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The Impact of Aboriginal Health Liaison Officers and Culturally Safe Strategies on Emergency Department Leave Events: A Scoping Review

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ABSTRACT

In Australia, First Nations Peoples are reported as 1.5 times more likely to leave the Emergency Department before treatment completion. Reasons are multifactorial and complex, including length of wait times, lack of cultural safety and persistent institutional racism. This scoping review aimed to determine the impact of Aboriginal Health Liaison Officers on First Nations Peoples' rates of Take Own Leave in Emergency Departments. The Joanna Briggs Institute methodology for scoping reviews, the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping reviews, the associated checklist, and the CONSIDER criteria enabled the synthesis of the best available evidence. The search included CINAHL Plus with Full Text (EBSCOhost), Medline (Ovid), PsycINFO (Ovid), Scopus, citation searching and Grey Literature. A total of 533 articles were screened, with seven relevant studies included in this scoping review. Robust research evidence of the impact of Aboriginal Health Liaison Officers on leave events was largely absent in the literature. Strategies designed to improve cultural safety were found to improve rates of healthcare attendance. The Aboriginal and Torres Strait Islander Quality Appraisal Tool was used to appraise the quality of the included studies, finding limited consultation with First Nations Peoples in research design. Findings highlight that improved cultural safety improves First Nations Peoples' Emergency Department attendance. All studies are specific to the Emergency Department setting with projects implemented to reduce leave events and/or implementation of Aboriginal Health Liaison Officer roles. The review provides some evidence that Aboriginal Health Liaison Officers would improve Emergency Department attendance.

1 | Introduction

First Nations Peoples experience a greater burden of ill health due to the ongoing impacts of colonisation, including chronic and life-threatening diseases such as diabetes, cancer, and rheumatic heart disease [1]. Although current Australian data identifies some improvement in life expectancy, the gap is reported as 8.8 years lower for males and 8.1 years for females due to poor health outcomes and significant barriers to care [2]. Of note, existing data does not cover all states and territories [3].

In Australia, First Nations Peoples are reported to be 1.5 times more likely to leave emergency departments (EDs) before completing treatment [4]. Of these First Nations patients who do not complete treatment, 63% leave before seeing a medical practitioner (Did-Not-Wait; DNW) and 37% leave at their own risk (LAOR) [4]. Reasons are multifactorial and complex, including

the length of wait times, dissatisfaction with care, lack of cultural safety, persistent institutional racism, concerns about hospitalisation and infrastructure, fears of inter-hospital transfers and limited autonomy in health decisions [5–7]. In fast-paced EDs, assessment and clinical decision making may be adversely affected by implicit bias ('negative attitudes outside of an individual's conscious awareness' leading to discriminatory behaviours') [8]. Rates of leave events can be used as a proxy measure of cultural safety and competency in the healthcare setting [5, 9].

The 2025 Closing the Gap Implementation Plan highlighted the need to report on institutional racism and measure access to culturally safe services for First Nations Peoples [10]. It also includes a commitment to strengthen the First Nations' health workforce [10]. There is a need to develop a '*right relationship*' between First Nations Peoples and institutions which is one based on shared power, recognition of sovereignty and rights and acknowledgement of historical and ongoing injustices [11].

Historically, hospitals have been seen as a place to 'come to die', and a place that restricts passing to The Dreamtime after death, as would happen when the person dies on ancestral lands [12]. Historical and cultural factors impact on First Nations Peoples' ED attendance. In the Australian context, Aboriginal Health Workers (AHW) have held a variety of roles in different contexts over more than 70 years to enable access to culturally safe healthcare for First Nations Peoples [13]. Aboriginal and/or Torres Strait Islander Health Workers, a non-clinical role and Aboriginal and Torres Strait Islander Health Practitioners (AHP), a nationally registered clinical role have been identified as related professions (scope of practice is distinct) [14]. In the acute care setting, emerging evidence suggests Aboriginal Health Workers and Liaison Officers (AHWLOs) play a vital role in enhancing First Nations Peoples' access to culturally safe healthcare and addressing the ongoing inequities they face [15, 16]. This includes advocacy, education and support for First Nations patients, as well as acting as an '*intermediary*' between patients and healthcare staff [12]. However, ensuring that Aboriginal Health Workers and Aboriginal Health Liaison Officers (AHLOs) are employed to support communication and continuity of care requires both implementation and evaluation.

