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ORIGINAL PAPER

# Cultural Safety and Child Protection Responses in Hospitals: a Scoping Review

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## Abstract

The objective of this scoping review was to map the current practice and best evidence for embedding cultural safety in child protection responses for Aboriginal families in hospitals. Electronic databases were searched systematically and the reference lists examined. Efforts to reduce the risk of bias were made including using an inductive approach. Eight research papers were included following the exclusion of 25 papers for the final analysis. Three main themes in relation to what is necessary to embed cultural safety for Aboriginal families when child protection responses are raised in hospital were found. These were (a) relationships, (b) organisational processes and (c) culture. The analysis underscores the need for development of child protection strategies that focus on cultural safety rather than cultural competence alone. This provides some direction for policy and practice development in this field, and has also highlighted the deficiencies in evidence and urgent need for further research.

**Keywords** Cultural safety · Hospitals · Aboriginal · Child protection

**Key Points** • This study underscores the need to build stronger evidence for embedding cultural safety in frontline health professional child protection responses for Aboriginal families. The available evidence points to three key elements that are necessary: relationship building, strong organisational processes and respect for culture.
• The results suggest that process-driven approaches to child protection responses in Australian hospitals be replaced with relationship-building approaches for Aboriginal families at risk of engaging with child protection services.
• Organisations that form strong partnerships with Aboriginal communities and services and employ dedicated Aboriginal staff are likely to succeed in their attempts to promote cultural safety for Aboriginal families at risk of engaging with child protection services.

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## Introduction

Australian Aboriginal and Torres Strait Islander (respectfully referred to hereafter as Aboriginal) children benefit from a strong sense of cultural identity, and emerging evidence supports the strengths of Aboriginal cultures in contributing to safe, stable and supportive family environments (Young et al. 2017; Lohoar et al. 2014). However, many contemporary Aboriginal families live with a deeply emotional history of cultural destruction (Firpo and Jacobs 2018), resulting in inter-generational trauma and widespread disadvantage (Duthie et al. 2019). This is evident in the disproportionality of Aboriginal children in child protection interventions and out-of-home care services (AIHW 2019; SCRGSP 2019) and related indicators that include experiences of homelessness, interactions with the juvenile justice system and hospital admissions for injuries and assault (AIHW 2014).

A public health approach to the prevention of child abuse and neglect involves the provision of universal prevention and early intervention services that are intersectional and trauma-informed and incorporate cultural strength–based practice (CFCA 2015). Identification of the centrality of culture is developing in Australian literature with examples also found in child protection frameworks internationally, including Canada (IPAC and AFMC 2009; Shah and Reeves 2015), New Zealand (Aspinall et al. 2020), the USA (Darroch et al. 2017) and Europe (Spratt et al. 2015).

Australian policy statements affirm the need for action, firstly in the deconstruction of thinking and structures that perpetuate the existing status quo of Australian child protection systems (Lewis et al. 2017), as well as the need for culturally competent staff and culturally safe child protection services (Lonne et al. 2016; Lonne et al. 2013; AGDH 2013; ACSQHC 2017; CATSINaM 2017; AGDH 2014; AHMAC 2017). However, there is little empirical evidence available to inform the translation of cultural safety policy into health professional practice (Lock et al. 2020).

The Australian cultural reform agenda includes incorporation of cultural safety principles in health and child welfare practice guidelines and curricula (AHPRA 2020; SNAICC 2008; Lewis et al. 2017; AGDH 2014; Fernando and Bennett 2019; AASW 2020). Operationalisation of these principles often relies on professional development training to improve interpersonal communication. Whilst cultural training is reported as essential to attitudinal change (Kerrigan et al. 2020), establishing evidence of effectiveness is challenging (Truong et al. 2014; Di Ruggiero et al. 2020).

Frontline health professionals who learn and practice within this context of cultural health reform are confronted with conceptual barriers in cultural terminology. Cultural safety (Williams 1999; Bin-Sallik 2003) emphasises the power of the patient to determine what is culturally safe practice, asks health professionals to reflect on their profession's role in colonisation and requires services to respond to cultural differences (Fleming et al. 2019). In contrast, cultural competence (Cross et al. 1989) locates power in the professionals' hands to determine competent care and predicates service delivery on 'treating everyone the same' (Carberry 1998; Pon 2009), which can reinforce a deficit view of Aboriginal cultures. It is argued that child safety must include cultural safety (SNAICC 2008) and cultural competence is necessary to deliver culturally appropriate services (SNAICC 2010), locating health professionals in a complex conceptual landscape.

Therefore, the objective of this scoping literature review was to understand current practice and best evidence recommendations for embedding cultural safety in child protection responses for Aboriginal families in hospitals. The rationale for the review was to address a translational policy to practice gap in Australian hospitals leaving health professionals in need of evidence-based strategies and tools to provide culturally competent care for Aboriginal families with children involved, or at risk of becoming involved, in child protection services. The research questions were as follows:

i. What is the current practice of health professionals in child protection responses to Aboriginal families in the hospital setting?
ii. What are the current best evidence recommendations for embedding cultural safety in health professional child protection responses to Aboriginal families in the hospital setting?

## Methods

### Approach

This paper reports on the results of peer-reviewed journal articles, with analysis of grey literature to be presented elsewhere. The rationale for the methodology is as complex as the cultural landscape of Australian and international First Nations Peoples' cultures (Anderson et al. 2016), and informed by a sharing and integration of health, research and Aboriginal peoples' cultural knowledges.

The review methodology was informed by Williams' (1999) Australian definition of cultural safety, as a 'shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening' (p. 213). As non-Aboriginal ($n = 3$) and Aboriginal ($n = 3$) researchers, the authorship represents a diverse team of clinicians, educators and researchers, working across the cultural interface (Nakata 2013) of professional, personal and family experiences with child protection services and health systems.

### Search Strategy

Scoping literature reviews aim to detect literature on disparate topics, map conceptual inter-relationships and ascertain gaps in knowledge for future research. This scoping review explored literature in the domains of health, child protection, inter-professional collaboration, Aboriginal families and culture. Relevant concepts were established and search terms were built iteratively from the published literature through a scoping review methodology (JBI 2015).

Relevant concepts were as follows: Aboriginal, Indigenous, Torres Strait Islander, First Peoples, healthcare professionals (clinicians, paediatricians), emergency department (hospital, tertiary), child protection, family, cultural safety, cultural competence, non-accidental injury, clinical governance, Australia, SCAN (suspected child abuse and neglect), ROSH (risk of significant harm), out-of-home-care, maltreatment, collaborative, integrated, communication and screening. These concepts informed the development of the search domains: Aboriginal children and families, needs assessment, child

protection services, inter-professional collaboration, cultural safety and cultural competence and hospital. From this, a search strategy was built (see Fig. 1).

