Traumatology Talks – Black Wounds, White Stitches

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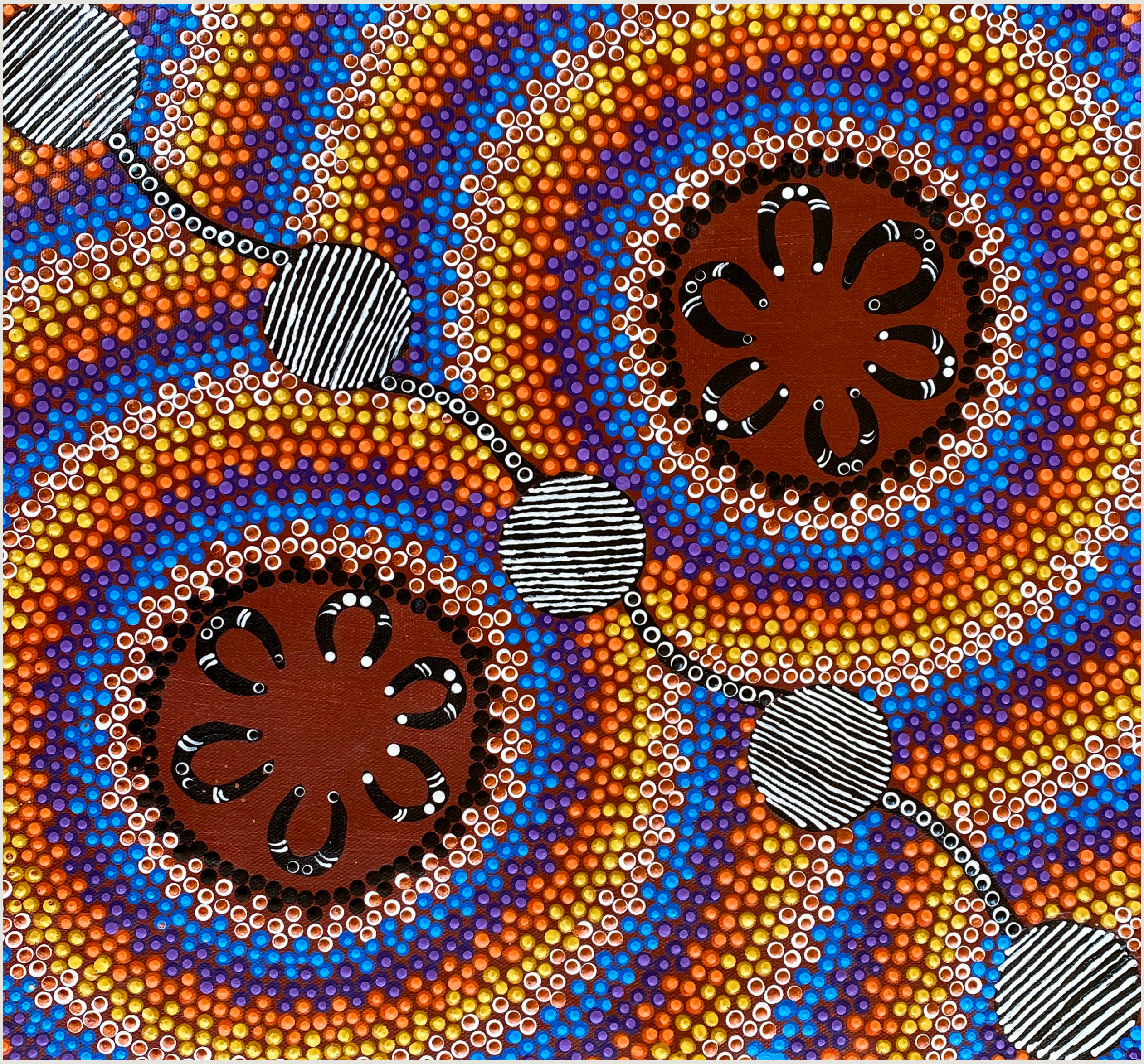

About the artwork

The striped circles are the black wounds, white stitches referred to in the title of this report. Purple and blue represent the doctors and nurses, and the orange and yellow express the feelings people sometimes have when they are in the emergency department. The white with brown dots are the cultural safety measures that need to be addressed to have better health and consultation outcomes for all. The people in the middle are all those involved in making people's experience of emergency departments more comfortable through a better understanding of cultural safety in hospitals around Australia.

— Margie Lankin

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ISBN: 978-0-6488733-5-8
First published December 2020

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A PDF version of this report is available at:

Karabena Consulting
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Australasian College for Emergency Medicine website
https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Indigenous-Health-and-Cultural-Competency-Resource

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Suggested citation: Arabena, K., Somerville, E., Penny, L., Dashwood, R., Bloxsome, S., Warrior, K., Pratt, K., Lankin, M., Kenny, K. & Rahman, A. 2020, *Traumatology Talks – Black Wounds, White Stitches*, KCT Publishing, Melbourne.

Professional disclosure statement
This report was commissioned by the Australasian College for Emergency Medicine and completed by Karabena Consulting. It has been prepared in good faith based on the research and information available to us at the date of publication without any independent verification. We do not guarantee the accuracy, completeness or currency of the information. Karabena Consulting does not accept any liability if this report is used for an alternative purpose, nor to any third party in respect of this report.

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Acknowledgments

We respectfully acknowledge the Traditional Owners of the lands on which this project took place. We are humbled by all that you do for your families and communities, and your commitment to stay true to values that have long been the social, cultural, spiritual and commercial fabric of your nations. We look to the lessons you offer us.

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To all the emergency department workers and first responders, Aboriginal Hospital Liaison Officers and other Aboriginal health professionals who were interviewed for this project and who have made a difference to all those for whom they care, often as isolated practitioners in culturally unsafe or under-resourced environments. You have persisted in the delivery of services that matter and have continued to uphold the values of your discipline, training and workplaces in sometimes difficult circumstances. We acknowledge your contribution to the health and wellbeing of all Australians and are grateful to you for generously giving us your wisdom, knowledge and time during this project.

To the Aboriginal people accessing emergency departments who agreed to be interviewed by our community researchers. Without your open and honest accounts of your hospital experiences, and valuable insights as to what could be improved, this project would not have been possible. Your words give the report meaning, value and authenticity.

To our Aboriginal co-authors – community researchers Dr Ryan Dashwood, Sharon Bloxsome, Keith Warrior, Katie Pratt, Margie Lankin and Kevin Kenny – who were key to the implementation of this project both through facilitating the local community consultations and interviewing Aboriginal community members. We deeply appreciate your guidance and assurance that our people's voices are heard, and for acknowledging the strength, cultural capacity, resilience and courage of all our people as they engage with institutions that can make them feel incredibly vulnerable. We honour your work and are proud of how you are striving to achieve good health and wellbeing for our current and future generations.

To the emergency department directors and staff in each of the three hospitals that participated in this project – Lyell McEwin Hospital in Elizabeth, South Australia, Alice Springs Hospital in the Northern Territory, and Shoalhaven Hospital in Nowra, New South Wales – and to staff within St John Ambulance Australia NT. Your dedication and commitment to improving emergency care for your patients drove the need for this research.

To the Lowitja Institute and their hard-working staff who played a pivotal role in brokering and implementing the project, in particular Aishah Jameel who assisted Associate Professor Aziz Rahman in the complex ethics application process and early project management.

To the staff at Karabena Consulting for their incredible organisation and oversight of the project, and their sensitivity and skill in getting this report published.

To the staff, the Fellows, the Board and the Reconciliation Action Plan Working Group members of the Australasian College for Emergency Medicine. In addition to funding this project, we also offer deep and sincere thanks for your thoughtful advice, strategic advocacy, wonderful vision and inspired aspirations for fair, equitable and just societies throughout Australasia in which all people can thrive and flourish.

And, finally, a special thank you to Rosemary Gilby, whose extensive experience and wisdom defined the early parameters of the project and guided the direction of our work.

Abbreviations

A&E	Accident and Emergency
ABN	Australian Business Number
ACCHS	Aboriginal Community Controlled Health Service
ACEM	Australasian College for Emergency Medicine
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHLO	Aboriginal Health Liaison Officer
AIDA	Australian Indigenous Doctors' Association
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
ED	Emergency Department
GP	General Practitioner
HREC	Human Research Ethics Committee
HREOC	Human Rights and Equal Opportunity Commission
IPP	Indigenous procurement policy
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NCCIH	National Collaborating Centre for Indigenous Health
NSW	New South Wales
NT	Northern Territory
PTSD	post-traumatic stress disorder
RACP	Royal Australian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RAP	Reconciliation Action Plan
SA	South Australia
SEC	Social Emergency Care
UN	United Nations
US	United States of America

About the Title: Traumatology Talks – Black Wounds, White Stitches

Traumatology: the study of wounds and injuries caused by accidents or violence and the surgical therapy needed to repair the damage.

Aboriginal and Torres Strait Islander peoples'[1] traumatology: Intergenerational trauma resulting from genocide, forced separations and removal with epigenetic, telomeric and associated biological changes that are exacerbated by re-traumatising events, poor social and cultural determinants of health, and narratives of desperation, disadvantage, marginalisation and vulnerability.

Across the globe, a growing recognition and celebration of the vital roles that emergency workers play in caring for people has been highlighted because of the response to pandemic influenza. Gratitude to health care personnel for their dedication to their calling has inspired entire nations and given hope to many during heightened global health concerns. The dynamic emergency environment responded to the pandemic by a series of adjustments that impacted staff's workloads, rosters and work environments to accommodate new hygiene protocols and treatment regimens to prevent the spread of the disease, with health professionals often risking their lives to do so. In Australia, we have taken a precautionary approach in line with national preparedness and response guidelines, working collaboratively across State and Commonwealth jurisdictions to implement strategies to minimise disease transmission and maximise the capacity of the health care system to cope with the demand and need for specialist services.

The success of emergency response plans is dependent on the work of emergency care workers, particularly those who specialise in detecting the extent of damage to individuals, work to eradicate population-level threats and are driven to save lives. How this is done is dependent on several factors – clinical severity, transmissibility and the capacity of the health care system. In emergency departments (EDs) across Australia, health workers deal both with fatalities and with injured people and their families daily, often in chronically overcrowded and under-resourced settings. Decision making in these situations is proportional to the level of impact of the damage or threat. It is guided by clinical and surgical guidelines, hierarchical workforce structures, strong ethical parameters and environments that enable scaled surgical and disease-based interventions.

The scientific underpinning of trauma as experienced by Aboriginal and Torres Strait Islander people commenced centuries ago. Today, trauma is embedded in, and frames the lived experiences of, First Nations people in Australia. To reflect this, Atkinson (2002) developed a six-generation traumagram that successfully links historical events with the colonisation of Aboriginal and Torres Strait Islander lands (accidental epidemics, massacres, starvations, and the removal of people to reserves) to increases in the rates of family violence, child sexual abuse and family breakdown in communities. Multiple studies demonstrate a clear link between the imposition of government policies and interventions, and variations in behaviours associated with the trauma experiences of Aboriginal and Torres Strait Islander people (Atkinson et al. 2010).

Exposures to psychological trauma is understood to be a risk factor for several debilitating disorders including post-traumatic stress disorder (PTSD) and depression (Youssef et al. 2018). Several authors (Atkinson 2008; Atkinson 1990, 2002; Cameron 1998; Milroy 2005; O'Shane 1993) have asserted that diagnoses such as PTSD are unable to capture, on a conceptual level, the chronic ongoing stress that First Nations' peoples experience in their everyday lives. The sources of this stress are multiple, repeated and of great severity, and are operating at unacceptably high levels. In addition, such stress is compounded by (1) the inability to identify and overcome a single source of stress, (2) the presence of cumulative stressors, and (3) the realisation that many of these stressors are inflicted by people well known to those suffering from stress (Atkinson et al. 2010).

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[1] In this report, the term 'Aboriginal' is most often used in relation to this project, as no Torres Strait Islanders were involved as clients, patients or workers. However, more generally we refer to Aboriginal and Torres Strait Islander and First Nations' peoples.

When Aboriginal and Torres Strait Islander people present to EDs, the full manifestation of their trauma experience presents with them. This includes trauma related to historical events with intergenerational and transgenerational impacts; exposure to complex, chronic life stressors; trauma from specific, intense life experiences; and complex and developmental trauma arising from adverse childhood experiences (Dudgeon, Watson & Holland 2017).

The Australian Institute of Health and Welfare (AIHW) report *Insights into Vulnerabilities of Aboriginal and Torres Strait Islander People Aged 50 and over* explored factors that might be associated with trauma-related vulnerability, such as ‘aged care, health and functioning, social and emotional wellbeing, housing and homelessness, financial circumstances, alcohol and substance use, traumatic life events and safety’ (AIHW 2019a:58). Aboriginal people involved in the study articulated that triaging for their experiences of embodied trauma is not generally effective, because the discipline of traumatology is premised on triaging for clinical severity and treatment options. It should instead be carried out through a lens of trauma-informed practice, as this is more likely to ease the burden of trauma-related vulnerabilities underpinning Aboriginal people’s presentations to the ED.

Emergency medicine arose out of a progressive social demand for services tied to the moral and ethical aspects of providing care to all people, not just those who could afford it, and is underpinned by the threads of egalitarianism, social justice and compassion. In the ED, advocates are asking for a reimagining of these roots not only in diagnosing and treating wounds, infections and injuries, but also in expanding the role of diagnosing and treating the social determinants of health and wellbeing for all populations. They are advocating for the introduction of Social Emergency Care, an emerging field of practice that can be delivered in concert with emergency medicine, but one that can more appropriately respond to the social and cultural determinants of health. This makes it a specialisation that can emphasise the particular requirements of Aboriginal and Torres Strait Islander peoples.

There are also other populations in Australia who might find Social Emergency Care more appropriate to their needs. They include those with historical traumas, those who have been dislocated from their countries of origin and those with multiple, chronic and overwhelming stressors. So many of those presenting to our EDs carry with them deep and pervasive societal wounds, which cannot be stitched back together by emergency medicine alone and thus will never heal. The complexities and prevalence of this situation have led us to make the case here for an **Australasian discipline of Social Emergency Care**.

Introduction

The Australasian College for Emergency Medicine (ACEM or the College) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak body for emergency medicine, the College has a significant interest in ensuring that the highest standards of medical care for patients are maintained in EDs across Australia and New Zealand.

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ACEM's vision is that the provision of culturally safe and quality acute health care in Australian hospital EDs is vital to true reconciliation with Aboriginal and Torres Strait Islander people. ACEM's 2019–2021 Reconciliation Action Plan (RAP) aims to achieve health equity for Aboriginal and Torres Strait Islander people by being culturally responsive to the patients, family and staff who access emergency services, and by promoting, recruiting, retaining and supporting Aboriginal and Torres Strait Islander medical graduates undertaking emergency medicine training (ACEM 2019).

ACEM is responsible for setting standards for EDs across Australia and Aotearoa New Zealand and, as such, is a key stakeholder in influencing how culturally safe care is provided. It has identified the following four elements as being pivotal to achieving health equity for Aboriginal and Torres Strait Islander Australians:

1. **Relationships** – engaging with Aboriginal and Torres Strait Islander communities, representative organisations and other relevant stakeholders to build and maintain these strong relationships.
2. **Respect** – ACEM respects and values the rich diversity of Aboriginal and Torres Strait Islander cultures, languages, histories, customs and practices as a critical component of the reconciliation journey.
3. **Opportunities** – ACEM encourages Aboriginal and Torres Strait Islander medical students and graduates to consider emergency medicine as a career, thereby contributing to employment opportunities through improving business practices and building relationships with relevant stakeholders.
4. **Tracking progress and reporting** – ACEM has incorporated these reconciliation goals into all facets of its business and made a considerable effort to track the progress of implementation and the outcomes achieved, while identifying key challenges, learnings and achievements, and contributing to public accountability.

To inform the development of its Innovate RAP, ACEM developed a research proposal to study cultural safety in ED settings from the perspectives of service users and emergency service providers. The project was brokered through the Lowitja Institute, Australia's National Institute for Aboriginal and Torres Strait Islander Health Research, with Karabena Consulting applying to undertake the study. The project aims are:

1. To inform the development of an ACEM RAP Working Group's Cultural Safety Advocacy and Implementation Plan that will support advocacy at a national level to improve emergency care delivery for Aboriginal and Torres Strait Islander people.
2. To identify and apply Aboriginal and Torres Strait Islander conceptions of cultural safety by drawing upon research and best practice models of care specific to the emergency setting.
3. To identify and apply ED staff's conceptions of cultural safety to inform the development of further education and training opportunities for staff, future ED design, and ACEM's research strategies and investments.

Karabena Consulting is an Australian Indigenous Business focused on supporting agencies to achieve positive outcomes for Aboriginal and Torres Strait Islander people's health and wellbeing. Primarily engaged through Lowitja Consulting, and more latterly by ACEM, Karabena Consulting undertakes strengths-based research underpinned by principles of First nations' community-led development and localised research support. Our work is premised on culture being the main protective factor in ensuring the health and wellbeing of multiple generations in families. Embedding this approach throughout this project has generated evidence that is both informed by, and culturally appropriate to, Aboriginal and Torres Strait Islander people.

Strategies first devised to implement this project had to be amended due to the impacts of COVID-19 and the length of time it took to secure ethics approvals from all the sites involved in the project. However, once the research process got underway, it included the following activities, which we have grouped under the established phases of the project.

Phase 1

Confirming governance and working arrangements

The agreement between ACEM, the Lowitja Institute and Karabena Consulting facilitated a co-design process to design the implementation and governance arrangements of the project. Our methods included establishing project governance structures and seeking clarity regarding reporting requirements so as to ensure that project findings were effectively communicated to the Reference Group (see below) and ACEM. The project team also discussed and agreed to changes in timeframes for conducting key activities for each part of the evaluation, which had been delayed because of:

— the length of time in acquiring ethics approvals across three States;

— new contractual arrangements being negotiated mid-project to reflect transferring the work from the Lowitja Institute to Karabena Consulting; and

— COVID-19 impacting our ability to travel, thereby transitioning much of the planned face-to-face activity to online interviews and the training of local community researchers to gather information from local people attending the ED at the three participating hospitals.

A Reference Group was established after preliminary conversations with ACEM and the Lowitja Institute. Data collected by ACEM identified the sites where there was the highest rate of attendance at emergency departments (EDs), and then leaving without being seen. The Reference Group established by ACEM and the Lowitja Institute confirmed these sites would provide sufficient information about the experiences of cultural safety and provide answers as to why Aboriginal and Torres Strait islander people left the ED without completing treatment.

Terms of Reference were drafted and agreed to prior to Expressions of Interest being sent to individuals and organisations in a targeted campaign led by ACEM Fellows at the three chosen pilot sites: Lyell McEwin Hospital in Elizabeth, SA; Alice Springs Hospital in the NT; and Shoalhaven Hospital in Nowra, NSW. The Reference Group was engaged through face-to-face meetings (in December 2019) and individuals were asked for input and advice on a case-by-case basis. In September 2020, a final Reference Group meeting was held to present the findings of the interviews and decide on recommendations for inclusion in the Final Report, as these will directly impact the work of the College through the development of ACEM's Cultural Safety Advocacy and Implementation Plan.

A data collection plan confirmed the project questions and aligned them with the most appropriate data sources and methods of collection for addressing each point in the project's implementation. ACEM and Karabena Consulting staff then met to determine the specific qualitative and quantitative data to be collected, and the level of analysis needed.

Associate Professor Aziz Rahman, an experienced researcher, led the development and submission of ethics applications for this project to the following Human Research Ethics Committees (HREC):

- Australian Institute of Aboriginal and Torres Strait Islander Studies HREC (National);
- Aboriginal Health and Medical Research Council Ethics Committee (NSW);
- University of Wollongong's HREC (Shoalhaven-specific location);
- Central Australian Human Research Ethics Committee (Alice Springs location);
- North Adelaide HREC for research projects being undertaken in hospital settings in SA; and
- Lyell McEwin Hospital site-specific HREC.

On completion of this phase in July 2020, project staff were able to start the interview process and to complete the review of the literature needed to produce this Final Report.

Phase 2
Community and stakeholder engagement

Karabena Consulting has developed methods that involve community members as co-creators in the processes of engagement, implementation, evaluation and knowledge exchange. Our methodologies are inclusive of Indigenous research leadership, narrative practices, cultural protection and data sovereignty that reflect the values and diversity of First Nations' communities. The initial team members are skilled hospital-based practitioners, cultural advisors and mentors, trainers of the next generation of health professionals, and researchers with decades of experience in supporting the implementation of culturally safe practices in hospital contexts. These team members, however, could not undertake face-to-face research strategies due to travel limitations brought about by COVID-19, so instead opted to work with male and female local Aboriginal staff connected to the hospital who would undertake the interviews with community members.

The team confidently employed two-way learning approaches and listening techniques that combine Indigenous ways of knowing with Western science and research methods. Interviews with local Aboriginal community members were led by Aboriginal staff, and, where possible, the Otter App was used to capture voice recordings for analysis by Karabena Consulting staff. A final virtual meeting with the six community researchers and Aboriginal members of the project Reference Group was held in August 2020 to discuss and clarify the project findings, and whether they appropriately reflected their interview experiences.

It was envisaged that there would be four face-to-face Reference Group meetings of those who provided governance and cross-organisational support to the project. Due to time and travel restrictions, however, this format changed to include one initial face-to-face meeting and another using Zoom software part-way through the project, plus a final Zoom meeting prior to the delivery of the Final Report to ACEM. The Reference Group reviewed the integrity of the consultation approaches and sought assurances that the methods used to collect information were culturally safe, within scope and aligned to the aspirations of those current and potential service users. Teleconferences were used to provide up-to-date information as required, and a secure project management group using the software Basecamp supported Karabena Consulting in its work. ACEM staff members further contributed to the project by engaging with hospital staff and ensuring adequate support to the implementation team, particularly considering COVID-19 arrangements.

A significant proportion of the evidence base for this project was established through on-site consultations. Although a mixture of focus groups and interviews were originally deemed to be appropriate, we moved to online one-on-one interviews with ED staff and service users led by a team of six community researchers. To support this community research team, Karabena Consulting:

- developed interview guides to provide context, purpose and the questions to be asked;
- sent detailed invitations to each of the sites to inform people of the project, how we wanted to work with staff and patients during the interviews, and from whom we needed input;
- worked with on-site contacts to identify the best possible times for interviews, and determine who could be involved in the project and their availability;
- put together pre-reading materials on the reasons for the consultation;
- developed a distress protocol for each location in case anyone became distressed as a result of participating in the project; and
- transferred cash funds to the community researchers to give to the service users interviewed for the project.

The region-specific information was compiled, and a summary of issues given to key contacts from each of the sites to provide site-specific feedback on what was recorded and to seek advice as to what to include in the Final Report and the Cultural Safety Advocacy and Implementation Plan. The project team also identified and reported on best practice examples of cultural safety strategies in each of the regions to illustrate key insights and learnings from the project.

Phase 3
Analysis and reporting

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Where possible, all interviews were analysed using thematic and trend analysis techniques. This information informed the development and delivery of the project progress reports and was used to validate themes for inclusion in this Final Report. Just as a virtual stakeholder roundtable was used to initiate the project, a second roundtable formed part of the exit strategy for this project. At this final virtual roundtable, we were able to share with participants the project methodology and findings, including the identification of key challenges and enablers in ensuring that EDs are culturally safe both for patients and the workforce, and explore the final findings and recommendations with them. Attendees were encouraged to identify and understand the current activity relating to improving cultural safety in emergency care for Aboriginal and Torres Strait Islander people, and to explore the main barriers to, and enablers of, success in delivering such care. Findings from this roundtable have been incorporated into this Final Report.

The project also incorporated key thinking about how to transition to the new arrangements recommended in this Final Report. Rather than imposing a 'one size fits all' approach to implementing cultural safety in emergency services, we suggest seeking instead to learn lessons from regional and place-based models and those with national and international relevance. An additional component of the overall methodology was to consider the roles of ACEM, policy makers, program implementers and cultural leaders in different jurisdictions, and the mechanisms they can use to facilitate and ensure that accountable, culturally safe and respectful emergency care is provided to Aboriginal and Torres Strait Islander people. ACEM needs to ensure that this also aligns with the commitments in its Aboriginal Health Plan and Reconciliation Action Plan.

Structure of the Final Report

The **Introduction** highlights the research aims and outlines how the project was managed by the research partners and the Reference Group, provides an overview of the methodology and discusses how issues of vulnerability have been managed in the project.

Section 1 is a literature review undertaken so as to have a better understanding of the cultural safety needs of Aboriginal and Torres Strait Islander patients. It also focuses on international research that can inform the development of a strategy around Cultural Safety Training and an Advocacy and Implementation Plan for the uptake of our recommendations in EDs across Australia. There are elements of our work which might also have relevance for Indigenous peoples living and working in Aotearoa New Zealand.

Section 2 outlines information from the patient interviews. The local research teams recruited more than 40 people, some of whom were new clients while others had been engaged with the ED for 5–10 years. In addition, key information regarding patterns of ED use, social determinants of health and recommendations to improve services are considered.

Section 3 captures the data derived from the interviews with ED staff, paramedics and Aboriginal Hospital Liaison Officers (AHLOs) associated with the project. These interviewees were identified by ED directors, with interviewees volunteering their time to discuss the challenges they experience in implementing culturally safe emergency services, and their recommendations for improvement.

Section 4 includes the Recommendations that have emanated from each of the previous Sections and combines this with the project's findings to inform the development of the Cultural Safety Advocacy and Implementation Plan for ACEM.

In the Emergency Department, advocates… are advocating for the introduction of Social Emergency Care, an emerging field of practice that can be delivered in concert with emergency medicine, but one that can more appropriately respond to the social and cultural determinants of health.

Section 1 / Literature Review

ACEM's Statement on Culturally-competent Care and Cultural Safety in Emergency Medicine recognises that patients' cultural background – their 'learned system of beliefs, values and attitudes that shape and influence a person's perception and behaviour' – will factor in their presentation to, and management in, emergency departments (ACEM 2015:1).

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Using standards adopted by the peak medical bodies in Australia and Aotearoa New Zealand, ACEM acknowledges that the right of every person to quality health can only be upheld if cultural issues are core business at every level of the health system. This statement advocates for systemic, organisational, professional and individual considerations to be accounted for when developing and delivering culturally safe services (Medical Council of New Zealand 2006). ACEM's Statement positions the College to advocate for all EDs to continue to develop culturally safe environments to reflect and represent diversity, provide patient-centred care and enhance patient outcomes through the establishment and nurturing of local relationships. These strategies, combined with consumer engagement and enhanced staff–client interactions, are fundamental to ACEM's future work, and have been endorsed by non-Indigenous and First Nations' peoples across both Australia and Aotearoa New Zealand.

Framed by Reconciliation Australia's RAP process, ACEM provides a framework for its Fellows and accredited EDs to support the national reconciliation movement. The College is entering the 'Innovate' phase of developing respectful relationships and creating opportunities for Aboriginal and Torres Strait Islander people. Reconciliation Australia's website describes an Innovate RAP as one that focuses on: developing and strengthening relationships with Aboriginal and Torres Strait Islander peoples, engaging staff and stakeholders in reconciliation, [and] developing and piloting innovative strategies to empower Aboriginal and Torres Strait Islander peoples (Reconciliation Australia [n.d.]:3)

Additionally, the College is determined to 'close the gap' for Aboriginal and Torres Strait Islander people in health outcomes through the work of EDs across the nation. This effort is framed by the Closing the Gap strategy, which began in response to a call for governments to commit to achieving equality for Aboriginal and Torres Strait Islander people in health and life expectancy within a generation (Calma 2005). In 2020, the Australian Government recognised that this is a collective journey in which there is a demonstrable commitment to empower Aboriginal and Torres Strait Islander people to live healthy and prosperous lives (Australian Government 2020a). After significant consultation with stakeholders, Aboriginal and Torres Strait Islander health agencies and communities, the Australian Government is localising partnerships to drive change, heralding both the end of an era in which governments set targets and movement towards shared accountability, and jointly developed frameworks and new targets.

New strategies will enable:

- the devolution of decision making to local areas;
- moving to a strengths-based agenda; and
- enabling more community control and shared decision making.

These approaches have been negotiated as the first round of *Closing the Gap* targets failed to deliver the reforms needed to improve health outcomes for Aboriginal and Torres Strait Islander people (Lowitja Institute 2020), with multiple reports concluding that more effort was needed to ensure mainstream health services are culturally safe (AIHW 2019b; Laverty, McDermott & Calma 2017; NATSIHWA 2016; Rix & Rotumah 2020).

Using both the RAP and the Closing the Gap imperatives to inform the development of an implementation plan to advocate for cultural safety in EDs, this literature review focuses on the past five years of peer-reviewed national and international literature, with a specific focus on First Nations' populations across Australia and Aotearoa New Zealand, Canada and the United States of America (US). Patterns of colonisation have resulted in similar experiences of displacement, segregation and separation, leading to intergenerational traumas and suspicion, the consequences of which are visible today in many EDs (Dell et al. 2016).

Areas emphasised in this literature review align to the aspirations and responsibilities in ACEM's Statement (ACEM 2015) and support us to understand and to implement best practice cultural safety in EDs. The areas of focuses are:

- Health and human rights relating to presentations at Australian EDs.
- Contextual barriers to and enablers of quality cultural safety in EDs.
- Principles and practices needed to implement effective cultural safety practices.
- The role of advocacy in implementing strategies for impact in EDs.

Health and human rights: Presentations at Australian EDs

Across Australia, ED staff treat the most acute of the manifestations of health inequities between Aboriginal and Torres Strait Islander and other Australians, and are thus in a unique vantage point to witness the consequences of these societal health disparities (Dell et al. 2016). Health is a human right in Australia, a right not equally experienced by all First Nations' peoples and often expressed as disproportionate burdens of addiction, mental illness, physical trauma, chronic disease and infectious diseases (ACEM 2018; Gadsden et al. 2019). Aboriginal and Torres Strait Islander people are variously described as:

- continuing to experience higher rates of infant mortality and lower levels of life expectancy compared to non-Indigenous Australians (HREOC 2005; Australian Government 2020b);
- overrepresented in EDs, relative to population size (AIHW 2016);
- more likely to delay their care until their illness is advanced (Gibberd et al. 2015);
- more likely to experience avoidable presentations across populations and within age groups (Guthrie 2012); and
- feeling culturally unsafe in mainstream services and reluctant to present (Mbuzi, Fulbrook & Jessup 2017).

Many Aboriginal and Torres Strait Islander people living in rural and remote locations in Australia experience lengthy and complex patient journeys for both emergency and planned care (Kelly et al. 2015; Kelly et al. 2016). Kelly et al. identified that care pathways are often clinically complex due to a higher incidence of comorbidities, and also 'logistically complex because of the vast geographic distances, the number of healthcare locations and extensive travel required' (2017:526). Over the course of the patient journey, one Aboriginal and Torres Strait Islander person may interact with 50 or more health professionals as they travel from home to hospital and home again with most of these conversations occurring in English.

With English as a second or third language for many people from remote areas, access to interpreters is critical but too often unavailable (Kelly et al. 2017). In addition, they may or may not be travelling with family members, which means that Aboriginal and Torres Strait Islander people in this situation are sometimes required to make significant and life-changing decisions while alone and a long way from home (Lawrence et al. 2010).

A rights-based approach to health calls for resources to be shared more equally, especially in remote areas, and, if needed, for Aboriginal and Torres Strait Islander people to have assistance with asserting their rights to health services. This could be implemented by giving them better access to health care services in the area where their language is spoken, thereby ensuring they understand how to address their health issues (Creamer & Hall 2019).

According to Gray & Bailie (2006), the capacity of human rights discourse to improve the health of Aboriginal and Torres Strait Islander Australians through international law is limited. They argue that ‘neither the legal nor moral imperative associated with a ‘human right to health’ can overcome the barriers to its implementation and enforcement’ created by successive Australian governments (Gray & Bailie 2006:449). Despite having ratified several international human rights treaties, Australia has been the subject of international criticism for failing to incorporate many of these rights into Australian legislation, which means they are not enforceable in the Australian legal system as domestic rights (Gray & Bailie 2006).

Arguably, the moral imperatives created by human rights are still significant, which is illustrated by subsequent government policies and actions (Mazel 2018). For instance, one of the principles informing the approach of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (National Health Plan) is health equality and a human rights approach to health (Australian Government 2013). Building on the United Nations Declaration on the Rights of Indigenous Peoples (UN 2007), the National Health Plan’s human rights-based approach focuses on ‘providing equal opportunities for health by ensuring availability, accessibility, acceptability and quality health services’ (Australian Government 2013:10). There are various other Commonwealth and State policy documents outlining the importance of Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing and education to complement the National Health Plan. These policies prioritise Aboriginal Community Controlled Health Services (ACCHSs) along with their human rights-based approach as an ‘integral part of improving health systems for Indigenous Australians’ (Mazel 2018:15).

Despite the creation of these policies, the right to health for Aboriginal and Torres Strait Islander Australians has not been formally implemented into legislation in Australia in any comprehensive way. However, human rights ‘can be seen to strengthen capacities, promote productive cultural hybridities and empower innovative processes that operate within and beyond institutional systems and structures’ (Mazel 2018:15). According to Mazel (2018:16):

> **the synergy between the rights-based approach and Indigenous led initiatives has elevated the importance of the social determinants of health, the need for specialised rights and for community participation in the design the delivery of comprehensive health care models.**

General Comment No. 14, released by the Office of the United Nations High Commissioner for Human Rights, is widely accepted as an authoritative guide to interpreting the right to health, though it is not legally binding (Burkholder, Hill & Calvello Hynes 2019). The document provides six core obligations:

- access to health facilities, goods and services on a non-discriminatory basis;
- provision of essential drugs;
- equitable distribution of all health facilities, goods and services;
- adoption and implementation of a national public health strategy and plan of action that addresses the health concerns of the whole population;
- access to essential food; and
- access to shelter and sanitation.

It also includes the four interrelated elements outlined in the National Health Plan, which are 'essential to an emergency care system that respects, promotes and protects the right to health' (Burkholder, Hill & Calvello Hynes 2019:614). While these essential elements are useful for setting implementation and funding priorities, they do not represent the exhaustive list of functions required for a complete emergency system, which are:

Availability: Health resources must be available in sufficient quantities to manage the population's needs. It is essential for there to be equitable distribution of health facilities, goods and services, ensuring that remote, marginalised communities are provided with adequate, non-discriminatory access to services.

Accessibility: Health facilities, goods and services must be accessible to everyone without discrimination, with special consideration given to vulnerable populations, underserved geographic regions and affordability.

Acceptability: Emergency health services must be provided in a culturally appropriate manner and be respectful of medical ethics. For instance, emergency systems should take account of local customs and needs by encouraging community participation.

Quality: Emergency care must be scientifically and medically appropriate, with a focus on quality, ensuring best practice and measuring outcomes.

The implementation of a rights-based framework for emergency care requires legislation that ensures access to non-discriminatory care, as well as the establishment of a regulatory body with appropriate oversight to monitor the laws. Burkholder, Hill and Calvello Hynes (2019) argue that the obligation to respect, promote and protect the right to the highest attainable standard of health cannot be fulfilled without a rights-based approach to the provision of good quality emergency care.

Cultural safety in EDs

A review of the literature shows that the main barrier to providing effective care to First Nations' peoples in emergency settings is poor cultural awareness and safety. According to Dell et al. (2016), a lack of cultural safety can reduce effective access to health services by alienating patients, reducing adherence to treatment, exacerbating psychological trauma, and leaving patients with a diminished sense of autonomy and empowerment. The authors proposed adopting the following principles to address cultural safety in emergency care (Dell et al. 2016:303):

- acknowledging the patient is a partner in the health care decision-making process and that their way of knowing and being is valid;
- recognising the impact of complex intergenerational traumas on health and access to health services; and
- having the patient determine whether or not the care they have received is culturally safe.

They suggest actions such as:

- recognising that most patients do not draw on a strictly biomedical approach and respecting alternative perspectives;
- avoiding assumptions regarding the patient's knowledge or desire to access traditional Indigenous medicines or ceremonies;
- providing information using posters or notices to let patients know that traditional Indigenous medicines and ceremonies are respected and can be part of their care if desired;
- ensuring the patient and family understand what is happening with their care and that resources and support are available (traditional healers, patient advocates etc.);
- working in partnership with the local Aboriginal and Torres Strait Islander community to optimise cultural safety in the ED;
- creating designated spaces for Aboriginal and Torres Strait Islander patients in consultation with community when possible; and
- using non-judgmental and non-shaming communication is used.

Cultural safety is only acquired when the patient determines that they have been provided with culturally safe care (Fenwick 2006). Health providers must be trained in cultural awareness and ensure that they acknowledge and understand the holistic view of health held by Aboriginal and Torres Strait Islander people. It is well recognised in Australia that hospitals are places to fear for many Aboriginal and Torres Strait Islander Australians, due to past experiences of racism, cultural insensitivity and lack of knowledge and confidence about the quality of health care they will receive (Victorian Government 2010). A Victorian Government report outlines the following recommendations for improving experiences for First Nations' peoples in the ED:

- building positive relationships with the local Aboriginal community, and working with them to identify and implement projects to improve patient experiences in the ED;
- undertaking environmental improvements to enhance cultural safety in the ED, such as displaying local artwork and artefacts, and providing culturally appropriate, Aboriginal and Torres Strait Islander-specific health brochures;
- providing cultural awareness training for staff, including guidance on effective communication with Aboriginal and Torres Strait Islander patients; and
- developing and implementing an Indigenous employment strategy (Victorian Government 2010).

Fenwick (2006) found that communication and dialogue could be improved between hospitals and the Aboriginal and Torres Strait Islander community through formal engagement with Elders, and spending time with community groups to build relationships, promoting trust and familiarity. Further, First Nations' peoples have expressed that displaying identifiable cultural features, such as First Nations' artwork or the Aboriginal flag, assists them to feel comfortable and also signifies to other cultures that they are welcome (Fenwick 2006).

The availability of an Aboriginal Hospital Liaison Officer has also proven to be effective in enabling quality health care. Studies have shown that an AHLO was 'perceived as shifting the power paradigm back in the direction of the patient and re-established their identity and place as clients within the system' (Fenwick 2006: 52). A case study from St Vincent's Hospital in Melbourne discusses the hospital's strategies to address access barriers. The study outlines barriers including a mistrust towards hospitals due to health authorities' complicity in the forcible removal of the Stolen Generations. Other access barriers include distance, language and cultural barriers. They found that AHLOs provide a 'culturally sensitive link' between health providers and patients, working with and educating other staff in being culturally sensitive to the needs of First Nations' patients (RACP [n.d.]:3).

In 2015, St Vincent's established an Aboriginal-staffed Aboriginal Health Unit, which incorporates the existing AHLO Program. The hospital also has an Aboriginal Health Care Coordinator in the Assessment Liaison & Early Referral Team, who works with complex-needs patients providing advocacy, connecting them to other services and supporting their attendance at outpatient appointments. Further, an Aboriginal Employment Officer is responsible for the recruitment and support of Aboriginal staff (RACP n.d.). The underlying principles which make the Aboriginal Health Unit successful are:

- Aboriginal and Torres Strait Islander leadership;
- culturally safe and equitable services;
- person-centred and family-oriented;
- sustainable and feasible;
- integration and continuity of care; and
- quality and accountability.

