‘Stopping the run-around’

Addressing Aboriginal community people’s mental health and alcohol and drug comorbidity service needs in the Salisbury and Playford local government areas of South Australia

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Thesis submitted for the degree of Doctor of Philosophy
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July 2015
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Abstract

In Australia, many mental health (MH) and alcohol and drug (AOD) services treat people’s MH and AOD problems separately, depending on the particular service’s primary focus. Commonly, this leaves people with co-existing MH and AOD conditions (MH-AOD comorbidity) in a service gap. Once in the MH or AOD service, they are referred backwards and forwards – getting the “run-around” – rather than being treated holistically. This leads to poor treatment outcomes or no treatment when people drop out of treatment or stop seeking help. This situation is particularly problematic for Aboriginal people, whose overall social, physical and mental wellbeing is significantly challenged compared with the rest of the Australian population. Despite Aboriginal and non-Aboriginal health care professionals being committed to closing the gap between Aboriginal and non-Aboriginal health and wellbeing, the MH-AOD service gap is widening. This gap is identifiable in underprivileged areas like the research site – the Salisbury and Playford LGA region of Adelaide – one of the most socio-economically underprivileged regions in Australia. Home to approximately one quarter of South Australia’s total Aboriginal population, it has high unemployment and incarceration, and poor housing and education that seriously compromise the local population’s physical, social, economic and mental health.

This research, an offshoot of the larger project titled Stopping the run-around: Comorbidity Action in the North (CAN), aimed to determine the MH-AOD service needs of Aboriginal people aged 12 years and over living in the study region, identify and devise strategies to “stop the run-around” for Aboriginal people through local, culturally-appropriate, on-the-ground service, and make recommendations for holistic, coordinated MH-AOD care.

Participatory action research (PAR) ensured inclusion of the people most affected by the MH-AOD service issue. Importantly, the researcher formed a co-researcher partnership with a respected Kaurna Aboriginal Elder and local Aboriginal people who became regular members of the CAN Aboriginal Working Party (AWP). People from the local Aboriginal community (n=19), Aboriginal and non-Aboriginal clinicians and workers from government and non-government MH or AOD services (n=9), and support service staff (n=5) participated in individual and joint interviews, and focus
groups. All co-researchers and participants engaged in reflective PAR cycles of “look and listen, think and reflect, collaborate and plan, consult and act”, combined with the Aboriginal concepts of *Ganma* (sharing knowledge) and *Dadirri* (respectful listening).

This research uncovered three overarching themes: *comorbidity, a complex problem; current structure of MH and AOD services; and the future: needs-based MH-AOD services*. The major finding was that the Salisbury and Playford LGA region had no dedicated service providing holistic MH-AOD care. Some services treat MH issues; others treat AOD issues. Looking to the future, local Aboriginal people stated that this structure needs “healing”.

It concluded that MH and AOD services should stop “lip service” and provide “real service”. Action must be taken to meet the local Aboriginal community’s real MH-AOD service needs by providing locally-available, culturally-appropriate MH-AOD care. This responsive MH-AOD care approach will enable a “no wrong door” service for consumers and help close the MH-AOD service gap for Aboriginal people in the study region.
Foreword: Message from co-researcher Kaurna Aboriginal Elder Aunty Coral Wilson

I think the CAN Aboriginal study should have been done a long time ago because things are pretty bad now in the comorbidity area. Doing this research has made me more aware of the problems in the Aboriginal community. Even though I live and work in that community, there are some things you don’t see very often and when you do, you think, “Well, gee, how long has that been going on? Why hasn’t somebody done something about it? It’s getting out of control. Community people don’t know how to deal with it”. I think it would be excellent for the community if a service became available specifically for comorbidity. It would make the community more aware of what comorbidity is, because even myself, I didn’t know what comorbidity meant. I’d never heard of it before but I’ve known for a long time the impact of alcohol abuse, and more so now, drug abuse, on the community; how it affects them. So I think that this project was an eye-opener for me too.