The search was conducted from November 2018 to February 2019, and included government policy documents and Internet sites of journals and professional associations. An example search string used was (JT:Aborig* OR JT:Indig* JT:Or JT:"torres strait") AND hospital AND children. The specific information sources were ATSIHealth, APAIS-ATSIS; Informit Indigenous Collection; DARE; CINAHL Complete; PubMed; Scopus, ProQuest (Medline, Australia & New Zealand Database, Family health database, health and medical collection, nursing and allied health database, public health database and e-book central), the Campbell Library, the Cochrane Library, the Web of Science, EBSCOhost, Prospero and MedNar. Search strategy and inclusion/exclusion criteria are included in Figs. 1 and 2.

The search strategy for grey literature used keywords in each website from the following: The Australian Indigenous Health*InfoNet* (sic); the Closing the Gap Clearinghouse; the NSW Ministry of Health, the National Aboriginal Community Controlled Health Organisations and the Healing Foundation. The returned results from each webpage were scanned for relevance for the length of 10 pages. The reference lists of all documents were scanned by title and potential journal papers retrieved. All Australian-only articles were screened regardless of quality and type of research, from any year of publication. All citations were imported into Endnote X7 referencing software, with duplicates removed.

Relevant data tables were developed and the results from the data extraction completed by a non-Aboriginal lead researcher (TF) were verified by both Aboriginal (ML, JS, DH) and non-Aboriginal (JF, BL) members of the research team. Quality appraisal was conducted using the Joanna Briggs Institute's Checklist for Qualitative Research (JBI 2015) and included in Table 1.

## Analysis

The analytical rationale was informed by the Ngaa-bi-nya Aboriginal and Torres Strait Islander program evaluation framework (Williams 2018) and the translational research framework i-PARIHS (integrated Promoting Action on Research Implementation in Health Services). The i-PARIHS framework has been applied previously in Aboriginal research (McCalman et al. 2014; Laycock et al. 2018), and reflects Aboriginal peoples' world views of health, facilitation through multiple levels, the significance of

1. Health professionals OR health care providers OR health workers OR health administrators OR health workforce OR nurses OR doctors OR allied health workers OR medical practitioners OR health services OR primary care OR private practice OR community health OR hospitals OR paediatricians OR clinicians AND interprofessional collaboration.
3. Hospital OR Emergency department OR Tertiary OR Acute
5. Screen OR Assess AND non-accidental injury
4. Indigenous OR Aborigin* OR Torres Strait Islander OR First Nations AND Child* OR Infants OR Families AND child protection services OR out-of-home care
5. Model of Care AND healthcare setting
6. Australia
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6.

**Fig. 1** Search strategy

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| A focus on either Aboriginal families with children involved, or at risk of becoming involved in child protection services **OR** Australia's First Peoples healthcare | Not Australian, non-healthcare setting, focus on disease or illness, or included adults only |
| **AND** | |
| Interprofessional/health professional collaboration **OR** emergency department assessment and screening processes **OR** models of care in the hospital setting | |

**Fig. 2** Inclusion and exclusion criteria

relationships and communication and integration through multiple organisations within different social policy domains, with a view of 'culture' as complex integrated patterns of norms. The Wiradjuri (Aboriginal) worldview embedded in Ngaa-bi-nya, and associated foundational concepts of relationships, holistic views of health, and Aboriginal rights, informed subsequent research and model of care development.

This framework maintains an emphasis on the construct of facilitation to traverse multi-dimensional views, primarily through improvement of communication (Jennings et al. 2018) and relationships (Molloy and Grootjans 2014) with Aboriginal peoples. Processes of integration are in alignment with intersectoral collaborative policy (Harfield et al. 2018), Aboriginal holistic views of health (Lutschini 2005) and 'integrated patterns' as definitions of culture (Bamblett et al. 2010).

An iterative and inductive three-staged thematic analysis (immersion through detailed reading and re-reading, coding and re-coding) (Bernard and Ryan 2010) was sensitised by the Ngaa-bi-nya and i-PARIHS frameworks, with four interrelated governance dimensions: how things get done (processes); the interaction and connection between people (relationships); how processes are operationalised (institutions); and key concepts or activities (structures) (Gwynn et al. 2015).

The intersectional complexity is captured in the heuristic of safe cultural governance (Fig. 3), with its seven hexagonal cores (Aboriginal families at the centre of care) connected to one another (box arrows) and to each other (double-headed box arrows). The Ngaa-bi-nya domains (resources, ways of working, learnings and landscape) wrap around Aboriginal families. The i-PARIHS framework is apparent in the 'facilitation' swirl that interconnects contextual levels in Western governed systems (Harvey and Kitson 2014). The intersectional themes are positioned between the Ngaa-bi-nya domains and touch the i-PARIHS facilitation swirl to indicate the 'shared' ethic of cultural safety. Whilst at times critiqued as simplistic stylisations of complicated and interwoven factors, such heuristics are also a valuable component of the translational research process.

## Results

The database searches identified 1050 papers of which the titles and abstracts were screened by two researchers (ML, TF). Inconsistencies in reviewer assessments were resolved by consensus, to leave thirty-three articles for full reading by three researchers (ML, TF, JF) (see Fig. 4). After quality appraisal of twelve of these

**Table 1** JBI quality appraisal assessment culturally safe care for at-risk Aboriginal children and families in hospital

| | Is there congruity between the stated philosophical perspective and the research methodology? | Is there congruity between the research methodology and the research question or objectives? | Is there congruity between the research methodology and the methods used to collect data? | Is there congruity between the research methodology and the representation and analysis of data? | Is there congruity between the research methodology and the interpretation of results? | Is there a statement locating the researcher culturally or theoretically? | Is the influence of the researcher on the research, and vice-versa, addressed? | Are participants, and their voices, adequately represented? | Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? | Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data? | Overall appraisal |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Attwood et al. (2015) | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | - | ✓ | ✓ | Include |
| Chamberlain et al. (2016) | ✓ | ✓ | ✓ | - | ✓ | - | - | - | - | ✓ | Include |
| Chapman et al. (2014) | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | ✓ | ✓ | ✓ | Include |
| Chong et al. (2011) | n/a | n/a | n/a | n/a | n/a | - | - | n/a | n/a | n/a | Exclude |
| Durey et al. (2012) | - | - | - | - | - | - | - | n/a | n/a | - | Exclude |
| Herring et al. (2013) | - | - | - | - | - | ✓ | Partially | - | - | - | Exclude |
| McAullay et al. (2018) | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | n/a | ✓ | ✓ | Include |

**Table 1** (continued)

| | Is there congruity between the stated philosophical perspective and the research methodology? | Is there congruity between the research methodology and the research question or objectives? | Is there congruity between the research methodology and the methods used to collect data? | Is there congruity between the research methodology and the representation and analysis of data? | Is there congruity between the research methodology and the interpretation of results? | Is there a statement locating the researcher culturally or theoretically? | Is the influence of the researcher on the research, and vice-versa, addressed? | Are participants, and their voices, adequately represented? | Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? | Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data? | Overall appraisal |
|---|---|---|---|---|---|---|---|---|---|---|---|
| McAuliffe et al. (2016) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | ✓ | ✓ | ✓ | Include |
| Nyanga et al. (2018) | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | ✓ | ✓ | ✓ | Include |
| Raman et al. (2017) | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | - | ✓ | - | Include |
| Tanner et al. (2005) | ✓ | ✓ | ✓ | ✓ | ✓ | - | - | ✓ | ✓ | ✓ | Include |
| Watson et al. (2013) | ✓ | ✓ | ✓ | - | - | - | - | - | ✓ | - | Exclude |