According to Edgill & Sabbioni (2018), cultural safety in the ED requires the following:

- **Knowledge**: Health workers must develop and maintain an understanding of the factors that influence their patients' health, as well as the environment they live in and why they present at that point in time.
- **Response**: It is important for health workers to communicate in a manner that facilitates the patient to feel they are being treated in a respectful manner by empowering them to participate actively in interactions and to feel valued, understood and taken seriously. This gives patients the power to comment on their care, which reinforces positive experiences, and enables them to be involved in any changes to services that have had reported negative experiences.
- **Flexibility**: Health services should adapt their environment to provide health care that supports cultural safety.
- **Workforce**: Health services require workers to identify effective, appropriate strategies for cultural safety and be part of the decision-making process.
- **Systems**: Health services must have systems that allow implementation and sustainability of strategies from both an organisation and a government level, ensuring there is collaboration with other agencies and organisations.

To provide a culturally safe environment, it is important to incorporate diverse health beliefs and priorities into ED care and management plans (ACEM 2015). Health workers should ensure that patients feel comfortable, being mindful of both verbal and non-verbal responses that may indicate their level of comfort. It is important to facilitate an environment that is quiet, not rushed and non-judgmental (Edgill & Sabbioni 2018). Emergency department staff should take a cultural history from patients and ensure that they, their families and their carers have access to support people, such as a cultural representative of their choosing. Further, patients must be provided access to an interpreter in their primary language, if required (ACEM 2015). Finally, health workers must ensure that they provide clear, detailed explanations to patients, including about their medical condition, the importance of asking questions, confidentiality, giving the choice to withhold information, and the option to choose a different health professional. Most importantly, it is vital that patients feel their priority is always being met (Edgill & Sabbioni 2018).

Cultural safety does not necessarily require health providers to learn the cultural customs of different groups, rather cultural safety 'seeks to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe' (Curtis et al. 2019:13). Health professionals should examine the potential impact of their own culture on clinical interactions and question their own biases, assumptions and prejudices that may result in the provision of a lower standard of health care. Curtis et al. (2019) recommend considering the following steps to take a more comprehensive approach to cultural safety:

- Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development.
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification.
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes).
- Require Cultural Safety Training and performance monitoring for staff, supervisors and assessors.
- Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous health (Curtis et al. 2019:14–5).

The National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health provides a detailed guide on improving cultural competency. It provides key tasks including encouraging health services to refer to the national Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health, to develop partnerships with First Nations' communities and to implement an Indigenous employment strategy (ACSQHC 2017).

It is difficult to measure cultural safety and, until recently, there have been no critical indicators or empirical measures of cultural safety from the patient perspective. However, Elvidge et al. (2020) have recently developed a Cultural Safety Survey Scale that could be a useful tool for measuring cultural safety in hospitals from the perspective of First Nations' patients. According to the authors, this measurement model will allow hospitals to measure the effectiveness of their services in providing culturally safe care, with the hope that it will be used to benchmark performance and eventually be adopted as a performance measure for hospitals (Elvidge et al. 2020).

Enhanced models of care in the ED

Enhanced models of care are those that are designed to be culturally inclusive and appropriate to the patients and staff involved in the delivery of emergency services. EDs are under increasing pressure due to high demand, lack of available resources, overcrowding and prolonged patient waits, which have led to a call for improved operational efficiency in all States and Territories (NSW Government 2012). Across Australia, the ED model of care is based on the principle that EDs cater for emergency patients. Patients who would be better served by an alternative care provider should be referred directly to that provider, and EDs should not be used as an alternative when other services are not available. Instead, care should be streamlined and there should be no duplication of assessment and treatment (NSW Government 2012).

All the participants in this study either work in or have presented to the Triage and Registration model of emergency care. Triage systems have traditionally been used to ensure that the most urgent patients receive timely care (Romeo & May 2018), and are relatively simple in the way they seek only to put patients in order so as to prioritise care or allocate appropriate services. Other interventions include Fast Tracking and Rapid Assessment models using whiteboards and computerised tracking systems, which can improve patient flow, shorten waiting times and reduce 'left without being seen' rates, as well as improving patient and staff satisfaction and communication (Chartier et al. 2015; Romeo & May 2018). There are indications that these models are being implemented to varying degrees across Australia.

Innovative strategies to reduce overcrowding in ED services

Under the College's Australasian Triage Scale, a 'clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient', EDs employ five triage categories to assess clinical urgency – from Category 1: 'an immediately life-threatening condition that requires immediate simultaneous assessment and treatment' through to Category 5: 'a chronic or minor condition which can be assessed and treated within two hours' (ACEM [n.d.a]). The categories can be found in Table 1.

Table 1 Australasian Triage Scale

Triage Scale categories	Treatment acuity (Maximum waiting time for medical assessment and treatment)	Performance indicator threshold
Category 1	Immediate	100%
Category 2	10 minutes	80%
Category 3	30 minutes	75%
Category 4	60 minutes	70%
Category 5	120 minutes	70%

Increased demands on EDs can result in lengthy waits for non-urgent Categories 4 and 5 presentations. New models such as Triage and Treat pilots have been evaluated in regional ED services and have been found to improve patient outcomes, including in the effectiveness of treatment, their length of stay, patient flow and patient satisfaction with emergency clinical care, particularly for the management of minor wounds (Van Donk, Tanti & Porter 2017). In these models, some patients are given definitive simple treatments in the triage area and/or are given advice regarding self-care, while nursing staff are able to triage, treat and discharge certain patients presenting to the ED (van Donk, Tanti & Porter 2017). However, in the case of Aboriginal and Torres Strait Islander communities, these models need to be operationalised in well-functioning and connected service delivery systems to avoid cases in which people die from preventable illnesses after having been turned away from EDs and hospital services, and where cultural sensitivity was not recognised nor responded to, e.g. as happened in several high-media cases over the past few years (McQuire 2020).

Aboriginal and Torres Strait Islander people often leave EDs without being seen, are less likely to be admitted, and are more likely to leave at their own risk prior to, or at the completion of, treatment. In some studies, they were overrepresented in the less severe triage categories (King et al. 2019), with suggestions that the administration of medicine was the most common reason for ED presentations (in specific locations). Thus, managing medicine dispensary functions through triage could reduce waiting times.

Emergency models ensuring more patients see a practitioner

Aboriginal people interviewed in this project stated that their experience at triage indicated what the rest of their experience would be, particularly if they were presenting with Categories 4 and 5 concerns. The triage model, then, could be further adapted to meet the needs of clients in a diverse range of settings. Interviewees also highlighted that the length of time to transition from triage to the waiting room, then from the waiting room to the back area and then to be seen by a medical officer caused them deep concerns. Many of the issues they presented with, what could be understood as a 'quick treatment' only, ended up with them having to wait the longest (Subash et al. 2004). The following models have been included as they have proven to impact positively on the patient experience of EDs and have supported staff to operationalise emergency services.

Team Triage strategy

Research by Xi & Dalal (2015) has shown that the presence of a family medicine resident physician in the ED is associated with reduced waiting times and fewer patients leaving without being seen. Quite often, and for less complex ailments, a medical assessment is a duplication of the triage assessment. Although nurse practitioners have the necessary qualifications to assess some patients, other complaints, both minor and major, require medical evaluation. Combining doctor, Aboriginal Health Worker and nurse assessments could provide greater efficiencies, particularly at peak times in EDs.

Triage teams could undertake medical evaluations, offer medications, order investigations and make decisions about treatment and discharge. Small triage consultation teams have been found to have positive impacts by keeping patients moving and reducing demands for new space as patients were 'treated and streeted' or sent straight to radiology or other hospital departments without having to wait in a cubicle (Subash et al. 2004). Aboriginal Health Workers with prescribing rights could make a valuable contribution to these small triage teams by supporting Aboriginal people in Categories 4–5 needing access to services.

Additional triage-based strategies – such as being able to access ED-based Aboriginal practitioners at various points during the day and having triage nurses ordering laboratory-based tests, radiography and other therapeutic services – could also improve efficiencies. The approach requires the input of experienced doctors and a culturally safe small triage-based workforce to optimise outcomes for all patients and their families.

The main effects of a Team Triage strategy would be fewer patients leaving the ED without being seen by a practitioner, and the more rapid streaming of patients (Oredsson et al. 2011). This strategy, through the participation of a physician as the leader, could be one of the benchmarks for ACEM to achieve, particularly in accredited hospitals.

Alternative care facilities and enhanced care coordination

Increasingly, Aboriginal patients are using the enhanced care coordination services attached to primary health care centres outside the hospital, such as ambulatory care facilities, that have been established to support patient- and family-centred care. Clients are supported with booking clinical appointments and better connections to hospitals and community-based care, and their collaborative governance models and agreements both minimise the service gaps and are a more efficient use of available resources.

For paediatric cases, models such as the Wadja family program at Melbourne's Royal Children's Hospital and the Koorliny Moort program, operating from Perth Children's Hospital (Strobel et al. 2020), have been established to support outpatients' appointments and reduce hospital utilisation. Evidence suggests that these enhanced models of care can significantly reduce hospitalisation admissions, ED presentations, non-attendance at appointments and the mean length of hospital stays (Cresp et al. 2016).

Experienced-based co-design

These approaches are particularly empowering for Aboriginal and Torres Strait Islander Australians who have often experienced poor communication (either rushed, disrespectful or unclear) and sometimes an added financial burden when attending emergency services. Concern about the latter was clearly articulated by participants in one study, who stated that 'lack of money, costs associated with public transport, petrol, parking fees, food and drinks for themselves and their children led to more stress and frustration' and was a key factor in their non-attendance at planned appointments (Strobel et al. 2020b).

Independent of which models are implemented, experience-based co-design strategies are useful approaches for encouraging collaboration between patients experiencing vulnerability, families and carers, and staff in complex health care environments.

Flexible implementation and piloting of innovative ideas

The flexibility of these models allows the specific needs of participants to be accounted for in time-sensitive environments. For example, ED staff might be able:

- to facilitate discussions with local services, AHLOs or cultural leaders about service-level interventions intended to improve care quality;
- to hold a meeting with families and Elders to discuss how palliative care services could be delivered in culturally sensitive ways;
- to hold a workshop for those working with, or who have lived experience of, how to manage mental health requirements for Aboriginal people and to find out any cultural remedies which could be useful;
- to work with local healers to create 'rubbing oils' or bush medicine to have available for people experiencing distress; and/or
- to engage local healers in triage processes so as to meet the cultural needs of people from regional and remote areas.

Evidence suggests that some appropriate and systemic strategies used to achieve cultural safety are as follows:

- the accreditation of hospital-based cultural competencies;
- working with the cultural determinants of health;
- using skilled interpreters, who can understand complex medical information;
- having Aboriginal staff present in the ED;
- staff education and training;
- quality improvement strategies;
- co-design processes or committees of Aboriginal people who can provide advice and feedback;
- creating a welcoming and safe environment; and
- employing more Aboriginal staff and using Indigenous communication techniques.

All these and other strategies require practitioners, managers and ED staff to allow greater equity of access to appropriate interventions that address social and cultural health needs. Cultural safety acknowledges the barriers to clinical effectiveness and moves to redress this dynamic by making clinicians' cultural understanding a critical focus for reflection, and by empowering Aboriginal people with health literacies (Laverty, McDermott & Calma 2017).

Employment of Aboriginal and Torres Strait Islander people in EDs

All the respondents in the study said their work would be enhanced by having identified positions in the ED to undertake support for Aboriginal people prior to their admission. Interviewees advocated for the employment of Aboriginal people to support people both through triage and in the waiting rooms, and while they were waiting to see a practitioner. In other words, a 'professional greeter' who could advocate for patients and communicate to them what was happening with regards the length of time they would have to wait, their progression in a queue and so on.

Additionally, participants advocated for clinical positions to be made available in the ED: for example, a specialist health worker position, a triage health worker and, in the instance, where there was an emergency pharmacy, a qualified health worker who was able to dispense medication.

Aboriginal people also thought healers would help patients remain calm, while providing pastoral care for those who were dying would be a welcome addition to emergency care. Other positions that people thought could be provided through an Aboriginal business were drivers and transport officers, administration staff and positions that support people with discharge planning and accessing different hospital-based services including radiology, X-Rays, MRIs and CT Scanners. The literature supports these employment aspirations to enhance cultural safety, along with more First Nations' nurses, doctors and registrars.

Principles and practices that can enhance cultural safety in EDs

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Recognising the gaps between Aboriginal and Torres Strait islander and non-Indigenous people's health outcomes is a well-documented priority within national and State-based hospital and clinical services. Despite a plethora of cultural capability programs, study participants reported having one cultural awareness session at the commencement of their employment and no further formal training after that time. As the ED is the front door to a wide range of hospital experiences, and in many ways 'sets the scene' for the rest of the patient's experience, greater attention needs to be paid to strategies that enhance cultural safety in emergency care.

ACEM's position on cultural competency in relation to emergency medicine is to improve the quality of health care services and outcomes for all patients (ACEM 2015). Principles underpinning this statement include:

- non-discrimination and the right to culturally safe health care;
- that all trainees and Fellows continually improve their cultural competency;
- adapting service implementation strategies to reflect the diversity between and within cultures, including addressing institutional discrimination;
- putting feedback mechanisms in place for consumer engagement, which is representative of the cultural diversity of the ED's population;
- giving all patients the opportunity to speak to a cultural and/or religious representative of their choosing; and
- providing patients who do not speak English as a first language with access to a professional interpreter in their primary language, including for Indigenous language speakers.

Principles of cultural safety

Internationally, a principles-based approach to addressing cultural safety in emergency care has been developed, with the implementation strategy providing a supportive environment in Canadian Aboriginal populations. Dell et al. (2016) suggest that the following principles will alleviate suffering and enhance cultural safety:

- validating the patient's way of knowing and being;
- making the patient a partner in the health care decision-making process;
- recognising the impact of complex intergenerational traumas on health and access to health services; and
- allowing the patient to determine whether the care received is culturally safe.

Principles supporting increased cultural responsiveness

Leckning et al. (2019) identified principles that should be implemented in emergency services for people experiencing poor mental health, principles that will facilitate culturally responsive psychosocial assessments to ensure clinicians are sensitive to the social and emotional wellbeing requirements of people experiencing self-harm and/or suicidal thoughts and behaviours. The aim of these guidelines is to develop the cultural competency of staff; recommend practices and strategies that encourage patient and cultural safety; improve the quality of assessments and clinical decision making; promote a person-centred approach and community-based recovery; and increase patient and staff satisfaction.

Leckning et al. (2019:5) recommend that the following principles be implemented, alongside appropriate policy and practice guides:

- understanding the importance of social and emotional wellbeing to First Nations' peoples;
- respecting the diversity of Aboriginal and Torres Strait Islander Australians;
- acknowledging local cultural protocols and kinship structure;

- understanding culturally sanctioned behaviours, including self-harming behaviours, and social explanations of mental illness and wellbeing;
- having the cultural resources to promote health and the resolution of cultural issues;
- being sensitive to feelings of shame in patients as this will make it difficult for them to share information; and
- understanding gendered information and age sensitivities, such as exposure to self-harm, substance misuse, domestic violence and social exclusion (e.g. wrong skin relationships).

Cultural safety networks

In Queensland, a network of specific cultural safety groups has been established, auspiced by the Queensland Emergency Department Strategic Advisory Panel, to provide an ongoing avenue for members to share ideas and collaborate at a State-wide level. Having developed a resource pack for other EDs, the Cairns Base Hospital's Accident & Emergency Department has reduced barriers to Aboriginal and Torres Strait Islander patients' attendance by implementing specific actions within local ED teams under the following domains:

- demonstrating respect based on Increased understanding;
- building relationships; and
- understanding reciprocity and creating opportunities.

Implementation strategies emerging from this network have greatly enhanced access and improved cultural safety, patient engagement and staff wellbeing by:

- improving staff education;
- creating a more welcoming physical environment;
- utilising existing resources effectively;
- enhancing engagement with community organisations;
- improving identification of Aboriginal and Torres Strait Islander patients so as to provide culturally and clinically appropriate treatment in EDs;
- ensuring Aboriginal and Torres Strait Islander staff have a culturally safe place to work; and
- taking steps to increase the Aboriginal and Torres Strait Islander ED workforce.

Recognising culture as a protective factor for families

Presentations to emergency services can be influenced by dynamic factors that are episodic or enduring and may have cultural reasons or explanations underpinning them. The cultural dimensions of presentations can contribute to the anxiety or distress experienced by a person and can be described as family stress, unresolved trauma and grief, and exposure to sorry business or recent adversity. Similarly, cultural activities, strategies and solutions might be appropriate as well, and it is recommended to seek and participate in meaningful activities that are culturally based (e.g. ceremonies, hunting, art, sports, music).

Conclusion

Based on the literature, ACEM's Cultural Safety Advocacy and Implementation Plan will need to include strategies that support and promote the principles of cultural safety in the workforce, in the built environment and through innovative programs. Of critical importance will be promoting partnerships and coordination between services, extending the capacity of referral pathways to accommodate social and cultural determinants of health, and establishing local networks of practitioners to create a throughput of cultural safety in the patient journey. In concert with Aboriginal people, and inclusive of an Indigenous workforce, the literature also promotes the development of, and innovation within, triage systems, rapid assessment models and alternative care facilities to enhance culturally safe care.

Specific recommendations and strategies for ACEM's RAP Working Group in the development of the College's Cultural Safety Advocacy and Implementation Plan can be found in Section 4, where we summarise the findings emanating from this review of the literature as well as those from the interviews with both the staff and the community.

Section 2 / Optimising Emergency Services for Patients

> **Illness is huge. Illness or, more accurately, our relationship to it, threatens the way we know ourselves and how others know us also. Anything that helps put illness in its place, that allows us to feel that we are who we are despite it, is welcome. (Weingarten 2001)**

Western cultural ideals of health and wellbeing are evident in discourses that fetishise fitness, accomplishment, success, individualism, materialism and progress (Eckersley 2006). Alternatively, Western cultural ideals that have direct bearing on the health and wellbeing of Aboriginal and Torres Strait Islander people are fetishised using the five 'Ds' – Disparity, Deprivation, Disadvantage, Dysfunction and Difference (Walter 2016). These discourses are perpetuated by data environments that obstruct rather than assist Aboriginal and Torres Strait Islander people achieve their health, wellbeing and life goals by focusing on the negative, being inaccessible and promoting unsustainability (Walter 2018). Western cultural ideals reflect back to all members of societies the acceptable and tolerable priorities and norms, while highlighting the social, cultural, behavioural and racial dimensions of wellness, and the social construction of 'Indigenous illness'.

Discourses of non-Indigenous people's wellness and Aboriginal and Torres Strait Islander illness are communicated through words, phrases, sentences and grammatical structures and are embedded in communiques, policy and programming, position statements and speeches. Analysing the Australian health landscape, Aldrich, Zwi & Short (2007) found four dominant discourses permeate Indigenous health policy and programs, and demonstrate a link between these discourses and the health outcomes of Aboriginal and Torres Strait Islander people. According to Aldrich, Zwi & Short (2007) these discourses problematise Aboriginal and Torres Strait Islander people and call into question the 'competency and capacity of First Nations' peoples to manage their own affairs; positions Aboriginal and Torres Strait Islander people as the 'other' and actively included or excluded based on whether this is acceptable or not; or being 'problematised'; suggesting a link between racial inequality and racially aligned social and cultural differences.

These discourses can be responsible for statements and stereotypical identities such as the following:

> **The poor health of Aboriginal people is their own fault because ultimately, they are the ones who, through their behaviour and their choices, are responsible for their own inequality...**

> **Poor parenting, poor school performance, early school leaving, unemployment and drug and alcohol use is the reason people offend...**

> **Aboriginal people get free houses, and still they live in deprived conditions...**

These statements are not social facts but 'predictable outcomes of long standing social, cultural and racial inequality that is the signature product of colonising settler states' (Walter 2016). Bonilla-Silva (2010) showed that these discourses are not impartial, nor are they objective. These discourses, which manifest statements such as those above, are not only used against individuals and families, but are embedded in institutions across the country. Therefore, cultural safety practices on their own are not enough.

In Australia, the primary focus of race relations remains between the majority white population and the First Nations' peoples of Australia. These race relations are mediated through the historic and contemporaneous experiences of colonisation, and hospitals have been the site of many colonising practices that have caused untold harm to Aboriginal and Torres Strait Islander people, including:

- male gynaecologists involved in the delivery of Aboriginal babies;
- children removed by child protection from mothers in birthing wards;
- deaths from preventable diseases; and
- poor palliative care.

While these services are different to those offered through EDs, some of the Aboriginal people we interviewed stated they have 'actively avoided EDs whenever possible' based on their own and other's previous poor experiences in emergency care and at hospitals in general. When forced to seek emergency care, some interviewees did so with feelings of shame and unworthiness, which were triggered by interactions with ED staff and the general public in the waiting areas. People who need help and attend EDs shared similar stories of seemingly punitive treatment, the experience of racism and 'being left alone for hours at a time', which generated feelings of shame, avoidance and anxiety, often with terrible health and wellbeing consequences.

The people we interviewed wanted positive encounters in their engagement with EDs, in which they received treatment as usual with no judgment. Some of the respondents felt this expectation may have come from Aboriginal people's experience of seeking GP services or attending primary health care or community health clinics.

In the interviews people were able to recount the times when they had care that was delivered with kindness and told the interviewers how this kindness had encouraged them to return to emergency services. Those who experienced authoritarianism, or who were left alone or made to feel unsafe in the waiting rooms, stated categorically that those interactions which perpetuate power imbalanced relationships and negative stereotypes were undesirable. Aboriginal and Torres Strait Islander people are a population for whom a presentation to the ED is something to avoid as it highlights the interface between the experiences of 'ill Aboriginal and Torres Strait Islander people', and the 'well non-Indigenous people providing Emergency Medicine'. This can lead to misunderstandings, including feelings of irritation, anger and frustration and cause people to leave without having their health issue attended to.

Patients and interviewees

People contributed stories of their experience of hospital emergency departments in Shoalhaven, Alice Springs and Adelaide, with the key themes emerging from these accounts of their most recent and relevant experiences summarised in this Section. In total, 45 Aboriginal people provided feedback based on four questions asked by community researchers.[2] The interviewees represented 29 women (aged 17–68) and 19 men (aged 22–70), from either urban or regional areas, who needed emergency services in the past few years and had experience of one or more of the following situations:

— were elderly and had multiple chronic conditions to manage;

— had arrived at the ED in an ambulance;

— had been escorted off the hospital grounds by police;

— were responsible for children taken to the hospital;

— had been a primary support person for people who needed care;

— had attended the rooms of loved ones who were dying;

— had difficulty managing diabetes and dialysis;

— were young and had no children but were fleeing violence;

— needed support from the emergency mental health care team;

— had English as a second language;

— had been in the ED and discharged, but then admitted to hospital within 48 hours;

— were mobility impaired;

— had to travel more than 20, 50 and 100 kilometres to the nearest ED;

— needed immediate surgery; and

— had self-harmed while intoxicated.

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[2] Due to of COVID-19, Aboriginal people were interviewed by local Indigenous people who had an association with the local hospital, and included three AHLOs, an ACEM Fellow, an audiologist and her son, and a peer researcher aged in their early twenties.

People with an illness or injury who presented to EDs reported they were in a heightened state of emotional distress, in pain and often having to 'mentally prepare themselves' to enter these spaces and places. This is because EDs are unfamiliar, have a negative and colonial history, and are loud, busy and trauma-provoking.

> **You really know you are Aboriginal when you go to accident and emergency, especially in the waiting room... and you have to be ready, you have to be prepared...**
> **(Adelaide)**

The illness narratives used by Aboriginal people upon presentation to the ED are in many ways framed by, and in response to, dominant cultural ideas that characterise illness, experiences of pain and the relationships between First Nations' populations and mainstream society. It is little wonder, then, that comprehension is a defining issue for people in whether or not to attend and work in EDs, and was most frequently mentioned by interviewees in the study as an enabler or a barrier.

Patient experience of EDs

Although there have been multiple government reports promoting better access to culturally safe emergency services, it is recognised that EDs in hospitals are fear-invoking places where Aboriginal and Torres Strait Islander people have experienced racism and cultural insensitivity in the past, and that they do not possess enough information about the health care they will receive and confidence in it (Victorian Government 2010). They are often so concerned about the care they will receive that they do not (or incorrectly) identify as Aboriginal or Torres Strait Islander (Mahoney 2020). Mahoney's earlier (2017) study of 784 cardiac patients found that only 60 per cent of the Aboriginal patients were accurately recorded as 'Indigenous' at the hospital. Further, his study found that this reluctance to identify was because of their uncertainty around why they must prove they are Aboriginal (even though proving Aboriginality is not a requirement of service), their mistrust of hospitals, previous negative experiences and concerns about confidentiality, and/or clinical and cultural stereotyping.

Another State-based report identified that these issues are a driving force for Aboriginal people 'taking their own leave', a phenomenon in which Aboriginal people are described as disrupting their medical treatment, absconding or going missing, self-discharging or 'leaving at their own risk' (Aboriginal Health Policy Directorate 2018). Definitionally, this descriptor again emphasises the 'incapacity' for Aboriginal people to take good care of themselves and are choosing to leave, rather than the health services focusing on their own institutional racism, stereotyping, and the quality of the environments in which pe3145

ople are seeking to treat their health. The narratives from hospital staff highlight racial bias with respect to Aboriginal patients:

> **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 issues** (Aboriginal Health Policy Directorate 2018)

A set of interrelating factors impact people's attending, staying and leaving emergency and hospital-based services, many of which have historical, cultural, social, political and economic factors at play (Bessarab et al. 2012). These factors – combined with statistics showing that Aboriginal people experience longer wait times for surgical procedures, fewer diagnostic interventions for complex health issues and higher death rates after leaving hospital (AIHW 2019c) – will also impact Aboriginal people's health-seeking behaviour. As with the discourses explored earlier in this Section, Mahoney (2017) states it is not uncommon to hear rhetoric suggesting this lower standard of care is somehow the fault of the patients:

> **… that poorer outcomes can be put down to incomplete health records, lower levels of education, or competing personal and family demands. Cultural misunderstandings, transport issues, financial constraints or 'being more mobile' are also sometimes used to excuse poor health-care delivery.**

These narratives reinforce dominant cultural views about Aboriginal people's participation in their health and wellbeing, while explaining away systemic shortcomings and engendering institutional environments that are racially intolerant toward 'non legitimate' (Category 3–5) ED service seekers and providing acceptable services to those in the more urgent Categories 1 and 2.

The following information has been structured to reinforce both the positive and challenging experiences that Aboriginal people found themselves in, so as to establish community-led parameters and solutions to doing this work well.

Pre-ED health-seeking behaviours

Respondents experiencing a crisis, often described using multiple strategies before they attend the ED. People reported talking to family and friends, seeking appointments at the local ACCHS, primary health care clinics, or Medicare-funded GP services, and visiting chemists and pharmacies. If these options were not able to support them, then they came to the ED. Aboriginal responders in this study said that despite their misgivings, multiple referral pathways led them to the ED (telephone counselling, referrals and supports), and the immediate relief of getting to the ED was overcome by the experience of being triaged, then prolonged exposures to the discomfort, behaviours, views and circumstances in waiting rooms that were overwhelming.

> **The brightness and the pace of the ED made it difficult to talk privately and to calm myself down… when they put me in the back room by myself my anxiety got worse… I had breathing troubles; I was trying to control my breathing but it was so hard…**

This reinforces evidence generated from a study which sought to identify factors, unrelated to chronic conditions, that contribute to frequent presentations by Aboriginal young people to the Katherine Hospital. Frequent Attendees – those Aboriginal patients who attend EDs more than six times a year – had strong associations between homelessness, significant burdens of disease associated with poverty and poor housing, and limited access to services that provide safe housing (Quilty et al. 2016). They also found that among people who presented to hospital with genuine clinical needs related to alcohol and not violence as the major contributing factor, there was a higher degree of certainty they would be admitted. For those people who were able to be triaged and admitted to the 'back room' (the places in EDs where you have access to a bed or a comfortable chair or a bed without having the experience of the waiting room), the ED was a sanctuary.

The ED as sanctuary

Emergency departments can be a sanctuary for those who are at risk of violence and who have nowhere else to go.

> **We know a lot of those young girls come up from the riverbed and can go to sleep in the ED waiting room if they are not safe – that big security guard keeps everyone away!**

> **My granddaughter felt safe going to ED after being assaulted by her boyfriend, must be caring staff for them to keep going back there.**

This commitment by ED staff to human rights and social justice is steadfast and critically important to the community. As difficult as accessing EDs are, they are the backbone of the Australian health care system and the front face of the hospital wards and the patient's journey. There is a concerted effort though, in working with mental health consumers in Western Australia and across the country, to establish Safe Havens – co located on the hospital premises and or community hub. It can be in the form of a cafe and is 'manned' by peers, ED staff and physicians. Considerable effort has gone into facilitating this kind of environment to reduce the impact of barriers to access and encouraging people to seek support and assistance from outside the ED space. While they can be a sanctuary, EDs were established to transition patients to other services not to hold people there for long periods of time.

Triage

The triage experience was a key determining factor in whether people stayed or left the ED, and whether their emotions were heightened or, alternatively, whether they were able to remain calm. If staff in the triage area were able to provide people with privacy, a gender-appropriate experience and a place where people felt safe to explain their issue, then it buoyed their confidence to go to the waiting room or to another area of the ED.

Great triage person and the other staff – if they just engage with you nicely then it makes the world of difference. If they are blunt or rude, then it sets the tone for the rest of the experience. Especially on a Saturday night – footy night – you will be waiting a long time. If the triage nurse could just tell us that, it would be good to know.

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The triage nurse was the only one there – they asked me questions but didn't want to check to hear. With everyone standing behind you I didn't want to make a big deal about the pain I was in because everyone can hear what you are saying... there was no privacy and I am not going and telling them everything with everyone else hearing about your problems.

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Nursing staff and front of desk – that would be a good starting point before they came to work there - they could do cultural training that they require and that can be done in blocks – they don't need to take all the staff away and this training would give them a better understanding as to why they have to wait 24 hours in ED when they [staff] are so busy and run off their feet.

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In Australia, patients are triaged according to their presenting condition 'in an attempt to regulate the flow of patients and identify clinical urgency' (Wright 2009:81). There is often a lack of understanding about the triage system, as patients are seen in order of priority and not arrival, which can lead to increased anger and frustration. In a comparative study of Aboriginal and non-Aboriginal people who did not wait for treatment or were discharged against medical advice from rural EDs, Wright (2009) found that Aboriginal people were 1.5 times more likely to leave emergency care prior to being seen by a medical officer. The majority of these people had been triaged to a Category 4 or 5. Aboriginal people were also 2.5 times more likely to discharge against medical advice than non-Aboriginal people. According to Wright (2009), various studies found a consistent over-triaging of non-Aboriginal people which suggests that resources were allocated toward less urgent non-Aboriginal patients. They also found high admission rates for Aboriginal people from lower triage categories, which indicates a consistent under-triaging of Aboriginal people. Statistics from 2017–18 also found that a higher proportion of Aboriginal and Torres Strait Islander Australians were assigned to the semi-urgent and non-urgent triage categories compared with other Australians nationally (AIHW 2018).

According to Wright, studies suggested several possible explanations for this including 'conscious or unconscious bias, cultural differences in disease presentation, social and compliance issues, communication barriers, and the effects of drugs and alcohol' (2009:82). Similarly, Preisz and Preisz found that EDs 'have had a high failure rate in delivering adequate and timely care for Aboriginal people', with the unacceptably high rate of failure (measured as 'did not wait' to be seen and 'discharged against medical advice') due to a number of factors including the ED's lack of accommodating the culture, needs and beliefs of First Nations' peoples (2020:1). This often results in 're-presentation, unplanned readmissions and more broadly, much poorer health outcomes' (St Vincent's Health Australia 2020).

To address the high rates of incomplete treatment for Aboriginal and Torres Strait Islanders, the St Vincent's Emergency Department, in conjunction with the Aboriginal Health Unit, has launched a new Flexi-clinic, known as 'Stayin' In, Stayin' Deadly'. It aims to have a welcoming, reassuring approach with distinct process flexibility. Flexi-clinic is activated at triage for all Aboriginal patients (who are identified in accordance with standard NSW Health Policy) by sending an SMS text to the rostered Aboriginal Liaison Unit Officer to greet the patient in the waiting room (Preisz & Preisz 2020). Aboriginal Health Unit team members are available to support the patient throughout their treatment and follow-up care, fostering a sense of cultural safety for Aboriginal patients in the busy and unfamiliar ED environment. An allocated senior clinician is simultaneously alerted to attend to the patient within 30 minutes, significantly reducing waiting, testing and diagnostic times. After assessment and initial management, patients who require ongoing care are offered various options appropriate to their needs including remaining in the ED, hospital outpatient services, the Aboriginal health-care service or attending a local GP. If patients need to leave prior to completion of their treatment and are safe to re-present at a convenient time, they are given a Flexi-clinic card. Patients can present this card when they return to the ED, so that care can resume as required and without the need for an appointment.

The new Flexi-clinic project has resulted in 'exponential improvements', with average waiting times for patients reduced to just 16 minutes. ED failure to complete treatment rates for Aboriginal patients fell from a rate of 19.5 per cent to a 'staggering' 1.6 per cent, making St Vincent's one of the best performers in Australia (St Vincent's Health Australia 2020). So far, the program has received positive feedback from staff and Aboriginal patients, who found that the approach 'valued and respected Aboriginal patients, supported ongoing well-being and built therapeutic trust' (Preisz & Preisz 2020:3). Effective triage processes that contribute to closing the gap require 'sustainable, innovative health-care models like Flexiclinic, developed with and for Aboriginal people' (Preisz & Preisz 2020:3).

Death and dying

Emergency services were never established to provide palliative care or mental health services, but they receive many presentations from people who need these services (ACEM 2020a; AIHW 2020). For Aboriginal people, the process of death and grieving is such that multiple people will be present to witness the start of their loved one's journey to the Dreamtime. Aboriginal people who have been at hospitals to support the process of dying have said they needed 'spill over rooms' or 'segregated areas' in which to grieve:

> **Our families have 5–6 people who will attend – we need a segregated place to grieve. Accident and emergency department waiting room's too visible and triggered trauma part of it all... and you know we have different groups all coming to the one place. We are all emotional, it is easy to ramp it up which isn't good for us, and isn't good for the other people waiting or for staff.**

Cultural understandings for death and dying also permeate the experience of death and dying, that are not well understood by non-Indigenous staff members:

> **People go in threes or seven – that is our dreaming around here... seven sisters dreaming, seven seasons.**

> **Rather than be brought here, what we need are places on country where people can go and die with dignity with their family around them. I'm lucky I have a place like that where people can come then we ring the police afterward and they come and check and take them away after that. I think it's better for us to have some space around us for some experiences... it's just too raw!**

While the focus on emergency care is on pain management for the people who are dying, specific attention is also needed for the pain and suffering of families and friends to adjust to the dying process (Bhatt, Givler & Maani-Fogelman 2020). Cultural considerations, therefore, need to accommodate the patient's quality of care, provide support for family and friends in overcoming barriers to palliative care and decision making regarding pain management, and work with families to address language barriers that might impede appropriate end of life care.

Miscommunication

Communication plays a vital role in ensuring patient safety and providing quality health care, particularly in high-stress contexts such as EDs (Matthiessen et al. 2015). Communication is widely understood to contribute to the satisfaction of the patients and clinician satisfaction and retention (Slade et al. 2015). Slade and her colleagues (2011), who examined clinician–patient communication in five EDs across Australia, report that the quality of patients' care and experience are affected by the contextual complexity of EDs and by the foregrounding of the medical aspects of communication over the interpersonal aspects. A key finding from a review of communication across five EDs found that patient–clinical staff member interaction was rarely patient centred, with little rapport and empathy being developed between patients and clinicians:

> **While acknowledging the challenges that affect the development of rapport and empathy, such as the severe constraints on the time that clinicians have face-to-face with patients and the lack of pre-established relationships between patients and clinicians, we argue that this dimension of communication is critical for safe and effective care.**
> **(Slade et al. 2015)**

The evidence they have of more than 80 patient recordings from triage to disposition is that positive interpersonal relationships between clinicians and patients result in a higher degree of patient involvement, which in turn produces better clinical outcomes, such as mutually agreed treatment plans and better patient adherence. One of the Aboriginal patients in the study confirmed the importance of overcoming miscommunication as a way to increase access:

> **You can overcome miscommunication by, you know, talking to them. Some people are illiterate, and they just have different barriers like that. People don't have trust in the health care system and that's a big barrier for our people to come here.**

Several experiences of miscommunication were relayed by respondents to the interviewers about their engagement with ED staff, including the very obvious issues of language use and diversity of dialects that make it difficult for staff to communicate with the patients. However, one Aboriginal staff member observed that some of the interpreters, when used, also had difficulty in effectively communicating complicated medical words and concepts:

> **Miscommunication is occurring when the staff use interpreters, but the interpreters do not repeat what is being communicated by the doctors and nursing staff to the patient, not because they don't want to, but because they don't understand complex medical language...**

Evidence shows that there are three communication problems that fit into three main groups in EDs: the experiential parameter (procedures and policies); the interpersonal parameter (clinicians' engagement with patients and other clinicians); and contextual factors (time pressures and patient expectations) (Pun et al. 2015). When communication is effective across these groups, respondents reported a good outcome:

> **Attended ED last year for heart problems, I feel that I was treated fairly and fully understood the doctors and what my treatment would be. I was told I was flying to Adelaide for further treatment and explained everything I needed to know.**

Additional considerations need to be given to the real and significant language barriers that exist across urban, rural and remote area services and a multiplicity of languages, and the lack of resourcing to support multiple language speakers have a good experience of care.

Shame proneness

An overlaying issue across all areas of communication is the issue of shame, shame proneness and sensitivity to being shamed:

Just being unwell, just don't want everyone lying there looking at you. First time I was like shame when I was lying there in the waiting room with everyone else.

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They don't speak to us with respect because we're Aboriginal people and I think they are racist.

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Waiting in ED for a doctor and I needed to use the toilet. I asked to be wheeled to the toilet and that was done by a female. I feel this needs to be looked at because she was trying to wipe my bottom and that is not right. It's not our culture for a woman to take a man to the toilet, we feel really shame and not happy.

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Harkins (1990) was able to distinguish shame from other related concepts such as 'shyness', 'being ashamed' or 'ashamed', and related shame to a situation in which a person has been singled out for any purpose, scolding or praise or simply attention, in which the person loses the security and anonymity provided by the group. Kwok (2012) describes shame as a way of being able to embody boundaries, particularly when Aboriginal people are engaging with the dominant culture. Shame is the debilitating feelings of unease, discomfort and anxiety which are the concomitants of everyday encounters and negotiations at the interface of mainstream engagement, something that is habitual, strategically deployed and '*brings an appreciation for the lived experience of the colonised minority throwing into relief complex struggles over meaning, manners, personal values, social allegiance and cultural survival*'. In culturally safe environments, the need to experience or express shame reduces and alleviates the internalisation of these experiences.

Aboriginal people may seek medical attention accompanied by a support group who will describe the health issue or symptoms on behalf of the patient in situations where the patient is 'shamed' (Morgan et al. 2008). Individualised consultations away from a support group of family members can cause shame to the patient, by being singled out or removed from peers (Morgan, Slade & Morgan 1997; Kruske, Kildea & Barclay 2006). Therefore, the involvement of and respect for a patient's support people/s during clinical experience is paramount to ensuring a positive experience for the presenting patient (Morgan, Slade & Morgan 1997).

