





Indigenous People's Experiences and Expectations of Health Care Professionals When Accessing Care for Family Violence: A Qualitative Evidence Synthesis

Renee Fiolet¹ , Jacqui Cameron¹ , Laura Tarzia^{1,2} , David Gallant¹,
 Mohajer Hameed¹, Leesa Hooker³ , Jane Koziol-McLain⁴,
 Karen Glover⁵, Joanne Spangaro⁶, and Kelsey Hegarty^{1,2}

Abstract

Although many Indigenous peoples demonstrate resilience and strength despite the ongoing impact colonization has on their peoples, evidence suggests poor experiences and expectations of health care professionals and access to health care. Health care professionals play an essential role in responding to family violence (FV), yet there is a paucity of evidence detailing Indigenous people's experiences and expectations of health care professionals in the context of FV. Using a meta-synthesis of qualitative studies, this article aims to address the following research question: What are Indigenous people's experiences and expectations of health care professionals when experiencing FV? The inclusion criteria comprised a qualitative study design, Indigenous voices, and a focus on expectations and experiences of health care professionals when FV is experienced. Reviewers independently screened article abstracts, and the findings from included papers were subject to a thematic analysis. Six studies were included in the final meta-synthesis representing studies from Australia, the Americas, and New Zealand. Three themes were identified. Health care professionals need to center the Indigenous person in the care they provide and demonstrate cultural awareness of how history and culture influence an individual's care requirements. Health care professionals also need to ensure they are connecting for trust with the Indigenous person, by slowly developing a rapport, yarning, and investing in the relationship. Finally, Indigenous peoples want their health care professional to work on strengthening safety from culturally inappropriate care, institutional control, and potential lack of confidentiality associated with tight-knit communities.

Keywords

cultural contexts, family violence, intergenerational transmission of trauma, family issues and mediators, indigenous health

Indigenous peoples of the globe are also referred to as First Nations peoples, Aboriginal peoples, Native peoples, and other specific names based on their location (e.g., the Sami people of Northern Europe and the Maori people of Aotearoa [New Zealand]). Indigenous peoples draw strength from their culture (Gallant et al., 2017). Nevertheless, almost universally, they are known to experience poor health outcomes when compared to their non-Indigenous counterparts (Gracey & King, 2009, p. 408). Indigenous peoples have modest expectations and poor experiences of health care professionals when accessing health care according to the global evidence (Browne et al., 2011; Cerón et al., 2016; Goodman et al., 2017; Hansen, 2015; Hole et al., 2015; Nelson & Wilson, 2018; Palmer et al., 2019; Slater et al., 2013; Wotherspoon & Williams, 2018). Even when compared to other minority populations such as culturally and linguistically diverse populations, Indigenous peoples report higher rates of poor treatment (Aspin et al., 2012; Reading & Wien, 2009; Shepherd et al., 2018).

Researchers have argued the ongoing impact of colonization continues to be a key contributor to poor health outcomes found within Indigenous communities (Gracey & King, 2009; Paradies, 2016; Paradies & Cunningham, 2009; Shepherd et al., 2018). Despite efforts to increase practitioner awareness, cultural safety, and competence (Clifford et al., 2015; Herring

¹ The University of Melbourne, Australia

² The Royal Women's Hospital, Melbourne, Australia

³ La Trobe University, Melbourne, Australia

⁴ Auckland University of Technology, New Zealand

⁵ South Australian Health and Medical Research Institute, Adelaide, South Australia, Australia

⁶ University of Wollongong, New South Wales, Australia

Corresponding Author:

Renee Fiolet, Department of General Practice, The University of Melbourne, 200 Berkeley St., Carlton, Victoria 3053, Australia.

Email: renee.fiolet@unimelb.edu.au

et al., 2013), racism and discrimination are still prevalent (Paradies, 2016) and deter Indigenous people from accessing formal health care services (Nelson & Wilson, 2018; Shepherd et al., 2018). Despite this, the voices of Indigenous peoples are rarely used to inform their care needs, particularly in relation to family violence (FV) response (Fiolet et al., 2019).

The reluctance of Indigenous peoples to access health care settings is particularly problematic in the context of FV. FV includes interpersonal violence, also commonly called domestic violence and abuse (World Health Organization, 2014a). Indigenous people in some countries prefer the term FV because it broadens the notion that violence can occur in the home and within the community (Gallant et al., 2017; Yates, 2020). FV has increasingly been recognized as a health issue (García-Moreno et al., 2015). Alongside this, the role of health care providers in identifying and responding to FV has been recognized (García-Moreno et al., 2015). FV is prevalent in Indigenous communities (Australian Bureau of Statistics, 2016; Breiding, 2014; Brownridge, 2008; Burczyk & Conroy, 2018; Sinha et al., 2013) and is compounded by social problems such as racism, low literacy rates, and poor socioeconomic status (Blagg, 2018; Nancarrow, 2010; Olsen & Lovett, 2016). A scoping review of existing evidence suggests that Indigenous peoples are reluctant to engage in help-seeking for FV support (Fiolet et al., 2019). The review, which drew on evidence from 15 studies internationally, indicated that Indigenous peoples often avoid seeking support because of shame, perceptions about lack of confidentiality in tight-knit communities, and feelings of mistrust and fear toward service providers (Fiolet et al., 2019). The findings of the review also indicated that Indigenous peoples are more likely to access informal support networks and will only access formal services when they reach a crisis point (Fiolet et al., 2019). This is concerning, given the vital role health care professionals have in responding to FV (García-Moreno et al., 2015) and the poor health outcomes associated with FV (García-Moreno et al., 2013).

Despite recent evidence that Indigenous peoples avoid formalized help-seeking for FV (Fiolet et al., 2019), there is still a paucity of evidence detailing the experiences and expectations Indigenous peoples have of health care professionals who respond to FV. Without an understanding of these perspectives, health care professionals and organizations will continue to fail in making support more accessible for Indigenous, marginalized populations. Therefore, the meta-synthesis aimed to explore and synthesize qualitative data to extract meaning about the experiences and expectations Indigenous peoples have of health care professionals when experiencing FV.