This scoping review aims to determine the impact of Aboriginal Health Liaison Officers on First Nations Peoples' rates of leave events in Australian Emergency Departments.

Review questions sought to identify:

- How do AHLOs impact leave event rates for First Nations Peoples in Australian EDs?
- What are alternative strategies in Australian EDs that reduce leave events for First Nations Peoples?
- Is research with First Nations Peoples being conducted in a culturally safe manner and with community consultation?

This review was conducted in partnership with and in the best interest of First Nations Peoples and took place on the traditional lands of the Gumbaynggirr Peoples in the Mid-North Coast of New South Wales (NSW). An Aboriginal Reference Committee on Gumbaynggirr Country was consulted to ensure preferred terminology is used; hence, 'First Nations Peoples' will be used to refer to Aboriginal and Torres Strait Islander Peoples. A strength-based approach has been chosen to avoid the deficit modelling of existing literature. As First Nations Peoples deserve to thrive and be healthy, to compare suggests a need to attain a non-First Nations level of health, placing First Nations Peoples below non-First Nations Peoples.

Inconsistent terminology for reporting 'leave events' has been detailed by the Australian Commission on Safety and Quality in Health Care, including variations across services, states and territories [3]. In this review, the broad term 'leave events' has been adopted [3, 17]. To avoid confusion, the terminology specific to each reviewed paper (with the authors' definition) is detailed in Table 2 and used when reporting project specific findings.

2 | Methods

2.1 | Protocol and Registration

The review was guided by the Joanna Briggs Institute (JBI) methodology for scoping reviews [25] and is reported against the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping reviews (PRISMA-ScR) [26]. The scoping review protocol was registered on Open Science (OSF) [27].

2.2 | Inclusion Criteria

The following table (Table 1) presents the inclusion and exclusion criteria using the Population, Concept and Context (PCC) approach.

2.3 | Data Sources

Four databases were selected based on relevance and scope. The initial searches were carried out in November 2024 using CINAHL Plus with Full Text (EBSCOhost), Medline (Ovid), PsycINFO (Ovid), and Scopus. Hand searching and Grey Literature searches were also conducted.

The grey literature search included targeted searching of key sources (Informit, the Australian Indigenous HealthInfoNet, the Lowitja Institute) for their relevance to First Nations' health. The same eligibility criteria and search concepts were applied to grey literature sources as to database searches, focusing on AHLOs, ED presentations, and leave events among First Nations Peoples. Google Scholar, reference lists and citations of relevant literature were also hand-searched to identify additional materials not indexed in the selected databases. The grey literature and citation searching yielded 31 relevant articles, which were screened and included according to the PCC framework and scoping review protocol. The search including citation searching was updated in May 2025 and again in December 2025.

TABLE 1 | Inclusion/exclusion criteria.

	Inclusion	Exclusion
Populations	First Nations Indigenous Aboriginal and Torres Strait Islander	No mention of First Nations, Indigenous, Aboriginal and Torres Strait Islander
Concept	Aboriginal Liaison Officer Cultural liaison/ Interpreter Liaison staff Liaison officer Did Not Wait Discharge Against Medical Advice Take Own Leave Walk Out Self-discharge Early discharge	No reference to Aboriginal Liaison Officer/ or similar term
Context	Emergency Department/Service Accident and Emergency department/service Casualty department Trauma centre/centre Acute care	Non-acute services only Community services only In-patient services only
Study characteristics	Quantitative Qualitative Mixed methods Quality improvement Implementation evaluations	Opinion Viewpoint Literature reviews Service description

2.4 | Search Strategy

Search terms used to find relevant literature included concepts of First Nations (and synonyms) and Emergency Department (and synonyms). This search also included references to 'liaison officer', 'take own leave' and other variations of these terms. Articles had no restrictions on date or language. The search strategy, incorporating all identified keywords and index terms, was tailored for each database and information source. An example of a search string is as follows: (First Nations OR Indigenous) AND (Emergency Department) AND (Liaison Officer OR did not wait OR incomplete OR take own leave OR walk out) (see Supporting Information Appendix for Search Strategies).

2.5 | Selection Process

All identified studies were uploaded into the Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia, www.covidence.org), where duplicates were removed. After a first pilot of the eligibility criteria, three authors independently conducted title and abstract screening, as well as full-text screening. Differences of opinion concerning eligibility for inclusion were resolved by consensus among all authors.

