

‘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

Hepsibah Sharmil Francis Jebaraj

Thesis submitted for the degree of Doctor of Philosophy

Faculty of Health Science

School of Nursing

The University of Adelaide

July 2015

Table of contents

ABSTRACT.....	X
FOREWORD: MESSAGE FROM CO-RESEARCHER KAURNA	
ABORIGINAL ELDER AUNTY CORAL WILSON.....	XII
DECLARATION.....	XIV
STATEMENT OF THE CONTRIBUTION OF OTHERS.....	XV
ACKNOWLEDGEMENTS	XVI
DEDICATION.....	XVIII
TERMINOLOGY	XIX
ACRONYMS.....	XXII
1 INTRODUCTION.....	1
1.1 AIMS, OBJECTIVES, METHODOLOGY AND METHODS	1
1.2 JUSTIFICATION FOR THIS RESEARCH	2
1.2.1 <i>MH and AOD services, and MH-AOD services</i>	3
1.2.2 <i>On Kaurna Country – the study region</i>	3
1.2.3 <i>Poor socioeconomic profile reflecting comorbidity</i>	4
1.3 THESIS STRUCTURE	6
1.4 SUMMARY	7
2 THE COMPLEX LANDSCAPE OF MH-AOD COMORBIDITY FOR	
ABORIGINAL PEOPLE	9
2.1 INTRODUCTION	9
2.2 LITERATURE SEARCH METHOD	9
2.3 ABORIGINAL AUSTRALIANS’ HEALTH STATUS: NO “HEALTH FOR ALL”	11
2.3.1 <i>Aboriginal Australians’ cultural history: Their inherent strength,</i> <i>resourcefulness and resilience</i>	<i>12</i>
2.3.2 <i>The legacy of colonisation, marginalisation and discrimination</i>	<i>13</i>
2.4 EMOTIONAL, SOCIAL AND MENTAL HEALTH WELLBEING.....	16
2.4.1 <i>Social determinants of Health</i>	<i>16</i>
2.4.2 <i>Mental health and mental ill-health</i>	<i>17</i>
2.4.3 <i>Alcohol and Other Drug (AOD) use/problems</i>	<i>20</i>
2.4.4 <i>Comorbidity: Co-existing MH-AOD issues</i>	<i>22</i>

2.5	MH-AOD SERVICE PROVISION.....	30
2.5.1	<i>Importance of culture in MH-AOD services</i>	30
2.5.2	<i>Access to MH-AOD comorbidity services</i>	33
2.5.3	<i>MH-AOD comorbidity care</i>	33
2.6	WHAT IS BEING DONE: THE CURRENT MH-AOD SERVICE SYSTEM.....	35
2.6.1	<i>The South Australian health care system and MH-AOD comorbidity</i>	35
2.6.2	<i>The Australian Aboriginal health policy landscape</i>	36
2.6.3	<i>Prevention, management and brief intervention</i>	42
2.6.4	<i>Comorbidity service strategies and their effectiveness</i>	44
2.6.5	<i>Comorbidity programs and initiatives</i>	45
2.7	THE COMPLEX COMORBIDITY “RUN-AROUND”	46
2.7.1	<i>Barriers to treatment</i>	47
2.7.2	<i>Constraints</i>	48
2.7.3	<i>MH-AOD services: Policy gaps</i>	49
2.8	WHAT NEEDS TO BE DONE: SIGNIFICANCE OF THIS RESEARCH – REFLECTING ON THE LITERATURE REVIEW AND ABORIGINAL PEOPLE’S OWN UNDERSTANDING.....	49
2.9	CONCLUSION	50
3	METHODOLOGY	53
3.1	INTRODUCTION	53
3.2	RATIONALE FOR THE METHODOLOGY	53
3.2.1	<i>Critical theory and PAR</i>	55
3.2.2	<i>Ethical considerations</i>	57
3.3	METHODOLOGICAL FRAMEWORK.....	57
3.3.1	<i>Phase 1: Look and listen: Knowledge-sharing</i>	58
3.3.2	<i>Phase 2: Think and Reflect: Critical theory</i>	63
3.3.3	<i>Phase 3: Consult and Plan: Interpreting and Analysing</i>	68
3.3.4	<i>Phase 4: Take Action: Working together</i>	70
3.4	THE BROAD SCOPE OF PAR	73
3.5	TAILORING PAR CYCLES TO ADDRESS THE MH-AOD CARE PROBLEM	73
3.6	CONCLUSION	74
4	METHODS.....	75
4.1	INTRODUCTION	75
4.2	ABORIGINAL COMMUNITY CONSULTATION: CO-PLANNING THE RESEARCH	76
4.2.1	<i>Local Aboriginal people taking the research lead</i>	76
4.2.2	<i>The central part of the research: Aboriginal Kaurna Elder as ‘co-researcher’</i> ..	80