In particular, men expressed a deep desire not to experience shame in an emergency setting. Canuto et al. (2018) explored perceived barriers to Aboriginal and Torres Strait Islander men accessing and utilising primary health care and found that a common barrier was Aboriginal men feeling 'shame' about talking about health issues in a culturally inappropriate way (Canuto et al. 2018). Shame can be experienced by or for an individual when they act or are forced to act in way that is not sanctioned by the group and at odds with cultural obligations or reflects 'a potential disruption to cultural identity' (Morgan, Slade & Morgan 1997; Kruske, Kildea & Barclay 2006; Treloar et al. 2016). Canuto et al. (2018) found that Aboriginal men sometimes decided to put their health at risk and discontinue with a treatment in order to comply with cultural protocol and avoid any shame associated with a culturally inappropriate interaction (Canuto et al. 2018).

> **While in as an inpatient in ED, I overheard an old man shouting at a nurse telling her not to touch him in his language (Pitjantjara), 'I'm a man (wati) and you a Women (kungka) and you can't touch me'. I called out to the nurse to explain this situation and advised [her] to get an AHLO (Aboriginal Hospital Liaison Officer) that can speak his language. I felt for both because there was an obvious clash of cultural knowledge that led to a breach in protocols. In my time there, I have never seen an AHLO attending to patients in ED...**

Canuto et al. (2018) reported similar situations where initiated men being treated by a female health practitioner would decide against treatment to avoid shame associated with the interaction. Feelings of shame are increased when discussing content of a sexual nature with a health professional of the opposite sex and can be considered the 'height of shame' given the cultural inappropriateness to Aboriginal and Torres Strait Islander people (Westerman 2010; Canuto et al. 2018). Although the impact shame can have on Aboriginal people's health and health outcomes is not fully understood, there is clear evidence that the fear of experiencing shame due to culturally inappropriate actions, can prevent Aboriginal people seeking health treatment (Morgan, Slade & Morgan 1997; Canuto et al. 2018).

The long-lasting impact of shame can also impact Aboriginal women and their enthusiasm to participate in health care or treatment. For instance, a significant concern and catalyst of shame for Aboriginal women continues to be male health practitioners being present for child birth, which is considered women's business. (Ireland et al. 2011; Kruske, Kildea & Barclay 2006). In these situations, Aboriginal and Torres Strait Islander culture is being breached and it can cause great shame and distress to new mothers (Kruske, Kildea & Barclay 2006). The study with Aboriginal men by Canuto et al. (2018) highlighted the need for culturally appropriate and gender-specific services, especially when discussing culturally taboo topics such as sexual health (Canuto et al. 2018). With the predominance of female health professionals, it could be argued that shame is experienced by Aboriginal men at a higher rate.

Cultural shame is often not well understood by health practitioners (Kruske, Kildea & Barclay 2006), and shame responses are often missed or misinterpreted as the patient being 'non-communicative' or 'difficult to engage' (Westerman 2010). In some cases, a misunderstanding can result in misdiagnosis, such as young women exhibiting shame response when questioned by male health practitioners about sexual concerns, being interpreted as depression or anxiety (Westerman 2010). Shame can also be brought about by an Aboriginal person feeling like they are being put 'under the spotlight' (Tamisari & Milmilany 2003; Westerman 2010). This feeling can be accelerated by direct style questioning, feeling stared at in a waiting room, being treated in an open area (with no partition separating other patients), or experiencing ward round visits (Tamisari & Milmilany 2003; Westerman 2010; Morgan, Slade & Morgan 1997). A lack of privacy limits can incite feelings of shame in Aboriginal patients and as a result can limit their willingness to communicate with medical practitioners which in turn can have an impact on the effectiveness of their health care treatment (Shahid, Finn & Thompson 2009). One respondent interviewed relayed not feeling comfortable relaying to triage what her presenting issue was due to other people in the waiting room being within earshot, so spoke about her headache which she was instead treated for. This resulted in the woman being rushed back to hospital in an Ambulance for the actual presenting health issue the next day.

Waiting, waiting, waiting

> **I'm a very patient person. But when you know that once you come in here, because you have to get seen [as there is] a lot to do with your diabetes, it's just waiting. The waiting period I think is probably the biggest factor for them leaving because they're waiting too long, that's what I'm thinking. Why not have a black face in here? A person that's just going to go around and see the Aboriginal patients or people that come in. Yeah, a friendly face just to keep them calm...**

Aboriginal people are consistently over-reported in the data looking at those who either waited or did not wait or discharged themselves from EDs, often against medical advice (Wright 2009). Katzenellenbogen et al. (2013) cite that Discharge Against Medical Advice (DAMA) from the hospital is associated with adverse outcomes and is considered an indicator of the responsiveness of hospitals to the needs of Aboriginal and Torres Strait Islander Australians. The need to understand the risks and reasons is important in emergency care policy, and proactive management for those at risk of DAMA is key. Katzenellenbogen et al. (2013) found that improving care to prevent DAMA should target unplanned admissions, rural hospitals and young men, Aboriginal people and those with alcohol and mental health co-morbidities.

Mental health presentations

> It was so horrible. I went in to get help and other people were arguing… I was there for my mental health, and they escorted me out by security and then had me taken off the premises by the police and told me I was banned for 24 hours… so I went back in by ambulance. They then made me wait until one o'clock in the morning to go out the back. Even to get a bed I had to literally say something because I was sitting in the recliners and some other person would come in and needed the recliner more than me so I gave it up. And then they gave them a bed and still expected me to sit in the corner for another hour and a half…

Then they told me I was getting 24- to 48-hour admission. I then went to the short stay in mental health, and I said to him, 'Can I please stay longer'. And then they asked the doctor, because I asked for reassessment, and the doctor pretty well said if I wasn't happy with that then I had to go. I've said, 'Can you get me a lift'. I looked, and there was security coming at me. I then got a bit angry at him and they then had me escorted out of the place… I told him how much I needed help. I've been here more than once. I've been here about five or six times. Every time I'm in here, they don't help me much. Like, I asked for a psychologist, psychiatrist sorry, and they always refer me and I always get declined. They don't know how to help people that have disabilities, or mental health issues or [who are] Aboriginal. They're pretty bad at it.

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Yeah, I do notice that they actually prefer to put people that are coming off their drugs and alcohol in first before they actually put someone that's mental health is playing up into ED and out the back first for help.

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[I was] having a bit of trouble breathing and they just didn't treat me like I thought they would, they left me in the room. They told me to just slow your breathing down… that didn't help me. So I decided to get up and off the bed, and there was still no one around. They told me to go back to the room, and then wait there for the doctor so I ended up walking out. I've done that a few times.

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… there wasn't even a bed in there, there's only a seat. And, yeah, my phobia anxiety went up when I was in there. I started singing out and then all the doctors and security guards came… it was just overwhelming you know and then they threatened to strap me to the bed and give me a shot to calm me down. I ended up getting, I lost it a bit, and they ended up locking me up there, keeping me against my will under the Mental Health Act, which was the last thing I wanted them to do. I had to wait for the next morning and the psychiatrist and get evaluated. But yeah, I hate going there but sometimes I have to because the pain is too much or I get blacked out, but I don't like it in there at all.

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… a friendly face, someone they can talk to, without being judged. You know everything would work out, or even be close to perfect.

Increasingly, EDs are playing a role in treating mental illness for all populations, often as an initial point of contact or for after-hours care (Morphet et al. 2012).

The mental health needs of First Nations' people are significantly higher than those of other Australians, with levels of psychological distress among Aboriginal and Torres Strait Islander adults (aged 18 years and older) at almost three times (2.7) the rate than for the non-Indigenous population (National Mental Health Commission 2014). There has also been an increase in ED presentations by Aboriginal adolescents and children for mental health-related issues, which Williamson et al. (2018) argue may be reflective of a lack of access to culturally appropriate primary mental health care. This highlights the vital role social determinants of health have in influencing the mental health and wellbeing of Aboriginal and Torres Strait Islander young people and their families (Williamson et al. 2018; National Mental Health Commission 2014).

Not surprisingly, the rate of mental health-related ED presentations among Aboriginal and Torres Strait Islander Australians is more than four times that of other Australians (AIHW 2020). Aboriginal and Torres Strait Islander people account for 10.9 per cent of mental health-related ED presentations, despite only representing about 3.3 per cent of the Australian population (ABS 2018). Despite the higher number of presentations, a 2017–18 ED patient survey found that Aboriginal and Torres Strait Islander people and those with mental health conditions were two of the key groups more likely to report a negative experience in ED (Bureau of Health Information 2019).

Mental health services in EDs should not represent, nor extend, aspects of colonial thinking and action to people whose cultural understandings of mental health are not well understood. In some instances, addressing the mental health of people presenting to EDs might need different approaches, ones that are localised, culturally mediated and socially negotiated with the individual and members of their family. The issues addressed in the next Section will be critical in addressing the health and wellbeing issues for Aboriginal and Torres Strait Islander people presenting to EDs.

Major theme 1: Comprehension issues

Western cultural narratives of illness, disability, medical and mental health disorders, chronic conditions, accidents, trauma, disease, intoxication and death permeate emergency departmental culture. These narratives are embedded in the Australian-based training and employment of professionals who refer, transport, admit or treat Aboriginal people in EDs. Emergency staff in this review include ambulance paramedics, emergency physicians and registrars, hospital medical officers, interns, nurse practitioners, allied health professionals (such as physiotherapists, occupational therapists and ED pharmacists), mental health emergency care teams, care coordinators and technicians (including radiographers, sonographers and radiologists), administrative staff, orderlies and environmental services staff, security staff, and hospital-based AHLOs and social workers (Victorian Government 2020).

Communication patterns and personality traits

Studies suggest those drawn to emergency medicine have significantly different personality traits than are the norm for physicians (Jordan et al. 2018). While not a homogeneous group, ED staff can be characterised as 'resilient and stable', and able to accelerate and multitask. However, these same personality traits can also produce anxiety and poor mental health outcomes for workers exposed to situations that lead to moral distress or burnout, which in turn can impact communication styles and techniques on and off the job (Hojat et al. 2015; Jordan et al. 2018; Pajonk 2011). The patterns of language used in this environment are highly instructional, site specific (where in your body do you feel…) and often time-sensitive, all of which can be perceived as abrupt by people with different patterns of communication that privilege relationships and connections over pointed questioning about a specific issue in the body.

First Nations' people are less likely to communicate so directly about affective, felt knowledge, which is deeply interconnected and important for kinship relationships, governance structures and linked so extensively to physical, emotional, spiritual health and wellbeing across multiple generations (King 2011). The language patterns of Aboriginal and Torres Strait Islander peoples also take time, and often starts with 'who is your mob?', so the initiating conversation is to 'place' people in a 'web of connection' (Butler 2017).

Narratives of trauma and worthiness

At the ED, Aboriginal people are expected to share a trauma narrative that depicts them and their communities as 'ever wounded and in desperate need of state assistance' (Meissner 2018). Million (2014) identified a paradox that impacts First Nations' people's access to culturally safe programs, and has direct bearing on this work. Those agencies seeking to implement programs to empower Indigenous communities actually undermine empowerment because of (1) commitments to trauma or illness narratives; and (2) that these trauma narratives are invoked where First Nations' peoples are expected to articulate their wounds to oppressors:

> **In the same arena Indigenous peoples seek to define terms of self-determination, outcomes of prior colonization are measured and diagnosed as trauma. This creates a site for our healing, our reconstruction and its management. This is actually a dangerous position...The space of our medicalised diagnosis as victims of trauma is not a site wherein self-determination is practiced or defined. (Million 2014:150)**

Trauma narratives 'undermine Indigenous attempts at truth-sharing' and have the potential to compromise Indigenous self-determination (Meissner 2018:270).

Literature also identified a belief system among ED staff in which patients were valued for their legitimacy to be treated within the ED. Ekebergh, Elmqvist & Fridlund (2012) identified that ED staff were always in readiness for life-saving work and described it as 'running a sprint race, performing quick measures for acutely ill patients'. Other international works found those patients presenting with minor or routine complaints that could have been treated elsewhere were a source of frustration to ED staff, and caused feelings of resentment that took their attention away from 'the job of saving lives' (Carlsson, Gunningberg & Muntlin 2010; Hart, Person & Spiva 2013; Sbaih 2002). Such groups of patients often earn the titles 'regulars', 'frequent flyers' or 'complainers' (Bergman 2012; Nyström 2002).

Ethnographic studies by Fry (2012) in Australia found that staff held collective beliefs about which patients were considered worthy of ED care. Patients attending who 'breached these beliefs' caused resentment which was stated as having negative consequences for the patients, such as increased waiting times. Aboriginal people are particularly sensitive to these beliefs, with respondents stating:

The doctor who saw me second time round – apologies, real apologetic for that. My pain tolerance is very high but being polite doesn't get me anywhere. Don't want to change my personality to get more attention. If I was swearing or carrying on, I would get more attention. Nurses aren't coming to me and asking what is happening.

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... I know people are allowed to have downtime but I was really sick in there and it doesn't make you feel any good when you're there waiting for a doctor and you see people laughing and joking around and laughing. And I am a patient woman but when I have been waiting for a long time...

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The belief system implicit within ED practice has been shown to conflict with public expectations. According to Fry (2012), as long as patients continue to be unfamiliar and uncertain of ED expectations, staff-patient negotiations could potentially fuel further tension and aggression. It is important for staff and patients to gain a better understanding of embedded beliefs and attitudes towards emergency care. In particular, clinicians should examine their own belief systems which will, in turn, result in the delivery of more thoughtful, equitable, culturally competent care (Fry 2012).

Body-parts approach versus person-centred care

Comments from Aboriginal people interviewed were able to demonstrate how personality traits and communication styles common to ED staff were perceived as transactional, pointed, direct and instructional, with one respondent commenting:

> **They listen to you when you are giving details about the reason why you are there, but they are not interested in who I am as an Aboriginal person...**

> **I got told to go here, go there, go for tests here, but I didn't know why. The more times I had to go somewhere, the more scared I was. I was getting very worried because no one told me why.**

The community-controlled primary health care service delivery system is premised on a holistic concept of health which, over two decades, has been shifting focus from a body-parts approach in service delivery to working with the whole person, their family and cultural connections, lived experiences and aspirations. The literature examining person-centred care in EDs shows that although whole-of-person approaches are advocated for in international policy and strategy, there are failings in health care systems that negatively impact on the care experience for patients and staff (McConnell, McCance & Melby 2017). Key findings from the literature and community voices suggest person-centred care is difficult to achieve in an emergency environment. The findings from the literature and feedback from the community interviews are included in the following five groups.

Group 1: Medical–technical interventions

Literature globally denotes the common theme that EDs value medical–technical tasks over caring tasks (McConnell, McCance & Melby 2017). This approach has become common practice, as ED staff employ strategies to bring order to the unpredictable, stressful ED environment. Emergency departments are characterised by a performance-focused culture, as life-saving is the highest priority and staff are always at the ready. The intensity of this focus is on maintaining patient flow and, in time-sensitive and under-resourced environments, it is difficult to provide individualised care to patients in lower triage categories when staff are performing other critical tasks. Respondents often spoke about the inability of staff to meet their basic patient needs, like providing a bedpan. In these situations, providing care and responding to patient requests becomes a task for unqualified staff:

I was in a bed out in the back of ED and we had been left there for a long time. I was sitting across from a little old lady and no one was coming to her. She was buzzing and I was buzzing because she needed a bedpan and she ended up wetting herself. She was so shame and I was shame for her... those sorts of things could be done by an Aboriginal worker... if they are doing some of the things that nurses can do and work all different hours then that can make it easy for some of the nursing staff. We don't need to feel shame because we wet the bed...

… Yep, there's just no empathy, or acknowledgment of history of culture. But the main thing is the communication between the patient and the doctor and the nursing staff. One of the nursing staff was pretty arrogant and there was no friendliness – just not a nice person, you know. I had a bladder infection and needed to go to the toilet regularly. The nurse said she was going to get me a bedpan and I waited and waited. I ended up ringing the hospital, to put me through to ED to ask that nurse to come back with a bedpan for me! If I didn't have access to a mobile phone and the bell system doesn't really work – not when you are left, there with that much fluid and wet the bed that is a shame job…

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Some of the nurses are caring and they try to make being there in ED easier, it's stressful sitting around most of the night being sick.

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This valuing of medical and technical interventions might provide good results for those who are in high triage categories, but those who presented and were deemed to be in the lower categories reported being scared and uncomfortable, and struggled with feelings of unworthiness because they were afraid to ask busy people to explain medical terms and their illness to them:

> **… The doctor really didn't give me the right answers, he was giving me my results in medical terms and numbers. He didn't explain any of that in plain English. I walked out of ED still not knowing what was wrong with me…**

> **… I rang a friend's mum and she told me to go up to maternity and they should be able to help me. Once I saw someone in maternity, they had explained everything. I didn't feel good about the results, but it really affected the way I feel about going to back to ED.…**

> **… The doctors don't explain things properly to patients, they scare us and we don't feel comfortable…**

> **… Some nurses are grumpy, making us feel uncomfortable. They give smart comments and treat us with disrespect…**

… It would be good if the nurses would do frequent check-ups instead of just putting me in the room and leaving me there just waiting. Because I am alone, I was worrying, and if someone had just checked on me I would have felt better. We know it is busy but just to even look at you, walk past and check in on you. It is good to know that people see you. I have had seizures in the past and you can't push a button when you are having one. And when you ring the bell no one comes anyway…

For others who presented with two or more conditions, the medical issues were given priority, often with negative consequences for the patient:

... Only a few times I had to come in for anxiety and not diabetes type 1. When I come in for diabetes you get seen and tested straight away. Because I came in with a mental health issue, I got pushed down the back because the mental health issue is not as important as a medical issue....

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I presented to the hospital with a headache and bad stomach pains. Because at triage there were people standing around, I didn't talk about my stomach pains, I talked about my headache so they were treating me for [that]. I had to wait so long that at about 4 a.m. I ended up leaving because my doctor would be open soon. So I went to my GP in the morning and I got sent back into hospital in an ambulance, my appendix had burst. I went straight through to out the back and got prepped and got fixed up.

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... I went to ED with very bad pains in all of my joints and also feeling weak. Once going through to see a doctor, my notes showed I have the condition Lupus, so the doctors put me on some IV pain relief for a few hours and then the medical team decided I can go home. I didn't feel well at all on leaving and got to the reception and fainted. They quickly came to me and took me back in and did other tests and observations, which they should have done in the first place. The results came back saying I had low iron and I was given medication for that...

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The respondents' views confirm the literature findings that the ED lacks a holistic perspective. Patients felt as though their mental health was not taken seriously and they were afraid of being forgotten. The valuing of medical and technical interventions in the ED is particularly troublesome for First Nations' peoples due to their holistic understanding of health and wellbeing.

Group 2: A culture of worthiness

International literature examining feedback from ED staff indicates an emerging pattern of classing patients as 'legitimate' or not, with non-urgent people seen as being too demanding during busy periods (McConnell, McCance & Melby 2017). In addition, doctors expressed irritation when nurses did not direct patients with minor conditions to other, more appropriate, forms of care. While staff valued 'worthy' patients, others caused them frustration and resentment leading to adverse consequences such as increased waiting times. Because of the layout of the EDs, these issues sometimes played out in front of patients. One respondent who had spent more than 20 hours in a overcrowded emergency waiting room, in pain, said:

> **... I don't want to say they didn't care, but I was just sort of left there [even though] they knew I wasn't well and in a lot of pain. I know doctors know what they are doing, but, because I have a chronic illness, I know myself very well. And the fact the two teams were arguing about whether I was going to be admitted or not made me feel very uncomfortable but I was too sick to leave...**

> **... Some nurses are grumpy, making us feel uncomfortable. They give smart comments and treat us with disrespect...**

Others presented due to their children being ill and were made to feel like their child's health was not as valued. In some cases, the parent and carer's attempt to escalate their child's being seen was not, in their view, handled appropriately:

> **... I took my baby in because she was sick and the waiting times in there were really bad. I kept on asking how much longer? We waited a long time until we were seen. The nurses were rude and talked to us like we was dogs... I haven't gone back there since...**

> **Presented to Alice Springs Hospital ED with a two-year-old toddler with a wheezy cough. My child was admitted in ED for over three hours under observation then we got sent home with Panadol. We were back the next day and was admitted into the paediatric ward by another doctor for a second opinion...**

Patients sensitive to the issues of ‘worthiness and legitimacy’ described ‘trying to be good’ and attempting to adapt their behaviours and requests to fit in with ED demands and the environment they were in:

> **You can feel it, you can just sense it in the waiting room… [that you are a blackfella]… from the front triage and then the experience of the waiting room it would be very good to have someone there to yarn and calm you down while we are coming to terms with the whole ED experience.**

As waiting times extended, patients felt uncertain, insecure and unsafe. Time spent waiting in ED exacerbated the feelings of fear and not being trusted, particularly for older single people. Elders have felt unsafe and afraid while younger people have been made to feel like they were ‘faking it’ to get access to medication.

> **I went to the ED because I was having bad stomach pain in my tummy. I had been there before with the same thing and the doctor looked at me a funny way. He said are you sure you got pain or are you lying and just wanting strong medicine? I was upset about that because I had pancreatitis and he shouldn’t talk to people like that…**

> **They are really rough; they leave us there for a long time in the bed. They just think we are faking…**

> **I had been in the waiting room for a while then finally got the chance to go to a recliner chair out the back. I was left there with two men who had extreme mental health issues, [and] they were getting worked up over something that could easily be fixed. It was a long time before I was checked up on and I was frightened. They were yelling and swearing and screaming and I was scared, and it was a long time before someone came to check on us…**

Patients do not want to bother staff unnecessarily and tried to develop a better relationship with them by joking and trying to ‘demonstrate their worth’ so as to reduce the waiting times in the hospital. Some respondents indicated that it would be better to put on a show in order to get seen earlier:

Patients are categorised based on medical criteria and perceived moral worth, which provides staff with control over what they perceive to be ‘inappropriate demands for the service’. This is experienced by staff attitudes and is a major reason for people leaving EDs.

My missus had to ring up for me. Lucky the ambulance came. I was confronted with the fact of the seriousness of the issue and so when the ambulance mob came round home, I was trying to joke it off. Then they saw how much blood I had lost and I was up in the back of that ambulance [pronto and] I felt much better. Then I heard them on the radio pre-warning the hospital of my arrival. I was happy that I went straight to the resus room. That was good that time. Other times I have come in the ambulance then I have been parked in the hallway for a long while and left there…

Brought in by an ambulance – taken straight through. Last time I was there I was in the emergency area for 10 hours. I was out the front for six hours and then we went out the back and we were out the back for another three hours. No one came to see me. I was there trying to manage pain and you can see nurses all standing around laughing. Because it was the early hours of the morning and I know my doctor would be open in another few hours, so I left to go home and wait to see my GP.

Communicating – yeah, and especially when you're talking about elderly Aboriginal people coming into this sort of environment. How they speak to you. I actually take notice and am very particular in taking notice of how people speak to you. Like it's not in a caring sensitive way. Yeah. You're just a person here. Yeah, how do you take your blood pressure, blah blah blah and it's just the way of communicating.

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You've got the nurses or the admin people or whoever are behind that, I mean they're talking and yarning about other different things, rather than tending to us. I am actually quite outspoken so I said, 'Excuse me, can you come here rather than talking about what happened on your weekend?'.

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I need to come up to ED every so often. I watch them sitting in their office bit and they will be sitting there for a good half an hour doing nothing. No, no, they got a lot of people to look out for and look after but you know they're just, it's just unbelievable and you can sit there and watch them. You have to call out at least three or four times to get a drink of water or something, it's just not right.

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Patients, therefore, make a moral call based on cultural respect and personal perceptions of deservedness in ED waiting rooms.

While in as an inpatient in ED, I overheard an old man shouting at a nurse telling her not to touch him in his language (Pitjantjara): 'I'm a man (wati) and you a woman (kungka) and you can't touch me'. I called out to the nurse to explain this situation and advised to get an AHLO [Aboriginal Hospital Liaison Officer] that can speak his language. I felt for both because there was an obvious clash of cultural knowledge that led to a breach in protocols. In my time there, I have never seen an AHLO attending to patients in ED…

* * *

I came from community health and was in the waiting room in a lot of pain. I saw one old man there and I could tell he was really sick. His face and body was all swollen and he had been sitting there longer than me. I said, 'You better take him first, he is really sick'…

* * *

… Yeah, that was the front emergency area and if I didn't ask for a bed I probably wouldn't have, you know, been offered a bed. But there was an older lady, an elderly lady that was there, she was there for like seven hours just laying on the bed. And the emergency room was packed. No one saw her and I felt sorry.

* * *

… I think a lot of the doctors or the nurses… I get annoyed with them and I say what I have to say. I watched a nurse speak to an elderly gentleman [and] I was thinking well that's just not on. I said to the nurses, 'Why do you talk that old fella like that?' You know, it's that respect for older people, our Elders. Our Elders, yes, they're the ones that will sit there quietly alongside all this while they are waiting…

* * *

Cultural awareness programs for ED staff might need to consider not only how to be culturally aware, but also how to recognise when cultural protocols are being carried out in EDs by Aboriginal people and not 'punish' people for practising culture in institutionalised settings.

… I seen one man in ED give up his bed for an Elder in the ED waiting room, I could see he was being respectful to Elders, the nurse came back round to him and said 'Well, you are ok now. If you can stand up then you can't be that sick and you need to leave'…

Group 3: Managing the patient journey through ED

The literature indicates that staff are often overwhelmed due to patient volume. As EDs are frequently short staffed, they struggle to control patient flow and are continuously boarding and prioritising patients. EDs have inflexible work capacity and space, leading to overcrowding. Staff manage their time across several patients to minimise the impact of waiting periods, leading to fragmented care. Further, staff are often 'at the mercy' of other departments to allow patient transfers, which limits their capacity to process patients quickly (McConnell, McCance & Melby 2017). How patients experience triage indicates how they will be treated over the rest of their patient journey. While experiences are often negative, Aboriginal people described the positive experiences they had of this transition in the interviews:

After leaving ED to be admitted in paediatrics, the staff looked after me during the evening and I really appreciated not having to go home in order to be admitted.

* * *

Yeah, they treated us like an individual they, I don't know, I felt respected. I felt heard as well. How would I write it? I just feel very supported. I was actually saying to the Health Worker that the nurses are lovely and the doctors that we've come across. So that's how I'd rate my experience, they rushed us in. I knew I was a pretty messed up and worried when I first came in here; I felt it.

* * *

They always treat me ok, firstly I couldn't understand but asked more questions and got the answers I needed.

I feel that due to me deciding to go to the hospital ED for a check-up because I didn't feel well, after tests the doctors found that I was having a heart attack. The positive was the doctors were quick and acted to my needs.

Other Aboriginal patients' experiences of their patient journey are documented below. In the first instance, people felt they had better outcomes if they were able to advocate for themselves and/or their loved ones:

> **Being heard early in consultation is so important. They don't listen, and I got quite upset and angry and spoke up. That's when they started to listen. They shouldn't assume I am here for the same thing all the time. They got it all wrong.**

> **... medical professionals here, and the clinicians or whoever's talking with that patient like giving feedback. And when they leave here as well, it would be good to have like knowledge of services out there and a clear referral pathway where that treatment is still going to continue. When they're treating people equal, not judging automatically, and they're getting my story from me, but I need a story to tell them too...**

Nurses have described their EDs as 'constipated', 'gridlocked' and 'bottlenecked' (Braithwaite et al. 2014). It appears that patients often do not receive the care and attention they expect and deserve, largely due to staff needing to manage their time across multiple patients and responsibilities in a highly stressful environment.

Group 4: A stressful environment

The ED environment is fast-paced and chaotic and a source of stress for staff and patients alike, which can exacerbate symptoms (Healy & Tyrrell 2011). Busyness and long waiting times are important contributory factors to patients' experiences of services. Staff see themselves in a caring capacity and cannot understand why they are the target of verbal outbursts and physical abuse. Further, some ED terminology has 'aggressive connotations' and are often misinterpreted by patients (McConnell, McCance & Melby 2017:4). The main causes of aggression and violence include lengthy waiting times, overcrowding, poor layout, lack of communication and staff attitudes toward patients.

Further contributing factors include poor behaviour due to alcohol and drugs, or associated with mental illness and not understanding the system. EDs have been constructed to facilitate transiting patients and are not suitable for those having to wait lengthy periods of time in that environment, all of which negatively impacts on the quality of care delivered.

It's not divided up properly. [If you have] mental health issues, you are put in with violent swearing people. That's not what we are used to.

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Patients need to be informed and [there should be] many more changes – doctors give an answer that might need to be interpreted.

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They take their time in the emergency department. I am now getting everything checked at the local doctors instead of coming to the hospital.

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The effects of stressful incidents on ED patients can be profound. Witnessing aggression, violence or the death of patients and loved ones can be emotionally and physically demanding. Comprehension issues impact patients' experiences of these stressors, with many explaining they feel ill-prepared and under-supported to cope with them.

> **... I was in the front of the emergency department and there were already a lot of people intoxicated or under the influence there. Then this one woman came in swearing up and screaming and making a big noise... The ED staff tried to calm her down; that didn't work so then the security guards had to come and restrain her on the floor. They finally took her away. It was terrifying. She was setting off everyone else and I hadn't heard people talk that way before. It was shocking...**

Organisational-level interventions that improve the work conditions of ED staff, provide wellbeing and quality of care are needed, as are Aboriginal and Torres Strait Islander staff in the ED to support people through their patient journey. Many people reported experiencing racism in the ED waiting room, from other patients as well as staff.

Although some respondents saw security guards as important for ensuring safety of people in the ED waiting room, others reported that they made them nervous, expecting surveillance and control rather than help and support. Lack of privacy was stated as a major concern in the patient's ED experience, with people preferring to wait outdoors or other areas of the hospital grounds rather than in the ED room. This impacted their ability to be seen by a practitioner, with some stating that they had been 'passed over' in terms of accessing care.

> **I had an Aboriginal lady call me a white person. I said we're all here to get help, we are all human beings. I do have Aboriginal in me too; I walked outside...**

> **I'm constantly sitting in the waiting room, and my depression is building up because people are arguing to me, and I'm asking to get put through and it's... constantly pushed further down the list until you are fed up and go...**

The patient experience in emergency care is emerging as a key factor in overall patient satisfaction and outcomes, with 'wayfinding strategies' implemented to support patients access different services in complex physical environments through consistent signage, enhanced communication strategies and improved facilities in waiting rooms. Additional strategies have been identified as enhanced guidelines for volunteers in ED settings and emergency maternal care information. Also considered are the policies and guidelines used to strengthen the delivery of culturally sensitive triage for Aboriginal people, such as making AHLOs available at reception and triage (Victorian Government 2009).

Group 5: Patients and relatives experience of care

I don’t want to be pushy when I go in. A family member will come in with me but they don’t listen to a family member. They will listen for details, but if you are doing advocacy while people are there then they leave.

> **What made me feel comfortable is I actually had my family with me in the ED. And my cousin, he sat there with me the whole night, and they still disrespected him and made him going in the back of a police car to go home. I thought it was a bit disrespectful.**

The involvement of, and respect for, a patient’s support people/s during clinical experience is paramount to ensuring a positive experience for the presenting patient (Morgan, Slade & Morgan 1997). Carers in EDs have different roles and responsibilities including cultural mediation, interpreting – not only the provision of linguistic services but also in mediating conflicting cultural and ethical values – and promoting the maintenance of patient autonomy (Kaufert 1999). Although carers, family members and others who attend ED with the patient can mitigate against causes of leave events on one hand, those who did not attend ED with the patient can also be the reason why people leave. A systematic literature review conducted by the George Institute on behalf of the Australian Commission on Safety and Quality in Health Care (June 2020) found that family accompanying the patient was a protective factor against personal factors that contribute to a leave event. These can include past negative experiences, a distrust of health services, the impact of intergenerational trauma, an association of hospitals with death, feelings of isolation and loneliness, feeling unwelcome or misunderstood, a limited understanding of illness, not being able to smoke on the grounds and a longer than expected length of stay (ACSQHC 2020).

> **… Yeah, they do, they treat you like criminals. And although, like I said, I’ve been in on my own accord to get help, because I feel like self-harming myself sometimes. I told him I wanted to talk someone to get help. And then they know how much I smoke, and they wouldn’t even come out with me, the security guy wouldn’t even come out and I didn’t go in and got locked up. I went there on my own accord and I said to them, ‘I’ll leave my phone and everything in my wallet and everything here, if I can just fire up a smoke. I’m not gonna go anywhere.’ And they still wouldn’t even let me do that, [and was treated] pretty much like you’re a criminal.**

When the patient advocate (family, relative, partner) determines that the patient is experiencing harm, they will often be the ones to catalyse leaving:

> **I have walked out because of how ignorant they were to me and my wife. Not very good communication when they do that with you. We need to have more explanation and we need to have more communication, [then] I would have been happy. I have lost my patience and walked out.**

Family often attend with the patient, and have pooled resources to get to the ED as they have family, cultural and social obligations to care for the person presenting. They are there to protect patients from workforce factors, for example, workers speaking roughly and mistreating patients, inappropriate and insensitive behaviour by staff and negative stereotyping. Patient advocates in ED settings also provide important support for people through complicated admission and discharge procedures, personal and institutional racism, and miscommunication and misunderstandings. They can also support people staying in the ED when the waits have been long and they want to leave.

> **I was in the ED waiting for a long time with haemorrhoids and I was waiting there a long time. I was getting worried because I had my dog in the car. My wife had to come in her car to get my dog so I could stay at ED. If she hadn't have been able to come, I would have left...**

Patient advocates are also carers of children who are the responsibility of the patient.

> **I had line of sight of my three-year-old grandson in the car, I had it parked in the emergency driveway while I helped my wife get inside. While I was taking her in, I could see him ok, he was sleeping. The nurse talked to the security guard and it was ok, but I was nervous he was going to tell me to move it but I couldn't get my wife in and look after the baby at the same time...**

In work completed by Strobel et al. (2020b), four key themes were identified from interviews which sought to understand the Aboriginal and Torres Strait Islander child's journey through paediatric care in Western Australia. Using an Indigenist method that privileges Aboriginal people's voices and situates them as central to the research process, the team identified four key themes that showed the patient experience of the barriers and enablers in their children's journeys related to inpatient and outpatient care: hospital admissions, discharge and follow up outpatient appointments; communication; financial burdens; and cultural issues. Other common threads that impacted their experience included how doctors and nurses communicated information about their child's condition and subsequent discharge. This was again explained by one of the respondents who said:

> **I took my son [to the] ED because he was having some pain in the lower belly area. Once the doctor had seen him and done all the obs, she decided that he had a fungal infection and gave me cream for my son to use for a few days until better. I was so upset about this and asked if I can see another doctor because a fungal infection won't be causing my son to be feeling sick and in this much pain. Once the other doctor came and saw my son, he did other tests and even an ultrasound, [and] the results were frightening as the other doctor was sending us home with fungal cream. My son was admitted and put on the surgery list for the next morning for removal of his appendix. The surgeon visited after surgery and advised us that he was very lucky as it was ready to burst and there would have been some disaster.**

Other elements that Strobel et al. (2020b) identified as causing concern among parents and carers of children presenting to emergency included:

- transportation for patients to and from hospital;
- extra costs while in hospital;
- concern about other family members; and
- staff responses to Aboriginal cultural issues.

Their findings indicate that health care delivered to Aboriginal children in mainstream health services can be improved when culturally appropriate care can be provided, however there is a lot of work remaining in the wider hospital system for Aboriginal families to feel culturally safe accessing standard services:

> **What is needed is a strong commitment at the organisational policy and practice to embed culturally safe and appropriate care in their service. This requires relationships between mainstream services and Aboriginal families to be established and maintained so trust can develop, and improvements can be sustained. This also includes engagement and building strong relationships with Aboriginal Community Controlled Organisations who are the frontline service for many Aboriginal families and work in the community for their community. (Strobel et al. 2020b:101)**

Lastly, a dedicated commitment is needed by policy makers, mainstream services and Aboriginal stakeholders to work together to ensure such programs are ongoing, well-resourced and remain effective.

Conclusion

In emergency situations, if communication breaks down between potential victims and first responders/medical personnel, it can have dire consequences including unnecessary pain, misdiagnosis, drug treatment errors, unnecessarily long hospital stays and even death. Communication breakdowns occur for multiple reasons, and may be related to previous medical conditions, language barriers and the fact that communication can be difficult under intense stress. The communication gap between health professionals and Aboriginal and Torres Strait Islander Australians has a significant health impact on outcomes (Lowell et al. 2012; Cass et al. 2002; Mitchell, Lowell & Ralph 2016; Amery 1999). Most Aboriginal people in the study can have a conversation in English on everyday matters, yet they described their difficulty in understanding English to convey health meaning and health promotion messages:

> **Communication with the staff; you just don't know what to say and how to speak. How to talk to doctors to get what you need. When you are in pain, you are getting frustrated and angry.**

Language boards are described as being some of the most helpful tools for communicating in the field. If a person does not have a clear command of English, is too ill or traumatised to speak clearly, or has a chronic speech problem, language boards enable patients and first responders to communicate through words and pictures (Austin et al. 1995; Delp & Jones 1996). Trudgen (2000) was able to use a diagram of a kidney to show 2 per cent of kidney function, as Yolgnu do not 'understand the concept of percentages', going on to estimate that 75–95 per cent of the communication with Yolngu fails, even with Aboriginal health staff involved.

> **Aboriginal health workers are not necessarily trained interpreters, nor is interpreting their primary role, although they are often expected to interpret. (Amery 2017)**

Many instances of costly repeat visits come from patients' misunderstanding of, or failure to, follow physicians' instructions correctly (Scheeres et al. 2008). The addition of illustrations or communication boards can significantly improve patient comprehension, thereby supporting pre-ED care, assisting patients to communicate effectively during their stay and enabling discharge instructions. Adding illustrations to discharge instructions has been found to cut down on health institution costs because patients are less likely to return for retreatment (Austin et al. 1995).

Patient compliance with home care instructions is crucial to cutting costs of repeat visits to health care institutions. Using cartoon illustrations can provide an effective strategy for conveying information and improving patient compliance with ED release instructions – including reading, remembering and carrying out the instructions – and has proven to be effective the world over. Products such as the Kwik Point Medical Translator have boards aimed specifically at emergency situations. These boards include pain scales as well as picture sets to express nausea, dizziness and other common symptoms. Although language boards are simple devices, they quickly provide paramedics and emergency medical technicians with the communication skills necessary to assess a patient's condition. In addition, materials originally developed for health care settings (such as Vidatak boards) can also prove useful in emergency settings.[3]

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[3] For more information, see: https://www.patientprovidercommunication.org/about-ppc/.

Major theme 2: Pain management

> **I was getting tired... and the pain is so bad and it is dangerous for me. The pain is so bad and I stay home and I try to keep things to myself, but my mother and brother know things are the matter with me so they make me stay at the ED.**

> **I was in pain and going through pain and I was getting impatient because it was taking too long....**

Even though pain management or pain relief was nominated as a major reason for presentations to the after-hours ED, there appears to be limited literature focusing specifically on pain management for First Nations' peoples in emergency settings. Therefore, we examined papers that discussed their experiences of care in emergency settings, as well as best practice in safe pain management and providing care in EDs, both in Australia and internationally.

There have been 'limited studies informing the concepts of pain, pain assessment and pain relief among Indigenous people', with most of the current literature focusing on Caucasian populations (Jamieson, McNeil & Mittinty 2018:53). The literature illustrates a stark difference in the way pain management and care in emergency settings is administered to First Nations' (and those from culturally and linguistically diverse backgrounds) compared to non-Indigenous patients. For instance, various reports from Canada and the US outline the challenges faced by patients belonging to a non-dominant culture, or who speak a language that is different from their health care provider (Dell et al. 2016; Meghani, Byun & Gallagher 2012; Narayan 2010). These challenges often result in poor pain management and health outcomes.