Initial screening included non-Australian sources. Following consultation, inclusion criteria were updated to limit studies to Australian papers acknowledging the diversity of First Nations communities globally and widespread differences in health systems. Given the limited number of studies, programmes designed to reduce leave events but not specifically focused on implementing AHLO roles in the ED were included.

2.6 | Critical Appraisal

Historically, First Nations Peoples have viewed research negatively due to the dehumanising and unethical research practices employed by western researchers [28]. Ensuring collaboration with First Nations communities across the entirety of the research process is essential to implementing '*decolonising methodologies*', prioritising the needs of the community over the needs of the researcher [29–31]. Included studies were critically appraised against the Aboriginal and Torres Strait Islander Quality Appraisal Tool [32].

2.7 | Data Extraction

Data extraction was completed using Covidence. Authors 1, 2, and 4 used a data extraction template that included title, author, Australian state and geographical location. Other fields included study aim, terminology used to determine focus (e.g., DNW, TOL, DAMA), study design, mention of community consultation, participants, project, setting, findings, limitations, research gaps, and points of interest.

3 | Results

3.1 | Source Selection

Thirty-two full-text sources were assessed against the inclusion criteria, with seven articles fulfilling requirements included in the final review. See Figure 1 for the PRISMA-ScR [12] flowchart.

3.2 | Study Characteristics

Table 2 outlines the characteristics of the seven included papers, three mixed-methods studies (two reporting on different aspects of the one study) [21, 22], two quality improvement projects, and two implementation evaluations. Of the seven articles, six were focused solely on the ED, while one included the ED in a service-wide program. The extracted data were then independently summarised by Authors 1 and 2, and reviewed by Author 4 with further discussion to reach consensus.

