

# ‘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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## 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: 14<sup>th</sup> 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)

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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)

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Ms. Jo Robertson, Management Facilitator, Emergency Department

Mr. Douglas Sansbury, Former Aboriginal Liaison Officer

Ms. Coral Cooper, Former Aboriginal Patient Pathway Officer

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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

# 1 Introduction

This thesis describes the *CAN Aboriginal study*, a nationally-funded research project undertaken between 2011 and 2015 with local Aboriginal community people in South Australia’s Salisbury and Playford LGA region, located 30 kilometres north east of Adelaide. It was initiated in response to the longstanding concerns of Aboriginal community people and MH and AOD health service staff<sup>1</sup> in Adelaide’s northern region about the lack of a local, appropriate service to provide MH-AOD care. Consumers and service staff had to run around to service providers in various locations to access coordinated treatment.

The *CAN Aboriginal study* was conducted concurrently with, and as a sub-project of, the larger, multi-phased, nationally-funded ‘*Stopping-the-run-around*’: *Comorbidity Action in the North (CAN)* project (referred to throughout this thesis as the *CAN project*) undertaken in the same study region. The *CAN project* involved an initial regional scoping study of all government and non-government MH and AOD services or programs in the study region (Cairney et al. 2015), which was used to inform the *CAN Aboriginal study*’s aims and objectives.

## 1.1 Aims, objectives, methodology and methods

The study aimed to determine the MH-AOD service needs of Aboriginal people aged 12 years and over living in the Salisbury and Playford LGA 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.

Its overriding objective was to find ways to achieve its aims within a constantly changing health system, beginning with working in partnership with the local Aboriginal community people and services to identify real need and collaboratively develop the best possible MH-AOD care model to meet that need. This would be achieved by:

- a) identifying MH-AOD service-related problems faced by Aboriginal individuals,

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<sup>1</sup> The term “service staff” incorporates MH and AOD clinicians and workers, and support service staff



families/carers and the community regarding people's comorbidity needs and ability to access local MH-AOD services;

b) collaborating and agreeing on what current MH and AOD services meet Aboriginal consumers' MH-AOD service needs, why they do so, how they do so and how this affects people;

c) discussing, agreeing on and developing together practical strategies and recommendations to guide delivery of improved Aboriginal-oriented MH-AOD service.

The aims and objectives required the use of a qualitative research methodology that gave equal voice to all participants to tell their service experiences and needs, and to encourage them to have their say about what they thought would improve MH-AOD care and how it would work. Therefore, participatory action research (PAR), informed by critical social theory (CST) and based on the democratic principle of equality, was chosen in conjunction with the Aboriginal concepts of *Ganma* (mutual knowledge sharing; Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (respectful listening; Ungunmerr-Baumann, 2002) as the most suitable research methodology. This emerged as an appropriate partnership model for pursuing tangible action.

Aboriginal community consultation and purposive sampling were used to select participants. Data gathering consisted of in-depth conversation-style interviews and focus groups with 19 Aboriginal Consumer Advocates, 9 clinicians and workers from MH and AOD services, and 5 support service staff. Data were analysed using contextual thematic analysis and critical analysis, then triangulated with the *CAN project* data.

## **1.2 Justification for this research**

Significant numbers of people with MH and AOD problems have combined MH-AOD (dual diagnosis) that requires treatment. Comorbidity, in general, refers to the co-occurrence of more than one health problem, and situations where there are two or more co-existing illnesses and diagnoses (de Crespigny, Groenkjaer, & King, 2004), for example AOD dependence as well as MH disorders (Hall, Lynskey, and Teesson, 2001). Teesson and Byrnes (2001) recommended broad inclusion of MH and AOD disorders within "comorbidity", while later research has described comorbidity and best practice holistic clinical and service responses (Sherwood, 2006; Allsop, 2008; Berry & Crowe, 2009; Gray, Stearne, Wilson, & Doyle, 2010; Cooper, 2011; de Crespigny &

Talmet, 2012; Deady et al., 2013). However, there seems to be no reported research about the nature, cultural influences, experiences and diagnoses of MH-AOD amongst Australian Aboriginal or Torres Strait Islander peoples. This study fills that gap by providing Aboriginal and Torres Strait Islander people's stories of their own and others' experiences of MH-AOD linked to colonisation, discrimination, grief and loss, decades of stolen generations, abuse, poverty, depression, post-traumatic stress disorder (PTSD), self-harm, suicide, incarceration and psychosis associated with substance use problems and dependence (addiction). It also highlights their experiences of lack of local, culturally-appropriate MH-AOD services in the Salisbury and Playford LGA region.

### **1.2.1 MH and AOD services, and MH-AOD services**

In Australia, commonwealth and state governments fund MH and AOD services and programs separately, with the expectation that people attending either of these types of service will have their MH-AOD conditions attended to effectively. (While there is private health insurance for these health conditions, the private sector is outside the scope of this study). Despite at least 15 years of government policies, directions, strategic plans, funding incentives and calls for professional education, most MH and AOD services have poor recognition of this complex and chronic cluster of relapsing illnesses, and lack responses to address these holistically and cohesively, resulting in poor treatment outcomes. The recommendations from this study should go some way to filling the gap in knowledge about how to address MH-AOD holistically and cohesively, and toward taking action to implement appropriate service delivery strategies to meet this unmet need.

### **1.2.2 On Kurna Country – the study region**

The *CAN Aboriginal study* was conducted on the Kurna Aboriginal people's Country. Historically, this was open woodlands with many water holes. European settlement and urban development of the Salisbury and Playford LGA region began around 1838, with negative impacts of colonisation similar to those experienced by Aboriginals Australia-wide. Early colonisers "claimed" the land under the British Government's "Terra Nullius" declaration (empty of people and free to "take") (Black, 1994), erected windmills, planted crops, and farmed cattle, dispossessing the Kurna people of their land, gathering of natural foods and access to water (City of Salisbury, 2013).

The Kurna people lost their traditional lifestyle and autonomy; a serious disruption

to their culture. Later, the introduction of missions resulted in relocation to distant regions regardless of tribal rites, languages, lore and cultural customs. Forced removal of Aboriginal peoples from their traditional lands, removal of generations of infants and children, and “white man’s” disease-related deaths seriously damaged whole communities, families and kinship systems. Poverty, overcrowding in unnatural living conditions and foreign foods replaced the Kaurna people’s previously healthy lifestyle (Mattingley & Hampton, 1988). The link between health, family, culture, society, spirituality and land has been well-established (*National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*, 2007).

Currently, over 6,500 Aboriginal people live in the study region, representing 1.7% of the region’s total population – almost double the percentage of Aboriginal people living in Adelaide’s other metropolitan regions and approximately 25% of South Australia’s overall Aboriginal population (ABS, 2010). Kaurna people living there today still feel their sacred connection to the land as their “Country” (City of Salisbury, 2013).

### **1.2.3 Poor socioeconomic profile reflecting comorbidity**

The study region, which contains 24% of South Australia’s population, is amongst the most socioeconomically underprivileged regions in Australia (ABS, 2011), with high proportions of jobless families, under-employment, insecure housing, poor educational levels, early school leaving and significant incarceration levels (Glover, Hetzel, Glover, Tennant, & Page, 2006). The physical, social, economic and mental health of the majority of the general population is seriously compromised, as evidenced by the Australian Bureau of Statistics (ABS) Socioeconomic Indexes (2014). The lower the index number, the greater the disadvantage and vice versa. The national average is 1,000 but Salisbury scored an average of 936.7 and Playford 871.3, indicating significant economic disadvantage (ABS, 2011).

A clear link between socioeconomic disadvantage and AOD misuse has been identified more widely:

Clearly... now it is widely recognised that socioeconomic factors play a part in the general aetiology of poly drug use – alcohol, cannabis, petrol sniffing – including poverty, hunger, illness, low education levels, unemployment, boredom and general feelings of hopelessness. These form the environment in which such self-

destructive behaviour takes place and as a result need to be addressed cohesively and concurrently through comprehensive intersectoral action. (de Carvalho, 2007, p. 4)

It is not surprising, therefore, that Aboriginal people in the Salisbury and Playford LGA region have significant MH-AOD comorbidity, resulting in premature deaths, complications or serious deterioration in their general and mental health, as well as high levels of family distress and social alienation (2007). Research into health care service accessibility, availability and quality is important for identifying how best to respond to the needs, issues and service improvements required by particular clinical populations, (de Crespigny et al., 2006; Kowanko et al., 2009), such as Aboriginal people experiencing MH-AOD comorbidity in the study region. Responding to needs requires consultation with the local Aboriginal people about what types of comorbidity services should be developed and delivered to meet their particular cultural and health care requirements. Aboriginal people's MH-AOD problems need to be understood and addressed within the cultural context of their holistic view of MH, AOD use and physical health. This study consulted the local Salisbury and Playford LGA region's Aboriginal community about their MH-AOD service needs and how these could be met. While the study region is not without specialist services that address the discrete elements of MH-AOD comorbidity, including mainstream services and Aboriginal-specific services governed by federal government, state government and non-government organisations, there is not a single service to provide care for multiple MH-AOD conditions, as identified in the *CAN project* scoping study.

#### **1.2.4 Something must be done: The author's experience**

MH-AOD comorbidity has been an escalating health issue in the northern areas of Adelaide for many years (Urban and Regional Strategy, 2012). It has contributed to the deaths of several young Aboriginal people and caused irreversible harm, leaving consumers with severe disabilities (Hunter, 2007). As a registered nurse, I became involved in northern Adelaide health care by working in the Emergency Department of a local hospital. I met Aboriginal and non-Aboriginal people with serious MH-AOD conditions and mothers with unwell children who had chronic petrol sniffing, amphetamine and alcohol habits, accompanied by self-destructive behaviour. I recognised this as a continuing problem, reflecting the health system's lack of effective service delivery to appropriately address the impact of MH-AOD issues for affected

individuals, their families and their wider communities. These experiences were the catalyst for this research. I applied for a PhD scholarship and began working with Aboriginal people with the *CAN project*, where I teamed up with Kurna Elder Aunty Coral Wilson, who worked with the School of Nursing at the University of Adelaide as a Community researcher/Kurna Aboriginal Elder. How we proceeded with the research is detailed in the Methods chapter.

### 1.3 Thesis structure

The thesis structure and writing style is designed to meet both academic and research partners' expectations. The Kurna Elder and the AWP members argued that it must be written to present the facts "strongly" and clearly. Therefore, each chapter has pictorial representations as well as text for those who connect to visual cues more than written cues. I have striven to respect Aboriginal cultural knowledge by maintaining a balance between academic rigour and the inclusion of Aboriginal and non-Aboriginal participants' knowledge in their own words as italicised verbatim quotations. I have used identity codes to respectfully maintain participants' confidentiality and privacy. Each participant's preference for either public acknowledgement or anonymity has been respected. Where possible, both oral and written Aboriginal knowledge sources have been used in recognition that much knowledge remains unwritten. Community consultation and Aboriginal community people's contributions form a significant oral knowledge.

The thesis consists of ten chapters. In this chapter, I have outlined the research aims, objectives, context and justification.

In Chapter 2, I explore the literature about the complexities of MH *and* AOD and MH-AOD care in Australia, with particular emphasis on South Australia, government reports and the impact of policies on MH-AOD health issues since colonisation.

In Chapter 3, I explore the theoretical concepts of PAR and critical theory, and the Aboriginal concepts of *Ganma* (knowledge sharing; Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (deep listening; Ungunmerr-Baumann, 2002) to explain the methodology used in the study.

In Chapter 4, I discuss the Aboriginal health research ethics approach I used, and describe the data collection and analysis methods, including field notes, conversational in-depth, semi-structured interviews, couple interviews and focus group discussions.

In chapters 5, 6 and 7, I present the findings, consisting of the perspectives of Aboriginal community people (through the Aboriginal Community Advocates), MH and AOD clinicians and workers, and support service staff about the current MH-AOD care system.

In Chapter 8, I triangulate the findings of this research and the statistical findings from the *CAN project* to ensure the rigour of the research.

In Chapter 9, I discuss the CAN Aboriginal workshop at which research participants, partners and associated stakeholders validated the findings and suggested strategies for improved MH-AOD service provision aligned to consumer need.

In the final chapter, I discuss the overall research and findings in conjunction with the available literature, and recommend actions for moving forward with consideration of implications for practice.

## **1.4 Summary**

Having outlined the background to MH-AOD comorbidity and related service issues for the local Aboriginal people in the study region, the key terms and concepts used in this thesis, the research aims and objectives, justification for this research and the thesis structure, I will now discuss the extant literature about the complexities of MH-AOD and its service delivery for Aboriginal people.



## **2 The Complex Landscape of MH-AOD Comorbidity for Aboriginal People**

### **2.1 Introduction**

Mental Health (MH) and Alcohol and other Drug (AOD) comorbidity (MH-AOD) cannot be discussed in this thesis without understanding the overall health care, policy and social systems' contexts in South Australia. This chapter reviews the extant research literature and reports, government reports and policies about MH-AOD comorbidity as these relate to Aboriginal Australians. While various comorbidities involve co-existing physical or MH disorders, this review focuses particularly on Aboriginal people's MH-AOD service needs. It highlights the complex landscape of MH-AOD comorbidity – the contexts and factors contributing to comorbidity and its consequences, particularly the ongoing impact of colonisation. These are all central to understanding Aboriginal people's MH-AOD service needs and what may enhance MH-AOD service provision for this population living in the study region.

In keeping with this study's PAR approach, Aboriginal community co-researchers guided essential elements of this literature review to enhance its appropriateness. Nothing has been included without their consent. Therefore, the review provides a community and researcher critique of relevant literature in three major parts: 1) Aboriginal Australians' health status; 2) emotional, social and mental health wellbeing, including MH and AOD problems, and comorbidity; and 3) MH-AOD service provision, focusing on what works, what is being done, what does not work and what needs to be done.

### **2.2 Literature search method**

Search strings were developed and used to identify relevant, reliable literature, and entered into HealthInfonet, Lowitja, Scopus, Pubmed, CINAHL, PsychINFO, Web of Knowledge and the Australian Medical Index. Key words and terms (see Table 2.1) were used to find extant research discussions, as well as relevant government documents from organisational publications and government-specific internet sites. Items referenced in bibliographies were also sought to capture other relevant



information. Additional searches were conducted through the Drug and Alcohol Services of South Australia (DASSA), and state and university libraries.

**Table 2.1: Search grid**

<b>Aboriginal</b>	<b>Comorbidity</b>	<b>Service needs</b>
(Aborig*[tw] OR Indigenous[tw] OR Torres Strait Islander*[tw] OR health services, indigenous[mh] OR Oceanic Ancestry Group[mh] OR koori[tw] OR tiwi[tw])	“Diagnosis, dual (psychiatry)”[mh] OR dual diagnos*[tw] OR comorbid*[tw] OR coexisting[tw] OR coexisting[tw] OR ((drug*[tw] OR alcohol*[tw] OR substance[tw] OR mental*[tw] OR psychiatr*[tw]) AND (dual[tw] OR comorbid*[tw] OR coexisting[tw]))	Health services needs and demand[mh] OR needs[tw] OR needs assessment[mh] OR Healthcare[tw] OR health care[tw] OR service*[tw]

Literature from English-speaking countries comparable to Australia, such as Canada, New Zealand and the United States (US), was searched and sorted to identify international Aboriginal literature on Aboriginal MH-AOD health issues and services. ‘Aboriginal’, ‘First Nations’, ‘Indigenous’, ‘American Indian’ and ‘Māori’ were used as search terms. Terminologies including ‘services’, ‘evaluation’, ‘collaboration’, ‘partnership’, ‘engagement’, ‘yarning’ and ‘participation’ were paired with these terms to collate research done with Aboriginal people.

Significant shortcomings in the literature on this topic motivated further exploration of Aboriginal-specific government publications and reports, with a focus on what needs to be done, why and how. Recognised Aboriginal and non-Aboriginal authors were cross-referenced and their publications consulted to inform the essential elements to be addressed.

Along with the illustrated service grid to find relevant background information to assist in providing appropriate context-specific services, terms like Social[ti] OR emotional[ti] OR history[ti] OR historical[ti] OR colonisation[ti] OR colonization[ti] OR (determinants[ti] AND health[ti]) were used. Relevant government strategies, reports and position statements from the National Drug Strategy (2011; NDS, 2014),

NDS Household Survey (2011a, 2014b), National Indigenous Drug & Alcohol Committee (NIDAC, 2009, 2014), Aboriginal Drug & Alcohol Council (ADAC, 1993-2015), Beyond Blue (2015), Black Dog (2015), Australian Institute of Health and Welfare (2015), National Centre for Education and Training on Addiction (NCETA, 1992-2015), and Department for Communities and Social Inclusion (DCSI, 2014) were also accessed as resources regarding improved, more appropriate and more easily accessed comorbidity services.

The priority was to address the importance of understanding the past to inform the present to gain deeper knowledge about the disparities in Aboriginal health overall, and for the purposes of this study, particularly those associated with MH-AOD comorbidity.

### **2.3 Aboriginal Australians' health status: No "Health for All"**

Between 1996 and 2001, the life expectancy for Aboriginal Australians was estimated to be 17 years lower than that for non-Aboriginal Australians (Closing the Gap, 2009, p. 10). In 2005, it was reported that Australian Aboriginal people's significant financial disadvantage and marginalisation compared with non-Aboriginal Australians contributed to the continuing disparity in their health status (Eversole & Routh, 2005). The World Health Assembly (WHO, 2009) endorsed a resolution to decrease health inequalities that particularly affect Aboriginal populations in their own lands (Pulver et al., 2010) but Indigenous life expectancy remains lower overall worldwide.

Comparisons of life-expectancy of Indigenous versus non-Indigenous populations in Australia, the United States of America, Canada and New Zealand show similar life expectancies for each country except Australia (Indigenous Observatory, 2011). The life expectancy of Aboriginal and Torres Strait Islander peoples is significantly more compromised (AIHW, 2011a) than for Indigenous people in those comparative countries. More recently, the Australian Institute of Health and Welfare (2012) identified that while non-Aboriginal Australians enjoy a 25-year higher life expectancy than a century ago, Aboriginal Australians' life expectancy is 12 years less.

This literature indicates the very poor health status of Aboriginal Australians and the urgent need for Australia's health services to contribute to closing the disparity in their life expectancy. Taking steps to close the gap and really enable "health for all" involves more than focusing on "not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community" (Ganesharajah, 2009, p. 2;

National Aboriginal Health Strategy Working Party, 1989). Equitable Australian government investment in health services is needed to acknowledge Aboriginal people's disparity in health, ill-health and life expectancy compared to the rest of the Australian population. Investment decisions must involve appropriate consultation with local health service providers and Aboriginal people, amongst others. In 2012, 9.4% (\$121.4 billion) of total government expenditure went to health, with four in every 10 dollars going to hospitals (AIHW, 2012). In 2014–2015, the Australian Government is spending more than \$920 million to provide health programs and services specifically for Aboriginal Australians (Department of Health, 2014). The continued decline in Aboriginal Australians' health status, however, implies that this money is not being spent in the most effective ways to meet this population group's health care needs. This issue needs to be reviewed and addressed urgently.

### **2.3.1 Aboriginal Australians' cultural history: Their inherent strength, resourcefulness and resilience**

To appreciate the contemporary reality of Aboriginal Australians, their cultural history needs to be understood. Australian Aboriginal culture is based on respect for the land and for their Elders (Korff, 2015). Originally, 50,000 to 120,000 years ago, the land of Australia belonged to Aboriginal Australians and Aboriginal community people; its "traditional" custodians (ACME, 2015). Helen Milroy (HREOC, 2008) (Human Rights and Equal Opportunity Commission) talks about the importance of the land as part of the "Dreaming", which "provides time on earth, a place to heal, to restore purpose and hope to continue our destiny" (p. 14). Land is fundamental to Aboriginal Australians collectively and individually.

Adapting well to the environment, the early Aboriginal Australians were seminomadic hunters and gatherers. They were non materialistic and placed great emphasis on social, spiritual and cultural beliefs (Berndt, 1988). Their concept of land was different from that of Europeans (Dudgeon, Wright, Paradies, Garvey, & Walker, 2010b). They did not see themselves as owning the land like Europeans do, but as custodians; it was their job to look after the land and they belonged to the land. Family groups belonged to certain territories, and each person had obligations to, and spiritual connections with, those territories. Religion was based on the philosophy of oneness within the natural environment.

Australian Aboriginal society was structured around diverse communities and networks of strong family and kinship links within them. The kinship system determined their code of behaviour and outlined their obligation. People had definite roles according to gender and age. In a sense, an individual person was not alone. The kinship system placed each individual safely in a group (Berndt, 1988). Sharing and reciprocity are important characteristics of Aboriginal Australian communities. The Australian Aboriginal people gain a sense of strength, unity and identity from being part of their community.

### **2.3.2 The legacy of colonisation, marginalisation and discrimination**

The European colonisation of Australia and intensive colonial government control over Aboriginal Australians caused massive destruction of traditional Aboriginal family groups, lifestyles and culture; it effectively destroyed Aboriginal people (Kidd, 1997). Despite the diversity of Aboriginal cultures across Australia today, all Aboriginal Australians share the European oppression of their cultural heritage, which to this day has enormous consequences for their health and wellbeing (Smith, 2012).

On arrival, early explorers observed that Aboriginal people were well fed and healthy (Blainey, 1985). However, the colonial settler's community and the impact of colonisation, beginning officially with the first penal colony in Sydney in 1788, was a "death blow" to Aboriginal people (Berndt & Berndt, 1988, p. 518) who were denigrated as "non-human, filthy and dirty beasts" (Pattel-Gray, 1991, p. 170). They were killed intentionally through massacres and exposure to foreign diseases (Elder, 1988). Aboriginal women were raped (Budden, 1986) and the people dispossessed of their 'Country', their culture and their languages (Elkin, 1964).

Forced removal of Aboriginal children (Burridge, 1988) by successive governments using the "protectorate" system, missionary intervention and compulsory segregation decimated families and tribes, and Aboriginal identity and independence (Murphy, 2013; Rowley, 1978). The Australian Government's Assimilation Policy (1961), in which Aboriginal people had to "fit into" mainstream white Australian society, led to forced mobility, disruption and trauma in Aboriginal people's lives (Gale & Brookman, 1972), which were compounded by racial prejudice. In the 1960s, Aboriginal people were still banned from using public places such as swimming pools, hotels and parts of hospitals (Curthoys, 2002). More Aboriginal children were forcibly removed from their

families and sent to live with European families, supposedly for the children's "wellbeing". Evidence suggests that the "stolen generations" of children commonly had less positive life outcomes than children who remained with their Aboriginal families (Australian Human Rights Commission, 2009).

The White Australia Policy entrenched racial discrimination against Aboriginal people by strengthening Australia's white colonising population (97% of immigrants under this policy were British-born). The introduction of Australia's Multicultural Policy in 1973 (Cawte, 1980; Fact Sheet 6-Australia's Multicultural Policy, 2007), encouraging culturally and linguistically diverse groups of people to settle in Australia, disregarded Aboriginal Australians' diversity. Although officially included in the Australian census after the Aboriginal Citizenship Referendum in 1967, Aboriginal Australians remained generally discounted and "invisible" (Russell, 2005). It took until this 21<sup>st</sup> century for the Australian Government (Settlement and Multicultural Affairs, 2014) to revisit its *Multicultural Policy* in terms of inequities for Aboriginal Australians.

On 13<sup>th</sup> February 2008, Aboriginal people's contribution to Australian society and their suffering from colonisation were officially recognised. The Australian Government, through then Prime Minister Kevin Rudd, made the *National Apology* to Aboriginal Australians in accordance with the United Nations Declaration on the Rights of Aboriginal People (Human Rights and Equal Opportunities Commission, 2005). However, the impact of continuing colonisation on Aboriginal Australians' health and social and emotional wellbeing continues.

The ongoing assault on Aboriginal people's physical, emotional, social and spiritual wellbeing, including racism and racial policies and their impact, is linked to disconnection from country, extreme poverty, loss of traditional foods, poor nutrition, inactivity, alcohol consumption and tobacco smoking (Kidd, 1997; Ungar, 2015). Mortality from psychoactive substances, including alcohol, is reportedly higher for Aboriginal Australians than for non-Aboriginal Australians (Wilson, Stearne, Gray, & Sagers, 2010), as is a higher incidence of incarceration due to AOD problems (ABS, 2013). Despite Aboriginal Australians making up only 3% of the total Australian population, they make up 28% of the total prison population (Korff, 2012). The 1991 *Royal Commission into Aboriginal Deaths in Custody* found that untreated mental illness among Aboriginal people in prison contributed to their high risk of suicide

(Cunneen, 2001). In the year 2010–2011, Aboriginal people accounted for 29% of all deaths in police custody, 21% of deaths in prison custody and one death in juvenile detention (Lyneham & Chan, 2013).

Aboriginal Australians are also hospitalised more often than the rest of the population, particularly due to MH and behavioural disorders, including AOD issues (AIHW, 2012). This situation may be attributed to differences in cultural understanding of MH by non-Aboriginal psychiatrists and MH workers, poverty and low English literacy, compromised living situations (unsafe housing, poverty and unemployment), and being a marginalised, minority population (Berry & Crowe, 2009).

The unique history of Australian colonisation has inculcated problematic constructions for Aboriginal Australians. Finding a balance between “official” history and the truth is essential. The impacts of colonisation continue today, compromising Aboriginal people’s health and wellbeing. It is easier to blame Aboriginal Australians for their health and wellbeing issues than to reflect on the real cause. There is an urgent need to reflect on the full spectrum of the cause and effect of past actions and government policies. Strong evidence of disadvantage, poverty, illness and marginalisation cannot be denied. Reflecting on this evidence points the way to envisaging a solution to Aboriginal Australian’s health and wellbeing issues. Truthful, culturally appropriate, respectful consultation with Aboriginal Australians to seek their input into what needs to be done to address those issues must be a starting point. Acting on this consultation, the health system must review its agenda and contextualise health care to meet Aboriginal Australians’ specific cultural needs. The system needs to implement culturally safe policies and services, and to constantly proceed in consultation and mutual partnership with Aboriginal Australians.

### ***2.3.2.1 Inter-generational grief and cultural alienation***

Atkinson (2006) proposed that Aboriginal Australians’ unhealed physical and psychological trauma resulting from colonisation is the primary factor influencing inter-generational comorbidity issues. While non-Aboriginal Australians may see colonisation as “just a story”, it is a very real and enduring experience for Aboriginal people who have had to suppress their distress to survive. There is evidence of links between people internalising their distress through alcohol misuse and domestic

violence in Aboriginal communities (Cusack et al., 2007; Wilkes, Gray, Casey, Stearne, & Dadd, 2014).

The massive trauma inflicted on the Australian Aboriginal population as a result of the stolen generations continues, greatly affecting Aboriginal people's psychological wellbeing (Williams-Mozley, 2012). Early childhood bonding through strong infant-parent attachment and closeness with siblings, grandparents, aunties, uncles and wider family relationships are essential for physical, spiritual, emotional and psychological wellbeing, and social adjustment in later life (Strahan, 1995). When these are disrupted, family attachment is threatened and possibly harmed. A compromised early childhood has been associated with depression in adult life (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990), and lack of solid parent-child relationships has been found to significantly influence future adult interpersonal relationships (Hazan & Shaver, 1987; Strahan, 1995).

Aboriginal Australians have generally been left far behind their non-Aboriginal counterparts, as exemplified by their higher levels of homelessness, chronic illnesses at a young age, poverty and lower educational status (AIHW, 2011a; Atkinson, 2006). Abysmal social determinants of health experienced by many Aboriginal people clearly place them at risk of MH-AOD comorbidity.

## **2.4 Emotional, social and mental health wellbeing**

### **2.4.1 Social determinants of Health**

Social determinants of health – the conditions in which people are born, grow, live, work and age, including their social, economic and political status, and in/equalities – strongly influence their health and ill-health because “it is factors in the social environments that determine access to health services and influence lifestyle choices in the first place” (WHO, 2012, p. 3).

Colonisation and discrimination against Australia's Aboriginal people have ensured they experience worse social determinants of health than the rest of Australia, and therefore poorer health (TNS Social Research, 2014). Despite successive Australian governments instigating many public health programs since 1970 to improve Australians' overall quality of life and health (National Hospital and Health Service Commission, 1973), Aboriginal Australians overall have remained sicker than non-

Aboriginal Australians (Donato & Segal, 2013; National Health and Hospital Reform Commission, 2009).

Undoubtedly, social determining factors bring forth inequalities in health within a society (AIHW, 2012, p. 13). As Osborne, Baum, and Brown (2013, p. 31) recount, it is Aboriginal people's welfare that is affected. The impact of social determinants highlights the causative factors for the breakdown of Aboriginal Australians' general and mental health and wellbeing (Carson, 2007). Therefore, it is imperative that MH-AOD services, along with all relevant stakeholders, should address their Aboriginal consumers' social determinants of health.

#### **2.4.2 Mental health and mental ill-health**

The 'National Mental Health Plan' (Australian Health Ministers' Advisory Council, 2003) described MH as:

... a state of emotional and social wellbeing in which the individual can cope with the normal stress of life and achieve his or her potential. It includes being able to work productively and contribute to community life. (p. 35)

Similarly, Aboriginal Australians define health as a whole of life view; "the social, emotional, spiritual and cultural wellbeing of the whole community" (NACCHO, 2014). NACCHO described MH holistically, preferring the term "emotional and social wellbeing" over the term "mental health". This positive, holistic approach (The Social Emotional Wellbeing of Aboriginal Health Industry Roundtable, 2006, p. 4) comprises happiness, strength, social responsibility, resilience, lore and land, and incorporates spiritual strength and connection to ancestors. This more holistic concept enables examination of a situation at a much deeper level for both individual and community wellbeing (Chalmers et al., 2014). It considers MH-AOD comorbidity along with people's unresolved loss and grief, physical and mental illness, violence, abuse and trauma, AOD issues, separated and broken families, stolen generations, and disempowerment and disadvantage in social and economic environments (Kidd 2006; Dudgeon, Kelly, & Walker, 2010a) description is closely aligned with the World Health Organisation (WHO, 2014) definition of MH and wellness as a positive state of individual and community wellbeing.

Mental ill-health is defined in Australia as "the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people"



(Australian Health Ministers Advisory Council, 2003, p. 5). In other words, “mental illness” entails “abnormal” changes in a person’s thinking, feeling or behaviour, and distress and difficulty in overall functioning (Mental Health Foundation of Australia, 2015). Mental illness constitutes different types of disorders such as depression, anxiety, psychosis or AOD dependence, and may involve varying degrees of severity (SANE Australia, 2014). Mental illnesses, like physical illnesses, are professionally diagnosed according to how they fit with defined psychiatric categories. Mental illnesses may be once off, occasional or chronic, and can significantly interfere with a person’s cognitive, emotional and social capacities.

Recovery from mental illness is described as:

A journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (Mental Health Services Plan June 2009, p. 11)

This recovery perspective of healing mental illness can offer hope for improved wellbeing through holistic assessment, treatments, and support for the individual, family and community (Garvey, 2008).

#### **2.4.2.1 The Australian mental illness profile**

The facts and statistics from the latest National Survey of Mental Health and Wellbeing (AIHW, 2014a) give an overall picture of mental illness in Australia, as follows:

##### **How many Australian people are affected with mental illness?**

- One in 5 (20%) Australians are affected with mental illness in their lifetime.

##### **How common are specific MH disorders?**

- Anxiety disorder affects 14% of Australians per year.
- Depression affects 4% of Australians over a 12-month period and 20% in their lifetime.
- 10–20% of new mothers are affected by postnatal depression.
- Psychotic illnesses, including bipolar mood disorder and schizophrenia, affect 3% of Australians, and about one in every 100 Australians suffer from schizophrenia.
- Around 2% of Australians experience some form of eating disorder, and of

these, 90% are women.

- Borderline Personality Disorder affects 2–5% of Australians, with women 3 times more likely to be affected than men.

### **What is the variation in MH illnesses between men and women?**

- Women experience anxiety disorder (18% compared with 11.1%) and affective disorder (7.1% compared with 5.3%) more than men in their lifetime.
- Schizophrenia affects men slightly more than women and women tend have later onset, with lesser periods of illness and better prognosis.

### **How common is mental illness in young people?**

- 14% of Australian adolescents aged 12–17 years are affected with mental illness (around this percentage of MH problems is reported in all ages and genders, although boys are slightly more likely to be affected than girls).
- Depression is one of the most common MH problems in young people (AIHW, 2014a).

### **Are these patterns similar for Australian Aboriginals?<sup>2</sup>**

- The burden of mental health issues is high in the Aboriginal population (Hunter, 2014).
- Aboriginal Australians are 14 times more likely to be incarcerated than non-Aboriginal Australians and most are diagnosed to have a MH issue per year (Heffernan, Andersen, Dev, & Kinner, 2012)
- Hospitalisations of Aboriginal Australians due to psychiatric disorders (schizophrenia and delusional disorders) are 2.4 and 1.5 times the rate of non-Aboriginal Australians respectively (Hunter et al., 2012).
- There is a higher prevalence (50%) of psychological distress (depression and anxiety) in Aboriginal adults, which is three times higher than for non-Aboriginal Australians (Jorm, Bourchier, Cvetkovski, & Stewart, 2012).
- In a two-year span, the majority of Aboriginal suicides were under 35 years (71.4%). The remaining suicides were aged 35–54 (28.6%). This was 28%

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<sup>2</sup> The term ‘Aboriginal’ is used in this study to represent Aboriginal and Torres Strait Islanders

higher than for non-Aboriginal Australians (De Leo, Svetcic, & Kumpula, 2013)

- Aboriginal children who were forcefully removed from natural family were twice as likely as others to be suffering with behavioural difficulties and significant emotional problems (Zubrick et al., 2005).
- Potential indicators of psychological distress were associated with fewer educational qualifications, unemployment and adverse life events (Jorm et al., 2012).

### **2.4.3 Alcohol and Other Drug (AOD) use/problems**

According to the Australian Drug Foundation, a psychoactive drug is a substance other than food which, when consumed, changes the way the brain and body function. Alcohol is a drug classed as a “depressant”, which many Australians consume. Legal drugs in Australia include alcohol, nicotine, caffeine and various prescribed and over-the-counter medications, with quantity, availability and price restricted by law (The Australian Drug Foundation, 2015). Illegal drugs include cannabis, ecstasy, amphetamines, cocaine, non-prescribed sedatives, steroids and opiates, and heroin (Drug Info, 2015).

In Australia, alcohol is the most extensively used psychoactive drug and is commonly used by those with MH problems (AIHW, 2014b). Excessive alcohol consumption can contribute to family breakdown, antisocial behaviour, violence, child neglect, increased incarceration and increasing poverty due to alcohol consumption costs (AIHW, 2011b). Harm associated with high risk binge drinking or alcohol dependence affects general and mental health, and the wellbeing of the users’ families and communities (Kowanko et al., 2009; Gray, Siggers, Wilkes, Allsop, & Ober, 2010, p. 34).

Rates of AOD use in Australia (AIHW, 2011b), indicating prevalence of use in the general population and the Aboriginal population, are presented below. Overall, two in every 5 people smoked tobacco, consumed alcohol at risk levels and used an illicit drug at some time.

#### **Alcohol and tobacco**

- Almost four in 5 (78%) Australians aged 12 years and over had consumed

alcohol at some time, with 46% consuming it at least weekly.

- Men are three times more likely than women to be affected by alcohol disorders.
- 13.1% of people aged 14 and over had driven a motor vehicle under the influence of alcohol.
- 32% of Australians consumed alcohol at risk, of whom 23% were males and 9% were females .
- One in 7 (15%) Australians aged 14 years and over were daily smokers (AIHW, 2014b).

### **Illicit drugs**

- 15% of Australians aged 14 years have used illicit drugs at some time.
- Cannabis was the most common illicit drug (10.3%), followed by amphetamines and ecstasy (3.0%), and cocaine 2.1%.
- Many people who used illicit drugs also used licit substances.
- Around 8% of Australians aged 16–85 years have experienced AOD disorders, including regular harmful use and dependence.
- Men are twice as likely as women to experience substance use disorders (7% compared with 3.3%) (AIHW, 2014b).

### **Variation rates in tobacco smoking between men and women**

- Males aged 12 years and over were more likely to smoke than females.
- People aged 40–49 years were more likely to smoke than other age groups.
- 5% of teenagers aged 12–17 years smoked tobacco daily, with girls (3.2%) smoking more than boys (1.8%).
- People aged 60 years and over were the biggest group of ex-smokers (AIHW, 2014b).

### **How common is tobacco use in young people?**

- Around one in 40 (2.5%) youth aged 12–17 years, and 1 in 8 (13%) young people aged 18–19 years smoked daily (AIHW, 2014b).

## **Aboriginal people's use of AOD**

- The pattern of AOD use by Aboriginal Australians varies from non-Aboriginal Australians.
- Almost 50% of Aboriginal Australians aged 15 years and over were smokers, and over 60% had tried to reduce and cease smoking.
- More than one third of Aboriginal people aged 15 years and over did not drink and 46.3% drank at low risk levels. Those few who drank at high risk levels had greater levels of psychological distress and poorer physical health than non-Aboriginal high risk drinkers.
- Aboriginal men and young people who drank at risky levels consumed more alcohol at high risk levels than non-Aboriginal people.
- 13% of Aboriginal children aged 4–14 years had a friend or family member with AOD problems (AIHW, 2014b).

### **2.4.4 Comorbidity: Co-existing MH-AOD issues**

Globally, five out of 10 leading causes of disability and premature death are due to MH and AOD disorders (WHO, 2002; Jnae-Llopis & Matytsina, 2006), while 38% of the overall global disease burden falls within the area of MH-AOD comorbidity (Rehm et al., 2009). It is known that people with mental illness smoke tobacco at rates of 35–40%, while those living with psychosis smoke at a rate 73% higher than other people (Scollo & Winstanley, 2012). According to Moore, Mancuso, Slade, Galletly, and Castle (2012), smoking tobacco contributes to premature morbidity and mortality among people with MH-AOD comorbidity, but this tends not to be addressed significantly in any comorbidity treatment planning by MH or AOD services (Dual Diagnosis Subcommittee of the Ministerial Advisory Committee, 2011 ).

It is not surprising that the National Drug Strategy Household Survey (AIHW, 2014b) indicated a significant rate of MH-AOD comorbidity amongst Australians with AOD dependence and mental illnesses. Clinical evidence shows that people with anxiety disorders often consume alcohol and prescription medicines (e.g. benzodiazepines), and/or illicit drugs (e.g. cannabis or stimulants). This may be for symptom relief (Vorspan, Mehtelli, Dupuy, Bloch, & Lépine, 2015). Similarly, people needing AOD treatment were more likely to experience comorbidity disorders (Bartoli,

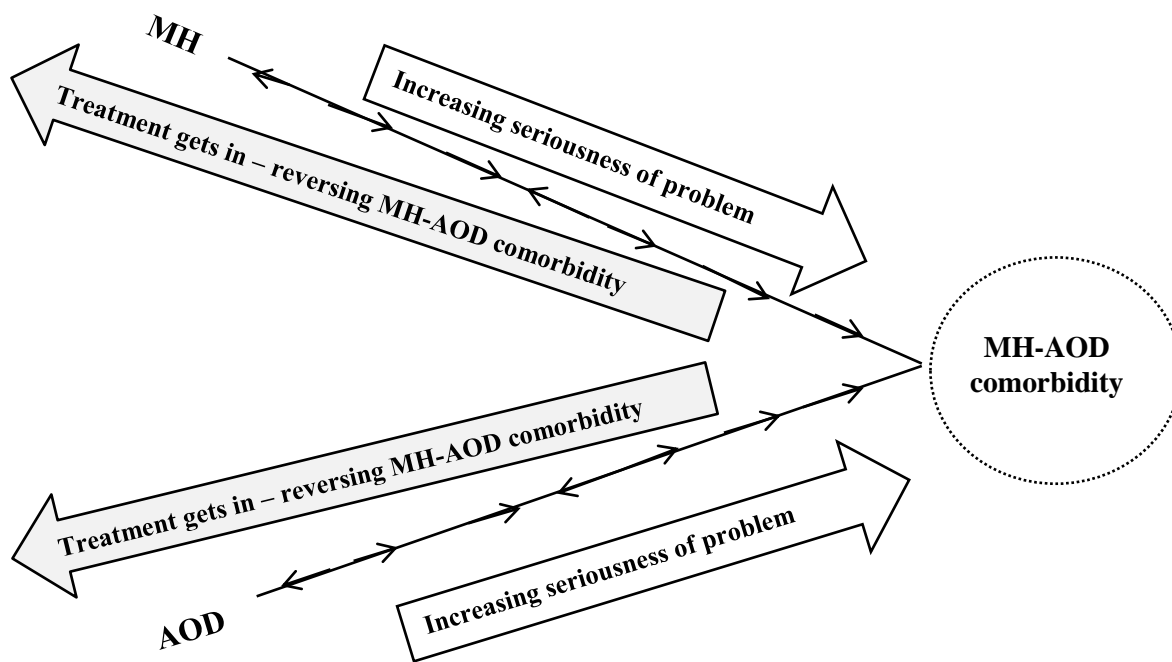
Carretta, Clerici, & Carrà, 2015). It is estimated that 70–90% of registered consumers receiving treatment in either a MH or AOD service have diagnosable MH-AOD comorbidity (Deady et al., 2013).

