aboriginal workforce

Aboriginal people are significantly under-represented in the healthcare workforce¹⁶. The presence of Aboriginal staff in a health service can improve the cultural safety for Aboriginal patient's and help to mitigate feelings of isolation, unease and/or distrust of the services. Aboriginal staff, including Aboriginal Liaison Officers (ALOs) and Aboriginal Health Workers (AHWs), bring a diverse range of skills to the health sector including the ability to break

¹⁴ Aboriginal Health Policy Directorate 2017, *Understanding Institutionalised Racism*, Western Australia Department of Health, Perth.

¹⁵ Green A, Carney D, Pallin D, Ngo L, Raymond K, Lezzon L, Banaji M 2007, 'Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients', *Journal of General Internal Medicine*, vol. 22, no. 9, pp. 1231- 1238, viewed July 2018, <https://link.springer.com/article/10.1007%2Fs11606-007-0258-5?LI=true>

¹⁶ Australian Commission on Safety and Quality in Health Care (ACSQHC) 2017, *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health*, ACSQHC, Sydney.

down barriers, provide cultural knowledge and perspective and reduce the likelihood of the patient experiencing racism during treatment^{6,7}.

Contributing factors to the inadequate number of Aboriginal employees in the health system include:

- low rates of Aboriginal people receiving qualifications in health related occupations
- difficulties in the recruitment and retention of Aboriginal people particularly in remote regions
- inconsistent policies and understandings of the role of ALOs and AHWs throughout the WA health system.

5.5 Communication and language

Communication barriers between patients and staff have frequently been identified as a contributing factor to TOL, and can exist where patients do not speak English as a first language and/or have low literacy levels⁵. Appropriate use of interpreters and effectively utilising the Aboriginal workforce can improve communication with Aboriginal patients and reduce the risk of TOL¹⁶.

Clear communication is critical to reducing fear, misunderstandings and confusion for the patient. Poor communication between hospital staff and Aboriginal patients can lead to a misunderstanding of the nature of health issues, treatment options, consent, processes, expected timeframes, length of stay, and whether or not it is okay for the patient to leave⁵.

Miscommunication can also lead to patients feeling that staff are being disrespectful or aggressive and can lead to a breakdown of the patient-doctor relationship. This in turn may impact a patient's willingness to complete treatment leading to DAMA⁵.

5.6 Family, cultural and social obligations

It is critical for health staff to understand that Aboriginal people have a holistic view of health that encompasses mental, physical, cultural and spiritual health and is impacted by connections to country, family and community. Aboriginal concepts of kinship and family differ from Western understandings and include strong connections to extended family⁶.

Aboriginal people often have responsibilities and obligations to family (including extended family), community and country¹⁷. These obligations can lead to pressure to return home and can impact on TOL rates, for example, a grandmother may be the primary care giver to a child through kinship relationships and may need to leave hospital to arrange childcare. To help support Aboriginal patients to balance these obligations and responsibilities along with their health care needs, health services should respect and consider these obligations and responsibilities when treating Aboriginal patients.

5.7 Social determinants

Aboriginal people experience higher levels of social disadvantage than non-Aboriginal people². Social disadvantage not only leads to significantly high rates of burden of disease and less access to health care service, but also impact the likelihood of TOL. The social determinants of health need to be understood within the context of the broader social,

¹⁷ Commonwealth of Australia 2014, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice second edition*, Commonwealth of Australia, Canberra.

political, economic, and environmental conditions that may impact Aboriginal people⁶. Examples of social disadvantages include:

- Poor health literacy levels might lead to confusion or misunderstanding of the seriousness of a condition and the required treatment process⁵.
- Transport cost and availability, especially for patients living in remote communities, may lead a patient to self-discharge when transport becomes available.
- Financial difficulties and responsibilities can impact on a person's ability to stay in hospital until the completion of treatment, and has been linked to increase incidences of TOL⁵.

5.8 Alcohol and other drugs

"If you (Indigenous patient) go to a health service and you're made to feel unwelcome, or uncomfortable or not deserving or prejudged and there are lots of scenarios of Aboriginal people being considered to be perhaps being seriously intoxicated when in fact they've been seriously ill." - Romlie Mokak CEO Australian Indigenous Doctors Association.

Consultation has indicated that the impacts of stigma, racism and stereotyping in relation to Aboriginal people and alcohol and other drug use increases the risk of TOL. Assumptions that an Aboriginal person is intoxicated or has a drug issue coupled with stigma towards alcohol and other drug use can lead to TOL and poor health outcomes. According to the 2012-13 Health Survey Aboriginal people were 1.6 times as likely to abstain from alcohol as non-Aboriginal Australians⁸.