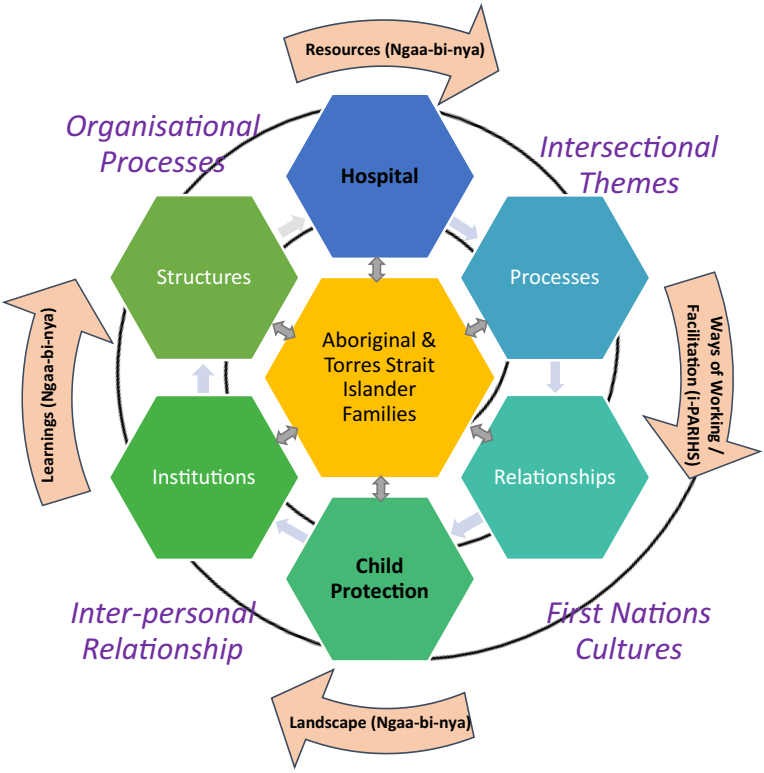


**Fig. 3** Heuristic of safe cultural governance for the intersection between healthcare and child protection

(Table 1), eight were included for full analysis. Summary characteristics of included articles are shown in Table 2. Thematic analysis revealed three intersectional themes crossing the disparate literature: relationships, organisational processes and culture. The overall emergent theme was of culturally safe governance, and is detailed below. Results were translated into practical considerations on a foundation of the analytical methodology (Table 3).

## Current Practice in Child Protection Responses

The published research in this period (2004–2020) indicates that there had not been any strategic approach to developing the field of research directed towards intersectional practice for the benefit of Aboriginal families. The emphasis of each article differed, from hospital document analysis of admissions data (Attwood et al. 2014), care coordination framework development (Chamberlain et al. 2016), perceptions of experiences of Aboriginal people in attending a hospital emergency department (2014), relationship between organisational participation in a continuous quality improvement programme and improving care and outcomes (McAullay et al. 2018), relationships in child protection practice (McAuliffe et al. 2016), cultural competency training in health professionals in a tertiary hospital (Nyanga et al. 2018), health development needs and

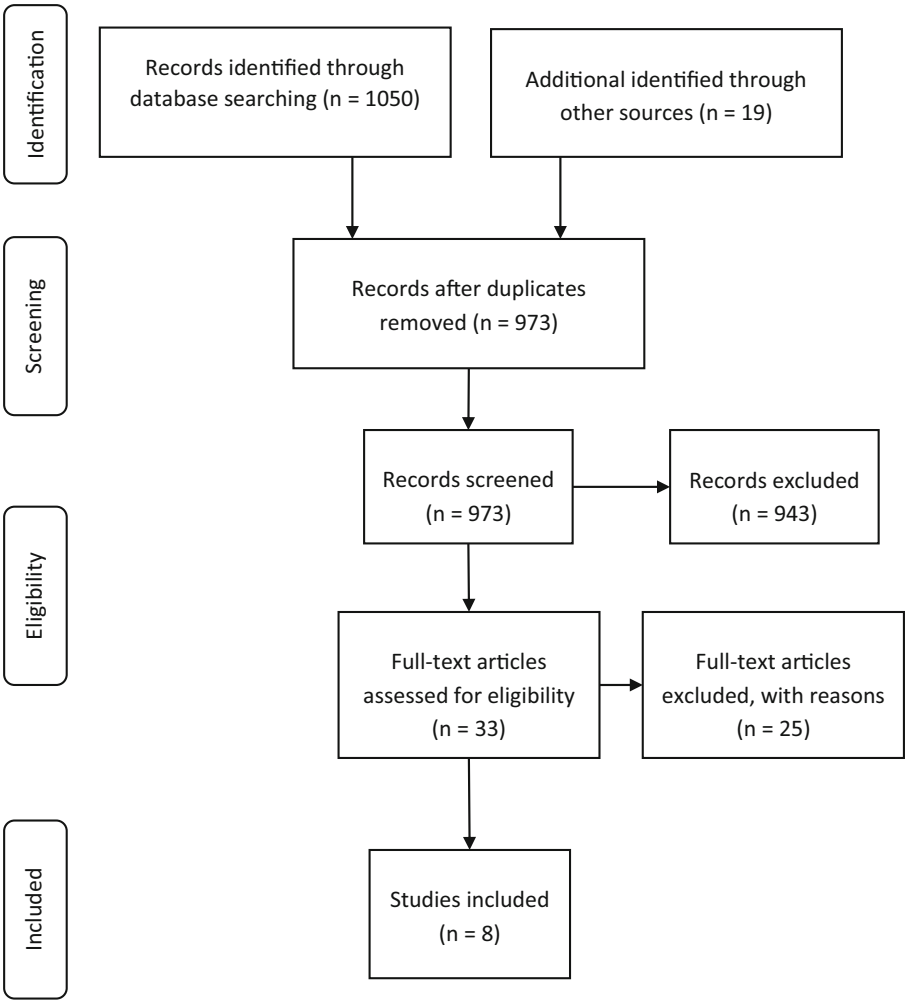


**Fig. 4** PRISMA flow diagram for culturally safe care for at-risk Australian Aboriginal children and families in hospital

outcomes of children in out-of-home care (Raman et al. 2017) and the hospitalisation experiences of remote Aboriginal families visiting an urban hospital (Tanner et al. 2004). Taken together, this indicates fragmented research effort exploring child protection responses.