A review in the US found that a 'systematic bias operates in the treatment of pain that is qualitatively different for certain groups and outcomes' (Meghani, Byun & Gallagher 2012:158). It noted a pronounced risk of undertreatment for minorities, with a large difference in analgesic treatment between Caucasians and some racial and ethnic groups. Further, studies in Canada have shown that Aboriginal patients frequently feel judged for being Aboriginal or presumed to be expressing illegitimate pain, with almost half of those who participated in one survey rating their care in the ED as fair or poor (Dell et al. 2016).

Wylie and McConkey (2019) found three key sub-themes of discrimination towards First Nations' peoples and other minority groups within the health care system – an unwelcoming environment, stereotyping and stigma, and practice informed by racism – all of which can affect the quality of care in emergency settings. Negative experiences associated with discrimination – such as the stereotyping of First Nations' peoples as being more vulnerable to substance abuse (Dell et al. 2016; Narayan 2010; Jamieson, McNeil & Mittinty 2018), long wait times and a lack of cultural respect – too often causes them to delay seeking further treatment or repeat trips for care due to feeling they had not been heard or were unable to convey their pain. This can result in 'overwhelming feelings of frustration and even anger' (Finley et al. 2014:135).

Pain management in Australia

The Australian literature shows similar findings to those in North America. When pain is being assessed in a bi-cultural environment, there is potential for ineffective pain management and unnecessary suffering for First Nations' peoples (Fenwick 2006).

> **... taking too long to do simple things and feeling unsupported in the hospital setting – too long in between being seen – not communicating and what the plan was. They could tell me a bit more about what is going on, sometimes they just leave you there waiting...**

A 2019 systematic review noted the 'paucity of literature regarding pain and its management' for Aboriginal and Torres Strait Islander Australians (Arthur & Rolan 2019:1). The review found that issues can arise when health providers and patients hold conflicting views and beliefs in relation to causes of pain, with Aboriginal and Torres Strait Islander patients attributing pain to causes outside of a biomedical model. Different cultures hold adverse health beliefs, which is 'central to negative experiences with health care', therefore it is 'imperative to understand the cultural epidemiology of pain' and how it influences pain experiences for Aboriginal and Torres Strait Islander Australians (Jamieson, McNeil & Mittinty 2018:53).

Arthur & Rolan (2019) found that several studies identified a theme of reluctance to or not reporting pain. Some health professionals have indicated that First Nations' peoples do not seem concerned about receiving pain relief and label this behaviour as stoicism (Fenwick 2006). A study in Canada similarly found that First Nations' children's pain expression included stoicism and hiding behaviour. Native Americans were also found to report pain only when it is severe and to use vague descriptors for it (Finley et al. 2014). However, Arthur and Rolan (2019) found there is a risk of harm due to cultural misunderstandings, and the misconception that First Nations' peoples have a high pain threshold, requiring less pain relief, is outdated and erroneous.

[I was at the ED] mainly for pain relief associated with chronic illness. I was in agony and still had to wait to get in. My bladder had retained over a litre of fluid and a catheter went in and the relief was good.

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We are only getting pain relief and the pain is not being managed well in the ED.

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In one study, underreporting of pain by Aboriginal and Torres Strait Islander Australians was identified as being due to the burden of emotional pain from historical factors, the reluctance to report physical pain, the perceived negative attitudes of health professionals and communication issues (Huggins et al. 2015). Explanations for not expressing pain included a cultural preference for bravery, not trusting medical staff, and feeling there was no point as they were not listened to. When people perceived a lack of interest from health professionals, they did not seek further help unless they were desperate. Further, participants reported difficulties describing their pain issues, in making themselves understood and in understanding what they were being told. The use of pain scales, which are commonly used when assessing pain, has been found to be unsafe and counterproductive as a numerical scale has no significant meaning for some First Nations' peoples (Arthur & Rolan 2019; Fenwick 2006; Finley et al. 2014).

> **They discharged me straight away because they needed beds. The specialist wrote me a letter to come back in and it went on for three weeks, in and out of emergency, and I was in a really bad way. Finally got a different doctor, we scanned my abdomen for infection and I had a massive infection. I wasn't going back there for the fun of it, I could hardly walk. I couldn't walk out when they discharged me.**

Cultural and social environment – including beliefs, customs, languages, and relationships with self and society – significantly influence the way in which individuals experience and express pain, and varies considerably in people (Jamieson, McNeil & Mittinty 2018; Fenwick 2006). If pain assessment fails to recognise and address these unique differences, there is a 'significant risk of ineffective treatment, dissatisfied clients, and sub-optimal care' (Fenwick 2006:219). The literature reveals a lack of knowledge and understanding by health providers of the importance of the holistic framework when considering overall health and social and emotional wellbeing (Jamieson, McNeil & Mittinty 2018; Huggins et al. 2015).

Recommendations to improve pain management

To improve pain management for Aboriginal and Torres Strait Islander Australians, emergency settings must ensure that they are culturally safe. Cultural safety is only acquired when the patient determines that they have been provided with culturally safe care. When a health provider conducts culturally safe pain assessment practices, it will improve the overall pain management provided to patients (Fenwick 2006). Thus, health providers must be trained in cultural awareness to ensure that they acknowledge and understand the Indigenous holistic view of health. It is well recognised in Australia that hospitals are places to fear for many Aboriginal and Torres Strait Islander Australians, due to experiences of racism, cultural insensitivity and lack of knowledge and confidence about the quality of health care they will receive (Victorian Government 2010). A Victorian Government report (2010) outlines the following recommendations for improving experiences for Aboriginal and Torres Strait Islander people in the ED:

- Build positive relationships with the local Aboriginal community, working with them to identify and implement projects to improve patient experiences in the ED.
- Undertake environmental improvements to enhance cultural safety in the ED, such as displaying local artwork and artefacts, and provide culturally appropriate, Indigenous-specific health brochures.
- Provide cultural awareness training for staff, including guidance on effective communication with Aboriginal and Torres Strait Islander patients.
- Develop and implement an Indigenous employment strategy.

Fenwick (2006) found that communication and dialogue could be improved between hospitals and the First Nations' community through formal engagement with Elders. Investing in time with community groups assists in building relationships, promoting trust and familiarity. Further, First Nations' peoples have expressed that identifiable cultural features, such as the display of Indigenous artwork or the Aboriginal flag, assists them in feeling comfortable and also signifies to other cultures that they are welcome (Fenwick 2006).

The availability of an AHLO has also proven to be effective in enabling quality health care. Studies have shown that an AHLO was 'perceived as shifting the power paradigm back in the direction of the patient and re-established their identity and place as clients within the system' (Fenwick 2006:52). A case study from St Vincent's Hospital in Melbourne discusses the hospital's strategies to address access barriers, such as a mistrust of hospitals due to health authorities' complicity in the forcible removal of the Stolen Generations. Other access barriers include distance, language and cultural barriers.

The study found that AHLOs provide a 'culturally sensitive link' between health providers and patients, working with and educating other staff in being culturally sensitive to Aboriginal patient needs (RACP [n.d.]:3). As a result, St Vincent's established an Aboriginal and Torres Strait Islander staffed Aboriginal Health Unit in 2015, which incorporates the existing AHLO Program. The hospital also has an Aboriginal Health Care Coordinator in the Assessment Liaison & Early Referral Team, who works with complex needs patients to provide advocacy, connect them to other services and support their attendance at outpatient appointments. Further, an Aboriginal Employment Officer is responsible for the recruitment and support of Aboriginal staff (RACP [n.d.]). The underlying principles that make the Aboriginal Health Unit successful are:

- Indigenous leadership;
- culturally safe and equitable services;
- person-centred and family-oriented;
- sustainable and feasible;
- integrated continuity of care; and
- quality and accountability.

Good pain management requires appreciation and respect of varying cultural perspectives regarding pain. A lack of request for pain relief from Aboriginal and Torres Strait Islander people should not be interpreted as a lack of need. When experiencing pain, they may be reserved and practise centring, which involves being still and 'entering a deep spiritual and psychological focus to shut the pain out' (Australian Government 2018:65). As Aboriginal and Torres Strait Islander people may not actively report pain, even when specifically asked, health providers should consider:

- giving patients the option to discuss safe pain management with a health professional of the same gender;
- offering oral pain relief, considering that some patients may not be comfortable with pain relief administered via injection or an intravenous drip;
- using a pain tool that is culturally appropriate for the local community;
- explaining fully all the options, usage and side effects of pain relief; and
- providing information about services that can assist with pain management.

Finally, it is crucial that widely used pain assessment scales are studied, with approaches adapted to capture Indigenous cultural values more accurately and understand how they frame the experience of pain (Jamieson, McNeil & Mittinty 2018). This will mean that health providers will be able to conceptualise pain and its associated co-morbidities, thereby increasing awareness and providing much-needed information about potentially important health conditions (Jamieson, McNeil & Mittinty 2018). The development of pain assessment instruments that are reliable in the Indigenous health context may pave the way for tailored pain measurement that can be applied broadly in the health care of both Australian and international First Nations' populations.

Major theme 3: Recognition of lived experiences

> **I had a really bad experience in ED [after] I was assaulted by my boyfriend and my granddad took me to the hospital. I was seen by a doctor and, due to my injuries, I had to be admitted to the paediatric ward. I wanted my granddad to stay with me as I was afraid and wasn't sure if my boyfriend would turn up. The staff in the ward did not allow my granddad to stay and that made me really upset as he was my carer along with my nanna. Later the nurses comforted me and told me that I would be ok.**

This Section refers to a major theme identified in this study, that of creating culturally safe and appropriate solutions for Aboriginal people that take into account their lived experiences. One such solution is the Black Dog Institute Aboriginal and Torres Strait Islander Lived Experience Network, which has been built to inform, enable and deliver better services, care and programs to improve health outcomes and save lives (Black Dog Institute 2020). Despite many families maintaining strong family practices, others experience poor maternal and family mental health, homelessness, violence and alcohol or other drug issues (Lima et al. 2019; AHMAC 2017). Strobel et al. (2020a) state that presentations to EDs can also trigger a family's exposure to child protection, maternal mental health and other service responses targeting low socio-economic and vulnerable families.

Thus, a new approach is needed, one with affirmative policies, improved access to services, a reduction in social inequalities and empowering families to support themselves and their children. While there are different categories of high-needs patients upon being triaged in the ED, particularly the clinical Categories of 1–2, these new interventions need to recognise that social, cultural and environmental determinants of health are contributing to presentations in the ED.

Social Emergency Care is a form of practice that may be more appropriate for Aboriginal and Torres Strait Islander care. The fact that ED staff are working with patients who have social, cultural and physical manifestations speaks to a field of practice that provides care to a large volume of vulnerable patients who seek refuge in EDs (Anderson, Lippert et al. 2016). To improve the health and wellbeing of Aboriginal patients, ED practitioners will need to expand their role to ascertain when a patient's illness has been caused by the social determinants of health, and respond appropriately. Anderson, Lippert et al. (2016) state that EDs will need to 'develop systematic interventions, measure their effects, collaborate with others and advocate for policies that improve the health of patients'.

Taking on this additional burden will interfere with the primary mission of caring for the acute and emergent medical problems of patients, but the results could impact longer term health costs as inadequately treated patients return to the ED. Among Aboriginal health organisations, there is a stronger focus on social and cultural determinants of health and wellbeing requiring a greater emphasis on partnerships, collaboration, preventative practice and the development of communities of practice. Similarly, there will be an expectation on Social Emergency Care practitioners to network, and to establish and foster collaborations, the combined efforts of which could culminate in the advocacy of policies to combat the adverse health impacts that 'stem from the vastly disparate conditions in which people are born, grow, live, work and age'.

People presenting to ED have stated that there are significant monetary issues that impact their ability to attend, and to stay, in ED.

> **One Aunty had a double mastectomy and was unwell so we took her to ED where she had to wait nine hours before being seen. The nursing staff thought Aunty was her namesake – her niece who is 30 years younger – the staff didn't realise it was the older Aunt. We only had money to get there and back, not enough to go home and come back again. I tried to get her seen sooner, but they must have thought I was a humbug more than anything.**

For others who had minimal funds to last them through to payday, the financial pressure of attending hospital was a common theme for participants in a Perth-based study. Lack of money, costs associated with public transport, petrol, parking fees, food and drinks for themselves and family led to more stress and frustration and was a significant factor in non-attendance at planned appointments (Strobel et al. 2020b).

> **I've only got $60 left and I have spent so much money – I have brought food and paid for parking and it really goes down quicker.**

Respondents said they were nervous to stay a long time as they were concerned about parking fines:

> **Car parking is hard for people. People always worry about that. People come in and got stuck and been admitted and then the car is stuck there. Worry about accruing a bill that you don't have the money for.**

Other participants advocated for stronger emphasis on cultural determinants of health, advocating for cultural staff and supports inside the ED.

> **I think [where] we probably need support for cultural safety is on the floor. Workers know the actual things that are getting changed and… cultural [awareness] training is, it's all done from people above, the big bosses and executives. So we don't get a lot of say in that training, and that's maybe something that should change. It's us on the ground workers, the AHLOs and allied health staff, who need more say in the development of the cultural safety programs. That's because they know what's going on in the ED and the big bosses don't.**

Some advocated that cultural safety should be compulsory for all ED staff so as to stop them being 'racially profiled'. While this is not possible, there needs to be stronger relationships between practitioners and Aboriginal families, and services need to be developed and sustained so there is greater knowledge about, and empathy for, the lived experiences of Aboriginal people and a focus on addressing the underlying issues for presentations to EDs.

This would support calls from participants in the study to 'have someone there who can make a connection to community', nominating that perhaps part of the training program could take a 'cultural look inside the ED – so there is a shared experience of how it would be for an Indigenous person to go through the ED department'.

Given other Australian-based studies that identified homelessness, social supports and economics as influential on biologic disease, along with calls from the community-controlled sector for greater attention on the social and cultural determinants of health and wellbeing, there is a need to intervene on social determinants of health in daily patient care (Neel 2015). Axelson, Stull & Coates (2018) note that the ED is a place where race, sex, identity, illness and policy converge. The social determinants of health contribute to recidivism, including economic disadvantage, low health literacy and much else. Acknowledging that while emergency physicians may not be trained to identify and intervene on the social or cultural determinants of health, they may experience a sense of futility in their daily practice that can impact on their sense of job satisfaction or hasten their burnout (Alexson 2018).

There are calls from the community to invest in the development of social medicine curriculum to support practitioners to differentiate between patient disease and their experience of poor social determinants of health and wellbeing.

> **That cultural awareness training… that's the issue in my eyes. And we see things all the time. Other barriers I suppose would be getting more Aboriginal staff in the ED, having interpreters maybe even in the ED… I don't know how that would work but we've always got issues with interpreters and people don't even bother to get them. And then the patient obviously doesn't feel culturally safe because no one can understand what they're saying and they don't understand what the doctors are saying. So yeah, more Aboriginal staff and those jobs to be respected as they should be. I also think that people working in ED need to go out to see where people live and how they live, so they lose their judgments of us and understand where we are coming from.**

Several strategies that could be used to achieve this outcome could be:

- Introduce social determinants of health to emergency medicine residents during their initial orientation period – for example, a simulated poverty immersion experience showing the challenges of daily life for their clients (e.g. https://www.povertysimulation.net/).
- Organise visits to community organisations and homeless and other shelters, addiction services and outpatient clinics (e.g. https://www.pcori.org/).
- Engage with pre-ED specialists, community social workers, outreach workers and others who will form part of the referral pathways across a region (develop a place-based response to Social Emergency Care).

Conclusion

Developing community partnerships with organisations and agencies, and familiarising emergency physicians, ED social workers and allied health professionals with them, is critical. Important partnerships might include community food banks, homeless shelters, domestic violence resource centres, substance abuse and rehabilitation programs, and routine-free or low-cost health care clinics. Patient-centred programs that involve input from the community can lead to improved health outcomes, particularly if co-designed together. Some suggestions for approaching the needs of people with lived experience include:

- Establishing partnerships with the Aboriginal Lived Experience group in the Black Dog Institute and with the First Peoples Disability Network to discuss the impacts of emergency care on people with lived experience, and to co-design strategic initiatives to support and design effective spaces for them.
- That ACEM implement a sub-category of emergency medicine focusing on Social Emergency Care, and advocate for this approach in areas where the majority of presentations are by Aboriginal people.
- Work with a network of Indigenous businesses to develop and support a peer researcher and peer support workforce, and ensure that agency procurement targets are met.
- Work with Indigenous businesses to develop a transportation service that can be contracted to deliver patients home as part of a door-to-door service experience.
- Provide staff with effective orientation experience that is inclusive of extreme poverty and disaster modelling scenarios.
- Create regional responses to the effective implementation of Social Emergency Care from all key players in the region.
- Facilitate through the waiting room area greeters and a small funding pool to assist people with parking fees and the like.
- Create different spaces for people with lived experience to wait for their appointments in ways that are responsive to trauma-informed approaches to care.

Major theme 4: Addressing needs of people presenting for Categories 3–5 issues

Many ED staff believe that current services are not designed to address cultural needs and Aboriginality. Particularly for patients with chronic diseases, there is recognition that care arrangements should be family focused and culturally safer. Shortfalls in cultural safety and a lack of trust and rapport between practitioners and patients can result in patient disempowerment and suspicion toward health care services (Burnette & Kickett 2009a). Much of the inability and frustration from staff to improve Aboriginal patients' experience of ED can be due to the constraints of the current service design and delivery, with some believing it to be very rigid and largely inappropriate for people who are triaged into Categories 3–5 (Rix et al. 2013). Aboriginal people's experience of ED waiting times was seen to contribute to feelings of disempowerment, anxiety, and suspicion. Respondents in the study advocated for the following solutions to this experience:

Aboriginality should establish a priority flagged for early being seen. If our health is so poor, we should be seen straight away.

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Need to have an Aboriginal person there at every visit, not once you are admitted but when you are actually in the ED. That would make me feel heaps more comfortable.

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There are not many Aboriginal workers – don't always get to EDs.

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They have got mental health response teams, cardiac arrest response teams, what about Aboriginal response teams?

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EDs are not the most appropriate environment for those patients who have been triaged into lower categories. Respondents have described the various ways they navigate trips to the ED to try to maximise their experience.

Different referral pathways into ED

Many respondents in this study noted that services were increasingly over stretched, under pressure and with no visible staff resources available to them on entry:

> **That's what I can say, we wouldn't, not as Aboriginal people, some people wouldn't even know there was an AHLO here, we didn't know that. So there was no referral pathway and I think the lack of education showed. I don't know that they've been educated in that stuff they talked about; you need support from the AHLO.**

And that having Aboriginal people enhancing the patient experience could be very helpful:

> **I just said I think it's so important and it's got to start up the top and come down and people have got to actually see it as an issue. Like I don't know if all staff are like that, not all staff down in the ED [are] like some of them are really good, but it's just about education, lack of education and those system.**

> **That just don't fit for Aboriginal people. I think it needs to change from the top.**

Some said they knew the wait time would be long and difficult, so had worked up different solutions to gain access to a practitioner in the shortest amount of time:

> **I go and get referrals from my GP and I get straight into ED, where I will be waiting for a ward bed for a couple of days to manage my chronic illness.**

> **Yep, the GP referrals get you in quicker but it does depend on the clinic you use or your own GP being accessible on the weekends.**

Others have had incredible anxiety about the wait in the waiting area and have called the ambulance – not to necessarily get in earlier, but knowing they would be in a different part of Emergency so as to avoid the long wait times in the waiting room:

> **It took a toll... my daughter and relatives have rung an ambulance which they think will get them in hospital. Maybe not be quicker but at least you are in the area where you will get checked out and not in the big waiting room area.**

People have asked for different spaces and resources to manage the Categories 3–5 client groups.

We need more rights-based information in the ED – our right to an interpreter, basic stuff. We should have access to an interpreter all the time.

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More allied health services available to people. There's nothing in there, no brochures on Aboriginal health or programs or anything. It would be good to have someone come and say okay, 'Why are you here?', that sort of thing. And that person could come in if they're on call and help us.

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The Aboriginal Liaison Unit is good, they help us liaise with community health, give us good information, support us with discharge planning. This is a good support for us.

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Need two Aboriginal people in there who are fairly well trained and lucky enough to get an ED person, Liaison Officer's hours need to be extended to the weekend.

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More Aboriginal workers in the emergency area – they can guide the team – helping patients and walking out the front see who is in emergency and make them feel at ease. And helping people with information about where they are in the list and if there have been any accidents which have pushed us further back...

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People have also asked to access Aboriginal staff on a 24/7 basis, particularly for interpreter support at night:

> **Aboriginal staff on call during the night shifts, more Aboriginal staff working in ED.**

> **Better case management, our people are dying of conditions that could have been prevented.**

> **Aboriginal health staff, can help us understand what the doctors and nurses are saying, especially in the night.**

> **Ensure interpreters are available for people who need them.**

Transportation support is another key factor in waiting times – often at times Aboriginal people cannot get a lift home from the hospital.

More Aboriginal staff/interpreters and liaison officers at night. Assistant for people to get home after sitting in ED all night and being discharged in the early hours.

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More Indigenous nurses and interpreters, maybe a service to take patients home. We sit in ED for hours and don't have transport most times.

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More Aboriginal people working in ED, also transport.

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Resources can also be helpful for people who are waiting:

> **Need to see some of the brochures in the hospitals with Indigenous themes.**

> **Resources Aboriginal friendly – people who can go out the front to yarn to people to calm them down for mental health.**

Gendered approaches to supporting men and women wait will be key:

Gender balance for traditional men and women. Interpreters/Aboriginal Liaison and/or Health Workers. Waiting times can be improved.

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Staff should assume that Aboriginal men have been through lore from the age of 12-year-old, to be more culturally aware and give privacy.

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Pain management during waiting times needs to be attended to:

> **I had to wait five hours for two Panadol. It was ridiculous, I was so angry! We need other access points… maybe an AHW in pharmacies to do distribution of medication would take pressure off hospital ED waiting room…**

> **Pain relief will really help people in pain.**

These respondents have varied experiences and preferences when it comes to navigating referral pathways into the ED. However, a common theme is the lack of efficient, consistent pathways to enable patients to receive the care they need in a timely, culturally safe way. Once patients have arrived in the ED, there needs to be clear referral pathways for them to be visited by AHLOs and have access to interpreters.

Conclusion

First responders encounter traumatised families on a daily basis, with a high prevalence of exposure to traumatic events among many Aboriginal people. Presentation to the ED can be challenging for patients because the environment and their experience of care can trigger traumatic memories. Trauma-informed care is an approach to practice that is guided by knowledge of how trauma affects people's lives and their health care needs. Despite the increasing prevalence of health care delivery in EDs, the translation of trauma-informed care into emergency practice in this setting is largely unknown. Molloy et al. (2020) undertook a narrative literature review, the aim of which was to gather evidence relevant to trauma-informed care in the ED and provide guidance on this practice for emergency nurses. Three emergent themes were identified from the literature: an access point for quality health care; staff attitudes; and the ED experience.

In an ED context, and for trauma-informed ED practice to be efficient and effective, the following solutions have been offered:

- provide culturally safe pain management;
- have a clearer understanding and acknowledgment of the family members who attend with the patient and show them appreciation for their advocacy on behalf of the patient;
- employ Aboriginal staff in ED waiting rooms and triages and also provide pain medication or other ambulatory services on site or in the community;
- locate ED staff in other locations frequented by Aboriginal people – e.g. emergency nursing staff based at intoxication or detoxification units, and ED staff at women's shelters and in drug and alcohol recovery centres;
- offer different access points for Aboriginal clients to appropriate care – Team Triage arrangements, waiting room greeters, healers – to help them become calm or self-soothe;
- extend trauma-informed practice to pre-ED admissions and in-community triage systems;
- ensure staff are oriented to the region, not the service;
- offer traditional rubs, cleansing practices and ceremonies;
- identify and pilot different models to supporting patients in Categories 3–5, including the Safe Haven model and Aboriginal response teams; and
- consider changes to the physical layout of the ED so that people are not triggered into trauma.

Major theme 5: Spaces and places in EDs

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ACEM's *Emergency Department Design Guidelines* (ACEM 2014a) are intended to support clinicians involved in the design process to inform government, health planners, architects and designers about what constitutes a contemporary ED in Australasia. Designed with the clinical requirements, functional needs and practical requirements of the ED in mind, the Guidelines also recommend the provision of other spaces for distressed family rooms and contain some comments under the patient experience section. However, they are silent on the cross-cultural considerations that enhance the patient experience of Aboriginal, Torres Strait Islander and other First Nations' peoples accessing EDs in Australasia. Although the Guidelines acknowledge they are not an exhaustive guide to models of care and patient pathways, the co-design practices they promote are strongly clinically focused. According to the Guidelines, the purpose of the ED is to receive, triage, stabilise and provide acute health care to patients, including those requiring resuscitation and those with emergent, urgent, semi-urgent and less urgent conditions based on the Australasian triage scale (ACEM 2014a).

The Guidelines do have some design strategies to enhance the functional relationships with external agencies, including road transportation to attend hospital for diagnostic tests, but the emerging methods for planning ED size and inclusions are scant on how to initiate co-design with service users. Obviously, the availability of art on the wall will make people feel more welcome, but if the design elements of the EDs are not conducive to all patients, then the current issues of space and place will continue to overwhelm clients who need the services the most.

The literature reinforces what respondents said in this study: that an unwelcoming environment and unfamiliar routines can lead to Aboriginal patients feeling fear, anxiety and social isolation. Further, sterile environments and lack of outdoors space (including waiting areas) and larger meeting areas for family to gather, along with the belief that the hospital is associated with death, are all likely to see a person leave before treatment (Shaw 2016; ACSQHC 2017).

> **This place has got a children's section for babies and kids. Other people need separate spaces... we need different places to sit. It's not good to mix older people with people who have mental health issues, with people who are grieving, or who are getting frustrated.**

Despite the Guidelines stating the need for comfortable seating arrangements and for people to be afforded privacy, this was rarely the experience of Aboriginal people in EDs, particularly those experiencing pain and who may be unable to soothe themselves.

The waiting area is never comfortable, the seats are awful. If you come in by ambulance [at least] you are on a bed. If you are seated it is uncomfortable, and if you are in pain it is so much more difficult to sit, especially for long hours.

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Bad experience last time in ED. Went in with severe back pain and they wheeled me in and put me on a bed that was so small I could not turn or I would fall. They should and can see that I was a big person and put me on the right size bed. I was only given a bigger bed because I asked and eventually was moved.

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Others recognised the necessity for access to equipment that was not readily available:

> **Hospital needs an MRI/CCT machine – too much pressure to get transported to another facility to get into the public system.**

However, much of this was able to be addressed by the presence of local Aboriginal people in EDs:

> **When I see who it is and know that they're local mob from around here... I guess that empowers the person doing it as well. I'm in this hospital and I don't think it's tokenistic because we've come from such a small town and community and they've employed us and I guess that's a good thing. So, yeah, it's good that they're doing it now. I don't know the reasons behind it but it is good to see them there. It makes me feel good as an Aboriginal person. Thank you.**

Consideration in new builds should be given to other design criteria that will facilitate culturally safe care to people in need, and alternatives to the ED waiting room as an experience for people who are often subject to racism, pain, disease and poor mental health.

Conclusion

In May 2019, ACEM and Royal Australian and New Zealand College of Psychiatrists (RANZCP) released a consensus statement that included a recommendation for engagement of people with lived experience as part of a process of reforming EDs (ACEM & RANZCP 2019). By working with people experiencing mental health issues, there are a growing number of specialised treatment areas for people experiencing mental health issues who are presenting to EDs and require close observation and intervention in a more clinically capable and appropriate environment (Government of Western Australia 2018). By engaging with those agencies who represent the interests of people with lived experience, new service models may be developed to create enhanced areas of engagement in the emergency department servicescape. Alternatives to EDs may require consideration of the following:

- in-hospital or on-campus access points, so that café-like waiting areas can then be in an outside secure setting with engaged peer workers;
- alternative waiting rooms with one-to-one peer support;
- peer-supported transition programs – ED to home;
- crisis houses offering peer support and access to clinical assessments;
- in-home options and mobile services such as those developed by the RPH Homelessness Street Health services; and
- the delivery of more telehealth, online and text chat services.

Some key considerations for further development of specialised spaces or alternatives to ED have become apparent from the interviews and identified in the literature. These include that the service:

- is available 24/7, staffed by peer workers, and in a location that is safe at night;
- provides for privacy in conversations and promotes dignity; and
- is both a sanctuary and an active source of support with links to other services (Consumers of Mental Health WA 2019).

Robust models of care will need to be more closely aligned with the holistic concepts of health and wellbeing, which is the cultural basis of life and living. A stronger focus on the social and cultural determinants of health will be required, rather than a specific focus on clinical interventions alone. The development of alternative places and spaces for Aboriginal people to access emergency services, particularly those in Categories 3–5, will require a regional approach to developing effective relationship building with existing crisis services, emergency response services, ACCHSs and other community-controlled organisations. While appreciating that regional politics exists between service-delivery types, a ‘cut-through’ strategy could be deploying Indigenous businesses to provide or cater to some of these services in the region.

Each government contract has within it a requirement to spend 1–3 per cent of the entire contract on Indigenous businesses through the Indigenous Procurement Policy or IPP (Australian Government 2020b). Business interests are different to the community-controlled sector and are essential for promoting family emancipation and economic empowerment. Businesses are not seen to be ‘competing’ with services for service delivery and thus can generate good outcomes for people who would normally be ‘locked out’ of employment because they do not meet contractual or literacy requirements, yet have great skills – e.g. in safely transporting people to and from ED, providing welcome and translational services – that will enable them to facilitate regional outcomes and promote innovation and strategy.

Section 3 / Reflections from the Emergency Department

In Section 3 we capture the data derived from the interviews with emergency staff, paramedics and Aboriginal Hospital Liaison Officers associated with the project.

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Emergency department staff were interviewed from three hospital sites in Alice Springs, Shoalhaven and Adelaide. Those interviewed were employed to work in EDs (or in pre-hospital care) as ambulance paramedics, ward clerks, registered nurses, nurse practitioners, ED support officers, occupational therapists, aged care services emergency team, hospital medical officers, medical directors, emergency physicians and registrars, interns, administrative staff and AHLOs.

Interviewees were identified by each site's investigator/director of ED, and all participants volunteered their time to provide their views as to the challenges they experience in the implementation of culturally safe emergency services, and their recommendations for improvement. In total, 35 ED staff participated in semi-structured interviews, with participants representing 20 women and 15 men.

Emergency staff interviewed in this study understood that Aboriginal people experience poorer health and lower life expectancy than the general community. They readily identified the enablers and barriers to Aboriginal people accessing health services generally, and how issues such as remoteness, poverty, homelessness and previous negative experiences of hospital services impact people's presentations and treatment in emergency care settings. Many of the practitioners interviewed understood that hospitals can be fearful places and that Aboriginal people are subject to experiences of racism in health care, and expressed a genuine desire to improve their practice. However, they also noted several systemic, policy and programming, organisational and regional barriers to this occurring.

Becoming culturally competent

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Emergency staff have generally stated that the only time they have access to formal Cultural Safety Training is at the commencement of their employment, often during their orientation to the service. In Australia, the aim of Cultural Safety Training is to:

- extend practitioner knowledge of Aboriginal and Torres Strait Islander history and culture;
- explore how attitudes, values and perceptions can influence people's assumptions and behaviours in a clinical setting; and
- co-designing interventions with Aboriginal people to be more culturally aware.

ACEM's Indigenous Health and Cultural Competency program develops tools and resources for Emergency Medicine physicians designed to enhance culturally competent communication and overall care for Aboriginal and Torres Strait Islander peoples, Māori and other linguistically diverse patients (ACEM [n.d.b]). Most of this program is delivered on-line with modules aiming to enhance the provision of culturally competent, patient centred approaches to emergency care. The three overarching learning objectives underpinning all modules include increasing awareness and knowledge of culture and health; improving skills in culturally competent care and prompting self-reflection (ACEM 2014b). There are several examples of case studies showcasing patient centred decision making in complex retrieval cases; health and cultural beliefs in the Torres Strait and various cultural safety initiatives in Cairns, Joondalup, Townsville and Alice Springs which highlight the importance of accessing interpreters, the importance of Aboriginal staff, spaces to accommodate family members, culturally competent triage and the need for effective communication. These strategies actively reinforce the principles that (Dell et al. 2016) have identified:

- the patient's way of knowing and being is valid;
- the patient is a partner in the health care decision making process;
- recognising the impact of complex intergenerational traumas on health and access to health services; and
- the patient determines whether the care they have received is culturally safe.

The level of cultural safety in health care for Aboriginal and Torres Strait Islander Australians is monitored by AIHW through a framework that uses an evidence-informed approach to assess progress towards achieving cultural safety. This national framework references the experience of Aboriginal and Torres Strait Islander health consumers, the care they are given, and their ability to access services and raise concerns (AIHW 2019b). Some of the essential features of cultural safety include an understanding of one's culture, an acknowledgment of difference and a requirement that caregivers are actively mindful and respectful of this difference (AIHW 2019b).

The importance of cultural respect and cultural safety is outlined in the following documents:

- *Cultural Respect Framework 2016–26 for Aboriginal and Torres Strait Islander Health* (NATSIHSC 2016)
- The *National Aboriginal and Torres Strait Islander Health Plan 2013–23* (Australian Government 2013).
- The *National Safety and Quality Health Service Standards*, which includes six specific actions to improve care for Aboriginal and Torres Strait Islander people in mainstream health services (ACSQHC 2017).

The emphasis in these reports is on how culturally safe health care is provided and how it is experienced (see NATSIHSC 2016; CATSINaM 2014; AIDA 2018; Victorian Government 2016; NACCHO 2011; Australian Government 2015). Certainly, staff interviewed in this study were able to identify the core activities needed to change the experience of Aboriginal people coming to ED, as well as their own practice, both of which form the basis of recommendations.

In this Section, we detail how staff provide culturally safe care that focuses on the behaviour, attitude and culture of providers, and respects and understands First Nations' culture and people. We also detail the governance structures, policies and practices that catalyse or inhibit the provision of care. Staff perceptions inform how the delivery of emergency care is perceived to be experienced by Aboriginal people. Again, we detail this using the literature and statements from those interviewed to reflect whether they perceive that Aboriginal patients feel safe, connected to their culture and cultural identity, and that EDs are responding to their experience of care.

Encouragingly, some staff recognised that as soon as Aboriginal patients are removed from their communities, particularly those from remote area locations with English as a second language, that the act of coming to town for treatment exposes them to significant risks with regard to their cultural safety, both within the patient journey and the obligations they may experience in town camps.

> **... Oh, just about the unknown, it is a bad thing to be disconnected from the family for too long, you know. This is only my perception but being amongst a whole lot of white people where they feel like they're not going to be understood, or like for them not understanding what the doctors or nurses are telling them, particularly the oldies. The old darlings they're just beautiful, but you can tell that they frightened...**

Staff noted that in the circumstances where patients are not supported to attend EDs, they are being called on to provide or support others through kinship obligations or are exposed to hardship through poverty, lack of transport, violence and unsafe accommodation. For example, a staff member at Alice Springs Hospital reflected on the difference in experience for patients of remote area ACCHSs, whose door-to-door model of care provides a great deal more cultural safety than government department-funded patient travel assistance schemes (Conway et al. 2018).

> **... sometimes cultural safety doesn't need to be bound up in the institution as much as a person's experience of being in Alice Springs.**

Dislocation from Country and family significantly contributes to a sense of loss and disempowerment (Burnette & Kickett 2009b), often to the detriment of social and emotional wellbeing (Preston-Thomas, Cass & O'Rourke 2007). While there was a recognition of the importance of Country to Aboriginal people's identity, and its relevance as foundational in the promotion of holistic health and wellbeing concepts, a large proportion of ED staff are unable to pay appropriate levels of attention to the uniqueness of that connection in their current work environments due to time pressure, a focus on chain of command medical practice, traumatology and acuity medical practice.

The emergency care culture is strong and sometimes difficult for one or two people to ‘cut through’ to make the necessary changes in their current practice from pre-ED to discharge:

I think just ongoing preconceived attitudes need to be addressed... We have a bit of a hierarchy and we also have some strong personalities, with strong opinions... We have like a bit of a power divide as well... although you’re still like responsible for the care of the patient, one person is in charge. So that power divide, if you’re working with someone that’s strong and opinionated, it can be really hard to broach subjects...

* * *

... I am acutely aware of some of the issues. I’ve spent some time working for the retrieval service in Alice Springs, and also visited the APY lands and other Indigenous communities, so I have also added a kind of on-the-ground perspective of where our patients are coming from. I work in a very busy emergency department. We have a high volume of patients with high acuity multiple and complex comorbidities and different needs, including social needs. It’s quite overwhelming at times. We don’t have enough space, we don’t have enough cubicles, don’t usually have enough staff, doctors say we don’t have enough nursing staff. I don’t mean to sound like this is a whinging platform but unfortunately when you work in that sort of environment, no matter which culture the person comes from, it is sometimes not important at all because of all the other things that are trumping being culturally sensitive.

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No offence to them, but I think the doctors are oblivious to cultural safety. Doctors are very task orientated so they do the assessment, and then they find what’s wrong and then they fix it. That’s it...

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Staff recognised that welcoming environments also impact patients’ perceptions about their ability to access services from EDs. Staff stated that, for many, the experience of walking into an ED was one that not only invoked fear but exposed them to unfair racism. Attempts to make EDs more culturally safe and welcoming by including artwork, for example, was undermined by insensitive decision making.

> **Just an aside, we’ve got some Aboriginal art in our waiting room, which is nice, but they put a phone charger in the middle of it, showing complete disrespect to the artist and the artwork.**

Additionally, staff attitudes toward the provision of cultural safety for one racialised group as opposed to all racial groups was questioned, because of a strong focus on equality not equity. Some reported how the experience of bad behaviour by Aboriginal people presenting at the ED tended to influence staff working with Aboriginal people in general:

We need to know and work on the biases we ‘project’ at the front of house. If we’re projecting a vibe which tells Aboriginal people that makes them feel that they’re not welcome, then they may feel like they should just leave; but I don’t think that’s unique to Aboriginal people...

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... There may be some things that that we just need to actively try and fight. Because we see the section of Indigenous communities that will trigger us as clinicians and health care staff to having a negative feeling towards a particular social demographic. I think we’ve just got to very consciously fight that on an ongoing basis because it is undoubtedly a challenge. if you do get verbally and physically abused when you come into work by someone that you can readily identify as coming from a particular social demographic, as a human being you will be more likely to carry a degree of judgment towards them. Even addressing ways to break that down in terms of education would be good. Understanding why those biases are there and getting training in deescalating these behaviours so that they are less common...

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There was also a desire to coordinate services between different agencies more effectively but, reportedly, local-level politics between services was divisive and, as emergency medicine is precise and chain of command driven, many of the staff traditionally work in silos. Additionally, some staff were dismayed by the perceived ‘treatment’ some Aboriginal patients received from other colleagues, especially those who leave before being seen or whose behaviours are misunderstood. Some staff identified that Aboriginal patients appear to be ‘punished’ because they could not integrate well with the workplace culture and processes integral to the delivery of emergency care.