A number of studies have observed an association between alcohol and other drug issues and patients who DAMA⁵, and where an Aboriginal person is assessed as having an alcohol and/or other drug issue, staff's approach is critical to whether or not a person will TOL. Appropriate communication, assessment and treatment are essential and should not be influenced by any personal assumptions or judgements¹⁸. Experiences of withdrawal can also lead a patient to TOL.

It is acknowledged that intoxicated patients may be difficult to manage and assess and/or may go missing while intoxicated. Intoxication does not minimise the responsibilities of a health professional to provide safe and quality health care¹⁸.

Based on various national and international studies it is estimated that at least 30-50 per cent of people with an alcohol and/or other drug issue also have a co-occurring mental illness¹⁹.

5.9 Mental health and social and emotional wellbeing

Stigma and discrimination associated with mental health issues can affect access to treatment¹⁹. In 2014-15, Aboriginal people with a mental health condition were more likely

¹⁸ Malone D, Friedman T 2005, Drunken patients in the general hospital: their care and management, *Postgrad Medical Journal*, no..81, pp. 161-166, viewed August 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743218/pdf/v081p00161.pdf>

¹⁹ Western Australian Mental Health Commission 2015. *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, Western Australian Mental Health Commission, Perth.

to have experienced problems accessing health services (23%), than people with other health conditions²⁰.

Mental health issues are a predictor for DAMA for Aboriginal people²¹. In the case that a patient has a mental health illness, access to services, medical information and their current medication is crucial to support the patient to stay in treatment.

General TOL studies have shown that within psychiatric inpatient wards the contributing factors for instances of TOL include:

- being involuntarily admitted or admitted during crisis
- poor assessment and admission procedures
- inadequate staffing leading to patient receiving less counselling/attention
- lack of communication with patients and a threatening atmosphere
- an overall breakdown of the patient-doctor relationship²².

Consultation has indicated that in some instances stigma and stereotyping of people with mental health conditions, lack of cultural understanding of staff, and barriers accessing mental health services, can impact the treatment and care of Aboriginal patients and the instances of TOL.

5.10 Admission and discharge procedures

Consultation with HSPs indicates that patients are sometimes being admitted for minor issues, such as wound care, instead of being referred to an outpatient clinic. These patients will likely not be a high clinical priority, meaning longer waiting periods and increased likelihood that patients will TOL.

Consultation with HSPs also shows that there is confusion among hospital staff about the coding of TOL events, in particular the belief that events are being incorrectly coded as DAMA. This is a misconception as eventually incidences of a patient 'absconding', 'missing' or 'away without leave' will all be coded as DAMA (see section 3.5 TOL recording and coding pathways).

In addition, hospital procedures such as whether or not patients and family are included in admission and discharge planning can impact TOL rates. Good discharge procedures and planning can also influence the patient's treatment outcomes and reduced chance of readmissions²³.

²⁰ Australian Bureau of Statistics 2016, *Aboriginal and Torres Strait Islander people with a mental health condition, Cat. 4714.0 – National Aboriginal and Torres Strait Islander Social Survey 2014-15*, viewed 1 August 2018, [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20\(Feature%20Article\)~10](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20(Feature%20Article)~10)

²¹ Henry B., Dunbar T., Barclay L., Thompson R 2007, *Self-discharge against medical advice from Northern Territory Hospitals*, Department of Health and Community Services, Darwin.

²² Brook M, B.S., Hilty D, M.D., Liu W, M.S., Hu R, M.D., Frye M, M.D. 2006, 'Discharge Against medical Advice From Inpatient Psychiatric Treatment: A literature Review', *Psychiatric Services*, vol. 57, no. 8, pp. 1192- 1198.

²³ Australian Commission on Safety and Quality in Health Care (ACSQHC) 2017, *Indicators of Safety and Quality - Avoidable Hospital Readmissions*, viewed 17 August 2018 <https://www.safetyandquality.gov.au/our-work/indicators/avoidable-hospital-readmissions/>

6. Recommendations for improvement

Improving the cultural competence of health services and creating culturally safe environments will help address barriers for Aboriginal patients receiving and completing treatment, and will improve TOL rates for Aboriginal people⁷.

Aboriginal people have a holistic view of health and wellbeing⁶. A lack of knowledge of the historical impacts and cultural beliefs and practices of Aboriginal people affect the cultural competency of a service and therefore, the likelihood of Aboriginal patients to TOL. Aboriginal people have responsibilities and obligations to family (including extended family), community and country that need to be respected and considered when treating an Aboriginal patient⁶.