#### **2.4.4.1 Why MH-AOD comorbidity occurs**

Although it is difficult to show causality of connections between MH and AOD disorders, the literature suggests that certain MH disorders are risk factors for AOD problems and vice versa. There is a known direct relationship between some MH problems and the use of certain drugs (Allsop, 2008), for example psychosis is associated with heavy amphetamine use (McKetin, McLaren, Lubman, & Hides, 2006). The Diagnostic and Statistical Manual of Mental Disorders (DSM) classifies such disorders (e.g., alcohol use disorder or drug use disorder) as a continuum from mild to severe (American Psychiatric Association (APA), 2013; DSM, 2013).

Chronic MH and AOD problems can make people vulnerable to comorbidity. Untangling overlapping and inter-connected MH-AOD symptoms is difficult, which makes diagnosis and treatment complex. However, correct diagnosis is crucial for ensuring effective and appropriate integrated treatments. Failure to recognise and treat MH-AOD comorbidity by MH and AOD specialists can seriously jeopardise the affected person's prognosis and likelihood of recovery (Allsop, 2008; Deady et al., 2013).

The high incidence of MH-AOD comorbidity amongst clinical populations is not indicative of whether either disorder “caused” the other. The spectrum of MH-AOD comorbidity varies in duration and severity, including its course and outcome, as shown in Figure 2.1.



**Figure 1.1: Spectrum towards developing MH-AOD comorbidity (de Crespigny, 2015)**

Onset of the symptoms of MH or AOD disorders can be subtle until they reach a point where MH-AOD comorbidity starts to affect the person’s behaviour. People with mild to moderate MH problems may consume alcohol or other drugs at harmful levels to self-medicate. However, the majority of people with AOD-induced disorders in the absence of MH disorders rapidly improve when they stop AOD use (Schuckit, 2006). People with comorbidity experience more complex and severe clinical conditions than those with MH *or* AOD dependence, bringing enormous distress on themselves and their families (Deady et al., 2013). Comorbidity magnifies an already heavy burden on people with MH and AOD problems, particularly young people, where mental disorders represent 45% of their overall disease burden (Gore et al., 2011).

MH-AOD comorbidity is significant, especially amongst vulnerable communities (Teesson, Slade, & Mills, 2009; Wilson, Stearne, Gray, & Sagers, 2010; Black et al., 2015). Patterns of mental illness, harmful AOD use and MH-AOD comorbidity differ greatly according to age, gender, cultural norms, stage of development and psycho-social-economic circumstances (Teesson & Mewton, 2015). For example, more men drink heavily than women, while more women develop dependence on benzodiazepines (Darke, Ross, Teesson, & Lynskey, 2003), and young people may prefer cannabis and stimulants (Degenhardt, Hall, & Lynskey, 2001).

#### **2.4.4.2 Aboriginal MH-AOD comorbidity contributing factors**

AOD use and emerging MH conditions, particularly anxiety, depression, self-harm and severe psychological distress account for a high number of adolescent Aboriginal Australians' hospital admissions. In 2008–2009, the number of Aboriginal youth aged 12–24 years admitted to hospital for MH and AOD or other behavioural disorders was three times that of age-equivalent non-Aboriginal counterparts (AIHW, 2011a).

Coexisting and chronic MH and AOD problems are high among fewer overall, but still significant, numbers of Aboriginal people compared with non-Aboriginal people. This situation can be linked to the impact on them of cultural stereotyping, racism, shorter life expectancy, premature deaths of family members, including suicides, high infant mortality, self-harm and violence, and disrupted cultural tradition and connection to their own land – their Country (Kirmayer 2000; Paradies 2008). Hospitalisations for MH conditions associated with AOD use were 4.5 and 3 times more prevalent among Aboriginal men and women (respectively) than their non-Aboriginal counterparts (AIHW, 2011a). The burden of such MH-AOD comorbidity is 4.5 times higher among Aboriginal Australians than non-Aboriginal Australians (Gray, Stearne, et al. (2010).

The forced separation of Aboriginal children from their mothers, fathers and wider family and community has been identified as a key contributing factor to higher risk AOD use among Aboriginal Australians (Kariminia, Butler, & Levy, 2007). Forced separation deeply affects not only the adults but also the children, who consequently suffer psychosocial and other developmental problems, and high risk of drinking as well as other substance use from a very young age, for example petrol sniffing among Aboriginal adolescents (Sheldon 2001). The introduction of 'Opal'<sup>TM</sup> fuel has significantly decreased petrol sniffing in communities where it has replaced unleaded petrol, but contextual influences and individual reasons for petrol and poly-substance misuse among children and adolescents have not yet been adequately addressed (Nicholas, 2007).

It must be noted that while AOD problems affect both Aboriginal and non-Aboriginal people in Australia (AIHW, 2014b), with alcohol consumption – a preventable cause of comorbidity – accounting for 3.2% of the general population's overall disease burden (NHMRC, 2015), more Aboriginal Australians refrain from alcohol consumption than non-Aboriginal Australians on a comparative per capita basis.



However, Aboriginal individuals who do consume alcohol do so at higher risk levels (Andrews, Henderson, & Hall, 2001; de Crespigny, 2014). A significant increase in abstinence from alcohol occurred amongst the 12–15 and 16–17 year age groups from 2007–2010 in the Aboriginal population (69.9% in 2007 and 77.2% in 2010) (AIHW, 2011a), yet 17% of Aboriginal individuals from 15 years of age reportedly consumed alcohol at high risk levels (ABS, 2010). Episodic and frequent binge drinking were more common among Aboriginal drinkers.<sup>3</sup> In 2010, Aboriginal Australians had higher percentages of chronic AOD use among both males and females than other Australians (ABS, 2010).

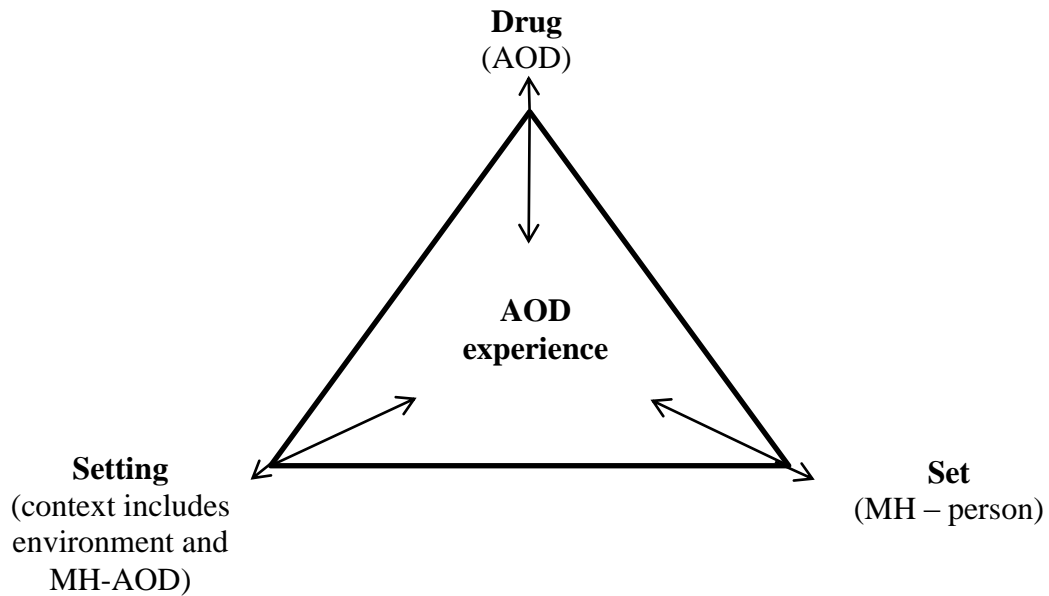
#### **2.4.4.3 MH-AOD effects: The Zinberg model of “drug”, “set” and “setting”**

When considering people’s AOD experiences at particular times in their lives, it is important to recognise that inter-related factors dynamically influence these experiences. Environmental and other contextual factors, including living conditions, influence an individual’s AOD use. Susceptibility to MH and mental illness can also result in vulnerability to developing AOD-related comorbidity problems.

According to Zinberg (1984), three dynamic, inter-related factors together determine an individual’s AOD use experience and outcomes. A person’s experience may differ according to the influences of these factors on their AOD experience at the time. The factors are: the drug’s psycho-active properties, dosage, administration method, quantity, quality and dose consumed (AOD=“drug”); the person’s particular reasons for using AOD at the time, for example their motivation, gender, age, physical and mental health status, life experiences, cultural beliefs, upbringing, desire for fun or dulling pain, hope or despair, and personality (“set”); and the influencing physical and social environment – “setting” (see Figure 2.2). This relates to the context of a person’s AOD use, such as: availability and cost of AODs; legality of AODs used; in a safe or unsafe place; being with other people who do or do not use AODs riskily; or being alone.

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<sup>3</sup> Not all ‘alcohol use’ is ‘alcohol misuse’, the latter being harmful to misusers or others.



**Figure 2.2: The Zinberg (1984) model in the MH-AOD context, indicating the dynamic inter-relationship between each influence**

Access to, and availability of, AOD is an influencing factor; when the AOD is more available, people’s usage can increase. For example, if most people nearby smoke cannabis or consume alcohol, this may influence a naïve or inexperienced person to believe that this type of AOD use is “normal” and therefore it is reasonable for them to participate too. As identified earlier, a person’s environmental and social situation, including factors such as poverty, age, un/employment and MH status influence the person’s AOD use. Cultural norms play a part in how AOD use affects the individual, for example, social sanctions about what is harmful (Write, 2013).

In general, mental illness can impact on an individual’s capacity to function well, and there are strong links to them developing MH-AOD and becoming more dysfunctional and distressed (Miller, 2013). Such a person’s overall wellbeing deteriorates if their MH-AOD is left untreated and unsupported; commonly, social alienation, marginalisation and discrimination occur (Gracey & King, 2009). Hunter (1993) and O’Shane (1995) purported that an individual’s or group’s risk of harmful AOD consumption can be heightened when exposed to hostile “settings”, for example family or community dislocation, violence, cultural alienation, poverty, rapid urbanisation and community acceptance of unsafe AOD consumption (the “setting”). Settings are influential in improving or worsening AOD use, MH and mental illness-related comorbidity in Aboriginal communities.

#### **2.4.4.4 Unmet needs and hidden consequences of MH-AOD comorbidity**

MH and AOD problems are identified as placing Aboriginal people at high risk of frequent health crises and repeated episodes of hospitalisation. Premature morbidity and mortality, incarceration, self-harm and suicide, inter-generational welfare dependence and children being placed in foster care are some of the hidden consequences of unmet MH-AOD needs (ABS, 2013). Unrecognised MH-AOD comorbidity is linked to Aboriginal people's poor compliance with treatment of mental illness (Nagel, 2006, p. 1).

The most commonly identified consequences of untreated MH-AOD comorbidity include incarceration, poverty, unemployment, homelessness, death and suicides, yet seldom are these fully recognised as such. Other serious consequences of MH-AOD comorbidity that impact on individuals, families and communities involve family separation, chronic ill-health, threats to culture, dis-connectedness from Country, psychological [dis]stress and violence (including homicide) (Davis, 2003; Procter, 2005; Gordon, 2008; Chalmers et al., 2014). Guilt, shame, rejection and disparity between individuals and families associated with AOD and mental illness commonly occur (Procter, 2005).

##### *Incarceration*

There was a 52% increase in Aboriginal incarceration between 2000 and 2010, with no comparable increase among the non-Aboriginal population (AIHW, 2011a). In 2012, 25% of all prisoners (male and female) were Aboriginal, with females representing a 20% increase from the previous year (ABS, 2013). Alarming, in 2010–2011, Aboriginal young people aged 10–17 years were significantly more likely to be in detention or under supervision than their non-Aboriginal counterparts (AIHW, 2011a). According to Heffernan et al. (2012), most Aboriginal prisoners experience MH problems (commonly PTSD) in the year prior to incarceration. It was previously found that Aboriginal prisoners had MH and AOD problems prior to their imprisonment (Indig et al., 2010). Most importantly, incarceration impacts on the health and wellbeing of families and children as well as prisoners (Levy, 2013).

##### *Poverty, unemployment and homelessness*

An Australian Institute for Health and Welfare (AIHW, 2011a) report showed that only 65% of Aboriginal working age people were employed – 14% less than for other Australians. This causes high levels of psychological distress, creating mental health

problems that prevent 38% of sufferers from working or participating in day-to-day activities (ABS, 2012). Hence, Aboriginal communities lack the MH benefits associated with employment (Dollard, 2002).

Homelessness, and physical, financial and social stressors, as well as reduced access to health care services compound the high rates of MH-AOD comorbidity in Aboriginal communities (Tatz 1999; Hunter 2007; Velleman 2007). Recent evidence suggests that specialist homelessness, AOD and MH services are being approached to provide support outside their normal programs for homeless individuals (Flatau et al., 2013). Consumers and service managers are seeking improved service integration, aware that much more must be done to address the above-mentioned problems, which appear to be associated with untreated or undertreated MH-AOD comorbidity.

#### *Death and suicides*

Contextual analysis argues that all self-harming behaviours should be seen as a sweeping response to stressful experiences (Westerman, 2010; Walker, 2012). For example, suicide by hanging carries significant messages of hurt feelings, injustice and tyranny. MH-AOD comorbidity is linked to high rates of Aboriginal suicide, particularly amongst 15–34 year olds, with 25–29 year old males representing the highest age-specific rate of 90.8 deaths per 100,000 population. The highest rate for Aboriginal females is 21.8 deaths per 100,000 population, which is among 20–24 year olds (ABS, 2010). In a 2007 analysis, suicide accounted for 4% of the mortality gap between Aboriginal and non-Aboriginal Australians (Vos, Barker, Begg, Stanley, & Lopez, 2009).

Aboriginal Australians experience alcohol-associated harm, including deaths and hospitalisations, at a much higher rate than other Australians. In 2009, alcohol-associated death was 5–19 times higher among Aboriginal people than the rest of Australia's population (Steering Committee for the Review of Government Service Provision, 2009). Pascal, Chikritzh, and Gray (2009) identified alcohol as the major factor associated with suicides in Aboriginal communities.

Given that Aboriginal Australians are twice as likely as non-Aboriginal Australians to experience psychological distress and violence (AIHW, 2011a), and twice as likely to commit suicide (ABS, 2010), more must be done urgently to meet their MH-AOD needs, including provision of local, culturally-appropriate and holistic comorbidity

treatments and supports.

If the Australian mental health recovery pathway (National Mental Health Strategy, 2013) considered and included MH-AOD comorbidity recovery in the principles, priorities and practices of MH and AOD services, the consequences of MH-AOD may be lessened. Currently, the MH and AOD services independently offer different (silos) therapeutic philosophies, priorities and service models, resulting in exclusion of MH-AOD comorbidity holistic treatment despite many people's need for an MH-AOD holistic recovery model in both types of services. Additionally, well-coordinated assessment, treatment and social care should focus on Aboriginal (Kowanko et al., 2009) and other consumer's overall health and wellbeing (Cairney et al., 2015). If all MH and AOD services jointly applied a combined MH-AOD recovery model, they could offer holistic treatment, care and support for MH-AOD recovery and wellbeing (ADCA, 2008; Deady et al., 2013). This might stop the referral-induced service run-around and interrupt cycles of crises, relapse and deterioration in MH-AOD comorbidity that seriously impact individuals, families and communities (Garvey, 2008).

## **2.5 MH-AOD service provision**

There is a paucity of evaluation of Aboriginal-specific AOD and MH comorbidity interventions (Steering Committee for the Review of Government Service Provision, 2009). Gray suggested that Aboriginal Australians should be key players in the design, implementation and evaluation of interventions intended to address Aboriginal people's harmful alcohol use, with a central focus on capacity-building within Aboriginal community-controlled organisations (Gray, Stearne, et al., 2010). Overcoming systemic service barriers by implementing tailored intervention strategies arising from practical experience and flexible services as part of integrated care have been reported as a pathway for further progress in MH-AOD service delivery (Teesson & Proudfoot, 2003; Allan, 2010). However, according to the extant literature, little has emerged since then with regard to progressing the development of Aboriginal MH-AOD services per se.

### **2.5.1 Importance of culture in MH-AOD services**

The ability of MH and AOD services' non-Aboriginal workers to work effectively with Aboriginal workers from Aboriginal-specific and mainstream services is essential to providing MH-AOD care for Aboriginal people. Additionally, services must operate in accordance with Aboriginal cultural requirements for their MH-AOD service provision

to be accepted and effective, which will depend greatly on staff conveying respect and non-racist attitudes, and having a sound knowledge of Aboriginality (Vicary & Westerman, 2004).

Thus, clinicians and workers need both cultural and clinical competencies to provide effective MH-AOD services for Aboriginal people (Westerman, 2004; Hunter, 2014). Cultural competencies involve the ability to assess, identify and treat MH-AOD problems with respect for culture as the central therapeutic element (Dana, 2000). Clinical competencies involve practising effective interpersonal skills and therapeutic techniques that can be useful in treating particular disorders (NATSIHC, 2003). Integration of cultural awareness and knowledge into the MH-AOD clinical context has been shown to help achieve better consumer outcomes (Cusack et al., 2007).

Communication style is an important aspect of consumer engagement, with many Aboriginal people considering direct questions inappropriate (Cusack et al., 2007). A method of three-way talking involving the consumer, a mediator such as a trusted family member, and a clinician or worker may be useful (de Crespigny, 2014). In a qualitative study investigating the existing MH system and the MH of 70 Aboriginal Australians, Vicary and Westerman (2004, p. 9) concluded that non-Aboriginal people with some understanding of issues confronting Aboriginal people, and who were willing to listen, learn and apply a blend of Aboriginal knowledge with Western psychology, were more likely to succeed in delivering their services to Aboriginal consumers. It has been suggested that the best approach to delivering effective therapy with Aboriginal people involves a narrative communication style that includes positively-phrased, open-ended questions; “yarning” (Bessarab, 2010) and storytelling about the problem (Harris, 1977; Wingard, 2001; Vicary & Westerman, 2004).

Some consider group psychotherapy a culturally-appropriate tool because it reflects the Aboriginal tradition of sharing stories (Chenhall, 2006). Group processes can provide a social environment that supports an individual’s therapeutic needs, as well as connectedness and relatedness in the context of cultural practice (Ryan & Deci, 2000). Residential MH-AOD treatment programs for Aboriginal people may be appropriate, however these need to be flexible and modified by incorporating Aboriginal cultural components (Brady, 2004; Hinton, Bradley, Trauer, & Nagel, 2014).

Prevention, promotion and therapeutic MH-AOD services need to establish

collaborative partnerships with other rehabilitative support services, including “health, child protection, housing, education, employment and criminal justice” sectors to ensure effective care management (Mental Health Commission, 2011).

It has been suggested that the features of cultural competency should be organised under the concepts of cultural awareness, cultural knowledge and flexibility (de Crespigny, 2014). The Royal Australasian College of Physicians (Rowley, 2004, p. 7) outlined five guiding principles of cultural competence: the value of diversity; maintenance of the capacity for cultural assessment; awareness of the dynamics that are inherent during the interaction of cultures; cultural knowledge to be institutionalised; and service provision that reflects an understanding of cultural diversity.

For many Aboriginal people, any health care needs to take into account family, community and Country. The Ngarinman people of the Northern Territory describe how their health encompasses both Country and person (Atkinson, Graham, Pettit, & Lewis, 2002). They refer to *Punya* – being “knowledgeable, strong, happy, beautiful, clean, safe and socially responsible”, and being within the Ngarinman law, along with caring for, and being cared for by, others (Mobbs, 1991). Wilkes et al. (2014) identify that delivery of culturally-respectful AOD services should be based on a:

Holistic model of health and wellbeing with a grounded understanding that historic factors have influenced the use of alcohol, drugs and substances causing harm; the core component is culture, reinforcing and supporting the family system of the Aboriginal community with care and responsibility; Aboriginal control and ownership; and recognising the diversity in Aboriginal communities. (p. 127)

Working with Aboriginal consumers, considering how each person’s family and community group view their behaviour, and questioning whether the MH-AOD symptoms adversely affect their usual environment (Westerman, 2004) may be beneficial. Aboriginal cultural consultants often work with non-Aboriginal clinicians and Aboriginal people by engaging with, and vouching for, these clinicians, as well as acting as the first contact between clinician and consumer (Westerman, 2004).

Aboriginal consumers’ preference is often for a cultural consultant of the same gender and from the same language or tribal group, but this is not always possible due to the small number of Aboriginal consultants across the Australian health system. Therefore, Vicary and Westerman (2004) recommended involving cultural consultants

as “co-therapists” with clinicians.

Cultural competency of all MH and AOD staff in MH-AOD services has been recommended to increase Aboriginal consumer trust and engagement in services and treatments (Vicary, 2002). Wendt and Gone (2012) argue that only by services moving beyond general cultural competencies guidelines and considering their effects in practice can culturally competent, effective and sensitive treatment become meaningful.

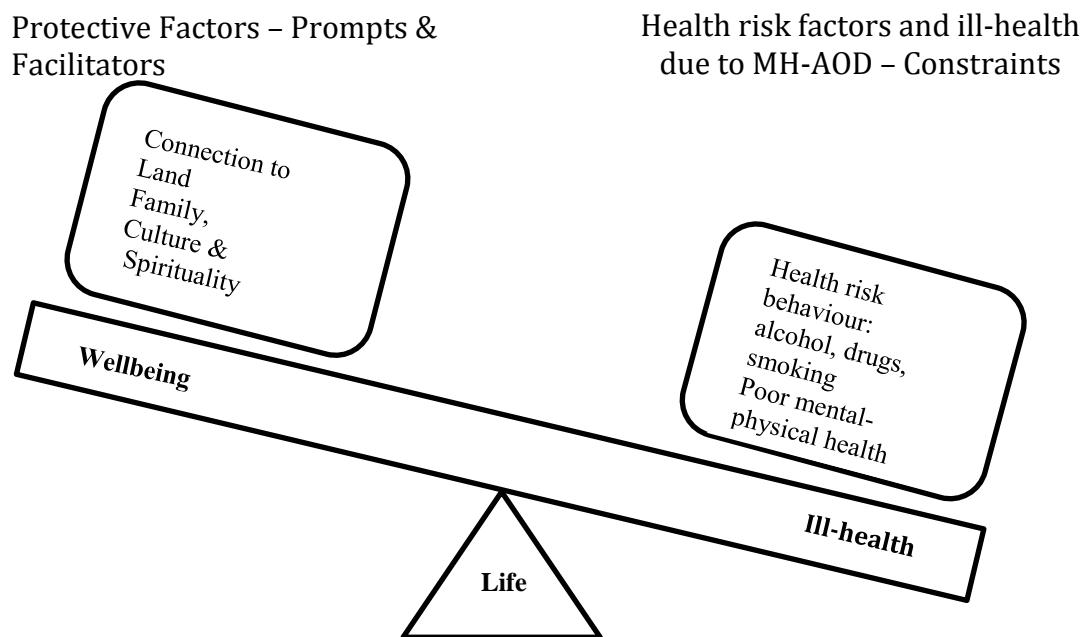
### **2.5.2 Access to MH-AOD comorbidity services**

MH and AOD treatment services and models are overwhelmingly based on European knowledge and philosophies, and are not necessarily appropriate for Aboriginal people. Psychotherapy, a European therapeutic model, can be problematic due to its intrusive and personalised focus (Krawitz & Watson, 1997; McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014). Despite assertions that group psychotherapy fits with storytelling, its intrusive nature may inhibit Aboriginal people’s involvement. Reasons why Aboriginal people may choose not to access mainstream services at a level consistent with their need (Westerman, 2010; Kowanko et al., 2012) include inter-generational distrust from present or past negative experiences of racism and/or poor treatment (de Crespigny & Talmet, 2012); lack of cultural appropriateness and preparedness to engage consumers and their family in the service being provided; or lack of engaging with Aboriginal concepts of wellbeing (Cusack et al., 2007; Wendt & Gone, 2012). Vicary and Westerman (2004) suggested that a broader professional-consumer relationship is needed along with acknowledgement of the role of gender when exchanging sensitive information with Aboriginal people (Cusack et al., 2007).

### **2.5.3 MH-AOD comorbidity care**

Consumers experiencing comorbidity require intensive, integrated assessment and treatments for their complex, co-existing conditions (Teesson & Byrnes, 2001). The determinants of their physical health and MH-AOD comorbidity have not occurred in isolation. Figure 2.3 illustrates a suggested wellbeing model that could assist some Aboriginal people wanting a model for their MH-AOD recovery. The therapy uses “prompts”, “facilitators” and “constraints” (Dudgeon et al., 2010b).





**Figure 2.3: Adapted: ‘Protective and risk factors for MH-AOD wellbeing (Dudgeon et al., 2010b, p. 81)**

Prompts and facilitators reflect protective wellbeing factors, while constraints reflect poor wellbeing factors. This adapted MH-AOD wellbeing model may assist Aboriginal people conceptually, whereby the seesaw could be seen to be “upped” towards balanced wellbeing by reflecting and finding new ways to receive therapy – better ways to manage the “downed” risk factors at the other end. There would be a strong focus on finding ways to maintain people’s connections to Country, ancestors, culture and traditions, spirituality, family and community because these are protective factors that can moderate the impact of distress, trauma and imbalance in people’s lives, and create a sense of wellbeing. These are “their reservoir of strength” that can assist Aboriginal people to start recovering from the impact of their MH-AOD comorbidity (Kelly, Dudgeon, Gee, & Glaskin, 2009).

Facilitators are elements that promote MH wellness by assisting and enabling individuals to face challenges and strengthen their development of personality, temperament and adaptation to change (Werner, 1992; Wilkes et al., 2014). Strong family support to encourage a person’s connection with family and culture through language and education is a facilitator.

## **2.6 What is being done: The current MH-AOD service system**

### **2.6.1 The South Australian health care system and MH-AOD comorbidity**

The South Australian (SA) health care system is subject to both state and federal budget restraints and operational complexities, with state-based public and NGO-funded health and community care arrangements (Savic, 2010). Primary health care (PHC) is delivered through general practitioners (GPs), hospitals, community health services, Aboriginal-controlled and government-funded health services, and allied health and dental services (Swerissen & Duckett, 2002). The federal government co-funds the state to deliver state government public hospitals and some specialist services, including state MH and AOD services (Gruen, Weeramanthri, & Bailie, 2002). The remainder of health care is federally-funded predominantly through Medicare and the universal health insurance scheme.

The SA health care system provides MH and AOD services through regional sectors (SA Health, 2013). The Adelaide metropolitan area has three regional Local Health Networks (southern, central and northern), each providing a network of MH services and basic AOD services (SA Health, 2013). The Women's and Children's Hospital and Child and Youth Health Service is a state-wide service alongside these. There is one centrally-located Aboriginal community-controlled health service (Nunkuwarrin yunti) based in Adelaide's CBD that provides culturally-sensitive primary health care for Aboriginal people, with some additional regional outreach clinical support (Panaretto, Wenitong, Button, & Ring, 2014).

South Australia has yet to develop adequate MH-AOD policy, service structures and therapeutic practice models that can best meet community needs and the Aboriginal community's particular needs. These are currently seriously lacking compared with other Australian states and territories, and considering the common federal and state health funding arrangements (Minas, Klimidis, & Kokanovic, 2007). Many of the other states already have localised practice models for improved MH-AOD care, including strategies to increase Aboriginal-specific MH-AOD services (NSW Health, 2008; Queensland Health, 2012; Dual Diagnosis, 2013; WA Parliament, 2014).

Collaboration and cooperation between MH and AOD services, and community organisations is also seriously lacking in SA (*SA Strategic Plan*, 2013). Insufficient funding, over-demand and lack of information from other bodies to identify risk factors

(WAAMH, WACOSS, & WANADA, February 2013) hamper effective MH-AOD service delivery, particularly in regard to primary prevention, early intervention and education programs, acute services and support for people re-entering the community after time in prison (*SA Strategic Plan*, 2013). South Australia needs to urgently address this situation by providing support for Aboriginal community organisations to deliver sustainable, targeted services based on their connection with their local Aboriginal communities.

## **2.6.2 The Australian Aboriginal health policy landscape**

Each Australian state and territory has recognised the need to improve Aboriginal Australians' health. Aboriginal health reports, policies and issues-specific health plans have been developed (*National Strategic Framework for Aboriginal and Torres Strait Islander Health*, 2007), with issues-specific portfolios formulated to examine policy impacts on Aboriginal people and communities (Dudgeon et al., 2010b). However, no policy specifically addresses key AOD-MH strategies and resources to meet the MH-AOD comorbidity-related needs of Aboriginal people or their service providers.

The 1989 *National Aboriginal Health Strategy* (NAHS) remains the most comprehensive articulation of aspirations for Aboriginal health, but a 1994 evaluation found that it has not been “effectively implemented” and no meaningful partnerships between the mainstream health system and Aboriginal people have eventuated (*National Strategic Framework for Aboriginal and Torres Strait Islander Health*, 2007). The Aboriginal and Torres Strait Islander Commission (ATSIC), established on 1<sup>st</sup> January 1990, aimed to give Aboriginal and Torres Strait Islander people more autonomy in planning and delivering Commonwealth Government programs and services through their own local and regional ATSIC representatives (ATSIC, 1990). The Torres Strait Regional Authority (TSRA) was also established in 1994 and aimed to strengthen Aboriginal and Torres Strait Islander people's economic, social and cultural development (Torres Strait Regional Authority, 2000).

In the 1990s, the *Royal Commission into Aboriginal Deaths in Custody* (1991) exposed the need to urgently address Aboriginal MH through law reform and changes in policing strategies (HREOC, 2005). It recognised the need for cultural sensitivity and acknowledged colonisation as a major factor in Aboriginal mental illness and suicide.

*The Ways Forward: National Consultancy Report on Aboriginal and Torres Strait*

*Islander Mental Health* (Swan & Raphael, 1995) confirmed the link between the threats to Aboriginal people's social emotional wellbeing and the continuing consequences of colonisation, and advocated Aboriginal consultation in all health matters. A multiple health risk behaviour approach to treating MH-AOD comorbidity is important, incorporating a needs-based approach to the treatment of co-existing problems without consumer stigma, thus reducing consumer resistance (de Crespigny, 2002). A move away from treatment planning specifically for MH *or* AOD problems towards holistic consideration of the person with co-existing MH-AOD comorbidity in a broader health care context is needed through one integrated treatment program (Deady et al., 2013), including interventions across a range of health problems (Zinberg, 1984; de Crespigny, 2002). This could be possible in the future by means of MH-AOD services targeting multiple co-existing problems simultaneously, with services improving diagnosis and prognosis for coexisting MH-AOD disorders (Gordon, 2008; Australian Institute of Primary Care, 2009).

The *Social Well Being (Mental Health) Action Plan 1996–2000* was developed largely in response to recommendations of the *Royal Commission into Aboriginal Deaths in Custody* (1991) and *Human Rights and Mental Illness: Report of the National Inquiry into Human Rights and Mental Illness* (“Burdekin Report”) (1993). Both called for “culturally-appropriate and accessible Aboriginal mental health services” to address “deaths in custody, youth suicide and transgenerational loss and trauma” (Young, 2001). Administered by the Office for Aboriginal and Torres Strait Islander Health (OATSIH), the *Action Plan* aimed to provide a consistent “integrated approach to Aboriginal mental health”, based on Aboriginal Australians’ cultural perspectives, particularly their belief that “land is the centre of wellbeing”. The *Action Plan* stressed the need to recognise colonisation’s ongoing impact on social emotional wellbeing and inter-generational trauma and loss (Dudgeon, Walker, et al., 2014a); social respect for Aboriginal people’s right to easily accessible, culturally-safe services; understanding the strength of kinship as opposed to an individual-centred care approach; and respecting Aboriginal people as diverse individuals and communities with different languages and lifestyles, skills, abilities and values (Young 2001). It also aimed to reduce young Aboriginal people’s suicide rate, and increase research and evaluation of Aboriginal MH issues and services to inform new policy and actions (HREOC, 2005). However, a 2001 evaluation found that the *Action Plan* only partially implemented its policy elements and had little impact

on MH service provision for Aboriginal people (Dudgeon et al., 2010b, p. 49). The evaluation suggested developing the plan into a strategic document, setting out a conceptual framework to identify “appropriate roles, planning mechanisms and core areas for action” (Dudgeon et al., 2010b, p. 50).

*Ways Forward* (Swan & Raphael, 1995), the *Burdekin Report on Human Rights* (Burdekin, Guilfoyle, & Hall, 1993) and the *Royal Commission into Aboriginal Deaths in Custody* (Aboriginal and Torres Strait Islander Commission, 1992) all emphasised that health care professionals working in MH and AOD services have a limited understanding of Aboriginal culture, and that community consultation is essential for developing health services that would benefit the local community (Swan & Raphael, 1995; National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013, 2007). The uniqueness of Aboriginal people’s MH and AOD problems (Eley et al., 2006) demands a unique response, with Aboriginal-specific MH-AOD services as a core element.

Overall, there is a compelling need for a competent and capable MH-AOD workforce to be developed along with MH-AOD social and health care teams within Aboriginal community-controlled health services to ensure they, too, can provide additional, easy-to-access specialist expertise, including support for visiting specialist MH-AOD care workers; workforce development in cultural competence for mainstream MH-AOD service staff; more Aboriginal staff at all organisational levels (Couzos, Lea, Murray, & Culbong, 2005; SA Strategic Plan, 2013); and increased collaboration between state and territory MH-AOD services in partnership with Aboriginal communities.

The *Better Outcomes in Mental Health Care* initiative (2001–2005), funded by the Australian Government Department of Health and Ageing (Australian Government, 2005), was implemented in 2001. It supported people with mental illness (but not others with AOD dependence) through an incentive payment for health care services to provide “assessment, a mental health care plan and review” (Britt et al., 2009, p. 37). A *Better Access to Mental Health Care* initiative built on this would “enable community access to mental health professionals and team-based mental health care” provided by collaborating “GPs, psychiatrists, clinical psychologists and other allied mental health care providers”. It intended to enable “an extended GP consultation for mental health care” as a Medicare item of the Australian General Practice network (AGPN) (Howard

2009, p. 48), whereby clinicians could *refer* consumers to other related health professionals under the “access to extended services” initiative (Morley et al., 2007, p. 144).

Next came the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013* (NSFATSIH), which was also developed to deliver accessible treatment and culturally-appropriate health services to Aboriginal people for a decade. The framework prioritised emotional and social wellbeing and developmental health (Roxbee & Wallace, 2003), and “key result” areas for immediate action in MH, suicide, AOD misuse, family violence, child abuse and general health (*National Aboriginal and Torres Strait Islander Health Council, 2003–2013*, 2007). The framework adopted an approach endorsed by all state and territory Cabinets. It recommended an increase in funded and accessible Aboriginal community-controlled health services’ participation in government; operating with mainstream health services; structural reform of the whole health system to be more responsive to Aboriginal Australians’ needs; improved inter-sectoral collaboration; workforce development for both Aboriginal and non-Aboriginal people; improved evidence base to inform policy; resource allocation to reflect areas of greatest need; and a greater focus on the relationship between social determinants of health and comorbidity (*National Strategic Framework for Aboriginal and Torres Strait Islander Health*, 2007). According to Eickelkamp (2010), despite some progress in addressing the key MH and AOD areas, implementing appropriate MH-AOD services for Aboriginal people remains inadequate. It is an ongoing issue, possibly due to the way indicators of MH and AOD are diagnosed, which miss the emotional and social wellbeing factors that are needed for an effective model of care.

In February 2006, the Council of Australian Governments (COAG) committed to a five-year action plan to improve MH services nationwide by expanding the number/type of services and the number of health professionals across the MH care system, and reforming the way individual health professionals work to develop allied health care teams (Dudgeon et al., 2010b, p. 55; see also Dudgeon, Milroy, et al., 2014b). All levels of government were expected to commit to primary MH care programs in schools, and community-based MH care services and clinical MH services, including counselling, treatment and rehabilitation services for MH consumers’ recovery and return to life in the community (Allan & Campbell, 2011).

All Australian state governments signed the *Aboriginal and Torres Strait Islander Health Framework 2007–2013* agreement, binding all health sectors, ATSIC and the Torres Strait Regional Authority to provide increased resources, improved data sharing and joint planning for Aboriginal and Torres Strait Islander health service delivery. According to the *Australian Government Implementation Plan* (2007, p. 7), local and regional planning processes are fundamental to ensuring coordinated mainstream and Aboriginal community-controlled health services’ planning and delivery for emotional and social wellbeing, and MH under the auspices of the National Aboriginal Community-Controlled Health Organisation (NACCHO). In addition, Aboriginal community-controlled health services reportedly provide approximately 100 AOD services for Aboriginal people around Australia. This, however, does not involve MH-AOD comorbidity, which neither featured nor was embraced in the *Implementation Plan*.

The *National Apology to the Stolen Generations* delivered by then Prime Minister Kevin Rudd on 13<sup>th</sup> February 2008, which used the word “sorry”, was a major first step in the healing process for Aboriginal and Torres Strait Islander people (and many non-Aboriginal Australians) (Dow (2008). Christina King, the spokesperson for the Stolen Generations Alliance, said, “Sorry is the most important word because it has great meaning in our community; it means having empathy and compassion and understanding” (ABC, 2008, p. 1). The *Apology* (13<sup>th</sup> February 2008) was followed by the National Aboriginal Health Equality Summit in Canberra from the 18<sup>th</sup> to 20<sup>th</sup> March 2008, at which all sides of the Australian Parliament and heads of Aboriginal and mainstream health organisations signed the *Statement of Intent to Close the Gap*, which aimed to “achieve equality of health status and life expectancy between Aboriginal and non-Aboriginal Australians by 2030” (Pulver et al., 2010, p. 34). Its key points were to: consult with Aboriginal people and work collectively to build an evidence base to target their needs, in particular to address the social determinants of health; and to increase Aboriginal people’s autonomy. This was to be achieved largely through more Aboriginal community-controlled health services in all regions of Australia; improving mainstream services in terms of accessibility, affordability and respect for Aboriginal people’s cultural needs; and evaluating progress through monitoring and reporting.

Also in 2008, The Australian Health Ministers endorsed the *National Mental Health Policy* with the aim of implementing a “whole-of-government” approach towards MH

(Commonwealth of Australia, 2009) and a MH system equally accessible to all Australians, which would be based on early detection of, and intervention in, mental ill-health to achieve greater rates of recovery and community support. It recognised that Aboriginal people had a higher risk of developing mental ill-health, and included a focus on reducing stigma around mental ill-health and assisting people with MH problems to participate to their fullest in community life (Commonwealth of Australia, 2009).