## Best Evidence Recommendations for Embedding Cultural Safety

When the quality appraisal was undertaken, it revealed that four potentially relevant articles (Table 1) were excluded due to poor methodological, empirical or cultural rigour in research design. The eight articles that were included gained similar scores on all quality questions, with a noticeable absence of statements locating the authors culturally or theoretically. Reflection of their influence on the research was missing (Table 1, columns 6 and 7). Methods used were diverse: document analysis and

**Table 2** Summary characteristics of included articles

| Author/year | Aims | Participants | Method | Results/outcomes | Conclusion |
|---|---|---|---|---|---|
| Attwood, L., Rodrigues, S., Winsor, J., Warren, S., Biviano, L. & Gunasekera, H. (2014) | Identify opportunities to improve healthcare delivery for urban Aboriginal children requiring hospital admission and to determine their characteristics. | Admissions data of recorded as Aboriginal and/or Torres Strait Islander | Document analysis and descriptive statistics of admissions data. | In 2010, 543 (2%) patients admitted to the institution were identified as Aboriginal and/or Torres Strait Islander. Of all admitted children, 148/543 (27.3%) were referred to Aboriginal health professionals during admission, more when length of stay was greater than 7 days (61% vs. 23%, $P < 0.001$). There was documentation of Aboriginal and/or Torres Strait Islander status in 8/543 (1.5%) medical and 1/543 (0.2%) nursing discharge summaries. | Several opportunities to improve culturally appropriate healthcare delivery for Aboriginal and Torres Strait Islander children admitted to hospital were identified, including improved recognition of Aboriginal and/or Torres Strait Islander status of patients, improved access to Aboriginal health professionals and increased performance and documentation of basic anthropometry, ear examination and immunisation catch-up. |
| Chamberlain, C.R., MacLean, S., Bawden, G., Kelaher, M., Munro-Harrison, E., Boyle, J. & Freeman, K. (2016) | Develop a care coordination framework that has been developed from a limited range of clinical settings. | Service providers and an Aboriginal mother | Narrative synthesis from stakeholder consultation, service mapping and in-depth interviews. | A fragmented range of services support Aboriginal families with complex and changing needs, highlighting the importance of care coordination. Relationships underpinned care coordination; however, few opportunities were identified for developing relationships and several factors that | The Care Coordination Framework enabled a 'systems-perspective' of the main care coordination domains for Aboriginal families from individual experiences. However, there were some limitations in capturing subtle historical and cultural dimensions affecting care coordination in this context |

**Table 2** (continued)

| Author/year | Aims | Participants | Method | Results/outcomes | Conclusion |
|---|---|---|---|---|---|
| | | | | undermined relationships, including unclear accountability mechanisms, resource constraints, anxiety about follow-up and transfer of information to child protection. The Care Coordination Framework enabled a 'systems--perspective' of the main care coordination domains for Aboriginal families from individual experiences. | where healthcare practice in large institutions is framed by the dominant culture. An additional 'equity' domain would capture these dimensions, address a growing international policy challenge and strengthen the framework. |
| Chapman, R., Smith, T. & Martin, C. (2014) | Explore the perceptions of Aboriginal people regarding their experiences of attending an Australian ED | 16 Aboriginal community members | Thematic analysis. This study utilised a qualitative approach with Aboriginal community members who were invited to participate in semi-structured focus groups/yarns ($n = 3$). | Three major themes that either enabled or acted as barriers to the Aboriginal community accessing the ED were identified from the data. These included organisational processes, interpersonal interaction with staff and strategies for improvement (waiting room, communication strategies, cultural awareness training and identifiable cultural features). | Adds insight into the barriers and enablers Aboriginal patients experienced when accessing a metropolitan ED. The information gained from this study will assist hospital and ED executives to work in collaboration with the Aboriginal community to develop and implement policies and practices that ensure Aboriginal patients receive culturally appropriate quality care. |

**Table 2** (continued)

| Author/year | Aims | Participants | Method | Results/outcomes | Conclusion |
|---|---|---|---|---|---|
| McAullay, D., McAuley, K., Bailie, R., Mathews, V., Jacoby, P., Gardner, K., Sibthorpe, B., Strobel, N. & Edmond, K. (2018) | Determine whether participation in a continuous quality improvement programme improved care and outcomes for Aboriginal children. | Data were collected from 59 Australian primary healthcare centres providing services to Aboriginal people and participating in the programme. Children aged less than 2 years. | Odds ratio (OR) and 95% confidence interval (CI) were calculated. Outcomes were related to age-relevant health issues, including prevention and early intervention. | During the audit period, there were 2360 files from 59 centres. Those that had a recall recorded improved from 84 to 95% (OR 2.44, 95% CI 1.44–4.11). Hearing assessments improved from 52 to 89% (OR 1.37, 95% CI 1.22–1.54). Improvement in anticipatory guidance, treatment and follow-up of medical conditions was almost universal. | There were significant improvements in quality of care of Aboriginal children. Outcomes and their corresponding treatment and follow-ups improved over time. This appears to be related to services participating in annual CQI activities. However, these services may be more committed to CQI than others and therefore possibly better performing. |
| McAuliffe, D., Tilbury, C., Chenoweth, L., Stehlik, D., Struthers, K., & Aitchison, R. (2016) | Examine the inter-relationships between practitioners, agencies, families and community members in child protection practice with Aboriginal families. | 30 child protection practitioners (16 non-Aboriginal, 14 Aboriginal, 8 males, 22 females). | In-depth semi-structured interviews. | The three relationships were (i) the relationship frontline child protection workers have with children, young people, families and communities; (ii) the relationships between Aboriginal and Torres Strait Islander and non-indigenous practitioners; and (iii) the relationship between statutory and non-government service providers and agencies. | Practitioners in this study sought to build respectful relationships with families and communities—and specifically with Aboriginal and Torres Strait Islander people. Their capacity and scope for providing what they deemed to be effective care and support was limited by statutory requirements, including the decision-making, recording and administrative requirements of their work. |

**Table 2** (continued)

| Author/year | Aims | Participants | Method | Results/outcomes | Conclusion |
|---|---|---|---|---|---|
| Nyanga, R., Biviano, L., Warren, S., Windsor, J., Zwi, K. & Gunasekera, H. (2018) | Determine the cultural competency training, knowledge and attitudes of health professionals about Aboriginal and healthcare delivery. | Medical ($n = 75$), nursing ($n = 88$) and other health professionals ($n = 123$). | Survey of health professionals working in two tertiary paediatric hospitals in December 2013. | Survey responses from 286 of 572 (50.0%) staff with valid emails. A minority reported receiving specific Aboriginal health training (44.8%) and Aboriginal cultural competency training (37.1%). Medical staff were less likely than others to report Aboriginal healthcare training ($P = 0.01$), cultural competency training ($P < 0.001$) and that their training equipped them to manage Aboriginal patients ($P = 0.04$). Few medical staff reported a good/very good knowledge of the services provided by the Aboriginal Community Controlled Health Services (20.0%), the Federal Government Closing the Gap initiative (14.7%) or the Royal Australasian College of Physicians' Reconciliation Action Plan (8.0%). Only 21.7% of staff agreed that they usually asked patients/parents | The opportunities identified to improve healthcare delivery to Aboriginal patients include increasing Aboriginal cultural competency training, correct identification of Aboriginal patients, referring Aboriginal patients to Aboriginal healthcare services and increased awareness of Aboriginal Community Controlled Health Services. |