4.2.3	<i>My role as researcher</i>	81
4.3	ETHICS APPROVAL AND DATA SECURITY	82
4.4	RESEARCH STRATEGY	82
4.4.1	<i>Strategy 1: Meetings with Aboriginal community members</i>	83
4.4.2	<i>Strategy 2: Meetings with local MH and AOD clinicians and workers</i>	84
4.4.3	<i>Strategy 3: Meetings with support service staff</i>	84
4.5	SHARING OUR WORK: INTEGRATED PERSPECTIVES	85
4.6	DATA COLLECTION.....	85
4.6.1	<i>Purposive sampling</i>	88
4.6.2	<i>Participants</i>	90
4.6.3	<i>Informed consent and confidentiality</i>	92
4.7	QUALITATIVE RESEARCH METHODS: IN-DEPTH CONVERSATION-STYLE INTERVIEWS AND FOCUS GROUPS	92
4.7.1	<i>Semi-structured questionnaire</i>	93
4.8	DATA ANALYSIS	97
4.8.1	<i>Coding as themes</i>	98
4.8.2	<i>Categorisation</i>	99
4.8.3	<i>Interpretation and understanding: Theme creation</i>	99
4.8.4	<i>Triangulation with the CAN project data</i>	100
4.8.5	<i>Summary of the analytical strategy</i>	100
4.9	RESEARCH INTEGRITY AND RIGOR	100
4.9.1	<i>Audit trail</i>	102
4.10	CONCLUSION.....	103
5	FINDINGS I – PERSPECTIVES OF ABORIGINAL CONSUMER ADVOCATES	105
5.1	INTRODUCTION.....	105
5.2	THEMATIC FRAMEWORK	105
5.3	OVERARCHING THEMES	107
5.4	OVERARCHING THEME 1 – COMORBIDITY, A COMPLEX PROBLEM	107
5.4.1	<i>Main theme 1: Experience</i>	107
5.4.2	<i>Main theme 2: Culture, community and family</i>	113
5.5	OVERARCHING THEME 2 – CURRENT STRUCTURE OF MH-AOD CARE	117
5.5.1	<i>Main theme 3: Access</i>	117
5.5.2	<i>Main theme 4 – Non-responsive MH-AOD service</i>	121
5.5.3	<i>Main theme 5 – Referral: Fishing for Nunga places</i>	126
5.6	OVERARCHING THEME 3 – THE FUTURE: NEEDS-BASED MH-AOD SERVICE.....	131

5.6.1	<i>Main theme 6: Need</i>	131
5.6.2	<i>Main theme 7: Strategy</i>	136
5.7	CONCLUSION	144
6	FINDINGS II – PERSPECTIVES OF MH AND AOD CLINICIANS AND WORKERS	145
6.1	INTRODUCTION	145
6.2	THEMATIC FRAMEWORK.....	145
6.3	OVERARCHING THEME 1 – COMORBIDITY, A COMPLEX PROBLEM	147
6.3.1	<i>Main theme 1: Experience</i>	147
6.3.2	<i>Main theme 2: Culture, community and family (Aboriginal culture)</i>	151
6.4	OVERARCHING THEME 2 – CURRENT STRUCTURE OF MH-AOD CARE	155
6.4.1	<i>Main theme 3: Access</i>	155
6.4.2	<i>Main theme 4 – Non-responsive MH-AOD service</i>	161
6.4.3	<i>Main theme 5 – Referral: Fishing for Nunga places</i>	167
6.5	OVERARCHING THEME 3 – THE FUTURE: NEEDS-BASED MH-AOD SERVICE	172
6.5.1	<i>Main theme 6: Need (MH-AOD service practice)</i>	172
6.5.2	<i>Main theme 7: Strategy</i>	176
6.6	CONCLUSION	185
7	FINDINGS III – PERSPECTIVES OF SUPPORT SERVICE STAFF.....	187
7.1	INTRODUCTION	187
7.2	THEMATIC FRAMEWORK.....	187
7.3	OVERARCHING THEME 1 – COMORBIDITY, A COMPLEX PROBLEM	189
7.3.1	<i>Main theme 1: Experience</i>	189
7.3.2	<i>Main theme 2: Culture, community and family</i>	192
7.4	OVERARCHING THEME 2 – CURRENT STRUCTURE OF MH-AOD CARE	196
7.4.1	<i>Main theme 3: Access</i>	196
7.4.2	<i>Main theme 4: Non-responsive service</i>	200
7.4.3	<i>Main theme 5 – Referral: Fishing for Nunga places</i>	204
7.5	OVERARCHING THEME 3 – THE FUTURE: NEEDS-BASED MH-AOD SERVICE	208
7.5.1	<i>Main theme 6: Practice</i>	208
7.5.2	<i>Main theme 7: Strategy</i>	211
7.6	CONCLUSION	221
8	SYNTHESISED FINDINGS – PERSPECTIVES OF ABORIGINAL COMMUNITY PEOPLE, SERVICE STAFF AND THE CAN PROJECT	223