Method

The approach for this review involved the following phases: (1) Deciding on a research question and appropriate search terms, (2) systematically searching the qualitative evidence, (3) using inclusion and exclusion criteria to screen retrieved studies, (4) undertaking data extraction, (5) assessing the cultural

appropriateness of the included studies using the Aboriginal and Torres Strait Islander quality appraisal tool (QAT; Harfield et al., 2018), (6) assessing the quality of the included data using the Critical Appraisal Skills Program (CASP, 2018) Qualitative Checklist, (7) synthesizing the findings, and (8) using Confidence in the Evidence from Reviews of Qualitative research (CERQual; Lewin et al., 2015) to assess the quality of the themes that were identified from the synthesis.

Search Strategy

A protocol was developed and published (PROSPERO 2018 CRD42018089185) on the PROSPERO International prospective of systematic reviews (National Institute for Health Research, 2018). We searched the bibliographic databases MEDLINE, Embase, PsycINFO, Cochrane Library, CINAHL, SocINDEX, ASSIA, and ATSIHEALTH for relevant studies with no date restrictions applied. These searches involved four platforms: Ovid, EBSCO, ProQuest, and Informit. These searches were supported by nonsystematic searching of Google Scholar, GreyLit, and OpenGrey; reference checking of included studies; forward citations; and consultation with other experts in the field of FV. No restrictions on geographic location or year of publication were applied in an attempt to generate a substantial number of studies informed by global Indigenous voices, which are recognized as being underutilized in FV research (Fiolet et al., 2019). Only English-language articles were included. See study protocol for limits, inclusion and exclusion criteria, and search terms. The Ovid search was developed first with input from the authors and a specialist librarian at the University of Melbourne. We used subject headings, keywords, and text words across the following three broad categories: FV, qualitative research, and Indigenous populations. See Online Appendix A for an example of the original search terms.

Study Selection

The search produced 1,514 results (Figure 1). Following removal of duplicates, 1,106 studies were imported into Covidence, a program to assist with study selection for reviews (Covidence Systematic Review Software, 2018). Four reviewers (R.F., L.T., M.H., and L.H.) commenced title and abstract screening applying the following inclusion criteria: (1) qualitative data collection and analysis method or mixed methods design if qualitative data collection and analysis method is separate, (2) population of Indigenous peoples, (3) focus on FV, and (4) health care experiences and expectations. Studies were excluded under the following conditions: (1) a quantitative study design, (2) non-Indigenous participants, (3) perspectives of health care professionals rather than service users, and (4) not related to either experiences or expectations of health care professionals. This screening resulted in only 47 studies demonstrating enough relevance to have their full text reviewed.

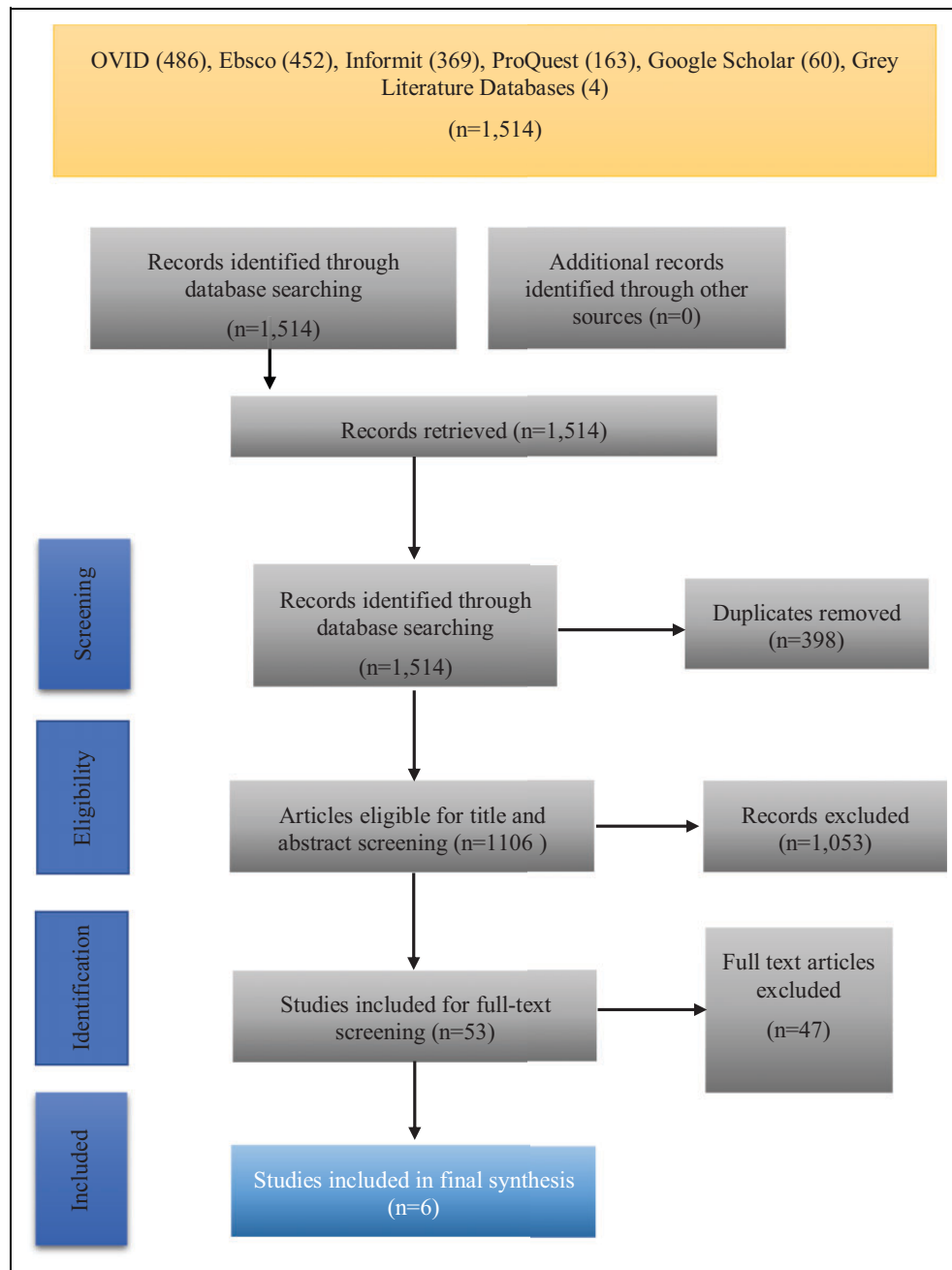


Figure 1. Search results.