The *Fourth National Mental Health Plan*, endorsed on 4<sup>th</sup> September 2009, called for “collaborative government action in mental health from 2009–2014” in five priority areas: social inclusion and recovery; prevention and early intervention; service access, coordination and continuity of care; quality improvement and innovation; and accountability – measuring and reporting progress (Commonwealth of Australia, 2009-2014, p. 11). This plan acknowledged the poor access to mental health care in rural and remote Australia, and the need for multi-sectorial partnerships to achieve the best MH outcomes (Taylor, Edwards, Kelly, & Fielke, 2009, p. 217).

In February 2009, the Council of Australian Governments’ (COAG) National Reform Agenda launched the “Closing the gap” initiative to be implemented through the *National Indigenous Reform Agreement (NIRA)* (CTG, 2009; National Indigenous Reform Agreement, 2011, p. 3), focusing on outcomes in early childhood, schooling, health, healthy homes, safe communities, economic participation, and governance and leadership (National Indigenous Reform Agreement, 2011, p. 4). Aboriginal community-controlled and government-run health services are located in regions where Aboriginal people experiencing comorbid conditions commonly live (Baeza & Lewis, 2010). If available, Aboriginal community-based MH or AOD services can be tailored to address Aboriginal consumers’ MH or AOD issues in culturally-appropriate settings. However, while seven *Closing the Gap National Partnership Agreements* between the Australian, state and territory governments were set up to implement programs, none had any Aboriginal involvement (Closing the Gap, 2013).

In 2010, the Australian Health Ministers’ Advisory Council endorsed the *Aboriginal and Torres Strait Islander Health National Workforce Strategic Framework*, which aimed to increase the number of Aboriginal health workforce professionals and improve non-Aboriginal health professionals’ cultural competency, as well as standardise Aboriginal health workers’ training and competency (Australian Health Ministers’



Advisory Council, 2011).

Currently, the Western Australian Government is working on launching a MH and AOD services plan for 2015–2025 (2015) to ensure that people have the right to access the service they need, when they need it and where they need it (right location) so they will not fall through the service gaps. The government suggests that this requires appropriate cooperation and implementation by all related service sectors, and substantial state and federal government funding. This research study has the potential to add to this plan and, more importantly, to future South Australian planning for workable MH-AOD local service delivery to Aboriginal people in Salisbury and Playford LGAs as a result of their significant input into addressing their urgent need for localised comorbidity services.

### **2.6.3 Prevention, management and brief intervention**

Given that positive family functioning and education are key elements of health and wellbeing, preventive education and risk management in the early stages of life are seen as an investment in future health and wellbeing (Campbell & Brown, 2004; Cox, 2015), and therefore in preventing MH and AOD problems. Primary prevention aims to prevent health problems through health education and dissemination of knowledge about risk and protective factors, beginning with programs educating parents about the risks for their children, including unborn babies, and supporting parents and families of new born babies (Gray, Sagers, Atkinson, & Wilkes 2008). Evidence that a child's early years impact on their later health and social development (Stockwell, Gruenewald, Toumbourou, & Loxley, 2005), including AOD risk-taking (Loxley, et al., 2004), can inform primary prevention programs.

Australian Aboriginal communities have identified the importance of primary preventive interventions, including developing self-esteem and “cultural connectedness”, as well as positive family relationships in regard to harm reduction from AOD use. Health education and support in school, parent education programs (Loxley, 2004), and sporting, recreational and cultural activities that provide alternatives to AOD use have proven successful (Gray, Stearne, et al., 2010).

The *National Alcohol Strategy 2006–2009* (Ministerial Council on Drug Strategy, 2006), as the government policy targeting alcohol misuse, “aim[ed] to prevent and minimise alcohol-related harm to individuals, families and communities in the context

of developing safer ... drinking cultures in Australia” (Gray, Saggars, Sputore, & Bourbon, 2000; Wilson et al., 2010). It suggested the need for primary, secondary and tertiary level strategies to minimise harm from alcohol misuse. However, evidence for the effectiveness of harm minimisation programs for Aboriginal Australians is scarce and unreliable (Lynch, 2000), and knowledge about preventive MH-AOD care does not consistently translate into policy and practice (Butler, 2005). Translations of mainstream programs have had promising outcomes when implemented culturally and contextually-appropriately in consultation with relevant local Aboriginal communities and organisations (Lynch, 2000; Proude, Lopatko, Lintzeris, & Haber, 2009).

Secondary prevention aims to prevent harmful AOD consumption and dependence, thus reducing the risk of comorbidity (Wilson et al., 2010). Substantial timely brief interventions provided through primary health, MH and AOD services are important for secondary prevention. There is evidence that some of these interventions are more effective than longer-term treatments (rehabilitation), and may have positive outcomes in Aboriginal settings if delivered to non-dependent people in culturally-sensitive, respectful, non-judgemental ways (Gray, Saggars, Atkinson, & Wilkes, 2008).

However, there are very few secondary prevention programs available for Aboriginal Australians. The Indigenous Risk Impact Screen (IRIS) has been identified and validated as a useful screening tool for identification of AOD use and MH risk among Aboriginal populations (Schlesinger, Ober, McCarthy, Watson, & Seinen, 2007). It highlights the importance of access to, and use of, Aboriginal-specific therapeutic tools to make it easy for services to recognise and respond to the vast cultural differences between Aboriginal people and mainstream Australians and their health services. While the IRIS and AUDIT-C alcohol misuse screening tool have been developed, validated and adapted for Aboriginal settings (Panaretto et al., 2010) to enable earlier detection of MH and AOD problems, these are not consistently applied.

Tertiary prevention (comprehensive and appropriate treatment) aims to treat complex MH-AOD comorbidity, thus reducing or ceasing AOD use and resolving MH issues (Wilson et al., 2010). It aims to improve physical, social and mental health, and reduce harmful behaviours and AOD use.

Aboriginal people have the right to receive the same range of AOD and MH primary, secondary and tertiary treatment options as non-Aboriginal Australians. As

with many other illnesses, they commonly present for AOD treatment at a later stage when they have complex physical and MH comorbidities that require intensive therapy and supportive treatment programs (Loxley et al., 2004). Few AOD programs, let alone comorbidity programs, have been formally evaluated or made sustainable for Aboriginal people (Wilson et al., 2010) despite guidelines for the treatment of Aboriginal people with alcohol-related MH and AOD health issues (Cusack et al., 2007). Gray, Wilson, Allsop, Siggers, Wilkes, & Ober (2014) identified barriers to tertiary intervention, including: Aboriginal people not accessing AOD or MH services for cultural reasons; there not being the full range of comorbidity services available; and very limited availability of after-care services, family support, and pharmacotherapies to prevent and manage AOD or MH relapse.

Some Aboriginal Australians prefer to use mainstream services to avoid the community “shame” factor associated with others knowing about their MH-AOD comorbidity problems (Bazeley & Jackson, 2013; Clifford, Pulver, Richmond, Shakeshaft, & Ivers, 2009). However, all MH-AOD services need appropriately qualified cultural consultants and culturally competent staff, as well as sufficient resources to provide access for all Aboriginal consumers (Gray, Stearne, et al., 2010). Clifford et al. (2009) suggested that training and employing Aboriginal staff in mainstream services, as well as developing collaborative partnerships with locally-based Aboriginal-controlled organisations, can help achieve this.

#### **2.6.4 Comorbidity service strategies and their effectiveness**

In the current service system, people experiencing MH-AOD comorbidity are considered responsible for understanding and following their treatment advice, often in the context of MH or AOD services using differing treatment philosophies and practices. Historically (Deady et al., 2013, p. 8), *sequential treatment* directs therapy to the primary condition (e.g. AOD) and then to other problems (e.g. MH). Sometimes, the condition that may have occurred first is treated first, but it is difficult and possibly unhelpful to try to disentangle the sequence of MH-AOD conditions. Additionally, there are practical difficulties in reliably diagnosing primary and secondary conditions (Baker & Velleman, 2007). Even with completion of AOD treatment, there is no guarantee that any subsequent MH treatment will be available if MH services are not co-located with AOD services (Proudfoot, Teesson, Brewin, & Gournay, 2003) or not willing to engage with the person. *Parallel treatment* involves treating the AOD and MH problems

simultaneously but through different programs and services. If such programs and services are coordinated through effective partnership between different services, they may be helpful. *Integrated treatment* involves treating the person's MH-AOD conditions simultaneously and holistically, and explores the relationship between the co-existing conditions so as to individualise appropriately-combined therapies. *Stepped-care* matches treatment intensity to the severity of a person's MH-AOD comorbidity at the time. Intensity is based on assessing and prioritising treatment requirements, and according to practitioner and consumer preference (Deady et al., 2013, p. 8). Significantly, this literature review found no publications or reports on *stepped-care* treatment modalities for Aboriginal people.

Most MH and AOD services segregate treatment according to which diagnostic groupings their service prioritises, that is MH *or* AOD, based on the primary diagnosis such as depression, anxiety or psychosis, *or* AOD dependence, which typically results in individuals with acute comorbid AOD issues being refused entry to MH programs. They are told they must first seek treatment for their AOD problem, or vice versa (Teesson et al., 2009; Staiger, Howard, Thomas, Young, & McCabe, 2014).

#### **2.6.4.1 Single service point: "One door" for MH-AOD service**

Donald et al. (2005) suggested that integrated services are essential for effective treatment of co-occurring MH-AOD conditions, and Kenny (2007) has advocated for a single service contact point, claiming it can reduce the burden on the consumer, potential communication problems, discordant treatment philosophies and the chance of consumers "falling through the gaps". Baker and colleagues (2010) have evidence of this, reporting that integrated psychological treatment of depression and problematic alcohol use is associated with a greater reduction in drinking days and level of depression compared with single-focus interventions.

#### **2.6.5 Comorbidity programs and initiatives**

According to Brunette (2001), people with MH-AOD comorbidity benefit from residential treatment programs that involve intensive therapeutic services, assistance with daily living and the opportunity to develop recovery skills. These programs should provide safe, supportive housing to consumers who are either homeless (Caton et al., 2005) or live in unsafe housing environments. They should offer a supportive social network with consistent contact with treatment services and positive peer support to

assist consumers to overcome refusal and to connect with their treatment (Drake, Mueser, Brunette, & McHugo, 2004). Ray, Weisner, and Mertens (2005) suggested that longer stays in residential treatment programs, and participation and support in after-care programs such as effective outpatient treatments, may result in better MH-AOD comorbidity outcomes.

### **2.6.5.1 MH-AOD care-specific initiatives**

Various Commonwealth Government mainstream initiatives have attempted to overcome the systemic barriers to implementing MH-AOD treatment for over a decade. These are:

1. *National Comorbidity Project 1998–2003*, which aimed to identify comorbidity and effective treatments, and improve response.
2. *National Comorbidity Initiative 2004–2008*, developed to improve coordination of service and treatment outcomes for people with comorbidity. It raised awareness, promoted good practice, provided clinical support and resources, and improved data collection methods and systems. Funding was allocated and directed to MH as well as AOD services to assist in this endeavour.
3. *National Comorbidity Collaboration 2010–2011*, focused on improving coordination, education and service delivery through guidelines.
4. *Improved Services Initiative 2006–2012*, focused on building non-government agencies' capacity and workforce development.

Deady et al. (2013) report that such initiatives could add complexity to an already fragmented and disparate “system”. Additionally, it has been suggested that governments have not committed enough resources or effort to developing and implementing comorbidity services and support initiatives for Aboriginal and Torres Strait Islander Health (*National Strategic Framework for Aboriginal and Torres Strait Islander Health*, 2007). This is an ongoing situation; little has been done to date (2015).

## **2.7 The complex comorbidity “run-around”**

People with MH-AOD comorbidity experience serious challenges when trying to find and navigate multiple government and NGO services for their MH, AOD and primary health care (PHC) needs. This is what the larger *CAN project* has termed the “run-around” for people with comorbidity. The health care system currently has many disparate points of entry, exit and treatment modalities (Teesson et al., 2009; Mills et al., 2012). Navigating complex pathways to enter MH and AOD services hinders

consumers' ability to seek and receive the services they need. MH-AOD comorbidity is like an iceberg of issues. Only the tip of the iceberg is seen by any one service (e.g. one presenting MH issue or one AOD use issue), while the major portion of the health problem (comorbidity) remains unseen and unaddressed.

Evidence reviewed in this chapter suggests that the following actions *increase* the run-around for Aboriginal people affected by MH-AOD comorbidity:

- Not involving Aboriginal community members and MH-AOD consumers in service design, delivery and evaluation.
- No thorough and real consultation with Aboriginal people – not working together with local Aboriginal people to address their local MH-AOD service, treatment and support needs, and an ad-hoc approach to MH *or* AOD service or program implementation, which relies on a “handful” of workers.
- Short-term competitive funding to establish services for people with complex issues and needs to demonstrate “success”. Loss of such funding contributing to unstable MH and AOD services and programs, and community and workers' disappointment, disbelief, distrust, loss and anger towards the system. Also, forcing consumers to repeat their stories again and again with no positive outcomes ( Deady et al., 2013; Osborne, Baum, & Brown, 2013; Cairney et al., 2015).

### **2.7.1 Barriers to treatment**

Community advocates have provided a broader opinion of cultural engagement with Aboriginal Australians, including in relation to their engagement or disengagement with MH and AOD services. Berry (2013) identified that, depending on local need, structuring reliable services that incorporate and respect Aboriginal culture can open doors to appropriately engaging Aboriginal consumers. Cultural engagement measures, such as engaging traditional healers in treatment services, have proven effective in reducing high-risk alcohol consumption and related harm (Stone, Whitbeck, Chen, Johnson, & Olson, 2006).

Discrete MH and AOD services that respond to only one of a client's comorbidity issues (MH or AOD) create serious barriers to their MH-AOD care. Individuals must

repeatedly visit these different and distantly-located MH and AOD services instead of receiving integrated, holistic, comorbidity care through one MH-AOD service. Being forced to go to-and-fro between AOD and MH services contributes significantly to Aboriginal people's poorer prognoses (Gordon, 2008). Further deterioration of people's MH and general social wellbeing, with increasing vulnerability to chronic illness, MH complications and premature death, are known to occur (Andrews, Henderson & Hall, 2001). Lost opportunities place a severe burden on individuals experiencing MH-AOD comorbidity, their families, and community.

### **2.7.2 Constraints**

Hard-to-reach, marginalised and stigmatised people needing change in accessible service development and provision (Freimuth & Mettger, 1990) typically have difficulty accessing the right services due to factors such as their culture, age, race, language, income and associated resource deprivations, including service hours of operation, location and client entry criteria (Flanagan & Hancock, 2010). Many remain hidden and unheard; their situations and needs go unrecognised because they do not know about, or cannot access, suitable services, or they mistrust services due to poor confidentiality or previous experience of personal or systematic discrimination by services and staff (Cairney et al., 2015). Others experience particular therapies and treatments as “controlling”, or not relevant to, or mindful of, their needs (Barlow, Kirkpatrick, Stewart-Brown, & Davis, 2005). The stigma and shame associated with MH-AOD problems prevent people from even seeking treatment for fear of further discrimination and difficulty in finding employment (Drake & Wallach, 1989; Andrews, 2008; Degenhardt & Hall, 2001).

In an attempt to address this issue, treatment protocols for MH or AOD conditions have been developed for exclusive use by specialist clinicians to assist them with the care of consumers and organisations (Carrington, 1991; Gibbs & Gambrill, 2002). However, limiting use of such protocols to specialist clinicians prevents Aboriginal health workers from working in partnership with them and sharing their on-the-ground understanding about how best to educate the local community and those affected by MH-AOD about how they can be helped. In this context, specialist service providers also appear hard-to-reach.

MH and AOD services are typically difficult to access in regions where they are in

high demand but constrained by funding and staff shortages, thus creating service gaps as well as unnecessary duplication ( Warner & Leukefeld, 2001; Norden, 2004). Constraints faced by Aboriginal people living in more remote regions, in conjunction with judgemental and stigmatised attitudes towards them, suggest that provision of current MH and AOD services may not be commensurate with this population's needs (Gulliford et al., 2002).

### **2.7.3 MH-AOD services: Policy gaps**

Despite Australian Government policies demonstrating a significant commitment to improving MH and AOD problems, poor coordination (Nous Group, 2013) and collaboration continue to impose sequential fragmentation between MH and AOD services, resulting in totally inadequate MH-AOD service integration and holistic treatment. This impacts on not only consumers and the wider community, but also clinicians and workers who continually encounter barriers across an inadequate and fragmented referral-based system (Kavanagh et al., 2000). Existing fragmentation of the government and NGO MH and AOD health care system, and complexity in consumers' attempts to access its services, results in Aboriginal consumers, their families, supporters and on-the-ground workers all trying to navigate a maze of disparate and uncoordinated services ( Deady et al., 2013; Cairney et al., 2015).

## **2.8 What needs to be done: Significance of this research – reflecting on the literature review and Aboriginal people's own understanding**

Previous research has been undertaken to identify acute and chronic comorbidity health issues and to inform the development of appropriate comorbidity services. However, the issue of culturally-appropriate, integrated MH-AOD services has not yet been investigated in terms of engaging Aboriginal Australians in their design and development.

This research builds on the extant literature and local Aboriginal people's knowledge and experience about barriers that Aboriginal consumers and families face in trying to access culturally-appropriate MH-AOD services that will meet their needs locally; and to find strategies to facilitate stopping the MH-AOD service and treatment run-around for Aboriginal consumers, MH, AOD and support services, clinicians and



workers. For example, Australia's commonwealth, state and local governments have policies that emphasise the importance of ensuring all government services are culturally-appropriate for Aboriginal people.

Seldom is Aboriginal people's orally-presented knowledge on issues requiring research considered an equivalent component of the literature search. Accordingly, I consulted local Aboriginal key informants about what they knew or did not know about MH and/or AOD services, and what they provided particularly to meet the needs of Aboriginal people. They reported that nothing been done to explore and analyse the study topic because Aboriginal people experienced many barriers to receiving MH-AOD services locally. They reported there were no such services anywhere that they knew of, and the few mainstream MH and AOD services or programs they knew existed were not particularly culturally-welcoming or appropriate. They also reported that these services employed few or no Aboriginal clinicians and/or health workers.

The rationale for the approach of seeking Aboriginal people's oral knowledge was fourfold. Firstly, "the people" are the best judges of their service needs (Habermas, 1974; Ledwith, 2007; Blodgett et al., 2011). Secondly, Aboriginal and mainstream people and services hold differing perspectives (Humphery, 2001). Thirdly, it is important to recognise both the intended and unintended impacts of mainstream policies on Aboriginal consumers. Fourthly, those who can best identify the exact service gaps in MH-AOD care are those most knowledgeable about, and impacted by, those gaps (Teesson & Byrnes, 2001; de Crespigny et al., 2010).

## **2.9 Conclusion**

This literature review, including Aboriginal oral knowledge, has presented and discussed the complex landscape of MH-AOD comorbidity and its care in Australia, particularly for Aboriginal people, with emphasis on policy, service provision and barriers to accessing services relevant to Aboriginal people. It has highlighted the disparity between the MH and AOD problems of Aboriginal and non-Aboriginal Australians in terms of their social determinants of health and wellbeing, inter-generational impact of colonisation, Aboriginal consumers' low level of engagement with MH and AOD services (with the likelihood of not being provided holistic, integrated MH-AOD treatment by such services), and the importance of consulting and involving Aboriginal people. It has emphasised the necessity to respect Aboriginal

people's autonomy by engaging Aboriginal consumers and families in their choice of MH-AOD therapies, support and recovery programs, and to ensure delivery of culturally-appropriate MH-AOD care.

The next chapter describes the methodology underlying this research.



## **3 Methodology**

### **3.1 Introduction**

This chapter describes the theoretical framework for the study – participatory action research (PAR) underpinned by critical theory. Aboriginal community members’ partnership with the researchers, and their engagement and participation throughout this research, ensured that the methodology was respectful, collaborative and culturally-appropriate. A key focus was on the importance of consultation with Aboriginal community members and collaboration with them in the form of *Ganma* (knowledge-sharing; Yunupingu & Watson, 1986, in Muller, 2012). A reflective PAR cycle was used firstly to seek feasible solutions to the problem of Aboriginal people having to search for comorbidity services, and secondly to design appropriate local comorbidity care pathways and services for them.

### **3.2 Rationale for the methodology**

The starting point for this research was to design a sustainable and culturally-appropriate methodology that would incorporate the diverse voices of Aboriginal community members as co-researchers and advocates, and on-the-ground MH and AOD clinicians and workers, and other support service workers as service representatives. This was to enable data collection and reflection on, and systematic use of, the findings (Grierson et al., 2009). Critical reflection about possible research methodologies pointed to PAR as the best option as a science in the form of knowledge-building, action (practice) and participation throughout cooperative enquiry (Kemmis, 2009, p. 469). PAR is a systematic approach to investigation that enables people to consider and find effective solutions to problems they confront in their everyday lives (Stringer, 2007, p. 1). It was also considered appropriate for people requiring, or involved in, health care participative enquiry to improve health care practice (Parkin, 2009). Whether those involved are consumers or service providers, they informally observe, evaluate and judge service provision while interacting with one another. PAR is unique in its elucidation of real issues that affect real people. It aims to clarify how things happen, and how stakeholders and the people concerned perceive their situation, infer the need for change and respond by taking action (Stringer, 2007, p. 10).

A phenomenological research approach could have been used for this study for its focus on people's experience (Groenewald, 2004). So, too, could have the interpretive approach, explicating the inner sense and meaning of people's demeanour and experience, or a hermeneutic approach (the theory of understanding what people choose to remember and disclose) (Packer, 1985; Bakir & Todorovic, 2013; Finlay, 2013). However, these research methodologies lacked the premises of genuine engagement, participation and action throughout the research that would lead to a more sustainable solution to the problem.

While research projects using reflective practice and emancipation attempt to deliver workable solutions to everyday health care problems, both can preclude consumers' partnership in the whole research process. In reflective practice, knowledge of practice is the central theme, with the practitioner asking questions about the intervention and clinicians analysing the intervention *for* their consumers. In emancipatory research, questions may be posed with *preconceived assumptions* about vulnerable and affected people, but with *no contribution* from these people in terms of *their* participation or consultation. This PhD research required recognising and respecting Aboriginal ways of knowing; understanding that their lived experience enables evaluation of service provision in practical terms; and understanding that Aboriginal people's battle against oppression is the key to analysing and evaluating the structure and delivery of the comorbidity services that they require – that is, understanding whether these services are justifiable, respectful or colonising.

The three main principles of Aboriginal research espoused by Rigney (1999) are emancipation, political integrity and privileging Aboriginal people's voices. This involves recognising self-determination, and attempting to affirm the individual and community through political freedom and sociocultural liberation. These ideas were instrumental in choosing PAR. Similarly, de Crespigny, Emden, Kowanko, and Murray (2004) conceptual *Partnership model for ethical Indigenous research* provides a culturally-safe, holistic, ethically-sound Aboriginal research model with four key features for creating collaborative engagement with Aboriginal people: "Respect"; "Collaboration"; "Active Participation"; and "Meeting Needs" (de Crespigny et al., 2004, p. 11). The *Partnership model* draws attention to the required ethical guidelines for Aboriginal research (NHMRC, 2003, 2014), which incorporate a PAR approach.

Thus, PAR was considered the best tool for interlinking Aboriginal and non-

Aboriginal research knowledge application and information resources (Beck & Somerville, 2005; Carter, 2008; Haswell-Elkins et al., 2009; Adams & Faulkhead, 2012), and engaging, integrating and balancing Aboriginal participants' cultural responsibilities. It could foster partnerships to effectively solve the fragmented MH-AOD service issue, and assist in a shift towards the local Aboriginal community being recognised as accountable partners, advisors and advocates in its resolution (Eversole & Routh, 2005).

### **3.2.1 Critical theory and PAR**

The power of particular social ideologies, political systems and economic pitfalls generates disparities that can significantly impact people's life situations (Campbell & Bunting, 1991). Critical theory goes hand-in-hand with PAR and underpinned the methodological framework used for this research (see section 3.3).

Critical theory originated in Germany in the early 1920s among German intellectuals from the Frankfurt School (Jay, 1996; Baddou, 2012) who undertook an interdisciplinary social and critical analysis of contemporary society. They philosophised that free thinking in real world situations is essential to the constituted reality of society and for contributing to society's wellbeing (Baddou, 2012).

Critical theorists over the years have espoused various concepts related to critical and social analysis. Hegel, for example, believed that individual consciousness is fundamental to objectivity; it emancipates the mind and soul to set reality "free" (Hegel, 1991). Karl Marx's philosophy of the materialism of daily life, developed from his dialectical revolutionary analytical praxis of class consciousness and class struggle, espoused capitalism as dehumanising for some members of society (Fay, 1987). Theodor Adorno shared Marx's view of capitalism, critiquing the importance of the value placed on consumerism (Adorno & Horkheimer, 1997). Adorno asked where, in consumerism, is acknowledgement of consumers' needs and values?

Jurgen Habermas, a notable second generation critical theorist, called on the far-reaching, coercive nature of society to inform emancipation through mutual understanding, appropriate communication and critical reflection (Marrow, 1994; Crotty, 1998). He believed that critical research would uncover hidden domination and oppression, and enable exposure and analysis of power systems, thus contributing to liberation through change (Harvey, 1990).

Paulo Freire, an exiled Brazilian philosopher and teacher, believed that people from deprived socioeconomic and cultural circumstances had limited freedom. He further developed the emancipatory aspect of critical theory. In *Pedagogy of the Oppressed*, Freire (p. 2) described oppressors as one group of people suppressing others by restricting their freedom, explaining that the suppressed could liberate themselves by reflecting on their situation and taking action to overcome oppressive social structures. He believed that marginalised people's wisdom and knowledge is the best resource for achieving realistic solutions to the issues they encounter in everyday life (Freire, 1970). The process of self-determination gives a voice to Aboriginal people to control their wellbeing. Aboriginal people speak for their own cause instead of other people talking for them, which can slow the progress of self-determination (Fontana, 2004). This self-reflection enables people to develop insight to identify oppressive circumstances and recognise the issues that limit health care service utilisation (Fontana, 2004).

Critical theory proposes that owners of power for their own advantage (oppressors) will necessarily continue the status quo; they will make the oppressed subconsciously adopt their values (Kincheloe & McLaren, 2011, p. 288). Freire (1970) stated that this is how oppressed people are forced to accept their powerless position. In such a situation, critical theory raises questions about inequality, helplessness and injustice, and strives to bring about social change. Lincoln and Guba (2003) observed that even democracy can be termed "dictatorship" if domination triggers oppression.

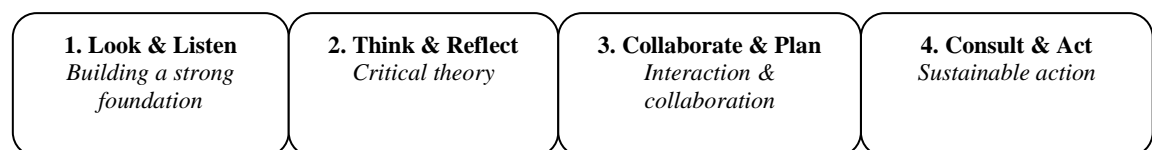
Critical theory advocates for, and with, the most marginalised people in society, such as Aboriginal Australians. It fits within the philosophy of liberation and the epistemology of radicalisation (Kemmis, 2008). The ontology of critical theory identifies and challenges power structures and is congruent with Aboriginal people's ways of knowing (Denzin & Lincoln, 2008). Critical theory encourages people to look deeply into the service provision system in order to analyse consumer utilisation, satisfaction and benefit. Thus, critical theory can initiate Aboriginal people's self-empowered action for transformative change in their health status. It enables people to develop conscious awareness of political structures and the health care system so they can advocate for appropriate, necessary structural and service modifications. This research has drawn from critical theory in order to explore the barriers in MH-AOD service delivery, and enable construction of appropriate MH-AOD services.

### 3.2.2 Ethical considerations

The Cooperative Research Centre for Aboriginal Health (CRCAH, 2006) identified that Aboriginal people and Aboriginal organisations should be engaged in, offer directions about, and predominate in the approval of health research. The World Health Organization (WHO, 2009) has directed that it is a human right for Aboriginal people to be involved in research and health programs involving their communities. This engagement must take precedence over external academic requirements or the researchers' personal interests (Brands & Gooda, 2006; Fredericks, 2011). Increased participation of recognised Aboriginal people has enabled them to influence research priorities, and to find ways to address health service gaps and formulate service protocols (Kowal, Anderson, & Bailie, 2005). In the case of this research, it was a requirement of the NHMRC (2003) and the SA Aboriginal Health Research Ethics Committee (2015) that Aboriginal people be actively involved (for details see the next chapter on methods). The fundamental Aboriginal ethical principles are survival and protection, spirit and integrity, responsibility, reciprocity, equality and respect (NHMRC, 2003, 2014). Therefore, the ethics application for this research was prepared and processed collaboratively, entailing extensive consultation with a key Kaurna Elder (Auntie Coral Wilson) and mentors, Aboriginal community members, health service staff and the Aboriginal Health Council of South Australia (AHCSA), which was a major partner in the *CAN project* as well as this PhD project.

### 3.3 Methodological framework

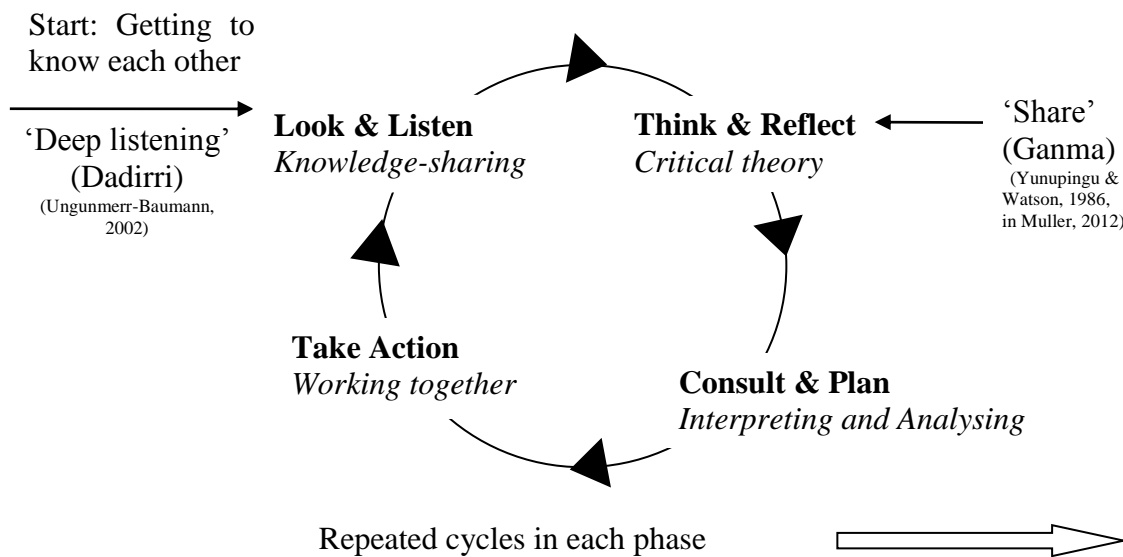
The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2007) recommended use of the partnership model for research involving Aboriginal people across organisations and institutions. This partnership concept is a demonstrable activity that needs to be communicated to all involved. Kemmis' reflective framework of communicative action (Kemmis & McTaggart, 2007) (Figure 3.1) underpinned the phases of the PAR methodological approach (Figure 3.2).



**Figure 3.1: Methodological communicative action framework**



The framework reinforces how each phase is interlinked to inform the others.



**Figure 3.2: PAR inquiry cycle**

### 3.3.1 Phase 1: Look and listen: *Knowledge-sharing*

The ‘look and listen’ phase involved understanding, describing and recording accurately to provide the foundation for reflective thinking and action (Quixley, 2008) It illuminated new information by involving community people and service providers in examining service provision efficacy. Their shared experience and knowledge provided substantial information about what had or had not occurred. This information was used to identify the gaps in service provision; in this case, MH-AOD service provision.

This first phase aligned with Rigney’s (1999, 2006) position that Aboriginal people’s diverse experience should underpin construction of the methodology – their voices must be heard. The ‘look and listen’ phase involved consultation with Aboriginal community members and using *Dadirri* (listening deeply to individual people; Ungunmerr-Baumann, 2002) at every stage of the research, from planning, data collection and analysis through to recommendations for action, without making assumptions about what might be appropriate for them or the wider Aboriginal community in terms of the research process and recommendations for effective MH-AOD care. *Ganma* (knowledge-sharing; Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (Ungunmerr-Baumann, 2002) enabled development of a trusting, collaborative partnership between the researcher and Aboriginal community members (Checkland & Holwell, 1998). We became a sustainable research team.

Therefore, it was essential to look at, listen to, and understand Aboriginal people's concept of knowledge, sometimes described as *Ganma* (knowledge sharing; Yunupingu & Watson, 1986, in Muller, 2012), and their innate spirituality involving deep, quiet, non-judgemental listening, known as *Dadirri* (Ungunmerr-Baumann, 2002). Understanding these concepts and practising them in the research process enabled the collaboration needed to plan the research.

### **3.3.1.1 *Ganma***

The Yolgnu people from Arnhem Land in the Northern Territory of Australia originally described *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) as the two-way sharing of cultural knowledge and interaction between Aboriginal and non-Aboriginal people. *Ganma* is representative of knowledge-sharing phenomena intended to improve the relationship between Aboriginal people and non-Aboriginal people around the world (Hughes, 2000).

“Aboriginal knowledge” represents water from the river (fresh water), while “Western knowledge” represents water from the sea (salt water). When these waters run together at an interface, they mix with each other to form a foam that represents the creation of new knowledge that has been generated from the interaction and collaboration of Aboriginal and Western knowledge (*Ganma*) (Chambers, Turnbull, & Watson, 1989). It is a situation whereby Aboriginal people share their cultural knowledge to inform non-Aboriginal people about how Aboriginal and Western knowledge can collaborate while maintaining their separate identities. The process of interaction and knowledge-sharing also has memory; forgetting people's history is at the cost of losing one's identity (Pyrch & Castillo, 2001). However, the foam retains individual particles of both fresh water and salt water, which continue to carry their own identities and memory.

*Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) describes the context of collaboration, interaction and knowledge-sharing phenomena whereby each person is mindful of the other's individual and combined experiences, and contribution to the collaboration. *Ganma* provides the pathway to connecting people and bringing them to actively work together to create new knowledge that is not claimed as “mine” or “yours”, but as “ours” (Hughes, 2000). The Yolgnu people explain that if the foam (knowledge) is cupped roughly in the hands in an arrogant way, it evaporates. It must be

handled smoothly and held gently to reveal its true nature. It is also necessary to be quiet and patient, and to listen deeply to hear the foam's soft sound (Pyrch & Castillo, 2001). Similarly, members of the AWP informed me that for people to understand and work with Aboriginal ways of living and culture, they need to “work with sheer good heart (understanding), mind (attitude) and hands (skill) to render sharing hands to walk together” (Field Journal, 2012).

Thus, Ganma clarifies how collaboration and interaction happen through respecting the integrity of both Aboriginal and non-Aboriginal cultures (Hughes, 2000). First and foremost, the initial stage “to listen” requires respect for, and understanding of, Aboriginal people's discrete knowledge (awareness) about “collaborative doing” (action).

### **3.3.1.2 Dadirri**

The Aboriginal word *Dadirri* (Ungunmerr-Baumann, 2002) refers to a unique spiritual attribute of many Aboriginal community members; an inner, deep, quiet listening and profound awareness that recognises the “deep spring of sentience that comes from within” (West et al., 2012, p. 1584). *Dadirri* (Ungunmerr-Baumann, 2002) comes from the Ngangikurungkurr (river people) from Daly River in the Northern Territory of Australia. However, the practice of *Dadirri* is similar across all Australian Aboriginal communities (Creative Spirit, 2012).

As stated previously, Aboriginal Australians have high regard and respect for their land and nature, and there is a strong, unique sense of connectedness within their communities. The principles of *Dadirri* (Ungunmerr-Baumann, 2002) are:

- 1) *Dadirri* involves knowledge and gives importance to the uniqueness and diversity each individual brings to the community
- 2) It considers ways of relating and acting within the community
- 3) It is non-intrusive, deep listening
- 4) It is reflective and non-judgemental, and considers what is and what is not heard
- 5) It is a responsible process of purposeful planning to act, based on learning and listening informed by wisdom and knowledge (Leaver, 2006).

The fundamental aspect of *Dadirri* is interpersonal and social interaction with mutual respect, but these elements were lost during the period of invasion (colonisation) and because of the Stolen Generations (West et al., 2012) (see Chapter 2, sections 2.3–2.4). *Dadirri* (Ungunmerr-Baumann, 2002) brings peace, understanding and increased awareness (West et al., 2012). It is about the process of contemplation an in-depth understanding and awareness of one’s “thoughts, words and deeds” from within and without (Atkinson,

2002, p. 15); of not rushing into things but waiting for the right time to do them with care (Creative Spirit, 2012).

Ungunmerr-Baumann (2002), an Elder of Daly River who is also the Principal of Daly River School, claimed that Aboriginal people have endured learning the Western way and listening to what they say for many years, and, while much of this was acceptable, some was obligatory and Aboriginal people were forced to listen. She said, “We still wait for fellow Australians to take time to know Aboriginal people and to be still and to listen to us” (p. 3). She argued that listening and learning must be both ways; Aboriginal and Western knowledge together without one ruling the other (Ungunmerr-Baumann, 2002). This was a guiding principle in this research.

*Dadirri* (Ungunmerr-Baumann, 2002) in many ways describes how deep listening facilitates *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012). Atkinson (2002) explained that *Dadirri* has guided her in non-judgemental watching and listening “from the heart and ears” before acting in good faith. Profound listening creates knowledge and, when people’s experiences are heard and acknowledged, it brings healing. Thus, health care practitioners are encouraged to step beyond their basic clinical responsibility by listening to, and understanding, the factors affecting people in need of their services.

*Dadirri* (Ungunmerr-Baumann, 2002) also represents awareness of self and reality through thematic investigation based on interaction. Thematic investigation attempts to discover the reality of a situation and find the most credible resolution to issues affecting marginalised people by utilising their contributory wisdom and knowledge, which makes it a starting point in the educational process (Freire, 1970, p. 79). Freire (1970, p. 3) also stated that recognising “humanisation” will lead to recognition of “dehumanisation in both histological and ontological perspectives” of reality. *Dadirri* (Ungunmerr-Baumann, 2002) is considered humanising for Aboriginal people who have

been marginalised through prolonged and inter-generational colonisation, and bureaucratic, non-inclusive research methodologies.

### **3.3.1.3 The intersection of *Dadirri* and the PAR paradigm**

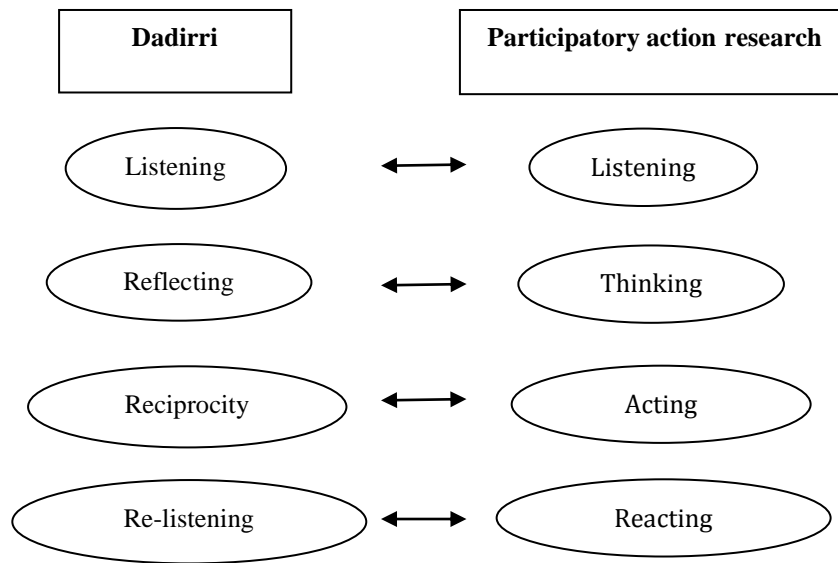
The “best way to learn is by doing and the best way to do is by learning” (Freire, 1993, p. 33). The two components of doing and learning inform each other in action research, which becomes no different to practice; the two are intertwined.