People have got to understand that comorbidity is a widespread problem now and it should be dealt with. You can’t just let it go on and on and on without trying to understand it and do something about it because a lot of people complain that, “Oh, nobody listens to me”. I hear that nearly every day from people. “You know, no one understands me and no one listens to me”. And then there’s a big breakdown and people fall down. When that happens, people say, “That’s the drink”, or “That’s the drugs”, and I say, “That’s the problem”. People need to recognise that. It’s like a book; they’re looking at the cover and not looking inside. There’s always a reason; always inside it will tell you the story of what’s going on with these fellas that are caught in the grip of alcoholism and drug addiction. No one has actually taken into consideration the plight and the background, the history and the culture of Aboriginal people, and therefore they’re expected to go to mainstream services. But people of culture have got their own beliefs. I think if you’re going to have a service for comorbidity, you need to spread that around. I mean, it’s no good having it in the centre of Adelaide for people to go and get a service there. Aboriginal people live all over the place and many of them live in the northern area. I think there should be services for people everywhere, not just one big service. It’s like Nunkuwarrin Yunti up there. A lot of people don’t go there. A lot of
people will go to Port Adelaide that live in that area, or go to Elizabeth if they live in that area. People won’t put themselves out just to go to one service. They like services to be in their community, so I think that’s the way it should be.

I would like the work from this research to go to the government and for the government to give us some funding so we can have little centres here, there and everywhere, and in the Aboriginal community. That’s what I’d like to see, otherwise, what’s the good of doing the project? We’ve got to get funding to enforce what we’ve done otherwise what have we done it for? You know, you always get funding for these little projects and for fine tuning them, but then there’s nothing at the end. Well, there’s got to be something at the end of this because it’s a much needed project and a much needed service that must be there for all the Aboriginal people; and not only Aboriginal people. I mean, we work typically for Aboriginal people but this problem is widespread and I suppose later on non-Indigenous people will use the services as well. I think eventually it will come to that because a lot of the time now, many non-Indigenous people look at what services are available for Aboriginal people and ask, “Why not for us too? We need something like that too”. I’ve heard that many, many times in prisons when there’s Aboriginal ALOs there and we only visit Aboriginal prisoners. The non-Aboriginal fellas, say, “We need to have a service like that”.

So, when you think about reconciliation, I think the mainstream services should be for everybody. Aboriginal people more so, because Aboriginal people have always been left behind. I think, for Aboriginal people, it would be excellent to have comorbidity services in small centres and also Aboriginal friendly mainstream services because it would take a lot of worry and concern away from the Aboriginal community if they knew their people were going to be using these services and getting support.

It’s been a great pleasure for me to be involved in this project, and especially to work with Hepsi and the University people involved with the CAN project. I thought, “I’m always there for you, Hepsi, if you struggle or you want to know something or you need support in something, well, that’s what I’m willing to give you”. I knew I could give you those things and I did. So, you’re going to India saying “Nukkan” (see you) and a few of those Aboriginal words that I taught you. I feel that this project has been an achievement on my part too because I worked here, there and everywhere, and each little job was different. The only thing that was the same was the people, and that’s what I liked most.
Declaration

I certify that this thesis does not contain any material previously submitted for a degree in any University. To the best of my knowledge and belief, it contains no material previously published or written by another person, except where due reference has been made in the text.

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Date: 14th July 2015
Statement of the contribution of others

This research was made possible with the support, contribution and guidance of many.

Supervisors

Professor Charlotte de Crespigny

Professor Cherrie Galletly

Associate Professor Janet Kelly

CAN research mentors (University of Adelaide)

‘Aunty’ Coral Wilson, Kaurna Elder, CAN project Aboriginal community researcher

Imelda Cairney, CAN project coordinator, University of Adelaide

Dr Tim Schultz, CAN Research Analyst

Aboriginal Working Party

Ms. Coral Wilson, Mr. Paul Elliot, Ms. Joanne Else, Mr. Trevor Warrior, Mr. Trevor Wanganeen, Mr. Robert Taylor, Mr. Frank Wanganeen, Mr. Jodus Madrid, Ms. Lisa Warner and Ms. Mandy Brown

Northern Adelaide Local Health Network (Lyell McEwin Hospital)

Ms. Deb Lewington, Clinical Service Coordinator, Emergency Department

Ms. Jo Robertson, Management Facilitator, Emergency Department

Mr. Douglas Sansbury, Former Aboriginal Liaison Officer

Ms. Coral Cooper, Former Aboriginal Patient Pathway Officer

Financial Support

Australian Research Council Linkage through the University of Adelaide with an award of $27,651 per annum.
Acknowledgements

I thank the Almighty for today, yesterday and tomorrow. Appropriate research can make a significant contribution in addressing the health and social inequalities in society. I am humbled and honoured to have been able to spend significant time talking with Aboriginal communities, the health care sector and the research community, on the strengths, challenges and opportunities that exist to improve the health of Aboriginal community people. This research was undertaken with collective commitment to pursue excellence for the best, most appropriate health services.