8.1	INTRODUCTION.....	223
8.2	THE <i>CAN PROJECT</i> FINDINGS	224
8.3	PARTICIPANTS	225
8.4	OVERARCHING THEME 1 – COMORBIDITY, A COMPLEX PROBLEM	226
8.4.1	<i>Experience of unmet comorbidity care.....</i>	226
8.4.2	<i>Culture, community and family</i>	227
8.5	OVERARCHING THEME 2 – CURRENT STRUCTURE OF MH-AOD CARE	228
8.5.1	<i>Access.....</i>	228
8.5.2	<i>Separate MH and AOD services non-responsive to MH-AOD needs.....</i>	229
8.5.3	<i>Referral: Fishing for Nunga places</i>	230
8.6	OVERARCHING THEME 3 – THE FUTURE: NEEDS-BASED MH-AOD SERVICE.....	231
8.6.1	<i>Need/Practice.....</i>	232
8.6.2	<i>Strategy</i>	232
8.6.3	<i>Moving forward – addressing service breakpoints.....</i>	234
8.7	CONCLUSION.....	236
9	CONFIRMATION OF FINDINGS WITH PARTICIPANTS – CAN	
	ABORIGINAL WORKSHOP	239
9.1	INTRODUCTION.....	239
9.2	METHOD.....	239
9.2.1	<i>Bringing together the CAN project partners with the CAN Aboriginal study partners.....</i>	240
9.2.2	<i>Stakeholder and participant collaboration</i>	240
9.3	ENVISIONING THE WORKSHOP	241
9.3.1	<i>Knowledge-sharing: Recognition of the wider community’s needs</i>	241
9.3.2	<i>Reflect, discuss and plan.....</i>	241
9.3.3	<i>Developing a workshop planning team.....</i>	242
9.3.4	<i>Roles and responsibilities: Teamwork</i>	242
9.3.5	<i>Aboriginal-preferred way of knowledge-sharing: Moving towards the vision</i>	243
9.3.6	<i>A culturally-respectful, safe and cost-effective venue.....</i>	243
9.4	THE WORKSHOP PROGRAM.....	244
9.4.1	<i>Welcome, acknowledgement and knowledge-sharing facilitators.....</i>	244
9.5	WORKSHOP OUTCOME: A MH-AOD SERVICE MODEL.....	246
9.5.1	<i>Strategies for implementing learnt knowledge in practice.....</i>	246
9.6	NEED FOR ABORIGINAL AND MAINSTREAM SERVICE COLLABORATION.....	246
9.6.1	<i>Concerns</i>	247
9.6.2	<i>Unexpected outcomes.....</i>	248