Aboriginal people also experience higher levels of social disadvantage and have reduced access to the social determinants of health than non-Aboriginal people^{2,6}. Aboriginal people have higher exposure to risk factors than other population groups, contributing to the gap in health outcomes⁶. These, and the broader context of social determinants, need to be considered and managed by health services and employees to better provide care and prevent episodes of TOL from Aboriginal people.

6.1 Strategies

Although all of the strategies will contribute to the cultural competency of a health service, the following specifically relate to the culture awareness and knowledge of the service and workforce.

Cultural competency – embedding respect for patient’s cultural needs through developing the cultural awareness, knowledge and skills of the health workforce and service¹⁶.

- Cultural competency training should be of an ongoing nature and be mandatory for all staff to complete.
- Cultural competency training should be continuously reviewed and improvements made to ensure training is comprehensive and effective at the local level.
- Recognise that Aboriginal people’s concept of health and wellbeing are different from Western characterisations and that this might impact on how an Aboriginal patient feels about certain treatments. Any concerns from the patient should be respected and addressed.
- Recognise the role of family in an Aboriginal person’s health and wellbeing. Health service staff should ask Aboriginal patients if they would like any family members to be included in health care discussions and planning.
- Understand that Aboriginal concepts of kinship and family differ from Western understandings and include strong connections to extended family. For example, a grandmother or aunty may be the primary care giver to a child through kinship relationships.
- Understand how Aboriginal people’s history and prior experience may impact their feeling towards and interactions with government institutions.
- Staff should recognise the imbalanced power relationship between Aboriginal patients and the health system and take the time to build trust with patients.
- Implement the National Best Practice Guidelines for Collecting Indigenous Status and recording categories on data collection forms and information systems.

Consultation, engagement and partnerships – focus on engaging Aboriginal staff and community groups in the future planning and design of policies, facilities and programs as well as in their own medical treatments at health services^{7,16}.

- Ensure the use of Aboriginal Health Impact Statement Declarations (ISDs).
- Support coordination between hospital and community care providers to allow more Aboriginal patients to receive care in their communities.
- Establish partnerships and protocols with Aboriginal stakeholders to improve coordination and continuity of care.
- Improve the rate of patient survey completions and the use of such information.
- Engage with Aboriginal stakeholders to ensure that the clinical and cultural needs of Aboriginal people are being addressed holistically, including the relevant HSP Aboriginal Health Strategy Units.
- Greater focus on Aboriginal people being included in governance arrangements.

Communication & language – better communication prior to treatment, throughout hospital stay and during follow ups⁵.

- The strategic policy position on Aboriginal health is clearly and consistently communicated including messages on zero tolerance of racism and prejudice.
- Address the concerns and expectations of patients, e.g. explaining waiting times.
- Clear communication and consent obtained for Aboriginal patients to be seen by groups of students and before treatment preparations are undertaken.
- Implement the *WA Health Language Services Policy* and Toolkit and the *Western Australian Language Services Policy 2014* and Guidelines.
- Increase use of interpreters and ALOs.
- Develop culturally appropriate health information resources and make these available for Aboriginal patients who require support and/or assistance navigating and adjusting to hospital admission and stay.
- Identify low health literacy in patients and ensure that patients adequately understand their diagnosis, treatment options and the associated risks and benefits, and the risks of not completing treatment.
- Improve health literacy through social marketing and education activities.

Hospital environment – culturally safe environments are welcoming and accommodate the cultural needs of Aboriginal people and their families^{5,16}.

- Create culturally safe and friendly spaces within the hospital built environment including the display of Aboriginal artwork, maps and flags and seeking the input of Aboriginal communities in infrastructure design and landscaping.
- Provide clear signage and culturally appropriate pictures and visual aids can improve understanding and navigation of the system for Aboriginal people.
- Enable access to family including provision of large spaces for family to gather and flexible visiting hours.
- Respond to specific patient cultural needs including access to outdoor spaces (including waiting spaces), access to communication (telephone, Skype etc.), provision of designated spaces for women and men where appropriate, and provision of traditional or familiar food where possible.

Aboriginal workforce – greater Aboriginal workforce numbers and range of positions^{6,7}.

- Provide pathways for Aboriginal people to achieve qualifications in health related occupations and advancement pathways throughout the hospital for Aboriginal staff.
- Implement the mandatory *Aboriginal Workforce Policy* in order to support the attraction, recruitment, retention and development of the Aboriginal workforce at all levels.
- Implement recruitment and retention strategies for Aboriginal health professionals in acute care, especially in rural hospitals.
- Develop consistent scope of practice for AHW and ALO roles.