> **... behaviours that are acceptable and not acceptable are opinions formed around how the hospital likes to run... making things difficult for the people who need treatment but don’t wait for it and come back. I think there are policy changes [responding to people who leave] that could make a difference there...**

> **They may find it a hostile and uncomfortable place and we are trying to be kind and patient and accepting...**

> **I know in some places, Darwin and Alice Springs, they have Indigenous art on the walls and that sort of thing and actually I think they do at the Lyell McEwin too. But still, it’s just a piece of art, it’s not really going to make a difference to people’s care...**

Culturally safe practices must enhance the experience of cultural congruence for staff and for patients attending. Workplace health and safety studies for front-line and first responders have highlighted that the culture of an organisation is bound by shift work, unpredictability and variability in routine and shifts. We need to understand the relationships between the culture of the workplace in EDs and pre-ED services, and appreciate that while Aboriginal people have a specific cultural context, so too do emergency staff. Culture provides the context for all health care and social service throughout the human lifespan. Enhancing patient and family outcomes requires nuanced understanding of cultural contexts for those who provide care and those who receive it (Schim & Doorenbos 2010). To understand the cultural drivers in an ED context, we asked practitioners why they were drawn to do emergency work and for their reflections on cultural safety.

Emergency medicine practitioners

Overwhelmingly, saving lives was nominated as the major reason for being drawn to emergency medicine, as well as an acknowledgment of liking the pace, the ‘adrenaline rush’ and the variability of presentations:

... I just love the fast pace and the blood and guts and the excitement... I love having to think on my feet. I think sometimes in emergency medicine you probably get used to more complexity, you like the challenge of a complex case with multiple things going on at once...

… I started when I was a student, and I just had placements in emergency. And then just got the taste for it I think and then from there when I finished my graduate career, I just extended my time and just sort of loved it and I love that changes all the time and I'm always learning something new. I've had friends that worked in Alice and said it's a great experience. It's something completely different to what I'm used to and then I came to McEwin and love it…

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… I don't know, particularly. It was my favourite placement in my grad year, and I was a lifeguard prior to starting nursing. And I did lifeguard all the way through my training, so I guess I was probably predisposed to be in emergency. I just loved it and I thrive on the adrenaline and I'm good at taking charge and being able to plan out processes of intervention when everything else is going to chaos. I really enjoy the challenge, I like it…

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… I like dealing with crises and sometimes that can be quite draining, but I guess the bottom line is, I feel very motivated to help fellow humans. It sounds really twee and a little bit crass, but I actually just want to help, and I want to do something meaningful, really… There's massive reward in that feeling that you've made a difference for somebody, and it's harmless, obviously, but like it's a privilege too. And so, I'm grateful for the opportunities I've had, really grateful. I was born into a family who encouraged me to achieve my aspirations, and I'm privileged. And if I can share and use that for the greater good, then I feel like that's what I should be doing…

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Overseas trained doctors coming to work in Australia were surprised when a single population group were 'singled out' and the basis of cultural awareness and cultural sensitivity toward one racial group and asked for more context with some admitting that the lifestyle and circumstance of some Aboriginal patients was difficult to comprehend:

… But you know, I maybe had an expectation of what an Aboriginal or Torres Strait Islander [person] would look like, you know, I thought I'd be able to actually pick them out, which is a horrible way to put it but I'd be able to pick them out in a line-up… But then I started realising people who identify as Aboriginal or Torres Strait… it's not just that straightforward…

… So that was quite interesting and an eye opener. I guess when they first opened the module and I saw 274 slides, I just started reading up more and more about it. I did some couple of extra modules just to kind of bring myself up to date. I find it interesting, because I was surprised by how I wasn't more aware of all the history.

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… So within the reading there were a few links to various things that I should have followed and looked up. You know how it is when you get on the Internet you click on one thing and that [leads] onto another and that onto another. I mean the whole thing about the stolen generations, I was just like, 'Oh my goodness that's really a horrible background'…

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…It's like, I can remember speaking to the AHLO about it and saying this is not ancient history. This is quite fresh and I guess I was really shocked to read all the things that I was reading. Needless to say, I was quite embarrassed that I didn't know more about them…

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… I mean I know I speak the same language, but I also am quite closeted. It's difficult isn't it because I closeted myself with educated people from similar backgrounds and probably similar political viewpoint. So it's very easy to think that you are very aware of stuff and sometimes it's just not the case. I remember coming out to Australia as a junior doctor and being quite shocked at the racism that I encountered in the emergency department. I'm not saying it doesn't exist in the UK, I'm sure it does. But it hadn't been something that I had [been] confronted with or seen as much, like the way people speak to Aboriginal people [here] really shocked me…

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There is an emerging evidence base in Australian Cultural Safety Training that shows the need for a paradigm shift (Kerrigan et al. 2020; Brascoupe & Waters 2009; Johnstone & Kanitsaki 2007) and an analysis of cross-cultural training for all medical and nursing staff, particularly those from overseas. Evidence suggests there is a need for further cultural training in intercultural communication including communicative norms, and some key phrases and dialects that are relevant to the places where people will be practising. The power of local stories was also described, as was having Elders and others from the region come in to share stories:

> **But it was that whole people telling their story… that was like the most powerful thing. Because I think that is what, when you can, or when you listen to some of the trauma, some of the vicarious trauma [that] people experience, and how they've come to be in that role and their background. I remember one of the AHLOs, she couldn't say the name of the place that she'd been born. I was like, 'Wow, look I hadn't even thought about like being a thing', but it was really powerful and I really appreciate that whole human connection. I think it's listening to people's stories and seeing and building relationships with people; it's that sort of response we kind of want to make, we want people to work alongside us. Here we all are trying to make the best of this situation for everybody.**

Additional information on kinship systems and multigenerational, dynamic expressions of family were needed, as was the history of colonised Australia. Teaching on history was considered vital by those recently arrived in Australia. What was highlighted in the work of Kerrigan et al. (2020) and Brascoupe & Waters (2009), is that cultural training needs to stimulate further enquiry, to be contextualised in local and regional experiences, and to be applied to the clinical environment. Participants in our study highlighted the importance of using local and regional content to address unconscious bias and institutional racism and advocated for critical self-reflection and cultural supervision. These statements have been used to benchmark the cultural safety comments made in this study, which are reflected on the following pages.

Reflections on cultural safety

Respondents in the study were able to identify that cultural safety means that patients coming into the ED have the right to feel safe:

> **… knowing that it's a safe place that they can come here and not be not be judged about who they are or what they believe in, or what their priorities are and how much they do know or don't know about their own health situation…**

They were also able to describe that if cultural safety was not provided, then it would be difficult to build rapport with the patients.

In currently structured EDs, cultural safety is enhanced by the health literacy of the patient. Some respondents noted that they had better communicative experiences with those Aboriginal people who were professional, had a sound comprehension of English and could follow instructions, could find their way around the hospital campus and who could understand discharge summaries and other notes. Comprehension and communication issues were at the forefront of people's working experience in EDs.

> **Just in terms of communication and making sure that patients understand what we're explaining to them and why we feel like they need to, for example, stay in hospital or have these medications and things like that.**

> **He kind of bridges two communities: white ancestry and Indigenous ancestry. So he is a really good person to speak to people. A lot of it is the language that is awkward. You don't want to sound offensive or racist… when you talk about Aboriginal patient. [It] is difficult for people that don't come from Australia, don't understand all the complexities and the sensitivities around words. So, some language education would be good.**

Awareness of the impact of the workplace culture on cultural safety was also paramount, with staff readily acknowledging that the ED environment is stark, chaotic and stressful for everyone. There was also an indication that the nature of the work itself impacts on the ability to care for patients:

> **I think it's just a lot of awareness [that] it has to do with. And, you know, making sure that everyone in our department especially is aware of the culture that's around us and how it impacts their health and wellbeing very, very good at having things in place, and provide that to our patients…**

… We're working in a pandemic situation, [and] there is a lot of stuff we need to know [about] from our own safety perspective and from clinical medicine. So I can't allocate as much time to that sort of thing [cultural safety] as perhaps they'd like. I'm mindful that there are hundreds of things that we want to know about, a whole range of different things, and the time must be allocated to balance. But critical remains critical…

Interviewees were able to identify the multiplicity of cultures at work in the ED and their impacts. Firstly, the hierarchical, fast-paced nature of work was seen to impact the working relationships between doctors and nursing staff, which had a flow-on effect to the types of engagement they had with patients including Aboriginal patients. Secondly, a recognition that burnout and fatigue is impacting the communication styles and strategies with patients. And, thirdly, a recognition as to the amount of support that staff received from colleagues and managers to do their work effectively:

... I probably wouldn't pursue a career in emergency medicine. I enjoy it and I've done a lot of it in my short career but, in the long run, I think full-time emergency medicine is really exhausting, particularly for me now. It's largely just shift work and I guess I work in a busy hospital in an area that's in a low socio-economic region so you see a lot of people in crisis. It's quite exhausting and mentally taxing. And I see that in my colleagues as well. I think emergency medicine as a career is very tiring as a concept. I think a lot of us could probably do it for a few years and enjoy it. And some people go on and so spend their careers in it, but you see a lot of a lot of burn out....

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... To be honest, no I don't feel supported. Generally, it's completely overwhelming. When I come down to it, I like people and I like my job and I like doing the work. However, at the same time, it is overwhelming and there's always people I have just wanted to cry on the case for, because I felt so frustrated. It was actually a refugee patient of mine, but, you know, you can't advocate for them...

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... It felt like the right thing for them wasn't even hard, but there was obstruction from people that you would think have a different approach. Surely, you know, where's your compassion? I find it really shocking but, in a way, it makes me kind of more determined... It's really easy to feel like you almost become the problem, I mean by calling the issues out, if that's part of advocating. I think systems need to hear it, they need to hear when stuff doesn't go right, because if ignoring it is your modus operandi then nothing will change, and bad stuff happens. This is why I am really passionate about changing things, and looking at ourselves, looking at how we can be better, seeking feedback, that's really important...

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The built environment in the ED was also seen to be inhibitive and a strong understanding that emergency medicine is a largely Eurocentric system designed to care for people with Categories 1 and 2 presentations:

> **Picking one form of cultural safety is difficult because there's lots of different cultures at work here and lots of different cultures that we look after as well. And one of the big issues here is most of our patients are Indigenous...**

> **In terms of our clientele and where they come from, everyone's cultural requirements differ. So, many differences can be slight while with others there might be a lot. We're not privy to all of that either. I think it's particularly hard when you have females dealing with males out here. The safety for the patient around that can be really hard because they're not going to tell you anything, they're not going to let you in. But if you don't have a male then you're kind of stuck between a rock and a hard place. And that's just one area.**

I think to me cultural safety is a few things. I think it means acknowledging that the way that we practise health and practise medicine comes from a Western sort of Eurocentric place. The way that we're taught and trained to deliver health care to people, I think that that sort of training doesn't reflect the diversity in the patients that we care for. And it doesn't reflect the importance of, or I guess it's not reflective of, the needs of culturally, linguistically diverse people, and how that links into people's experiences of the health system and how likely they are to engage. After having a positive or a negative experience I think it does really undervalue how important things like language [are], and the way that information is delivered. It is because we were [too] busy to do it well.

Overall, there was a genuine recognition of what cultural safety was supposed to mean in the context of the ED and in some pre-ED services, and that some of the medical school and nursing school simulations could have set people up with biases that have been reinforced rather than addressed. Thus, instead of systematising responses to cultural safety, some staff indicated a 'trial and error approach':

… I am coming to terms with my own internal biases and prejudices. I have even assumptions that I make that I've tried to work on. A lot of that learning has come from, like fucking up. Going to a person who's quite unwell and putting them on the seat, instead of putting them on the stretcher. That doesn't sound like a big deal, but it is. I go back and I think, 'Oh, shit! They are sick! Why did I put them on the seat instead of the stretcher?' Maybe it's because I didn't take them at their word… it's those learnings which have come from making mistakes, and not giving the best patient care I could have given, through my own internal biases I've picked up over time… I feel like if we could have better, regular training and having that like from an organisational level, maybe I wouldn't have to make those mistakes in order to learn. I think training on what it means to have a bias, how do we overcome that, how do we become aware of it and overcome it, so that's probably the biggest thing…

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… It's funny because part of my role now is working at the simulation centre so doing a lot of health education through clinical simulation. And when we create scenarios, the stigma that is typically used is that an Aboriginal person comes in and they've got all the horrible health conditions whether it's diabetes, blood pressure, they might be using drugs or anything like that. So, I guess, trying to break down that barrier in terms of perceptions that we have created in previous years is hard, in that, that's the typical presentation for an Aboriginal person when it's not. And so, we, as a health profession, have been guilty of perpetrating that cultural stigma…

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A growing number of Aboriginal and Torres Strait Islander academics and practitioners are calling for health care systems to address casual racism and unconscious bias, which has implications for what is taught in workforce training programs. For example, Phillips (2019) advocates for workforce training programs to teach about white privilege, anti-racism, unlearning unconscious bias and white supremacy, intended or not. The College could support the development of resources and educational programs that speak specifically to addressing unconscious bias, promoting positive workforce socialisation strategies and co-designing with people from various backgrounds – youth, LGBTQI, language experts and people with lived experience – strategies, physical environments, and social medicine strategies to transform the lives and experiences of people whose presentations relate to social and cultural determinants of health and wellbeing. To support these actions, consideration needs to be given to the development of, and access to, Cultural Safety Training.

Access to Cultural Safety Training

Emergency department staff reported accessing Cultural Safety Training in two forms: an online cultural awareness course, and face-to-face workshop style gatherings led by people and agencies in local and regional areas and offered to new employees as a part of their orientation. Respondents stated Cultural Safety Training is critical to improving the quality of care they provide to patients. Strategies to promote better health outcomes, information about the local colonial experience and the health and wellbeing issues that are likely to present to the ED was considered helpful in supporting staff to care for the community to the highest possible standard.

Cultural Safety Training is predominantly based on adult learning principles and cultural ways of knowing, being and doing that are particular to the region. Current cultural safety programs emphasised the importance of self-directed learning, in which staff members might identify elements of the learning program that encourages active participation and involves reflection and evaluation of what was learned (RACGP [n.d.]). Even though the programs are well designed and deeply considered, emergency staff do not access regular, coordinated, localised, face-to-face formal Cultural Safety Training and there are conflicting opinions as to the value of the experience. For some who participated in one off events, the training provided some much-needed information but was not substantial or focused enough and failed to provide information in a way that was digestible and sustained over time.

… when I first started we had a chat, which is like a cultural awareness program that happened probably two months into my time being here. It was a day, and I just discussed the languages and the different things they do and their skin names and all that sort of thing and just how to approach some situations. So it was good. I don't think I've had anything since, but I've liaised with AHLOs who seemed to be really helpful and that is really good…

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So everybody should always have to do Aboriginal cultural awareness workshops. You get a certain amount of time to do the workshops. It's good to learn things when you have never lived here before. The course instructors explain to you things like, [what would happen] if a white woman was to go out to an Indigenous community with no knowledge whatsoever of Aboriginal people and that person started taking photos. They [the instructors] break it down and tell you that it's wrong, [that] you need to go see an Elder. I guess it was good to learn about that, in the training.

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… You have the ICAP [Improving Care for Aboriginal and Torres Strait Islander Patients] program when you come to town so it's a one-day, face-to-face session with an Indigenous teacher, and you sit down and you learn all about it. You don't learn about specifics, but you learn about it in general. Normally, for most people, it's just a slap in the face and this is what you've got to [do to] change your practice, to be able to nurse around here. It's just been so bloody hard because a lot of us go to university and get those professional qualifications and then you've almost got to unlearn them…

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Some noted that they had not had a lot of Cultural Safety Training and that a 'helicopter view' of cultural determinants did not address the issues they were seeing in the ED:

I wouldn't say we've had lots, and I think certainly people can fall through the network. The hospital does have cultural awareness inductions but it doesn't deal with some of the cultural factors we see in ED

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So it's like software that you do online in modules; I think it goes through about two hours online that we need to complete. But once you've completed it you don't have to do it again. So you can always like do it, I guess, but I mean it is two hours.

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The formal training was very 'helicopter like' as such it was very superficial because it wasn't really drilling down to what you need in an accident, emergency context. It's great stuff as an introduction to some of the issues if you've never been to Central Australia before.

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So we've got mandatory education programs, which always engender a certain degree of resentment because we just have a long list of things that we've got to do and it's just another task. They probably help to a degree but on a relatively superficial level.

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Cultural 'congruence', comprehension and gendered approaches underpin the patient journey at the patient, emergency care provider, and system levels. Social and cultural determinants of health provide the foundation for the expectations, actions, interactions, and meanings of care. Some staff indicated they had felt inadequately trained to meet the needs of Aboriginal patients, finding the care required by Aboriginal patients and their families outside of their scope of practice.

Patients, families, staff and communities grapple with the realities of human mortality in the ED. During times of trauma, issues of culture come into focus. Increasingly, health care providers interact with Aboriginal patients dealing with life-limiting diseases. Social and cultural determinants of care become critically important and ED staff interviewed in the study advocated for cultural advice, or the ability to have cultural supervision:

> **... thinking about presentations in an Indigenous context, the issues around their behaviour can be as much related to the historical baggage as to the practitioner, and the practitioner needs to not take it on as a personal kind of thing...**

> **... engagement with the Aboriginal communities to understand how we can better achieve the best outcomes – both avoiding coming to ED and making a visit to an ED the best experience possible. There will be things that we're blinded to and don't have insight to – the history of the region, the role the ED has played in the community, if there have been bad experiences. Otherwise, it is difficult to know when to say this, [as it's] something I need to solve for all patients who are heightened and scared or otherwise, do I need to have a specific kind of approach...**

Even though culture is continually being defined and debated, Triandis (2007) identified a consensus across the literature that culture consists of three interrelated characteristics: culture emerges in interactions between humans and environments, consists of shared elements and is transmitted across time periods and generations. In the ED, the interface between the culture of the ED and the interdisciplinary teams engaged in emergency health care is difficult to change to accommodate the needs of a particular cultural group. The workplace culture of emergency medicine has largely focused on the work effort of physicians and nursing staff, with the rationale that these two disciplines represent the majority of practitioners and, therefore, should have the greatest potential impact on client outcomes in emergency settings.

There is a wide range of ancillary staff who have been largely left out of these processes and discussions, including pre-ED services (ambulance officers), allied health professionals and mental health workers. As such, an Aboriginal emergency workforce, which is still at its inception phase, is necessary to support culturally safe interactions between the disparate cultures of the work environment and the different workforces, to be aware of the cultural needs of Aboriginal clients, and to manage the dynamics between families and communities. To understand the experience of this interface, we asked respondents in this study for their perceptions regarding cultural safety education to see whether the training had enough quality content to enhance their work with Aboriginal patients and their families in EDs.

Perceptions of quality and content in current Cultural Safety Training packages

Participants suggested it was useful to understand the regional context and other pertinent issues impacting the health and wellbeing of the local community. Importantly, having an Aboriginal person with the appropriate authority to co-present or teach the program was rated highly. Respondents also felt the training had to demonstrate to practitioners the contribution that culture and cultural safety made towards ‘closing the gap’. Also crucial were practical strategies to identify and address cultural biases, with reference to understanding how these biases have developed and how to unpack and address them in an ongoing way. Other key contributions of training courses would be to identify appropriate role models who had different kinds of expertise to help shape the staff’s practice and promote understanding around gendered issues; to refer and work with local-level cultural practices; to support people in using local words and phrases; and to offer advice on issues such as dealing with extended family members and ensuring you have consent.

Other respondents, particularly those trained overseas, needed extra supports to recognise Australian-based stigma and when to deploy culturally safe practices:

And again, I was a little bit surprised by it because it was a strange thing. Initially I kind of thought is setting something up like this, is it helping or is it stigmatising because we’re having this level of input? That kind of started me and so why do we do things differently if they’re coming in the hospital with medical conditions? If an Aboriginal person comes in with a heart attack, why do we need to have the Aboriginal [Hospital] Liaison Officer? If they’re coming in with a heart attack, for a heart attack management and treatment it’s the same! Is there a risk that because we’re getting these people involved that we could be labelling them? Could we be introducing a bias into this process?

* * *

… When I started doing the reading up and appreciating the higher risk factors within those, those groups of individuals, you start to realise that actually no this is quite relevant, it’s about minimising and reducing risks and making sure that we have the right processes available for patients whenever they come in, with regards to delivery of safe care with the hospital…

* * *

In part, the difficulty in linking cultural competence to patient and family outcomes derives from a failure to consider the cultural domains that patients bring to health care encounters. What staff indicated they needed, was some more detail about the client level dynamics of health care, specific to a region or a place. Informal training happens when you have good managerial support and effective staff. However, staff reflected that it still doesn’t mean it’s culturally safe.

> **… Educators at the time were very good. We had a lot of informal education sessions about what is typical to be seen around here and what to expect and how to deal with that and our manager in particular is very big on Indigenous health and how we influence them and how we can make it easier for them and better for them. But it’s not coming from an Indigenous person…**

> **… cultural safety is about how the patient is interacting with the health professional. Having that interaction happen in a way that the client, not the health professional feels is real, and safety needs to be something they can trust and invest in. It's the responsibility of the health practitioner to make they do everything they can to get that right every time; it is not something to put on the patient…**

> **… but you know there are a lot of good people who are not doing this well. I think being a good human is part of it. But I think you can certainly be a good human and that's not enough…**

Most staff said cultural safety is enhanced when staff have access to an Aboriginal workforce, although some overseas trained doctors felt like Aboriginal people were being singled out and at risk of racist experiences because of this focus. In emergency care, practitioners interact with people of similar and diverse backgrounds, and are unaware how personal criteria, preferences and experiences impact quality care for all patients, including those who are Aboriginal. It wasn't until engaging with an Aboriginal workforce or community presenter that they understood the different and compelling historical factors contributing to Aboriginal patients' presentations:

> **… I initially thought we are introducing a bias, and almost racism, within the system because we were identifying these people as being different even when their health needs are like the rest of the community. This is before you start to read up on it, when you realise there is a difference and there are risk factors…**

… This doesn't seem right, why are we labelling these people? But then when you start talking to people, especially AHLOs, and she says I need to consider the complex networks people are part of, you see the complexities and really start to understand, but I really feel like I'm still very much at the starting boxes of this. And I'm a little bit concerned that I've missed those opportunities for making appropriate referrals and so yeah, we need to do a lot of reflective practice…

The meaning of illness and treatment is similarly rooted in the knowledge, beliefs and values of Aboriginal patients, family members and community's experience of health care; particularly when presenting with health and illness issues that have been categorised as triage Categories 3–5. To support an effective response to the cultural and moral dimensions of care, we asked respondents to consider the cultural training they received and whether the quality, delivery mode and content of the course supported them to be effective.

Cultural content in lessons

Cultural content is delivered through several modalities, including on-line, face-to-face and region-specific training by local Aboriginal educators. The latter two are particularly powerful and long lasting, as they provide an opportunity to engage local Aboriginal people in ways that extended the range of contacts and referrals. In other EDs and through cultural safety networks emerging in Emergency Medicine, cultural safety as an ideal is initiated in training. It is then embedded in practice through the implementation of yarning circles, having people from community working with ED staff to share ideas on communicating complex medical terms and holding regular community lunches.

Shift work and other time-related issues impacted on ED staff's access to education, with nursing staff in particular nominating the '5-minute huddle before a shift starts and in amongst handovers' as the only time available to them for paid education that could help enhance their work practices. In all other instances, access to education happened in their own time. Others articulated needing cultural content in lessons to facilitate:

- Improvements in comprehension – to work with people effectively through their patient journey: health promotion, overcoming language barriers and improving consent and other practices;
- Gendered approaches to health and wellbeing – so that the shame experience can be minimised;
- Practical guidelines and simple words to use to engage patients and their families;
- How to approach large family groups and communicate effectively (collective decision making instead of individual decision making);
- When to call an AHLO to come and meet people in the ED;
- Self-reflection as a strategy to address biases and racism;
- Cultural Lore and Legal issues and ensuring cultural congruence;
- How to build rapport in time pressured circumstances;
- Referral pathways – where can people be referred to?

For those staff not raised in Australia, there is an urgent need to educate them as to the historical reasons for a singular racial group being privileged over others, particularly in workforces used to working in multicultural settings and among staff who themselves may be from different cultural backgrounds. In an Australian environment, the realities of the population demographic will be such that cultural diversity will remain a remarkable part of health care arrangements – both among people who are providing services, and those receiving treatment and care.

Additional attention needs to be given to the different experiences and understandings of traumatology, including of the concepts of embodied trauma, intergenerational trauma, payback and cultural responsibilities, an example of which can be found in a story from 2010:

> **The young Aboriginal girls involved in an horrific car crash near Port Hedland that resulted in the death of a 13-year-old friend have allegedly been subjected to tribal punishment. *The West Australian* understands that some of the four girls – aged 13 and 14 – who survived the crash were hit with a traditional Aboriginal stick by a relative of the dead girl at a meeting of families last Sunday following a funeral.**[4]

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[4] J. Strutt 2010, Crash girls 'get tribal punishment', *The West Australian*, Perth. Available at: https://thewest.com.au/news/australia/crash-girls-get-tribal-punishment-ng-ya-216249.

One staff member shared the following story, which opened her eyes to the difference in her experience and understanding from that of her patient who had had a car accident in which a passenger had been injured:

> **… and that person was so worried about being blamed for what had happened. I can't completely understand but I can appreciate that you would be so worried about getting blamed for something like the seat that was in your car and you had responsibility for the person you were transporting in your culture in your worldview.…**

While understanding that health care systems and providers will need to learn about cultural diversity and become culturally competent, what needs to be addressed as a matter of urgency are two issues that emerged from the interviews. The first is the issue of equality and equity, and the second is about racialised care as these concepts apply to First Nations' peoples in colonised countries. In June 2020, ACEM developed a Statement on Equality and Equity of Access to Healthcare affirming the College's commitments to equity and equality in health care in Australasia, and nominating that all hospitals must be open, fair and accessible to all (ACEM 2020b). Although the Statement affirms there is 'no place for racism' and that 'everyone has a right to health care', the nuances in the application of equality and equity have emerged as a key finding in this report. Thus, this needs to be addressed through education and training, as does the issue of racialised health care.

Emergency medicine, equality and equity

There are many factors impacting the delivery of effective, equitable care in places that are increasingly overcrowded and present significant barriers to care for populations of people experiencing vulnerability and marginalisation. In the context of emergency care, Hwang et al. (2011) define equitable as

> **… the principle that all individuals have the same access to quality emergency treatment and receive the same standard of care regardless of race, age (children, elders), sex, ethnicity, income, insurance, geographic location, barriers to communication or mobility, or any other demographic detail.**

The same authors detail that patients for whom bias can result in less than equitable care are those with mental illness, substance abusers (particularly 'drug-seekers'), frequent ED visitors and undocumented visitors. In developing a research agenda to review the impact of overcrowding on equity of access and treatment, Hwang et al. describe equity of access as:

- Belonging to a certain group or possess a specific characteristic;
- Scarcity of nearby facilities or delays in accessing these facilities;
- Impacting EDs who serve a higher number of the population impacted by poverty;
- Particularly affects poor people in remote areas.

Inequality of treatment looks like:

- Receipt of delayed, less adequate pain control than others in emergency settings;
- Differences in diagnostics, testing and evaluation and care of heart health;
- Care of paediatric patients and maternal care patients; and
- Lack of access to interpreter services.

Among the respondents from this project we were able to identify two key factors that impacted cultural safety, and which could be enhanced by access to education and training to deter practitioners from thinking Aboriginal people get special treatment. These are described below.

Aboriginal patients: Special treatment

* * *

… One of our nursing staff made a comment, when some of the Black Lives Matter stuff was happening. I'm trying to remember what he said. I think there is still this sort of a sense in some people thinking they maybe get too much, like that there's too many resources being put in that space, and that people should let the past be the past and stop harping on about it and move forward. Like I think there is that attitude. Yeah, it's not uncommon for people to hold those kinds of views, people that work in emergency departments, I've had various people express things like that.

* * *

… Well, you know, if this is designed to make sure they don't wait as long as everyone else I'm not really into that because why shouldn't they wait like everyone else. And so like I gave that example just to illustrate that there is a sentiment that exists, they shouldn't be getting special treatment because they're Aboriginal. They shouldn't get to jump the queue, that was sort of what he was saying. And this is a guy that spent time in Aboriginal communities and is very interested in that, so I was surprised that he said that, I didn't get time to explore it more with him because it was just sort of a comment.

* * *

… Yeah, sometimes I do think that it takes a little bit longer to establish rapport and, like I said before, and so gain their trust. What you're doing is necessary. And we're not just sticking a needle in just because we can. We need blood tests and we need to give patients some treatment. But it depends where they come from. If they're urbanised, they're probably just like anyone else…

* * *

… Look, I don't know if this is if this is necessarily true, I'm sure that there will be different opinions on this, but my personal view is that if every patient is treated in a textbook experience in the emergency department, then it really doesn't matter, necessarily, whether in the majority of cases [we're] focused on cultural safety for Aboriginal or Torres Strait Islander or not. It's not at the forefront of my mind. I would say that if every patient that walks into the ED was looked after in a caring way, in a medically good way, in a timely way, then I'm not sure that that would actually matter whether there were specific kind of focus on their Aboriginality. Given that the system is not perfect, that's where the cultural safety thing is more likely to be of importance… You know, if everything's running to plan, if everything's been done really well and the patient feels important and cared for, it's probably less important that we focus on their specific cultural needs… It's when the system doesn't work well – which is often the case when things are disjointed or when explanations are not given very well or when patients are waiting around for a long time – that it's more important for us to be aware of specific cultural needs…

* * *

Former Aboriginal Social Justice Commissioner, Professor Tom Calma, in describing how to change the health and wellbeing challenges experienced by Aboriginal and Torres Strait Islander people in a generation, took a human rights-based approach to determining the relationships between equality of care and addressing inequity (Calma 2005). The first step in achieving equality was to recognise that health inequities are 'avoidable and systematic' (RACP 2005; Dwyer, Willis & Kelly 2014). Equality in health and life expectation refers to statistical equality between Aboriginal and Torres Strait Islander and non-Indigenous Australians across a range of health indicators. Equity on the other hand, speaks to addressing decades of underinvestment in Aboriginal affairs. The Closing the Gap campaign highlights that while there have been improvements on some measures of Aboriginal and Torres Strait Islander health status, these have not been at the same rate of gains made by the Australian population at large (AHRC 2020). A human rights-based approach to health means the application of the overarching principles of *non-discrimination and progressive realisation, the emergence of literature that connects human rights standards and participatory development processes, and the content of the right to health itself* (Calma 2005).

The implementation of these actions obliges health agencies to redress inequality in the enjoyment of economic, social, cultural or civil and political rights and to pursue courses of action that mean government-funded institutions must progressively achieve the full realisation of relevant rights and to do so without delay. Because of the College's commitment to human rights, training is needed to provide context for the inequality of health and wellbeing while addressing inequities: that is, to invest in programs, policies and technical assistance to realise human rights, to develop and implement standards in consultation with Aboriginal people, and to develop the capacity of staff to meet their obligations as 'upholders' of human rights.

The second emerging trend that could be supported by more comprehensive Cultural Safety Training is the phenomenon of 'racialisation in the provision of health care'. McFadden & Ericson (2020) undertook research in which they detailed how race becomes ascribed through theoretical processes and workplace socialisation processes. In racialised environments, they were able to show that socialisation in the workplace was a key place in which people learned about and reproduced racialised stereotypes that shaped the care they provided. In this study, when ED staff actively attempted to resist racialised stereotypes, most participated in essentialised emergency departmental practices by using racialised institutional practices.

So, breaking down our own cultural bias in seeing that that's the only way Aboriginal people present is that they're drunk, high on drugs, we've got some health problems. So, I guess that's something that we take back and say no, that's something we need to start to change... I think that's already a bias that we've got in our own minds. You know Aboriginal people don't seek health care they don't follow through on our medication plans, they don't go to the specialist we refer them to and things like that. So, you've got that bias in your own mind before a lot of people even treat them...

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... the lack of ongoing training and the lack of cultural safety being at the forefront of services, I think also impacts my ability to work with community because I'm only as good as what I know. I have an active interest in trying to be better but if the majority don't, then that is a major barrier to being a good health care provider... if you're like one person in a group of 40 emergency staff who like to reinforce each other and the status quo, it can be pretty hard for one person or two people to try and make any kind of difference really, except for leading by example which is like a big one. There are no words, or you're not getting anywhere with your words, then consistent behaviour is needed...

Many health practitioners have the understanding that everyone should be treated equally, regardless of race, religion, gender, sex, sexual orientation, culture, ethnicity and age (McGibbon & Mbugua 2017). Most are trained in disciplines that promote 'scientific objectivity', where there is an implicit assumption that medical facts and truths can be identified and treated. However, study respondents did not always consider that historical injustice, prejudice, discrimination and practitioner bias are rarely accounted for in assessments and courses of treatment and care. Treating everyone the same persists as an ED ideal, but this is largely dependent on the incorrect assumption that race and other socially constructed differences do not exist, and that dominant cultural experiences and ways of knowing are the same for all cultures. More emphasis on understanding the role of bias, workplace socialisation strategies that reinforce racialised health care, and the concepts of equality and equity need to be explored in cultural safety awareness and training.

Are EDs culturally safe? Challenges, barriers and enablers

The respondents in this study talked about how they strived to provide cultural safety, but also recognised the significant barriers to providing culturally safe care because of the diversity of Aboriginal people's cultural groups, language barriers and capacity to operationalise cultural safety in overcrowded, busy and stressful environments. These were characterised by poor physical layouts, crowding, fewer resources (interpreters, culturally validated pain scales), and a siloed approach to delivering episodic, fragmented care for Aboriginal patients presenting in Categories 3–5. Another barrier impacting cultural safety in EDs was the issue of privacy, with:

— curtained bays not facilitating privacy;

— no sound barriers making it difficult for people to discuss topics that are sensitive; and

— not enough separate places for men and women.

Staff were concerned they were shaming Aboriginal patients, but that most of their learning had to come from trial and error:

I think we're bad at shaming patients, yeah. So, an example is obviously we have like a lot of patients around Central Australia who unfortunately are dependent on haemodialysis to leave. And that's sort of three days a week, you spend X number of hours at a dialysis centre. Sounds like an absolute drag and probably wouldn't do it to be honest with you, but then you know when we pick up people who say they miss dialysis is a very common presentation now. So when people miss the dialysis, or they have had, they've been prescribed antibiotics for a chest infection they haven't taken antibiotics, there's is real, like triggers, on the like finger on the trigger type of way that we start shaming people about what he typed or anybody explaining to your dialysis during the knowing that you need to go to dialysis, otherwise you're going to die. And people hear that I can imagine, from the moment we pick them up, they hear it from the triage nurse, they hear it from the handover nurse, then they hear from the doctor, and then they've had probably five white people in the space of about an hour tell them how to live their life… All that is like this compounding thing of like white people telling you how to live your life. And then we wonder why nobody wants to come to hospital any more.

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I think we need to reflect on the way we think we do the right thing. If I were to shame people. And I'm assuming it's because people are lazy or because they want to just come and get dialysis when it suits them without asking them, 'Hey, when you got your meds from the pharmacy did they explain to you how to take them? Did you feel comfortable with that?' Because people are afraid of taking medication as well. So, I wouldn't take something if I didn't know where it was if I didn't understand how it works. No way.

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Additional barriers were identified in relation to accessing resources that would support people though their patient journey, with staff recognising that:

— AHLOs play a significant role in facilitating safety by working with others to promote cultural sensitivity and helping staff communicate complex issues in the 'Aboriginal way'. However, these positions need to be available across the hospital and there are currently no AHLOs employed directly in the ED.

— Specific language speakers employed by the hospital might need to transport a client back to their community, but if that language resource is out of the hospital grounds this can delay important and time-sensitive interventions.

Comprehension is key and not always available for people in EDs:

… We can get translators on the phone for a Spanish person 24 hours a day. But we can't get somebody to interpret for an Indigenous person if it's after 4.21pm in the afternoon. I mean, I find it quite bizarre, quite unusual and quite confronting. Aboriginal [Hospital] Liaison Officers can assist, but they're working in other parts of the hospital and there are no Aboriginal staff that are specifically there for the accident and emergency department…

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Language barriers mean that we are really compromised in knowing whether someone truly understands what they've given consent for is that correct. It is absolutely abysmal. I find sometimes here the consent process is hard, like [with] somebody signing a form. Unfortunately, a lot of the local population here if you point and say 'sign here', they'll sign here but they don't actually know what they're giving consent for. And some of the consent issues in an accident and emergency department are significant…

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Legal issues also became apparent in interviews with staff, with some being particularly concerned that the legal requirements around consent can compromise people's cultural connections. Furthermore, in an ED context, language resources are not able to be accessed for fear of compromising privacy laws:

> **Even if someone from the patient's family or language group came in for a visit, you will still not be able to use them to translate. New confidentiality laws mean you can't get them to interpret for them. We are still relying on a service that's only available five days a week for eight hours. Still, depending on other calls for their time, staff are not available five days a week for eight hours.**

The ability for staff to implement cultural safety depends on workplace culture, the length of employment by the on-the floor staff in different jurisdictions, and the support they receive from their colleagues and managers:

> **I suppose if I'm having trouble with a patient on issues of cultural safety, or if I'm having trouble dealing with something, then yes, I would feel quite supported to solve the issue. There are colleagues around, and the senior staff and the senior permanent staff of this department would all be very supportive, no matter who you are. I just think the opinion between someone who's been here three months and myself would be different….**

However, their Aboriginal colleagues still felt that some of the behaviour of staff was disrespectful not only to patients but to Aboriginal staff members. This was particularly the case for staff who emphasised people's race over their professional or patient experience, which made one staff member say that attending Cultural Safety Training was best not to be done:

… that's my honest opinion I don't think they [Cultural Safety Training sessions] are helpful…

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I believe there's a spot for them to be helpful, yes, but you hear people come back from these sessions or before they go in, they're always whinging about it. 'Why do we have to do this? That was a waste of time.' Just comments on that. And when I heard that sort of thing, I guess, ah how I can I put it nicely, it hurts me, when I hear that. But I guess, that's just the culture we work in...

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There's a patient aged 25, and he has been on dialysis for several years now, end-stage renal failure... He is essentially dying; he's being palliated, being made comfortable, and the type of chat that gets around about this person; 'how they need to take responsibility for their own health care', to me is just like so devastating. I think we really lack the understanding of people in that situation, we're desensitised to it and we think it's normal and it's not normal. It's an absolute atrocity! It's devastating for someone that age to be palliated because their kidneys are like destroyed. But I think because in that moment where, you know, we're frustrated that we have to transport these patients into the hospital for the second time that day. And that inconvenience was caused because they don't take the responsibility for their own health care where like knowing a little bit about this person, their life like all the events that have transpired are important to know. We just have no idea, like we have absolutely no idea...

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Everyone at work knows I'm Aboriginal, I'm quite proactive about Aboriginal Health at work. But I do get a lot of comments regarding my skin colour not being dark, you know, things like that. They're all jokes, and I get along with all my colleagues, very well. But there definitely comes to a point where it's just, it gets to. You can only take a joke so far....