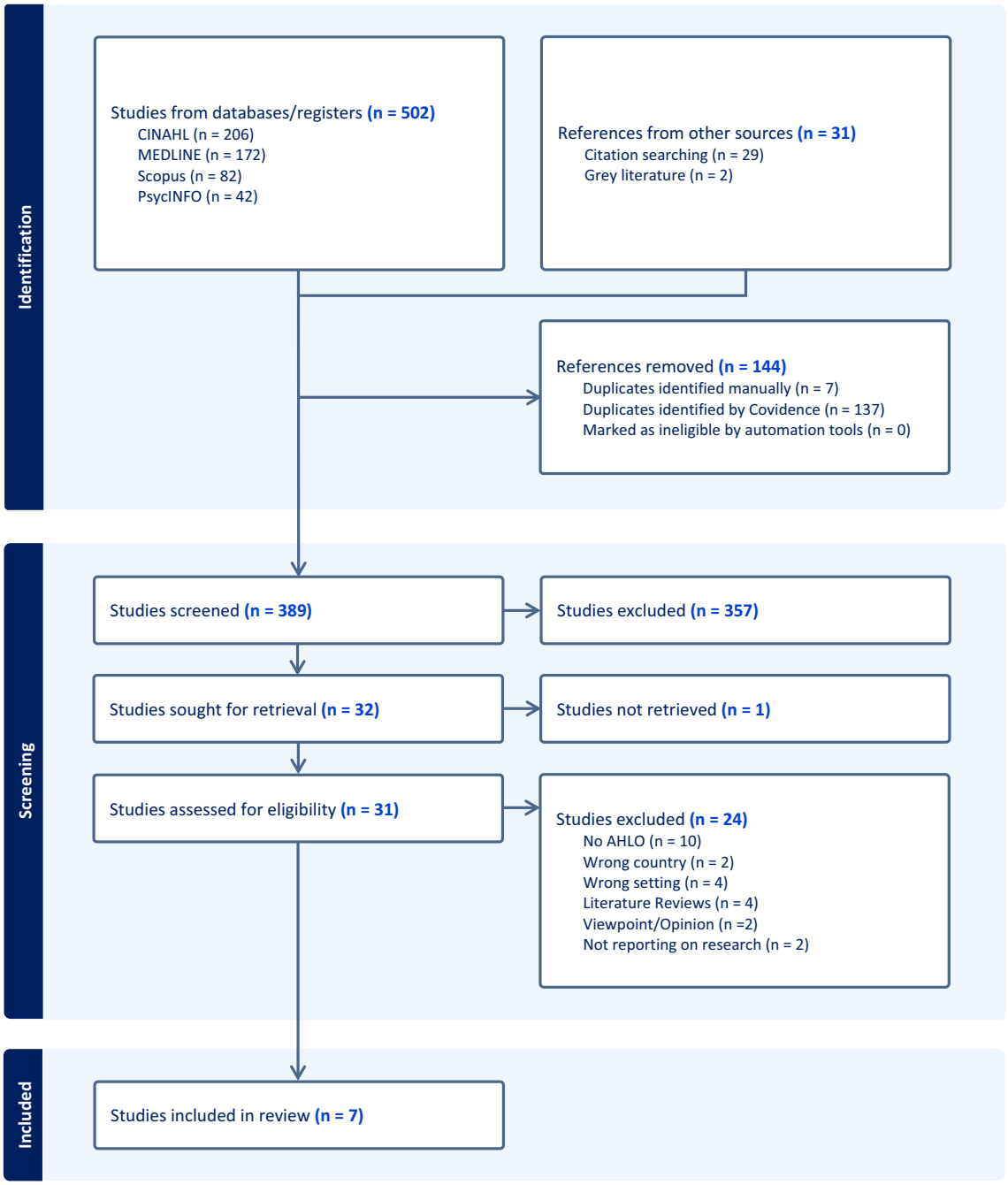

FIGURE 1 | PRISMA diagram outlining selection process.

3.3 | Findings

3.3.1 | AHLO Services in ED

Dalarinji Flexiclinic is a culturally safe, flexible ED service designed for First Nations Peoples [20]. This inner city programme in NSW included a rostered ED senior clinician and Aboriginal Health Worker (AHW) who received referral text-messages for all First Nations patients triaged 3–5 and clerical staff announcements of 'Flexiclinic Patient' [20]. 'Dalarinji' cards (summary of the patient's management plan) were given to show on re-presentation, fast-tracked medications were provided on discharge and patients were followed up within 48 h [20]. First Nations Peoples waited on average 13 min to be seen, had a five-fold decrease in summed rates of DNW and LAOR (25.2% pre-implementation, 5.1% post), without adversely impacting non-First Nations health outcomes [20].

In Queensland (QLD), the Deadly RED Project (clinical redesign and implementation) incorporated focused attention to welcoming and orienting First Nations patients, follow-up for those who TOL to facilitate access to community health services [21, 22]. A key component included cultural capability training sessions with 75 ED staff. The project was adversely impacted by the COVID-19 pandemic with increased ED length of stay, acuity and processing times [21]. This contributed to rising rates of TOL from 13.0% pre-implementation to 21.3% post-implementation [21]. Participants described the pandemic as

TABLE 2 | Included studies.

Author(s)	Location/state	Aim	Setting	Study design	Project	Time period	Participants	Main findings
Gadsden et al. [18]	Urban, Rural NSW	To investigate whether a Continuous Quality Improvement (CQI) project: • Improved accuracy of reporting of Aboriginality • Reduced rates of incomplete ED visits for Aboriginal Peoples • Improved cultural safety in ED	ED	Continuous Quality Improvement Project Quantitative data, document review and interviews	CQI project with a focus on working with Aboriginal people to improve the cultural safety of ED This project included increasing the presence of ALOs in ED.	1st January 2010 to 31st March 2015	Total patients: 2010: 273014 ED visits 2015: 371221 ED visits Staff interviewed: Total: $N = 23$ – 6 of the 23 were Aboriginal 50 documents reviewed that were assessing changes to ED system and environment	The AIHQIP was not associated with a decrease in incomplete ED visits among Aboriginal people in any of the 8 EDs from the control period to the end of the project period. Accurate recording had a significant increase in two EDs. With all EDs combined, there was no change in trend of accuracy. Incomplete visits include either leaving before medical assessment or before care was completed.
O'Connor et al. [19]	Regional, Northern Territory	To explore whether improved interpreter uptake reduces self-discharge rates in ED and hospitalised patients and the likely contributors for improved interpreter uptake	ED, ICU, HDU, CCU, NICU, Telephone	Implementation evaluation using Template for Intervention Description and Replication framework	Bundle: 1. Aboriginal Interpreter Coordinator 2. 'Working with Interpreters' Training for healthcare providers 3. Championing of interpreter use by Junior Medical Officers	2-year baseline: April 2016 to March 2018 1 year intervention period: April 2018 to March 2019	Total: 2291 2-year baseline period: 1333 1 year intervention: 958	Cultural safety lens identified as integral to program delivery and evaluation. Overall, statistically significant inverse association between interpreter bookings and likelihood of self-discharge among Aboriginal patients. Self-discharge rates fell from 12% to 10% (220 individuals avoiding self-discharge per year out of > 10,000 admissions) Aboriginal Interpreter Coordinator was the most important contributor. NB: Coordinator had trained and was experienced in Aboriginal Health Practitioner and Aboriginal Liaison Officer roles. NB: Minimal increase in interpreter booking requests from ED from baseline to 1-year intervention (from 2% to 3% of total requests). Self-discharge described as *'left against medical advice/discharge at own risk.'*