9.6.3	<i>Cultural approval to use Ganma with PAR through Dadirri</i>	248
9.7	THE WORKSHOP OUTCOME	249
9.7.1	<i>AWP members' reflection</i>	249
9.7.2	<i>My experience of partnering with co-researchers</i>	250
9.7.3	<i>Synergy between Aboriginal knowledge and PAR</i>	250
9.8	SUMMARY	251
10	DISCUSSION AND CONCLUSION: MEETING ABORIGINAL	
	PEOPLE'S MH-AOD SERVICE NEEDS	253
10.1	INTRODUCTION.....	253
10.2	THE IMPORTANCE OF DETERMINING COMORBIDITY SERVICE NEEDS THROUGH PAR AND CRITICAL PRAXIS	253
10.3	CLOSING THE GAP BETWEEN MH AND AOD SERVICES	255
10.3.1	<i>Respect, listen and act in accordance with the voices "on-the-ground"</i>	255
10.4	FUTURE PATHWAYS TO HOLISTIC MH-AOD CARE	256
10.4.1	<i>Trust, collaboration and partnerships: Communication as a vital tool</i>	257
10.4.2	<i>Understanding the uniqueness of Aboriginal culture</i>	258
10.4.3	<i>Early intervention</i>	259
10.4.4	<i>Easy access</i>	259
10.4.5	<i>Developing sustainability</i>	260
10.5	RECOMMENDATIONS: ABORIGINAL MH-AOD SERVICE IMPROVEMENTS AND IMPLEMENTATION IN THE SALISBURY AND PLAYFORD LGA REGION	261
10.6	CONCLUSION	266
10.6.1	<i>Strengths, challenges and limitations of this research</i>	266
10.6.2	<i>Moving towards better MH-AOD services</i>	267
	REFERENCES	270
	APPENDICES	318
	APPENDIX 1: ETHICS APPROVAL LETTERS	319
	APPENDIX 2: LETTERS OF INTRODUCTION FROM SUPERVISOR	325
	APPENDIX 3: ABORIGINAL WORKING PARTY (AWP)	328
	APPENDIX 4: PARTICIPANT INFORMATION SHEET	332
	APPENDIX 5: CONSENT FORM	335
	APPENDIX 6: SEMI-STRUCTURED INTERVIEW/FOCUS GROUP GUIDE	336
	APPENDIX 7: AUDIT TRAIL	342

APPENDIX 8: THEMATIC ANALYSIS	344
APPENDIX 9: CAN ABORIGINAL WORKSHOP	348
APPENDIX 10: COMMUNITY REPORT.....	354
APPENDIX 11: DISSEMINATION OF RESEARCH	365
APPENDIX 12: POSTERS	367
APPENDIX 13: CAN BRIEFING AND RECOMMENDATIONS.....	369

List of tables and figures

TABLE 2.1: SEARCH GRID.....	10
FIGURE 1.1: SPECTRUM TOWARDS DEVELOPING MH-AOD COMORBIDITY (DE CRESPIGNY, 2015)	24
FIGURE 2.2: THE ZINBERG (1984) MODEL IN THE MH-AOD CONTEXT, INDICATING THE DYNAMIC INTER-RELATIONSHIP BETWEEN EACH INFLUENCE	27
FIGURE 2.3: ADAPTED: ‘PROTECTIVE AND RISK FACTORS FOR MH-AOD WELLBEING (DUDGEON ET AL., 2010B, P. 81)	34
FIGURE 3.1: METHODOLOGICAL COMMUNICATIVE ACTION FRAMEWORK	57
FIGURE 3.2: PAR INQUIRY CYCLE.....	58
FIGURE 3.4: THE COMPONENTS OF DADIRRI AND THE PAR CYCLE.....	63
FIGURE 3.5: PROGRESSIVE MODEL OF THE PAR CYCLE.....	73
TABLE 4.1: THE ROLE AND DETAILS OF THE ADVISORS AND GROUPS PARTICIPATING IN THE RESEARCH.....	79
FIGURE 4.1: CURRENT RESEARCH ADAPTATION OF WOLCOTT'S MODEL FOR DATA COLLECTION	87
FIGURE 4.2: SERVICE STAFF RECRUITMENT GRID WITH CODING	90
FIGURE 4.3: ABORIGINAL CONSUMER ADVOCATE ELIGIBILITY	91
FIGURE 4.4: ANALYTICAL COMPONENT OF THE RESEARCH STRUCTURE	101
TABLE 4.2: AUDIT TRAIL – MONITORING THE RESEARCH JOURNEY	102
FIGURE 5.1: THEMATIC FRAMEWORK OF COMORBIDITY SERVICE NEEDS: ABORIGINAL COMMUNITY PERSPECTIVE	106
TABLE 5.1: SUB-THEMES AND INTERNAL COMPONENTS OF “EXPERIENCE”	107
FIGURE 5.2: FLOW CHART ON HIDDEN IMPACT OF MH-AOD COMORBIDITY	112