The Western system has offered Aboriginal people knowledge transformation while the Aboriginal knowledge system wants to offer the Western system information exchange to create an integrated, unambiguous approach to research. One of the most powerful ways of ensuring authentic Aboriginal research is by using Aboriginal knowledge in its unique, original form. However, from the beginning of colonisation until the recent past, marginalised Aboriginal people have found it difficult to voice and share their knowledge; to have it manifested equivalent to the Western system. They have had difficulty maintaining their cultural markers, such as language, land, and their system of knowledge and practice, due to various oppressive barriers (De Souza & Rymarz, 2007).

This research has addressed the lack of Aboriginal voice regarding MH-AOD services by undertaking a joint venture with Aboriginal people from the local community. We have adapted *Dadirri* (Ungunmerr-Baumann, 2002) to provide an extra foundational layer in the project’s empowerment phase. PAR methodology is visualised in Aboriginal people’s familiar knowledge of mutual democratic partnership (Esler, 2008, p. 458). One of PAR’s key outcomes is building the participants’ capacity to involve community people in self-evaluating their needs. In this research, *Dadirri* (Ungunmerr-Baumann, 2002) provided a respectful platform for hearing the diverse voices of the local Aboriginal people and stakeholders, and for valuing the inner expressed meaning of their needs in relation to the delivery of MH-AOD services. It also offered hope of training people within the community to spread skills and knowledge regarding these services. Thus, *Dadirri* (Ungunmerr-Baumann, 2002), in synergy with PAR, promised a wealth of information, mutual support and encouragement to resolve the issues that prevent easy access to MH-AOD services for Aboriginal community members.

The PAR methodological process that contributes to emancipation was chosen in

consultation with the Kurna Elder/co-researcher and local Aboriginal community members who agreed to be research partners/team members. This acknowledged the principle of reciprocity, sharing information through consultation and participation. This research is considered to be knowledge application in partnership between me, as the researcher, the Aboriginal community members and *Dadirri* as a knowledge process built on the deepest level of understanding and re-listening that involved cycles of reflecting on feelings, experiences and actions (Atkinson, 2002, p. 19), and PAR (see Figure 3.4).



**Figure 3.4: The components of Dadirri and the PAR cycle**

### 3.3.2 Phase 2: Think and Reflect: Critical theory

This phase involved stepping back and reflecting on shared knowledge and possibilities, enabling collaborative consideration of the range of meanings and the floating of ideas; a process that reinforced the competing evidence of knowledge, experience and shared information, and led to alternative explanations for decision-making. This phase involved time spent on thinking and negotiating for deeper understanding before transferring knowledge into action (Kemmis & McTaggart, 2007). As Ledwith (2007, p. 600) stated:

If action is to be sufficiently critical to engage with transformative change, the theory that informs it needs to be vigilantly critiqued.

Reflecting on the factors influencing people's actions and experiences enables identification of long-term social structures in order to achieve emancipation

(Habermas, 1974). The epistemology of critical theory (that is, the philosophical knowledge underpinning the theory) states that experiences from the past influence the present, and the knowledge perceived and expressed related to those experiences is of the utmost importance in knowledge creation (Campbell & Bunting, 1991).

Rigney (1999) stated that critical theory concurs with the Aboriginal view of the “just world”. Ungunmerr-Baumann (2002) holds a similar view, stating that Aboriginal people identify themselves with their land, and there is a strong sense of belonging to communities because “all people matter and all people belong”. Moreover, people can learn how to liberate themselves from oppression through education, which can begin by incorporating them into the PAR research process and involving them in knowledge-sharing, an action that can eventually empower them to escape from oppression (Ungunmerr-Baumann, 2002).

### **3.3.2.1 Critical theory’s role in Aboriginal research**

In regard to New Zealand Aboriginal people’s history, the Maori author Smith (2005) writes that the protest against the *Treaty of Waitangi* (1840) raised concerns about the enforced power of colonisation. It highlighted democracy’s failure, evidenced by injustices against the Maori people’s social and political structures. Similarly, the Aboriginal people of Australia have used critical theory extensively to resolve issues related to race, culture, ethnicity and socioeconomic determinants (Anderson 2004; Sherwood & Edwards 2006; West et al. 2012); all factors affecting their wellbeing. Indigenous scholars such as Smith have described the act of colonisation as an ongoing process that has had a profound effect on the first peoples of Australia and their traditional cultures. Smith (2001, p. 217) has stated that colonisation still exists in “different other forms” and causes Aboriginal people to distrust mainstream Australia society.

West et al. (2012) suggest that Aboriginal people in Australia prefer critical theory as a research methodology and choose to work with critical researchers who engage with people to critique the sociocultural and political status quo. Denzin and Lincoln (2008) support this concept. They make it clear that for critical theory research to succeed, it must be localised and established in a specific context within the relevant community.

Critical theory incorporates the idea that an individual’s past experience influences

their current perception. This concept is congruent with Aboriginal people's knowledge of paradigms. Their retraced knowledge, based on their experience and perception, is an essential component of current knowledge (Foley, 2003). Language and dialogue are central to creating and disseminating knowledge and understanding, but some Aboriginal languages are extinct. Despite diverse Aboriginal people identifying themselves with specific language groups (Getty 2010), all have retained other traditional means of communication in the form of shared ways of knowing (West, Stewart, Foster, & Usher, 2012). It was important in this research to recognise and reflect on this knowledge and experience. Aboriginal people's knowledge of lived reality and stories of imposed power resulting in inequalities, helplessness and voicelessness must be addressed in the form of a collective discussion using their own words (Anderson 2004).

As a researcher using critical theory, I understand that Aboriginal community members, as research participants, must take equal control of the research process to promote democracy and emancipation, and to empower them and their community to address the imbalance in health service structures (Lincoln & Guba 2003; West et al. 2012).

### ***3.3.2.2 Critical theory for thoughtful conversation***

Habermas posits that solutions can be achieved through thoughtful conversation about, and meaningful reflection on, situations and behaviours (Habermas, 1974). Use of critical theory can initiate people's collaborative participation through thoughtful conversation and interaction because to talk you need to know, to know you need to understand, to understand you need to analyse, and by analysing you can reach an insightful solution (Kincheloe & McLaren, 2011, p. 306). The paradigm of knowledge transformation in critical theory opens up genuine dialogue consisting of reciprocal interaction, which is the cornerstone of critical theory and research (Stevens, 1989). Therefore, in this research, we examine the structure of health services imposed on Aboriginal consumers through a critical lens; an inquiry that fosters in-depth communication to examine the "monocratic condition" (Barton, 2004, p. 520). There is continuous interaction and social reciprocation among the whole research team.

Foley (2003) stated that critical theory empowers people to facilitate critical conversation; it considers language as the means for knowledge generation and creation



of reliable concepts. It empowers people to think, analyse and reflect on the circumstances that constrain their actions. Campbell & Bunting (1991) emphasised that critical theory enriches people's ability to plan for lasting radical change for improvement, raises marginalised voices and encourages action through research toward prospective practice. It honours liberation of people from oppressive circumstances that prevent them from achieving their potential and promoting their health and wellbeing.

Pertinent use of critical theory in this research engaged everyone in a collaborative, thoughtful conversation (Byrne, 2001) to examine the factors influencing Aboriginal community members' MH-AOD service needs in order to provide a structural solution to the issue of access to MH-AOD care. Open-ended semi-structured interview questions were used to provoke conversation, and encourage participants to communicate freely and share information (see next chapter on methods). As part of the conversation, we sought critical enlightenment and emancipation by analysing the competing power of individuals and institutions within this society to identify who gained from MH-AOD service delivery, and who did not (Kincheloe & McLaren, 2011). We attempted to identify the forces that were stopping Aboriginal people affected by MH-AOD comorbidity from making decisions that could significantly affect their lives (Kincheloe & McLaren, 2011).

Critical theory did not involve observing the characteristics (Stevens, 1989) of Aboriginal community members or service staff. All participants were considered partners in, not subjects of, this research; we were all members of the research 'team', working together for restorative change, sharing and exchanging information to resolve the problem to benefit the wider community.

### ***3.3.2.3 Reflection on post-colonial theory***

Recognising the importance of colonisation and questioning concepts of post-colonial theory were important steps in developing this methodology. Smith (2001) argued that the theory of post-colonialism implies that colonisation is a finished chapter. She thus denies the use of the term "post-colonial theory" (Smith, 2012), reasoning that colonisation continues in various forms of disempowerment of generations of Aboriginal people, which affect their health, social, economic and overall wellbeing. Some researchers have used post-colonial theory in the past to substantiate research in which Aboriginal people were mere subjects; they were not involved in the research

development, application or collaborative consultation processes or benefits (Grande, 2000; Getty, 2010; Greenberg, 2013). Therefore, Smith and non-Aboriginal scholars who genuinely collaborate with Aboriginal community members advise that all researchers involved in Aboriginal health projects should acknowledge that colonisation continues to disempower Aboriginal people (Henderson et al., 2007; Zsuzsanna, 2011).

Disempowerment resonates with various other forms of oppression, such as the maze-like social structure of health services that continues to impact on Aboriginal people's health and wellbeing (Kowanko, et al., 2009; Hayman, 2010). Smith (2001, p. 215) suggested that the main focus for empowerment should not be to merely strive against colonialism but to respect and empower Aboriginal Australians.

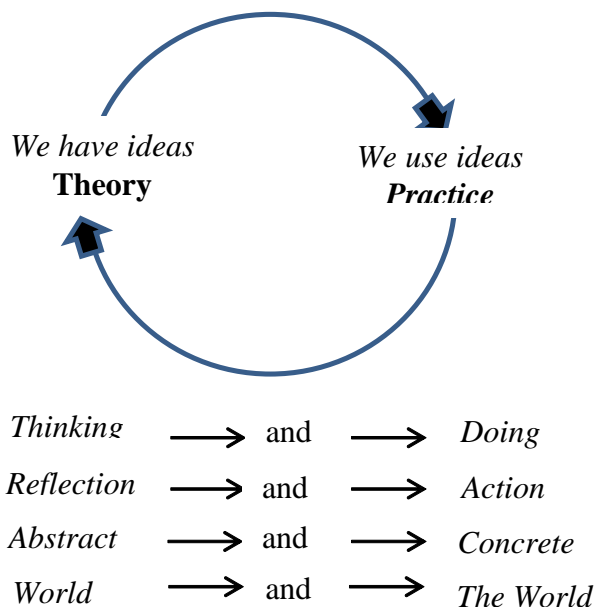
The impact of colonisation and determinants of health and wellbeing for Aboriginal Australians in the so called "post-colonial period" cannot be generalised to people from deprived sociocultural and economic backgrounds in other societies (Getty, 2010, p. 7). Getty (2010) challenged the argument that post-colonialism is applicable to everyone and all countries that have been colonised (Anderson, 2004, p. 239), claiming that this argument depicts perpetrators as victims. Smith identified this as another reason why Aboriginal people mistrust researchers' use of the term "post-colonialism" (Smith, 2005). She (2001) recommended that if Aboriginal research is to contribute to decolonisation, it must focus on Aboriginal people's self-determination, which will also increase the findings' validity and applicability. She also stated that Aboriginal people consider cultural values, behaviour and attitudes as an integral part of any research methodology, and rationalisation as the hallmark of epistemology (philosophy of knowledge) (p. 217). Therefore, in research with Aboriginal people, it is more important for researchers ("partakers") to reflect on how they have accomplished their role than to look at the reliability and validity of the research process. Aboriginal people's concept of truthfulness in research methodology is mainly about accountability, which means being accountable to them as the study's partners and participants (Wilson, 2009, p. 177).

Aspects of the concepts of post-colonialism must be viewed appropriately, which involves examining the underlying issues of structure, power, historic institutionalisation and different forms of oppression (West et al., 2012). In the current study, we have utilised critical theory, viewed through the lens of Aboriginal people's experience of colonialism, to offer insight into the delivery of, and access to, MH-AOD

services for Aboriginal Australians. Applying the lens of colonisation reflects the impacts of colonisation (Durie, Milroy, & Hunter, 2009) on Aboriginal people’s knowledge systems, and local Aboriginal people’s individual and community contribution to society. We have looked at the situation deeply at the grassroots level, not just at the shallow surface level (de Crespigny & Valadian, 2011). We have worked to understand the primary causes of continuing power issues and to find answers for the concerns raised in relation to access to culturally-appropriate MH-AOD services: Who has the power? How has this been utilised? Who is benefiting from the situation? (Habermas, 1974). In terms of this research, these questions translate to: How are MH-AOD services structured? Does this benefit Aboriginal consumers? How easy is it for Aboriginal consumers to get access to these services?

### 3.3.3 Phase 3: Consult and Plan: *Interpreting and Analysing*

The consult and plan phase of this PAR research cycle involved mutual interaction and communication, which could only occur through recognition and sharing of all research team members’ knowledge, ideas and concepts. It clarified the questions asked, identified possible action and developed the plan of action. Pupedis et al.’s (2007) interactive cycle of theory and practice (see Figure 3.3) illustrates the links between theory and practice as used in this research.



**Figure 3.3 Interactive cycle of Theory and Practice (Pupedis, Bellman, Arrowsmith, Holden, & Ramos, 2007, p. 2)**

### **3.3.3.1 Consultation and collaborative partnership**

Many Aboriginal people view health differently from mainstream Australians (Henderson et al., 2007). Therefore, it is essential to consult them about their comorbidity service needs and to present their opinions in their own voice, without researcher assumptions. The consultation for this project, in the form of regular “Yarning” (conversation), ensured active participation and interaction, which strengthened the partnership in terms of communication, responsibility and accountability to face ongoing challenges together.

Higher levels of collaboration are based on effective teamwork. Therefore, collaboration involves more than just establishing favourable relationships. It requires ongoing support and genuine motivation. The motive is to bestow ongoing partnership and interaction, with appropriate consultation for decision-making. In other words, mutual partnership considers the needs of every person and “not one person ruling over another” (Freire, 1970, p. 65); in this case, the needs of the Aboriginal community members, the service staff and the researcher. It is acknowledged that this aspect of interaction encourages true communication. The researcher is seen as one among the team and the participants are the resource people.

Collaborative community partnership requires team members to be flexible, truthful and confident in communicating with clarity and transparency. This develops emancipation through free-flowing communication, and sharing ideas and concepts to generate strategies that will foster autonomy. Collaborative community participation considers people’s wishes and beliefs as an important hallmark for community transformation (L'Etang & Theron, 2012). Unlike traditional hegemonic research, the collaborative research mutual partnership approach offers reciprocal relationships between the researcher and participants (Lalibett'e, 2012). It is not a step-by-step process following a systematic formula but entails dual consultation, mutual acceptance, reciprocation and understanding about each team member’s contribution (Minkler, 2005). Mutual partnership entails a two-way knowledge-sharing phenomena (*Ganma*; Yunupingu & Watson, 1986, in Muller, 2012). True interaction occurs when individuals look deeply at their social reality and develop critical thinking, which is transformed into action (Freire, 1993).

### **3.3.3.2 Enhancing communication**

Real communication is the heart of conversation and occurs when there is an unbiased and respectful relationship. Enhanced communication provides the transparency to know who we are, what we hope to achieve, what benefit research brings, and for whom (Adams & Faulkhead, 2012). Individuals who are more “comfortable” with each other will have more mutual trust and will exchange information more effectively than individuals who have less contact or are less at ease (Goodman & Abel, 1986). Using the Aboriginal cultural expectation of reciprocation and the interaction-based strategies of *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (Ungunmerr-Baumann, 2002), I, as the researcher, and the participants shared enhanced communication through ongoing respectful contact and mutual learning.

### **3.3.4 Phase 4: Take Action: Working together**

This phase was a reflective cycle of consultation and action, which was repeated until a solution was reached (Blodgett et al., 2011). It involved carrying out the decided plan of action in a collaborative, systematic, logical and appropriate way, then reflecting on it.

Listening to one’s inner self and others is a form of reflexivity that involves critical examination of the implications of the research process at every stage (Martin, 2003; West et al., 2012). According to (Rigney, 1999), reflexivity is essential to designing Aboriginal research methodology. It is like a reciprocal trustworthiness between the researcher and participants during information exchange (Atkinson, 2002, p. 19). It involves listening to each other sincerely, taking time to plan and act, and moving together with understanding as the river flows in accordance with the current (Ungunmerr-Baumann, 2002, p. 2). Reflexivity is also a hallmark of PAR.

Aboriginal research methodology is based on the holistic paradigm of Aboriginal knowledge (Martin, 2008). Designing a research project using an Aboriginal research approach, underpinned by Aboriginal values and culture, ensures reciprocal, transparent sharing of knowledge. *Dadirri* must be acknowledged as unique Aboriginal knowledge (Reason, 2006) that is congruent with, and parallel to, Western epistemology. This phenomenon occurs when people engage in meaningful communication that helps them better understand themselves, each other and the issues at hand (Martin, 2008).

Research becomes PAR when people who are confronted with an everyday problem reflect on their experience to find an effective solution (Lalibett’e, 2012). Action-

oriented participatory research will improve outcomes for the wider community through community members' involvement in the research design and action (Kemmis & McTaggart, 2007). PAR, as a community development approach, enables people in an affected community to identify the problem that needs research; thus, the problem does not originate from an external researcher working in isolation from the community (Carr & Kemmis, 1986). The participative paradigm of action research is to understand health in the context of a person as a whole. The credibility of this methodology is its applicability to complex situations.

Crotty (1998, p. 41) stated that “health and illness are largely determined by social and economic arrangements, and so health for all is not possible within capitalistic societies”. However, PAR enables stakeholders and consumers to focus critically on the reality of health issues in a specific context to improve the situation for them and the wider community. It encourages stakeholders to critically analyse their service management, enabling service providers to take appropriate progressive action to improve service delivery; in this case comorbidity care. Thus, the purpose of PAR in the health context is to optimise the quality of health services to support service providers and consumers to improve service provision. The essential elements of this approach in relation to health service provision are *Action-Evaluation-Reflection*.

#### **3.3.4.1 Participation and action**

The key idea in PAR is using living knowledge to inform change through sharing and developing the practical knowledge people use in everyday life (Minkler, 2000). The contribution of research in action is working together for a practicable outcome and to create advanced, deeper level understanding. It requires understanding and reflection, theory and action, because, according to Kemmis (2009, p. 468) theory without reflection and action is meaningless.

Participation and action are key features of PAR in health care, including:

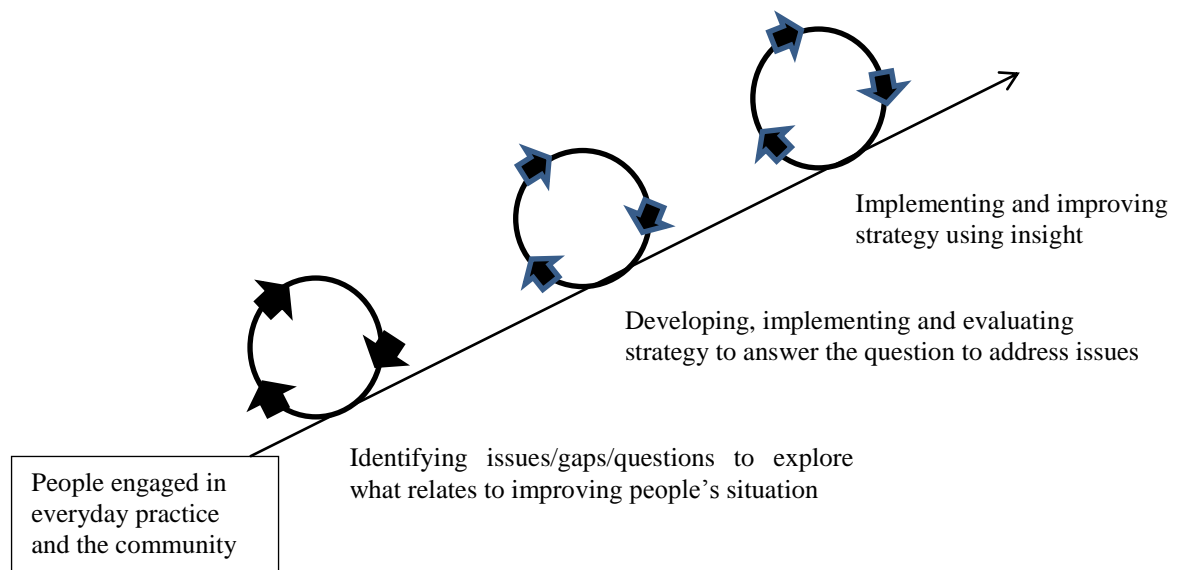
- Active participation based on specific context
- Reflection based on genuine interpretation
- Action created by practical knowledge
- Solutions for improvement (Kemmis & McTaggart, 2007, p. 276).

The process of “trustworthy action” arises through participation – mutual consultation, collaboration and collective reflection towards the collaboratively-decided goal (Kemmis & McTaggart, 2007). In relation to understanding the nature of MH-AOD issues in health care, the inclusion of consumer and workforce participation provides the opportunity for people to get involved, to better understand the ethos of service provision, to analyse community members’ experiences of service provision, to identify problems and to decide on appropriate action to reach a solution to those problems.

Active participation motivates people to engage in quality improvement activities, which in turn encourages them to become involved in action and gain a sense of ownership of effective solutions. It motivates a diverse mix of relevant stakeholders to work together to create a positive, mutually trustworthy atmosphere that facilitates the generation of an everyday workable solution; everyone has a stake in the outcome (Minkler, 2000). The nature of participation in the PAR approach enables practicality because the research is carried out “with, by and for” individuals and communities, involving stakeholders in the process of inquiry for sense-making, which informs action through integrated research (Crane & O'Regan, 2010, p. 1). It is a process that involves people and their social circumstances, with the aim of changing their situation for the better (Meyer, 2000).

Action is a process of getting together; a form of real engagement that is the most important prelude to constructive participation. Engaging participants and stakeholders in the PAR planning process is essential for enabling sustainable outcomes to the research problem. In this research, we achieved this by seeking and obtaining community people’s consensus prior to constructing the research paradigm.

The ongoing collaborative approach and reflective process aimed at achieving workable solutions to the problem of accessing MH-AOD care was like a rolling ball. As the ball completed each full roll, it reconnected in a systematic and appropriate process of enquiry for improving people’s understanding of the situation and thus improving practice (Crane & O'Regan, 2010, p. 7). Figure 3.5 illustrates the rolling PAR cycles as they developed during this research.



**Figure 3.5: Progressive model of the PAR cycle**

### 3.4 The broad scope of PAR

PAR values the experiences, perceptions and insights of all health care consumers, from children to the aged, people who work with the consumers either providing direct clinical MH and AOD services or support services, other health care organisations and the wider community. PAR is an effective instrument for pursuing better consumer outcomes. It offers opportunities for young and older community members to foresee the most important issues they are facing and to determine the most helpful strategies to address these (Blodgett et al., 2011). It also has the capacity to improve working relationships between service providers, clinicians, community members and workers, and to facilitate identification of service deficiencies (Quixley, 2008). PAR can assist government and non-government agencies and support services that deal with complex issues to avoid service overuse by identifying and filling service delivery gaps and pathways to meet people's needs (Parkin, 2009). PAR can build community involvement and ownership, and an organisational approach to service delivery that best suits the local context (Minkler, 2005, p. 5), resulting in improved service provision and enhanced community support.

### 3.5 Tailoring PAR cycles to address the MH-AOD care problem

Tailoring PAR cycles to better examine MH-AOD service provision in the study context was considered the best strategy for enabling service providers to find ways to restructure their services to meet local Aboriginal community needs.



We agreed that the PAR cycle would enable close examination of the issues experienced by local people, with a focus on good practice. The collaboration was intended to lead to improved coordination and integration of local MH and AOD services by providing local Aboriginal community members with the opportunity to share their opinions and requirements about service design for easy access and greater utilisation. Consumer feedback was a central element of our decision to use PAR because this on-the-ground consumer involvement could act as a tool for establishing work plans and refining service delivery structures, including enhanced service provider record keeping and accountability. It could also develop a self-reflective service culture and best practice as evidence of appropriate action (Reason, 2006).

In the context of health service provision, the dynamic nature of reflection meant that using critical enquiry to explore every challenge could lead to a heightened understanding of what was needed to plan for more appropriate and useful design of future services and service delivery (Checkland & Holwell, 1998).

### **3.6 Conclusion**

While it can be challenging for MH-AOD care health practitioners, service providers and policy-makers to design and implement services according to their Aboriginal consumers' needs, there is a solution. Inclusive participation of Aboriginal people in informing ways to design culturally-appropriate and sensitive services and care pathways can lead to appropriate ways to address the current barriers to their access to MH-AOD services.

This chapter has described how PAR methodology, underpinned by critical theory and incorporating the main principles of Aboriginal research, as well as *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (Ungunmerr-Baumann, 2002), can enable this solution focus by creating a truly inclusive, integrated, collaborative four-phase, cyclical framework for sharing multiple Aboriginal and non-Aboriginal knowledge and experiences of MH-AOD care.

The next chapter explains the methods used to undertake the research in keeping with the PAR methodology.

## 4 Methods

### 4.1 Introduction

This chapter describes the research design and methods. It includes the researcher's engagement with, and access to, the community, and consultation in co-planning the research to ensure integrity. There is particular emphasis on the uniqueness of the local Aboriginal people's situations and experiences in regard to service access. The chapter also describes the audit trail used to establish credibility, reliability, dependability, conformability and validity of the data analysis methods and the resulting interpretation (see Appendix 7 for more information about the audit trail). The conclusion summarises the acceptability and applicability of this PAR to the local Aboriginal participating community members and workers in the study region.

I begin with a Preface to emphasise the research context and the value of gathering data regarding people's experience, through the PAR process, as evidence of the dire need to bring about change.

#### ***Preface***

As I write this chapter, I hear the sad news that a young man has committed suicide. His mother shared her story with me. While it is very unusual for a woman to go to a designated men's group, the harsh impact of her oldest son's suicide from MH-AOD comorbidity-related factors made a mother take this step to do her best to support her second son who was also struggling with depression.

*A 21-year-old young man committed suicide. An Aboriginal mother was attending a designated Aboriginal men's group for support, and she informed me that she had brought her second son, who is 18 years old, to get support for his depression. She shared the news about her 21-year-old first son who had died just two weeks before, and had long been sick with psychosis and an illicit drug problem. He had been repeatedly looking for help for his deteriorating mental health condition, and recently the mother had asked the staff if he could be admitted as it was nearing the weekend and she was very concerned about his coexisting problems of mental health and drug abuse. When the staff at a health centre replied that he was*

*unlikely to be admitted immediately because he had to wait for the doctor, the mother left with her son without seeing the doctor, who might have identified an acute comorbidity issue.*

## **4.2 Aboriginal community consultation: Co-planning the research**

In 2011, my principal supervisor introduced me to the larger CAN Advisory Committee and the project's Kurna Elder/community researcher who facilitated my networking and engaging with local Aboriginal people and staff from a range of MH and AOD services, agencies, programs and other health care units, predominantly mainstream but a few Aboriginal-specific.

A Kurna Elder advised me that Aboriginal people did not want research for its own sake but wanted research that would result in credible action that could improve their health and social conditions. She firmly believed that MH-AOD problems seriously affect many Aboriginal people, and that this research would motivate Aboriginal people, various workers and service providers to share their thoughts, experiences and expertise to explain the need for more culturally-appropriate and better MH-AOD services.

### **4.2.1 Local Aboriginal people taking the research lead**

Early in 2012, six months after my first meeting with the CAN Kurna Elder, she and I formed the Aboriginal Working Party (AWP). It originally consisted of seven local Aboriginal people from the Salisbury and Playford LGA region (Kurna Country). These original AWP members welcomed the study and agreed to be co-researchers. They nominated other local Aboriginal informants who then also agreed to be members of the AWP, which finally comprised ten members. The AWP members were the CAN Kurna Elder, local health and support workers, and consumer advocates, all of whom had work and/or community experience with MH-AOD service matters.

AWP meetings were held locally at least bi-monthly in the friendly *CAN project* meeting room. Nutritious snacks were provided to encourage a comfortable atmosphere. Aside from formal meetings, ad hoc phone conversations and emails between members and myself also occurred as the project progressed. This flexible partnership approach enabled information sharing, problem solving and networking to occur. Once local

Aboriginal community members, and Aboriginal and non-Aboriginal workers from MH, AOD and support services started hearing about me and our research, people started approaching me for further information and consultation about it. Consultation was centred on finding out what the Aboriginal people in the Salisbury and Playford LGA region needed in terms of MH-AOD services and service delivery.

#### **4.2.1.1 *What's needed?***

When I asked the Kaurna Elder and AWP members what they believed the research focus should be, and how it should be conducted, they spoke about the priority service needs of Aboriginal people experiencing MH-AOD comorbidity. They focused on the everyday needs and stresses that affected families when caring for their MH-AOD dependent family members.

The AWP members indicated their interest in participating in this research as partners with me, particularly in planning and implementing the PAR model by taking action together to investigate the community's MH-AOD service problems, and finding solutions. Over time, members of the AWP and I got to know and understand each other, and their trust in me developed. This led to their commitment in being involved as co-researchers in this research. As such, the AWP members assisted me to explain the aims and style (PAR) of the research to the community, services and potential participants. This information included ethical issues such as giving informed consent, confidentiality and people's own choice about whether they agreed (or not) to participate in an interview or focus group, and the extent of their participation.

The Kaurna Elder, AWP co-researchers and I continued to foster our trusting relationship throughout this PAR project, based on partnership and mutual respect.

#### **4.2.1.2 *My own journey of engagement***

Having met regularly with the Kaurna Elder and AWP, I was invited to attend the local Aboriginal church, community gatherings and events at which some Aboriginal people shared their experiences. At an early gathering, an older Aboriginal woman asked me where I came from and what I knew about Aboriginal culture. She spoke about the history and importance of Aboriginal culture today, then asked me about my culture. I responded respectfully, acknowledging the diversity and uniqueness of Aboriginal cultures. I invited her to add her perspective of culture to discussions about local comorbidity service needs. She accepted the invitation to be a key informant and her

contribution enriched our on-the-ground research dissemination and partnership ties with all those at the gathering.

#### **4.2.1.3 *Mentorship and transparency for trust***

The Kurna Elder, AWP members and key informants became my mentors throughout the study. They contributed across all stages of the project in areas such as action planning, discussing emerging themes, and consulting with the community and stakeholders. They enabled me to follow a clear PAR pathway, and to liaise and engage with an expanded range of participants. Different clusters of people, including local Aboriginal people and those working with Aboriginal people, contributed in varying ways, which added an extra layer of strength to the research by enabling it to reach the previously unreached. This demonstrated the Aboriginal people's dynamic commitment to involvement, empowerment and consequent interest in this research as a meaningful activity with their community.

Transparency in working together was crucial to my ability to develop and maintain a sustainable trusting relationship with the AWP members and their local Aboriginal community. It was important for me to undertake the research in a culturally-appropriate way with local Aboriginal community members and workers, and clinicians and workers from MH, AOD and support services from whom Aboriginal people seek help for MH-AOD comorbidity. I learnt that by learning about each other and sharing our knowledge we could apply qualitative PAR methods meaningfully with local Aboriginal people and services. I also realised that to achieve this it was important to enhance the AWP members' PAR research literacy, including knowledge of ethics and qualitative methods, through this experience.

#### **4.2.1.4 *AWP partnership in action***

The AWP helped me form a partnership with "key informants", who consisted of local Aboriginal community leaders (n=5), non-Aboriginal leaders working with local Aboriginal communities (n=5), Aboriginal Elders and community members (n=10), and Aboriginal health service consultants (n=3). These key informants linked me to the wider community by taking me to meet and talk with "hard-to-reach" community members and workers. They played a vital role in introducing me to their community and sharing information about this research. Roles of AWP members, key informants and all participants are summarised in Table 4.1.

**Table 4.1: The role and details of the advisors and groups participating in the research**

<b>Who</b>	<b>Role</b>	<b>Details</b>
CAN Advisory Committee for overall project (including CAN Aboriginal study)	Representative members from formal CAN partner organisations including Aboriginal health Council of SA; local government; government and non-government MH, AOD and primary health services; carer advocate.	One nominated AHCSA represented and 2 nominated members from the AWP.
‘Aunty’ Coral Wilson, Kaurna Elder	Kaurna Elder/Co-researcher; co-chair AWP	<i>CAN project</i> Community researcher
Aboriginal Working Party (AWP)	Co-researchers	Local Aboriginal health workers and community members guiding the research; suggested potential participants –local Aboriginal people, clinicians and workers
Key informants	Aboriginal and non-Aboriginal people who work closely with local Aboriginal groups	Information pertinent to the research; suggested potential participants –local Aboriginal people clinicians and workers. They were not involved as participants.
Group A Participants: Aboriginal Consumer Advocates including carers	Participants from local Aboriginal community	Involved research focus groups and interviews
Group B Participants: clinicians and workers from local MH and AOD services (government and non-government)	Participants from local MH and AOD services, including doctors, nurses, specialist clinicians	All participating workers were supported by their organisations to be involved. Each participant chose voluntarily whether to be involved in an interview or not and this decision was kept confidential.
Group C Participants: Workers from local support services	Participants, e.g. local support services, including emergency department nurses, ambulance and Aboriginal health workers, service coordinators, managers	Only those who worked closely ‘on-the-ground’ with local Aboriginal people and others affected by MH-AOD and other health and social problems,

The Aboriginal Elder and AWP members guided and accompanied me through all matters regarding community, service and worker engagement, sampling and recruiting, and arranging data collection. If the Kurna Elder/co-researcher could not accompany me for any preliminary “getting to know us” community meetings, interviews or focus groups, the next available AWP member took on that role.

#### **4.2.2 The central part of the research: Aboriginal Kurna Elder as ‘co-researcher’**

The Kurna Elder, the study’s co-researcher, used her experience as a facilitator to guide me compassionately throughout the research process. Her guidance enabled me to listen, learn, understand, reflect and challenge myself to share the research in order to move forward alongside the Aboriginal community people. I learnt about their personal experiences of the impacts of colonisation, exclusion, inequality and discrimination on them and their forebears. As described by Atkinson (2002) and Ungunmerr-Baumann (2002), I listened deeply with my heart and head by practising *Dadirri*. Mutual trust developed between the Kurna Elder and me, and consequently between the Aboriginal community people and me, as we shared our thoughts. Cultural permeability and cultural exchange increased (Kelly, 2008, p. 119; Kuprecht, 2013). We recognised and understood that we had shared our different life experiences. In the soft flowing *Ganma* of two-way knowledge-sharing, we were able to understand each other better as individuals and as people (AWP, 2012b).

The Kurna Elder/co-researcher encouraged us to move forward by being individually accountable for who we are and what we choose to do, at the same time recognising that the dynamics of the MH and AOD health service structure, and complexity of the situation, may prevent us from taking positive action (AWP, 2012a). Understanding the privilege of being accepted as part of the community as an Australian resident and a general nurse, I grappled with my privileged position when trying to understand the impact of colonisation on generations of Aboriginals up until today and on their diverse cultures. From a different perspective, I came to see the MH and AOD health care system as the service structure wherein people in need may be accepted for, or excluded from, service through the service model’s regulations and implementation. As Franks and Curr explained (1996, p. 109), rather than being seen as a practising and knowing professional, I learnt not to be enigmatic. Instead, I ensured I listened deeply. I learnt to understand and recognise different views of the world. Over time, I understood

and realised the importance of contributing to cultural interactions.

Having established a solid, trusting partnership, the Kurna Elder/co-researcher, AWP members and myself began outlining similarities and differences between various health care sectors that provided MH-AOD services and why they were expected to respond to MH-AOD comorbidity. The AWP members and the Kurna Elder/co-researcher described the various services to which an Aboriginal person is referred and services they might receive for their MH-AOD problems.

### **4.2.3 My role as researcher**

It was essential in my role as a researcher to learn about, and understand, the diversity of Aboriginal languages and cultures. As a nurse working within the Australian health care system, I also understand how mainstream health services are structured and delivered. I acknowledge that I bring my own values-laden approach to this research; the values of a mother, woman, wife, daughter and nurse. However, not being an Aboriginal Australian or an Australian-born nurse, but as a person of Indian origin, I bring a freshness to the research with my various life roles, which inform and nourish me as a responsible person and respectful researcher. I have learnt extensively about Aboriginal people's cultures, beliefs and values through various Aboriginal and non-Aboriginal mentors who have worked with, or close to, the Aboriginal community in the study region. In particular, the Kurna Elder/co-researcher taught me about her experiences during her early life on a mission<sup>4</sup>, about her culture, and about later life in the country and in wider society.

In my role as this study's researcher, I see myself as a "human instrument" who can provide unique and reliable data through appropriate engagement with local Aboriginal people. By being responsive, adaptive and dynamic, I have provided opportunities for clarification and trustworthiness of the data (Lincoln & Guba 1985, p. 192). Developing rapport with the Aboriginal people, and gaining their trust through consistent engagement and collaboration enabled me to work with them throughout this research, and to present findings representing their voices in a credible way (Lincoln & Guba,

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<sup>4</sup> Due to rapid colonial expansion there was a massive decline in the Aboriginal population. The ruling government during the colonial period established mission stations for Aboriginal people through churches. The mission stations are reserves where Aboriginal people who were removed from their families were educated in Western values and lifestyles. These reserves may have assisted physical survival of Aboriginal people but destroyed Aboriginal languages, and severely undermined their independence and culture (AIATSIS, 2008, p. 1).



1985; Moreton-Robinson, 2009).

When considering our work throughout this research, I recognised that the foremost essential step for me was to learn how to work accountably and respectfully with the Aboriginal co-researchers, Aboriginal community people, and service staff who work with them in the health care system. Learning in ways explained by *Dadirri* (Ungunmerr-Baumann, 2002) and *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012), I allowed myself to connect with others and become accountable as a responsible human being, not just as an ethical researcher. Engaging, connecting, learning and progressing together with the Aboriginal community people developed a sense of empowerment and ownership in them, which they expressed in our meetings. Their sense of ownership assured sustainable progression of the cyclic, interactive PAR processes.

### **4.3 Ethics approval and data security**

The ethics approval process entailed many meetings and discussions with Aboriginal health research leaders and ethics committees. We answered all of their concerns to ensure user-driven, meaningful research. We met the requirements of Aboriginal research in South Australia, as per the SA Aboriginal Health Research Ethics Committee (AHREC) and the *National Aboriginal Health Strategy* (NATSIHC, 2003), and followed the guidelines for Aboriginal research described in the previous chapter (section 3.2.2).

Formal ethics approval was applied for and granted by the AHREC, Queen Elizabeth Hospital, Women's and Children's Hospital, the Human Research Ethics Committee of the University of Adelaide (HREC), Anglicare and SA Ambulance (see Appendix 1). Letters of support in the form of site-specific assessments were sought and received from all relevant managers of the health service sites whose staff were to be approached to participate in interviews.

All data continues to be managed securely (for specific details please see participant information sheet, Appendix 4) in accordance with the NHMRC (2003, 2014) guidelines.

### **4.4 Research strategy**

We had a responsibility to develop and implement the research to suit the AWP and

others' lifestyle commitments. Therefore, we arranged community meetings, data collection, networking, negotiation and telephone communications at times to suit participants' capacity and commitments in accordance with their suggestions. Discussions happened at a time suitable to the health and wellbeing of the Elders, families, staff and workers.