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Most of the staff spoke about the way they used compartmentalisation as a strategy to ensure they were able to keep their behaviours in check, and that stressors in the work environments created either acceptance of their behaviours, or required them to take accountability, to uphold the human rights elements of the work. Most required appropriate access to debriefing, clinical and cultural supervision and regular visits to the employee assistance program or EAP, a confidential, short-term, counselling service for employees with personal difficulties that affect their work performance. Staff reported they had little capacity to understand the impact of the power relationships within the ED and how this influenced the language they use, the abruptness of their language patterns and the unequal power dynamics at play between colonial institutions and colonised people. Some felt it was critically important for staff to understand the power they had in shaping the experiences of people presenting to the ED, thereby demonstrating real insight:

> **When you open that door and you are the first point of call... I mean we have a lot of power in shaping somebody's experience and we have a lot of a lot of power in starting a good continuation of care or a bad continuation of care, just by how we refer to people. By starting a sentence with this so and so, they're drunk, or this so and so they've called me on today because they are blah blah blah. We within health care have so much power to either advocate or not, and in the split second we make that decision, and I think it really has an impact on then how that person receives care for the rest of their journey.**

There was also a call from staff to invest in research to create evidence to inform and transform people's practices in emergency care, and that a lot of the workforce are driven by evidence.

It's hard to discredit things that are evidence based, and so that's why I think science and data in these areas are so important. I mean it's easy to dismiss one person or a few people about it, we're so data driven... but then, we have this funny way of having selective hearing when it comes to research. We're doing really bad things for our patients because we're racist people, people that don't like it. But I think the more of this sort of data that exists in our space, people just have to start listening.

... more is coming out about institutional racism and how racism is terrible for people's health. I think this Black Lives Movement will encourage more data around how, you know, something that doesn't seem that important – it's just a comment here or a certain wording here – it really does have impacts on people's health... People might not necessarily respond to messages like, 'Don't be racist it's bad', but [it] could make a difference if we think about not being racist because you're not a good health care provider if it's affecting people's health...

Racial discrimination is real, it exists and negatively impacts the health and wellbeing of Aboriginal people and leaves staff feeling demoralised. In instances where staff can engage with and transform patients' experiences in EDs, they felt like they had been able to regain trust and deliver health care that is in keeping with their reasons for becoming health professionals. Barriers to being able to provide culturally safe care are listed in the Table 2.

Table 2 Barriers to providing culturally safe care

Heavy intoxication impacts cultural safety	*Yeah, and it's hard to be culturally safe for someone who's heavily intoxicated. Overnight, it's difficult to assess a patient who can become quite combative and aggressive towards staff and then I find sometimes staff can be short, I guess. Often what happens is they'll stay overnight to sober up for us to review in the morning, and then they'll just take themselves out and won't wait for any medical intervention.*
Aggressive and violent behaviour	*… alcohol and drugs can be a barrier to assessing patients and makes it hard to provide privacy and dignity because they might be yelling and screaming. And this is another really big barrier to sometimes providing that cultural safety…*
Involvement of police, particularly in issues of domestic violence	*… we may have had had a victim of domestic violence present and you've got them in the [emergency] department safely tucked away, and then the perpetrator is brought in by the police who has to be assessed. So sometimes we need to provide that cultural safety not only to the victim but to the perpetrator to. You can't be biased, and you keep that level of professionalism. Sometimes, you know, in your head, you're like I don't want to judge, I'm trying to provide this person with the same care provide anyone. It can be a really big barrier as well. So I probably say like alcohol and drugs aggression, and yet some of those issues can be big issues…*

Gendered approaches to emergency care	*Not having male and female staff members available on every shift. While this is not always possible, it should be the standard.*
Access to interpreters who understand complex medical issues	*Access to interpreters available for 24/7 – the issue of linguistic diversity makes cultural safety challenging.*
Availability of Aboriginal Staff	*AHLOs have other roles and responsibilities even though they have great language comprehension, they are often unavailable if they have to drive patients home, or be on the wards. The diversity of languages is difficult.*
Heightened emotional and cognitive distress	Emotionally distressed due to the reason for their presentation, safety depends on comfort provided by staff rather than a welcoming environment. *... you can get someone that comes in quite distressed and you're trying to get a story out of them, especially when they first present, and you would love to sit and talk for a long time to find out the full story and what's going on and things like that, but unfortunately I don't think that it always happens… the staff makes the patient feel comfortable but I think time constraints can sometimes affect that.*
Time constraints	*…we all do our best, but the reality of the Emergency Department is that we're pushed for time and people keep coming and so sometimes patients can feel like they are being pushed aside.…*
Funding	*We don't have an Aboriginal Health Practitioner at A&E, but they do have some on the wards, the renal ward and in ICU [Intensive Care Unit]. But we've only got one [AHLO staff member]. We put a business plan in here a couple years ago to get five Aboriginal health practitioners which then got pushed back, so they're trying to do it again and we are asking for one. And, you know, if you ask for one and get one and can prove that having one helps. Then you can ask for two and then you can ask for three…*
Balancing institutionalised responses and community need	*There is a problem of institutionalising them and they don't understand the service and then the service gets overwhelmed at the hospital and that's because it's being overloaded with people that need to go to their GP so it's a double-edged sword.*
Remoteness	*… Sometimes clients come to Alice Springs via the RFDS [Royal Flying Doctor Service] without a reason for admission to hospital. Clinics know their client's transport might be delayed if they're not of high acuity. The alternative is a clinic car and that might only drive to town twice a week. You know it's hundreds of kilometres away so that can also be a barrier to getting to emergency…*

ACEM's Reconciliation Action Plan contains strategies to enhance cultural safety, many of which have guided the implementation of cultural safety policies, programs and practices in EDs. Staff reported several initiatives that had transformed cultural safety to enable better contact and support. These included transforming the physical layout of triage so people have privacy and don't have to yell, and employing security officers both to protect patients in waiting rooms and to protect staff:

> **You know that it is a safe place and they can sleep, and get health care as well as security should they require it...**

> **... And you have got security guards that are there at night time in the waiting room area and that kind of thing so people feel at least safe; even if they are cold or it's not particularly pleasant, they're at least safe... Although sometimes I feel they can feel intimidated by the security depending on who it is. I have noticed that they used to give out warm blankets and cups of tea and things like that in the waiting room, but that's not something that we typically do now, because I think it came with a lot of issues. The waiting room, you know, would be full...**

Artwork had also been used to transform the places and spaces to make it more welcoming, but some staff cautioned that this on its own doesn't make for a culturally safe environment. However, it does mean that there is artwork on the wall, and that it could be a good place to start a conversation. Some staff referred to the importance of having outside secure places where people could wait and be called inside when their turn is up. They also talked of instances where there was an opportunity for co-design, with staff emphasising the importance of wider cubicles, inside and outside rooms being available to provide privacy, and perhaps taking gendered considerations into account, specifically in rooms where men and women have to share together.

> **If they're waiting, instead of having to wait inside a freezing cold air-conditioned waiting room, they can sit outside in the garden. Here the cubicles are more spaced out than normal emergency departments so you've got that bit more space, which helps because if you've got a female next to a male in a bed space, or even in two separate bed spaces that is still very close and they won't talk to you. They can hear that next person and they still can but there's still at least a couple of meters difference. I think this is fantastic compared to what we had, that was horrendous...**

The frequency of patient's presentations to the ED allowed the time for staff to build up a rapport with patients, and that this rapport supported positive health outcomes for patients:

I find that they are quite honest with me. If I'm saying this medication is for this reason, they're definitely much more receptive to take the medication. And the next time they come in they'll be like, 'Oh, my potassium is high I need the nebulizer', or they ask 'Do I need oxygen I'm not breathing well' or 'I'm feeling really weak'. It means they have some understanding of the impacts of poor health and are taking steps to tell us what is needed...

Sustainability of the management and executive management team in EDs was also inspiring for those workers who needed direction and leadership, and who could provide positive reinforcement to staff and role model safe behaviours:

… So, are you getting a lot of churn in those lower level positions, just six months is the average stay time for probably 50% of our base nursing staff. For other critical positions, the turnover is every three to four months. That's their rotation so that's what they're supposed to do, but they also won't stay in the hospital system for probably longer than a year…

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… it was just how I was trained by the previous educator. I've picked up habits and tips from other senior staff, and followed their advice on what to do to gather a good quick history and be able to make that decision at triage where you know whether they're a Category 2 or 3 or 5… It's very much on-the-job training and… a manager who has had many years' experience, they have got lots of things to share in making sure people feel comfortable coming to the emergency department…

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… Senior staff that have been in A&E for a long time and know a lot more about the communities and the culture have always been supportive. A lot of our senior consultants have been here quite a while as well so there's quite a lot of good help. And then during the week we've got AHLOs who are great, they're very helpful for me when the team leader is not available…

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There are a growing number of studies that show systemic racism is not the abhorrent behaviour of a few but is often supported by institutional policies and unconscious bias based on negative stereotypes. A range of strategies are needed to address this issue, starting first with the 'gaze' of emergency workers toward Aboriginal patients.

Staff perceptions of Aboriginal people as patients

Aboriginal people, in these interviews, have been described in a variety of ways and not all of them favourably. While there is a growing recognition of the cultural and social determinants underpinning the presentations to departments, Aboriginal people are still subjected to staff's perceptions of how they look, how they present and how they behave in clinical settings. Some staff were able to identify that EDs can be terrifying places for Aboriginal patients, but there is still a strong emphasis on conformity and compliance in accessing services in a timely and non-judgmental manner.

Sometimes [I see] that look of fear, of like I can't go there because I know I know what's going to happen there… I'm going to be judged I'm going to be sad and I'm going to be left… Working in EDs… I see that is real for you, and I see that that is what you would feel.

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Because we see Aboriginal people when they're angry, frightened, scared, in a chaotic, overcrowded and less than ideal environment, emotions tend to be heightened in my workplace and that's just the norm, the way it is. People aren't coming to see me because everything has been going wonderfully…

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There are a lot of stereotypes for Aboriginal people, and I think there's a lot in our ED. And in that other ED I was working as well, there was a lot. You do get the odd patient that is Aboriginal and very difficult to deal with, like violent, aggressive to staff, to other people. But I feel it's unfair that there are people that look at majority of Aboriginal people being like that.

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In asking staff about their views on why patients came to the ED, three main reasons were stated: for safety, the need for shelter and having acute medical problems requiring treatment.

You want to be open, you want to be welcoming, you want to make people feel safe. At the same time, we can't accommodate everybody so we need people to have that understanding that people need to see their GP or their health service. But we don't want to be seen to be turning them around and turning them away so that they don't come here when they are being assaulted, when they are vulnerable or when they just need somewhere to stay...

> **I think, safety and shelter would be the two main reasons, aside from having something wrong with them. A minimal percentage of presentations would be acutely unwell [and] needing the normal definition of an emergency department. However, people would come here, they prefer to come to us or the clinic or a GP because we're safe, because we're a bigger facility...**

Efforts to support Aboriginal patients were curtailed if the Admissions Clerks do not get to ask the identification question, to check in with someone if they are of Aboriginal or Torres Strait Islander descent. In some locations, the Aboriginality of a person is assumed. For some respondents, a client's Aboriginality would not impact their processes or procedures as stabilisation is prioritised over cultural safety:

> **I think admissions would definitely ask people but I don't think that it means we would treat them any different if you know what I mean... Our focus is on making sure their health is intact and they're stable so we would sort of do what we can. Then in terms of follow-up and other resources, then we could potentially ask, what's their history and if they are Aboriginal or Torres Strait Islander...**

Staff were asked to provide any insights they had to the changing nature of presentations to ED. They reported that domestic violence is evident at the commencement of every shift, and that mis-dialysis is another major reason for presentations, as are drug and alcohol misuse and motor vehicle accidents. The population-based presentations have changed due to alcohol interventions, the roll-out of vaccine programs and the management of bronchial problems is being done with better effect. However, an Alice Springs-based emergency worker said that 'stabbings and gastro' were pretty constant presentations. With the advent of COVID, Aboriginal patients did not want to come to hospital because there was an assumption among Aboriginal communities that 'that's where the core of the danger is'. This in turn impacted people being less compliant with their haemodialysis, and also meant that there were a fewer number of Aboriginal people willing to escort family members to ED.

Overall, there was a genuine understanding from staff that a myriad of systems have failed Aboriginal people, as well as a growing recognition of the inadequacies of treating Categories 3–5 and the increasing number of mental health presentations:

I suppose we see the things where, where the medical system sometimes has failed people or they can't, there is nothing within the system that will support them. I see them come in despite multiple interventions when it's all gone wrong and they continue to have recreational drug use, poor engagement,

treatment and come to me when everything's falling apart, when even their own family won't take them in... You see people who are difficult to engage and don't represent society as a whole. If I thought everyone was like everyone who presented to me in ED, I might have much stronger biases against them. I think I probably have some involuntary biases, like any human, but I need to try and fight right and ensure that you've got an awareness when you're carrying a bias against a particular demographic. But we're all human, and we probably have moments that were under pressure within work and we'll carry those biases through...

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A lot of Aboriginal people don't come in for treatment and I personally think the presentations have actually slowed down a bit. Yeah, it's like we had an elderly lady presenting yesterday or the day before... sorry my days are blurred, we've just been flat out. She was in there being triaged, and she had her granddaughter with her or a family member. She was in a wheelchair and we were flat, flat out outside like in emergency and because they had to wait, the elderly lady was getting very, very impatient. We had nowhere to put her. And actually the fellow that was in charge is an Aboriginal man, and he was frustrated because he couldn't actually get her to be seen straightaway. So what ended up happening was the old lady ended up telling her granddaughter to make, to leave, which was really unfortunate because she was in a lot of pain. They just couldn't wait so I don't know how we can fix that. So, usually it's if somebody is really sick, before someone actually comes in, which is how emergency it's supposed to do anyway. Patients are usually brought in by ambulance and there could be like a drug and alcohol issue or mental health issues mental health...

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Most presentations to EDs relate to drug and alcohol misuse, and it is easier to be judgmental of people experiencing these troubles than other Aboriginal people who can be engaged, setting up a dynamic of 'deserved' and 'non-deserved' among First Nations' populations:

> **We've seen some absolutely lovely people from an Aboriginal background. I had one lady who is diabetic hypertensive renal disease is difficult to manage but just an absolutely lovely person. It was really easy to have a conversation with her and was really easy to make sure that she had what she needed. And we addressed her needs and she had a plan for everything that she did. When you see someone come in the drunk, abusive and violent, it doesn't matter what their ethnic background is, it's very difficult to have that same relationship with them. Especially when you're being threatened, being spat on and shouted at, which is what happens in emergency departments. It happens with all ethnic groups, but it becomes very difficult to sort of look at someone and say 'Okay, is there something more behind this? Is there something cultural that we could do with this person or do we need to treat this patient any differently, provide them access to different services, not just manage their aggression or their intoxication?'**

Additionally, staff recognised that Aboriginal patients rarely come in on their own, and are often accompanied by multiple people and groups. While acknowledging this was an important cultural protection, it did make being seen in the ED difficult because staff were respecting the fact that they had support around them, and they were 'giving them some space':

... I mean, at times, I suppose, if there is an Aboriginal or Torres Strait Islander person in the [emergency] department, and they've got lots of family around them. It's an environment that I sort of go 'Okay, I need to let them be a bit'.

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... So you're not really pushing yourself forward into that because you're giving them their space and their time. Whether that comes across to them, as though you don't care as much, when really you're looking at it from a different perspective, possibly, that could be a barrier.

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You're more willing to go and talk to them about what's going on if there's the one person with them, but if there's a whole family group there, you're less inclined to do that as a worker. If there's a lot of people in one area, I can move on to the next one to restock and things like that. Yeah, so that would be another big barrier. And like I said, the perception that they may have of staff is that we are not approaching them, even though it's not intended that way, possibly.

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I have at times walked into those situations and just generally asked, 'Is there anything you need?' So at least they're aware that I'm thinking of them, and that sort of thing. But then it's usually just palmed off by saying, no, it's okay, they've got this huge family group... We are trying to make them feel as though we are here, we do care about you, but I'm trying to respect your privacy and your family grouping that you've got right now and I don't want to intrude, and overstep my mark. And I suppose that's the only way so far that I have dealt with that issue... Whether that's enough from their perspective. I'm not sure. I mean maybe that's an area we could improve on.

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.... you sort of want to help that in itself because then it's one family member coming up to a hospital situation that they don't necessarily feel comfortable in by themselves, not having the support [when they] come and visit a loved one. And then the loved one only having that one visitor. It doesn't really [provide] the environment that you've been told they like to have as a cultural thing.

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Patients' family members have been impacted by COVID and staff expressed concerned that it was affecting cultural safety.

... I suppose in this given time with COVID too limiting family members that can come in, you know you're not being culturally sensitive in doing that to the Aboriginal people because they do like to have big family groups around them [as] they help them feel comfortable. And if you go saying 'No, there's one visitor', which I know there is at the moment. Well, that's what I heard, just the other day.

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It's hard because I think with Aboriginal people, they tend to seem to feel more comfortable when they have like family and escorts with them. But obviously with COVID that becomes more difficult and I think in general. We can't just be like transporting them, there's got to be a balance. But I think, in the current in COVID times, I don't know what the hospital policies are around escorts. I just tend to bring whoever wants to come with the patient, I think encouraging people to bring family. I think there's probably more work that we could do, for [example], if it was like dependents at home being able to arrange for people to care for them so that the person going to hospital doesn't feel that pain or rush back home. You know there's probably more work that we could do in a pre-hospital space...

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... I don't really know how I can alter my practice to make them feel more comfortable. I usually have an idea and obviously consent it's a massive thing to me to make sure they're comfortable and they're happy for you to do things. But whether they're doing that out of politenesss [or] because they're unwell, and they might not... even care because they're so sick and they know that they need help. Or it can be the other way around and they think that they don't have another option.

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While a number of key issues were identified as problematic, very few staff members sought to develop collaborative strategies to these issues, in which communities could take ownership of solutions to improve the quality of the experiences in emergency settings. Without a shared investment in solutions to access and treatment, Aboriginal patients will continue to seek clinical care in highly stigmatised environments.

Racialised, stigmatised emergency care

And so, again, you know humans being use that sort of innate pattern recognition part of the brain that is the fast-moving part of the brain that makes assumptions. And it's only when you take the time to challenge them that you really see the full picture. And I think most people that work in EDs, don't have the time or haven't been trained to see the full picture...

Although racialised health care is a socially constructed category with no biological basis, it has been used for hundreds of years to argue for and promote hierarchies of supposed superiority and civility. It is a deeply embedded norm in Australian health care, despite an increasing number of overseas trained doctors who are part of the emergency medicine delivery team and a wider and more diverse population of people accessing emergency care.

> **The Aboriginal culture, but [also] other people from other cultures who might be waiting in the emergency department, other minority groups. I just think that it sort of makes me feel a bit uncomfortable sometimes, and maybe that's just because I am white Australian. I feel that I just treat everyone equally but perhaps that's not really how other people are, I don't know.**

> **I just think that in our multicultural world emphasising one culture over another, it kind of makes me uncomfortable, but at the same time it probably needs to be addressed for lots of reasons. I think it's a good thing a lot of people are talking and thinking about it.**

Social determinants of health approaches seek to understand not only the causes of health inequality but the root of these causes, and have the capacity to impact the delivery of emergency medicine through the implementation of Social Emergency Care. This marks a departure from strictly biomedical and health behaviour paradigms that tend to stereotype and pathologise people:

I found it very unsatisfactory. And I suspect that those people do not feel [there is] cultural safety when they come to an ED, because there really is a stigma attached to Aboriginal people in ED. Particularly because often it's, you know, people are presenting for alcohol-related injuries or intoxication, or seizures related to alcohol withdrawal, injuries from violence.

Generally, people get turned away when they can clearly be managed in primary care, where triage nurses will follow specific guidelines to identify specific conditions and refer people on to primary care. I think, again, I have nothing other than sort of intuition and conventional wisdom to back it up and I think this is going to sound really bad. But the more obviously Aboriginal someone is – isn't that an atrocious way of putting it? – the more an Indigenous person presents with darker skin and more obvious sort of features, the less likely they are I think to be turned away. I think people are more nervous about illness, significant illness and younger people in that age group. When you've got people that – and I'm trying to use my words really carefully here – don't look Aboriginal, maybe they get a slightly different view... Like they put on the paperwork [that] they are Aboriginal or Torres Strait Islander origin, but you wouldn't pick it up if you passed them in the street. They maybe get disproportionately discharged earlier...

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... [There] is a community of Aboriginal people, which I think is about half an hour away from the hospital, and I've seen quite a few people coming in from there. And I know from experience that a lot of the people there have got quite significant cultural issues and quite significant social problems. I've seen several cases of domestic violence, drugs, mental health. I've seen all sorts of things, and just generally kind of poor quality physical health...

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Some staff we interviewed recognised that the stigmatisation of Aboriginal people in hospital means that people don't always identify because of the way they believe they will get treated. This suggests that the binarised way of identifying through the records system (either you are or you are not) is impacting care in emergency settings. Instead, people should be able to determine how they want their treatment managed:

I've seen a high school teacher [at the ED] and they wouldn't necessarily expect to want to be met at the front door by an Aboriginal [Hospital] Liaison Officer.

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But I suppose this is where it's difficult isn't it because we're kind of just by using these binary terms – Aboriginal, non-Aboriginal – which is often the way in which these kinds of situations are coded when it comes to medical record keeping. You know, someone who at the front door says, 'Yes' [and] identifies [as] Aboriginal Torres Strait Islander is going to be, that's going to be on their medical EMR that everyone's going to look at. Then they will make assumptions about what that person needs or wants and doesn't want. Whereas then if the same person doesn't kind of say, 'Yes' [and] identifies, they're not going to get any of that. And it's a difficult one because what we're essentially doing is we're making these kind of broad generalisations about a very non-homogenous group of people that will be from different nations within Australia, potentially different upbringings, different educational backgrounds, different social backgrounds.

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Many effective interventions work for people in low-income communities and there needs to be a greater recognition in public health of the burden of social determinants of health and wellbeing and constructions of identity. While there is consensus on the need to strengthen health systems, there is less consensus on how to strengthen them. Part of the challenge will be to get existing and emerging knowledge about more (and less) effective strategies to put into practice. Despite the evidence base being weak, it is worthwhile considering advocacy strategies that can be embedded into family structures and kinship systems rather than in institutional settings. This should enable the continuation of health literacy and health care in community contexts, lead to more effective partnerships with emergency services and give patients more autonomy and decision making about their health.

Patient advocates

Patients have presented with family members in order to feel safe and supported throughout the ED experience. Many of those interviewed for this study concluded that, without their advocates, they would have felt unsafe when left alone in ED waiting rooms. The perception of patients is that they need to 'alter their behaviour' in order to get seen, which was recognised by ED staff as well:

How do you try and see it more broadly, and even think about the stuff that you wouldn't even necessarily consider, but make that a safer environment, one where there is [an] ability for Aboriginal and Torres Strait Islander people to engage with and feel they have some sort of voice within that system. Because we're really good at silencing patients and often… the elderly people [who] don't have a good advocate get overlooked. And it's that whole, 'You shout loudest you get seen'. I think often there isn't the right advocacy and, obviously, there is often just not the right environment…

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What I'm trying to say, that you sort of just said it in a better way, is that we do make assumptions about people's literacy and their competency just by looking at them, which is, you know, horrendous but we all do it. So, and I guess that probably what it's a part of [is] these people trying to like kill a fly with a sledgehammer, like we're going to approach all Aboriginal people in this way versus I'm going to actually interact with this individual as a person. And then from there, [we] decide about how we're going to play it… I tried to stop making assumptions about somebody's literacy, and they can say use terms that they're comfortable with. So I can [then] use terms back to them because I already know that they're comfortable with it because that's the way they've spoken to me, that makes sense.

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Family members' roles and responsibilities are cultural, familial, kinship based and comfort giving at a time of need. Family members can support Aboriginal patients through the sharing of 'bad news', discussing options for care, providing linguistic services to aid comprehension, and acting as advocates, a role that has a cultural underpinning. The processes of collective decision over individual decision making are often confronting for staff but fulfil cultural expectations that support people to share and maintain their personal power and autonomy.

> **You know it's positive because most people want to be advocates, but I think people just don't know how to be advocates in a culturally safe way. That's something I'm worried about, being another privileged person who speaks for somebody else instead of making space for them to have their own voice.**

Clinical staff seldom recognised the importance of cultural and family supports in treatment and recovery, with families visiting a relative often experiencing negative attitudes from staff who saw the family grouping as too large and overstaying visiting hours (Ristevski et al. 2020). Although emergency care providers sought family support to communicate information to patients whose English literacy was low, individual decision making is favoured over family decision making, particularly on issues of consent. With families a major support for individual Aboriginal and Torres Strait Islander people accessing EDs, because they provide transport, finances and carer responsibilities, they should be considered as a partner in developing alternative models of care.

Staff perceptions on why Aboriginal patients 'take their own leave'

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In 2018, the Aboriginal Health Policy Directorate nominated that patients who 'take their own leave' are more likely to disrupt medical treatment, are at risk of increased readmission and pose significant problems for patient continuity of care. Nationally, Aboriginal people self-discharge at between six and 19 times the rate of non-Indigenous people (AHMAC 2017). Incidents of discharge against medical advice is considered one of the measures of a culturally competent service and an indirect measure of cultural competence (Shaw 2016).

Staff in the study identified multifaceted reasons why Aboriginal people left without being seen or discharged against medical advice:

— Patients attend ED and are heavily intoxicated. They sober up overnight and leave in the morning prior to review. Up to 20 per cent of the beds each evening can be used for intoxicated patients who are not safe and have nowhere else to go.

> **There's lots and lots surrounding alcohol as well. Such as there's a bloke last week who came in, who was really, really drunk and said he wanted to kill himself. But by the time he sobered up in the morning, he couldn't remember this. Said he didn't want to kill himself [and] doesn't know why he said that. They still need to be seen by the mental health team [who] wants to solve it. [There's] a lot of that, unfortunately…**

— If a presentation to the ED means reporting or involving police, this can create problems for the patient involved.

> **As an ED staff member, you know they [women exposed to DV] are concerned what the partner is going to be saying or how the family is going to react because the woman came to hospital and the police will be called. A lot of women don't always want to involve police…**

— Comprehension issues on presentation.

> **People might be transported into hospital with an abscess. They may not feel sick now; but you know your abscess needs to be fixed or it's going to get worse and then you will get sick… So, it's actually more about not feeling sick rather not feeling safe. Once they find out they are not sick, then they are happy they are not sick and go away. An abscess is not a high-rating category and the wait times would be extensive. Quite a few people will leave if they know they are not sick. Knowing that is enough without being treated.**

— Needing sanctuary, not services, at the ED.

> **… a lot of it, especially when people are really drawn to the A&E, is because of a complete need for supportive care for the patient. It could be just an issue for bed space and that can be found in the accident and emergency…**

— Transported to the ED by police.

> **Now, when the police find people on the side of the road or in a garden or in a park and they're really drunk, that does affect how people come into the accident and emergency department. Depending on how they're actually transported there and If they can actually walk, then yeah, they generally don't last too long in the waiting room…**

— Overnight stay for review. In the evenings, Aboriginal patients examined by a medical doctor needing surgery or a review can stay in the waiting room overnight.

> **If there are no beds, but if the patient is medically cleared, they can stay in the waiting room until the sun comes up. This has been a very important strategy if the patients have no place to stay overnight. Then we go to the social worker and we make sure the patient leaves the hospital safely.**

DAMA is also dependent on the age of the patients. In the example where police bring a young person into ED, an immediate risk assessment is done to see if the child is at risk of leaving the hospital without being seen. Staff then try to find the parents and involve social workers to find a place to stay and support them if they have no housing or security. The common themes of waiting for surgery, sobering up, having a safe place to sleep and needing safety, not a service, provide the basis of why staff thought Aboriginal patients left.

A lot of people, not just Aboriginal Torres Strait Islander, but a lot of people present to ED for reasons that are not just medical so like social reasons, particularly at night when there's nowhere safe to go and the hospital is essentially just like a safe refuge. So those people will wait a long time because often it will mean that they will have to wait for business hours for other services to be available. That's really the only after-hours safe place for people to go...

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We haven't gone this social determinant of health care conversation but it's very hard to accommodate complex and erratic lives.

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There were a number of patient groups that staff would like to do more for, including women who are repeat presenters due to their experience of violence:

I often feel like I've not done enough to help this woman, or this man as it may be, but I generally have [more] to do with the women. They can't fathom having to try and get out of the violence, they would just prefer to go back to their partners. We have hospital social workers, we've got family liaison officer and other services in place, but that woman might take four, five or 10 episodes before you can get her out of that abusive relationship. They will not leave after they've been severely assaulted for the first time, it's partly their shame. But you always feel like you haven't done enough. How can I talk to this woman to make her understand that it's okay and not her fault, or that the children will be safe and all of that sort of stuff. That, I think, would be the biggest one that we need to improve on – it's such a big issue...

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Older Aboriginal people experiencing vulnerability was another key group:

Maybe it's just me, but I always feel for our older people. Elders in all cultures are always most vulnerable but especially older Indigenous population. One reason for that is old people generally not speaking English as a first language, so for people who are over 70 years old their English is not great. And then again because hearing isn't great as well because a lot of Indigenous people have chronic otitis media. Quite often with older people they are not actually communicating what they want or need and that just makes them exceptionally vulnerable... if you don't know how to, if you aren't aware of the culture, then you're going to struggle caring for that person.

Recommendations for improving the cultural competence of services will need to be premised on not using terms that blame Aboriginal patients, but rather to consider the systemic and interpersonal processes at play in EDs. Additional strategies covered in the literature include consultation, engagement and partnerships; effective culturally safe communication and language utilisation; creating culturally safe environments and building an Aboriginal workforce (Dwyer et al. 2011). An additional focus is on addressing the social determinants of health and addressing issues related to alcohol and other drug misuse. Other health presentations that will need to be addressed include a focus on mental health policies, procedures and practices to address the needs of Aboriginal people and provide structure to guide responses to community needs; the use of technology to support Aboriginal patients to contact family members and gain support; and the creation of a research agenda based on research gaps to promote the development, implementation and evaluation of evidence-based strategies (Aboriginal Health Policy Directorate 2018).

Issues impacting cultural safety: Staff perceptions

In 2016, ACEM undertook an integrative literature review of staff perceptions of their working environments in EDs (Johnston et al. 2016). Issues that negatively impacted staff perceptions included poor communication, a heavy workload and time pressures, and the emotional drain of working in high stress environments (ACEM 2016). These issues were similarly expressed in this study and are examined in detail here.

Staff attitudes and working conditions

Staff interviewed for the study understood the culture of the ED emerges from the dominant health system, which are difficult for people from different cultural backgrounds to traverse. They also identified that patients who did not behave favourably received different treatment and had different care experiences, and that part of the patient experience was closely associated to the experience of staff in their working environments:

> **You know, for me, like I work in an ED, but then I know society and I've grown up in that culture, and so I'm very comfortable in it. But I can see how any range of different cultures would not anticipate things that are going to happen in the way I would, or would not know how to interact with the people caring for them, such that they get a positive response back from them. I think if you do certain things, because of your cultural norms that you know say nurses the doctor might think, you seem ungrateful or you seem rude or unfriendly and, and then I think that affects your care. I think that's cultural safety but I think that's how sort of a lack of cultural safety could play out. That things that you're not even aware you're doing result in you being treated in a way that's less favourable for your health outcomes.**

I certainly have seen a lot over the years of people being treated a certain way, because of assumptions that are made about them because of certain behaviours they might exhibit that that would very much affect their care. The way they feel when they're being cared for, like they might feel not cared for or feel like an aggression towards them because of things that they unconsciously say or do that makes us react in a certain way. It's not that they didn't adopt being bad or horrible, but they're often sleep deprived during shift work, overwhelmed, maybe tired and hungry. And, and, I think, under those circumstances you use the patterns of thinking that are almost a bit primitive, so you just react to your gut instincts to things. So your gut instincts might tell you that this person is being ungrateful or being difficult or any one of those sorts of things. But you don't have the mental energy to challenge your gut instinct because you're too overworked. I think that results in kind of a mismatch whereby people are made to feel unsafe. And I think that happens a lot because often patients will say 'our nurse was so mean to me' or 'that nurse was so rude to me' or 'that doctor said this and I felt terrible'. And I think it happens all the time.

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Unfortunately, I do you believe sometimes there is an element where, if a particular patient represents numerous times, there can be a bit of a.... negative vibe from some staff. And if they happen to be the staff that are on at the time and not as sensitive to that person, I have known of patients that have walked out because of what staff have said to them. And that's a range of staff as well, which is not ideal. There are many reasons why that's happened too, you know, staff overworked and what have you on their last tether and then somebody mouths off at them, and then they say something back. That isn't necessarily appropriate. And, yeah, that's enough for them to fly [off] or [have] little niggles at patients, sort of push them to fire up a little bit, I'd hate to say. Whether it's from other patients in the waiting room as well, like I'm not saying it's all staff related, you can see that the buttons are being pushed...

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The intensity of the work was also seen to contribute to people's experience of cultural safety in EDs, with staff not so much concerned with cultural safety as saving lives. In such a highly stressful, largely hierarchical and male-dominated environment, most strategies, decisions and communication patterns were driven by, and were responding to, men's way of working in EDs.

I think at the moment, yes. I can see that working at the intensity that we do. You know, when you have 80 patients in a department that's maybe got space for 40, at three o'clock in the morning and they've been waiting for 8 to 10, 12 hours, I can see that eventually that does put a toll on you. I feel more supported here that I have been in other jobs in terms of support to maintain your work life balance, and there is pressure on you to go home on time. Rather than in the UK, where there is an expectation that you think you should stay an hour or two if there are still things that need doing. The expectation here is for you to go on time, which I think is much healthier for several reasons. Yeah, I think either the support I've had is good I think it's it works both ways you can put in a fair day's work, you get a fair day's way and you get treated fairly...

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And probably, which is why, how to say this without sounding offensive, it is a male-dominated field. I do wonder whether that's because there's so much confrontation, so much confrontation. You know you're dealing with patients and sedating them against their will and you're telling people, 'No, your mother's going to die'. And I wonder if we set men up being a bit emotionally blunted to deal with it better. I think that's changing, especially with more women coming up.

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Staff are more likely to be referred to as ‘racist’ in EDs by an increasingly younger demographic, noting that drug use and intoxication impact some staff’s attendance to their needs:

I think younger Aboriginal community members label us as being racist because we haven’t brought them through straight away. It could become quite violent in an escalated scenario, really, because we’re not giving them the care that they need. Or maybe it might be the fact that they’re not aware that you’re a category waiting your turn for a long time. You know something as simple as that. So I’m not sure if it is an issue about how long the wait will be, which they take that as that they’re not important, or we think they are not unwell or that we don’t care. Or we’re labelling them as Aboriginal so that means that we are not going to provide them with the help they need. I don’t know what their view on it is, but I think that might be part of it.

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Probably, I think that sometimes I’m prejudiced against being a white Australian and a female. I think sometimes when people come in, they’re not necessarily in a good place and will be yelling, it sounds awful, but racist taunts at me. And I think that gets people outside as well. So there is an element of that, that when Indigenous patients [are] intoxicated and needing help they don’t necessarily do the right thing by themselves to other patients. I think that that gets some people offside.

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You get some people who are more vocal about their Indigenous heritage. ‘You’re discharging [me] because I’m...’ No, I’m discharging you because we’ve assessed this person in the sense that we can’t find any significant illness or injury, and have determined you can go to your GP. ‘No, you’re sending me away because of...’ I think, no that’s not what you’re doing, you’re pulling... again I use the phrase cautiously, you’re pulling the Indigenous card out when there’s no need to do that. We’ve assessed you, we’ve treated you, and you’re abusing us because your race should be a lever for something. Again, I think that that skews our view of a population perhaps, which is unfortunate.

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Racism is described as the behaviours, practices, beliefs and prejudices that underlie avoidable and unfair inequities across groups in society based on race, ethnicity, culture and religion (Paradies et al. 2009). Although there is an emerging body of evidence about the impact of racism in the health care system, little has been written on racialised conversations between patients and non-Indigenous staff members, and culturally and linguistically diverse workers in the health care setting. What is not well understood by non-Indigenous Anglo–Australian staff members is recognising this behaviour, and that these sentiments reflect the cultural dominance in health care service delivery to Aboriginal people. In these instances, race is the organising principle underpinned by relationships of power, privilege and entitlement (Durey & Thompson 2012).

Hierarchical work environments

Staff also acknowledged that the hierarchical way of working impacted the quality of decisions, and for some of the lower level nursing staff, they felt they were unsupported in the decisions they were having to make. The workplace was also conducive to bullying and tensions could be frayed among collegial staff if self-care was not attended to. Self-care strategies are key as people’s sense of futility impacted the quality of work and the care delivered to patients. Self-care was important, although difficult to achieve, with more than a quarter of respondents stating they will be unlikely to stay in ED work full-time for any length of time, preferring a part-time position to buffer against burnout.

> **We need to please the executives and not look after the nurses; does that make sense? Nurses probably feel like they’re [at] the bottom of the pack [and] they must do what the executives want rather than what they would like to do. I’ve had deaths, I’ve had quite messy recusses at four o’clock in the morning, in an area where there’s all these people. But the person was way too unstable to move them. It was very messy. I think that as nurses we really identify with why sometimes we bring things home....**

> **... that consultant surgeon took his registrar to pieces and berated him for seven hours. And just went on and on and on and on and on. There's nothing like that today but there is still bullying. And it is getting better... I really went to bat off against the ED Consultant who was an absolute bastard. He doesn't have a job any more. So, I think it is changing. On the other hand, I can see the consultants, they have to deal with these interns who aren't necessarily very prepared for the work, and they are particularly stressed, because it is quite difficult. They are very wary of harassment claims and being accused of all kinds of stuff that's very, very, very difficult to defend yourself against. But again, it's sitting in the wider medical context... [It's] very emotionally draining; dealing with other people's shit all day is killing the people who are very unhappy. We are sometimes sick or suicidal or their family members are sick, and getting that emotional burden can be difficult, which is part of the reason I'm working part-time now.**

Given the limited number of studies on emergency care management in an Australian context, this is a gap in the research on which ACEM could lead, particularly the impact that workplace hierarchies and cultures have on the quality of services delivered, the satisfaction and professional growth of staff, protection from burnout, group cohesion and patient safety. Issues of resourcing also impacts on emergency care in Australia.

Lin et al. (2012) showed that hierarchical ED workplaces driven by a 'clan culture' (group cohesion) are overwhelmingly preferred to those driven by market or 'adhocracy' cultures in which system constraints play a role in determining patient outcomes.

> **... I think we all go in with the idea that we want to provide the care that we would want to receive, or [we would want] our family or friends... to receive. [It's] an absolutely awful battle every single day to be able to do that, because there are just a lot of constraints in the system. That trickles back to sort of financial constraints but also, I suspect, back to management constraints and just the ways that we could do things more efficiently. Probably doesn't get surfaced because people are too busy trying to manage in a job that takes all of your mental capacity just to do the job. So, we're not great at thinking of better ways to do things, and I think that's a barrier in providing good care to anyone...**

Narratives of legitimacy and worthiness

Evidence shows that emergency staff are troubled by encounters with patients who trigger moral judgments, and that these judgments can lead staff to appraise a patient's social worth and value (Hill 2010). There is scant literature on the actual prevalence and dynamics of moral judgment in health care, but it is heavily impacted on by the characteristics of the staff, patients, tasks and organisational factors. Just as there are narratives of legitimacy and worthiness in emergency medicine, there are both legitimate and illegitimate moral appraisals made in emergency settings.