Three reviewers (R.F., L.T., and J.K.M.) carried out full-text screening applying the inclusion and exclusion criteria. A significant majority of the studies had to be excluded because they focused on the perspectives of health care providers rather than Indigenous peoples as service users; another common exclusion was the tendency for many articles to focus on the experience of FV rather than experiences and expectations of care when experiencing FV. Disputes between reviewers were resolved through discussion with a fourth reviewer (K.H.). Six studies met all criteria and were involved in the final synthesis.

One reviewer (R.F.) extracted verbatim data from each study into a standardized extraction form checked by a second

reviewer (J.C.). The following study characteristics were extracted: location of study, participant characteristics, and study design (including data collection and analysis methods). We also included authors' reported and identified themes supported by verbatim participant quotes.

Thematic Synthesis

A thematic approach was used to synthesize the data according to the approach described by Thomas and Harden (2008). NVivo (2018) software assisted in managing the synthesis process. Data extraction forms containing original participant

quotes and relevant author observations were imported into NVivo. Both priori and a line-by-line analysis of the data were undertaken for descriptive coding. The descriptive coding was conducted by two researchers (R.F. and J.C.) who then met to compare and discuss similarities and differences (Thomas & Harden, 2008). Following the discussion of descriptive codes, R.F. and J.C. then grouped the codes into a hierarchical structure; the hierarchy was then discussed with a third reviewer (K.H.). These higher order codes were discussed by the three reviewers (R.F., J.C., and K.H.) concerning their potential implications for health care provision before being presented to the rest of the research team for examination and to confirm them as the analytical themes (Thomas & Harden, 2008).

Quality Appraisal

Indigenous quality appraisal. The Aboriginal and Torres Strait Islander QAT (Harfield et al., 2018) was used to assess the quality of research from an Indigenous contextual relevance perspective. Although the resource was designed specifically for the needs of Australia's Indigenous peoples—known as Aboriginal and Torres Strait Islanders—the values and ethics used to inform the QAT criteria are potentially relevant to other Indigenous populations. The tool includes 14 items that assess the appropriateness, quality, and relevance of the research that has been undertaken with Indigenous peoples. It does this by asking the reviewer to consider issues including Indigenous governance, leadership, and research methods used within the study as well as critique the translation and capacity building that results from the research. Three researchers (R.F., D.G., and K.G./J.C.) independently used the QAT to assess how well Indigenous values and ethics were applied to each of the studies.

Methodological quality appraisal. Three reviewers (R.F., J.K.M., and J.S.) appraised the methodological quality of each study independently using a modified version of the CASP Checklist. We modified the CASP so that instead of yes/can't tell/no being the only answers, there were four choices: yes/no/partial/unclear. By doing it this way, we were prompted to recognize attempts made in the original research to address the criteria; however, the efforts had fallen short of what we expected. These assessments were collated and reviewed by a third researcher (J.C.), who resolved one difference in judgment.

Determining confidence in findings. Following the identification of themes by two researchers (R.F. and J.C.), we used the CERQual (Lewin et al., 2015) to assess confidence in the qualitative evidence against four key areas. The first area measures methodological limitations (Munthe-Kaas et al., 2018), the second—relevance (Noyes et al., 2018), the third—coherence of the data (Colvin et al., 2018), and the fourth area is data adequacy that refers to the richness and quantity of the data within each theme (Glenton et al., 2018)

Findings

Six original studies were included in the review (see Table 1). The methods used for data collection mostly involved interviews, with two of the six studies including a mix of Indigenous and non-Indigenous women (Bates et al., 2001; Koziol-McLain et al., 2008). Health services professionals included general health, mental health, nurses, or midwives. Only two of these studies identified the intervention type.

Summary of Findings

Three main themes regarding experiences and expectations of Indigenous peoples when they access health care professionals for FV were identified through the synthesis: *cultural awareness*, *connecting for trust*, and *strengthening safety*. Although experiences and expectations informed each theme, they have been labeled in a way that makes them easy to apply to future practice.

Cultural Awareness

All six studies contained a reference to Indigenous people's desire for health care professionals to demonstrate cultural knowledge and understanding when providing care. The fundamental understanding of what is considered to be "culturally appropriate" is an essential element when responding to FV.

Two of the studies demonstrated this through examples of poor cultural knowledge and understanding (Bates et al., 2001; Jull et al., 2015):

They've treated me like . . . really disrespectfully, and, like [pause], I've just had really bad experiences at hospitals—yeah. (Jull et al., 2015, p. 410, participant quote)

There was a strong desire by women survivors for health care professionals who are trained and knowledgeable about culture and who can demonstrate a commitment to understanding the influence culture plays in the experience and recovery from FV. Professionals should attempt to understand the importance of connection to culture, land, their peoples, and spiritual connections.

Similarly, reconnecting with culture through traditional practices were demonstrated by one study as a means to help participants reclaim their identity (Oneha et al., 2010).

I'm part Hawaiian, who needs to reconnect with self. I know how to do it, and that is to get back to where I came from, which is to the land, put my energy and my thoughts into what I'm doing with the land, whether it's working in the lo'i, watering the yard, whatever the case may be, dancing. And it helps me to realign myself back to where I should be in my life. (Oneha et al., 2010, p. 7, participant quote)

Service users across all studies reported that health care professionals should also demonstrate knowledge of the impact colonization plays in deterring Indigenous peoples from using

Table 1. Study and Participant Characteristics.