(Continues)

TABLE 2 | (Continued)

Author(s)	Location/state	Aim	Setting	Study design	Project	Time period	Participants	Main findings
Preisz et al. [20]	Urban, New South Wales	To co-design a programme to improve care and address high rates of 'leave at own risk (LAOR)' or 'do not wait to be seen (DNW)' rates for Aboriginal patients	ED	Implementation evaluation	Flexiclinic includes a rostered ED senior clinician and AHW that First Nations patients triaged as category 3–5 (ATS) are referred to the clinic. Follow-up by phone within 48 h.	June 2019 to August 2020	2609 records (2069 pre-programme, 540 post) Average of 183 patients per month	Over first 3 months of introduction, this responsive model resulted in a five-fold decrease in summed average of LAOR and DNW rates (25.2% pre-programme, 5.1% post). *Cultural safety, co-design and ongoing engagement with the Aboriginal Health Unit* identified as key to reductions in LAOR and DNW Leave at Own Risk or 'self-discharge' or 'discharge at own risk' i.e., leaving before recommended by medical team Did Not Wait defined as person who registers and then leaves before assessment
Davison et al. [21]	Urban, QLD	To improve culturally competent care. To evaluate whether the implementation project reduced rates of Take Own Leave for First Nations Peoples.	ED	Mixed methods Pre/post-test quasi experimental study Participatory action research (PAR)	Deadly RED pathway (clinical redesign): 1. Early, culturally safe engagement and information sharing 2. Clinical screening of TOL patients (48-72 h follow up call) 3. Enhancing connections and supports through increased referrals to Indigenous Health Liaison Officers and community services	June to August 2021 (pre-implementation) June to August 2022 (post-implementation)	Total: 1788	Significantly more patients took their own leave during post-implementation period (13.0% pre vs. 21.3% post). Contributors—increase in presentations, slight increase in acuity and wait time. Post-implementation—themes in staff and patient data identified *'overall improvement across accessibility, acceptability and usability of care.'* Take Own Leave describes patients that 'did not wait' (DNW) or 'left after treatment commenced' (LATC)

(Continues)

TABLE 2 | (Continued)

Author(s)	Location/state	Aim	Setting	Study design	Project	Time period	Participants	Main findings
Davison et al. [22]	Urban, QLD	To evaluate the Deadly RED redesign pathway's effectiveness in improving treatment completion and culturally competent care	ED	Mixed methods pre/post evaluation Participatory Action Research (PAR)	*As above*	June to August 2021 (pre-implementation) June to August 2022 (post-implementation)	85 yarns total: 35 yarns pre, and 50 post	Number of patients who felt their treatment was incomplete was different to the number of TOL (18 of the 48) Increased culturally competent care when re-assessed with understanding of difference of '*completion of treatment*' with First Nations patients Post-implementation, patients felt comfortable telling staff they needed to leave and that they appreciated follow up.
Oribin et al. [23]	Remote, QLD	To explore ED staff members experiences and perceptions of patient factors leading to discharge against medical advice in one remote hospital To elicit recommendations for reducing leave events	ED	Mixed methods study Survey and semi-structured interviews	Exploratory study to inform future service improvements	Between 2016 and 2017	Total: 19 – 19 completed the survey – 14 participated in interview Nurses: 10 Medical doctors: 4 Did not provide profession: 5	*'Lack of culturally sensitive healthcare services'* (94.7%) was perceived to have a strong influence on DAMA Lack of AHW or Indigenous Liaison Officer (ILO) identified as an influencing factor (36.8%) Family commitments, cultural needs not being addressed Importance of ILO as an *'intermediary'* Not understanding diagnosis, length of stay, or treatment Focus on right communication, culturally safe care and right staff (including DAMA nurse) Discharge against Medical Advice (DAMA); also known as discharge at own risk, take own leave or self-discharge, when the patient chooses to discharge themselves before their recommended treatment is complete.