**Table 2** (continued)

| Author/year | Aims | Participants | Method | Results/outcomes | Conclusion |
|---|---|---|---|---|---|
| | | | | whether they identified as Aboriginal. Although 89.5% agreed that Aboriginal staff were an important resource, only 43.7% had referred Aboriginal patients to one. | |
| Raman, S., Ruston, S., Irwin, S., Tran, P., Hotton, P. & Thorne, S. (2017) | (1) Determine the health and developmental needs of a subset of children in out-of-home care with KARI; (2) identify child, carer and intervention characteristics that contributed to children doing well; and (3) identify enablers and barriers to providing culturally competent intervention. | Database, key informants. | Descriptive statistics and thematic review. Used a 'framework approach' to analyse the qualitative data (interviews and group discussion), indexing and charting (clinical audit), and interpretation. | The health and developmental profile of the 26 children identified as being in stable care was similar to that of previous audits. Most (88%) were getting speech pathology intervention; one-third were getting occupational therapy and psychological intervention; most children and their carers attended cultural programmes. The majority of children (25/26) improved in their developmental health. Caseworkers and therapists identified risk and resilience factors related to child, carer and home characteristics. They also identified elements of good practice; systemic issues prevented some | There are challenges delivering a trauma-informed, culturally respectful service to Aboriginal children in out-of-home care in an urban setting, but it can be done if attention is paid to culture and the enablers and barriers are identified. |

**Table 2** (continued)

| Author/year | Aims | Participants | Method | Results/outcomes | Conclusion |
|---|---|---|---|---|---|
| | | | | interventions from being carried out. | |
| Tanner, L., Agius, K., & Darbyshire, P. (2004) | Explore the hospitalisation experiences of families of Aboriginal children from remote areas and those of their primary nurses. | Nurses (2), Aboriginal liaison worker (1), family members (3), Aboriginal cultural advisor (2). | This small-scale exploratory study used Dadirri, an Indigenous research methodology developed from a practice of the Ngangikurungkurr people of the Daly River region in Australia's Northern Territory. Participatory design and engagement resulting in interview thematic analysis. | Themes: Coming down (very remote community to Alice Springs—'feeling scared and nervous'); being in hospital (hospitalisation as a significant culture shock); experiencing isolation and loneliness; importance of family; interaction with staff (professionals' failure to recognise culture shock, professional nature of interactions, misunderstood and unsupported); a play to stay (nature of hospital accommodation aggravated the feeling of isolation); and health (interconnectedness between family, culture and health). | This paper argues that many family members' experiences of 'coming down' and 'being in hospital' related to cultural safety. For the Aboriginal families involved in this study, cultural shock was extreme. The significant cultural differences between staff and participating families, fear, powerlessness and isolation from their family, their community and therefore their culture, all contributed to the families' health-impacting experiences of being culturally desituated and unsafe. |

**Table 3** Concept analysis of safe cultural governance with practical actions

| Safe cultural governance-Ngaa-bi-nya 'critical success factors' and i-PARIHS[a] | Practical and facilitation actions |
|---|---|
| Processes (i-PARIHS: facilitation actions, Ngaa-bi-nya: interconnecting links between domains)<br>• *journey and pathways* (referral, enter hospital, waiting room, present to triage nurse, moving into ED or proper wards, rates of presentation to hospital emergency departments; *admission*: emergency self-presentation or ambulance; booked, and other—e.g. transfers from other hospitals)<br>• *general barriers* (limited time and resources, long waiting times, monitoring and follow-up, transport, housing and links to relevant services)<br>• *system issues* (continuous quality improvement, standardised audits, Medicare 715 child health check, child listed on a recall system); *pathways* (early identification, treatment and specific follow-up)<br>• *professional practice* (plan of patient care, decision-making tools, statutory in-office tasks, visiting frequency)<br>• *quality improvement* (audit, good practice guidelines, multidisciplinary clinic model, assessment tools and criteria)<br>• *family barriers* (travel from a remote community to entering an urban hospital, finding accommodation, connecting with staff, allocated to care, understanding processes, coping with childcare, complex and changing needs) | Consider:<br>1. the family journey through their care plan, the organisations, and the system,<br>2. the general barriers that affect good service delivery,<br>3. the systemic issues that affect your service,<br>4. your standards of professional practice,<br>5. the quality improvement initiatives and<br>6. the family barriers affecting their engagement with the service. |
| Relationships (i-PARIHS: facilitation, recipients; Ngaa-bi-nya: ways of working)<br>• *identity* (access to Aboriginal staff, access to immunisation and Closing the Gap pharmaceutical schemes)<br>• *professionals/people/stakeholders* (Aboriginal health education officer, Aboriginal manager, ward clerk, longevity of staff, triage nurse, training staff in cultural matters and culture and protocols, Aboriginal liaison officer, auditors, pre-service and in-service training of healthcare professionals, child protection practitioners, Aboriginal staff, reliance on Aboriginal co-workers, non-indigenous practitioner confidence, scope of practice, employment, training, case-loads, medical, nursing, and other, training, Aboriginal staff to bridge cultures, caseworkers, therapists, clinicians, awareness of the contextual nature of family placements, kinship carers strongly culturally connected, clinical team, manage, training of health workers, system representatives, service providers, Aboriginal and non-Aboriginal community people, 'service navigator' or 'care coordinator' roles, reliance on informal personal relationships, high turnover of staff, and networks of sharing, nurses, team, trigger questions, meaningful access, Indigenous staff, staff attitudes, reflect on cultural identity)<br>• *attitudes*, *behaviours*, *values* (absence of staff interaction, mutuality and trust, effort made to maintain dignity and provide care, bedside manner, promoting hospitality through increased thoughtfulness, engaging more formally with Elders, spending time with community groups, | Consider:<br>1. asking about the cultural identity of Aboriginal families and if they would like to yarn with a First Nations liaison officer,<br>2. the range of stakeholders that families need to engage with in order to meet multiple needs,<br>3. reflecting on your attitudes, behaviours, and values; also reflect on your approach to professional practice,<br>4. attending cultural awareness training,<br>5. developing communication skills such a language use and style and<br>6. how families feel in the hospital environment and what can be done for their social and emotional wellbeing. |