Authors	Year (Country)	Objective	Qualitative Method (Analysis)	Type of health setting Type of clinician	Sample (Age Range)	Ethnicity
#1. Bates et al.	2001 (Australia)	To identify those elements of health care which women who have experienced domestic violence consider representing quality care and explore opportunities for a public health service to improve its service delivery to these women	Focus group (thematic analysis)	Variety of health care settings Health care practitioners	N = 17 (age range 30–59) (17/65; 27% Aboriginal women)	Australian Indigenous
#2. Burnette	2015 (USA)	The purpose of this critical ethnography was to gain a localized understanding of Indigenous women's experiences with formal services in this region	Life history interview (reconstructive analysis)	Mental health/behavioral health services Health care practitioners	N = 29 (age range 22–74)	Southeastern USA Indigenous community (76% Indigenous, 24% multiethnic)
#3. Jull et al.	2015 (Canada)	To describe the experiences of Aboriginal women when making health decisions by identifying decision-making needs, supports, and barriers	Interviews (descriptive content analysis)	Variety of health care settings Health care practitioners	N = 13	Canadian Indigenous (n = 4 Aboriginal, n = 3 Inuk, n = 2 First Nations, n = 1 Aboriginal/First Nations, n = 1 Ojibwe, n = 1 Anishinaabe, n = 1 Métis, Algonquin)
#4. Koziol-McLain et al.	2008 (New Zealand)	Ascertain the acceptability, usefulness, and harm of a brief health care site-based screening intervention	Interviews (descriptive content analysis)	Emergency department and Maori health clinic Nurses	N = 17 (age range 20–72) (17/36; 47% Maori women)	Indigenous New Zealanders (Maori)
#5. Oneha et al.	2010 (Hawaii)	Investigate the perceptions, responses, and needs of Native Hawaiian women regarding intimate partner violence	Interview and focus group (content analysis)	Primary health care and supportive services, mental health treatment services, and substance treatment services Health care practitioners	N = 10 (age range 17–61)	Native Hawaiian
#6. Spangaro et al.	2016 (Australia)	Test among Australian Aboriginal women, a model for decisions to disclose or not disclose IPV in the context of antenatal routine screening	Interviews (qualitative configurative analysis)	Hospital or Aboriginal Maternal and Infant Health service Midwives	N = 12 (age range 20–36)	Australian Indigenous

Note. IPV = intimate partner violence.

formal support; the systematic processes such as forced labor and the removal of children have resulted in mistrust. Inappropriate referrals (such as to foster care) may cause additional harm and should be carefully considered.

Two Australian studies (Bates et al., 2001; Burnette, 2015) reported that some service providers did not understand culture, which resulted in stereotyping, and exposed fears that can result from historical acts against the Aboriginal community such as the removal of their children. There was evidence of avoidance of help-seeking by women as a result of fear of being discriminated against and wanting to keep the family together. Perceptions that health care professionals tend to “look down” (Bates et al., 2001, p. 4) and judge Indigenous women were present (Bates et al., 2001; Jull et al., 2015; Koziol-McLain et al., 2008). There were indications that because they do not understand culture, HCPs tend to stereotype (Bates et al., 2001). As a result, often inappropriate responses were made by health care professionals such as encouragement for police involvement.

They stereotype us. You know, just because you have gone in there once with a, you know, say with a black eye or something else and they are going to say “well what’s the point of fixing her up.” (Bates et al., 2001, p. 4, participant quote)

In three studies, women reported/felt that health care professionals were not well trained culturally (Burnette, 2015; Koziol-McLain et al., 2008). These findings led authors to suggest that health care professionals must reexamine their approach in practice regarding aspects of care provision and in doing so being mindful of the colonial contexts that have informed the development of Western health care systems (Jull et al., 2015).

All studies discussed the need for health care professionals to be better informed about culture. There is a desire for health care professionals to understand Indigenous people’s connection to culture, land, spirits, and that these elements need to play a role in their recovery; their descriptions regarding the strength they get from culture are summarized in the following quote:

It also connects me with Native things that I’m doing and reconnecting with my heritage because . . . it’s making you-like, whole, and if there’s a reason and it’s all balanced . . . I don’t know, it’s cool. (Jull et al., 2015, p. 410, participant quote)

Having a health care professional encourage Indigenous people to build connections extended beyond culture.

Native Hawaiian women seek to re-connect or establish relationships with self, others, spirit, natural elements, cultural practices, and place/community. (Oneha et al., 2010, p. 7)

Three studies illustrated that women wanted to be looked after by their own peoples (Bates et al., 2001; Koziol-McLain et al., 2008; Spangaro et al., 2016).

I probably find I’m a little bit more open coming to this clinic, about questions they ask because it is an Aboriginal Medical Service and being Aboriginal, I just feel like they understand better. (Spangaro et al., 2016, p. 83, participant quote)

I think it has to be Maori to Maori. Maori getting together explain things more. (Koziol-McLain et al., 2008, pp. 406–407, participant quote)

Have an Aboriginal worker on stand-by, on call. Someone being here to talk to another Aboriginal person, you know a woman. (Bates et al., 2001, p. 5, participant quote)

There seemed to be a focus on just wanting the health care professional to have knowledge about culture or to attempt to understand cultural influence (Bates et al., 2001; Jull et al., 2015; Koziol-McLain et al., 2008; Oneha et al., 2010; Spangaro et al., 2016).

Connecting for Trust

All six studies discussed the importance of trust. Health care professionals were urged to demonstrate how they were going to invest in the relationship and further that they could be trusted (Bates et al., 2001; Oneha et al., 2010; Spangaro et al., 2016).

Helpful health care providers were described as those who built trust with the participants by demonstrating genuine interest and effort to communicate. (Jull et al., 2015, p. 408)

They also must demonstrate a willingness to have a relationship.