(Continues)

TABLE 2 | (Continued)

Author(s)	Location/state	Aim	Setting	Study design	Project	Time period	Participants	Main findings
Stewart et al. [24]	Urban, VIC	To investigate actions taken by patients who take their own leave, focusing on those at risk of health inequity (e.g., experience homelessness, First Nations Peoples and low socioeconomic status)	ED	Quality improvement project Quantitative data Follow-up telephone survey	Telephone follow up (TFU) for patients who took their own leave Identification of First Nations patients *-self-identified to registration clerks in ED who had all completed training in asking patients about ...identity in a culturally safe way.* Culturally safe care, follow-up and referral available for First Nations patients.	January to December 2022	Total: 841 • 83.4% left not seen • 10.6% Partial treatment only • 6.1% Triage advice only	97.7% expressed gratitude at being followed up, 2.3% met with complaints Fewer surveyed patients were: – Patients who experience homelessness (EW) (6.5% EW) – First Nations (4.8%) and low socioeconomic status (35.7%) under-represented in surveyed group First Nations and those with low socioeconomic status were as likely to have seen their GP within 2 days as other groups Take Own Leave (TOL) describes patients who after triage, *'leave the ED before receiving further assessment and/or treatment from healthcare practitioners'*

'making things harder' and contributing to 'poor waiting times' [22]. Nevertheless, this project increased referral rates to an AHLO (2.7% pre-implementation, 7.5% post-implementation) and improved cultural appropriateness of care, as observed by staff [21, 22].

A remote QLD study sought to explore ED staff experiences and perceptions of patient factors that led to Discharge Against Medical Advice (DAMA). Survey and interview data revealed a 'lack of culturally sensitive healthcare services', stereotyping, language barriers, racism and intimidation as strongly influencing rates of DAMA [23]. While only 36.8% viewed the lack of an AHW or AHLO as a direct factor, qualitative data emphasised the importance of AHLOs as an '*intermediary*' [23]. Contributing factors to DAMA included cultural needs not being met and people not understanding medical advice, both of which can be addressed with improved access to AHLO services [23].

In NSW, all staff in EDs are expected to ask all patients presenting to ED if they identify as Aboriginal and/or Torres Strait Islander. A Continuous Quality Improvement (CQI) project sought to enhance cultural safety by increasing the accuracy of recording of Aboriginality in eight NSW EDs [18]. Each ED tailored the strategies implemented to their site, with seven sites including increased AHLO presence [18]. Whilst no significant improvement in incomplete ED visits was found, two of the eight EDs showed improved recording of Aboriginality [18]. However, for some of the EDs, the recording of Aboriginality was already trending up, and when all EDs were combined, there was no significant improvement in the accuracy of recording [18].

3.3.2 | Other Strategies to Reduce Leave Events for First Nations Peoples

This review identified other strategies designed to promote culturally safe and supportive environments for First Nations Peoples. These included an Aboriginal Interpreter Coordinator [19], DAMA nurses (to engage with the person before they leave the hospital) [23], and community name cards to assist in language identification [18]. Renovations to reposition the Aboriginal Support Unit to the hospital foyer and showcase 'Aboriginal artworks and acknowledge traditional owners' were undertaken to improve cultural safety [19].

In the Northern Territory, First Nations languages are spoken by 58.5% of First Nations Peoples [33]. In an ED and hospital wide programme the Aboriginal Interpreter Coordinator (prior employment as an AHW and AHP) was integral to improved interpreter booking rates and reduced self-discharge events [19]. Interpreters acted as mediators of communication and cultural safety [19]. In other states where First Nations languages are not as prevalent following the forced suppression of languages as a result of colonisation, identifying the need for interpreter services is less likely to be considered [34].