Social determinants of health – consider a patient’s transport, accommodation and literacy levels^{5,13}.

- Services in rural and remote areas should consider the availability of local services, distances patients travel to receive treatment, and the need for links between metropolitan hospitals and Aboriginal Medical Services and other regional services. For further information see the below section 6.2 Rural and remote considerations.
- Provide access to suitable accommodation for Aboriginal patients where necessary (especially for regional and remote patients).
- Provide access to transport for patients attending treatment where necessary.
- Inform local communities about accessing hospital services and identifying and understanding serious medical conditions.

Alcohol and other drugs – improved training of staff to reduce stigma and stereotyping associated with alcohol and other drugs and to identify and manage intoxicated patients and patients with alcohol and/or drug addiction^{18,19}.

- Build the capacity of staff to address the stigma and stereotyping associated with alcohol and other drug use in particular, for Aboriginal patients.
- Build the capacity of staff to identify and manage patients with alcohol and other drug issues.
- All patients receive appropriate assessment to ensure that assumptions regarding alcohol and other drug use are not made.
- In the case that an Aboriginal person is assessed as having an alcohol and/or other drug issue or dependence, addressing withdrawal and offering support is a key aspect of supporting the patient to stay in treatment.
- Consider that other illnesses and issues can co-occur with alcohol and other drug use, including mental health issues, and develop effective strategies to assess and manage these issues.
- While managing difficult behaviours or patients with alcohol and other drug problems can be challenging, often effective and culturally competent communication can mitigate disruptive behaviour.
- Adopt a ‘no wrong door approach’ to providing care for Aboriginal patients with alcohol and other drug issues - intoxication does not minimise the responsibilities of a health professional to provide safe and quality health care.

Mental health - for instances where mental health issues exist, access to mental health service and coordination of treatment is particularly important as it can impact the patient's ability to stay in treatment¹⁷.

- All patients should receive appropriate assessment to ensure mental health issues are correctly diagnosed and appropriate treatments given.
- Cultural beliefs should be considered in relation to any mental health assessment.
- In the case that a patient has a mental health illness, access to services, medical information and their current medication is crucial to support the patient to stay in treatment.
- Adopt a 'no wrong door approach' to providing care for Aboriginal patients with mental health issues.
- Provide culturally appropriate mental health assessment.
- Consider the role of traditional healers in the provision of care as per the Charter of Mental Health Care Principles outlined in the *Mental Health Act 2014*.

Policies, procedures and practices – specific processes to address the needs of Aboriginal people and provide structure to guide health services in responding to those needs¹.

- Implement culturally appropriate pre-admission, admission and discharge policies and procedures.
- Ensure that there is consistency and understanding of admission criteria and processes to ensure people are not admitted for minor treatment when referral to an outpatient clinic is more appropriate, e.g. wound care.
- Services to develop and implement a TOL risk mitigation strategy to better understand the needs and requirements of the local area.
- Develop and implement standard follow up procedures when a patient discharges against medical advice (including abscond, missing etc.)
- Procedures in place to assist in the coordination of appointments, particularly for patients travelling extended distances, i.e. regional areas to metropolitan.
- Coordinate with Aboriginal Community Controlled Health Services (ACCHS) to improve transition care arrangements including discharge planning, transfer of patient records and follow-up care.
- Improve care coordination between services providing care to Aboriginal patients including primary, secondary and tertiary services to ensure continuity of care.

Use of technology – improving the patient journey and allowing Aboriginal patients to contact family members and obtain support⁵.

- IT systems are able to communicate with each other to ensure continuity in the patient journey and to allow multi-disciplinary team management.
- Allow patients to use phones or tablets to contact family members, particularly if receiving care away from their community.
- Utilise Telehealth to avoid unnecessary travel and/or extended waiting periods for assessment and treatment.

Research - further work in this area should be undertaken to address the current research gap and to allow development of evidence-based strategies.

- Conduct analysis to better identify any patterns associated with increased TOL rates, for example if events of TOL increase on weekends and or at night.
- Improve patient experience tools to better understand Aboriginal patient's experiences in the health setting and reason why they might TOL.

6.2 Rural and remote considerations

Service access in rural and remote settings is crucial to supporting Aboriginal people closer to their home, local community and culture⁷. Providing access to treatment closer to home addresses a number of the concerns Aboriginal people have that result in cessation of treatment. Considerations include:

- Developing partnerships and collaborating with Aboriginal Community Controlled Health Organisations.
- Regional hospitals and outreach services expanding to allow patients to be treated closer to home⁷.