She was very open with me and nice, and laugh, and bubbly. And I really like that in a person, it makes me feel comfortable with them. So, you know, you get the real sour ones and I’m just, like, “Aw, yeah, I don’t really feel like talking, or,” How can I have a laugh with her? And, yeah, she made me feel real comfortable. (Spangaro et al., 2016, p. 83, participant quote)

Relationship building is a slow process and rarely occurs immediately, it includes the building of rapport which can include strategies like having a “yarn” (Spangaro et al., 2016). Building the relationship helped to address the shame and embarrassment that was felt when disclosing.

Some women who had experienced IPV in the past expressed that they were surprised, embarrassed, or ashamed when initially asked about abuse. (Koziol-McLain et al., 2008, p. 506)

When a trusting relationship has been established, health care professionals should not be concerned about causing offense when using direct questions. It would be much more offensive to ask questions straight up without having “yarned” and developed a rapport in the first instance.

Christine indicated that the midwife had waited until the second visit before asking domestic violence questions and that she had

been open and “had a laugh” with her, which made her feel comfortable, evidence of building the relationship first. (Spangaro et al., 2016, p. 84)

Other constant features included privacy and time to build trusting relationships.

I was going to [go to therapy], but then I said no, because I knew at that time, it was not going to be kept to herself [therapist]. It was just going to be, it seemed like broadcast; so I didn’t want that. (Burnette, 2015, p. 1538, participant quote)

... greater skill was needed in judging the timing for when mothers (or female caregivers) could be sensitively screened in the paediatric emergency department setting. The importance of privacy was also affirmed. Although visitors were routinely escorted to the waiting room before screening, the emergency department private rooms, with a single curtained side, still lacked the absolute privacy that would maximally promote disclosure of abuse. (Kozioł-McLain et al., 2008, p. 508)

While there were some positive experiences by women survivors, it appeared that the expectation of care was low so that any small effort—for example, any demonstration of care and empathy—was appreciated.

It comes back to their attitude. If they have the right attitude, whatever they say won’t matter because we will know they care (Bates et al., 2001, p. 4, participant quote)

She was good. Just said to me if I ever needed any help and that, she’d always be there. (Spangaro et al., 2016, p. 85, participant quote)

Not all experiences were positive; the following demonstrated a feeling of not being respected.

The [care provider] kept mixing me up with other Native people that were coming to see [care provider], mixing up my story with other people. (Jull et al., 2015, p. 409, participant quote)

Borrowed trust was a concept articulated in Spangaro et al.’s (2016) paper which appears to be of value. They defined this construct as “a process used by Aboriginal people drawing on reliance on kinship obligations to protect each other, to establish whether mainstream services or service providers can be relied upon to be culturally safe” (p. 83). Although not articulated in other included papers, it reflects the difficulty Indigenous peoples have in trusting service providers and how they want reassurance from their own peoples that a service or health care professional can be trusted.

Strengthening Safety

Five of the six studies identified the need for safety as a critical expectation in the care Indigenous peoples receive for FV. The safety Indigenous peoples expect tends to be more complicated than for non-Indigenous peoples. The need for safety was at an individual, community, and organizational level. Individual

safety was not limited to physical safety from perpetrators or typical concerns for privacy and confidentiality; however, these were discussed.

There was genuine fear related to being unsafe, which caused limitations in disclosure:

I just didn’t tell the midwife because they could ring child welfare or other places on you. (Spangaro et al., 2016, p. 84, participant quote)

One study very strongly highlighted elements of needing to be safe from the “tight-knit” communities, particularly concerning the lack of confidentiality, with Burnette (2015) stating:

“Everyone is related to everybody.” She added: “Every entity that you encounter to receive some type of assistance—you have a relative there. That’s a conflict of interest.” (p. 1535, participant quote)

Feeling safe included wanting to feel safe from institutional racism. Spangaro et al. (2016) reported that many of the women interviewed who had elected not to disclose their abuse to health workers felt they lacked safety from institutional control or had identified concern about institutional racism. The authors reported that:

... in speaking about lack of safety from institutional control, most of the women did not identify this as an individual problem but explicitly linked it to the increased surveillance which they identified that Aboriginal people experience. (p. 85)

They’ve treated me like . . . really disrespectfully, and, like [pause], I’ve just had really bad experiences at hospitals—yeah. For the most part, [it’s] because I’m a woman and I’m Native. (Jull et al., 2015, p. 410, participant quote)

There is no fairness to any of it [the way the system works]; it’s not what you know it’s who you know It’s all about who you know, who you drink with, who you do favors for. (Burnette, 2015, p. 1538, participant quote)

Some studies concluded that health care professionals must be alert to potential individual and systematic issues with care provision that could compromise the safety of Indigenous peoples.

These findings suggest that health care providers must re-examine their approach to the relational aspects of care provision and must do so from within the colonial contexts that have informed the development of Western health care systems. With their clients, health care providers must choose to identify and then challenge these systems to function in a way that strives for equity in service provision. (Jull et al., 2015, p. 413)

Safety from culturally inappropriate care is also highlighted throughout the evidence. This was particularly the case because of the involvement of social services in the removal of Indigenous children from their kin. It meant a lot to women to have