Community consultations supported an integrated research strategy, which consisted of three interlinked strategies: consultation with Aboriginal community people; meetings with MH and AOD clinicians and workers; and meetings with support service staff. Overall integration of each strategy would occur as we shared findings from across all three areas. The research strategies aimed to answer the questions: What are the needs? What are the barriers? Where to from here? 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 in the Salisbury and Playford LGA region.

Each week I consulted the Kaurna Elder/co-researcher to discuss concepts and issues regarding Aboriginal health research ethics, PAR and collaborative research. Together, we worked out how these were essentially related to people's knowledge. I also brought ideas from key informants, and our co-writing and discussions then created a link between various groups of stakeholders and co-researchers. The *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) process provided us with information for further understanding.

#### **4.4.1 Strategy 1: Meetings with Aboriginal community members**

The first strategy was to connect with a wide range of Aboriginal community people from the Salisbury and Playford LGA region. This involved meeting people from the community through people from Nunga<sup>5</sup> gatherings, Grannies' group, school mothers' group, men's group and people camping out in Pitman Park, Playford. Collaborative and helpful activities, including taking Aboriginal individuals to hospital and supporting and assisting them through illness, strengthened our relationship. This is the core of PAR; to ensure a process of action through democratic partnership and reciprocation. This genuine acceptance and collaboration led to Aboriginal community people inviting

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<sup>5</sup> Nunga is self-reference term that many Aboriginal people of South Australia use to describe themselves

me to participate in Nunga cultural events, the NAIDOC walk, reconciliation parades, Nunga church services and fellowship teas, caring for their house pets while they visited family in other states and attending their children's graduation ("share our joy"). They shared their difficult situations and their family burdens. Quietly, through formal and informal discussion, this sharing built the relationship between Aboriginal community members and myself.

#### **4.4.2 Strategy 2: Meetings with local MH and AOD clinicians and workers**

We began to search for services that assessed, treated and managed MH-AOD comorbidity and other related problems. An ongoing issue for Aboriginal people was access to Aboriginal-specific MH and AOD services for individuals who preferred Aboriginal-specific care. The AWP members enabled networking with staff from various Aboriginal-specific and mainstream services. We were invited to programs such as "Kangawodli" and the Aboriginal unit grand rounds from the local hospital. An unexpected benefit was that when we liaised with one service, they linked us with another. This enabled us to consult the available specialised local services that provided care for Aboriginal consumers with MH and/or AOD issues.

#### **4.4.3 Strategy 3: Meetings with support service staff**

The AWP members talked about support service staff's crucial role in engaging local Aboriginal people with MH and AOD services. Support services were seen as a bridge connecting MH and AOD clinicians and workers with Aboriginal people. They could help us understand the existence, or lack of, MH-AOD care. Aboriginal people considered support services essential because support workers informed them about MH and AOD services. MH and AOD clinicians and workers had some connection with local Aboriginal people through support service staff's referrals. Support service staff's key knowledge and contact with MH and AOD services made them essential informants. They were on-the-ground staff – clinicians, practitioners, professionals and other workers – who had regular contact with Aboriginal people who had MH-AOD problems. Their contribution was to facilitate engagement and agreement of managers, leaders and other stakeholders to support and contribute to this research, and later to assist in implementing services to better meet Aboriginal people's MH-AOD service needs.

## 4.5 Sharing our work: Integrated perspectives

According to the NHMRC (2003), Stringer (2007), and de Crespigny, Emden, et al. (2004), an important ethical aspect of Aboriginal community health research is to ensure that the findings are shared, jointly owned and disseminated by, and with, co-researchers and community members. The Kurna Elder/co-researcher expressed her happiness when we discussed future collaborative dissemination of the findings.

The AWP members agreed it was essential to disseminate the findings to the wider community. When we called for an AWP member to co-present findings, all members nominated and seconded a member to represent them, who accepted the offer. In February 2014, one of our AWP members was invited to give a presentation at Tandanya, the National Aboriginal Cultural Institute in South Australia. The Kurna Elder/co-researcher, the invited AWP member and I jointly presented the study's analytic strategy.

Together, the Kurna Elder/co-researcher, AWP members and I organised a workshop to disseminate the findings of this research for consideration and validation by the local Aboriginal community in the study area. We invited all participants, local community members, workers, stakeholders, decision-makers and policy-makers (see Appendix 9, CAN Aboriginal workshop) to come and join the workshop and other conversations about the importance of priority implementation, need and respect for the Aboriginal community. We wrote the ideas on butchers' paper (Kelly, 2008), which enabled us to transparently and collaboratively create themes such as **health status + need = service**. Those attending the workshop spoke about capacity-building, stressing that there can be no real engagement and no lasting amelioration in Aboriginal health without appropriate understanding and knowledge-sharing. I documented all their ideas, concepts and feedback, which I later wrote up as a report for wide dissemination back to the community (see Appendix 10).

## 4.6 Data collection

I worked with the Kurna Elder/co-researcher and the guiding AWP members to undertake the data collection. Under their guidance, I held discussions with local Aboriginal groups, MH and AOD clinicians and workers, and support service staff from the study region. I informed them about the study and invited them to participate in the research. I explained the research aims and informed them about privacy, confidentiality

and the issues involved in it being ethically-sound Aboriginal research. I also informed them that should they agree to participate, they had the right to withdraw from the study at any time. I explained the process whereby they would become members of a large research team and would have the right to make suggestions at any stage of the research, including ratification of the findings.

The Aboriginal community people, MH and AOD clinicians and workers, and support service staff asked similar questions to ensure trustworthiness of the three data sets to determine people's MH-AOD service needs. We conferred, discussed, clarified meaning, and agreed on content analysis and interpretation of each data set to ensure trustworthy (valid), reliable content analysis that conformed to the critical theory and PAR empowerment approach. We then took our preliminary findings to the AWP for confirmation.

I adapted Wolcott's<sup>6</sup> tree model (Wolcott, 2002) to visually represent the whole data collection method, including all participants (see Figure 4.1, next page). The tree's roots represent the target *CAN project*, process of enquiry, AWP and research-relevant literature review. The tree's sap represents the researcher's roles as facilitator, enabler, critical analyst, negotiator and co-researcher to inform problem resolution. Its branches represent the different participants from services, with leaves as Aboriginal people and flowers representing data collection tools. The waterfall, flowing to nourish the tree, represents knowledge-sharing and information exchange. Contributing factors required for growth, such as the sunlight and a fertile environment – an important consideration – represent the researchers' ethically-sound code of conduct in line with Aboriginal research ethics requirements and guidelines (NHMRC, 2014; Aboriginal Health Council of South Australia, 2015), and the local service organisations' principles and protocols.

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<sup>6</sup> Wolcott readily gives licence to other researchers to use his model so that it can be adapted to explain a particular research design (Mittchell, 2006; Wolcott, 2002).

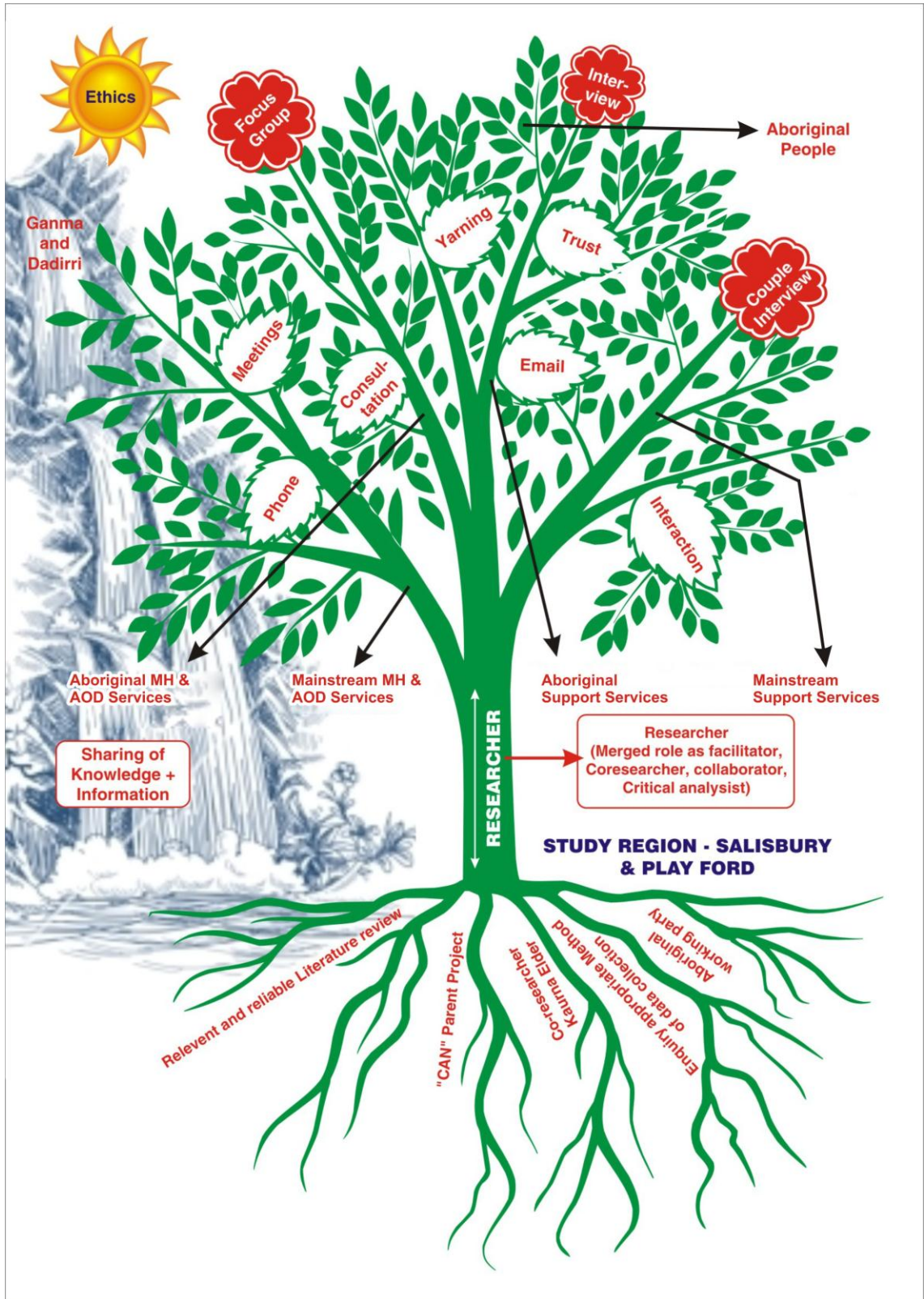


Figure 4.1: Current research adaptation of Wolcott's model for data collection

### **4.6.1 Purposive sampling**

Participant selection to ensure a purposive sample was important so this research could achieve its aims and objectives. Purposive sampling is the process whereby a well-established category or group of people is recruited specifically for their ability to provide relevant information to answer the research questions (Mason, 2002). The PAR critique developed my wisdom so that I understood the local social and economic structures influencing individuals' behaviour. Therefore, when recruiting participants for the research, it was important for me to focus on those most affected by MH-AOD comorbidity to provide data and help formulate the most appropriate future MH-AOD services in the participants' local context. Thus, purposive sampling was chosen because it enabled us to gather multiple sources of data from the specific study population (Lincoln & Guba, 1985), which added value by enhancing the findings' transferability and applicability to the similar wider community and possibly to future research. We considered it the optimum sampling method to achieve the research purpose (Lincoln & Guba 1985, p. 199) of how to engage this hard-to-reach population in the Salisbury and Playford LGA region.

#### **4.6.1.1 Participation criteria**

##### *4.6.1.1.1 Inclusion criteria for Aboriginal Consumer Advocates*

The AWP advised consulting Aboriginal people over 18 years of age because they were likely to be family members or adult friends of Aboriginal people under 18 years of age who needed culturally-safe MH-AOD treatment in the study region. These people were seen as being in the best position to tell us what they understood about barriers and issues faced by others affected by MH-AOD comorbidity. In summary, inclusion criteria were:

- Aboriginal community people aged 18 years and over who live in the study region
- Aboriginal community people willing and able to give informed consent to participate in this research
- Acutely or critically ill Aboriginal consumers needing MH and/or AOD treatment; we realised it was unethical to distress those needing treatment with inquiries reflecting the complexity of services.

- Aboriginal community people experiencing MH-AOD issues who were capable of sharing their knowledge and experience during the research.
- Aboriginal community people who understand the issue of access to MH-AOD services for Aboriginal people due to their direct knowledge or care of another Aboriginal person with comorbidity.

#### *4.6.1.1.2 Exclusion criteria for Aboriginal Consumer Advocates*

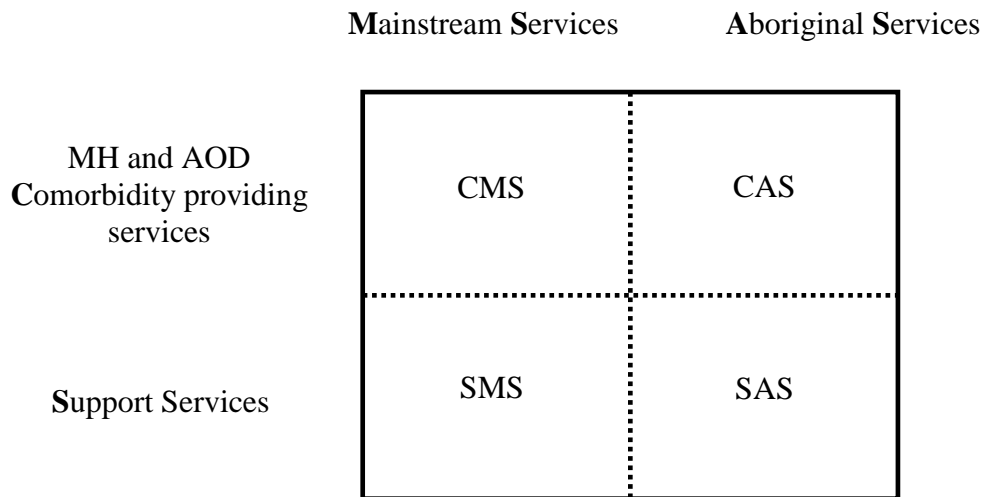
Non-Aboriginal people, Aboriginal community people under 18 years of age, Aboriginal people not living in the study region, and Aboriginal people needing treatment for MH-AOD, or MH or AOD problems at the time of recruitment were outside the criteria for Aboriginal Consumer Advocates. It was recognised that vulnerable young Aboriginal people under 18 years of age who were experiencing comorbidity and needed care and treatment services in the study region would face many challenges by participating. It was also recognised that these young people would require a culturally-safe and responsible environment in which to tell their stories and, if required, the offer of the specific support and expertise they may need at the time. Therefore, to raise this issue with young people and vulnerable people currently affected with MH-AOD comorbidity seemed unethical when we knew anecdotally that there were extremely limited MH-AOD services available.

Therefore, we decided to invite adult Aboriginal consumer advocates, who are likely to be family members or adult friends, to tell us what they understand about barriers and issues faced by young Aboriginal people under 18 years of age who need culturally-safe MH-AOD comorbidity treatment in the study region.

#### *4.6.1.1.3 Inclusion criteria for MH and AOD clinicians and workers, and support service staff*

As stated earlier, these two groups of participants have been termed “service staff”. On-the-ground service staff were sought because they are acquainted with individuals, and family and community knowledge through their hands-on experience in delivering services to Aboriginal people with MH-AOD problems. They have practical knowledge to bridge gaps between services and consumers. Only services that were accessed by Aboriginal consumers were considered eligible for this research. It was imperative to consult with them to better understand Aboriginal people’s MH-AOD comorbidity care needs and to evaluate whether current service provision is appropriate for Aboriginal people with comorbidity in the Salisbury and Playford LGA region.





**Figure 4.2: Service staff recruitment grid with coding**

Service staff participants were classified and coded into mainstream MH and AOD services, Aboriginal MH and AOD services, mainstream support services and Aboriginal-specific support services (see Figure 4.2). Mainstream MH and AOD services were government hospital and health centres that provide treatment and care for people with MH-AOD comorbidity. Aboriginal-specific MH and AOD services were those provided by Aboriginal organisations. Support services were those that assisted people, including those with MH-AOD comorbidity, to reach care, for example the ambulance service that transfers people to hospital.

**4.6.1.1.4 Exclusion criteria for MH and AOD clinicians and workers, and support service staff**

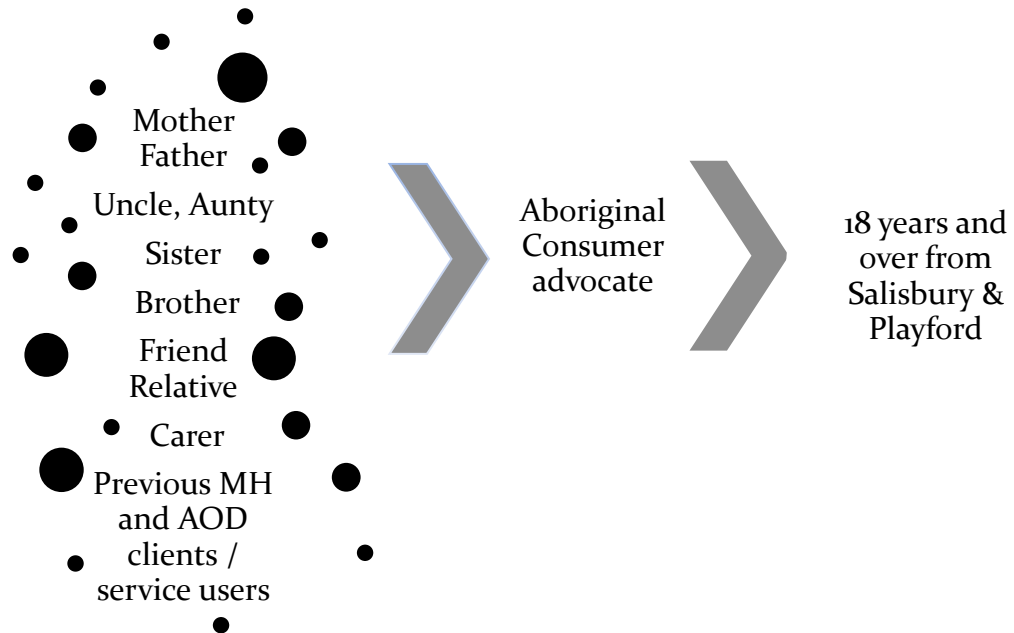
Service staff under 18 years of age, Aboriginal and non-Aboriginal clinicians/workers not willing or able to give informed consent to participate, and Aboriginal and non-Aboriginal clinicians/workers not involved in providing MH or AOD, or MH-AOD care, treatment or support services to Aboriginal adults and youth in the study region were outside the participation criteria.

**4.6.2 Participants**

The three groups of participants – Aboriginal Consumer Advocates, MH and AOD clinicians and workers, and support service workers – who met the inclusion criteria detailed above for each group cannot be described in detail for privacy and confidentiality reasons. They would be readily identifiable in this small region.

#### **4.6.2.1 Group A: Aboriginal Consumer Advocates**

Group A consisted of Aboriginal Elders, grandparents, parents, adults and young adults (Aboriginal Consumer Advocates, n=19; see Figure 4.3).



**Figure 4.3: Aboriginal Consumer Advocate eligibility**

These Aboriginal Consumer Advocates were considered to be well placed to describe the issues regarding the need for, and access to, culturally-appropriate, local MH-AOD care or treatment programs, as well as types of barriers to accessing care.

#### **4.6.2.2 Group B: MH and AOD clinicians and workers**

Group B consisted of frontline workers and clinicians in MH and AOD care, such as health workers, psychiatrists, psychologists, social workers and nurses. This group consisted of nine staff (n=9) from seven mainstream MH and AOD services and two Aboriginal-specific MH and AOD services, all of which were accessed by Aboriginal consumers. Five of the MH and AOD clinicians and workers were Aboriginal (n=5). It was assumed that the participating MH and AOD clinicians and workers were able to screen, assess, monitor, manage and treat Aboriginal people.

#### **4.6.2.3 Group C: Support service staff**

Group C consisted of five (n=5) local on-the-ground workers from two mainstream and two Aboriginal-specific support services. Four (n=4) of these participants were Aboriginal. Examples of support services included in the study were the local hospital

emergency department, ambulance, housing, community corrections and police.

### **4.6.3 Informed consent and confidentiality**

During this research, I sought to work together with Aboriginal people to enrich their social and health capacity, and support their wellbeing. While working and yarning with Aboriginal people, I gave positive reinforcement when they shared their concerns. Any form of research activity detrimental to their individuality, or family or community identity and principles was never considered.

A “Letter of introduction”, “Participant information sheet” and “Consent form” (see Appendices 2, 4 and 5) were developed using easy-to-understand, everyday English to ensure everything was clear to all participants and to encourage voluntary participation. Potential participants were provided with sufficient information to make an informed choice whether to take part in research activities. I hand-delivered all information to eligible participants at group meetings or gatherings at a place of their choice.

Those interested in participating were given a consent form and list of trigger questions to consider (see Appendix 6), and invited to participate in either interviews or focus groups of their choice. Information was provided on how to access MH-AOD information, support and counselling in recognition that the topic and research process, while educational, may cause distress. If a person could not understand, read or sign the consent form (e.g. due to poor eyesight, compromised literacy levels, physical disability etc), the forms were read to them and their oral consent was gained and documented. No data collection proceeded unless participants had either signed and returned the informed consent form, or given oral consent.

## **4.7 Qualitative research methods: In-depth conversation-style interviews and focus groups**

In-depth conversation-style interviews and focus groups were conducted to gain deeper insights into the comorbidity care issues currently faced by the local Aboriginal community members. Initially, we planned to have (individual) personal interviews and focus groups. However, an Aboriginal Consumer Advocate and one support service staff member preferred to be interviewed with their co-workers. Thus, joint interviews evolved. Similarly, at the beginning of the project we planned to hold separate focus groups for youth, adults and elders. However, the local Aboriginal community people

chose to have focus groups with youth, adults and elders combined so they could discuss the issues together.

The data from the personal interviews, joint interviews and focus group discussions were subject to systematic thematic coding and content analysis to explore and understand Aboriginal people's and staff experiences (Dwyer et al., 2011), and identify shared themes to determine their MH-AOD service needs. The barriers to, and facilitators of, accessing local responsive Aboriginal/culturally-appropriate services were identified and discussed with the CAN Advisory Team and AWP members, ensuring the study's credibility. Ad hoc CAN Advisory Team meetings, AWP meetings, conversations between co-researchers, storytelling, my field journal and relevant documentation enabled wider reflection on the data and also helped me to stay true to the data.

#### **4.7.1 Semi-structured questionnaire**

Interviewing took the form of a guided yet deep conversation (Rubin & Rubin, 2011). Semi-structured questions with prompts were developed through community consultation and revised as the PAR cycle evolved. Open-ended questions were used to elicit in-depth information and prompts encouraged participants to undertake more detailed conversation (Guba, 1990). This occurred in personal interviews (with one person), joint interviews (with two people) or focus groups (with three or more people). During all the interviews and focus groups, the Kurna Elder/co-researcher or an AWP member was with me. The Kurna Elder/co-researcher walked beside me and the AWP supported me. I was able to enter the community with confidence because the Aboriginal people already knew me through the "Nunga grape vine" (oral conversation within Aboriginal people). If relevant information emerged before its corresponding question was asked, that question was skipped. Participants chose to either have their conversation audio-recorded or have notes written only.

##### **4.7.1.1 Pre-interview preparation**

Each participant met with the researcher and Kurna Elder/co-researcher a minimum of three times: 1) at a visit to introduce and discuss the project; 2) at the interview or focus group; and 3) to check the interview manuscript. Participants chose the time and place for their interviews, such as a coffee shop, a participant's workplace, the School of Nursing meeting room or the CAN office. Participants' willingness to talk to me

indicated that my position as a researcher, nurse and student of the School was accepted and respected, and that I had presumably developed trust and transparency. All participants thanked me for taking up this challenging research and appreciated my effort in working collaboratively with such a wide range of Aboriginal and non-Aboriginal people and workers.

#### **4.7.1.2 Interviewing style**

Context-relevant plain English language was used at all times (Sweeney & Pritchard, 2010) to ensure everyone received the same information about the research in ways they clearly understood. For example, the term “access to service” was used when consulting with workers; “was it easy to reach?” was used with the parkland people; and “enabling factor” was used with the research academia. We used Aboriginal expressions the Kaurna Elder/co-researcher had taught me, such as “Yarning”, “Nunga friendly” and “Nukkan” when talking with Aboriginal community members. This communication strategy, aligned with the PAR cycles of “look and listen, think and reflect, and collaborate and act” enabled me to explore, learn and understand how to convey messages appropriately to diverse groups.

#### **4.7.1.3 Interviews**

Interview duration ranged from 30–90 minutes, with an average of 60 minutes. Many participants expressed willingness to yarn (an informal opening talk) before their actual interviews took place. Others were willing to be interviewed without this but had concerns about how much they could contribute. They were reassured that their knowledge and experience were valuable because they were “experts”, and encouraged to share their ideas and concepts through their own voice. They were encouraged to participate at whatever level they felt comfortable. Some were pleasantly surprised by their contribution when we reflected on their shared viewpoints after the interview. They appreciated that they had gained a greater understanding of their own knowledge and the topic of comorbidity and service provision. This reaction was similar to the benefits disenfranchised participants experienced in a study by Hutchinson, Wilson, and Wilson (1994). The unseen benefits of reassurance during periods of uncertainty about the topic and process can lead to participants’ enhanced healing, and a heightened sense of importance and empowerment through their reinforced self-acknowledgement (Hutchinson et al., 1994, p. 163).

#### **4.7.1.4 Focus groups**

Similar to the process for interviews, I met all prospective focus group participants with the Kurna Elder/co-researcher or an Aboriginal member from the AWP before each focus group was organised. Information about the aim of the study and the research process was provided and discussed with the potential participants, including how I and the Kurna Elder/co-researcher worked together, and how participants were considered important. Each focus group evolved after several months of networking and consultation. This length of time enabled participants to become familiar with me and with the research topic, and to decide on their participation. No focus groups were undertaken with staff due to confidentiality issues.

Three focus groups were conducted with twelve Aboriginal Consumer Advocates (n=12). These occurred in a pre-arranged communal gathering in comfortable, familiar places where participants could freely share their opinions. Focus groups provided the opportunity for people to unearth and share their experiences, clarify their thought processes and assist everyone participating to learn about others' input in a more natural conversational form.

A circular conversation style of information exchange evolved during focus groups (Davidson, Halcomb, & Gholizadeh, 2013), with limited use of direct questions. This enabled elicitation of the nuanced, rich experiences that people might share generously during relaxed conversation (Davidson et al., 2013). Participants noted the long time that was needed for genuine consultation (more than two years of ongoing interaction, collaboration and involvement), which enabled them to build trust and share sensitive information during focus groups.

The focus groups were flexible. Sometimes they occurred in the meeting room and at communal gatherings. Otherwise, I walked around in the fresh air having a conversation. This aligned more closely to knowledge-sharing through storytelling (de Souza & Rymarz, 2007).

#### **4.7.1.5 Member checking**

The next step in the interview and focus group process was member checking – a dynamic crucial process of member validation (Richards, 2003, p. 287) to establish credibility (Lincoln & Guba, 1985, p. 314). Member checking is a reflective process of interpretation with the research participants (Guilfoyle, 2008, p. 206) by taking ideas

back to them for their confirmation and co-construction by reengagement with them (Charmaz, 2006 p. 111; Harvey, 2015, p. 26). It relies on the triangulation for establishing a consistent, objective picture of the truth (Mathison, 1989, p. 323; Cho & Trent, 2006).

Once the interviews and focus group discussions were digitally recorded, transcribed accurately and checked by some participants (Morse, Barrett, Mayan, Olson, & Spiers, 2008), the participants had control over their information. They decided what could be retained and shared. Their decision was honoured to ensure research integrity. In recognition of some of the participants' prior negative experiences, or if reading literacy was a challenge for them, I read the transcription to them. I considered this essential to ensure data credibility for appropriate interpretation.

Some argued that member checking can cause confusion rather than confirmability because the person may change their mind (Angen, 2000). However, in this study, the themes that emerged were discussed with the participants for clarification. In most interviews, some discussion occurred immediately after the interview and, with the participants' permission, I wrote it up as notes. Later member checking involved participants reflecting on their conversations both within and after the interview. This process enabled confirmability of data rather than data confusion.

#### **4.7.1.6 Praxis: More than just conversation**

Praxis enabled reflection on the data by listening quietly (Guba, 1990). This quiet, critical reflection on the minutes of each meeting and dairies, and listening to stories aided a fuller understanding and interpretation of the data. It encompassed reflection on what was seen and heard. Praxis helped the interpretation stay true to the data.

Although the conversational model may seem relatively simple, a series of conversations requires a lot of work (Rubin & Rubin, 2011). Genuine awareness and understanding of Aboriginal people and the impact of their participation is required for consultation to be more than "mere tokenism" (Mohan, 2006). The involvement of local Aboriginal people, MH and AOD clinicians and workers, and support service staff enabled us to look at the comorbidity care problem from three key viewpoints. Firstly, from the experiences of local Aboriginal people; secondly, from the clinicians and workers on how they manage and treat comorbidity within their services; and thirdly, the support service staff who liaised with Aboriginal consumers, some of whom were

linked with services and some who were not. This enabled us to get a clear picture of the MH-AOD problem, the system of services and the level of services that really reach consumers who are in need of MH-AOD care.

#### **4.7.1.7 *Listening to storytelling***

Storytelling was an essential part of the conversational process. We used storytelling – an oral interpretive process shaped by documenting the research inquiry in a hermeneutic circle (Koch, 1998) – in our data collection, interpretation and discussion of the findings. Listening to participants’ stories encouraged me to visualise and learn about the Aboriginal community people’s and service staff’s experiences.

The value of storytelling in health research is that it conveys the core message of one group of people to others and informs them about knowledge that can make a difference (e.g. a pathway of care) (Kirkpatrick & Castelloe, 1997). According to Sherman (1994), storytelling enables problem-solving by showing where health care has gone wrong and identifying options to improve it. It can evaluate community development (Dixon, 1995), inform social policy (VanderStaay, 1994) and provide marginalised people with a voice that can be heard (Turton, 1997; Barton, 2004).

#### **4.7.1.8 *Field journal***

I noted all the research activities and my thoughts in a reflective journal (Dunbar & Scrimgeour, 2006). This helped to ensure my thought processes were clear and appropriate in the research context. It enabled me to reflect on this research journey, track important issues, events and themes, and express my thinking in the form of a mind map (Tattersall, Powell, Stroud, & Pringle, 2011). The field notes were invaluable during data analysis when I asked the Kaurna Elder/co-researcher to check the consistency of my analysis and interpretations.

### **4.8 Data analysis**

The aim of qualitative analysis in this research was to identify individual themes reflecting MH-AOD service needs. This research elicited the perspectives of the Aboriginal Consumer Advocates and service staff to find agreement as well as disparity between MH-AOD care needs and MH-AOD service provision. As stated earlier, in order not to confound the analysis, the service staff have been categorised as “MH and AOD clinicians and workers” (specialist staff of MH and/or AOD services) and



“support service staff” (allied service staff who support the clinicians and workers, and people, including those with MH-AOD comorbidity in the community).

Systematically organised contextual thematic analysis was used to analyse the range of qualitative data gathered through interviews, focus groups and synthesised CAN qualitative data. During this process, I documented the analytical strategy clearly, in a simplified manner, to indicate an audit trail (Grbich, 2012). Critical data analysis was undertaken through collaborative member checking with the Kurna Elder/co-researcher to evaluate the quality of the analysis. The data was analysed and reanalysed by close observation and critical enquiry to establish rigor. Data analysis was not a linear process; it was iterative, with the four highly interconnected back and forth steps of familiarisation, identification and coding of themes, categorisation, and then interpretation and understanding (Miles & Huberman, 1994; Groenkjaer, 2011).

#### **4.8.1 Coding as themes**

Codes and themes were identified depending on their meaning in the context of the study’s purpose (see figure 4.2, section 4.6.1.1.3). I read each transcription systematically, without any bias or assumptions, to find its core message. I then marked the repeated words and phrases, and identified ideas and concepts. I used memos and sticky notes to collate participants’ reflections and document related remarks. This revealed similar phrases, and enabled identification of patterns and relationships between them. Each piece of data was explored independently then checked simultaneously with the Kurna Elder/co-researcher. We undertook cross-analysis to identify the similarities and differences within the themes of all data sets (Miles & Huberman, 1994).

It was necessary to develop a “data encryption” coding system in consultation with the Kurna Elder/co-researcher, and at the AWP’s request, to include the de-identified categories of participant identity. The MH and AOD services were not separated in consideration of confidentiality due to very minimal AOD services in the region. There were many more MH service providers. Both MH and AOD services provided care for consumers with MH-AOD comorbidity, therefore all were purposefully coded as “Comorbidity services”. In keeping with this, we decided to code Aboriginal Consumer Advocates as “ACA”, MH and AOD mainstream clinicians and workers as “CMS”, MH and AOD Aboriginal-specific service clinicians and workers as “CAS”, mainstream

support service staff as “SMS” and Aboriginal-specific support service staff as “SAS”. An example is 1 CMS to denote the first interviewee from a mainstream comorbidity service. Focus group discussions were coded as FG.

#### **4.8.2 Categorisation**

The Aboriginal Kurna Elder, AWP members and I, as co-researchers, together discussed and defined how participants’ information was to be categorised into themes, which enabled translating their ideas into concepts, then concepts into theme-building and finally themes into an action plan (Boyatzis, 1998).

Categorisation involved contrasting and comparing the data. We had multiple codes, and many sequences and interactions. We merged the codes into meaningful categories (headings) under which we put relevant quotes or phrases. In this phase, I went through the codes repeatedly and collapsed multiple codes into categories, which the Kurna Elder/co-researcher checked for appropriateness and advised me accordingly.

#### **4.8.3 Interpretation and understanding: Theme creation**

Interpretation and understanding of the categories were pieced together in a back and forth process into patterns to create major themes with related sub-themes (Vaismoradi, Turunen, & Bondas, 2013). I, together with the Kurna Elder/co-researcher, printed out the categories and placed them on a table to visually examine their interrelatedness and perceive each theme’s development. I reflected on my interpretation of themes and sub-themes, and asked “why and how” questions to reach a final analysis while checking continuously with the Kurna Elder/co-researcher. Thus, themes were identified in accordance with three strategic phases:

1. Identifying the complexity of AOD and MH problems of people accessing services.
2. Identifying problems in providing and receiving MH-AOD care to ensure recognition of the severity of issues that Aboriginal community people and service staff experience.
3. Determining the key enablers for designing appropriate MH-AOD services.

After we had agreed on the analysis, I entered the data into the computer for comparison using NVivo (Bazeley & Jackson, 2013) to ensure I had not misinterpreted or imposed researcher bias, which could have influenced how the data were reported or

what information was shared (Fontana 2004, p. 721).

#### **4.8.4 Triangulation with the *CAN project* data**

Triangulation is widely used when different forms of data are sought to answer the same research question (Richards, 2010). Triangulation creates an opportunity to examine the phenomena from different perspectives beyond the numerical or narrative form to generate in-depth understanding of the context of people for whom the research findings and recommendations are pertinent (Bryman, 2004).

Therefore, cohesive triangulation of the qualitative data from this research and quantitative data from the *CAN project* was undertaken to provide an effective account of issues related to comorbidity services in the northern region of Adelaide. Linking both forms of data increased the reliability of the analysis (Mittchell, 2006). This was further confirmed by inviting the Aboriginal participants, MH-AOD clinicians and workers, and support service staff to participate in a CAN Aboriginal workshop with members of the wider local community.

#### **4.8.5 Summary of the analytical strategy**

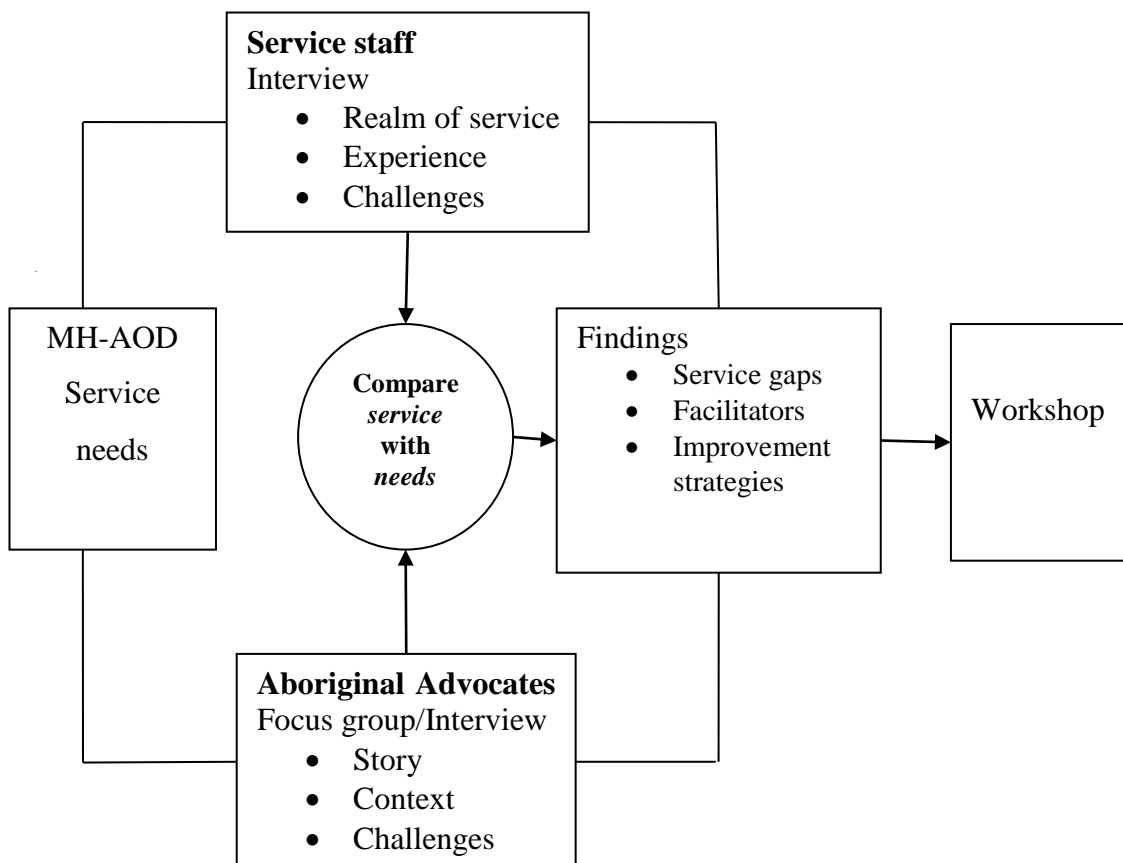
The analytical component of the overall research structure is depicted in Figure 4.4 (next page). “Service staff” includes the MH and AOD clinicians and workers, and the support service staff.

### **4.9 Research integrity and rigor**

Undertaking this project in the Salisbury and Playford LGA region of Adelaide, the local Aboriginal community people’s place of residence, added strength to its rigor, given that diverse participant involvement and the PAR approach are best experienced in the participants’ natural environment (Kowal, Anderson, & Bailie, 2005). Rigor had been established through the PAR “look, think, act and reflect” cycles. Members of the AWP, as “research partners” (Stringer, 2007), provided inclusive, practical and culturally-respectful means of engaging local Aboriginal people in seeking solutions to the problem of MH-AOD care. Further, triangulation of the data with the interrogated findings of the *CAN project* deepens the strength of the study’s rigor by demonstrating that the findings are credible, dependable, confirmable, reliable and transferable.

Integrity – trustworthiness endorsed through an audit trail, credibility, dependability, conformability and transferability (Golafshani, 2003) – was established through the

researcher’s ethical practice, interaction with the Aboriginal community and key informants, plus data triangulation. This research demonstrates trustworthiness and dependability by providing the “real picture” through meaningful collection of relevant data and analysis that clarified the results in order to implement PAR (Lincoln, Lynham, & Guba, 2011).