In urban Victoria, a programme follow up by phone within 24–48 h by a registered nurse of all those who TOL was mostly met with gratitude (97.7%) [24]. No difference in access to general practice attendance after TOL between First Nations and non-First Nations patients was identified [24]. This was

attributed to the close proximity of an Aboriginal Community Controlled Health Organisation (ACCHO) close to the hospital, with drop-in appointments available [24]. Improving access to culturally safe ACCHOs and providing referral systems between EDs and ACCHOs may be an effective strategy to facilitate engagement with healthcare.

3.3.3 | Holistic Understanding of Health for First Nations Peoples

In contrast with western notions of treatment completion, First Nations Peoples' holistic understanding of health may include consulting with a Ngangkari (traditional healer) [6], prioritising basic needs (e.g., food, water) and time to yarn [21, 22]. A yarning group conducted with First Nations People who TOL revealed ED processes may be misinterpreted [22]. Limited communication from ED staff resulted in misunderstanding when directed to the waiting room after arriving by ambulance, and a perception that paracetamol was administered as the 'shut up pill' [22]. ED staff members identified failure to identify and respond to family and cultural needs, such as an imperative to attend to Sorry Business as contributing to leave events [17]. Family and caring responsibilities and health literacy likewise impacted, highlighting the difference between perspectives on health between Western medicine and First Nations Peoples [23].

3.3.4 | Critical Appraisal

Consistent with recent publications, the critical appraisal of the studies included in this review found widespread failure to report implementation of all the ethical principles outlined for health and medical research that involves First Nations Peoples in Australia [18, 35] (See Table 3).

4 | Discussion

This review of the available evidence on the impact of AHLOs on First Nations Peoples' rates of leave events in the ED revealed limited robust research evidence that AHLOs can reduce leave events. First Nations Peoples' outcomes in the acute health care setting remain concerning. Recent data reports higher 7-day re-presentation rates and a statistically significant increase in 30-day mortality for Australasian Triage Scale categories 3 and 4 for First Nations Peoples presenting to the ED [36], while measures to increase the First Nations health workforce are identified as key to improving health outcomes [10]. Likewise, recommendations from the Australasian College for Emergency Medicine [37] and the Australian Commission on Safety and Quality in Health Care identify the importance of AHLOs in reducing leave events [3]. However, robust evidence evaluating programmes implementing AHLO roles and other measures to provide culturally safe health in the ED are needed.

The importance of cultural safety in reducing leave events for First Nations Peoples has been highlighted. Recently published NSW research has reported a positive association between access to an AHLO and a cultural safety score for First Nations individuals visiting hospital for care [38]. Each of the reviewed studies in this review identified cultural safety (or culturally appropriate care, culturally competent care) as integral to reducing leave events. The Dalarinji Flexiclinic was a successful programme that significantly reduced leave events [20]. The Deadly RED Project [21] and Gadsden et al.'s CQI Project were not associated with a decrease in leave events [18]. However, yarning revealed that the Deadly RED Project did improve culturally competent care and engagement with AHLOs [22]. Likewise, an Aboriginal Interpreter Coordinator improved interpreter booking rates and decreased leave events across acute care services [17]. Telephone follow-up revealed the importance of prompt, accessible, and culturally safe ACCHOs after leave events among First Nations Peoples [24]. These strategies highlight the potential benefits of increasing First Nations representation within the health workforce in combination with focused strategies adapted for local communities.

However, reducing leave events requires better representation of First Nations Peoples within the health workforce, improved partnership with First Nations Peoples during decision-making processes and a focus on meeting the needs of the community [17]. The 2025 Closing the Gap Implementation Plan includes recruitment of 260 new positions in ACCHOs [1], while the Independent Aboriginal and Torres Strait Islander Led Review emphasised the need to address the overwhelming cultural load experienced by First Nations individuals seeking to influence change and improve governmental funding support for ACCHOs [11]. Actioning the recommendations from this plan and the review to support partnership and referral-processes between ACCHOs and local EDs could be an effective strategy to improve health outcomes for First Nations Peoples attending an ED. Likewise all health care research that includes First Nations Peoples must closely adhere to the Code of Ethics for Aboriginal and Torres Strait Islander Research to ensure collaboration with communities and support cultural safety [39]. Consistent with these findings are recent recommendations from the Human Rights Commission that addressing pervasive racism requires cultural safety standards to be embedded in healthcare [40]. The need to expand interpreter services to enable equitable access is also highlighted [40].