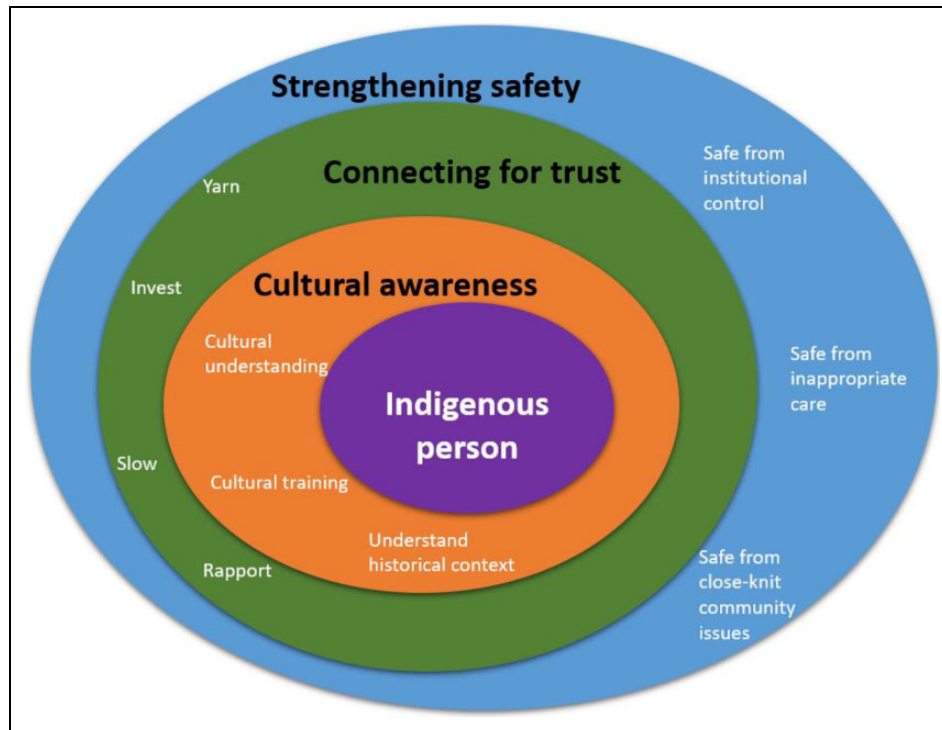


Figure 2. Indigenous health care model for peoples experiencing family violence.

a place to feel safe, and even small gestures were meaningful and led to perceptions of safety.

It's a good place, a safe place, where we are allowed to express who we are. (Jull et al., 2015, p. 408, participant quote)

Areas that provided a safe, private place enabled the women to relax sufficiently. (Bates et al., 2001, p. 4)

[If] I saw a poster or sign about domestic violence then I would feel comfortable. (Bates et al., 2001, p. 4, participant quote)

In summary, the findings demonstrate Indigenous peoples want their health care practitioners to have an appropriate level of cultural awareness and be able to show that they understand the impact of history on their culture. To develop a trusting connection, health care professionals have to indicate that they would invest in a relationship with the Indigenous person. Other factors that influenced trust included taking a slow approach and building rapport (that was developed from yarn-ing rather than merely answering questions). Safety from inappropriate health care provision and institutional control was highlighted in our synthesis. Safety from the potential confidentiality within tight-knit communities was also important. We have synthesized these findings into a model (see Figure 2) for how health care professionals can provide care that meets the needs of Indigenous peoples experiencing FV.

Confidence in Findings

Using CERQual, we found only minor concerns when assessing for methodological limitations and relevance of the three

themes. Regarding coherence, our assessment of the themes on cultural awareness resulted in minor concerns, whereas the theme connecting for trust demonstrated no or very minor concerns. Our assessment of adequacy—which proved to be challenging given the small number of studies—returned a moderate amount of concern. The overall findings for each of the themes were positive, with all three themes resulting in moderate confidence levels. Moderate confidence means that it is likely that the review finding is a reasonable representation of the phenomenon of interest that is Indigenous people's experiences and expectations of health care professionals when experiencing FV (see Table 2).

Indigenous Quality Appraisal

The quality of each paper was summarized against Aboriginal and Torres Strait Islander QAT criteria (Harfield et al., 2018). We found that earlier studies were less likely to use methods that were consistent with an approach inclusive of Indigenous engagement, sensitive processes, and build capacity. However, there has been significant improvement in the studies undertaken more recently. The most contemporary studies appear to have been informed by community needs and leadership as well as guided by an Indigenous paradigm.

Discussion

This study explored Indigenous peoples' experiences and expectations of health care professionals for FV. Only six papers were found that explored FV and Indigenous health care

Table 2. CERQual Assessment.

Theme	Studies Contributing	Assessment of Methodological Limitations	Assessment of Relevance	Assessment of Coherence	Assessment of Adequacy ^a	Overall CERQual Assessment of Confidence
<i>Cultural awareness</i> There was a strong theme from women that there is a need for HCP who are trained and knowledgeable about culture and can demonstrate a commitment to understanding the influence culture plays in the experience and recovery from family violence.	Studies #1–#6	Minor concerns about methodological limitations (six studies).	Minor concerns about relevance (six studies). Two studies provided rich data (#4 and #6), and four studies included suggestive data (#1–#3, and #5).	Minor concerns about coherence (six studies). The data were implicitly and explicitly present across studies, with clear examples not just found in the themes, but referred to in the discussion of these studies.	Moderate concerns about adequacy (six studies). The data included two studies (#4 and #6) which provided strong examples. Four studies (#1–#3, and #5) provided suggestive examples of what happens when cultural knowledge is absent.	Moderate confidence
<i>Connecting for trust</i> There should be a slow and respectful building of trust.	Studies #1–#6	Minor concerns about methodological limitations (six studies).	Minor concerns about relevance (six studies).	Minor concerns about coherence (six studies). The studies usually addressed this issue in passing and did not explore in detail what women meant when they were talking about trust. Two studies (#5 and #6) provided a greater level of detail regarding theme of trust.	Moderate concerns about adequacy (six studies). Two studies provided richness and quantity of data (#5 and #6). Four studies contributed weaker data (#1–#4).	Moderate confidence
<i>Strengthening safety</i> The desire for safety is more complex for Indigenous peoples: Safety is not limited to physical safety from perpetrators or usual concerns for privacy and confidentiality.	Studies #1–#4, and #6	Minor concerns about methodological limitations (#5 studies)	Minor concerns about relevance (five studies). One study (#5) did not contribute relevant data to this theme. Four studies (#2–#4 and #6) contributed strong evidence to this theme. One study (#1) contributed weaker evidence to this theme.	No or very minor concerns about coherence (five studies). The finding reflects the complexity and variation of the data and the association of experiences with “safety” and is well supported by underlying detail in the studies (#1, #3, and #5).	Moderate concerns about adequacy (five studies). These five studies gave more detailed and specific information about these factors. Based on an overall assessment of the richness of the data and the quantity of the data, we concluded that we had moderate concerns about data adequacy.	Moderate confidence

Note. CERQual = Confidence in the Evidence from Reviews of Qualitative research; HCP = health care providers.