**Table 3** (continued)

| Safe cultural governance-Ngaa-bi-nya 'critical success factors' and i-PARIHS[a] | Practical and facilitation actions |
|---|---|
| taking the time to interact, problem solving with participants, reflect on 'know it all' sense of superiority, reflect on value 'of no difference', engaging, manner, capacity to engage and develop rapport, time to be heard, consider staff role and professional identity, staff self-awareness, level of local community knowledge, cultural awareness, knowledge, attitudes, understanding, accessible, flexible, self-reflective, aim for positive connections to family, responsive, invested, experiences, collaborative, consultation, involved in decision-making, acutely aware of environment, awareness of being a minority, being balanced, recognition, and taking action)<br>• *communication* (yarning, not asked about identity as assumptions based on looks, lack of sensitivity to culture, protocol for cultural training, scarce information, sources of information and support, non-Indigenous unease, better understand culture and difference, local training, local context, learning is continuous, email, ask patients about their identity, communication difficulties/breakdown, connect with staff, role confusion, link to community and family, communication style, professional relationships, skills)<br>• *family barriers* (long waiting times, pain in children, having other children in the ED, waiting in the triage queue)<br>• *patient feelings* (scared, nervous, anxiety, fear, lost, appreciation, adjust parenting role, isolation, alone, depressed)<br>• *approach* (relationship-based practice, reflective practice, links three types of relationships, lack of trust in relationships, power relations, practitioner recognition, relationships with Elders to develop cultural knowledge, community development approach, affected by the legal framework, family, cultural protocols, collaboration)<br>• *intervention* (speech pathology, occupational therapy, psychological, group therapy, group discussion with structured topic guide) | |
| Institutions (i-PARIHS: outer context, inner context: organisational level; Ngaa-bi-nya: landscape)<br>• *health outcomes factors* (weight, height and head circumference; immunisation status; middle ear examination; socio-economic demographics)<br>• *bureaucracy* (lack of apparent 'policy and funding coordination', system complexity, multiple levels, care coordination framework, healthcare expenditure)<br>• *systemic issues* (cross-system, partnerships and system collaboration)<br>• *principles* (trust, constructive relationships, engagement, accountability, responsibility and advocacy)<br>• *symbolic* (Aboriginal signage, flags and artwork in public places)<br>• *history* (underlying anxieties and fears in accessing care; legacy of past removal, colonisation, white privilege, decolonisation, anger and mistrust, racism, role of trauma, traumatic past hospitalisation experiences, labelled, government policies: Stolen Generations, participation, social determinants of health) | Consider:<br>1. the history of society and governments affects families' willingness to engage with service provider organisations,<br>2. how social norms influence law, legislation, regulations and policies and strategies,<br>3. principles of the health and child protection systems,<br>4. the power of symbolism in flags, signs, artwork and language,<br>5. the perspectives embedded in the health and child protection systems,<br>6. the strengths of cultural aboriginal cultural norms and values and<br>7. the role that information—in all its forms—plays at every level from system to organisation to profession to practice. |

**Table 3** (continued)

| Safe cultural governance-Ngaa-bi-nya 'critical success factors' and i-PARIHS[a] | Practical and facilitation actions |
|---|---|
| • *perspectives* (humanist, managerialism, statutory powers, meaningful collaboration, value relationships, rules and regulations, decision-making process, interpretive lens of 'best interests', theorised understanding, government, Indigenous control, equitable, protection, resilience framework, Aboriginal community, therapeutic alliance, risk and protective factors, work together, participated, trauma-informed perspective, wellbeing, home level, family level, intervention and service perspective, tailored interventions; systems thinking, individual behaviour level, historical and cultural dimensions, equity domain to encompass cultural dimensions)<br>• *cultural* (culturally respectful to make an effort to understand culture and develop relationships, cultural competence, culturally appropriate, cultural practices, cross-cultural skills, cultural variation in child rearing, cultural programmes, guidelines for culturally competent care, cultural training, culturally congruent, culturally embedded framework, Dadirri, culture shock: mechanical difference, isolation, customs, attitudes and beliefs, and communication; community knowledge, culturally sensitive and respectful, cultural distance, definitions of cultural safety and of health, culturally threatened within the hospital environment, interconnectedness with family and culture and health, centrality of family and culture, conceptual frame of reference, language barriers such as the way of using language)<br>• *information* (research, statistics, literature, reports, quality data, informant interviews, statistics, engaging in research, list, information sessions, posters, interviews, instruments such as tape-recorded, interpretation, variables, administrative, health check, anticipatory guidance, specific health issues, Medicare number, immunisation status, geographic location, published literature) | |
| Structures (i-PARIHS: inner context: local and organisational level, facilitation: looks at; Ngaa-bi-nya: resources)<br>• *documentation* (medical records and scanned paper notes, poor documentation, departmental manuals and assessment tools, child safety framework, legislation and policies guiding statutory work, accountability through documents and forms, documented, handwritten notes)<br>• *electronic records* (emergency department notes, progress notes, consultation reports, inpatient identification sheets, elective admission notes, growth charts, medication charts and medical and nursing discharge summaries)<br>• *organisation* (service support organisation, primary healthcare centres, statutory agencies and community agencies, external agencies, community based Indigenous child protection agency, networks with agencies, resource constraints, tertiary paediatric hospital, Aboriginal community controlled health services, hospital as an institution, Kari Aboriginal Resources, hospital, organisational partnership, philanthropic organisations, non-government organisations, | Consider:<br>1. the many forms of documentation required to develop a complete and accurate family care plan,<br>2. the use of electronic record systems in an organisation and their importance in effective and efficient family care,<br>3. how many organisations, services, and programmes are in the health and child protection systems and why it is necessary to form partnerships with them and<br>4. increase reading of relevant policies and strategies in Aboriginal health and child protection. |

**Table 3** (continued)

| Safe cultural governance-Ngaa-bi-nya 'critical success factors' and i-PARIHS[a] | Practical and facilitation actions |
|---|---|
| service delivery, Memorandum of Understanding, accommodation, organisational policies, resources, power, vision and mission statements; organisational units, outpatient department, emergency department, paediatric wards)<br>• *service mapping* (thirty-one services providing a range of medical and social support services including four Aboriginal community controlled services, multiple services<br>• *geography* (large organisation, urban, city, community size, remote, access related to distance)<br>• *programmes* (ABCD programme, Aboriginal Hospital Liaison Officer Program, Improving Care for Aboriginal and Torres Strait Islander Patients)<br>• *policy and strategy* (Closing the Gap initiative, Royal Australasian College of Physicians' Reconciliation Action Plan, guidelines on the management of otitis media for Aboriginal and Torres Strait Islander populations, Respecting the Difference training, Aboriginal strategic plan) | |

[a] Governance is defined as 'the evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve the things that matter to them' (Hunt et al. 2008, p. 9)

descriptive statistics, narrative synthesis of stakeholder interview data, thematic analysis of focus group and interview data, statistical calculation of hospital data sets, staff surveys, and clinical chart and medical document audits. This indicates that judgements about 'best evidence' are elusive in the absence of a strategic research agenda or practice benchmarks. Rather, the evidence as presented indicates numerous points of practice that hold the potential for change.

## Relationships

Four articles presented data to inform the theme of 'personal relationships', which included concepts of communication, information sharing and trust. These articles were as follows: culture shock experiences of Aboriginal family members from rural and remote communities when attending an urban hospital (Tanner et al. 2004); interviews with Aboriginal community members on their perceived barriers and enablers of accessing healthcare through an Emergency Department (Chapman et al. 2014); a proposal to include an equity domain in a framework for assessing care coordination for Aboriginal families (Chamberlain et al. 2016); and interviews examining the inter-relationships between Aboriginal and non-Aboriginal practitioners, agencies, families and community members in child protection practice with Aboriginal families (McAuliffe et al. 2016).