Every accomplishment starts with an opportunity. Especially, I thank Dr. Rick Wiechula for the opportunity he gave me to pursue higher degree qualification at the University of Adelaide and for introducing me to the CAN team led by my supervisors.

The supervisors are the Gurus who teach, refine and mould a student to enable them to reach their full potential. I sincerely thank my three supervisors Professor Charlotte de Crespigny, Professor Cherrie Galletly and Associate Professor Janet Kelly.

Mentoring is ‘a hand to lead, an ear to listen, and a push in the right direction’. My heartfelt gratitude to Aunty Coral Wilson, Uncle Trevor Warrior, Joanne Else, Paul Elliot, Trevor Wanganeen, Frank Wanganeen, Jodus Madrid, Lisa Warner, Mandy Brown, Robert Taylor for your friendship, guidance and continued support as Aboriginal Working Party members. Many thanks to the Aboriginal Elders, parents, families, men, women, young people and staff working with Aboriginal communities, who gave their time, shared, and entrusted me with their stories and experience. This thesis has been made possible by your absolute involvement.

‘Those who know do and those that understand teach’. My sincere wholehearted thanks to “Professor” Margaret Bowden and special thanks to Imelda (Mel) Cairney, Dr Tim Schultz, Dr. Judie Magarey, Ms. Helen Murray, Dr. Rosie King (AHCSA), Mr. Robert Dann (AHCSA), and Dr. Mette Gronkjaer for sharing their expertise and research knowledge.

I am indebted to Deborah (Deb) Lewington and Jo Robertson from Lyell Mc Ewin Hospital, Northern Adelaide Local Health Network. I immensely thank you for your great support, good wishes and assistance by offering me employment and time to
study. You have been instrumental in enabling me to undertake this research.

I’m grateful for the scientific conversations of June Hindmarch, Dr Micael Adam, Nora Willis (Murray Chambers), Jim Manners and the research information scientist June Chin (DASSA library), Maureen Bell (UoA library), and my PhD student mates Javad Sadoghi (Iran) and Khaled Shukran (Malaysia) for sharing their valuable knowledge with me. I acknowledge the amazing contribution of you all which enabled me to draw a good research.

‘Near or far there’s always closeness’. Thanks to the abounding friendship of Brian Hayes (QC), Anne Skipper, Dr. Anand Gnanaraj, Dr. Henry Suresh, Senthil Raja, Greg Hollands, Barbara and Erick Harrold, and Shamrock and Hameed, my dear friends, for the most precious time.

I thank the teachers of my past who always wished the best for me. My brilliant school teacher Sir Atlas Johnson, Professor Moudgil for encouraging me to propel in research, Dr Preamkumari for the motivation through my career, and Iswariya the nurse-in-charge Neonatal Intensive Care Unit, Sri Ramachandra Hospital, my first nursing service mentor.

The ‘wind beneath my wings’ were my previous institutions that I worked with. The Madras Medical Mission, Modbury Hospital and Lyell McEwin Hospital, I highly respect the greatness of these established organisations.

I admire the love, care and inspiration of my family, particularly the loving blessing of my late father Sam Daniel, my mother Christella Jeyanthy, the real hero, my dear husband Francis and my beloved babies Jakyim (10yrs) and Beno (4years). I give my solemn thanks to late Uncle Amala Dass who always believed in me and my dreams.

We all walked together, shared our knowledge and celebrated our learning. I appreciate the enthusiasm that everyone has brought to this research and the benefits that means for the community. It is my earnest hope that all the contributions that have been made to this important research will be used by the policy-makers, decision-making authorities and service providers to make the best services available to comorbidity consumers.
Dedication

I dedicate this thesis to the Mother Land of Australia

Country of India

and

My Mother

Christella Jeyanthy Daniel
Terminology

1. Aboriginal
It is acknowledged that across Australia there are diverse cultural groups of Indigenous people, each with their own particular history, culture, names, identities and country. It is respectful to recognise the name ‘Aboriginal and Torres Strait Islanders’. The term ‘Aboriginal’ is preferred by the people involved in this research and so it is the term used in this research. The traditional land on which this research was conducted is the country of the Kaurna people.