**Figure 4.4: Analytical component of the research structure**

The requirements for validity were also met by including, and listening to, people who have lived the realities of the research topic; it captured what it intended to measure in order to inform the research findings (Golafshani, 2003). Hence, the wider community, by inference, can use the findings to influence policy-making, procedural protocols and recommendations driven by research integrity (Lincoln et al., 2011, p. 645).

The research is also credible due to the researcher’s “prolonged engagement” with the Aboriginal community, which is an essential component of PAR informed by critical theory (Guba & Lincoln, 1994). If the researcher is a trusted member of the society being investigated, and colleagues and participants see her/him as a credible

researcher, the research can generate reliable information and an accurate interpretation that leads to a credible research outcome (Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011, p. 1722). Ensuring participation of Aboriginal community people and service staff with on-the-ground experience of MH-AOD made this PAR credible because it addressed issues of justice, equality and inclusivity (L'Etang & Theron, 2012).

Confirmability and reliability were achieved through member checking to ensure the findings came from participants' responses and not from the researcher's subjective interpretation (Golafshani, 2003).

Inter-rater reliability was strengthened by the Kaurna Elder/co-researcher's involvement in analysis and interpretation of the data, and synthesising this with quantitative data from the *CAN project*.

Transferability to a similar range of people in similar contexts with analogous MH-AOD service needs was ensured by the varied range of participants and the PAR method.

#### 4.9.1 Audit trail

An audit trail was maintained throughout the research process (see Table 4.2) to address credibility and present the actual picture of the phenomena under scrutiny (Robinson, 2003). The audit trail also provides transparency through its detailed tracking of the research process, which justifies the findings (Shenton, 2004). Guba (1981) accentuated the essential four criteria of credibility, transferability, dependability and confirmability to establish trustworthiness.

**Table 4.2: Audit trail – monitoring the research journey**

Quality criterion	Appropriate method	Activities
Credibility	PAR	Participation and engagement of people from northern region related to MH-AOD care of Aboriginal consumers
	Engagement with services	Government and non-government MH and AOD services, including related support services
	Engagement of community	Networking and consulting with local Aboriginal people and service providers from the north
	Establishment of working party	Aboriginal Working Party members comprising local Aboriginal people from the north was formed
	Debriefing	Discussion on problems faced by local people in accessing comorbidity services

	Internal scrutiny of tool	Conversational form of semi-structured interview was created with prompts
	Critique/reflection	Consultation and feedback from AWP and CAN research team members for reliability of the data collection
	Sampling	Purposive sampling
	Data collection	Personal interview, couple interview and focus group
Transferability	Context of study	The approach of participatory action research can be transferred
	Geographic location	Salisbury and Playford
	Economic	2 <sup>nd</sup> largest economically deprived region in Australia
	Demographic	More Aboriginal people live in this study's region
	Cultural foci	Aboriginal culture and experience of comorbidity problems
	Study problem	Comorbidity problems – AOD & MH problems Comorbidity services – Aboriginal-specific and mainstream comorbidity services, including support services
Dependability	Critical theory	Empowering participants regarding the required MH and AOD and support services for MH-AOD needs
	PAR	Participants from the Aboriginal community and service staff are involved in research as partners and informants to guide and find feasible solutions to address MH-AOD problems and design appropriate services
Confirmability	Data analysis and synthesis	Thematic analysis of the interview data Identifying emergent themes Inter-rater reliability by member checking the coded data with AWP members Formulation recommendations in collaboration with key stakeholders
	Triangulation	Triangulation of the data – Scoped services from the <i>CAN project</i> and data from this Aboriginal study
	Integrity of research results	Comparing and contrasting information/study findings from service staff and consumer participants through a workshop Provision of a conducive model or service framework to meet consumers' comorbidity needs
	Transparency	Transparent communication of the findings, analysis of the gaps and facilitators

As described in the previous section, this research met all of these criteria. The audit trail provides clear evidence that the findings emerged from the data and not from my personal predispositions.

#### 4.10 Conclusion

This description of the methods used to collect and analyse data has emphasised the importance of partnership and respectful trust-building to ensure genuine participation. This assured rigorous, trustworthy (valid), credible and transferable research outcomes.

The substantial strength of the PAR cyclic processes was that it began when key people were involved, then over a period of time the scope increased and participation was maximised (Champion, Franks, & Taylor, 2008). The PAR process was time consuming but because the task was meaningful, participants were keenly involved throughout the repeated rolling cycles of enquiry, working towards the goal of improving localised MH-AOD service provision in the specific context of the Salisbury and Playford LGA region in South Australia.

The next chapter describes the study's findings from the Aboriginal community people's perspectives (Aboriginal Consumer Advocates). The Kurna Elder and AWP members (20.2.2012), as co-researchers, strongly suggested that I present the findings chapters by first addressing an account of service-seeking pathways, events and working relationships between Aboriginal community people, MH and AOD clinicians and workers who currently service MH-AOD consumers, and myself. This was because, in their experience, this approach is commonly overlooked in studies and reports. I have adhered to their suggestion because, from their perspective, it is essential and makes a difference to whether a research project or program will work.

## 5 Findings I – Perspectives of Aboriginal Consumer Advocates

### 5.1 Introduction

This chapter presents the Aboriginal community perspectives and the analytical findings, represented by the 19 Aboriginal Consumer Advocate participants ('Advocates') who knew a family member or friend with MH and/or AOD comorbidity, and had experienced MH and AOD services in the Salisbury and Playford LGA region. All Advocates met the study's inclusion criteria (see Chapter 4, section 4.6.2). De-identified Advocates' words are presented in italic block quotations and coded to differentiate comments from individual participants' interviews (ACA)<sup>7</sup>, the couple interview (ACA – C)<sup>8</sup> and focus group discussions (ACA – FG)<sup>9</sup>. Any names that were mentioned are denoted as [name removed].

### 5.2 Thematic framework

The findings in this chapter are arranged in a thematic framework (see Figure 5.1) that clearly identifies the problems that Aboriginal community people encounter in relation to seeking services for MH-AOD comorbidity. This framework illustrates both the widening gaps and difficulties in accessing comorbidity care, and suggests strategies to narrow the gaps. The framework is also used to organise the findings from MH and AOD clinicians and workers (Chapter 6), and support service staff (Chapter 7), with minor subtheme variations.

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<sup>7</sup> ACA refers to coding for Aboriginal Consumer Advocates – individual interview

<sup>8</sup> ACA-C refers to coding for Aboriginal Consumer Advocates – couple interview

<sup>9</sup> ACA-FG refers coding for Aboriginal Consumer Advocates – Focus Group discussion



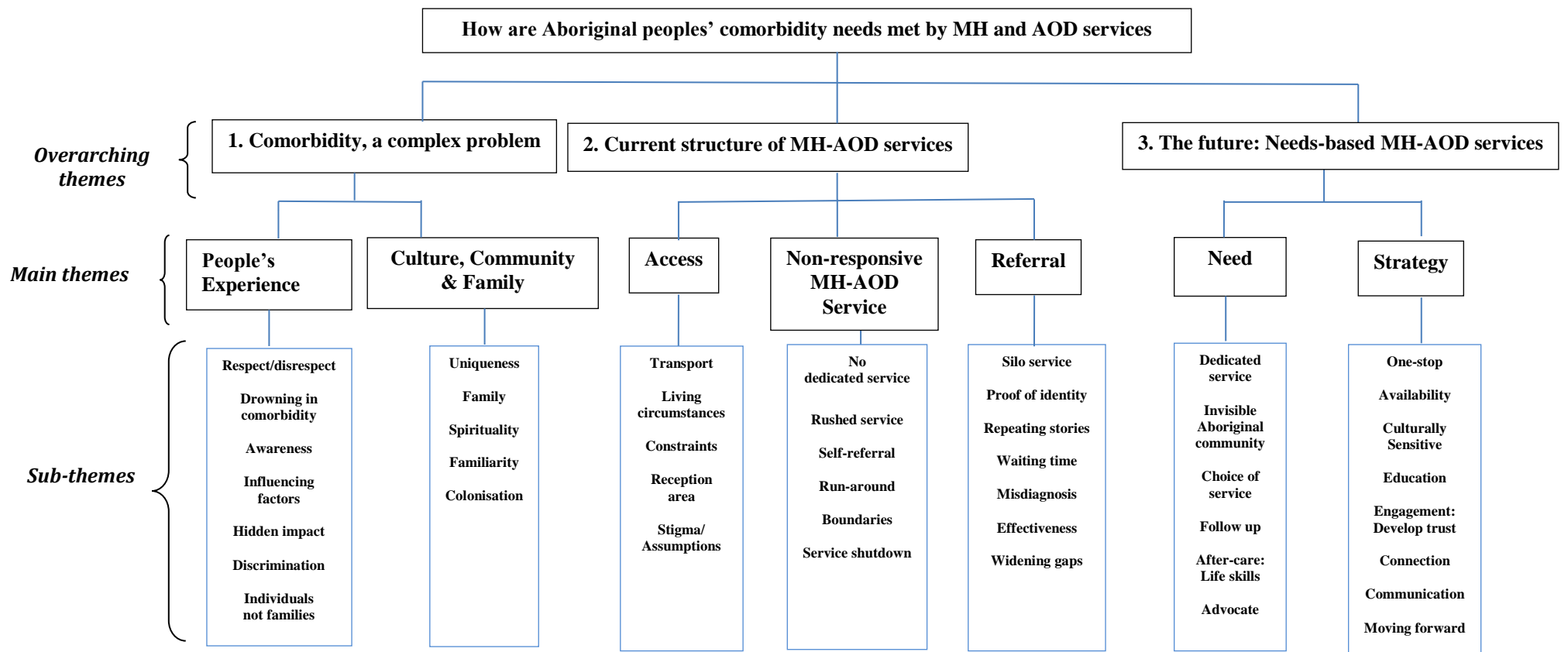


Figure 5.1: Thematic framework of comorbidity service needs: Aboriginal community perspective

### 5.3 Overarching themes

Three overarching themes arose from Advocates’ experiences of dealing with complex scattered and disconnected MH and AOD services and programs. These were: Comorbidity, a complex problem; Current structure of MH-AOD care; and The future: Needs-based MH-AOD service.

### 5.4 Overarching theme 1 – Comorbidity, a complex problem

The term “comorbidity” refers to the complex range of co-existing MH-AOD problems experienced by the study population. Many Advocates spoke positively about the services offered by MH and AOD clinicians and workers, but commonly talked of negative “experiences” from not receiving appropriate care for their complex comorbidity problems. MH and AOD clinicians and workers were most commonly considered as lacking any real understanding of, and respect for, Aboriginal “culture, community and family”.

#### 5.4.1 Main theme 1: Experience

“Experience” consisted of eight sub-themes, as summarised in Table 5.1.

**Table 5.1: Sub-themes and internal components of “Experience”**

<b>I Main theme: Experience</b>	<b>Internal components</b>
1) Respect / disrespect	Culturally-safe and respectful work Some staff not empathetic to consumer’s plight
2) Awareness of comorbidity	The person affected with comorbidity-related problems and the family are unaware of comorbidity Lack of awareness stops people from accessing and receiving the right service
3) Drowning in comorbidity	Mental health issues commonly seen with alcohol and drug comorbidity Family affected with interlinked comorbidity problems
4) Influencing factors	Mental health strongly influenced by cross-generational trauma <sup>10</sup> ; exhibited as negative emotions Young people at risk of alcohol and drugs

<sup>10</sup> Cross-generational trauma means intergenerational trauma. It refers to the unresolved compounding features of trauma experienced between generations due to the impact of colonisation

5) Hidden impact of comorbidity	Police custody and gaol Suicide Comorbidity cycle
6) Discrimination	Children are discriminated against Discrimination stops consumers receiving service Resilience and reconciliation
7) Individual not family	Individualised service is like repetition of assimilation

#### **5.4.1.1 Respect / disrespect**

*You get some fantastic people – you also get some not so fantastic people. (ACA – FG 8)*

Positive interpersonal experience with culturally-respectful clinicians and workers was considered a pressing need for Aboriginal people entering MH and AOD services or programs. Advocates had experienced committed staff as well others who did not “really care”:

*It’s about the people. ... they go around and see their consumers every week, once or twice a week – and they are people... on the hard drugs – and they’d be cursed and called everything and they’d still turn up ... over the years you see people getting better and better, and then they start walking around in society. (ACA – FG 9)*

*Some white workers are good – they patiently did their job in amongst the Aboriginal community. That’s the difference between respect and non-respect, and we pick it at 1000 paces. The ones that are only pretending, sooner or later words slip out their mouth and we know what those words represent. (ACA 6)*

#### **5.4.1.2 Awareness of comorbidity**

*People won’t admit that they’ve got it. ... It’s ... getting more open now. (ACA – FG 10)*

Advocates identified that when an individual is aware of their mental illness, it is easier to connect them to appropriate services. Commonly, individuals are unaware of their comorbidity. Others see they have a problem but do not understand comorbidity or how

to support them:

*We had a few mental people but we used to run away ... because we didn't want to confront them. We thought they was a bit "boonta"<sup>11</sup>. (ACA – FG 10)*

*Nobody tells you anything and she's not well. She's embarrassed about it all. ... I didn't know what I could do to support .... (ACA 2)*

*This young lad ... was going out with his peer group and they were all smoking marijuana together. So the mother decided ... "I'm going to stop my kid from hanging around all these other kids", so she decided to go out and purchase marijuana so that he can smoke it in the house, so she can monitor him. Her intentions were good, but ... all wrong. (ACA – FG 9)*

A focus group discussion suggested that early education about drugs, alcohol and smoking might help Aboriginal children develop resilience for a better future:

*I taught my kids about the dangers of drugs, smoking, all those things and you have to be good citizens. Once they got to year 12, my job was finished... (ACA – FG 10)*

#### **5.4.1.3 Drowning in comorbidity**

*A lot of ... our mental health issues ... are alcohol and drug related. (ACA – C 7)*

Advocates highlighted profuse comorbidity issues affecting physical, social, emotional and spiritual wellbeing among a minority of the people in the Aboriginal community, which overwhelmed individual, family and community wellbeing:

*The majority of us are doing alright in a way but the minority are really iron level needy people. (ACA FG – 10)*

Anxiety, stressful situations, insecurity and loss of loved ones, particularly removal of children, were identified as contributing to higher associated MH and alcohol problems:

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<sup>11</sup> Boonta: An Aboriginal word for "mad"

*... she is a good woman but if she hasn't had drinks by 10 o'clock in the morning she is vomiting. ... how do we fix her mental health when they took her kids away for no reason? ... split them up and put them into abusive households – how do we fix that? (ACA 6)*

Focus group discussions highlighted each situation's unique nature and inter-generational “drowning in comorbidity”:

*Every case is different. Sometimes it's the parents that are the problem and sometimes it's the kids' problems ... you've got to take it on a one-on-one basis. (ACA – FG 9)*

#### **5.4.1.4 Influencing factors**

*People don't become alcoholics or drug addicts when their mental health is good. So, you have to look at what affected their mental health. (ACA 6)*

Advocates understood that a combination of persistent problems affect individuals' long-term MH:

*Inter-generational inequality ... unemployment, exclusion, people telling you that you're shit all day long, will have an effect. (ACA 6)*

*... they carry around with them a lot of negative emotions. I always say that a negative emotion is one that we've never dealt with – once you're dealing with it here it's easy ... to move on. (ACA – C 7)*

Many highlighted the link between a disruptive family structure, mental ill health, and AOD comorbidity, with young children learning high risk alcohol and drug habits earlier in dysfunctional environments:

*It's our young ones at risk ... sometimes it's their parents too ... they learn that sometimes from older brothers and sisters, and mothers and fathers also could be on drink and drugs. So it's ... passed down. (ACA – FG 10)*

#### **5.4.1.5 Hidden impact**

*Poverty....hardship... funerals... it infuriates me. (ACA 6)*

All Advocates spoke about the devastation for family and community from witnessing an individual with comorbidity, its profound effects on children and the impact of no

available service (see Figure 5.2, page 112). One mother shared her story:

*One lad, he had lost his grandfather who was raising him, he'd lost his father and his best mate was killed in a car accident [clears throat]. He was able to cope with all the death until his best mate died in an accident. When that happened, I watched an impact. For, including my own son, the impact was that strong that they couldn't go to school and cope or function, so they started wagging school, then started to self-medicate with marijuana ... They couldn't get any help so they turned to Ice. These kids were robbing like you wouldn't believe. They are starting to get worse, telling themselves they are no good and they may as well be in [juvenile detention facility name removed]. What hope is there, what future is there, whatever is there? ... To know and watch them, all of this was such a terrible, terrible mess that would have impacted their lives and changed their lives to something they don't need. (ACA 6)*

Advocates discussed comorbidity's hidden impact in terms of police custody and gaol, suicide and a never-ending cycle of relapsing comorbidity:

*Look at our kids, I'm saying now after getting in prison, ask an adult inmate where their recidivism started from? Juvenile! ... lock them away from the drugs ... when they get out they probably go back on it ... do crime to pay for them ... a really ... vicious circle ... (ACA 6)*

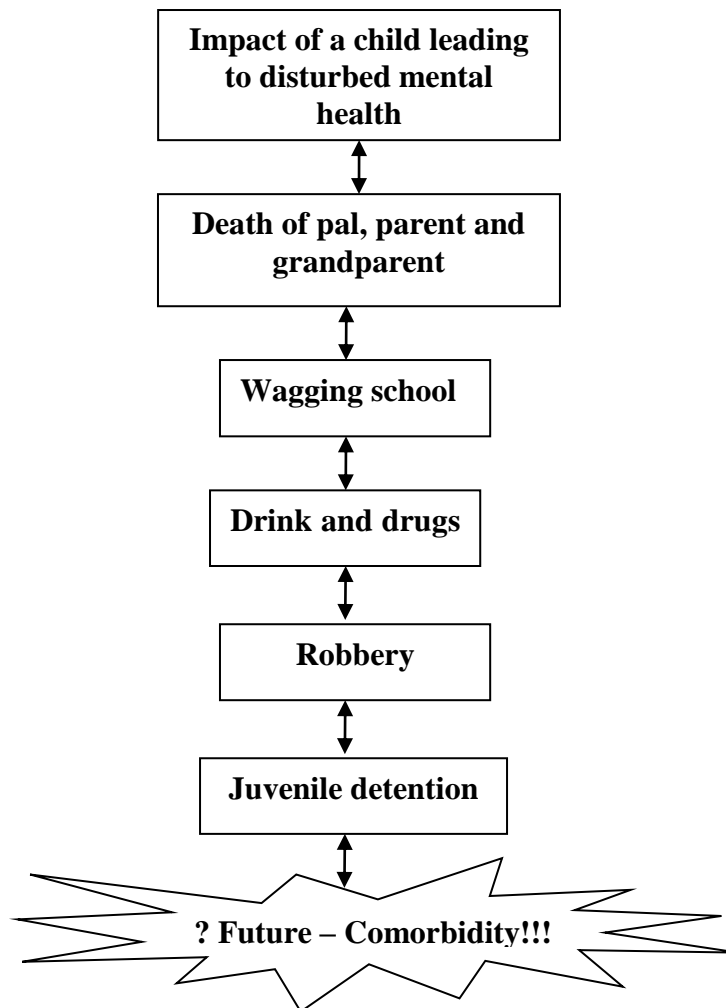
*Their home lives are not structured ... there's no food, money ... it's just their lives in general [says it slowly and looks emotional]. It's easier for kids if they're in [gaol, name removed]. Someone said, "I like it in gaol because I have cake on Fridays" [looks sad with a silence] (ACA– FG 10)*

*It's supposed to be against the law to commit suicide, yet we watch them kill themselves every day. (ACA 2)*

*I've known people, they suicide [looks very sad], they're just caught up, some people do get help but others just go to gaols [clears throat] ... they still get their drugs. They continue on the cycle. (ACA – FG 9)*

*They've never met them or talked to them. They took him out and put him in the [juvenile detention facility – name removed]. He got very angry. When*

he got released he ended up drinking too much, died in parkland. (ACA – FG 8)



**Figure 5.2: Flow chart on hidden impact of MH-AOD comorbidity**

Advocates emphasised the benefit of “getting all (consumers) around the table” to find a solution to support these “kids” with normal day-to-day activities, and provide a “holistic” and “productive” health and wellbeing comorbidity strategy. They singled out the ineffective and extended referral process as a suicide factor; “Referral to nowhere”.

#### **5.4.1.6 Discrimination/racism**

Discrimination/racism flows directly from colonisation. All Advocates spoke about the impact of trans-generational discrimination that Aboriginal people face in the health care system and all facets of life:

*Discrimination! ... Discrimination is rife, instituting discrimination through the medical system ... it's bad. (ACA 1)*

*I reckon my daughter teachers, they ... treat them like dirt ... She left high school because she couldn't handle that bitchiness .... (ACA – FG 8)*

*... If the whole world is telling you you're an "arsehole"<sup>12</sup>, why don't you think you're not? So our kids have got very fragile mental health to start with. ... How do we get them to year 12? How do we make them doctors? How do we make them lawyers? The systems are broken. (ACA 6)*

#### **5.4.1.7 Individual not family**

*Was your family included for those services? No! [silence] (ACA – FG 8)*

Advocates expressed frustration with the “individual-focused” system, which excludes family and goes against Aboriginal ways of doing things. They called for a serious rethink:

*My daughter suffered from bipolar and flat out even though we knew what was going on with her, we saw the symptoms on a daily basis, we were excluded from any discussion because she was over a certain age. ... It's like, “NO! NO! We are just going to deal with her ... every second time she went into hospital it was some sort of other disorder ... we all broke down. (ACA – FG 8)*

*Service providers have a major gap and really they've got to come back and think seriously about their priorities. ... senior managers down to even the cleaner. (ACA 1)*

#### **5.4.2 Main theme 2: Culture, community and family**

“Culture, community and family” consisted of five sub-themes, as summarised in Table 5.2.

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<sup>12</sup> ‘Arsehole’ means ‘bad and useless’



**Table 5.2: Sub-themes and internal components of “Culture, community and family”**

<b>II Main theme: Culture, community and family</b>	<b>Internal components</b>
1) Uniqueness	Aboriginal culture is diverse and unique
2) Family	Importance of family Inclusion of family in service Exclusion of family in the current service system
5) Familiarity	Major disconnect between Aboriginal and non-Aboriginal community understanding
4) Spirituality	Ngangkari <sup>13</sup> Spirituality not recognised Rebuilding spiritual connection Church and faith
5) Colonisation	Continued impact of colonisation Cross-generational trauma Non-recognition of Aboriginal culture is similar to assimilation

#### **5.4.2.1 Uniqueness**

Advocates stressed the need to recognise Aboriginal culture’s uniqueness and diversity to deliver culturally-appropriate and safe service:

*We are so diverse and our cultures are different. Nation to nation, then they turn around ... But that’s our way. It worked for us before they got here. (ACA 6)*

They felt that cross-cultural training would help bridge the culture gap between service providers and Aboriginal consumers, and boost consumer trust:

*People are scared. A lot of cross-cultural stuff needs to keep happening so they understand the importance of culture and family .... (ACA 2)*

#### **5.4.2.2 Family**

*Families help and not judge. (ACA 3)*

All Advocates highlighted the importance of family and understanding what “family”

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<sup>13</sup> Ngangkari means traditional Aboriginal healers

means for Aboriginal people, particularly in terms of family inclusion and support in comorbidity service provision to “push people along”:

*When I say “family”, to really understand, it’s extended family, it’s relations that are married in, they’re all your family. ... If anybody is left out they get their nose out of joint. ... “I’m their first cousin”, “I’m their aunty”. (ACA 2)*

*I remember there’s a lot of that. ... When your family’s there saying, “Come on, we are here to support you, you’re worth more than that, let’s work it”, we know this because your family’s saying this. (ACA – FG 8)*

### **5.4.2.3 Familiarity**

*See, we come from a community where there is a caring and sharing. Like everybody looked after each other, there’s that like leadership and it was a strong community. (ACA – FG 9)*

Advocates spoke widely about a major gulf in “familiarity” between Aboriginal and non-Aboriginal cultures:

*This is my bro, I grew up with him... She [refers to non-Aboriginal person, name removed] goes, “Oh, us white fellas would never do that”. See, that’s the difference between you and us because we’re one big extended families, we all do it. We’re all very familiar with one another ... and we know our limits too. (ACA – FG 9)*

*How they white fellas live so independently, like it’s just their family, that’s all that matters. Like they drive past their cousins who are being evicted in the street and then go home and talk about it to their partner. But we would be throwing things in the car and taking them to live with us ... I find non-Aboriginal ways of living very strange. (ACA 6)*

Advocates also explained the need for Aboriginal and non-Aboriginal cultural familiarity in mainstream health care services:

*... everybody is doing the right thing and coming down to visit him and stuff like that, but the staff ... can’t fathom how to handle it. They don’t know enough about Aboriginal people to feel comfortable and secure ... (ACA 2)*

#### **5.4.2.4 Spirituality**

*Sacred sites are now car parks ... ridiculous! ...we can't even get buried for nothing in our own country. That's wrong. (ACA – FG 9)*

Advocates explained spiritual wellbeing as the core of Aboriginal people's holistic health, with sickness being “interrupted spiritual wellbeing”. They advocated for “Ngangkari” to help heal “broken” spirits”:

*If there is someone giving them good advice and connected back to family and community, that's the way to get somebody back to health ... to gain their spirit. ... Aboriginal doctors [Ngangkari] would take them back to country to sit around that campfire and listen to the stories, work out a balance and a harmony again. What's good, what's wrong, to readjust and really look at your life with somebody that's trained. (ACA 2)*

*If we look back to primal times [Ngangkari] would have been the ones ... they know how to pump them up, and these people need to be identified and used. (ACA – FG 8)*

Some emphasised the importance of maintaining spiritual connections with their church and faith, but warned not to force this on others:

*Christianity seems to work hand in hand with a lot of people with mental health. So I'd say be gentle ... don't push it down their neck because they are very fragile. (ACA 2)*

#### **5.4.2.5 Colonisation**

*Uncle Charlie Perkins summed colonisation up perfectly, beautifully, in one line, “We don't live in the past, but the past lives with us”. (ACA 6)*

Advocates stressed the ongoing negative impact of the unresolved trauma of colonisation in terms of comorbidity that resulted in dysfunctional families and communities:

*Where does all of that come from? ... How did it get into the family and just like a contagious disease that goes right through the family? A lot of that comes through the traumas they have suffered in the past. (ACA1).*

*We're all going through a cross-generational trauma and that's sort of been handed from generation to generation and it all starts back through ... settlement when white fellas came... (ACA – FG 9)*

*Accept and acknowledge that's (trauma) what we're experiencing rather than we're just lazy, wanting to not work, wanting to use drugs, wanting to beat our families; until they accept responsibility we will continue. We still believe we are going down the pathway of ... cultural genocide. (ACA 6)*

## **5.5 Overarching theme 2 – Current structure of MH-AOD care**

Advocates described serious MH-AOD service gaps due to current “siloed” MH and AOD service structures. Gaps were identified particularly in terms of “access”, “non-responsive comorbidity service” and “referral”. The most crucial issue was that people were continually “running around” to find culturally-appropriate MH-AOD services.

### **5.5.1 Main theme 3: Access**

“Access” consisted of five main themes, as summarised in Table 5.3.

**Table 5.3: Sub-themes and internal components of “Access”**

<b>III Main theme: Access</b>	<b>Internal components</b>
1) Transport	Some services provide transport Need to travel to many services Financial difficulties
2) Living circumstances	Living conditions not asked or assessed Mobile lifestyle Require supported accommodation
3) Constraints for traditional Aboriginal people	Fear Language Alien hospital environment
4) Reception area	Some moody people Attitude in reception can turn people away from service Receptionist needs cultural awareness
5) Stigma/Assumptions	Stigma of mental illness Fear and shame to get to MH-AOD services

### **5.5.1.1 Transport**

Over half of the Advocates had no car and expressed concerns about poor transport options reaching appropriate health services. The remainder relied on local support agencies, family members or public transport. Those who did not express such concerns tended to use MH and AOD health services more:

*We've got some Aboriginal help here, so if a person is sick ... can get picked up and taken to [name of Aboriginal service]. ... Some are very vulnerable and lack confidence; they need that support ... it's their self-esteem, they'll access it by themselves but it's just that initial stage. ... more dollars need to be put into services to keep the programs running. (ACA – C 7)*

Travel costs and sickness impacted the ability to travel and “strangled” comorbidity care through missed appointments:

*You might be too ashamed to tell someone that you haven't got \$2 to catch a bus and that you're hungry, let alone worrying about going because you've got no \$5 to get your medication anyway. (ACA – FG 8)*

*Mental health has made me that violent I'm worried I'll lose control and hurt somebody ... I warned the Motor Vehicles application form that I have fainting spells and I'm fair dinkum<sup>14</sup> about not wanting to drive ... (ACA 4)*

They also appreciated the few supportive specialised Aboriginal services, although they lacked specialist comorbidity services:

*You've got [name of Aboriginal service removed] that helps out a lot. I think all they've got is just the outreach workers and nurses and transport drivers. You're still missing gaps. You've got to go all the way ... into the city to see a specialist. (ACA – FG 9)*

### **5.5.1.2 Living circumstances**

*Are you going back to a house where you're going to be mentally, physically and sexually abused? Are you going to take your tablets regularly? No, when I get home somebody will most likely steal them! (ACA 1)*

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<sup>14</sup> 'Fair dinkum' means 'serious'

Individuals' poor living conditions were identified as important in determining their ill-health. Advocates expressed frustration that services excluded this information from assessments:

*... you're excluded. Your information is not even ... [silence] they don't even ask for that information. (ACA – FG 8)*

*A lot ... have no accommodation, they're just couch surfing. They're going from here, there and everywhere ... (ACA – C 7)*

*Kids camp in empty buildings in the cold weather but some other people are supplying tents and that to camp in the parklands like they do in tent city. (ACA 4)*

Advocates suggested that supported accommodation with health education and health support would assist people with MH-AOD

*Have a few more houses for people who have mental health, and separate in case there are some bizarre behaviours or any fear of something happening. So they just can walk away in supported accommodation ... serviced by their own doctors, their own health workers, who visit on site with case manager to see they are getting everything they need ... (ACA 2)*

### **5.5.1.3 Constraints for traditional Aboriginal people – Fear, language and alien hospital environments**

*You never did belong anywhere and you were very lost... You no longer understood. (ACA 6)*

Advocates identified that Adelaide's northern regions have many Aboriginal people coming in from traditional remote regions and suffering fear and anxiety when entering health services, mainly because of enclosed spaces and not speaking English well:

*I suffer from panic attacks. I think a lot of Aboriginal people suffer from panic attacks. We don't feel comfortable; it's not a situation where we have some sort of control. (ACA 3)*

*Absolutely panicked in like cell rooms, in security locked, it's like prison, not being free. ... They feel very powerless, very scared in an alien hospital down here away from family and friends, it's just too far to come and visit*

*them ... They would want to die. They need to be out under the open skies ... in a spiritual journey place where they feel connected ... a supported environment (ACA 2)*

*Local language and stuff like that. Because a lot of people with language but they don't know anybody that can talk language to them. (ACA 5)*

*We don't speak English as a first language and our words come out wrong. Sometimes we end up more in the shit than we were if we just shut our mouths. (ACA 6)*

Consumers not understanding medical jargon was also a constraint:

*Them doctors, they've got to talk in human terms, not medical terms, because a lot of our people did not understand ... their medical jargon ... (ACA 4)*

#### **5.5.1.4 Reception area**

*Need to be a little more skilled. (ACA – FG 8)*

Focus group Advocates said the reception area needed to make consumers feel welcome. A “gatekeeper’s” (reception staff) “wrong attitude” (lacking effective communication skills and cultural awareness) could turn a health care institution into a scary place:

*Going into services to get somebody at the desk it's like, “And what do you want?” ... that person can just turn around and walk straight out if that girl gives her attitude. (ACA – FG 8)*

*Sometimes we have problems with people at reception ... where an Aboriginal person will come in, they just have to be looked at wrongly and ... That's why all staff have to go through cultural awareness training programs, even the receptionist. (ACA – FG 9)*

#### **5.5.1.5 Stigma / Assumptions**

*They didn't want to be seen, seeing that they've got a mental illness. (ACA – FG 9)*

Advocates pinpointed stigma as a deterrent to seeking MH or AOD services:

*There is a lot of stigma. I think they want to be... away from public eyes, be in a home for a while; they get medicated and stabilised. (ACA 2)*

*A lot are really embarrassed to ... go to those services. So we've got to find ways we can work with these young fellas and get them ... where they can get the support they need because stereotyping and stuff, that happens ... (ACA – C 7)*

### **5.5.2 Main theme 4 – Non-responsive MH-AOD service**

Six sub-themes arose within “non-responsive MH-AOD service”, as summarised in Table 5.4.

**Table 5.4: Sub-themes and internal components of “Non-responsive MH-AOD service”**

<b>IV Main theme: Non-responsive MH-AOD service</b>	<b>Internal components</b>
1) No dedicated MH-AOD service	System of service failed Services not equipped for traditional Aboriginal people No linked service from prison
2) Rushed service	Too quick to medicate Drug history not assessed in depth No interaction with family and consumer is too sick to listen
3) Self-referral	People have to self-refer Self-referral doesn't work People are too sick and unable to self-refer
4) Run-around	Appointments for many services
5) Boundaries	Work timing
6) Service shutdown	It is a lip service Stopping of Aboriginal services Pilot programs create a belief and then stop

#### **5.5.2.1 No dedicated MH-AOD service**

*The system failed them and failed badly. (ACA 1)*



All Advocates stated that there are “no comorbidity services” in the northern region to assess, manage and treat complex comorbidity problems:

*There’s never been any service to control it. (ACA – FG 10)*

*Nothing – here’s nothing, really. ... ‘What would stop a person from receiving care?’ Same thing – No services, gaps in service [silence]. (ACA 5)*

*There is not one place because doctors that we get are just local GPs, and to get other appropriate services you need a referral system. ... I ask for my own referral. If you don’t get a referral you can’t get checked by a specialist. ... They can’t go to one place and say, “I’ve got drugs, alcohol, mental health”. (ACA 1)*

The main message from participating parents was ongoing lack of services for children:

*We are banging our heads on the wall even harder. For 30 years there have been no programs for alcohol and drug support for kids under 16, but our kids are into drugs by 12 because of the disengagement and the harassment at school ... (ACA 6)*

*I had to take my son home and watch him 24/7 for a good week until he came completely out of it. I don’t know if they’ve got a service under 16 – that’s a huge gap. (ACA – FG 9)*

A parent’s first-hand account of a real life incident highlights the issue:

***Could you please tell us a brief story of a person who had combined problems of mental health, alcohol and drug services?***

*My son! [...silence]*

***Was it easy for him to get the services that he needed?***

*No – he doesn’t even now still have any services. [silence]*

***Has he approached any services or did any people from the service centre come and help him?***

*I think there is people been in for helping him – I don’t know who [silence... looks concerned, looks through the window]*

***What do you think will help people in such a condition?***

*A drying out centre! For both the alcohol and ... drugs. Like a house. But they've got nothing in the northern areas ... even for the people that come out of gaol they've got nothing. (ACA 5)*

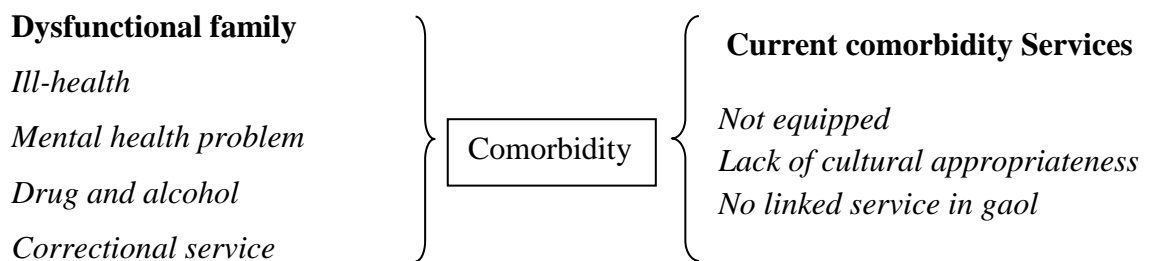
Nor are services equipped to deal culturally-appropriately with traditional Aboriginal people:

*They think they know what they're doing. ... they try to do their best, but culturally they're not delivering the best way and we know how it works; they won't do that. (ACA – FG 9)*

Advocates were concerned about the lack of interlinking between gaol and comorbidity services, particularly because:

*... the highest amount of first time diagnosis for mental health is made within the correctional services facility. ... But what do they then do? Nothing. ... The gaps are everywhere. (ACA 6)*

Figure 5.3 depicts the comorbidity problem and consumers' reality that there is currently no available dedicated MH-AOD service:



**Figure 5.3: Flowchart of “no dedicated services” for comorbidity problems**

**5.5.2.2 Rushed service**

*They just deal with the issue, they don't deal with any history. (ACA – FG 9)*

Advocates held deep concerns about rushed assessment and treatment management, feeling the focus was on medication at the expense of communication and family involvement:

*I don't think they are getting a true account, they are too quick to give drugs ... they are just giving them a cocktail. Medicate them or whatever ... but at least have that family support and go out of your way to build that so there is ongoing care after they have finished with the hospital system. (ACA 2)*

*... my experience with a psychiatrist. ... I think they find that the easiest thing to do sometimes, just pass out medication and that's their answer. That's how I felt but I admit it does help a bit, the medication. (ACA – FG 8)*

### **5.5.2.3 Self-referral**

*Our system is about putting up your own hand and asking for help. People with mental health issues don't usually do that. They don't have the confidence or maybe their illness is just preventing them; it's just too hard.*

*(ACA 2)*

All Advocates were concerned that “self-referral” did not work well with Aboriginal community people; many were “falling through the gaps”:

*It's left up to our 15 or 16-year-old child to wake up and say, “This is not good for me” ... (ACA 2)*

*They don't know what to say ... not going to say anything. (ACA 1)*

Advocates highlighted that self-referral further widens the gap in seeking help, stressing that even people who can self-refer still need proper support:

*Yeah... I do most of my own stuff. I still get help if someone can give me help. I'd rather for them to call me and tell me when to go and see them because I try to ... [Silence thinking] he said he would get back but I haven't heard ... (ACA–FG 8)*

### **5.5.2.4 Run-around**

Running around for services was a common scenario for individuals with MH-AOD comorbidity. The following story highlights the system's complexity and its detrimental effects:

*... this poor woman lives in a tiny little housing trust house. Her adult daughter with three children, and pregnant, had returned home. She has*

*mental health and drug issues. The next daughter down had been the victim of a crime and she had been hit in the head with a baseball bat, so she had mental injuries, then she had the little one who is like 10 or 11, she's trying to get her to school. We went to housing straight away and asked could we get like the daughter a house because she had overcrowding. "Oh no, we can't help you with that". Then we went to the mental health service. "Can you support them?" "Oh, she's got drug issues. NO, it's a drug problem thing". ... In the end, while we were mucking around fighting with all these services, welfare came and took her daughter, so with that she jobbed<sup>15</sup> her husband. Welfare, now they've got her daughter. ... (ACA 6)*

Advocates stressed that having to “run-around” to many services caused some consumers to give up:

*The fact that you have to go to five or six different appointments just to try and have your issue addressed ... you go through one step first, then to another before you finally get what you're wanting. It's just a long and drawn-out process; people get frustrated ... (ACA – FG 9)*

#### **5.5.2.5 Inflexible boundaries – work timing**

*They would rather do the 9 to 5 and that's it. (ACA 1)*

Many Advocates spoke strongly about services' inflexibility – “stubborn boundaries”, such as hours of availability (9am–5pm Monday to Friday only) and separated specialised types of care – although one gave them “marks” for trying:

*Boundaries have been created by non-Aboriginal people to basically keep Aboriginal people in them and ... these organisations should be getting together and saying, “This is what we should be doing”. (ACA 1)*

*... very hard to get into the service. ... “It's Friday and we don't want another thing to do”. (ACA 2)*

*He said something like, “I've opened up on Saturdays. Normally I don't do Saturdays but I've opened up Saturdays for you”, and it's like, “You're just rude”. (ACA – FG 8)*

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<sup>15</sup> ‘Jobbed’ = punched/hit

*... to be quite blunt, I think health is the only sector that's half functional.  
(ACA 6)*

### **5.5.2.6 Service shutdown**

*They can stop the lip service and start actually giving us a service. (ACA 6)*

Individual interviews and focus groups both highlighted how small programs come and go, grossly affecting the individual's trust:

*They talk it, they lip service it, it's written everywhere, write up framework after framework, we've got the Aboriginal mental, social and emotional framework, we've got the drug and alcohol framework. National all of them, but they're not ... mandatory. (ACA 6)*

*There's been so many little "pilot programs" ... they only go for six months, get everybody worked up into thinking that something big is known to be created and then the funding stops. They don't want it to happen. (ACA – FG 10)*

### **5.5.3 Main theme 5 – Referral: Fishing for Nunga places**

Major issues in "referral" are discussed as sub-themes, summarised in Table 5.5.