The importance of a variety of relationships was found between patient and provider (Tanner et al. 2004; Chapman et al. 2014), parents themselves (Tanner et al. 2004), Aboriginal staff and non-Aboriginal staff (McAuliffe et al. 2016) and relationships across services (Chapman et al. 2014; Chamberlain et al. 2016; McAuliffe et al. 2016). The impact of healthcare professionals' communication skills on the patient experience

of trust, power and identity was a central concept in each of the four studies (Tanner et al. 2004; Chapman et al. 2014; Chamberlain et al. 2016; McAuliffe et al. 2016). Adult patients and parents of paediatric patients found that relationships formed with other Aboriginal families (Tanner et al. 2004) and Aboriginal staff (Tanner et al. 2004; Chapman et al. 2014) had a positive impact on their healthcare experience, largely as a result of improved information flow, the restoration of trust and a resulting readjustment of the power differential. Also, investing time in growing relationships with the Aboriginal community and Elders was seen as crucial to improving access to healthcare, the flow of information and referral to appropriate services (Chapman et al. 2014; Chamberlain et al. 2016; McAuliffe et al. 2016).

### Culture

All articles except two (McAullay et al. 2018; Attwood et al. 2015) explored the theme of 'culture', encompassing cultural competence, Aboriginal staff, identity, culture shock and separation. Aboriginal and non-Aboriginal people consistently reported the importance of sensitivity to culture in healthcare provision (Tanner et al. 2004; Chapman et al. 2014; McAuliffe et al. 2016; Raman et al. 2017). The usefulness of cultural training for staff was emphasised by healthcare consumers (Chapman et al. 2014) and providers (McAuliffe et al. 2016; Raman et al. 2017; Nyanga et al. 2018) with child protection workers emphasising that this type of learning is continuous—'a progression thing' (McAuliffe et al. 2016, p. 370). Additional approaches to improve the cultural safety of patients included the display of identifiable cultural features (Chapman et al. 2014), sincere partnerships with local Aboriginal communities and services (Chapman et al. 2014; Raman et al. 2017) and dedicated Aboriginal staff (Tanner et al. 2004; Chapman et al. 2014; McAuliffe et al. 2016; Nyanga et al. 2018). Whilst Aboriginal staff were seen as crucial in terms of power, identity and place (Chapman et al. 2014), they also experienced burdens of responsibility (implementation of all cultural initiatives) (Chamberlain et al. 2016), and of resistance (confronting attitudes from other staff) (Chamberlain et al. 2016), and expectations (of unacceptable scope of role—'I can't do everything') (McAuliffe et al. 2016, p. 370).

### Organisational Processes

All articles addressed the theme of organisational processes, which included complexity, monitoring, referral to services and identification. The studies were primarily quantitative, and included the following: admissions data of Aboriginal children presenting to a tertiary children's hospital (Attwood et al. 2015); a mixed-methods exploration of the health and developmental needs of Aboriginal children in out-of-home-care (Raman et al. 2017); a survey assessment of paediatric healthcare professional's attitudes and knowledge concerning Aboriginal health delivery (Nyanga et al. 2018); and a continuous quality improvement programme for Aboriginal children attending primary healthcare centres (McAullay et al. 2018).

The issues of complexities and fragmentation were identified both at the service level and for families who received child protection services (Chamberlain et al. 2016). This impacted on referral of families to appropriate services within the hospital (Attwood et al. 2015; Nyanga et al. 2018) and also in the community (Chamberlain et al. 2016). Three hospital-based studies reported on the importance of accurate identification of Aboriginality

(Chapman et al. 2014; Attwood et al. 2015; Nyanga et al. 2018). Although this practice was viewed as important by patients (Chapman et al. 2014) and healthcare professionals (Nyanga et al. 2018), not all staff were 'asking the question' all the time (Chapman et al. 2014; Nyanga et al. 2018), and thus inaccuracies were evident in chart audit data (Attwood et al. 2015). Lower than expected rates of referral to Aboriginal services were also reported (Attwood et al. 2015; Nyanga et al. 2018).

Other organisational processes that had negative impacts on cultural safety included insufficient staffing (Chamberlain et al. 2016; McAuliffe et al. 2016), inadequate resources dedicated to early intervention and support (Chamberlain et al. 2016; McAuliffe et al. 2016), prolonged wait times in the Emergency Department (Chapman et al. 2014; Chamberlain et al. 2016) and inconsistent primary health nurse allocation in acute care (Tanner et al. 2004). Positive processes included official agreements with partner organisations (McAuliffe et al. 2016; Raman et al. 2017), Aboriginal staff (Tanner et al. 2004; Chapman et al. 2014; McAuliffe et al. 2016), monitoring processes as standard organisational practice (McAullay et al. 2018; Raman et al. 2017) and the provision of Aboriginal family-specific facilities (Tanner et al. 2004).

### Safe Cultural Governance

The value of safe cultural governance overlayed the intersectional themes of culture, organisational processes and relationships (Fig. 3). The four governance domains (processes, relationships, institutions and structures), sub-categories and supportive evidence were tabulated and are available on request. Each governance domain was represented to a varied extent, with distributions of keywords across sub-categories reflective of the included article aims and approaches. For example, Attwood et al.'s (2014) technical hospital audit contained limited governance content compared to McAuliffe et al.'s (2016) qualitative focus on relationships in social work and child protection practice. These domains, sub-categories and elements revealed a high degree of governance complexity which reflected the complexity of factors in both the Ngaa-bi-nya and i-PARIHS frameworks. To facilitate knowledge translation, this evidence was distilled into practical considerations for frontline health professionals in Table 3.

## Discussion

The stimulus for this review was to address a policy to practice gap in cultural safety in Australian hospitals for Aboriginal families with children involved, or at risk of becoming involved, in child protection services. An enabling policy environment respects the cultural strengths of Aboriginal peoples in healthcare and child protection systems (SNAICC 2008, AHRC 2018a, 2018b, AGDH 2019). However, the increasing rates of Aboriginal children removed from their families into child protection services and associated poor health outcomes reflect a policy and practice gap.

The eight articles in this review presented relationships, culture and organisational processes as core intersectional themes of a culturally safe child protection response to Aboriginal families in hospital settings. The intersectional nature of these themes partially reflects the holistic approach to Aboriginal and Torres Strait Islander peoples' health that

includes sharing, wellbeing and culture (Williams 1999; Bin-Sallik 2003). The themes are aligned to broader reform agendas for child protection systems that advocate for legislative, organisational, policy and practice changes to address the ongoing problems that beset existing child protection approaches (Lonne et al. 2020). These include conflictual practitioner-service user relationships, workforce issues and an overemphasis on stigma and risk over support and assistance to struggling families (Duthie et al. 2019; Lonne et al. 2016; Higgins et al. 2019; Lonne et al. 2019). The 'innovation' (following i-PARIHS) in our results is the notion of safe cultural governance (following Ngaa-bi-nya) which overlays the intersectional complexities of child protection system, healthcare, cultural safety, cultural competence and inter-professional collaboration (Fig. 3).

The practical translation of this scoping review was guided by the Ngaa-bi-nya Aboriginal and Torres Strait Islander program evaluation framework (Williams 2018) and the i-PARIHS translational research framework (Harvey and Kitson 2016). Both align with the themes of culture, organisational process and relationships through distinct world views. For example, the Western view of i-PARIHS emphasises organisational culture, whereas the Wiradjuri view of Ngaa-bi-nya emphasises the human cultures of Aboriginal peoples. Cultural safety can conceptually bridge such apparently oppositional frameworks through the facilitated transformation of innovation in organisational environments for the benefit of patient clinical and cultural safety (AHPRA 2020).