TABLE 5.2: SUB-THEMES AND INTERNAL COMPONENTS OF “CULTURE, COMMUNITY AND FAMILY”	114
TABLE 5.3: SUB-THEMES AND INTERNAL COMPONENTS OF “ACCESS”	117
TABLE 5.4: SUB-THEMES AND INTERNAL COMPONENTS OF “NON-RESPONSIVE MH-AOD SERVICE”	121
FIGURE 5.3: FLOWCHART OF “NO DEDICATED SERVICES” FOR COMORBIDITY PROBLEMS.....	123
TABLE 5.5: SUB-THEMES AND THEIR INTERNAL COMPONENTS RELATED TO “REFERRAL: FISHING FOR NUNGA PLACES”	126
TABLE 5.6: SUB-THEMES AND THEIR INTERNAL COMPONENTS RELATED TO “NEED”	131
TABLE 5.7: SUB-THEMES AND INTERNAL COMPONENTS OF “STRATEGY”	136
TABLE 5.8: BREAKPOINTS AND WIDENING GAPS IN COMORBIDITY SERVICES.....	141
FIGURE 5.4: DIVISION BETWEEN MH ONLY AND AOD ONLY ‘SILO’ SERVICES	142
FIGURE 5.5: SOLUTION TO MH AND AOD SERVICE DIVISIONS	143
FIGURE 6.1: THEMATIC FRAMEWORK OF COMORBIDITY SERVICE NEEDS: MH AND AOD CLINICIANS AND WORKERS.....	146
TABLE 6.1: SUB-THEMES AND INTERNAL COMPONENTS OF “EXPERIENCE”.....	147
TABLE 6.2: SUB-THEMES AND INTERNAL COMPONENTS OF “CULTURE, COMMUNITY AND FAMILY”	152
TABLE 6.3: SUB-THEMES AND INTERNAL COMPONENTS OF “ACCESS”	155
TABLE 6.4: SUB-THEMES AND INTERNAL COMPONENTS OF “NON-RESPONSIVE MH-AOD SERVICE”	162
TABLE 6.5: SUB-THEMES AND INTERNAL COMPONENTS OF “REFERRAL: FISHING FOR NUNGA PLACES”	167
TABLE 6.6: SUB-THEMES AND INTERNAL COMPONENTS OF “NEED”.....	172
TABLE 6.7: SUB-THEMES AND INTERNAL COMPONENTS OF “STRATEGY”	176
TABLE 6.8: MH AND AOD CLINICIANS’ AND WORKERS’ PERSPECTIVES: FIVE FACTORS AFFECTING ACCESS AND QUALITY OF CARE FOR MH-AOD ISSUES.....	183
FIGURE 7.1: THEMATIC FRAMEWORK OF COMORBIDITY SERVICE NEEDS: SUPPORT SERVICE STAFF.....	188
TABLE 7.1: SUB-THEMES AND INTERNAL COMPONENTS OF “EXPERIENCE”.....	189
TABLE 7.2: SUB-THEMES AND INTERNAL COMPONENTS OF “CULTURE, COMMUNITY AND FAMILY”	193
TABLE 7.3: SUB-THEMES AND INTERNAL COMPONENTS OF “ACCESS”	197
TABLE 7.4: SUB-THEMES AND INTERNAL COMPONENTS OF THE THEME “NON-RESPONSIVE SERVICE”	200
TABLE 7.5: SUB-THEMES AND INTERNAL COMPONENTS OF THE THEME “REFERRAL: FISHING FOR NUNGA PLACES”	204

TABLE 7.6: SUB-THEMES AND INTERNAL COMPONENTS OF THE THEME “PRACTICE”	208
TABLE 7.7: SUB-THEMES AND INTERNAL COMPONENTS OF THE THEME “STRATEGY”	211
TABLE 7.8: SUPPORT SERVICE STAFF PERSPECTIVES: FIVE FACTORS AFFECTING ACCESS TO, AND QUALITY OF CARE FOR MH-AOD ISSUES.....	219
TABLE 8.1 INTERROGATED RELEVANT FINDINGS FROM THE <i>CAN PROJECT</i>	224
FIGURE 8.2: NUMBER OF SERVICES WITH ABORIGINAL CONSUMERS – <i>CAN PROJECT</i>	226
TABLE 8.2: SYNTHESIS OF FINDINGS LINKING <i>CAN ABORIGINAL STUDY</i> FINDINGS WITH <i>CAN PROJECT</i> DATA FOR “MOVING FORWARD”	235
FIGURE 8.3: THREE KEY FACTORS AFFECTING MH-AOD HEALTH CARE	236
FIGURE 9.1: PATHWAY TO MEETING MH-AOD SERVICE NEEDS	246
FIGURE 10.1: ELEMENTS NEEDED FOR CONSUMERS TO APPROACH AND RECEIVE COMORBIDITY SERVICES	258

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 being 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 Nunkuwarri 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.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to provisions of the Copyright Act 1968.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Signature:

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 Jeyanthi, 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 Jeyanthi 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

services.

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

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