Emergency medicine is primarily about establishing whether there's anything life threatening or not threatening, anything that's going to acute care and addressing those issues first. Now if I've got 80 patients in my emergency department at three o'clock in the morning, my focus is not necessarily on providing comfortable pillows, blankets, access to an AHLO, access to a chaplain, access to any type of social support. My focus is on stopping people dying overnight and identifying effective interventions if nothing is life threatening and they have something that can be managed in the community by their own GP. I need to clear them from the [emergency] department to make space for the next critical patient. So the focus in emergency medicine is slightly different–- we don't have patients there for long. We shouldn't have them there for more than four hours unless they're in a short stay environment, in which case they shouldn't be there for more than 24 hours... So, we possibly don't pay as much attention to that side of things as we could. But our focus is different. It's sifting through 80 patients in the [emergency] department and identifying the one that, if they walk out because they've gotten tired of waiting, they are going to come back in dead or is going to deteriorate rapidly in the waiting room, and identifying the ones that don't need to be there at all...

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I don't know whether it's just that I have noticed it more with Aboriginal Torres Strait Islander patients. I think it's more the more vocal patients, the more extreme mental health issues. Maybe it's the patients that are getting there and saying, I have presented here five times, you know you're not helping me. I mean we do get some Aboriginal patients that present to get a warm blanket and a sandwich, and they don't actually necessarily have what is considered emergency medicine issues going on. So, they're sort of palmed off a bit. And I don't know if that's the right sort of approach. But, I mean, I'm not the one dealing with them either so I don't know full stories there either. But I do know a couple of what's considered 'frequent flyers' that do that sort of thing...

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... a lot of patients can come by ambulance and it may or may not be an emergency that they come via the ambulance for. For example, you'll have your really sick mis-dialysis that will come by ambulance, but you also might have someone come in an ambulance at three o'clock in the morning with a boil on their on their leg, something that could have been seen by the GP during the day...

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Persistent poverty impacts people's transportation to hospital and, consequently, the reasons they present. A lack of transport to hospital is a barrier to people accessing health and wellbeing services at appropriate times during the day and contributes to the misuse of ambulance services.

> **... Obviously they've called the ambulance because it's a means of transport to get to hospitals and sometimes they have a lack of transport options. Some people are in a low socio-economic stratum and they don't have access to a car, or they don't have a license and can't drive themselves to hospital...**

> **... People don't often have money to pay for a taxi to get to the hospital and night patrol only runs from 6pm to 2am. [It's also a problem if] you haven't got a phone or mobile phone or a landline, or you managed to walk to a phone box which there are not many of anymore. Transport can be a really big barrier to actually getting to the [emergency] department, I think, or to a hospital or a clinic...**

The difficult patient is one who makes staff feel ineffective, those who do not validate clinicians' perceptions of themselves as effective professionals, who threaten their control or who create 'fruitless work' (Hill 2010).

> **And, you know, they want to feel like being good humans is doing good stuff. And so they have a real problem with cultural safety because it is about the baggage, and them being a representative of the health service of the government that we don't trust, rather than anything to do with them as a human. And they kind of work from the position, 'They don't trust me, but I'm such good human', there's this kind of disconnect...**

We do not know which combinations of patient, clinician and situational factors trigger negative moral appraisals. Without this understanding, any well-meaning advocacy of non-judgmental attitudes and patient-centred care is not likely to achieve its goals if it discourages understanding what happens in health care relationships, and actively discourages patients from attending:

> **I used to work at the major trauma centre in Adelaide, and there's always a sense that patients should come here [when] they're really sick, or if they've got major trauma, and everyone else is kind of wasting our time. And so I think patients would have felt that, you know, probably both Aboriginal and non-Aboriginal patients would have felt that sort of sense that they think I shouldn't be here. It was real.**

Narratives of belonging or not belonging in emergency care were strong, particularly for those patients who experience chronic health problems:

> **I think also [that] Indigenous people have chronic health problems, so that complicates all of their presentations. They may come in with something simple and have a blood test, and then it shows that they've got renal failure or they've got something else and then you have to sort of chase down that result. I think their chronic disease burden also means they have a longer length of stay because people are trying to do everything for them, and they don't want everything done or maybe somebody else could be doing that. But I think emergency departments kind of fall into that trap with high disease burden.**

Emergency staff on the floor were also making judgments to ensure that people with different needs could be seen:

> **If I have an Aboriginal patient, I can see that they are just fed up. Personally, I will go and have a conversation [with them to] try and facilitate stuff happening. And people in the waiting room interpret that as jumping the gun, [as in] why are you seeing that person? Why are you seeing them? But it's also an acknowledgment of people's abilities...**
> **I'm gonna go and see the very small child because it's 11 o'clock at night and probably being in an emergency department is not what you need when you are a baby. It isn't great for the baby or their family. So, we try to prioritise, you know? It's that 'whole people' abilities and context [that] affects engagement, [and] to me that's the bottom line. So, if I can try and do stuff that makes people's engagement with the system benefit them, because I hear they have an issue I might be able to help with... then I will do that.**

Staff advocated for Aboriginal people to be working in EDs, despite a genuine concern that the experience of Aboriginal people in emergency care is complicated. Aboriginal health advocates, Aboriginal patients and emergency staff all asked for this to occur as a matter of urgency.

Limited access to Aboriginal staff and an Aboriginal workforce

The invisibility of Aboriginal staff in the ED is overwhelming. There are no Aboriginal people in the ED as volunteers, peers, occupational therapists, social workers, on mental health response teams, and seldom as health professionals; nor are they visible at the time of discharge. The AHLO and Aboriginal Health Program Managers interviewed in this study stated that they have multiple patients in the different hospital locations for which they are responsible, that they are sole practitioners even in a region with large populations of Aboriginal people, and that they are rarely called to the ED to support the team with an Aboriginal patient. In other hospitals, when Aboriginal people are called to ED their own work gets pushed aside, which means they must find additional, often out-of-work, hours to complete all tasks required of them. Having Aboriginal and Torres Strait Islander frontline workers across pre-ED and ED services, perhaps supported by two-way 'buddy' arrangements, will be critical in the development of cultural safety.

… It would be an Aboriginal health practitioner or two, that were in the [emergency] department and worked alongside us to correct what we do wrong to pick out what we don't even know isn't appropriate to communicate with the patients that just don't want to talk to us. I feel like that's a massive gap for us. Like 90% of our clientele are Indigenous, and you have three white fellows in their face when they're in crisis, or they're having a particular mental health crisis. They don't want to be talking to someone that doesn't understand them, and they want to be able to talk in their own language…

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… so long as people didn't lose access to the variety of Aboriginal health workers in the hospital, but having some Indigenous health staff in the [emergency] department might help us be better engaged with that group…

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… Having Indigenous health workers more embedded in the [emergency] department, rather than being a hospital resource that we can call upon in certain hours at certain… would be a great thing. I think that with the local context… the practical problem there is with the multiple language groups. The current system doesn't mean that, you know, because it's a hospital-wide service. There are multiple people covering multiple language groups, there are men and women, which is also important there at all times…

Staff also noted that once an Aboriginal person is a professional and working in the industry, their original love of 'what they wanted to do' turns into people not 'living their dream'. Aboriginal staff are being used by hospital services as 'recruiters' to gain more employees to meet their employment targets, noting that this approach impacts on people's professional career and choice:

> **It was in 2013 I met an Indigenous student who wanted to nurse, to work in a ward and look after people. But before he even qualified, he was being pressured and pushed into getting into like a HR recruitment role to get more staff. He was like, 'I'm just being forced out of nursing and I'm being pushed into roles that I don't want to do'. We do not listen well to our Aboriginal staff, we kind of push them into recruitment roles before they even qualify.**

Aboriginal staff employed on hospital grounds acknowledge that ED staff are trying to provide solutions that are not meeting deeper needs in the community, noting the mismatch between clinical training and social need:

> **We get trained in white medicine and we try and influence Indigenous health with white man medicine and that doesn't work for us all the time. It doesn't work for us. We've gotten good at twisting who we are and changing what we do. We do this, and we are trying to get Aboriginal health workers into the emergency department and the hospitals as well. Will that help cultural safety?**

Access to Aboriginal and Torres Strait Islander staff, night shelters and/or resources (interpreter services) and transportation services to safe and secure accommodation across all shifts was also acknowledged as an important resource, which is currently constrained by finances and qualification:

> **... I've worked quite a few night shifts in the last couple of weeks. I've been calling the AHLOs, the interpreter services continuously with no answer so it goes to message bank, and then we're stuck with people that would have a place a nice place for them to go, but we can't get them there... We're trying to get taxi vouchers, which is something that we sort of can give away. Often, transport to safety becomes a challenge and then we have some people [who] unfortunately have to sit in the waiting room overnight... It's quite cold and miserable and [they] have to sometimes just wait for sunlight to come up to be able to get home because unfortunately we don't have the bed capacity.**

Lack of Aboriginal staff has also impacted end-of-life care for Aboriginal patients, particularly where language comprehension and lack of access to interpreters can delay attending to critical times.

> **... It's horrendous to have to delay that [dying] for six hours to wait until the morning. And then cross your fingers and hope that that you can either contact family or friends or an AHLO. Again... even though to a certain extent it's okay, it just comes down to like consultant decisions. But it ideally should involve patients and family, absolutely should involve them in understanding and providing consent.**

Aboriginal staff can also provide social and emotional wellbeing support services to allow patients to be patients:

> **I think there's probably more work that we could do to arrange for, like if it was dependants at home, being able to arrange for people to care for them so that the person going to hospital doesn't feel that pain or rush back home. There's probably more work that we could do in a pre-hospital space.**

The calls for more First Nations' staff in EDs is consistent with ACEM's submission to the My Life, My Lead consultations (Australian Government 2017), in which the Chair of ACEM's RAP Reference Group, Dr Elizabeth Mowatt, advocated for an increase in Aboriginal and Torres Strait Islander staff, more effective Cultural Safety Training for non-Indigenous staff, and better engagement with both Aboriginal and community organisations in the regions, particularly where there is a higher population of First Nations' peoples and a greater proportion of them attending EDs. She also called for emergency rooms to 'become part of their local communities' and to develop 'relationships with local Aboriginal medical centres that would benefit patients' (Barrass 2017).

Limited engagement with community: Siloed practice

Generally speaking, staff interviewed for the project said there was no regular contact between staff in EDs and community organisations, nor any forum where EDs could receive feedback from stakeholder meetings at a regional level. Many stated that they worked in silos, but that there were strong relationships with agencies involved in through care or aftercare arrangements.

The catchment areas for ED services is extremely large and it is difficult for staff to know much about the circumstances and environment to which Aboriginal patients are returning to on discharge. For example, discharging patients from ED to remote areas with advice that they need to present again the week afterward is not practical; and yet these types of discharge practices regularly occur and are often conducted by people with limited Cultural Safety Training.

> **Trying to ensure continuity of care from pre-hospital space to hospital space is a challenge anywhere. It comes down to the fact that we probably don't ask enough questions about what kind of resources the hospital has. So, because we don't ask, we don't have a good awareness of what the hospital has to offer. People that are culturally and linguistically diverse have certain needs that we can't relate to. We probably don't ask for support or advice as often as we should, and we're not able to advocate for patients having access because we're ignorant to what they can access, which is not good enough.**

Categories 1–2 presentations require emergency medical interventions including the pre-ED experience. Greater attention could be paid to developing relationships and holding regular forums to develop culturally safe transitional services. Managing presentations who are determined to fall between Categories 3–5 will require a different approach, as many of the clinical presentations are premised on social or cultural determinants of health that have not been met.

Internationally, EDs are developing a disciplinary framework to enable Social Emergency Care practitioners to incorporate the social environments and circumstances into ED management practices and strategy (Tam & Targonsky 2020). The literature states clearly that most emergency workers are drawn toward trauma, acuity and procedures (Lipp 2020). Certainly, the current medicalised chain of command strategy in a stressful, chaotic environment is appropriate for Categories 1–2 presentations, but people presenting with ailments in Categories 3–5 require a different focus. In asking participants in this study about the changes they have seen in presentations, many attributed them to the experience of drug and alcohol misuse, intergenerational experiences of poverty, homelessness, mental health and violence (ACEM 2018). All of these produce a different form of trauma for Aboriginal and Torres Strait Islander Australians, one which is embodied in different ways and across generations, and requires a new approach.

ACEM Social Emergency Care: A new focus for investment

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Most of the presentations that I see within the Indigenous ED presentations tend to be disproportionately skewed towards drug and alcohol and mental health [issues].

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Particularly in Nowra, there's a 10-hour, 12-hour wait to see mental health nurses. Lots of patients go home, lots and lots of discharges there.

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I don't have insight to what happens, after we get people over to ED, but we certainly pick up a lot of people who leave hospital and then call back because they still feel rubbish or whatever the case may be... everything is multi-faceted and I think people end up waiting a long time. My inkling is sometimes people are probably under-triaged because they're a frequent presenter, or so people just look at them and go, 'Oh, they can wait'. A lot of people, not just Aboriginal Torres Strait Islander, but a lot of people present to ED for reasons that are not just medical. So like social reasons, particularly at night when there's nowhere safe to go and the hospital is essentially just like a safe refuge. So those people will wait a long time because often it will mean that they will have to wait for business hours for other services to be available.

... particularly in the sort of unsavoury hours, people present for more social reasons and they're not going to get seen straightaway. But I wouldn't discount the potential for there to be some level of, particularly somebody who's a frequent presenter, saying, 'Oh, that's just Jackie they can wait'.

Less adrenaline-producing, but just as important as traumatology, is the role of emergency workers in addressing social and cultural determinants of health and wellbeing (Lipp 2020). In an Australian context, ED presentations among Aboriginal and Torres Strait Islander people is inversely related to household income (AIHW 2019a) and other social determinants of health that have not been met. Among staff, persistent poverty is recognised as a key driver for presentations:

> **A lot of families do not have access to functioning cars, or their family member has borrowed the car and this impacts on access to ED...**

> **With mis-dialysis, some patients are out visiting family, or they have sorry business and then they are not able to get back into town, so transportation is a critical issue...**

> **Differences in being town based and regionally or remote area based [mean that] out of towners need safe accommodation. If it is not hospital then that is difficult...**

> **People get an ambulance to get closer to town, to where they go. When they arrive, they literally get out of the ambulance, walk through the waiting room walk down the steps and carry on walking because they needed to get to town. And that's not uncommon.**

Although there has been some movement toward addressing this issue through enhanced Cultural Safety Training, we propose that a new disciplinary focus within ACEM is necessary and timely.

Social Emergency Care recognises the unique position of emergency departments, which regularly provide safety nets for the health care system and act as a haven for some members of the community. Stanford Medical School has introduced Social Emergency Medicine as a discipline to 'use the perspective of the ED to investigate societal patterns of health inequity, identify social needs contributing to disease and develop solutions to decrease hospital disparities for vulnerable populations' (Stanford Medicine 2020).

Structured as a one-year program and supported by a Social Emergency Medicine Fellowship, the goals of Stanford's Social Emergency Medicine degree include:

— To conduct and disseminate rigorous, ground-breaking research to identify health disparities and the role and impact of social determinants in emergency medicine.

— To create innovative educational programming for students, residents, attendings and ancillary staff to stimulate discussion and collaboration in Social Emergency Care.

— To design and study novel ED-based interventions that confront the social determinants of health, with a particular focus on community service and engagement (Stanford Medicine 2020).

Social Emergency Care embraces the dual role of the EDs in acute care and population health (Anderson, Hsieh & Alter 2016), with literature noting the relationships between society and health, and the socio-economic and racial/health disparities in health status and health care. Emergency medicine, perhaps more than any other discipline in medicine, is 'enmeshed in the mores and practices of its immediate community as well as the social and regulatory milieu' (Levitt Center 2020). In the US, the Andrew Levitt Center for Social Emergency Medicine has been established to expand our understanding of the interplay between social forces and health in the ED. The purpose of the Centre is to provide long-lasting improvements in health equity and in responding to changes in population health, to develop interventions to reduce health crises, and to decompress overburdened EDs (Levitt Center 2020).

Recent literature reviews found a high prevalence of material need among patients in several ED studies (Malecha et al. 2018), and a strong association between social determinants of health and the utilisation of EDs (Kersten et al. 2018). The literature also identifies that the social risks of an individual may not align with their social needs, which has 'ramifications for policy, research, risk stratification and payment and for the measurement of healthcare quality' (Samuels-Kalow et al. 2020).

At ACEM's last conference, participants could sense the emergence of a new practice in emergency medicine because of the amount of time given to exploring 'social issues'. This was problematic for emergency physicians who wanted to discuss advancements in traumatology:

> **It's so much not what we're trained in as doctors. There is still this hierarchy about training you know, [whether] it's very technical training or it's to do with new technology or new equipment, that sort of really 'sexy' stuff. But if it's about how to treat people like human beings, it's almost like all the 'soft' stuff [and] that's not very important, which I think is very sad because that's the stuff I find really interesting. Like at one of our conferences there were a lot of people complaining that there just wasn't enough proper medicine discussed. It was too touchy-feely, there was a lot of discontent.**

Others interviewed in the study wanted to focus on Social Emergency Care, but did not know how to refer to it as a discipline:

I don't think it's a simple solution, it's kind of about empathy and it's about being able to walk a mile in someone else's boots. I think a lot of people in their lifetime might never get their head around what racial discrimination is, especially [when] you experience it every day...

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… Valuing patients' time, which I absolutely think is important. But I have been involved on more than one occasion with patients who are vulnerable, who have multifactorial, complex social issues. It feels like the whole hospital washes their hands of them because it's too hard. I'm saying you're left with this person that you're trying to advocate for because you know they're not safe and you know they can't go home. Equally, they cannot sit in your emergency department for the next however long it's gonna take to find an appropriate social placement.

I've been really shocked at the way the system has closed and gone, 'Well, it's too hard to try and figure out how we can manage that really complex group of patients who can't be discharged but really, there isn't there isn't an acute medical issue'. But social services aren't going to come to the party right now. We need a sensible pathway… I feel like this is a recurrent theme, and I think a significant portion of Aboriginal Torres Strait Islander people, who have significant social issues, face significant barriers in terms of their ongoing care… [We need to] start facilitating some straightforward pathways towards admission to safe social care, to crisis housing to whatever, without having to keep people in ED for ridiculous amounts of time, including a lot of mental health patients who stay in the waiting room for days…

I think clinicians need to try and give patients time to speak, to express their wishes and expectations of what a clinical interaction is likely to achieve, and the more we can try and achieve that within our working constraints [the better]. And [that] usually works better when multi-disciplinary supports, in terms of social supports and liaison officers, [are in place and] we can delegate things to other people to assist us much more. Because I tend to be very stretched thin as a consultant within ED, as regards the amount of time I can dedicate to a single individual on a prospective basis. It's just not always possible…

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Social determinants-related referral pathways were front of mind for some staff interviewed, who wanted stronger and more effective relationships with other organisations, or for EDs to develop closer local and regional ties:

So, the frustration comes out of the fact that you can tell nurses [that things aren't good for you], and they are going, 'Your leg's not amputated, you're not suffering cardiac issues, this should be dealt with in another environment to take away some of the strain on the emergency department'.

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We need a better set up. Like, I believe they need the blankets, they need the sandwiches. There is a reason behind that, and maybe there's mental health issues behind all that, that they need support for, but it's not necessarily an emergency in one sense. It's in a different sense, you know what I mean? I'm not saying it's not important because it very much is. I've heard nurses say, 'If we give them a sandwich it's just going to encourage them to come back'. And that has happened to me, that horrible term 'frequent flyers'. They know they can come get a sandwich, they can come get a drink, so they've come back. And like the nurses that have been on night after night and they keep seeing the same patient come back around dinnertime for the sandwich and what have you. They're getting frustrated with that because they are trying to see the patients that desperately need [help] for the immediate issue that's going on, but they've got these long-term issues that keep presenting. So I can see both sides, it's a hard situation. What is the answer and who funds it?

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I don't think we're addressing their fundamental needs. It might be addressing pain relief, but that's about all that addresses, it doesn't really address anything else. If every ED had more Aboriginal health practitioners, just even an Aboriginal health worker that could be in every emergency department on every shift and work through the issues for people there and then...

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As a group, emergency staff advocated for the following approaches to be developed to enhance their care of patients presenting in Categories 1 and 2:

— Use plant-based medicines to complement non-Indigenous medication

> **... There's lots of interesting medicines and plant-based medicines that people use... it's an interesting field but I don't think it's really recognised when Aboriginal people come to the hospital. They are relying on our health care.**

— Spend time with clients so they can better identify themselves to patients who might not have the language to express what they're feeling, and also identify strategies to promote holistic care in ED settings.

— Introduce Aboriginal access workers to explain, advocate and facilitate appropriate referral pathways so that the patients feel more control.

> **It's obviously a massive shift on so many levels really, because what I think about hospitals in general is they are created for the ease of the doctor, not for the ease of the patient. It's all just so siloed and just so hierarchical – even for someone who is highly educated, very privileged – to advocate effectively for themselves is so difficult.**

— Try different models of triage and care, including Triage and Treat, Team Triage and employ an Aboriginal workforce.

> **... if the system is running as it should, these specific cultural differences are less likely to be exposed. If everyone is seen within 25 or 30 minutes and if you had an Aboriginal health worker that was there to make contact with people at the front desk, or was stationed in the [emergency] department or working as part of the triage process, then maybe there would be less patients leaving. And if they did make noises about leaving or if they were seen to be wandering out... maybe they could intervene at that stage and just try to kind of convince them to stay.**

- Introduce training strategies and identify alternative referral pathways to accommodate people with mental health issues including psychosis.

> **How to deal with someone that's psychotic? Some of the interns don't know because no one has told them how to deal with these patients. I think that's probably slowly changing. A lot of the medical training is done by people in their 50s and 60s and there's a big cultural and generational difference there and a difference in the practice of medicine. It's changing slowly, it's just that medicine lags.**

- Address issues of multigenerational poverty and welfare dependency that impact on mental health and other presentations.

> **A lot of these mental health cases we deal with, the patient didn't have a job, lived in unstable social situations and so on. That's an incredibly hard cycle to break. There is a big thing about intergenerational poverty, [which is] probably driving a lot of it. Mental health services of Nowra are completely overwhelmed. Yeah, it's just the lack of mental health nurses, [and] whether it's worth training doctors to deal with these presentations. There's money in the system. Is this the best way of spending it? I'm not sure.**

- Introduce different ways of catering for correctional facilities prisoner needs in emergency care.

> **We have a whole lot of prisoners come into the ED in their prison gear and in handcuffs with police or with security. They have to wait in the same area as other people and it can be overwhelming for everyone. We need a different place for them to wait, or a different place to be seen…**

- Advocate for doctors to start bulk billing again, particularly on the weekend and public holidays.

> **That is a big problem down our way when we have the holiday seasons, we triple our population because of people coming to visit so that triples our workload. We try and have clinics, if there are minor injuries and things like that which can be seen to, that's on public holidays and long weekends. That's the only thing that I can see that if doctors were opened on weekends and public holidays, and a lot more of the bulk billing could get done. That's one of the reasons why we get a lot of people coming into the ED, because they can't afford to see the doctors and all the doctors are closed.**

- Make space for compassionate care in EDs.

> **I would just like to see a more understanding compassionate workforce really. Cultural Safety Training I think is useful and has its place, but I don't know how to actually make people engage with that on [a] level that changes their own beliefs.**

- Work to improve health literacy among patients.

> **When you come from a different background, the ED experience is probably amplified. [It's also] compounded perhaps with poor health literacy, [which means that] you might not [understand] the role of the emergency department and how the triage system works. So if you come in for a condition that is deemed to be non-urgent, you know, if you're Category 5 on the list, then you might not be seen for six hours of so…**

- Develop a series of TV advertisements with Indigenous TV and other mediums to advertise the experience of turning up to an ED. This will help people to prepare for, and overcome their fear of, just how confronting the experience can be. These advertisements could explain the triage Categories 1–5 (high to low), the physical environment of the ED and the stages you go through, including triage. We might also need a series that explicitly talks about the new COVID zones.
- Incorporate cultural safety trials in accredited hospital settings, including 24-hour access to interpreter services and Aboriginal Hospital Liaison Officers who might be specifically attached to emergency services. Also ensure that both men and women AHLOs are available all the time, and provide Cultural Safety Training to the security guards.
- Support the indigenisation of the emergency workforce. The College could consider:
  - Advocating for AHLOs in EDs (extend shift work opportunities).
  - Piloting the development of Emergency Professional Certificate courses, in liaison with the relevant Associations, for Aboriginal and Torres Strait Islander social workers, allied health staff, health workers, nurses and medical officers.
  - Sponsoring the training of community-based peer researchers to undertake household surveys with community people to ascertain the quality and suitability of services, with a focus on accredited EDs.

> **… We have them [Aboriginal and Torres Strait Islander staff] and we just want them a bit more hands on and a bit more clinical. We would really like that, but it's an all-encompassing subject and I don't know where it starts and ends, to be honest…**

- Advocate for increased access to interpreter services.

> **The AHLOs have taken on a lot of that work, but they're only here from 8.00 a.m. till 4.30 p.m. After hours and on weekends you can sometimes get an interpreter by phone for the client, but it's hard when a lot of the communication is body language, hand gestures and it's just, it's just more than it sounds.**

- Ensure access to CTG retrieval numbers so patients can get scripts filled from the ED or hospital pharmacy.

> **No, I haven't seen them, whether other people have I don't know, I haven't. I don't think we have the system. One thing, obviously scripts [from] hospitals you don't get to see CTG on. Okay, so you have to get to see CTG from the GP. And a lot of our patients [are] like, 'Oh, I am a CTG', but because we don't have the approval number, they have to go to the GP to get there CTG on the. That's kind of one thing because they do get a bit. So some of them go, 'No, I can't afford it, I've got the CTG.' And you're like, 'That's fine'. I get it but we don't put them on hospital scripts. Yeah, that's one thing that I found.**

Piloting different models of care

Staff recognised they have an important role to play in addressing social determinants of health. This largely comes from necessity as the number of vulnerable patients seeking refuge in EDs increases. Emergency medicine as it is currently structured in Australia works well for Categories 1–2, but not so well for Categories 3–5. As a consequence of this, staff are already trialling projects to address social health issues in the context of the ED, with some of these projects listed here:

— Undertake reviews to develop boutique management plans.

> **But one of the things I think we need to [have] developed in focus groups, where they have some kind of regular meetings. Now we're setting up what we refer to as our recurrent attender, or frequent flyer review groups. And what we've done is taken our top 20 frequent flyers, and our frequent attenders just trying to look up everything and develop a bespoke care plan to address their specific needs. This is a very fresh, very new project. If any of those who are [from an] Aboriginal Torres Strait background, I could bring in the AHLO and say, 'This is what we're faced with, this is our proposed management plan', and ask for their input to say, 'Is this actually going to fit? Does this suit? Is this going to work?'**

— Provide a door-to-door service.

> **Community-controlled services from South Australia support their patients to access culturally safe services and make sure people get back home again. Even if people have to travel to Adelaide, there is a bus so everyone is comfortable and supported on their way to hospital. Maybe we could work with other services to create a door-to-door service experience?**

— Have timely reviews of through care.

> **And that's probably where I changed my practice in probably taking a little bit more time to actually [ask], 'How are we going to get you to this appointment' or I make sure I've done appropriate education...**

— Engage Aboriginal Health Workers in EDs in the evenings.

> **So there is a general practice, just across a little roadway from our ED, for Aboriginal and Torres Strait Islander people. And they've got some funding to have some Aboriginal health workers in our ED in the evening to try and engage with people, to reduce the number of Aboriginal people that do not wait...**

Desirable pilot programs that people want to trial include developing an Indigenous Healthline and promoting local and regional cultural practices at the ED like smoking ceremonies, having Elders visit and trialling bush medicine:

What might be useful is a lot of Aboriginal or Indigenous Healthlines that they can ring rather than having to come into hospital by ambulance for an opinion. That might be helpful...

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Well, like I said in my study that I've recently done, being aware of smoking ceremonies and things like that, whether the Aboriginal [Hospital] Liaison Officer can help staff have more of an awareness of those sorts of things. I don't know how you would have a smoking ceremony in a hospital with the smoke detectors and other things to consider in that... There's Aboriginal people out there that still use bush medicine to try to heal themselves, and for them to have to come off Country and coming to the mainstream medicine, it's such an unknown for them. I can't speak from experience but I imagine that would be very scary.

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Conclusion

Major theme 1: Growing the Aboriginal and Torres Strait Islander workforce in EDs

An overwhelming number of respondents in this study identified the presence of Aboriginal and Torres Strait Islander staff in ED as enhancing their ability to implement a cultural safety environment. As similarly identified by Aboriginal respondents, Aboriginal staff such as Aboriginal Hospital Liaison Officers play a critical and valued role in cultural care for Aboriginal patients in ED:

> **… you know because it's that visual, especially for Aboriginal people coming into the place and they can actually say that there's other Aboriginal people there too that actually helps create safeness… like a physical presence. And that's where [the AHLO is] great because I've actually got her number too if I feel that she needs to come and see someone. If someone else hasn't called her already, [as] people are quite onto it. You know, to just let her know that someone's there and that they're needing, probably need to see her. She is throughout the hospital but she's a wonderful resource.**

Despite recognising the important role that access to Aboriginal and Torres Strait Islander staff plays in culturally safe care to First Nations' patients, there is a visible lack of these staff working in ED. Aboriginal Hospital Liaison Officers, like those interviewed in this study, are employed to support First Nations' patients throughout the entire hospital system, and are often the only AHLO in the hospital. This means they seldom have time to report to the ED, as they are under-resourced and having to work outside of work hours to keep up with the workload placed on them:

I guess I sometimes worry about whether there are deficiencies in the service out of hours, … and do this group get a better service during the day when we do have an AHLO available. Or do they get a diluted or secondary service when there's not an AHLO available. I guess I would imagine [she] is the only Aboriginal [Hospital] Liaison officer we have, [so] I think she's under-resourced. I would love to see her sort of coming into departments and have to check on things rather than relying on us to make the referrals…

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I would say the majority of the time, the AHLOs are only contacted and asked to be involved when there's a problem that's, you know, an issue. So, for example, there's a patient that's wanting to discharge themselves when they've got a serious medical problem or there's a specific issue with family or kids or whatever it is that they need help [with].

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In our ED now we have an Aboriginal Liaison [Officer]. I think it's really good… but I think we fall down quite a bit when we've only got one in the hospital and she only works, mostly, between business hours. I mean she is on call as well [but the] majority of the time it's just business hours for her. I've noticed when we do have Aboriginal people come in that their stay in emergency or they visit in the ED is made a lot smoother when, they are in contact with our Liaison Officer. Like she just comes down to know what's going on, and sometimes explains medical terminology, [which makes it] a little bit easier for us. I think it's a really good initiative. She is just not there enough.

ED is the first point of contact for an Aboriginal and Torres Strait Islander person coming to the hospital, and many respondents identified the comfort they would feel if they saw a ‘friendly’ Aboriginal face when entering. Aboriginal staff can provide cultural supervision to non-Indigenous staff who otherwise learn culturally safe practices through trial and error, either through providing cultural advice where requested or through a formal or informal two-way buddy system.

An Aboriginal workforce in EDs is vital to facilitating culturally safe interactions between the culture of the ED environment, and the cultural needs of Aboriginal clients, their families and communities. As already mentioned, miscommunication or miscomprehension can have serious consequences in the treatment of Aboriginal and Torres strait Islander people in critical care, especially in cases of end-of -life care (Kaufert 1999). Patients experiencing shame can lead to misinterpretation or misdiagnose by the practitioners, or result in patients leaving without receiving treatment in order to avoid culturally inappropriate interactions (Canuto et al. 2018). As identified previously, miscommunication can not only have serious health consequences in the treatment of Aboriginal and Torres Strait Islander people in critical care and follow up care, it can also have legal implications such as issues around adequate consent to treatment. Aboriginal staff can play a key role supporting non-Indigenous staff with common communication and comprehension issues which can be caused by culturally inappropriate interactions and differing patterns of communication, such as the direct, highly instructional, site specific and time-sensitive language often used by ED physicians. This is not to say Aboriginal staff such as AHLOs should be expected to provide interpreter services to patients in the ED environment; instead there should be serious consideration of the employment of interpreters for the key First Nations’ languages within the region.

Increased employment of Aboriginal staff aligns with ACEM’s call for more First Nations’ staff especially in regions with larger First Nations’ populations. An increase in Aboriginal staff could not only assist in shifting the racialised health care with ED, but could also provide support to existing Aboriginal ED staff, some of whom when interviewed for this study reported disrespectful and unsafe interactions with non-Indigenous staff:

I think my bosses wouldn’t allow it to happen to us or nothing but some staff members are set in their ways and aren’t so culturally sensitive. An example I can give you is reconciliation week the other month. I was wearing a badge to do with that and a nurse asked we what it was, so I explained what it was and she just laughed in my face. So I just I don’t think, it’s like everyone has their own opinion and I respect that, but there are some staff members, I guess, that aren’t so culturally sensitive.

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But then I started realising that people who identify as Aboriginal or Torres Strait, it’s not just that straightforward. So, for example, I’ve got two individuals who work in my department who, when I was chatting to them, one of them talked about his big family. And he says, ‘Well, you know he says it’s because of my Aboriginal family’, and I said, ‘Oh my god, I never would have [guessed]’, because he was, this is going to sound almost stereotyped, but he was red haired [and] freckled. I said, ‘I have to be honest with ya, I would have never have [picked that]’. [It was] really an eye opener for me. I was a little bit disappointed and upset by my naivety.

* * *

Aboriginal staff can also play a key role in identifying any incongruities between community needs and ED staff solutions stemming from their clinical training, as well as providing necessary conduits to the community for further engagement. The employment of Aboriginal access workers could provide the service of explaining, advocating and facilitating appropriate referral pathways to patients so they feel more in control and increases the likelihood of improved health outcomes and follow up, following discharge. Increased engagement with local Aboriginal Medical Service (AMS) and community organisations (See Major Theme 4) could lead to EDs requesting Aboriginal Health Workers to do evening shifts in the ED:

> **At that stage, they want to discharge against medical advice well obviously it's entirely their choice to do so. But from a medical point of view, anything that can be done to try to bring that patient around for their own safe, Safety and Health should be done. And that's also that's probably one of those occasions when I've used the AHLO more often. Someone that's close on hand, or even if you if you know that the patient's going to leave, regardless what you say having someone see them in the community or at least make a referral to someone else to follow them up and get them, get them follow up at the AMS is probably a useful thing to have.**

As a valuable asset to the triage team, Aboriginal Health Workers can, with input from experienced doctors, also facilitate Aboriginal patients requiring access to services in Categories 3–5 as well as assign access to ED-based Aboriginal practitioners when required. This is where the new approach to Social Emergency Care can provide social prescribing alternative triages with Aboriginal and Torres Strait Islander staff at the forefront of its implementation.

Major theme 2: Social Emergency Care

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The internationally recognised and implemented discipline of Social Emergency Care covers the interaction of population health and the social determinants of health in determining health inequity within a society, while also identifying the systematic change required to reduce this inequality (Anderson, Hsieh & Alter 2016). This is particularly relevant when addressing the number of Aboriginal and Torres Strait Islander people presenting to EDs with health issues classed as Categories 3–5, and the strong correlation between social determinants of health and the utilisation of EDs (Kersten et al. 2018). Although EDs work well for Categories 1–2, the current system's lack of a holistic view of health does not do well for those presenting with health concerns classed as Categories 3–5.

Some Aboriginal respondents noticed ED staff's frustration and assessment of a patient's 'worthiness' in cases where they presented for minor or routine complaints that could be treated outside of the ED (Ekebergh, Elmqvist & Fridlund 2012). Similarly, ED staff respondents reported the same frustrations of sub-acute presentations by patients, indicating that the ED was for traumatology not Categories 3–5, which should be treated outside of the ED. Narratives of belonging or not belonging in the ED are evident and observed by both service-users and service-providers in this study:

> **… I don't want to say they didn't care – but I was just sort of left there and they knew I wasn't well and in a lot of pain. I know doctors know what they are doing but, because I have a chronic illness, I know myself very well and the fact the two teams were arguing about whether I was going to be admitted or not made me feel very uncomfortable. But I was too sick to leave…**

Yeah, like the easiest form of medicine to deal with is acute medicine. Someone has a heart attack, good basic essential. So that's a really, really interesting problem-solving aspect to it. The difficult part of medicine is the chronic aspect which you're probably more interested in, which we don't have a good handle on. So I do have this like really nice problem-solving aspect.

> **There's a big problem here, I mean as a society here, we're not going around this the right way. I think that there needs to be diversions away from the ED. I think that making the ED a comfortable place for anyone is a fuckin, a really bad idea. ED is really well set up to deal with heart attacks, it's not really set up to deal with sub-acute presentations. Whether you can divert people, for example, to the AMS, and whether that's worth [it], that's a better idea, because clearly ED is an uncomfortable place. And if... you've got a bunch of people who don't want to wait, it's set up for that. The chairs are uncomfortable, the waiting room is full of nut cases. Things are loud, you're uncomfortable yourself. You want to go home. The problem is that the more comfortable you make it, the more people as a whole, as a society will turn up and be seen, and the more expensive that is. Whether or not this is been a diversionary thing because of cultural safety, I'm not sure.**

Although some staff recognise the need for EDs to address the social determinants of health, particularly given the increase of vulnerable patients seeking sanctuary in EDs, there appears to be a lack of understanding both of the influence these determinants can have on Aboriginal and Torres Strait Islander people's health, and of the correlation that cultural identify and connection have with their health and wellbeing (Kingsley et al. 2018). The Lowitja Institute defines cultural determinants of health as 'a strength-based perspective, acknowledging that stronger connection to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience' (Lowitja Institute 2014:2). Social determinants such as low household income, intergenerational trauma, imbalanced power relationships, and systemised and institutional racism, has been determined to contribute to lower health outcomes for Aboriginal and Torres Strait Islander people (Henderson et al. 2007; AIHW 2019b).

We propose a new disciplinary focus on Social Emergency Care within ACEM, one which incorporates into ED management practices and strategy an understanding of a patient's social contexts (Lipp 2020; Tam & Targonsky 2020). Social Emergency Care is an internationally implemented framework that aims to address those presenting to ED with health issues in Categories 3–5. Influenced by the effects of the social and cultural determinants on Aboriginal patients' health, the discipline of Social Emergency Care could be introduced by ACEM to examine and identify factors and patterns that lead to poorer health outcomes and societal inequity, and to develop strategies and approaches that address the socio-economic and health disparities in health care (Stanford Medicine 2020; Anderson, Hsieh & Alter 2016).

Social Emergency Care recognises the unique position that the ED holds in the wider health care system as a safety net for many vulnerable people within the community. Thus, the study of Social Emergency Care could examine and address the issues that lead to Aboriginal and Torres Strait Islander patients accessing ED as a sanctuary and not as a service. This could be achieved through educational programs and curriculum in social emergency care, a research agenda that focuses on research into the impact health disparities have on the number of ED Categories 3–5 presentations, and implementing interventions related to the impacts of the social determinants of health within EDs (Stanford Medicine 2020). The Social Emergency Care discipline could also lead training strategies and identify alternative referral pathways to accommodate people with mental health issues including psychosis.

Curriculum developed by ACEM for a year-long Social Emergency Care Practitioner Certificate could address the social and cultural determinants of Aboriginal (and other) people's ED presentations through core modules, project-based activities and a community of practice approach. The accredited Social Emergency Care Practitioner Certificate course could capture various subjects to reflect the needs of different workers within and outside the ED – e.g. Aboriginal Health Workers, nurses and doctors, allied health and social worker staff, ambulance paramedics, specialists and other professionals – who play a role in the health journey of First Nations' patients. Aboriginal and Torres Strait Islander-led local, regional, State and national action research projects could be undertaken in collaboration with graduates of the Social Emergency Care Practitioner Certificate, which can lead to evidence-based pilot programs.