4.1 | Recommendations for Further Research

Further research is needed to explore the impact of AHLOs on First Nations Peoples' engagement with the ED beyond simply measuring leave events. Qualitative studies that explore the experiences of First Nations Peoples in Australian EDs and the impact of AHLOs on attendance in the ED provide insights and perspectives to inform the implementation of effective programmes to support cultural safety and reduce leave events. The importance of qualitative research was demonstrated in the Deadly RED Project, where quantitative measures of TOL contrasted with those who felt their treatment was complete during yarning [22]. Likewise, utilising a robust monitoring framework is needed to support widespread measures to ensure cultural safety [41].

All further research should begin with a focus on responding to a need in the community, using strengths-based reforms,

TABLE 3 | Critical Appraisal against the Aboriginal and Torres Strait Islander Appraisal Tool.

Questions		Gadsden et al. [18]	Davison et al. [21]	Davison et al. [22] (Yarning)	Stewart et al. [24]	Oribin et al. [23]	Preisz et al. [20]	O'Connor et al. [19]
1	Did the research respond to a need or priority determined by the community?	Yes	Yes	Yes	No	Unclear	Yes	Unclear
2	Was community consultation and engagement appropriately inclusive?	Yes	Yes	Yes	No	Unclear	Partially	Unclear
3	Did the research have Aboriginal and Torres Strait Islander research leadership?	No	Partially	Partially	No	No	No	No
4	Did the research have Aboriginal and Torres Strait Islander governance?	No	Partially	Partially	No	No	Partially	No
5	Were local community protocols respected and followed?	Unclear	Unclear	Unclear	No	Unclear	Unclear	Unclear
6	Did the researchers negotiate agreements in regards to rights of access to Aboriginal and Torres Strait Islander peoples' existing intellectual and cultural property?	Unclear	Unclear	Unclear	No	Unclear	Unclear	Unclear
7	Did the researchers negotiate agreements to protect Aboriginal and Torres Strait Islander peoples' ownership of intellectual and cultural property created through the research?	Unclear	Unclear	Unclear	No	No	Unclear	Unclear
8	Did Aboriginal and Torres Strait Islander peoples and communities have control over the collection and management of research materials?	Unclear	Partially	Yes	No	No	No	No
9	Was the research guided by an Indigenous research paradigm?	Yes	Yes	Yes	No	No	Yes	No
10	Does the research take a strengths-based approach, acknowledging and moving beyond practices that have harmed Aboriginal and Torres Strait peoples in the past?	Yes	Yes	Yes	Partially	Partially	Yes	Partially
11	Did the researchers plan and translate the findings into sustainable changes in policy and/or practice?	Yes	Partially	Partially	Partially	Unclear	Yes	Partially
12	Did the research benefit the participants and Aboriginal and Torres Strait Islander communities?	Unclear	Partially	Partially	Unclear	Unclear	Yes	Unclear
13	Did the research demonstrate capacity strengthening for Aboriginal and Torres Strait Islander individuals?	Unclear	Unclear	Unclear	No	No	Unclear	Unclear
14	Did everyone involved in the research have opportunities to learn from each other?	Partially	Yes	Yes	No	Unclear	Yes	Unclear

First Nations leadership and a First Nations lens [42]. Without applying a First Nations lens, the interconnected determinants of health and wellbeing for First Nations Peoples can be overlooked [11].

4.2 | Limitations of This Review

A lack of consistency in terminology and definitions used for leave events was found in the reviewed papers, limiting comparison between programmes. For example, TOL incorporated both DNW and LATC as one data point [21, 22], while DAMA was extended beyond leaving against medical advice to include TOL, self-discharge and discharge before treatment is complete [23]. Of the seven studies, only two included rural locations [18, 23]. There is limited data on the differences in impact of programmes focused on reducing leave events in settings that are urban/metropolitan versus remote Australia.

5 | Conclusion

Consistently high rates of leave events by First Nations Peoples from Emergency Departments continue to be reported in the Australian context. While the positive impact of AHLOs situated in acute care settings has been reported, this review found limited research specific to AHLOs' impact on leave events explicitly in the ED context. Emerging evidence indicates implementing this role in the ED in conjunction with strategies to increase cultural safety offers an opportunity for a long-lasting reduction in ED attendance for First Nations Peoples.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** emm70230-sup-0001-supinfo.docx.