For frontline health professionals, bridging world views requires practice change through governance that encourages intersectionality, for example intercultural governance (Brigg and Curth-Bibb 2017) or cultural governance (Swift et al. 2020). This includes reflecting on the governance domains of processes, relationship, institutions and structures (Hunt et al. 2008); their overlay with intersectional themes (Fig. 3); and a consideration of the relevance in narratives of relationships, culture, and organisational processes (Table 3).

## Relationships

Addressing power in interpersonal relationships is at the core of cultural safety (Malatzky et al. 2020). In this review, strong relationships were fundamental to quality care for vulnerable Aboriginal families. The strength of these relationships was dependent on communication, information sharing and trust, which is reflected in the broader literature. Aboriginal 'yarning' is seen as a culturally safe form of communication (Durey et al. 2012; Lin et al. 2016) that addresses the need for increased information sharing (Stuart et al. 2003; McDonald 2009) and collaboration to facilitate trust (Fleming et al. 2019) and improved outcomes (McDonald 2009). Yarning and Dadirri reflect Aboriginal peoples' world views and their incorporation into professional practice is increasing (Tanner et al. 2004; Lin et al. 2016; Fleming et al. 2020).

According to Agar's theory of institutional discourse, language builds meaning (1994). Communication between non-Aboriginal clinicians and Aboriginal children and families defines the way the child and the family are viewed. Where the language and culture of non-Aboriginal clinicians is used, the family will need to assimilate to the dominant culture of the health service. That is, institutional discourse occurs in an institutional setting where the clinician is the expert driving the discourse. The filter that is placed over the Aboriginal family's culture and experiences needs to be removed to shift the dominant discourse in health and child protection services from that of the clinician to that of the Aboriginal child, family and community.

Unfortunately, however, the ways in which child protection services and healthcare services have worked together in the past have destroyed trust for many Aboriginal peoples (McCallum 2007; Herring et al. 2013; Cox 2007). Communication, information sharing and trust are also the foundation of collaborative relationships between service providers within and between organisations. Culturally sensitive consultation with Aboriginal communities can result in a culturally appropriate model of care, thereby improving service acceptance and utilisation (Thomas et al. 2015).

Whilst non-Aboriginal staff in the organisations studied by McAuliffe et al. (2016) reported a positive relationship with their Aboriginal colleagues, some Aboriginal staff in healthcare organisations report frustration at being excluded from strategic initiatives where their experience and knowledge would have a positive impact. Genuine inclusion of, and respect for, Aboriginal staff on committees builds strong relationships and may lead to improvements in care. A combination of approaches such as complementing formal with informal ways of working can facilitate collaboration and effective relationships (Thomas et al. 2015), sincere partnerships, organisational strategy and staff satisfaction.

### Culture

The centrality of culture, including identity, culture shock, separation and cultural competence of staff in facilitating the provision of culturally safe healthcare, was a key finding. Sincere respect for Aboriginal peoples' cultural practices and ongoing monitoring of organisational processes was seen to be crucial to address the impact of the historical policy of forced removal of Aboriginal children from their families.

Improving the cultural knowledge base of health professionals has the potential to meet consumer expectations in the Emergency Department (Stuart et al. 2003) and reduce cultural misunderstandings between health professionals and patients (Durey et al. 2012). For Aboriginal families, this may manifest as clients' needs to return home being misinterpreted by staff as 'poor maternal bonding', when it is nearly always due to more practical problems such as needing to care for children at home, or desperately missing other family members (Tanner et al. 2004; Middleton 2006). This is further exacerbated when a high-risk pregnancy or absence of local maternity services necessitates a baby being born off country (Middleton 2006).

Establishing culturally safe services involves addressing institutional racism and improving engagement of Aboriginal patients with healthcare facilities, as detailed in Table 3. Practical measures include providing privacy at triage, comfort and safety in waiting rooms (Stuart et al. 2003); including extended family and kin in patient education (Durey et al. 2012); and establishing a critical mass of Aboriginal staff. Finally, engaging local Aboriginal communities with the hospital (Durey et al. 2016), and incorporating Aboriginal cultural concepts of holistic health and wellness into a culturally appropriate model of care (Thomas et al. 2015), leads to greater acceptance and utilisation of hospital services (Thomas et al. 2015) and increased information transfer (Spangaro et al. 2016).

### Organisational Processes

Research interest in organisational processes was evident in all included papers with complexity, monitoring, referral to services and identification each addressed. These

findings aligned with previous research (Durey et al. 2016; Zon et al. 2004). In the application of cultural safety to child protection, Zon et al. (2004) described a litany of organisational factors (conceptual, legislative, non-Aboriginal staff turnover, qualifications and Aboriginal staff lack of power to influence decisions, procedures and policies) that, whilst invisible at the interface between the child protection services and Aboriginal families, nevertheless impacted on patients' wellbeing experiences.

Several attempts have been made to implement and evaluate tools to support a process-driven clinical decision-making approach in health (Le Grande et al. 2017). However, clinical decision-making is embedded in organisational processes, and research interest in re-orienting services towards relationship building with families is growing (McAuliffe et al. 2016). This strategy should be embedded within a structured and supportive pathway for Aboriginal staff, with leadership an essential component of effective partnerships, cultivating the ethos of the workplace and creating an environment where collaboration is supported (Thomas et al. 2015).

Establishing a culturally safe, collaborative workplace is driven at a national level by the Australian Health Practitioner Regulation Agency, which is committed to increased participation of Aboriginal peoples in the workforce and embedding cultural safety in regulation (AHPRA 2018). Some health disciplines already provide education standards that require stand-alone Indigenous health subjects in the tertiary setting (CATSINaM 2017). Such regulatory level processes are crucial to reduce institutional racism, increase Aboriginal identification and improve patient outcomes.

## Conclusion

This review provides an analysis of the available literature for embedding cultural safety for Aboriginal families with children at risk of engaging with child protection services in hospitals. No published articles were found that specifically addressed the intersection of Aboriginality, cultural safety, cultural competence and child protection in the hospital setting. This has been noted elsewhere for example by Priest et al. (2009) and Munns and Shields (2013), that most Aboriginal child health research focuses on physical health determinants rather than mental and social wellbeing, and the experiences of vulnerable Aboriginal families in the health service.

The thematic emphasis of relationships and culture that overlay organisational factors reflects the demand for strategies that focus on cultural safety rather than cultural competence alone. The language used by clinicians in hospital settings shapes the interactions they have with Aboriginal families. Families at risk of becoming engaged with child protection services are no exception. Ways to successfully shift the dominant discourse in health and child protection services from that of the clinician to that of the Aboriginal child, family and community remain underresearched.

These findings provide some direction for policy and practice development in this field, whilst also highlighting the deficiencies in evidence and urgent need for further research that projects the cultural voices of Aboriginal families and communities.

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