^aNote that the overall smaller number of studies that contributed to the themes resulted in a moderate concern for adequacy even though the data were rich in detail.

(Bates et al., 2001; Burnette, 2015; Jull et al., 2015; Koziol-McLain et al., 2008; Oneha et al., 2010; Spangaro et al., 2016). Using a meta-synthesis approach to review these qualitative studies, we were able to identify a pattern of findings that highlighted the key themes of cultural awareness, connecting for trust, and strengthening safety. These themes reflect the help-seeking deterrents in this population and the obstacles to support-seeking support (such as discrimination and shame) that need to be addressed to improve the expectations and experiences of care (Fiolet et al., 2019).

Health care practitioners must have the right knowledge, attitudes, and skills around cultural awareness and competency (Durey, 2010), as this synthesis indicated that cultural awareness was integral to the provision of good health care (Clifford et al., 2015; Truong et al., 2014). Ill-informed health care professionals who demonstrate a poor understanding of culture are significant deterrents to seeking care (Shepherd et al., 2018).

This synthesis indicates that for trust to be established, health care professionals need to work on the relationships they have with Indigenous peoples by becoming informed about historical trauma and Indigenous culture (Herring et al., 2013). Understanding the mistrust that has been generated through the racist mistreatment and colonial practices toward Indigenous peoples in health care is essential to appreciate how important it is to address trust through relationship building (Wylie & McConkey, 2019). Colonial policies and practices perpetuating racism were often carried out under the guise that Indigenous peoples' health and welfare were being prioritized; in reality, the removal of children, dispossession of land, and assimilation practices have created a mistrust Indigenous peoples carry toward health care providers who were often involved in this systemic racism (Allan & Smylie, 2015; Paradies, 2016). Given that mistrust leads to Indigenous disengagement with health services more broadly (Cerón et al., 2016; Isaacs et al., 2010; Nelson & Wilson, 2018; Paradies, 2016), it is not surprising the synthesis found that building trust is essential to Indigenous peoples experiencing violence. The findings suggest that expectations of good care may be low for some people due to negative past experiences, and even small gestures could improve Indigenous experiences of health care professionals.

Simple measures by health care practitioners, such as making the Indigenous person feel comfortable by providing a safe and welcoming environment, would be reassuring. This aligns with the World Health Organization's (2014b) clinical care guidelines. These measures could help address factors such as the legacy of forced child removal which continues to influence choices made by Indigenous mothers who have to weigh up the risks associated with protecting their children (Denison et al., 2014). In Australia, for example, this may take generations to resolve, particularly as many argue that this practice continues (Funston & Herring, 2016). If health care professionals attempted to understand culture and the influence it has on recovery, it would make a significant difference to the Indigenous peoples they care for.

Strengths and Limitations

This study is the first of its kind to synthesize the existing evidence of Indigenous perspectives regarding experiences and expectations of health care professionals when experiencing FV. Using the CERQual (Lewin et al., 2015) provided a systematic and transparent process that enhanced our ability to assess confidence from the findings of the synthesis.

Using the Aboriginal and Torres Strait Islander QAT (Harfield et al., 2018) encouraged reviewers to consider the quality of the methods used in each study to reach their findings. Using the tool meant that reviewers could appraise and discuss whether the studies were respectful of Indigenous values and knowledge, genuinely engaged Indigenous peoples, and beneficial to the populations explored. Engaging two Indigenous coauthors during the assessment of study quality and analysis added value to the synthesis and proved to be a positive learning experience for the non-Indigenous researchers.

A major limitation of the synthesis is the lack of evidence available focusing on Indigenous voices. This is despite recognition that FV has a significant impact on Indigenous people's health, and yet, they are unlikely to seek formal support. A further limitation is that most of the studies were not focused on trying to answer a question related to expectations and experiences of health care. CERQual was challenging to use with the small number of studies as the limited evidence had an impact on our ability to measure adequacy. The Aboriginal and Torres Strait Islander QAT was designed to appraise Australian Indigenous studies rather than evidence collected with Indigenous peoples from other countries. Yet, its questions contain relevance for other populations impacted by colonization and poor research practice and thus still provided value.

Implications for Practice and Training

Indigenous model of FV health care. Our proposed model (see Figure 2) illustrates that health care professionals need to center the Indigenous person when caring for them after experiences of FV but also focus on values that are culturally significant to them. To our knowledge, this model is the first of its kind to be informed by the voices of Indigenous peoples experiencing FV.

The proposed model signals that health care professionals must address the cultural needs Indigenous peoples have when accessing care for FV. The key differences for Indigenous people are the needs for cultural knowledge, trust, and appropriately safe cultural care. When centering the Indigenous person they are caring for, practitioners need to focus on values that are culturally significant to the Indigenous person such as being understood, developing connections, and feeling secure. Each of these elements of care requires health care professionals to have culturally appropriate knowledge, attitudes, and behaviors. An understanding of the barriers faced by Indigenous peoples when obtaining support would enable health care professionals to recognize the strength required by Indigenous people to access care.

The challenge that lies in adopting such an approach to care is that it requires commitment and dedication to learning from a profession that is already required to undertake significant professional development and ongoing training. Education targeting cultural awareness can often be ad hoc and poorly evaluated (Downing et al., 2011), so it is possible that only mandatory cultural training will engender improvement in health care professional knowledge and practice. Greater engagement with Indigenous voices may enhance what is currently known to be effective in responding to FV in marginalized populations (Fiolet et al., 2019) and help inform future health education programs.

More evidence informed by Indigenous voices and knowledges is required, and it should include purposeful methods that specifically address Indigenous needs in health care settings. In particular, further research from antenatal and child health services is needed, considering that FV is known to be experienced at high rates during child-bearing years (García-Moreno et al., 2013).