**Table 5.5: Sub-themes and their internal components related to "Referral: Fishing for Nunga places"**

<b>V Main theme: Referral: Fishing for Nunga places</b>	<b>Internal components</b>
1) Silo service	Silo services widen the gap Located far away from normal living environments Aboriginal people panic in isolation
2) Proof of identity	Proof of Aboriginal identity
3) Repeating stories	Repeating the same story again and again
4) Waiting time	6 week–6 month waiting period
5) Misdiagnosis	Keep changing diagnosis Hard to reach service
6) Effectiveness	Unfriendly service No straight answer Not listening

7) Widening gaps	Assessment leads to referrals Can't handle so refer Long frustrating process in referral to specialist
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### 5.5.3.1 Silo services

#### *Stop hiding inside silos! (ACA 6)*

Advocates spoke of services being in “silos”, isolated from other each other and the real needs of Aboriginal people experiencing MH-AOD comorbidity, managing only MH or AOD problems, and difficult to access:

*Silos! So they can protect their own funding. But this becomes such a dog-eat-dog war over the money because it is unaccountable funding; no one wants to work with anyone in case you need to see our budget. What's the point? ... this stuff is ... calculated. (ACA 6)*

*If you talk about comorbidity, you should ... talk about the gap because we've got a gap and until we fix it, until services stop providing services in a silo approach, we always going to have the gap. (ACA 1)*

*The mental health there [name of the service], they are out the way of everyone. (ACA – FG 9)*

### 5.5.3.2 Proof of identity

*You've got to prove that you are an Aboriginal. No, you prove that I'm not, that's how it should be. (ACA – FG 9)*

Focus group Advocates spoke about the irony of certain services requiring them to undertake a drawn-out process to prove their Aboriginal identity, having to reapply for original documentation each time proof was required:

*It took 29 years to find out I'm black – Legal Rights did the sign off ... I went to the doctor for a check-up and he did an eye check-up and he said, “You know you're colour blind”. I said, “I thought I was black”, and I went back to work and they said, “How did you go yeah?” “I just found out I was colour blind!” [laughs] Thank goodness we can laugh about it; if we didn't we would cry [a long silence]. (ACA – FG 9)*

*We've got documents around the place that shows what we call "dog tags". You had to carry a piece of paper on you that showed you were allowed to walk through. (ACA 6)*

### **5.5.3.3 Repeating stories**

A consistent reality for Advocates was the difficulty of getting any comorbidity service without going through various health care settings that required them to constantly repeat their stories:

*Repeating what you've already been told to a point. I guess one of the stand-out things, people are repressive. (ACA – FG 10)*

*He has to go to different workers every single time and repeat his story (ACA 6)*

### **5.5.3.4 Waiting time**

*Try getting into a 12-week program, you've got a 6-month wait. (ACA 6)*

Advocates talked about how the long waiting time to receive specialist comorbidity care, coupled with service unavailability, created additional problems:

*It is as if you look at us or our people who are going to go there, trying to get into [Alcohol detox service name removed]. They say you've got to ring there every week. I tried to ring them once, twice, three times and they tell you to ring back ... next week or the week after or the week after. ... it's easier for them if the cousins say, "Come over here and have a blast", and they are drunk. (ACA – FG 9)*

*How can people wait 6 months to get in and get support for drug and alcohol they been detoxed from? (ACA 6)*

The prolonged waiting time was a major stress because if consumers miss an appointment, they must wait all over again:

***Grief! Length of time for the appointment 6 to 8 weeks. That's the length of when I ring up to get some support and it might be because some funeral that's happened or someone's passed, but by the time I get there, somebody else has passed. There was another funeral. And now ... I haven't got time***

*to go down to appointment because I've got to go up the river ... and do family business. ... then I miss my appointment and I've got to wait another 6 to 8 weeks. Life's too difficult. ... **It took us two years of fighting in the system or fighting the system to actually get a psychiatrist.** (ACA – FG 8)*

#### **5.5.3.5 Misdiagnosis**

*They just keep changing the diagnosis. (ACA 4)*

Advocates described the confusion, misdiagnosis, multiple diagnoses and resultant lack of appropriate treatment caused by multi-agency involvement, too many links between health professions and inadequate cross-communication, leading some into deep depression:

*Hospital has diagnosed one thing, he's taking that religiously. His doctor has diagnosed something else and suggested you take something else, so he's taking both of them, there's no communication between both; he's over-medicated. He can't do his job, which goes very badly for his mental health. ... (ACA – FG 8)*

*You go out and you have the same problems, so you come back again ... the missing gap's for when they come out. Instead of referring you on to an agency to keep an eye on you, they just say, "See you next time. I hope not to see you anyway but we know we will, but [silence] .... (ACA – FG 9)*

*Some days I've been known to pull the blankets back over my head because it's just too overwhelming ... (ACA 6)*

#### **5.5.3.6 Effectiveness of referral**

*Have it people friendly. (ACA 4)*

An Advocate who tried to get his daughter checked said that when services are unfriendly, it is harder to make them understand consumers' needs:

*What I'm saying is that I didn't find them very friendly, very involved, they had a job to do and they were doing it and it all just seemed quite cold and clinical ... I rang [acute care response service name removed] but they didn't want to come. ... eventually they said, "OK, we'll come", and then the doctor said, "Yeah, she is very unwell". (ACA 2)*



Advocates reported that consumer policies and protocols were not conducive to meeting the individual's or their family's needs, and hampered recovery:

*Bad service providers! People not listening to what they are saying and no they didn't get well. ... it's not just yesterday, it's the children, it's the grandchildren. They are still not well. (ACA 1)*

### **5.5.3.7 Widening gaps – “pushed off”**

Most Advocates spoke about the complexity of, and gaps in, referrals because there is no single service where people can receive the comorbidity care they need, nor is there continuity of care from the point of referral; just more referrals. The drawn-out referral process left children particularly prone to slipping back into comorbidity problems:

*Once got assessed and ... you know that only so much can be done and so therefore once completed all that you have to do... [raises eye brow] refer on to other people ... There's gaps in the services ... they're a bit frustrated. (ACA – FG 9)*

*I could say something about kids in services. It's the services who usually push them off to a doctor who end up getting medicated on something. ... they just want to medicate them. (ACA – FG 8)*

*They could be trying to correct it now while they are young, but none of that is happening ... No planning, no nothing. ... she is back to smoking dope again and drinking, obviously going to head to another drug psychosis. (ACA 2)*

In spite of the widening gaps, focus group Advocates discussed their interpretation that referral does not simply mean passing on the responsibility to another service:

*Refer them off doesn't mean that...[silence] ... still chase them up and see how they're going, find out where they at, talk to that other agency and find out what they're doing for them. That's when you stop chasing and start asking. You've got to continue that monitoring ... (ACA – FG 9)*

## 5.6 Overarching theme 3 – The future: Needs-based MH-AOD service

Asked about future comorbidity service provision, Advocates spoke about needing an overarching, needs-based, dedicated MH-AOD service. This should encompass all relevant services and programs in one place. “Need” and “strategy” emerged as the two main themes.

### 5.6.1 Main theme 6: Need

“Need” consisted of six sub-themes, as summarised in Table 5.6.

**Table 5.6: Sub-themes and their internal components related to “Need”**

<b>VI Main theme: Need</b>	<b>Internal components</b>
1) Dedicated service	Need service in north Need services for children Need Aboriginal people to be more involved
2) Invisible Aboriginal community	Minority and not priority Years of neglect Second class citizens
3) Choice of service	Appropriate and confidential Aboriginal service Culturally-appropriate mainstream service Good mix with Aboriginal and non-Aboriginal people with Aboriginal ownership
4) Follow-up	No follow-up for mobile people No home visit No follow-up from Prison and Child detention centre Follow-up service helps individuals get back into community
5) After-care: life skills	No after-care employment service
6) Aboriginal advocate	Aboriginal advocate not consistently provided Adults need support Children need mentors

#### 5.6.1.1 Dedicated service

*We need more comorbidity services. ... Is it not better that the people decide what they need? (ACA 6)*

All Advocates stressed the urgency of addressing the northern Adelaide Aboriginal community's comorbidity service needs, particularly the intense need for children's comorbidity services:

*I think now there's more Aboriginal people living here in northern area than living down in ... western area, so they need to start working and making sure that the services are there. (ACA – C 7)*

*Isn't it better that the doctor decides? We've got doctors and that backing us ... but we are asking for things to make people's health better and the government's saying it doesn't fit a guideline. (ACA 6)*

*The kids are on all different types of drugs ... there's no appropriate facility for them ... (ACA – FG 9)*

*They have been physically abused, knocked out, kicked in the testicles, swollen and the neighbours have seen it. So those kids are just growing up like that and again, **who is around that supports this and to see that everything is alright?** [A big sigh and sadly looks through the window] (ACA 2)*

A young focus group Advocate shared his need for support for alcohol problems:

*For the young people there's a lot of boredom. ... that's why they've turned to alcohol and drugs ... I'm trying to stop drinking ... but there are not many organisations to help. (ACA – FG 10)*

### **5.6.1.2 Invisible Aboriginal community**

***We are invisible.** (ACA 6)*

Many people spoke about themselves as “Aboriginal communities” which, when comorbidity affects an individual, are invisible in the care system and wider society:

*Because “we are a minority, we're not a priority”. ... that's been going on for a long, long time ... It's like we're not supposed to have anything. We can only go so far and they put us down again. (ACA – FG 10)*

*We're not looked at as people. Prior to 1966/67 when the referendum ... we weren't even recognised as people. ... I think it plays a big part in the way*

*that we, as Aboriginal people, see things today. ... generation after generation ... Even now in this country of Australia we're second class citizens. (ACA – C 7)*

### **5.6.1.3 Choice of service**

The Advocates stressed the need for choice of culturally-appropriate Aboriginal and mainstream services, raising the issue of trust:

*When the non-Aboriginal services are still operating there's no connect ... no cultural understanding. (ACA 1)*

*I think there are services there that they can utilise but sometimes Aboriginals don't want to go to that service ... because of confidentiality issues. (ACA – C 7)*

*They will say things if they feel comfortable with you. It's how you get that balance in the community. (ACA – FG 9)*

Having a choice of mainstream services alongside Aboriginal services was deemed essential:

*I find this wrong too, whenever they have an Aboriginal issue they come and get him [Aboriginal health worker]. What they should be doing is sorting out the problems themselves but then if they have issues, come in and get assistance. (ACA 3)*

Advocates felt Aboriginal service ownership with a shared partnership with non-Aboriginal people would achieve the best outcomes:

*You also need to have a good professional and a good mix with Aboriginal people and non-Aboriginal people so that everyone is not fighting on their own. (ACA 3)*

### **5.6.1.4 Follow-up**

*... when they come back to their environment ... nobody wants to pick them up and do things for them. (ACA – FG 9)*

Advocates deemed follow-up services essential but they were not there; **no follow-up=relapse:**

*I wasn't followed up on. I had the hope that there was services here that could help me but no sort of clear passage to them. ... What about home visits, find out if you're alive, talk in their own houses where they feel comfortable... and what about the support for the families as well? ... Quite often ...the family are going through this by themselves and they don't fit into that box. (ACA – FG 8)*

*It was for youth, all of the kids at [children's detention centre name removed]. They had all sort of mental illness ... They were violent ... But, I think you go there, it helps them out a little bit but when they come back to ... Adelaide, there's no real follow-up services for them. (ACA – FG 9)*

Many Advocates stated that follow-up was needed to keep people out of comorbidity-related trouble and the justice system but there were no discharge plans, no support services to collect people on release and no one wants to know a “criminal”:

*Everything is a mess, you come out of prison and you've got nowhere to live, try going to the services. ... So what do you do? ... You go down the pub and you get drunk. This is about induced disassociation. (ACA 6)*

Advocates again stressed the importance of family in follow-up service:

*Bring them back home to people and family that they know, care about them, love them and give them something meaningful to do. (ACA 2)*

#### **5.6.1.5 After-care life skills**

*Service doesn't find them a job once you get them better. (ACA 1)*

Advocates acknowledged that getting employment after comorbidity recovery is difficult and stressed the need to assist recovered individuals get work:

*I mean a lot of our mental health issues ... in our community are alcohol and drug related. They then face difficulties when trying to go and get employment. ... Show them ... light at the end of the tunnel. Given the opportunity, we will be able to help people move forward in their life if they want to. (ACA – C 7)*

*When I was 16 or 17 I got a job in the nursing home. Then I got a job at BHP in administration. I learnt what I wanted to know. They dedicated a*

*plaque to me there. (ACA 4)*

*... it's having the skills and techniques of how to try and encourage them to do something about it when they're sober ... you've got to catch them at the right time ... (ACA – FG 9)*

#### **5.6.1.6 Aboriginal advocate**

Advocates spoke of needing Aboriginal staff as “advocates” in services to provide initial and ongoing support for Aboriginal consumers and their families. This is in line with current policy guidelines for Aboriginal consumers; but this does not happen in practice:

*The liaison officer – having an Aboriginal person available – I'm telling you, it makes the world of a difference. ... As soon as an Aboriginal person sees another Aboriginal person like that, they're very much more approachable straight away. That first assessment. If you have a white person, there's always that distance. (ACA – FG 10)*

*He didn't get any ALO<sup>16</sup> come and visit him in the hospital until he requested it and he made a big stink about it. They didn't like that either. The other thing was when he asked for two people to come in as an advocate for him, they said, “What do you need support for? No! No!” And he said, “Because I'm so under medication that I don't know what I'm saying and I would like these people to be character references or part of my advocacy”, and they flatly made him feel really...[no words, sad face expression]. These are mental health nurses, and doctors and psychiatrists. (ACA – FG 8)*

Advocates also identified that “ordinary Aboriginal people” are needed as “mentors” to educate service staff – for them to sit down and listen, learn and understand all of a consumer's comorbidity issues, and also to show children “the right path”:

*Look, good mentors around the place would be really, really good. We sadly in some ways, some of that family structure has fallen away. The thing is, we have people like Elders. (ACA – FG 10)*

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<sup>16</sup> ALO=Aboriginal Liaison Officer

*They achieve that goal and they go and achieve another goal. This is smart goals. It's got to be specific. It's got to be measurable to pass the baton on to them and let them run with it. ... (ACA – C 7)*

*Say middle-aged blokes go as mentors and take the young ones, especially if you've got a middle-aged bloke with say reformed alcohol or has given up alcohol. ... a young person would know that they don't have to live a life with alcohol dependency. (ACA – FG 3)*

*I, myself, I had some good mentors growing up, in particular my mum really, but then when I got into university ... Then in government, people I look up to ... [names of two people], quite a few people you know. Sid Sparrow! (ACA 3)*

Advocates considered mentoring for “kids” essential in terms of preventive education and building social literacy:

*A lot of our young people, I suppose you could say that it's not really a mental health issue that they face, but mainly literacy, numeracy and I suppose some self-confidence ... (ACA – C 7)*

### 5.6.2 Main theme 7: Strategy

The Advocates discussed eight strategies for achieving a dedicated MH-AOD service, as summarised in Table 5.7.

**Table 5.7: Sub-themes and internal components of “Strategy”**

<b>VII Main theme: Strategy</b>	<b>Internal components</b>
1) One-stop MH-AOD service	Drug and alcohol and mental health teams work together
2) Availability	Outreach to parklands Reachable distance
3) Culturally-sensitive service	Culturally safe Better relationship with family Evaluation of service
4) Education	Encourage and educate
5) Engagement	Engagement with culture Engagement with community of living

	Engagement through cultural awareness training
6) Connection	Lack of connection with family Family can give the missed information if connected Strategy to maintain connection with family Strategy to connect with service
7) Communication	Verbal communication Silent communication – just being with someone Visual communication, such as advertisements Attitudinal communication – friendliness and respect Communication builds trust and relationships
8) Moving forward	Breakpoints/gaps Five point framework to address breakpoints Moving to implement sustainable, culturally-appropriate, dedicated comorbidity service

### 5.6.2.1 One-stop MH-AOD service

*Mental health, drug and alcohol service needs to exist. (ACA 6)*

Advocates identified the need for a one-stop service that followed right through from assessment, problems identified and responded to (treatments), after-care monitoring, family support and evaluation to end the continual run-around and prevent service duplication:

*You do need a one-stop-shop if you've got a mental health problem (with AOD); go straight to some service provider and then go through everything with you on the day [stresses the words] ... it is all about you've got a mental health problem, you've got to look at all the issues that contribute to that and how you're going to ... fix that particular problem and all the other problems that go along with that. (ACA – FG 9)*

At the very least, they called for a collaborative “wraparound service” where AOD and MH teams work together to provide comorbidity care:

*Community services side, the hospital side is over there. (ACA – FG 10)*

*The healing centre, that's like with drugs and alcohol with young teenagers and that, and the older people. (ACA 5)*



They also discussed how the service should be designed for “someone to work one-on-one” with consumers; someone who would know all the referrals needed, enabling them to develop a relationship with relevant health professionals and services.

### **5.6.2.2 Available service**

*... being available to the people. (ACA – FG 10)*

Individual interviewees talked about the need for making services, such as “wellbeing volunteer services”, available to people living in the parklands:

*We now have got Aboriginal people that are either at Pitman Park or the park at Elizabeth ... there needs to be some sort of services provided for them ... we can't leave them there. (ACA – C 7)*

They insisted that primary health and rehabilitation should be provided within reachable distance:

*... not stuck in a hospital 1000 kilometres away with no support from family. (ACA 2)*

A 19-year-old youth suggested that people wished to have services within their reach so children could get appropriate care within their usual locality, among their community:

*In the northern area, put another service. I do feel comfortable here (north) and I don't feel comfortable in the city. If you have a mental health service near us ... definitely this would be a good place to base one, because people know about this place. (ACA – FG 10)*

### **5.6.2.3 Culturally-sensitive service**

Culturally-sensitive and safe services were deemed essential in the future MH-AOD service, including family involvement:

*Culturally sensitive! We're talking Aboriginal and Torres Strait Islanders. I would expect them to be culturally sensitive! (ACA – FG 8)*

*Family does need to get their questions answered and what they want to know about it too... explain and teach them so that they can help their relative better. (ACA 2)*

#### **5.6.2.4 Education**

*Encouragement and education. (ACA 4)*

Most Advocates stated the importance of giving individuals and their families responsibility by teaching them life skills, including appropriate care-related decision-making skills:

*Get them out in the community and there is a saying, “You teach them how to fish, they’ll fish for life”. You give them those skills so that they have the tools to be able to survive life in a real sort of area. (ACA – FG 9)*

#### **5.6.2.5 Engagement: Develop trust**

A respected Aboriginal community Elder living in Elizabeth suggested a method for naming the one-stop institution to engage with Aboriginal community people and develop trust:

*Whatever name’s appropriate for the language and tribe and the land. You’ve got to give it a Kurna name because you’re in KAURNA land. (ACA 5)*

Focus group Advocates discussed the importance of engagement with their own communities, and how peers play a major role in helping Aboriginal people with MH-AOD comorbidity to recover:

*A couple played footy this year with us. You’d never think they’d be running around on a footy field. A few years ago with drugs and alcohol they didn’t come to football and now started mixing with us. Now, like you sit down and have a drink with them, they have one or two drinks and say, “I’m going now”. (ACA – FG 9)*

They also suggested MH and AOD service clinicians and workers undertake cultural awareness training to engage consumers in their service:

*One of the ways is to engage all the doctors’ surgeries to register for a compulsory cultural awareness training program so that it makes them aware of who they are looking at ... and not to judge ... just treat them like a normal patient; treat them with a bit of respect. (ACA – FG 9)*

### **5.6.2.6 Connection**

*If you don't have that connection, then you're more likely not to go to appointments ... (ACA – FG 8)*

Advocates spoke mainly about Aboriginal people with comorbidity being disconnected from MH and AOD services, and their families trying to overcome the frustration arising from services ignoring their, and the community's, advice. They also emphasised connection between service providers:

*It may be as simple as going out and talking to the local Aboriginal health worker. You can collect all that information and bring family together and get versions of what they see is happening with that person. (ACA 2)*

*If they're coming from the remote areas, then the health service in the remote areas should be able to contact their health service here in Salisbury [names of services removed] and let them know that they are going to be here at such-and-such a time so they can go and pick them up. ... if they just come over without letting people know down here, then ... these fellas will have no accommodation, they've got no contact people ... (ACA – C 7)*

### **5.6.2.7 Communication**

Advocates said that verbal and non-verbal communication is the mediator for strong connectedness and deeper relationships

*You're just building a relationship with them. You're taking them on camps, drug and alcohol-free, and meeting people. Talk if you want to, don't talk if you don't want to, just keep around people all of the time. A break from formality. (ACA 2)*

They suggested that visual communication, such as advertising, and friendly, respectful staff can encourage trust:

*Communication. Unless things are hanging on the wall, we read about their prognosis and help and everything. (ACA 4)*

*It's like any organisation; there's got to be trust. You've got to build that trust within. You know... whenever you go to them, they make you feel comfortable. (ACA – FG 9)*

Advocates firmly believed it is hard to develop trust when there is insufficient or unsatisfactory communication:

*She signs a piece of paper, then the bottom line is she's our flesh and blood, she's our daughter ... here's a doctor who doesn't know her, he's getting all confidentiality; we can't trust necessarily what doctor's confidentiality is going to be about. (ACA – FG 8)*

### **5.6.2.8 Moving forward – addressing service breakpoints**

Information from Advocates illuminated crucial service breakpoints, which were identified as opportunities for service implementation.

*It's like one fella said to me, he said, "You put all the problems of Aboriginal people in a bucket and if the bucket has got holes in it, they are going to fall through those holes – fall through the system". (ACA 1)*

These are summarised in Table 5.8 as: 1) breakpoints, which inform the gaps in comorbidity services for MH-AOD care; 2) gaps widening due to barriers to accessing services; and 3) solutions for improved service implementation as suggested strategies.

**Table 5.8: Breakpoints and widening gaps in comorbidity services**

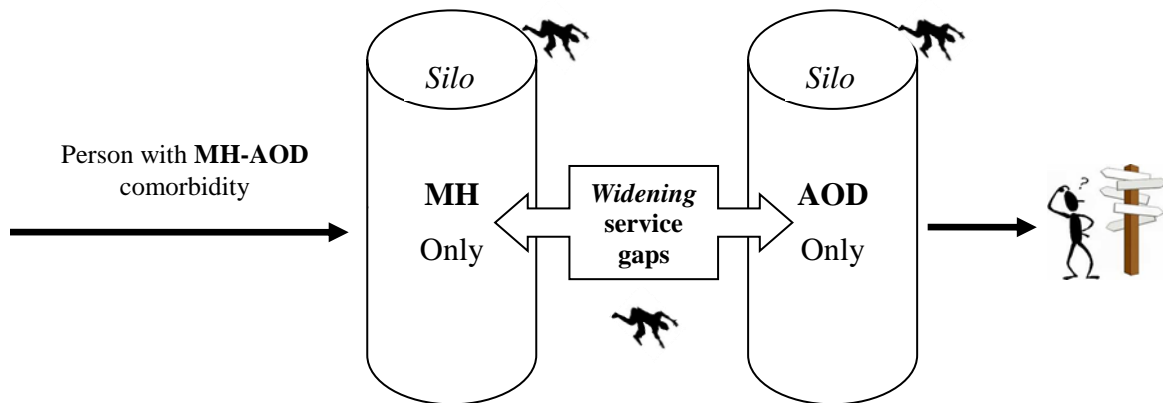
<b>1. Breakpoint</b>	<b>2. Widening gaps</b>	<b>3. Opportunities for service implementation</b>
<b>Locality</b>	Running around for service Distance of service Work timings	Locally-available service within reach
<b>Service division</b>	No comorbidity service No dry out centre No primary care: Education	A central service for combined problems of MH and AOD
<b>System</b>	Not Aboriginal friendly Celebrating multicultural and failing and forgetting Aboriginal Australia	Availability of Aboriginal-specific and mainstream services
<b>Longevity</b>	Unsustained service enhances loss of trust Diminished quality Wastage of material and manpower	Consistency of service with sustained funding
<b>Language</b>	Medical jargon No Aboriginal language interpretation	Clear communication and inclusion

#### 5.6.2.8.1 Locality

Given the real need for MH-AOD services in the study region, and consumer choice, Advocates preferred a local Aboriginal-friendly mainstream and Aboriginal-specific service that would work together to cater for the Aboriginal community, including transiting groups from rural and remote areas.

#### 5.6.2.8.2 Service division (silos)

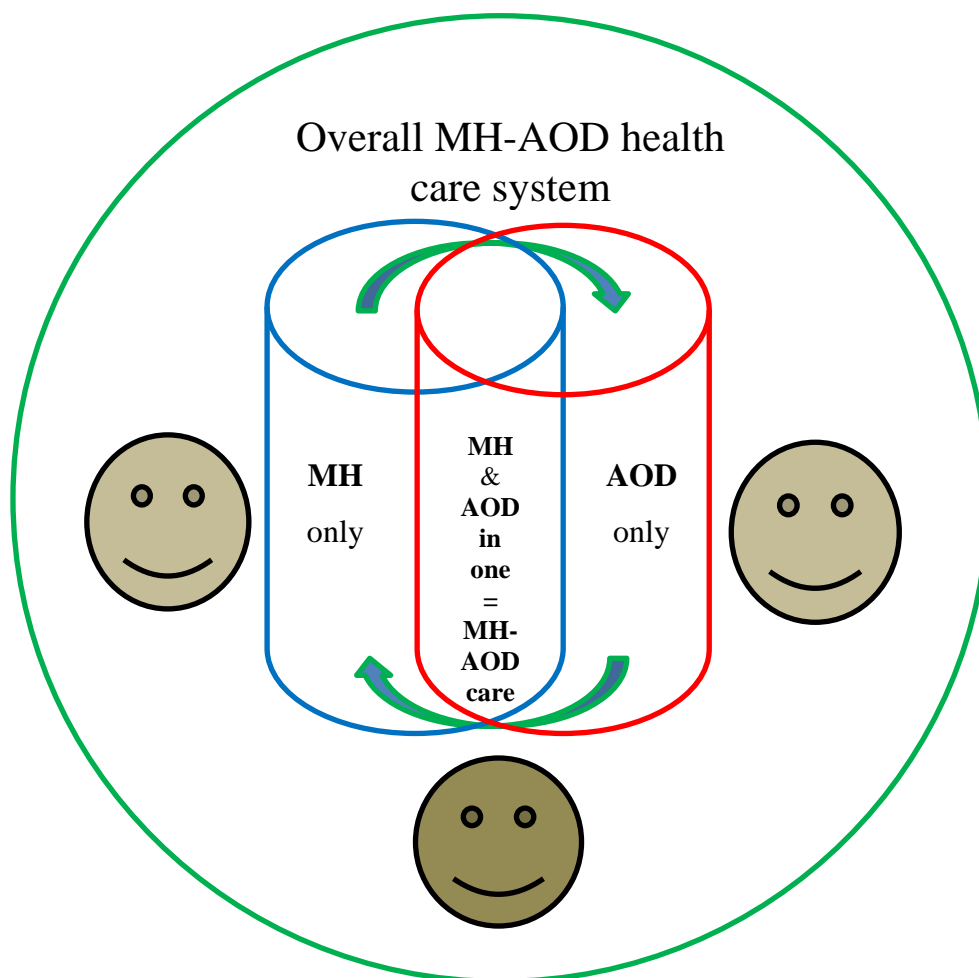
Divisions (silos) between services constituted the most significant access barrier experienced. As Figure 5.4 illustrates, while support services assisted consumers, there was confusion about which problem to address first and which service to refer to. The point of opportunity for a potential solution was the suggestion that MH services be equipped to treat AOD problems, and AOD services be equipped to treat MH problems, with a dedicated comorbidity-focused service for MH-AOD (Figure 5.5).



**Figure 5.4: Division between MH only and AOD only 'silo' services**

#### 5.6.2.8.3 System

Service coordination was a major challenge in the current complex, “fractured” comorbidity care system that involved running around to various related services to connect with comorbidity care specialists. This could be addressed using increased specialist MH and AOD staff and integrated services in a “one-stop-shop” providing culturally-appropriate, holistic MH-AOD care. This would reduce cost and waiting periods. Additional staff could come from cutting duplicate single services.



**Figure 5.5: Solution to MH and AOD service divisions**

**5.6.2.8.4 Longevity**

Advocates were frustrated that short-term programs had no long-term benefits. Policy change constantly removed options and stopped people from getting help. Advocates emphasised the significant need to increase Aboriginal-specific services and implement long-term support, such as follow-up life-skills and employment programs.

**5.6.2.8.5 Language**

Consumers’ ability to understand English, complex medical concepts and professional terminology was completely overlooked. The “silo” service approach and individualised nature of care (no family involvement) meant consumers had no primary carer to translate for them. Participants called for medical staff awareness of consumers’ circumstances and paraphrasing medical concepts so consumers can understand them, and providing a translation service if needed.

## **5.7 Conclusion**

The findings presented in this chapter highlight the issues reported by Advocates about the barriers and difficulties faced by Aboriginal people affected by MH-AOD comorbidity needing holistic MH-AOD care. Therefore, what they want is provision of “joined up”, integrated MH and AOD services that are able to provide consumers with a one-stop, comprehensive “no wrong door” MH-AOD service. They saw this as the logical solution to filling the current gaps. Essentially, the key finding is that there is currently “no dedicated MH-AOD service” in the Salisbury and Playford LGA region.

The next chapter presents the perceptions of staff delivering health care services for local Aboriginal community people in the study region.

## 6 Findings II – Perspectives of MH and AOD Clinicians and Workers

### 6.1 Introduction

This chapter presents the findings from interviews with nine on-the-ground MH and AOD clinicians and workers from seven mainstream and two Aboriginal-specific MH and AOD services and programs. Individual interviews were conducted with these participants to investigate their roles and perspectives regarding the complex journey of Aboriginal people with MH-AOD comorbidity when seeking help from their services. The data were coded to differentiate between mainstream service (CMS)<sup>17</sup> participants and Aboriginal-specific service (CAS)<sup>18</sup> participants, and also between MH and AOD services and support services (see next chapter).

### 6.2 Thematic framework

Thematic analysis of the MH and AOD clinicians' and workers' data is presented in a similar overarching thematic framework to the one described in Chapter 5 (Figure 5.1), with variations to the sub-themes and their components (see Figure 6.1). Any variations reflect these participants' different roles, perspectives and language compared with the Advocates. Participants' quoted contributions are presented in italics.

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<sup>17</sup> CMS = AOD and MH Comorbidity Mainstream Services

<sup>18</sup> CAS = AOD and MH Comorbidity Aboriginal Services



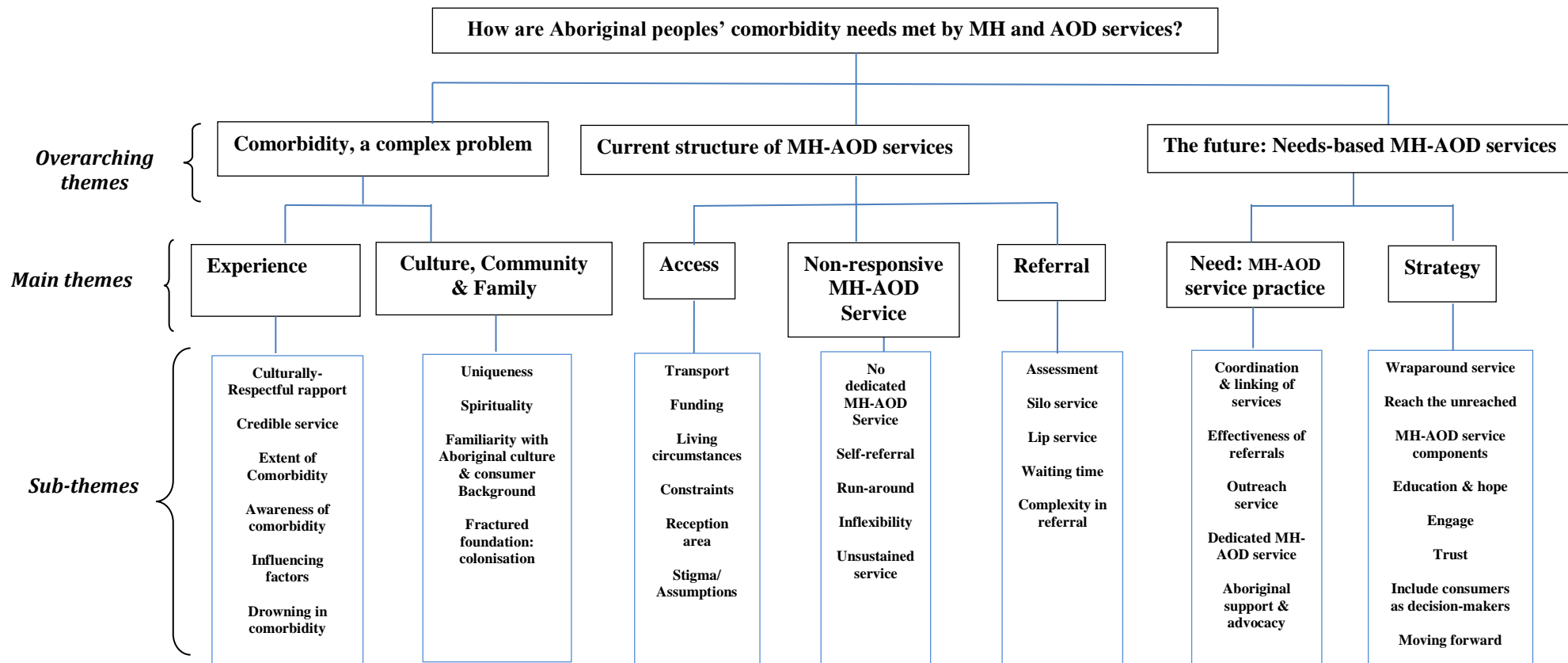


Figure 6.1: Thematic framework of comorbidity service needs: MH and AOD clinicians and workers

## 6.3 Overarching theme 1 – Comorbidity, a complex problem

MH and AOD clinicians and workers used the term “direct consumer care” to describe the interpersonal relationship between people undertaking these roles and Aboriginal consumers. Their main emphasis was on establishing good communication and trust with consumers by recognising their complex comorbidity problems, different worldviews and life experiences

### 6.3.1 Main theme 1: Experience

Participants’ perspectives related to their “experience” are discussed under six sub-themes, as summarised in Table 6.1.

**Table 6.1: Sub-themes and internal components of “Experience”**

<b>1 Main theme: Experience</b>	<b>Internal components</b>
1) Culturally-respectful rapport	Cultural understanding and culturally-safe service implementation
2) Credible service	Strong partnership between Aboriginal-specific service and Aboriginal community Word-of-mouth among Aboriginal people about good service
3) Extent of comorbidity	Kids commonly seen to be affected by comorbidity Mental illness and alcohol go hand in hand People with serious mental health issues self-medicate with cannabis and alcohol
4) Awareness of comorbidity	People unaware of their comorbidity issues
5) Influencing factors	Disrupted family structure Compromised living environment a major influence
6) Drowning in comorbidity: Hidden outcomes	Negatively impacts social functioning Cycle of comorbidity and same consumers Suicide Gaol and police involvement

#### 6.3.1.1 *Culturally-respectful rapport*

Participants stressed the importance of establishing cultural respect and rapport with Aboriginal consumers to develop trust, and enable knowledge-exchange and culturally-safe service according to individual socio-cultural needs:

*A lot of our people are strong ... but a lot of our guys suffer and it's ... just sad, but when you've got organisations like the [name of Aboriginal service removed], they're out there to try and do the best they can, especially when we're dealing with the domestic violence, child abuse. (CAS 9)*

*The Aboriginal people teach me a lot when they come in. They'll mention this mob and that mob and they are good. When you get them being who they are, they're lovely. (CMS 5)*

### **6.3.1.2 Credible service**

Service credibility was seen as essential. Participants recognised the power of “word-of-mouth” within the Aboriginal community in encouraging members to utilise particular services:

*I believe that all the services [name of Aboriginal-specific groups, names removed] for our people are really strong on how they come to be in partnership to work for our people ... So I think the health and services [name of Aboriginal service] is important. (CAS 9)*

*It's word-of-mouth too to Aboriginal people. There might be one or two people came to a certain service and they get used to that service, they like. They then tell their rellies, “Oh you should tell him to go there, and they're good”. (CMS 7)*

### **6.3.1.3 Extent of comorbidity**

The extent of comorbidity among children, who, like adults, get anxious or depressed and drink, was a major concern:

*A lot of times you will find that you'll get kids as young as 12 who are drinking with relatives because that's part of what's happening in that particular living environment. (CMS 5)*

Participants identified that MH and AOD problems were commonly seen together, contributed to each other and in some cases caused debilitating brain damage:

*Depression and alcohol abuse, they go hand in hand. The more people drink, the more sad they get ... people take certain amphetamines, speed, ecstasy, LSD ... and become psychotic for a period ... It also seems to*

*amplify their distress so that's when they become more suicidal. ... Depression and marijuana are very, very, heavily linked together. Marijuana brings on apathy anyway. (CMS 6)*

*Some of the fellas, they have an acquired brain injury and they drink because they don't have anything else to do [says in a gentle slow voice] ... (CMS 4)*

*Well, comorbidity is part of it. I've consumers who have schizophrenia, some are bipolar, some have brain damage, and some of them are drug and alcohol mental health induced. (CAS 8)*

#### **6.3.1.4 Awareness of comorbidity**

Participants said people were unaware of comorbidity and how this stops them from functioning effectively in daily life, and from seeking MH and AOD services:

*Sometimes people don't have all the problems together ... they might come to you with a need for food or something and you find out a little bit more about what's going on ... they're having issues with either mental health or alcohol. (CMS 7)*

*The drug and the alcohol stuff, they need to actually identify that as an issue, so that is a bit harder. ... it could be an everyday thing for them. (CMS 4)*

#### **6.3.1.5 Influencing factors**

All participants reflected on factors associated with comorbidity and the impact, particularly the links with historical influences, poverty and chaotic home environments, for example, loss and grief, sadness and unsafe relationships:

*... when people left the mission and came to live here, everything was available here for the women and kids, pensions and houses. All those proud men, they had no use for them anymore. ... So ... they drank, drank, drank. (CMS 4)*

*Common stuff with alcohol is domestic violence, child abuse, self-harm, a lot of it is with the Stolen Generation, just grief and loss ... (CAS 9)*

*...a young fella, he was struggling in moving ahead. Any time that his family had some chaos and there would be fights and drinking, that would then pull him down and he would start drinking ... (CMS 5)*

Participants working in child and adolescent AOD services detailed how increasing AOD use among children was often linked to influences in their home and community environments:

*Look at foundation of life ... say you are a princess, so you had all these servants running around looking after you and fed with a silver spoon, and ... teachers were so supportive of you, all the developmental stages were wonderful, so your foundations as a person would be really strong. Imagine growing up in a different situation where your mum doesn't like you, doesn't know if you are home or not home, your older brother and older sister sort of brings you up half the time, there's drugs all over the house, your mum's getting raped in the other room by her new boyfriend – what would that do to your structural foundations and your natural beliefs on how life should be? It's going to eschew at something shocking. ... They knew that drinking was bad ... but chose to keep doing it based on instant comfort for a long-term problem ... (CMS 6)*

#### **6.3.1.6 Drowning in comorbidity: Hidden outcomes**

Many participants outlined the “massive impact on people” (CMS 6) of untreated comorbidity and its hidden outcomes; a cycle of comorbidity relapsing problems, violence, suicides, homelessness, police involvement and imprisonment:

*We are pretty much working with the same consumers, it's the same issues. ... we have involved the police at that time if there is something like that at any house, alcohol, drugs, fighting, it's not safe for us to go there even if we knew them. (CAS 9)*

*There are a large number of suicides. There is alcohol involvement. It's quite high, it's above 80%. (CMS 5)*

*They don't want to just throw them out of their homes so they put up with ... comorbidity stuff. Those people who cannot be dealt with at home end up in*

*the parklands or ... [name of the place removed] prison. ... One hanged himself, the other OD'd himself [looks very sad]. (CAS 8)*

*Gaols are the places where there's a lot of mental health problems. (CMS 7)*

The following real-life comorbidity story, told by a non-Aboriginal participant from a mainstream AOD service, illustrates the complexities and devastation of comorbidity for the individual and AOD workers:

*We had an Aboriginal lady ... It's quite sad, we went round to her house, knocked on the window. She didn't move because she was drinking too much alcohol, doing nothing that was healthy for herself, and her comorbid physical health was shocking. The only time she would move would be to get more alcohol. She had numerous drug and alcohol charges. We called the police to see if they could get in there. They ended up getting her to move but they sent six police cars because she had so many warrants. The police said they would lock her up. We got her into hospital ... prison is not a good place for her. We did a detox in the hospital, booked her in to go to [name of person removed] in [name of detox centre removed] but she didn't go. She said, 'I couldn't get there because I had no transport'. Booked her in again and she didn't go because she didn't know people that were driving her. Workers booked her in again and I went down and picked her up and she was drunk and said she was not going, so in the end we just closed the case. We felt that we tried as much as we could to help her out and she wasn't helping, and it was a complete failure in terms of all we could do, because again we can't force drug and alcohol treatment on people ... (CMS 6)*

### **6.3.2 Main theme 2: Culture, community and family (Aboriginal culture)**

MH and AOD perspectives regarding “culture, community and family” are discussed under five sub-themes, as summarised in Table 6.2.