2. Aboriginal-specific services
Aboriginal-specific services are either community-controlled (by Aboriginal people) or government-controlled health care services. Aboriginal community-controlled health services are funded by the federal government and governed by boards of management comprising Aboriginal community members. They are guided by National Aboriginal Community-Controlled Health Organisation (NACCHO) principles.

3. Alcohol and Other Drug (AOD) problems
AOD problems involve the risky or harmful consumption of alcohol, tobacco, pharmaceuticals, and other legal or illegal substances. Problems can be once-off, occasional or regular, leading to injury, illness or death. Regular harmful use can cause substantial physical and psychological problems, including dependence. AOD problems impact on an individual’s physical, social and psychological wellbeing, and on their family and wider community. A significant sub-group of people who have more significant AOD problems experience MH-AOD comorbidity.

4. Comorbidity
Comorbidity is also known as “dual diagnosis”, “co-existing” or “co-occurring” problems. This research focuses on the co-existence of mental health (MH) and alcohol and drug (AOD) problems, referred to as MH-AOD throughout this thesis, except in findings chapters where participants used the term “comorbidity”.

5. Comorbidity services
Comorbidity services are specialised government and non-government MH-AOD services that are funded and expected to accept, assess, treat (care for) and support
people affected by MH-AOD comorbidity.

*In this study, the term MH-AOD services denotes services that provide MH-AOD care as “core business”. Alternatively, the term MH and AOD services is used when these services only treat one or other of these problems according to their service type, that is MH or AOD. The term “comorbidity service/s” is used in the findings chapters because this is how participants talked about them.*

6. Consumers
In this project, the term “consumers” refers to Aboriginal people affected by MH-AOD comorbidity who have been a client or patient of health services in the study region, and may include their family or other carers.

7. Local Aboriginal community people/Aboriginal community
Aboriginal people living in the Salisbury and Playford Local Government Area (LGA); the research study region.

8. Mainstream services
Mainstream services are health care services available to the general community in the study region (Salisbury and Playford LGA).

9. Mental Health (MH)
Mental health is a state of wellbeing in which the person has the capacity to reach their potential, cope with life’s normal stresses, work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2014, p. 3). Aboriginal Australians do not experience MH or illness separately from all elements of their wellbeing (or illness). Rather, elements that are integral to their health are spirituality, culture, social and emotional wellbeing, and psychological and physical wellbeing.

10. MH-AOD (mental health – alcohol and other drugs)
The acronym MH-AOD is used to denote comorbidity for the purposes of brevity and consistency throughout the thesis.

11. Support services
Support services (ancillary services) are hospital emergency departments, ambulance, GPs, allied health, housing, transport, legal and other services that assist people in the community, including those with MH-AOD problems. Some examples of what they offer include crisis help, transport, advocacy, jobs, accommodation and liaison with
12. **Trans-generational trauma**

Trans-generational trauma refers to the unique impact of colonisation in Australia on the family and parental functioning associated with alienation and disconnection from extended family, society and culture. Such effects are exacerbated by multiple bereavements due to high levels of stress and loss. It is a process of vicarious trauma that even when children are protected from traumatic stories about ancestors, the effects of past trauma still impact on children in the form of ill-health, early mortality, psychological morbidity, family dysfunction and community violence (Milroy, 2005, p. xxi).
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AHCSA</td>
<td>Aboriginal Health Council of South Australia</td>
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<tr>
<td>AHS</td>
<td>Aboriginal Health Service</td>
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<tr>
<td>ACCHS</td>
<td>Aboriginal Community-Controlled Health Service</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>ALO</td>
<td>Aboriginal Liaison Officer</td>
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<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<tr>
<td>ATSI</td>
<td>Aboriginal or Torres Strait Islander</td>
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<tr>
<td>AWP</td>
<td>Aboriginal Working Party</td>
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<td>CAN</td>
<td>Comorbidity Action in the North</td>
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<tr>
<td>CST</td>
<td>Critical Social Theory</td>
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<tr>
<td>DASSA</td>
<td>Drug and Alcohol Services South Australia</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MH-AOD</td>
<td>Mental Health and Alcohol and Other Drug Comorbidity</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>NACCHO</td>
<td>National Aboriginal Community-Controlled Health Organisation</td>
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<tr>
<td>PAR</td>
<td>Participatory Action Research</td>
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<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<td>SA</td>
<td>South Australia</td>
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<tr>
<td>UoA</td>
<td>University of Adelaide</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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