Conclusion

There is a lack of Indigenous voices informing their own care needs (Blagg, 2018). Our assessment of research methods used by each study demonstrated that although recent practices are more inclusive of Indigenous knowledge, values, and leadership, there is room for more inclusive opportunities to perform research in a way that is of benefit to Indigenous peoples and reduces the likelihood of harm.

Future health care professional training and research programs need to focus on cultural awareness, trust, and safety, with the engagement of Indigenous peoples to inform development. Health care professionals need to reflect on (and in) their practice to consider how effective they are in providing care for Indigenous peoples experiencing FV. It is essential that health care professionals consistently think about how they can build their awareness of culture, ensure safety, and build the trust in their relationships with Indigenous peoples.

Critical Findings

Indigenous peoples expect health care professionals to *demonstrate cultural awareness* and understanding when providing care by:

- Obtaining adequate cultural training,
- Undertaking a commitment to understanding the influence culture plays in the experience and recovery from FV,
- Demonstration of knowledge of the impact colonization plays in deterring Indigenous peoples from accessing support,
- Avoidance of stereotyping and judgments, and
- Understanding Indigenous people's connection to culture, land, and spirits.

Indigenous peoples want health care professionals to work with them on *connecting for trust* by:

- Demonstrating an investment in the relationship,
- Building the relationship slowly and being prepared to have a yarn,
- Demonstrating empathy and respect, and
- Reassurances of trust.

Indigenous peoples have an expectation that health care professionals will work on *strengthening safety* for them through:

- Reassurances that children will not be removed from their care,
- Protection from “tight-knit” community issues, for example, everyone knowing their business,
- Assurance of safety and protection from institutional racism, and
- Keeping them safe from culturally inappropriate care by institutions.

Implications for Practice, Policy, and Research

Practice

- HCPs should be well trained to understand Indigenous cultures.
- HCPS need to invest in relationships with Indigenous peoples.
- HCPs must build relationships slowly.
- HCPs should demonstrate an understanding of how history impacts on Indigenous peoples.
- HCPs should protect Indigenous peoples from institutional racism by challenging policies and practices that perpetuate racism.
- HCPs need to protect Indigenous peoples from the harms of “tight-knit communities” such as breeches in privacy by ensuring confidential care and respect.

Policy

- Policies that perpetuate racism should be challenged by HCPs.
- Health care agencies will involve Indigenous peoples in the creation of policies and procedures that are relevant to their care needs and protection.

Research

- Increase the involvement of Indigenous peoples in the identification, planning, and design of research that is to be undertaken on their peoples and in their communities and
- Highlight the voices of Indigenous peoples in research related to their care needs and protection


Declaration of Conflicting Interests


The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.


Funding


The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: National Health and Medical Research Council.

ORCID iDs

Renee Fiolet  <https://orcid.org/0000-0001-5503-9875>

Jacqui Cameron  <https://orcid.org/0000-0003-1253-1282>

Laura Tarzia  <https://orcid.org/0000-0002-0220-4985>

Leesa Hooker  <https://orcid.org/0000-0002-4499-1139>

Supplemental Material

Supplemental material for this article is available online.

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Author Biographies

Renee Fiolet is a nurse currently doing her PhD through The University of Melbourne, a scholar in the CRE Safer Families and researcher with the Sexual Abuse and Family Violence (SAFE) program. Her research interests include Aboriginal and Torres Strait Islander peoples, family violence, Indigenous health, CALD communities, technology-facilitated responses to family violence, and nursing curriculum development.

Jacqui Cameron is currently a PhD student at The University of Melbourne. Her research interests include domestic violence, substance use, mental health, workplace AOD, and knowledge translation. She holds a Bachelor of arts (criminal justice administration), Bachelor of social work, MPhil social science research methods, and Diploma of project management.

Laura Tarzia is an ARC DECRA senior research fellow in the Department of General Practice at the Centre for Family Violence Prevention at The Royal Women's Hospital. She is deputy lead of the Sexual Abuse and Family Violence (SAFE) program and a member of the Melbourne Research Alliance to End Violence against women and their children (MAEVe).

David Gallant is a PhD student at The University of Melbourne and has worked in various research roles over the last 8 years, all of which have been focused on improving the physical, social, emotional, and cultural outcomes for people in our communities. He has a strong background in providing research and evaluation-related services to both not-for-profit and government agencies.

Mohajer Hameed holds a master of psychoanalysis and PhD in developmental psychopathology, with an emphasis on quantitative methodologies. He currently is a research fellow within The University of Melbourne Safer Families Centre of Research Excellence.

Leesa Hooker works as a postdoctoral research fellow at the Judith Lumley Centre for Mother, Infant and Family Health Research, La Trobe University and is a lecturer in nursing and midwifery in the Department of Rural Nursing and Midwifery, La Trobe Rural Health School.

Jane Koziol-McLain has over 30 years of experience in her chosen field of nursing as well as a talent for research into the health system response to violence against women and children. She is the director of the Centre for Interdisciplinary Trauma Research while balancing teaching responsibilities and consulting work in the Pacific with the United Nations Population Fund.

Karen Glover is a Mein:tnk and Wotjobaluk woman from southeastern South Australia and northwestern Victoria. She holds a joint appointment as a senior research fellow at the South Australian Health and Medical Research Institute (SAHMRI) and the Murdoch Children's Research Institute (MCRI), where she is the coleader of Aboriginal health within the Healthy Mothers Healthy Families Group.

Joanne Spangaro is a professor and head of social work at the University of Wollongong. Her area of research is health responses to gender-based violence that draws on extensive direct practice and policy experience in domestic and sexual violence, with both victims and offenders.

Kelsey Hegarty leads the Safer Families Centre of Research Excellence. She also holds the joint chair in Family Violence Prevention at The University of Melbourne and The Royal Women's Hospital, and cochairs the Melbourne Research Alliance to End Violence against Women (MAEVe).