Service practices are also crucial to encouraging Aboriginal patients from rural and remote communities to receive and complete treatment. Considerations include:

- Developing good discharge planning processes from urban hospitals that link up to regional services to support the patient as they return to their community¹⁶.
- Ensuring that discharge planning involves the patients and any identified family/carers. If the patient is returning to rural or remote communities and requires follow up, ensure that discharge summaries are sent in a timely manner to the local GP or clinic¹⁶.
- Ensuring there is an effective process for follow up with 'frequent flyers' (patients who present at hospital and TOL)¹.
- Aboriginal patients may require help to complete forms to apply for Patient Assisted Travel Scheme (PATS) to access PATS, including for accommodation or fuel to attend specialist appointments.

6.3 Existing strategies and programs

There are currently a number of programs 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. These include:

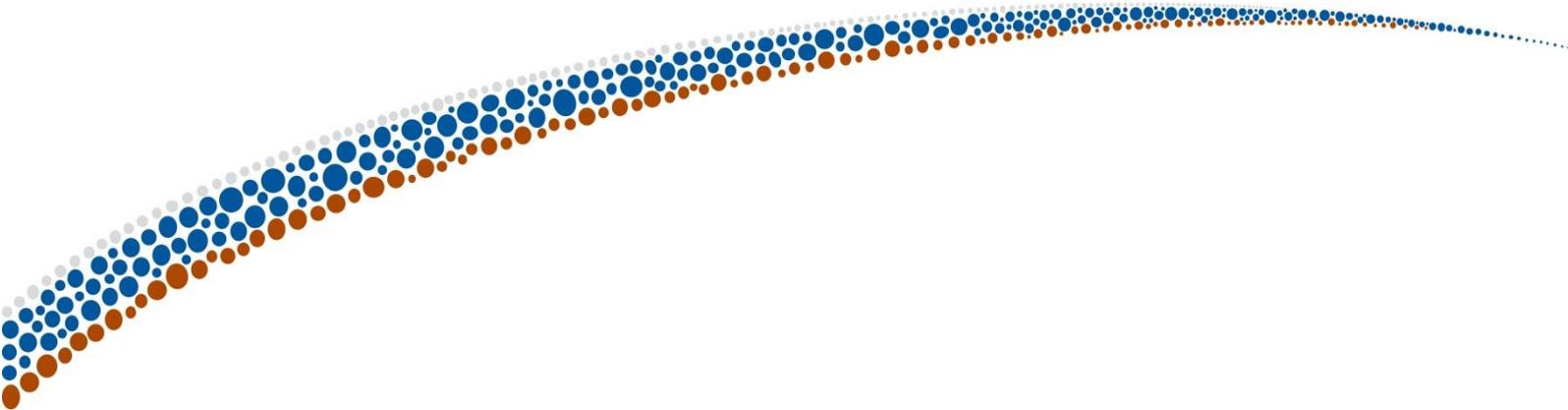
- Direct improvement programs:
 - The Light House project is being undertaken at Broome Hospital and aims to reduce DAMA in cardiac patients. This is expected to flow on to other diagnostic areas. Quality improvement workshops and a draft implementation plan have been developed.
 - WACHS's Take Own Leave (TOL) project aims to follow up Aboriginal DAMA patients in 'real time' for the purpose of identifying causes for DAMA and necessary follow-up.
 - The Wheatbelt's Aboriginal Health Service's Moorditj Pack is an essential items pack for sudden admission patients. It has been reported to help

- reduce a sense of shame if the patient doesn't have items such as clean clothes, toiletries, night wear, etc.
- Nicotine Replacement Therapy for Aboriginal clients who smoke tobacco, to reduce stress at hospital and the temptation for patient to leave hospital grounds so that they can smoke.
 - Aboriginal Interpreting WA Kimberley pilot program, will provide funding for additional Aboriginal interpreters in the Kimberley region for a six month period.
 - "Friends of RPH" who help with things such as, washing, shopping, banking, connecting with families/phone calls, etc., is expected to help patients stay in hospital till the completion of their treatment¹.
- Indirect positive flow on programs:
 - Traineeship, cadetships and graduate programs for Aboriginal people into the WA health system workforce.
 - Leadership programs for Aboriginal people within the WA Health System.
 - The Aboriginal mentoring programs, buddy programs and/or job-share including working with non-government organisations aims to improve the retention of Aboriginal employees in the health system.
 - Mandatory Aboriginal Cultural eLearning for all employees, to help improve the cultural awareness of staff and reduce discrimination and racism in the WA health system^{6,7}.

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