Programs stemming out of Social Emergency Care could support already established pilot projects that aim to address social health issues in the context of the ED, such as developing an Indigenous health Helpline and promoting local and regional cultural practices in the ED like smoking ceremonies and Elder visits.

Major theme 3: Cultural Safety Training

Overwhelmingly, improved cultural safety for Aboriginal and Torres Strait Islander people presenting to EDs – which can only be determined as occurring when a patient identifies their experience as being culturally safe – is needed. Current gaps in knowledge regarding how to implement cultural safety by ED physicians result in a lack of trust and rapport between practitioners and patients, which can lead to patient disempowerment and suspicion toward health care services (Burnette & Kickett 2009a). Respondents in this study reported that learning how to interact with Aboriginal patients in a culturally safe way was often done on the job by trial and error:

> **Yes, and I think in my experience that people... I speak to about this [are worried that] a lot of it has been through trial and error, which is not really ideal right? Like... [with] patient care... [it's] me coming to terms with, becoming aware of, my own internal biases. And prejudiced assumptions that I make and that I have and that I've tried to work on. A lot of that learning has come from, like fucking up.**

For me it [cultural safety] is part of a much broader area of emergency medicine, or medicine as a whole, that we're really not talking about how to relate to patients. We don't get taught any of [this]; people tend to pick [it] up the hard way.

For training and education to address the barriers to cultural safety evident in the EDs identified in this study, Cultural Safety Training will need to cover the following factors.

Overview of historical factors

These may contribute to Aboriginal patients' ED presentations as well as provide the context as to why a singular racial group is privileged over other culturally diverse groups. This study found that this factor to be particularly important for ED staff who did not grow up in Australia.

Trauma-informed care

Cultural Safety Training should cover trauma-informed care, the impact that complex intergenerational trauma can have on a patient's health and access to health services, and the varying understandings and experiences of traumatology from those who may embody trauma. Training could also include discussion around the narratives of trauma often expected or assumed from Aboriginal people presenting at the ED, and self-reflection on the worthiness of their presentations.

Concepts of equality and equity

Challenging the idea that Aboriginal people get special treatment has been identified as a key factor impacting on the ability of staff to implement culturally safe care. Training needs to contextualise the societal inequality of health and wellbeing, examine the systemic issues, and address the institutional bias of health agencies that has caused inequity (Zorbas 2016; Hwang et al. 2011). The concept of equitable (rather than equal) care challenges the ED ideal of 'I treat everyone equally', and the view held by practitioners that they are able to treat patients with 'scientific objectivity', which ignores the existence of racially and socially constructed differences (Dwyer, Willis & Kelly 2014).

Racialised health care

We need to shift the socialisation in the workplace where people learn and reproduce racialised stereotypes that negatively impact the way physicians treat patients and, in turn, reinforce racialised health care. Self-reflection could be undertaken by staff on the existence of systemic racism within the ED. Cultural Safety Training could employ Aboriginal Elders to share stories that counter racialised assumptions (Kerrigan et al. 2020; Brascoupe & Waters 2009).

Social and cultural determinants of health

Address the relevant social and cultural determinants of health seen in ED on a daily basis, and support practitioners to understand the contribution of culture and social determinants such as lower household income can have on presentations by Aboriginal and Torres Strait Islander people. Staff interested in this field could be encouraged to go on to complete a module or the Social Emergency Care Practitioner Certificate.

Community consultation, engagement and partnerships

Engagement with the wider local and regional community should be embedded in practice through yarning circles, working with community to develop translations to complex medical terms, and strengthening relationships with AMSs to improve both referral services and the overall journey to health for Aboriginal people.

Extra support for overseas staff

This study identified that ED staff from other countries often needed extra support to recognise Australian-based stigma and know when to deploy culturally safe practices. ED staff who did not grow up in Australia require some historical context about Aboriginal patients' presentations, as well as the reasons why a singular racial group is privileged over another culturally diverse groups.

Cultural respectful strategies and approaches

Providing ED staff with practical strategies and approaches that are culturally relevant to their local region could include, but are not limited to, the following:

- The importance of a gendered approach to health care, so that the shame experience can be minimised and cultural safety achieved.
- Family support – How to approach large family groups and communicate effectively (collective decision making instead of individual decision making) and acknowledging the roles and responsibilities of carers and others who accompany patients to hospitals.
- Cultural bereavement, grief, death dying and palliative care practices.
- Recognising when people are practising culture.
- Cultural lore and legal issues and ensuring cultural congruence.
- How to build rapport in time pressured circumstances

Culturally safe communication and language utilisation

This study found communication and comprehension issues between a practitioner and patient to be a key issue leading to unsafe care, often resulting in poor health outcomes for the patient. Cultural training could provide:

- Context to communication approaches – such as understanding the impact of power relationships and how this impacts upon the language used, the abruptness of language patterns and the unequal power dynamics at play between colonial institutions and colonised people.
- Training on culturally safe communication and language utilisation – such as using basic, layperson terms where possible and avoiding complex language, any known local language terms, picture boards in explaining complex medical terms, and language that does not blame the patient.
- Practical guidelines to effective communication and comprehension – strategies and techniques could include accessing Aboriginal staff or interpreters, recognising shame behaviour using simple or local language words when engaging with patients and their families.
- Discussion around the impact that comprehension issues can have on the health outcomes of First Nations' peoples and why people may leave ED or their treatment early.

Safe pain management in ED

Provide cultural training around culturally diverse experiences and presentations of pain that can impact if pain is sufficiently managed when treating First Nations' patients. Providing practical strategies which help avoid misinterpreting a patients' pain management requirement such as the use of pain tools, gendered-treatment and culturally respectful ways to illicit where pain management may be needed.

Reflective practice

RACGP identifies the importance of self-reflection as a strategy to address internal biases and racism. Training should include education about white privilege, anti-racism, unlearning unconscious bias and white supremacy, intended or not (Phillips 2019), while encouraging participants to practice critical self-reflection of their own unconscious bias and institutional racism (Kerrigan et al. 2020; Brascoupe & Waters 2009).

The development of, and access to, ACEM's Cultural Safety Training needs serious consideration. Respondents described having limited access to paid education opportunities, which meant they often had to undertake training in their own time. Where possible, time should be set aside for Cultural Safety Training for staff in work hours, and should be:

- engaging and stimulating;
- encouraging active participation;
- region specific to incorporate the regional context and pertinent issues impacting the health and wellbeing of the local community;

— focusing on local cultural practices and teaching staff local words and phrases for medical terms;

— presented or co-presented by a First Nations' person with the appropriate authority;

— an opportunity for ED staff to engage with local First Nations' people and community in ways that extend the range of contacts and referrals; and

— evidence and research heavy to reflect a profession driven by scientific evidence – e.g. racism is bad for people's health:

> **People might not necessarily respond to messages like, don't be racist it's bad, but [it] could make a difference if we think about not being racist because you're not a good health care provider if it's affecting people's health...**

Major theme 4: Community engagement and avoiding silos

Respondents reported a lack of regular and ongoing engagement and communication between emergency physicians and community organisations and Aboriginal Medical Services (AMSs). Once discharged, ED staff are often unaware of the circumstances they are sending Aboriginal patients to or the services that are accessible to them. Some of the staff interviewed expressed wanting to have an increased and more effective relationship with community organisations and AMSs, especially in cases of social determinants-related referral pathways. Other respondents reported that the local politics between services acted as a barrier, which meant many ED staff remained working in silos with the ED and hospital.

I've never had a phone call from the AMS [and] I've worked at this hospital for nearly three years now. I've never received a referral from the AMS. We get phone calls from GPs saying [we're] sending this person [but] I've never received a phone call from AMSs. So, whether that means that they don't send us many patients? I think it might be that they don't tend to be patient. I know that obviously lots of Aboriginal people end up in the [emergency] department, so it's not that Aboriginal people are managed exclusively in the community. So perhaps there is less communication, than that maybe would be useful.

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I don't think it exists at all [ED and AMS relationship]. Because it's sort of 'Oh well you're being discharged from the ED, back to the GP, and your GP can sort it out'. But if they don't have the time, they don't have that existing link, they don't feel comfortable with the GP, whatever it might be, that stops them going back to the GP, then they're lost.

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> **I find that a lot of Aboriginal patients present to ED perhaps with ailments or conditions that have a lower acuity. And so they often get, the care gets diverted to our sub-acute area, which often consistently has longer wait times. I think a lot of the presentations are perhaps things that would be better managed or could be more quickly managed in a GP or an AMS type setting. So I think from that perspective… [we need to] identify why they feel more comfortable coming to an ED, as opposed to a local health provider. And, therefore, if we could get into why that's happening, then we could perhaps try and lessen the number that come to ED with less acute problems, and then list [those who] don't wait if that sort of makes sense…**

Coordinating services and increasing the communication and engagement between agencies has the potential to have real benefit to Aboriginal and Torres Strait Islander patients, and is particularly relevant in regions with high First Nations' populations presenting to EDs. Increased engagement with regional community organisations and services outside of the hospitals is particularly important when it comes to presentations between Categories 3–5, given that many of these types of presentations are influenced by cultural and social determinants of health. There is vast benefit in also strengthening ties with the first responders' network (ambulance paramedics, police, fire fighters, child protection workers) to enhance the pre-ED cultural safety experience.

We propose holding regular forums attended by all regional agencies to develop culturally safe transitional services. The development of regional plans that aim to cut through existing silos could be developed as part of the increased focus on Social Emergency Care. In Section 4, we summarise the findings from the literature review, and the interviews with both the staff and the community into a series of recommendation strategies for ACEM's Cultural Safety Advocacy and Implementation Plan.

Section 4 / Recommendations for Inclusion in a Cultural Safety Advocacy and Implementation Plan

This study has identified an increasing emergence of dialogue and policy surrounding cultural safety in EDs, which acknowledges that a greater focus on the social factors is needed, particularly with presentations by Aboriginal and Torres Strait Islander people.

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In other countries, emergency medicine is now including provisions to address social determinants of health, but in Australia there remains a degree of uncertainty as to how this focus should be accomplished. Although our EDs are well versed in identifying and addressing clinical interventions, they need to shift their practice to consider the social determinants underlying health and illness. By responding in ways that maintain their high clinical standards, but also facilitate working with local and regional agencies, they can develop and measure systematic interventions and advocate for policies to improve the health of their patients. Such an approach will also alleviate some of the workforce stressors for emergency staff.

For ACEM, there is no 'one size fits all' approach to implementing this approach, but rather a range of strategies that advocates can employ. To achieve the outcomes of the College's Innovate RAP, for example, they could introduce teaching and training programs, undertake research, seize media opportunities, develop regional engagement and meet with policy implementers and influencers. The Cultural Safety Advocacy and Implementation Plan strategies can be topic based, deliberative, collaborative, nationally driven and/or locally applied. Careful consideration is required to determine what approach is likely to be most effective and to meet those priorities that are more likely to have a significant bearing and or impact on health.

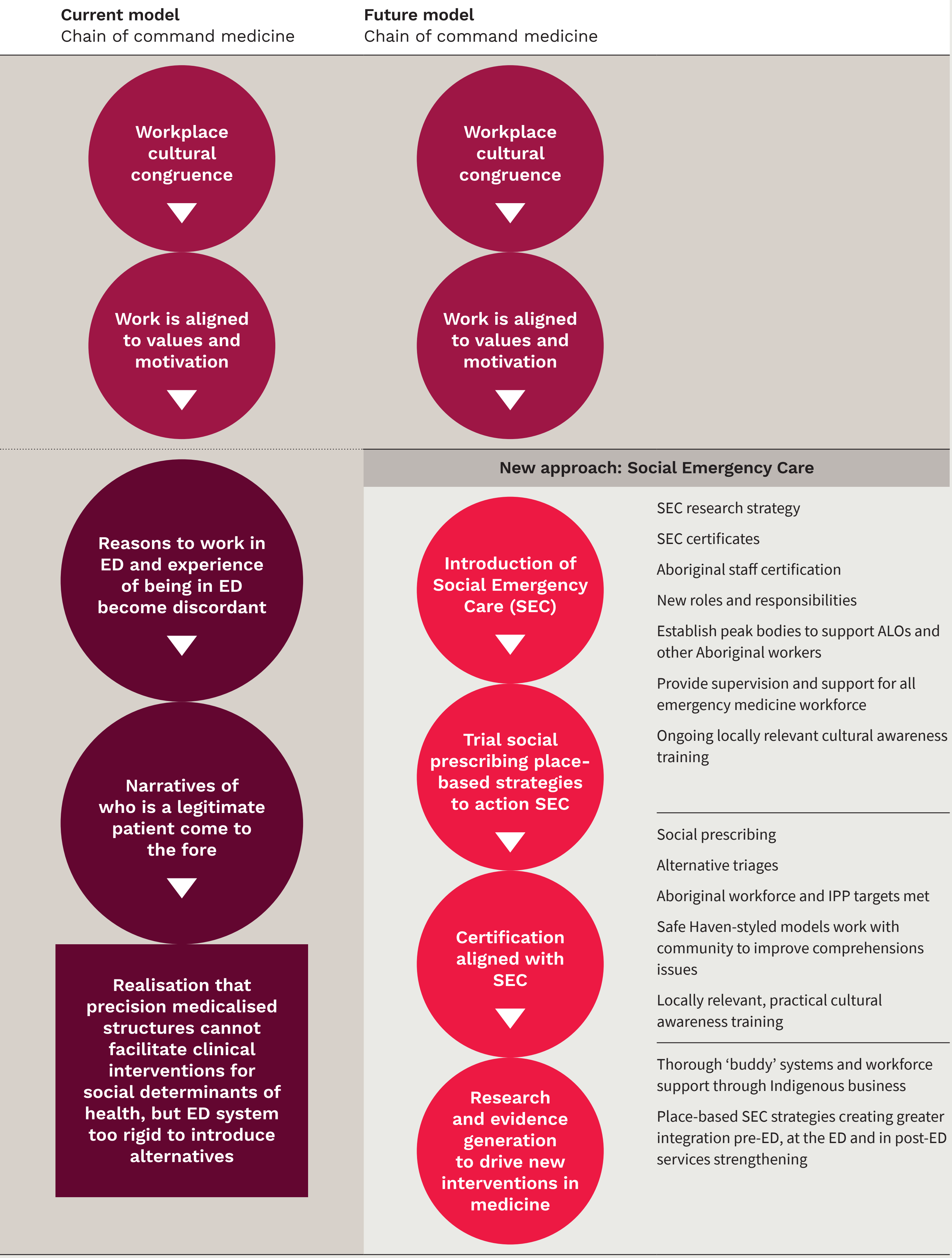
A key consideration for ACEM should also be on whether the College is best placed to advocate on all matters contained in this report, or whether partnerships should be formed with other professional bodies involved in the delivery of emergency services. Advocacy should improve the College's long-term standing and strength by way of establishing important networks, alliances, partnerships and profile in the policy arena. Additional consideration should be given to issues of capacity within the College – who can drive these agendas, develop localised governance groups and progress a regional agenda – and are there funds available to do the work.

Although this report combines a rich context for the implementation of the following recommendations, it also highlights there is more work to be done in the creation of an Australasian evidence base that is directly informed by staff and community people. There is also the opportunity to invest in an innovation agenda that can facilitate access to new resources previously unidentified in the requirements of hospitals and EDs, including the activation of the Indigenous Procurement Policy to support an ABN workforce.

There are a multitude of novel approaches to the work of traumatology, particularly for those Aboriginal and Torres Strait patients who consistently present and are triaged into Categories 3–5. We are advocating for the introduction of an Australasian discipline of Social Emergency Care, which is detailed further in Recommendation 1. To support this, Figure 1 lays out how the current chain of command model operates in emergency departments and how a future SEC approach might work.

Figure 1 A Social Emergency Care approach to emergency medicine

Community narratives of traumatology	Triage categories 1–5		Staff narratives of traumatology
Had a good experience. *Had all the information I needed.* *Was transferred to another hospital well.*	**Triage category 1**	Conditions that are a threat to life requiring aggressive intervention.	Chain of command Hierarchical Body parts approach Male dominated
Was picked up by ambulance and was happy to hear the ambos talking to the ED. *Got straight through out the back area and didn't have to wait in the waiting room.* *Got a comfortable chair but was left in rooms on my own.*	**Triage category 2**	Imminently life threatening, deteriorating so rapidly or organ failure if not treated within 10 minutes of arrival, or work to make significant effect on clinical outcomes or very severe pain.	Traumatic and exhausting Exciting and different Adrenaline rush Saving lives Families provide details Shift work and few resources Busy, making judgments Categories 3–5 take up time
You really know you are Aboriginal when you go into places like this. *When you only have $60 left for the next three days then going to ED costs a lot by the time you pay for petrol.* *Don't want to interrupt people because they are busy.* *Knew I would have to wait a long time so I tried to get in by ambulance because I will get out the back quicker.* *The doctors don't explain things properly to patients, they scare us and we don't feel comfortable.* *Need to have an Aboriginal person there at every visit – not once you are admitted but when you are actually in the ED. That would make me feel heaps more comfortable.* *Cultural training is all done from people above, the big bosses and executives… It's us on-the-ground workers, the AHLOs and allied health staff, who need more say in the development of the cultural safety programs. That's because [we] know what's going on in the ED and the big bosses don't.*	**Triage category 3**	People who need to have treatment within 30 minutes are categorised as having a potentially life-threatening condition. People in this category are suffering from severe illness, bleeding heavily from cuts, have major fractures or are severely dehydrated.	Poverty drivers Lack of transport Homelessness 'They should take better care of themselves' Too many family members in the room Frequent flyers here for the blankets and sandwiches Too busy to get people bedpans Nowhere else to send them Can't comprehend whether they know about consent
	Triage category 4	Condition may deteriorate, or adverse outcome may result, if assessment is not commenced within one hour of arrival in ED. Whether symptoms are moderate or prolonged, humane practice mandates the relief of discomfort or distress within one hour.	Domestic violence Stereotyping Aboriginal people as intoxicated Asking for pain relief akin to lying drug users Derogatory labels drive assumptions of worthiness Frustrated with families as advocates
	Triage category 5	Condition is chronic or minor enough that symptoms or clinical outcomes will not be significantly affected if assessment and treatment are delayed for up to two hours from arrival because of clinic–administrative problems.	Social issues recognised as contributing to presentations. Providing safety to those who need it Getting angry at bearing the brunt of people's wait time



Current model
Chain of command medicine

Workplace cultural congruence

Work is aligned to values and motivation

Reasons to work in ED and experience of being in ED become discordant

Narratives of who is a legitimate patient come to the fore

Realisation that precision medicalised structures cannot facilitate clinical interventions for social determinants of health, but ED system too rigid to introduce alternatives

Future model
Chain of command medicine

Workplace cultural congruence

Work is aligned to values and motivation

New approach: Social Emergency Care

Introduction of Social Emergency Care (SEC)

Trial social prescribing place-based strategies to action SEC

Certification aligned with SEC

Research and evidence generation to drive new interventions in medicine

SEC research strategy

SEC certificates

Aboriginal staff certification

New roles and responsibilities

Establish peak bodies to support ALOs and other Aboriginal workers

Provide supervision and support for all emergency medicine workforce

Ongoing locally relevant cultural awareness training

Social prescribing

Alternative triages

Aboriginal workforce and IPP targets met

Safe Haven-styled models work with community to improve comprehensions issues

Locally relevant, practical cultural awareness training

Thorough ‘buddy’ systems and workforce support through Indigenous business

Place-based SEC strategies creating greater integration pre-ED, at the ED and in post-ED services strengthening

Recommendations for inclusion in a Cultural Safety Advocacy and Implementation Plan

Recommendation 1

Introduce a Social Emergency Care discipline

— ACEM to introduce a Social Emergency Care discipline by developing curriculum to increase the number of SEC practitioners – clinicians who can treat clinical presentations, work to understand the experiences of those presenting, and ascertain the social and cultural determinants underlying Aboriginal (and other) people's ED presentations.

— ACEM is well positioned to develop, implement and evaluate the impact of an accredited Social Emergency Care Practitioner Certificate course, and the consequent work of the Fellows.

— In developing the curriculum for a SEC Practitioner Certificate, consider core modules, project-based activities and a community of practice approach over the course of a year. Different subjects could be developed to meet the needs of diverse groups such as AHWs; nurses and doctors; AHLOs, counsellors and psychologists; allied health and social worker staff; linguists and language speakers; administrators; transport drivers; ambulance paramedics; specialists and other professionals; and people who provide cultural supports in the patient journey.

— Create local, regional, State and national action research projects that can be completed by First Nations' researchers and consultants in association with agencies and practitioners engaged in the SEC Practitioner Certificate. As part of their assessment, course participants can complete position statements, organisational policies and practices, write up findings from projects and pilot programs, and deliver community-requested products on projects such as those identified by community people in this study.

— ACEM to engage Aboriginal and Torres Strait Islander professional associations and consultants to co-design, implement and evaluate the provision of cultural coaching, professional debriefing and support services to front-line responders and the emerging Social Emergency Care, cultural health and wellbeing workforce.

— Advocate for the discipline of Social Emergency Care to lead training strategies and identify alternative referral pathways to accommodate people with mental health issues, including psychosis.

Recommendation 2

ACEM education, training and accreditation

Social Emergency Care Training

— Create, in partnership with Aboriginal health professional peaks (e.g. Australian Indigenous Doctors' Association, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Indigenous Allied Health Australia, National Aboriginal and Torres Strait Islander Health Workers Association, Australian Indigenous Social Workers Association), an Aboriginal Emergency Health Practice Certificate specifically for First Nations' workers in the ED, or AHWs looking to enhance their emergency health practices (particularly the management of complex chronic illnesses in community contexts), which can extend into the SEC Practitioner Certificate course (see Recommendation 1).

- Facilitate a pilot program of 'Social Emergency Care Summer (or Winter) School: Specialisation First Nations'. In this scenario, relationships could be developed between higher education institutions and professional peak bodies to organise a specialised First Nations' pre-employment program, which could also act as an orientation to the region for new employees. Coordinators and implementers of the Summer School could be a combination of businesses – an ABN workforce of First Nations' trainers, consultants, cultural awareness trainers, caterers, traditional healers, coaches, program designers and facilitators – universities and relevant peaks to introduce a six-week pre-employment internship, during which people participate in a structured program to learn and demonstrate capacity in the following:
    - Trauma-informed practice – understanding and responding to the issues of 'distrust' by patients of non-Indigenous staff in EDs.
    - Social and cultural determinants of health – historical context and the social and economic conditions impacting ED presentations.
    - Client-centred referral pathways – course participants engage with local agencies and understand referral pathways including visits to remote areas as needed.
    - Aboriginal and Torres Strait Islander people's understandings – of kinship, family obligations, public and private information and gendered information-sharing strategies.
    - Presentations to EDs – issues of safety (being culturally safe), sanctuary (addressing issues of homelessness) and service (throughput care for urban, regional and remote services).
    - Participating in partnerships and collaborative actions – how to work with First Nations' staff and clients (e.g. going to someone's home, wherever that is and however they get there).
    - Walking through the ED department – from the perspective of First Nations' people.

Cultural Safety Training

- Develop culturally safe, evidence-based training that is presented or co-presented by a First Nations' person with the appropriate authority in ways that encourage active participation and is specific to the region in which the hospital is located.
- Together with Indigenous businesses, consultants and service delivery agencies develop a national online evidence-based Cultural Safety Training course for practitioners, detailing key aspects of the findings contained in the Final Report, that includes but is not limited to the following:
    - the holistic model of care;
    - effective communication (including the use of simple, plain English);
    - social and cultural determinants of health;
    - the concept of promoting equality versus enhancing equity;
    - racialised health care;
    - reflective practice;
    - trauma-informed care;
    - gender issues;
    - comprehension issues – picture boards;
    - poverty simulation;
    - historic issues impacting presentations to ED;
    - acknowledging the roles and responsibilities of carers and people who accompany patients to hospitals (treat them as navigators);
    - issues around bereavement, grief, death dying, palliative care;
    - culturally safe pain management;
    - recognising when people are practising cultural safety; and
    - place-based responses to emergency medicine.

- Develop separate and specific cultural Safety Training courses for doctors from other countries coming to Australia, as the specific knowledge and history of Australia's settlement is seldom known or understood.
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification with ACEM.
- Have regional-specific communication strategies incorporated into Cultural Safety Training programs to ensure the concept of 'shame' is well understood, as reducing people's exposure to shame is a key practice principle in social emergency care work.
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes).
- Implement cultural safety survey tools to benchmark performance in meeting people's needs (see Recommendation 6).
- Work with communities where English is not the first language to enhance the accurate translation of complex medical issues and ensure gendered, cultural communication techniques are always understood and able to be accessed.
- Change the descriptors of individuals from negative or deficit-focused language to positive and strengths-based language. For example, the descriptor of Aboriginal people 'taking their own leave' focuses on individual capacity to participate in ED processes, rather than on cultural safety in the ED and their experiences of institutional care.

Other training

- Implement an orientation program introducing social and cultural determinants of health to emergency workers. This could include a poverty simulation, and visits to homeless and other shelters, addiction clinics, outpatient clinics, aged care homes and, in agreement with local community people, places where patients live and/or are referred to and from. A 'Walk in their shoes' program could also be part of the program, perhaps with elements of the orientation led by a frequent service user.

Recommendation 3

Workforce advocacy

Innovation

- Advocate for more First Nations' staff to be employed by EDs, as Aboriginal patients and their families have asked for cultural relationship-styled support at this point in the patient journey. For example, First Nations' people could be employed under the banner of Enhanced Patient Experience roles as advertised by NSW Health.
- Appoint First Nations' people to roles in pre-ED services (ambulatory), triage and discharge. For example, Aboriginal Health Workers with prescribing rights could make a valuable contribution to a small triage team by supporting Aboriginal and Torres Strait Islander people needing access to medication and other ambulatory services at peak times during the day. They could also enhance cultural safety in the triage and waiting room process, ensure the comfort of people in situ (retrieve bedpans, answer buzzers, etc.) and support patients who are on their own in the ED. This is expected to reduce waiting times, minimise people's exposure to racism in ED waiting rooms, cut through any negative stereotyping (unconscious bias) and enhance accessibility.
- Work with local AMSs and GP services based in community-controlled organisations to see if AHWs could be employed during the evening shifts in the ED, so as to increase the hours in which Aboriginal and Torres Strait Islander staff can be accessed by First Nations' patients and their families.
- Employ trained interpreters who can work with complex medical issues and promote language development across different language groups around these core concepts.
- Ensure ED staff can provide accessible and available gender appropriate care and support to respond to both men and women in emergency services from pre-ED through to discharge.

- Create opportunities for cultural engagement, supervision and 'buddy' arrangements for people on the floor during shifts, with ED-based cultural mentors to enhance staff capacity to provide cultural care that is aligned to the opening hours of the ED.
- Ensure all security staff in EDs have Cultural Safety Training to understand their impact on the health and wellbeing of those in the ED and in waiting areas. Include information on the de-escalation and safe removal of people who are in heightened states of emotion.
- Ensure all internationally trained staff have access to Cultural Safety Training, relevant to the region in which they will be employed.

Recommendation 4

Empowering Aboriginal and Torres Strait Islander businesses

- ACEM to work with Reconciliation Australia and Indigenous business networks, Indigenous Business Australia and Indigenous Land and Sea Corporation, State-based Aboriginal Chambers of Commerce, IgNITE and corporate partners to invest in a sustainable ABN peer workforce of AHLOs, interpreters, translators fluent in First Nations' languages, cultural greeters and mentors, healers and bush medicine providers, cultural awareness trainers and supervisors, orientation service specialists, transport workers and recruitment agents. This workforce activates the requirements for hospitals and other services to spend 1–3 per cent of their entire budgets on for-profit Indigenous businesses through the national Indigenous Procurement Policy (Australian Government 2020b).
- Work with Indigenous businesses and institutes to create and support a peer workforce that also includes peer supports, researchers and educators to undertake surveys and work with different stakeholders to enhance understanding between patients and practitioners.

Recommendation 5

Emergency department design

- Investigate alternative triage models, e.g. Triage and Treat, Team Triage approaches and ensure Rapid Assessment and other models of early engagement with Aboriginal and Torres Strait Islander patients is done with and by First Nations' staff.
- Where possible, seek to promote the principles of cultural safety in ED settings, and activate strategies to enhance rights-based and First Nations-led initiatives, particularly in the planning of the built environment and introducing innovative programs.
- Implement environmental improvements to enhance cultural safety, including the display of Aboriginal and Torres Strait Islander posters, health brochures, local artwork, etc., and increasing the number of private areas (wider, curtained cubicles and sound-proofed rooms) for patients and their families to gather. Also needed are separate, gendered places for men and women in the ED to allow for culturally appropriate emergency care.
- Create designated spaces for Aboriginal and Torres Strait Islander patients, and/or provide more comfortable and secure places outdoors where people can wait and be called inside for treatment.
- Trial the development and implementation of a suite of translation resources into EDs (illustration boards, language resources, interpreters) to enhance the patient journey.
- Facilitate the development of accessible information – TV advertisements, social media, short videos in different languages, brochures with art designs from the region – to show to community and other services and in ED waiting rooms.

Recommendation 6

Research

Develop an ACEM cultural safety research program based around discrete projects as identified by community people in this study. The research programs advocated for include:

a Co-designing care models for people living in remote and regional areas and for at-risk and vulnerable communities: for example, adolescents with heightened anxiety, people who are ice addicted, exhibiting suicidal behaviour, have had gender reassignment surgery or are transitioning, and older single women living complex lives.

b Trialling picture- and illustration-based communication techniques in pre-ED and ED settings to enhance culturally safe communication with people who speak English as a second or third language.

c Providing culturally appropriate outreach emergency services to people experiencing homelessness.

d Supporting people who want to die on Country and providing culturally safe patient palliative care choices in EDs, including support for families through an ED-based palliative care and early bereavement process: for example, an 'Into the Dreamtime' project to manage early grief in ED settings and the adoption of names such as 'Walking with the Ancestors' for palliative care rooms.

e Acknowledging the cultural roles and responsibilities of the carer or person attending the ED with the patient, learning how to respond to their advocacy, and recognising and responding to these relationships.

f Designing physical spaces in the ED and surrounds, including 'extended' EDs (café-styled waiting rooms with peer supports on the grounds, community ambulatory services in community hubs).

g Learning to recognise and respond to people who are practising culture and cultural respect in ED contexts.

h Facilitating culturally safe pain management in ED waiting rooms.

i Ensuring gendered approaches to emergency care.

j Creating culturally safe referral pathways for Aboriginal and Torres Strait Islander people from the ED to other areas of the hospital campus, their transportation to other ED-ordered services, and upon discharge. These projects could emphasise strategies to enhance patient and family outcomes and reduce readmission rates.

k Establishing and sustaining an ACEM-led Social Emergency Care, cultural health and wellbeing workforce, cultural safety networks, and communities of practice instigated regionally but supported and reported on nationally.

l Implementing the Cultural Safety Survey Scale in EDs, a tool for measuring cultural safety from the perspective of First Nations' patients (Elvidge et al. 2020).

Recommendation 7

Place-based strategies, external partnerships and advocacy

— Work with pre- and post-ED services to adopt strategies that will enhance their capacity to be culturally safe. Trial different regionalised approaches to triage events including models that extend and include ambulance services, police and other first responders, GPs, community clinics and alternative referral pathways. This could be achieved through the adoption of Social Emergency Care as a discipline to address the social and cultural determinants of clients' health needs (see Recommendation 1).

— ACEM and others to auspice the development of a peak body for AHLOs and Aboriginal and Torres Strait Islander people involved in SEC to create professional development opportunities, establish regional communities of practice and promote career advancement to ensure client care along the patient journey from pre-ED to discharge and home again.

- Work with other institutions frequented by Aboriginal and Torres Strait Islander people – including in detox or 'dry-out' shelters, women's shelters and emergency accommodation – for the co-location of emergency services to alleviate cultural issues and promote different access points for ambulatory and emergency care.
- Engage national 'lived experience' organisations, including those that represent the interests of people affected by mental health – such as Black Dog Institute Aboriginal Lived Experience Group, Culture is Life (Aboriginal Youth Suicide Prevention Organisation), First Peoples Disability Network Australia, Thirrili (National Post Suicide Postvention Service) and Gayaa Dhuwi Proud Spirit Australia) – to revise elements of the ED Design Guidelines and facilitate discussions on advising the development of models, triage systems, content for Cultural Safety Training and workforce development strategies (see Recommendation 5).
- Build these strategies into place-based, regionalised responses that engage a range of services in the uptake and advancement of SEC, and cultural health and wellbeing strategies.
- Hold annual summits on regional cultural safety in the ED based on national standards and facilitated in partnership with local ABN holders, Traditional Owner groups and service delivery agencies. The summits will facilitate understanding and work towards addressing the gaps and barriers to, and celebrating the enablers for, cultural safety in the ED ecosystem, which extends from a person's home base to the hospital and other secondary and primary health care pathways.
- Strengthen ties with a first responders' network to enhance the pre-ED cultural safety experience, and create opportunities for ambulance paramedics, police, fire fighters and child protection workers, for example, to join this network. Develop regional plans for the activation of SEC work to cut through silos.
- Increase ED engagement with AMSs and other First Nations' community organisations in the hospital's region by developing relationships and holding regular forums to develop culturally safe transitional services.

Intersecting action areas

In response to the growing number of presentations by First Nations' people, and the stressors involved in delivering increasingly complex emergency care, ACEM will need to develop an Innovate RAP underpinned by sciences, technologies and patient care responses that are solution oriented and transdisciplinary in nature. This approach will necessarily draw on a range of disciplines in medicine, human and social sciences – as well as traditional and Indigenous knowledge produced within community-controlled organisations, Indigenous business, the private sector and civil society – putting into practice the types of place-based regionalised strategies for achieving the full promise of EDs being sanctuaries for those who are vulnerable. This approach will require the fostering of a development and implementation framework that can integrate policies, practices, interests and strategies to foster collaboration and address the social determinants of health through an active research program to co-design, co-produce and co-implement projects that will enhance cultural safety and workforce outcomes over the life of the next RAP.

Many Aboriginal peak bodies and organisations, and Commonwealth and State departments have well-developed strategies to enhance cultural safety. Those with relevance to emergency settings should be introduced and implemented where and when possible, and evaluated as to the impact of these approaches. This study also identified the following additional cross-cutting themes that are relevant to advocacy work in this area.

Advocating for trauma-informed care

Practising with trauma-informed care can strengthen the knowledge of ED staff about the association of past trauma and its impact on Aboriginal people. In doing so, ED staff could potentially avoid retraumatising patients and reduce the impact of aggressive and violent behaviour. It is key to recognising that staff are also impacted by trauma, which in turn will impact their work–life balance. Staff also need a framework in which to address key issues such as unconscious bias and racism, and implement new structural and programming options to trial in ED settings. This could include introducing 'buddy' systems, building an Indigenous ABN workforce and ensuring cultural debriefing, supervision and yarning circles can occur on a regular basis.

Pre-employment orientation

To promote regional options and enhance cultural safety, the College could trial Summer School internship arrangements. Coordinators and implementers of the Summer School could be a combination of Aboriginal and Torres Strait Islander businesses (an ABN workforce of First Nations' trainers, consultants, cultural awareness trainers, caterers, traditional healers, coaches, program designers and facilitators), universities and relevant peak bodies. The six-week Summer School would provide students with a long pre-employment internship, during which they would participate in a structured program to learn and demonstrate capacity in the following:

- Trauma-informed practice – understanding and responding to the issues of 'distrust' by patients of new non-Indigenous staff in ED Departments.
- Social and cultural determinants of health – conditions that impact presentations to ED.
- Client-centred referral pathways – course participants engage with local agencies and understand referral pathways including visit to remote areas as needed.
- Aboriginal and Torres Strait Islander people's understandings of kinship, family obligations, public and private information and gendered information sharing strategies.
- Presentations to EDs: issues of safety (being culturally safe), sanctuary (addressing issues of homelessness) and service (throughput care for urban, regional and remote services).
- How to participate in partnerships and collaborative actions; and how to work with Aboriginal staff and clients (going to someone's home – wherever that is and however they get there).

Service innovation

Working to achieve cultural safety outcomes for Aboriginal and Torres Strait Islander people in emergency care will not be different with those who presenting at EDs with Categories 1 and 2 conditions. However, in regions where Social Emergency Care is implemented, there will be a radical departure from the chain of command medical practice, which focuses on traumatology, to implementing strategies that necessarily focus on healing. This work will need the support of local and regional agencies and will best be delivered under the auspice of local community governance arrangements. It is under the banner of service innovation that emergency care workers can access information to enhance their Social Emergency Care practice, against a backdrop of EDs developing strategies to address social and cultural determinants of health.

Innovation will be delivered through the adoption of Social Emergency Care research; workforce development education and training strategies; the establishment of peak bodies to support a growing and emergent Aboriginal and Torres Strait Islander emergency workforce; and working with Indigenous businesses to provide supervision and support for all members of this workforce. Place-based and localised innovations should aim to enhance Aboriginal people's access to the following:

- social prescribing;
- alternative triaging arrangements;
- new models of care based on mental health interventions that are peer-based and supportive; and
- improved comprehension of staff, patients and their families.

Addressing power imbalances and creating a ‘first responder’ workforce

The successful implementation of Social Emergency Care will require people engaged in the process:

- to address power imbalances at the community and local levels;
- to work on co-design and the development of engagement protocols; and
- to develop long-term relationships and build the competence of people to deliver first respondent health and wellbeing services through culture in their homes.

Families are the first responders for their families, clans and communities, and form part of the cultural workforce discussed in this report. Health service interventions, health education, macroeconomic and social policies can improve health dramatically, and require the uptake of culture-led practices through change-ready and willing collaborations and partnerships. As always, critical connections are more important than critical mass (number of people and agencies involved), as Social Emergency Care frameworks utilise networks that actively promote social inclusion and equitable development.

Final word

Aboriginal culture is a mix of abstract worlds – of mind and spirit; of reality; of land, kinship and cultural activities. Cultural knowledge holders are conduits who connect the abstract and the real through the expression of images, dances, song, language, rituals, objects, gestures and more (Yunkaporta 2019). Culture is as much a language of the spirit, the spirit of Country and the spirit inherent in cultural practices. Connecting to Country and with cultural practices is a celebration of the birth of all things – of the sky and waters, of the earth and of space – and speaks of responsibility, of balance and of care and what needs attention paid to it. Customary practices teach First Nations’ peoples who they are and how they can be by promoting strength, deep knowing and good health and wellbeing.

ED workplace cultures are busy, chaotic and a place in which emergency medicine is practised. This culture is informed by precise medicine, surgical interventions and relationships founded on hierarchical structures and chain of command approaches to resolving critical issues in as quick and efficient a time as possible. ED culture has its own language, rituals, gestures and ways of connecting patients through triage and waiting rooms to the experience of seeing a practitioner. There is an incredible amount of responsibility, balance and care and clear information on how to prioritise what needs to be done to promote strength of purpose, deep knowing, health of the workforce and wellbeing.

Together, these knowledge cultures have become a bastion of light for Australia in the twenty-first century: Aboriginal and Torres Strait Islander people were intervening in the productivity of this nation and what has been learned through that process over many thousands of years will be useful to us all today (Pascoe 2018:156). The ED culture is a civilisational barometer, demonstrating a genuine commitment to human rights, and the provision of services and sanctuary for those experiencing vulnerability. For this emergency department culture to work actively towards addressing social and cultural determinants of health and wellbeing with First Nations people, we are likely to see the acquisition of skills that can greatly impact on the future wellbeing of all Australians.

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