**Table 6.2: Sub-themes and internal components of “Culture, community and family”**

<b>II Main theme: Culture, community and family (Aboriginal culture)</b>	<b>Internal components</b>
1) Uniqueness	Unique Aboriginal way of understanding how comorbidity affects the person Different use of terminology
2) Spirituality	Look at the person’s individual spiritual needs Ngangkaris Learn to ask consumers’ preferences and needs in relation to spiritual connection
3) Familiarity with Aboriginal culture and consumer background	Understanding between Aboriginal and mainstream services for Aboriginal people
4) Fractured foundation: Colonisation	Transgenerational trauma

### **6.3.2.1 Uniqueness**

*We all don’t wear the same size shoe. (CMS 2)*

Participants were aware of Aboriginal people’s unique understanding of their health and ill-health (including MH) as reflections of themselves holistically rather than of someone with a medical “condition” that has diagnostic terminology:

*A lot of the community will actually define the person as having disability as more so around describing how it affects the person. So let’s say grandma had an accident and ended up with a brain injury, instead of the family saying, “She has a brain injury”, it will be more, “Ok, since the accident, nanna is very forgetful”, or “trips a lot”. (CMS 4)*

*For Aboriginal people in particular, I don’t think that they see ‘mental health’ as being something that is really appropriate. I think they see “social and emotional wellbeing”. (CMS 2)*

Participants stressed the importance of recognising and respecting cultural uniqueness and cultural knowledge as intertwined, and of knowing about cultural norms to avoid misunderstandings:

*I met with an Aboriginal gentleman and he did not want to talk about “mental health” ... he was doing a bit of statue making and I just asked him, like, what sort of sand he used ... We had a conversation about that instead, which gave a lot about what I need to know about mental health. It was a different way of interviewing. ... at the end of the day he said, “Look, would you like a statue?” and I went, “Yes I would” ... We have to change our interview criteria to meet his needs but it is different from our needs. (CMS 6)*

### **6.3.2.2 Spirituality**

Aboriginal MH and AOD participants working in Aboriginal-specific and mainstream services explained the importance of acknowledging Aboriginal consumers’ spiritual needs and the role of Ngangkari in meeting these needs, particularly understanding their inseparable spiritual connection with Country, and Country’s connection with them and culture. They also highlighted non-Aboriginal clinicians’ and workers’ unawareness of Ngangkari:

*I have a strong advocacy for ... our spiritual mental health, and we call it ‘emotional social wellbeing’, and a lot of our people suffer cultural emotional issues as well, where the spirit has been damaged, and that’s a cultural thing ... a big thing in our community. (CAS 8)*

*They [non-Aboriginal clinicians and workers] don’t even know to ask that’s the problem. ... they would just think, “Okay, this person has a problem you know, psychosis”. Whereas me, I would first go, “Hang on a minute, you’re seeing ancestors – what does that mean to you, is that a positive thing or a negative thing? Is it scaring you or are you okay about that? Do you draw strength from it?” And the first thing I would think is, “Yeah, this person is actually seeing their ancestors”. They might be getting guidance or it might be warmth, it might be a whole heap of things, and if you don’t even know to look for it, you won’t. ... If somebody claims that they get comfort and feel better from being in the country, then that to me would be an alarm bell [clicks finger] ... and I would be trying to get them back there. If you don’t know that, you won’t ask that ... (CMS 2)*



*Not everyone knows about Ngangkari. That's traditional stuff ... But if they lived in rural areas, they would know more about Ngangkari. They ... always use them. ... There's bush medicines ... (CMS 7)*

### **6.3.2.3 Familiarity with Aboriginal culture and consumer background**

According to participants, familiarity with Aboriginal peoples' culture and social background is essential when providing them with MH and AOD services because these enhance understanding of their situations and needs, and possibility of linking them with appropriate assistance:

*I believe within [name of Aboriginal services removed] we have got a lot of knowledge because most of us are all Aboriginal and we know the community. It could be extended family. There is a lot ... of understanding within the consumer and everyone knows everyone... (CAS 9)*

*The Aboriginal agencies definitely are culturally-appropriate, the mainstream ones probably not so much. (CMS 4)*

All of the Aboriginal participants said that if non-Aboriginal clinicians and workers were unfamiliar with Aboriginal cultural diversity, they needed to ask Aboriginal workers and community members:

*Aboriginal people continue to have to justify "over and over" again about why they do things because it's just that we think differently to mainstream workers and we think about how culture relates to our wellbeing and we think about how spirituality relates to how we do in the community, and we get that. (CMS 2)*

In relation to familiarity with the uniqueness of Aboriginal culture, one Aboriginal participant said it was important for Aboriginal people to use mainstream services, but Aboriginal participants from those services said many Aboriginal consumers would not use them:

*We've got two primary Aboriginal health workers employed in our building. We've also got a couple of social workers that are heavily involved in helping the Aboriginal team, which is really good. I do think they get sufficient care or they get the offer of it. A lot of Aboriginals won't actually come to our service, which is unfortunate. (CMS 6)*

#### **6.3.2.4 Fractured foundation: Colonisation**

Participants commented on the profound trans-generational impact of colonisation as a “fractured foundation” and stressed the importance of everyone knowing that it still occurs:

*Okay, well, starting with the mental health perspective, of course Aboriginal families have experienced long-standing cultural trauma dating from the time of the arrival of European occupiers who seized Aboriginal land and killed Aboriginal people and introduced foreign diseases ... really displaced Aboriginal people from their lands, shattered their communities and assaulted their culture ... that’s had profound transgenerational mental health issues for Aboriginal people. (CMS 1)*

### **6.4 Overarching theme 2 – Current structure of MH-AOD care**

MH and AOD clinicians and workers spoke about a service structure being arranged according to separate types and different levels of care, and reliance on referrals to various other services. These challenged and broke continuity and coordination. Main themes identified included “access” to service, “non-responsive comorbidity service” and “referral – Fishing for Nunga places”.

#### **6.4.1 Main theme 3: Access**

The perspectives of these MH and AOD clinicians and workers on factors affecting Aboriginal people’s “access” to MH-AOD services are summarised in Table 6.3.

**Table 6.3: Sub-themes and internal components of “Access”**

<b>III Main theme: Access</b>	<b>Internal components</b>
1) Transport	Transport to access service Transport to deliver service
2) Funding	Limited resources Money wrongly spent
3) Living circumstances	Consumers’ life situation Not to make personal judgement Grandparent as primary carer Mobile lifestyle Level of clinicians and workers’ understanding about

	consumers' living circumstances
4) Work constraints	<p>Constraints for consumers</p> <ul style="list-style-type: none"> <li>○ Poverty, fear and shame</li> </ul> <p>Constraints on clinicians and workers</p> <ul style="list-style-type: none"> <li>○ Spending extra time travelling</li> <li>○ Inhibiting structure of policy</li> <li>○ Limited beds</li> </ul>
5) Reception area	<p>Importance of the person in the receptionist role</p> <p>Aboriginal face</p> <ul style="list-style-type: none"> <li>○ Reception area environment</li> <li>○ Understanding</li> <li>○ Culturally sensitive</li> </ul>
6) Stigma/assumptions	<p>All Aboriginal people have mental health, alcohol and drug problems</p> <p>“Palming off” consumers</p> <p>“Mental health” label</p> <p>Stigma – Aboriginal people not well accepted in certain services</p>

#### **6.4.1.1 NO Transport**

Most participants were concerned about Aboriginal people needing comorbidity care but having to travel long distances with much difficulty. Many do not have, or cannot drive, a car or cannot easily take public transport. Also, no or under-funding of local services for consumer transport and benefits derived from support workers transporting people to and from appointments act as barriers to accessing services:

*No money... no car ... Elizabeth... it all depends. (CAS 9)*

*... there's a massive gap in services for people that don't travel or don't have transport. If you're depressed, are you going to hop in a car and drive? Probably not. (CMS 6)*

*... I reckon that they used to have a bus running which used to take them home in the middle of the night but I don't think that's available any more. (CMS 5)*

*You drive someone, you can have a yarn, giving advice and coming alongside; give them listening ear. (CMS 7)*

### **6.4.1.2 Funding**

Aboriginal staff, while realistic about funding levels, discussed how Aboriginal people had to strive for funding over many years:

*Bandha!*<sup>19</sup> *Money! Bread! Funding! It's always very hard for Aboriginal people. It's funding, doesn't get funded, it's not that bad when you put that up to the funding bodies before years ago. (CAS 9)*

*I understand that we can't give everything that people want because it's not funded by that, but ... do they have connection education wise, do they have access to education, what does it look like, is it a positive experience? If not, why not? (CMS 2)*

Non-Aboriginal staff raised the issues of politics determining who gets funding and the appropriateness of such decisions affecting longevity (continuity) of health services:

*... the risk there is that politicians will say, "All right, we have only got one agency there, we don't need all these people, let's cut them down, let's get rid of a few people". Then you get less and less services ... (CMS 3)*

*... there is lot of money that they are throwing for Aboriginal communities, ... and they said, "But they are spending it wrong" ... It's about what they want in reference to what we can do. (CMS 6)*

### **6.4.1.3 Living circumstances**

All participants recognised that an individual's poor living circumstances contribute greatly to their lifestyle but may be a shock to some clinicians and workers. They stressed the importance of understanding the influence of living circumstances on consumers' comorbidity, and of ensuring consumers have access to the appropriate strategies and resources they need to help their recovery:

*It may be that a person struggles with drug and alcohol and mental health because ... economic and social, or it could be purely that they have grown up in a family that have had multiple issues with drug and alcohol and mental health, and those issues are all familiar ... (CMS 3)*

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<sup>19</sup> 'Bandha' is an Aboriginal word for money

*I've come across some workers ... co-worked with, and that might be the first Aboriginal family they have worked with ... (CMS 4)*

*See where they're coming from, that's how you can best help them. (CMS 7)*

Participants had different perceptions of how Aboriginal and non-Aboriginal clinicians and workers did or did not adopt non-judgemental (stereotype) approaches to Aboriginal consumers, recognising consumers' real social determinants of health.

*Obviously as far as the living conditions, you will need to know that their children are being well cared for, that the housing isn't full of vermin like rats or whatever else is happening. (CMS 5)*

#### **6.4.1.4 Constraints**

The MH and AOD clinicians and workers identified consumer and service constraints that could become barriers to consumers accessing services.

##### **6.4.1.4.1 Consumers**

Poor housing, unemployment, poor budgeting, poverty, isolation, illness, language and cultural confusion were seen as constraints to consumers' capacity to access services:

*They've got to lie, yeah (to get services), the unemployed mainly, they live in poor housing, cluster housing areas where a lot of other families are in the same bucket as they are, so ... they end up turning to crime to support their habits and their families. (CMS 5)*

*We had consumers that rocked up for a self-referral off their faces, drugged and stole handbags staff ... they pretty much will be the barriers or if they've got no money to ring up, and if they live alone, these are the barriers. (CAS 9)*

*They are out of step with their own culture and they are in our culture [stresses word] and they have difficulty assimilating. Often they'll present in crisis. ... (CMS 5)*

*No offence, but you have African workers there that help with the Africans, interpreters where they should have that with our traditional people .... Like from the lands up there Pitjantjatjara, they haven't got their language ... (CAS 9)*

“Shame” about individuals’ MH problems was a concern, as were trans-generational MH problems, including poor families who could not support their children fearing their children’s removal:

*The barriers for a person contacting us would be shame a lot of the times or confusion that they don’t want people to know ... (CMS 6)*

*People are frightened that we might make notifications about them and that we will somehow influence their kids being taken away. We are often seen quite connected to child protection ... (CMS 2)*

Gender issues (men’s business and women’s business) were seen as other constraints to decisions to access services and actual service delivery.

#### 6.4.1.4.2 Service

There was general agreement that MH and AOD services and community support being increasingly overstretched and inadequate were barriers to accessible services, and that greater government support was needed to address this widening service gap:

*It’s a very challenging job [a long pause, can’t talk, holds breath], it’s educational though, it really opens my eyes to things because there’s not enough people on-the-ground doing the work. There’s plenty of people up here saying, “You’ve got to do it this way, that way or directions”, but people actually on-the-ground doing the work, where are they all? That’s where I see the gap. (CAS 8)*

*Aboriginals work as themselves in organisations with whoever it is, they need a lot of support because a lot of times certain Aboriginal people (workers) are in the gap them self, they suffer things. They struggle with problems; they’re in the job, but that doesn’t really say they’re any better than anybody else. So they need support within the organisation ... Just support each other and you can work a bit better. (CMS 7)*

Participants talked about differing policies between organisations as constraining service delivery; there were not enough resources, resulting in inadequate service and wider gaps:

*There are not enough beds for people. ... night shift ... it’s not adequately staffed. (CMS 5)*

*One person can't cover all that area. You can do a lot of it but you're creating gaps. (CAS 8)*

*We have a person in Gawler one day a week, we have two people in Salisbury two days a week but [silence] we could certainly increase accessibility or improve accessibility by being more available to communities and perhaps co-locating with Aboriginal Services. (CMS 1)*

Aboriginal participants from mainstream services aired their frustration at organisational policy requiring them to be available for consultation for all Aboriginal consumers, but excluding them from advising and using their particular skills that Aboriginal consumers needed:

*I don't want to have to be the person that is consulted but has no control about the case. (CMS 2)*

#### **6.4.1.5 Reception area**

Participants emphasised the importance of culturally-respectful reception staff as “the face of a health service”:

*See Aboriginal people always like to go somewhere they think if there's Aboriginal faces at the counter, in reception, if there's Aboriginal paintings in the reception area, if there's a flag flying out the front, the Nunga flag, they feel comfortable in going there. If there's none of that stuff there, well then they say, “This is not for me”.*

*Receptionist is a very important person ... sometimes if they talk a bit abruptly ... and make you feel no good, it compounds the problem. And you either have a blow-up ... or you don't go back there and then you don't get nothing.*

*Another thing is staff at agencies. You know the reception area? They need to be aware and sensitive to a whole lot of different people coming in, like cultural sort of differences ... because they can sort of turn people off. ...*

*Understand the culture; be friendly. If somebody comes in suffering from depression or mental health issues, and somebody doesn't talk to them very*

*well at reception, their whole day falls. ... maybe head off and start drinking again ... they think no one cares. (CMS 7)*

#### **6.4.1.6 Stigma / assumptions**

Aboriginal and non-Aboriginal participants together highlighted stereotyped assumptions that constrained their service provision, such as believing the whole Aboriginal community has MH-AOD comorbidity, and all Aboriginal consumers need Aboriginal clinicians and workers. They described stigmatisation of Aboriginal people affected by MH-AOD comorbidity and said that “mental health” was a negative label, which resulted in some MH and AOD services and programs treating Aboriginal MH-AOD consumers disrespectfully:

*They have Aboriginal people in houses and they assume they've got mental health problems, drug and alcohol problems, so they assume that I can just go, and I can't just go. So there needs to be a better pathway ...I started working with all these non-Aboriginal services provided with our consumers. ... they were palming a lot of it onto me because Aboriginal consumer, Aboriginal worker [blows air and flips palms] ... just because they're black doesn't mean I'm the only one who can work with them. (CAS 8)*

*Mental health is not ... well accepted. I think that the name “mental health” doesn't really fit ... I think that is a huge barrier ... it's a stigma and nobody wants to think that their mental health is not right. (CMS 2)*

*If we sent our guys to [name of the service removed] for detox ... a lot of agencies out there get a bit funny when there's an Aboriginal consumer with mental issues related to drugs and alcohol. (CAS 9)*

Participants talked of Aboriginal consumer mistrust of their services as a constraint related to previous removal of Aboriginal children:

*There's a lot of stigma around what's happened in the past ... they (Aboriginal people) won't let you in the door ... (CMS 4)*

#### **6.4.2 Main theme 4 – Non-responsive MH-AOD service**

Participants discussed “non-responsive MH-AOD service” in terms of five sub-themes,



as summarised in Table 6.4.

**Table 6.4: Sub-themes and internal components of “Non-responsive MH-AOD service”**

<b>IV Non-responsive MH-AOD service</b>	<b>Internal components</b>
1) No dedicated MH-AOD service	Not much culturally-appropriate service Services are not within reach The extent of unavailable service
2) Self-referral	Consumers have to self-refer
3) Run-around	Getting into different and many services for comorbidity Services in different locations
4) Inflexibility	Boundaries: legislation, working times, area, lack of communication
5) Unsustained service	Unsustained service is temperamental

#### **6.4.2.1 No dedicated MH-AOD service**

All participants said there was no one service that provided holistic care for Aboriginal (or other) people with MH-AOD comorbidity in the Salisbury and Playford LGA region.

##### **Adult service says: No comorbidity service**

*There is no service here [stresses]. (CMS 5)*

*I don't know [silence, looks concerned]. (CMS 7)*

*There's the drug and alcohol services, we've got nothing. (CMS 6)*

*All we have available to us is [name of a drug and alcohol service removed] a card and most of them are aware of [name of Aboriginal service removed] you know, so there is no-one who will actually specifically go and talk to them about both of their issues. (CMS 5)*

##### **Child and adolescent service says: No comorbidity service**

*[Thinking-silence]. I don't know, not ours, not ours, no. (CMS 1)*

*For comorbidity (long silence thinking—with a sigh), I can't think of anybody does comorbidity work. They either do drug and alcohol or mental health work. ... Don't*

*think we have too many services that are connected enough to what they should be. We need people that have expertise in mental health and drug and alcohol or a service that sits together. (CMS 2)*

*We have about 500 cases in the team at any one, all the time, but we would not commonly be working with that issue [silent pause]. (CMS 1)*

**Aboriginal-specific service says: No comorbidity service**

*There's no special Aboriginal community service, except for [name of Aboriginal service removed] but I don't think they're mental health. (CMS 7)*

All were critical of the system of services dispersed outside the Aboriginal people's local region:

*They don't want to go to a million different services. They want one they trust and can work with to coordinate that stuff. (CMS 2)*

*You look at any country you like, you've got a medical service, and you'll find that people who use it are from a certain radius from their home. They won't go 100 miles to see a doctor, unless it's an emergency. (CMS 6)*

Participants identified the need for specialised Aboriginal services within all mainstream and Aboriginal-specific services to cover MH-AOD problems:

*I think, as in most services, we say that we're going to do Aboriginal business differently and culturally-appropriate, but actually I think we give them the same service we give anybody else. (CMS 2)*

The persistent and ineffective policy of identifying what/who to treat based on whether their primary issue was MH or AOD added weight to the argument now for a single service in one place to respond to MH-AOD comorbidity holistically:

*Again, which is first, chicken or the egg, in terms of is the drugs making someone unwell or is it un-wellness making them use drugs? Don't know, so why not treat both ... (CMS 6)*

The overriding message was the urgent need for accessible, culturally-appropriate MH-AOD services:

*Comorbidity, it's all part of the health service, so it's not a separate sort of area. We should all be comorbidity workers, especially in psych, because we do have more alcohol and drug and issues ... (CMS 6)*

#### **6.4.2.2 Self-referral**

While some services informed the community about AOD and MH services, Aboriginal and non-Aboriginal consumers of government MH services had to self-refer, which proved a barrier to accessing and receiving appropriate services, especially if consumers were too mentally ill to self-refer; they had “no support” and “no help”:

*It's pretty much up to the consumer themselves if they want that help. We can provide information, pamphlets, regarding other services. ... we don't know if they're looking for help. If we don't know that, how do we know if ... they need us ... (CAS 9)*

*They will be ... suicidal or quite aggressive, so the majority would be aggressive and suicidal at the same time due to the things that are happening in their lives ... (CMS 5)*

#### **6.4.2.3 The run-around**

*Some ... will go from this one and then go to another one, and then to another one ... there's not one place where you can go and get service adequately there ... (CMS 7)*

The run-around was stressful and complex for clinicians, workers and Aboriginal consumers:

*... I was that flat out last week and I had a funeral to go to, I totally forgot a consumer had an appointment on Monday at a hospital and I only realised that on Tuesday that I had actually missed, and it made me feel no good and it made me think, “Am I starting to lose my mind because I forgot that?” (CAS 8)*

*They do an assessment, and they work out what their needs are, what's going on ... they come back and start making referrals. ... It's going to other places, travel and expense. It's too hard for them. (CMS 4)*

Some used technology to assist consumers overcome the run-around:

*Say if I got a consumer sent to me from that way, my first call would be to go to [name of Aboriginal service removed], find out where the services are in there, jump on Google ... and then I'd go and engage with the service ... That's where we advocacies would do that. (CAS 8)*

Participants suggested the ideal would be to ring the worker of a one-stop MH-AOD service, walk the person to the service to introduce them and receive feedback about their progress and outcome.

#### **6.4.2.4 Inflexibility**

Several participants identified inflexible service boundaries – policies, hours of operation, geographical boundary and communication – as barriers to MH-AOD service delivery, with non-Aboriginal MH and AOD clinicians and workers from mainstream services believing that legislation has been the core reason for service inflexibility. They believed there was a need to make MH and AOD services more flexible to close the gaps:

*... we've got a National Mental Health Standards which should be culturally-appropriate but then legislation at times prohibits that. ... Protocols and procedures and regulations ... Most ... NGOs ... are only open on Monday to Friday, so if there is a crisis on the weekend, where do you go? Is there an emergency contact number...? Really not. Because the only mental health number they can contact is under our mainstream mental health services or under the [name of AOD service removed]. (CMS 5)*

*If families are really concerned about their children over the weekend, they need to go to the hospital through accident and emergency for an assessment. (CMS 2)*

*The one OD'd himself because he couldn't get access to service quickly enough and ... the staff here had done everything he could to help and then realised that they had to ring [name of acute service helpline removed]. They rung them the Friday to go and see him because he was talking very strangely about self-harm ... Come the Monday, the staff ... rang to see how it went. They hadn't got around to it yet, so the staff here rung the police to*

*do a welfare check and he was dead. ... we are aware now that [name of acute service removed] ... are short of clinicians and workers too ... (CAS 8)*

*We've got a lot of services already in our areas and programs, but there's a thing called "area". If they're in that area they can't come to this area .... Our mob move so it's weird. It doesn't make it really easy for them. (CAS 8)*

*Communication between adult health and child health was non-existent; there was a big barrier. ... They wouldn't tell us about the history of the child who is now becoming 18. So that was a big barrier for people. (CMS 6)*

A commonly-stated solution was:

*If a service comes to help a person, there should be a one-stop-shop and people working ... I don't know why there's a gap. (CMS 7)*

#### **6.4.2.5 Unsustained service**

All participants reflected on the uncertainty of government and non-government service sustainability due to short-term or inconsistent funding, moving services around, loss of partnerships and dealing with angry consumers, highlighting the system's non-responsiveness to mainstream and Aboriginal consumers' needs, and MH and AOD clinicians' and workers' long-term needs:

*Some funding has gone and they are not there and there are some services which are taking this service and working the same but the funding has been stopped. There are good services that are not consistently going on. (CMS 3)*

*One place has closed down hmm [can't remember, thinking, ticks finger], a dry out place hmm, hmm, hmm, and then there are other places like hmm, hmm [name of a non-government organisation removed] hmm. But some Aboriginal fella doesn't want to go to these places ... because they are not culturally friendly. (CMS 7)*

*Especially when you've got a mental health consumer or they get really, really annoyed and frustrated, and then you try and say, "Do you want to*

*come and do this?” “Nah, can’t be bothered ... What’s the point? It’s just going to stop anyway”. (CAS 8)*

Participants were frustrated, for example:

*I wanted the partnership [smiles and touches heart] ...They give us a bandaid to do a project and then they take it off us and our community get very upset about that. They don’t trust us because we set them up to fail ... (CAS 8)*

Special mention was made of the impact of unsustainable programs in the child and adolescent service on future generations:

*Support parents with their parenting with young children, which is the foundation for sound mental health later in life. So we offer security groups, we offer incredible years group. We have run those groups for Aboriginal families in the past. But we do not do so consistently because we do not have the resources. (CMS 1)*

#### **6.4.3 Main theme 5 – Referral: Fishing for Nunga places**

Five sub-themes emerged from “referral”, the process services use to meet their objectives, as summarised in Table 6.5.

**Table 6.5: Sub-themes and internal components of “Referral: Fishing for Nunga places”**

<b>V Referral: “Fishing for Nunga places”</b>	<b>Internal components</b>
1) Assessment	Essentiality of assessment Assessment leads to referral Need for tailored assessment strategy
2) Silo service	Silos of service approach Fragmentation within services Clinicians and workers unaware of other related services Constraints: silo service but comorbidity consumers Communication
3) Lip service	Handballing consumers
4) Waiting time	Problem getting into a service due to long waiting period

	Missing service due to long waiting period
5) Complexity in referral	Complexity in maintaining connection Service duplication Acute problem is taken care of but no referrals Falling through the systemic gap

### 6.4.3.1 Assessment

*Do a thorough interview and determine the issues in that person's life. More holistic purpose. (CMS 6)*

Most participants who shared personal experiences of assessment stressed the difficulties of thorough assessment, its importance for identifying hidden comorbidity and its purpose as a referral tool. They highlighted the value of informal conversation to determine and respond to Aboriginal consumers' immediate practical needs, and helping them to rebuild their lives holistically:

*A lot of our guys don't tell us everything. They don't want to give too much about what drugs they are on, how much alcohol they're drinking, so we've got to try and get as much information that we can in our assessment so that we can refer ... (CAS 9)*

*... you find out the reason why he struggled to pay bills or ... because of a mental health problem ... that might be compounded or made worse by alcohol, but you don't know that first off. (CMS 7)*

*Just talk and not force questions to meet our criteria. ... Do not just focus on psychiatry, look at other areas as well; social, medical, illnesses etc. Inform them of the issue, what has been done about it and this is what we recommend. (CMS 6)*

If MH clinicians and workers suspected contributing MH factors other than AOD use, they referred consumers to a psychologist for further assessment and diagnosis:

*Drug and alcohol issues do not tend to be raised within the first few interviews. It's something that's not talked about usually until some time down the track. (CMS 2)*

#### **6.4.3.2 Silo service**

*What we do is break services down so that they are so siloed ... they never meet and I think that's the problem. I think that's a problem for everybody ... (CMS 2)*

Some participants explained their own unawareness of each other's services:

*I'm still getting my head around what's available. (CAS 8)*

*As far as the services goes, I think they should all know what each other is doing so that it's a good referral thing to know ... You can say, "Go out there because they provide this, this, this". Not everyone is like that. (CAS 9)*

*I've been to meetings and you hear about the silo effect, like people in an organisation sometimes use a combination but they all operate within their own little camps and even in some organisations there's not a lot of communication and they fight. (CMS 7)*

They stressed that MH services look primarily at MH issues and refer consumers to other services for help with AOD problems, and vice versa, but needed to treat both:

*We deal with the mental health and they deal with the drug and alcohol aspect. So it is still very disconnected ... we might do some joint case work together ... It would be much better if it was co-located, looked at the whole person and understood the person in terms of their sense of community. (CMS 2)*

*... if our guy's got a mental health issue, we don't really deal with mental health. (CAS 9)*

#### **6.4.3.3 Lip service**

Participants spoke cynically about "lip service", or "handballing" consumers between services:

*There are some agencies that just handball the issue, which is sad because what a lot of our people, consumers, they might get aggressive or abusive due to the mental health and the agency, they might not want to deal with it, they don't know how to deal with that, they get intimidated. (CAS 9)*



*We would look at finding out enough information as soon as they raise it to work out what to do. Then we would make referrals. We wouldn't necessarily follow the referral through ... we would give the consumer the information and suggest they follow it up themselves. (CMS 2)*

#### **6.4.3.4 Waiting time**

“Fishing for Nunga places” encompassed frustrating, long drawn-out processes of getting Aboriginal people into a MH or AOD service, then losing them due to long waiting times and missed appointments:

*One night for this fella, I called five different accommodation places, just trying to get him something. ... all of that time he was sitting in the office waiting [sighs] ... (CMS 4)*

*... most people have problems with drug and alcohol or mental health ... it is human nature to say, “Look, we want to address that problem straight away”, and you tell them, “We would like to give you a service but unfortunately ... you will have to wait a few months or a few weeks or something” ... We lose lots of consumers that way. .... (CMS 3)*

*... they've got mental health problems and they are struggling to function in their relationships, ... in school or work and ... so forgetting appointments and not being able to make appointment; all part of the problem. (CMS 1)*

Participants wished for:

*... more resources and shorter waiting lists, but ... Mental health generally struggles to deal with the number of referrals they get and they see people on a priority basis. To see people straight away or in a day or two or three, it's not always possible. (CMS 3)*

#### **6.4.3.5 Complexity in referral**

Disconnected specialised services, complex range of referrals, consumers not fitting MH or AOD service criteria, service unavailability, case management and splits between services were all cited as reasons for complexity and ineffectiveness of referral:

*Generally we refer a lot of people to GPs all the time because GPs are meant to be the primary cook in the whole wheel of a person's life, they're*

*the ones who can loop them to all other appointments, so a lot of referring goes on ... (CMS 6)*

If a drug user has no ongoing MH problems, the MH service will no longer work with them, illustrating a break point/gap in continuity of care:

*We would request that they go off and get some help for their drug addiction. We don't take on a primary role with drug addiction. (CMS 6)*

Consumers are referred across various disconnected services as part of a 3–6 month case plan at every step of intervention for MH-AOD comorbidity because services do not have the facilities to cater for MH and AOD together:

*When we've got the referrals that means they're asking for help. That means we need you to go out there and see them, that's important. ... One day we might get 3 or 4 referrals, so it's always coming in. (CAS 9)*

*They tried to get that going and we're probably trying to get it going here but because, the problems somebody comes to your service for, but you can't deal with it, so you've got to refer them on to somebody else. (CMS 7)*

Many Aboriginal consumers are referred frequently (particularly children), creating service duplication:

*They have duplicated it; it's worth you contacting other agencies. (CMS 3)*

Participants had experienced working in a coordinated fashion with the disconnected services but said it created confusion; it did not work in practice:

*They've now integrated the teams and they've split the teams from Salisbury to Playford. I'm not sure whether they've retained that small team; they specifically work with Aboriginal people. So there are ... [thinks – looks up – silence] I'll have to check that out...hmm, actually we act as resource people hmm... [slight smile] ... There are lots and lots of breaks in the links, so there is a lot of doubling up of services. ... not enough communication between government and non-government organisations. (CMS 5)*

## 6.5 Overarching theme 3 – The future: Needs-based MH-AOD service

The overarching theme, ‘The future: Needs-based MH-AOD service’, emerged from participants’ perceptions and experiences of the current MH and AOD health systems’ capacity to effectively meet consumers’ MH-AOD care needs. Two main themes emerged; “need” and “strategy”.

### 6.5.1 Main theme 6: Need (MH-AOD service practice)

“Need” encompasses the five sub-themes summarised in Table 6.6.

**Table 6.6: Sub-themes and internal components of “Need”**

<b>VIII Main theme: Need (MH-AOD service practice)</b>	<b>Internal components</b>
1) Coordination/linking	Challenges in linking services Breaks in links Unclear pathway of linking and taking the lead Responsibility in linking
2) Effectiveness of referrals	Referrals: how it happens Causes of referral <ul style="list-style-type: none"> <li>○ No service</li> <li>○ Overload</li> </ul>
3) Outreach service	Outreach service <ul style="list-style-type: none"> <li>○ Home</li> <li>○ School</li> <li>○ Youth centres</li> </ul>
4) Dedicated comorbidity service	To be proactive rather than reactive
5) Aboriginal support	Involvement of mentors Advocate is needed with confidentiality

#### 6.5.1.1 Coordination and linking of services: How it happens and extent of service

Participants explained that coordination demands MH and AOD services to work with each other so as to jointly coordinate consumer care. One service has a comorbidity group that visits other Aboriginal services but there is no joint comorbidity service provision:

*Comorbidity working group primarily to look at comorbidity issues to connect services but we don't provide services jointly. (CMS 2)*

*I'm north, central and west. So we are trying to link them up that they still need that support. I'm trying not to take on no more, but that's difficult too because where do they go? (CAS 8)*

Participants shared their joint experience of one consumer whose comorbidity issues remained unresolved despite numerous services working to coordinate care:

*Collaborating, working together for the good of somebody and I do that ... there might be four organisations that you have to work with for one person. But sometimes in the extreme that could be twelve organisations ... and nothing's being fixed. Well that's referrals' role. (CMS 7)*

*I think our links with ... Indigenous services should be much stronger. I think we should probably be having a lot more regular contact ... (CMS 3)*

In practice, participants identified that MH and AOD services have difficulty working together while keeping up with providing their particular service:

*I don't think we have too many services that are connected enough to what they should be. We need people that have expertise in mental health and drug and alcohol. Or a service that sits together. (CMS 2)*

*To link up with other services that may be able to help and support, but it's getting that time to sit down and work on that to get that all in place, because apart from that this particular person, I'm doing, taking them to hospital appointments, making hospital appointments, he's a guy who needs someone to be with him every time you go to an appointment, he gets very agitated and very scared in the waiting rooms. But when you're with him though he's very calm, you can relax him. So a lot of my time is spent sitting in hospitals or sitting in waiting rooms with people...,but it's time consuming because there's other people that need things ...I do feel that the consumers aren't getting the full support they need. (CAS 8)*

#### **6.5.1.2 Effectiveness of referrals**

Participants felt that explaining the service referral structure – process of handing a

consumer over from one service area to another – complicates the referral process, as does the “split” in the service structure at every step of the recovery pathway, and ineffective communication between services:

*We would try and make sure that the consumer understood that, but sometimes things overlap and that’s when it gets messy. There is a fine line between mental health issues and drug and alcohol issues and what is the main concern. (CMS 2)*

*So we would be looking at, “Do they have an AXIS 1 disorder or possibly an AXIS 2 disorder that we can provide treatment for?” (CMS 6)<sup>20</sup>*

*For long-term consumers, do services talk with each other? Do they follow up if the consumer goes here and there? They should, but they don’t always. (CMS 3)*

### **6.5.1.3 Outreach service**

Participants highlighted the essentiality of follow-up after AOD detoxing in the form of outreach and rehabilitation services in the home, schools and youth centres, but this did not always happen:

*So it’s good to keep up those visits to make sure they’re progressing right, follow up! (CAS 9)*

*We offer an assertive outreach to Aboriginal families and other families and that includes home visiting, seeing children and young people in their schools but also youth centres. Outreach at Primary School, which is just over the road there ... (CMS 1)*

*We say that we do home visits and things like that but really, our service is so busy that we don’t do as many... (CMS 2)*

Other participants highlighted the importance of teamwork between Aboriginal and non-Aboriginal clinicians and workers and the consumer and family, and the need for more Aboriginal outreach workers:

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<sup>20</sup> According to the *Psychiatric Diagnostic Manual IV* (DSM) Axis 1 includes psychiatric diagnoses of depression, anxiety disorders, bi-polar disorder, psychosis and substance dependence, and Axis 2 includes personality disorders, behavioural disorders etc (PsyWeb, 2013).

*A lot of people won't go to houses and "goonyas"<sup>21</sup> won't go unless they've got an Aboriginal person with them. I see that as a very important thing. (CMS 4)*

*We need more outreach workers, Aboriginal outreach workers, a lot of Aboriginal homeless people have a comorbidity, mental health condition. I'd say 90% of them would. (CAS 8)*

#### **6.5.1.4 Need for a dedicated MH-AOD service**

Participants spoke of the priority for a proactive MH-AOD service that built a sense of community around Aboriginal people with MH-AOD comorbidity, and “desperate need” for a dedicated comorbidity service:

*What we are doing is **very reactive, it's not proactive** ... they are not really helping the people who are already ill from the consequences of what has happened to them before and that's black or white ... (CMS 5)*

*Aboriginal families come because they are desperate for a service. ... they feel like they have no other choice. (CMS 2)*

*It's been said for years, way before when I was boy ... I think it's important. ... I remember talking about it then, having our own detox and mental health place – Yeah! [Smiles]. (CAS 9)*

#### **6.5.1.5 Aboriginal support and advocacy**

Almost all participants recognised the importance of Aboriginal support for vulnerable Aboriginal consumers, emphasising how essential it is to escort them to appointments, and act as advocates and mentors:

*I had a lady, I took her to her social worker and the consumer, she got really annoyed, and just would keep walking out and ... obviously she doesn't like that worker ... And I have another consumer that goes, and she refuses to go, she will not get her depos<sup>22</sup> there. ... I met her worker one day and her worker was very rude, and I thought, “I need to meet with you”. So*

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<sup>21</sup> Goonyas = non-Aboriginal clinicians and workers

<sup>22</sup> “depos” – A slow release, long acting antipsychotic medication given as a deep intramuscular injection every 2 to 4 weeks

*I had to walk away then. Her attitude, her body language, everything was like ... (CAS 8)*

*They need someone to advocate for them because sometimes things have broken down, they're in a muddle, so they hit the bottle and that doesn't help at all ... sometimes need ... an advocate. (CMS 7)*

Aboriginal participants highlighted that Aboriginal consumers will not easily admit to having comorbidity problems but they may if they have an Aboriginal worker to discuss it with. Aboriginal workers can “get in the door” by breaking down cultural barriers straight away:

*When they see an Aboriginal face, you know, that's good. Especially if they know you, they know your name, they know who you are. (CAS 9)*

*A lot of service providers use me as a culture broker, because when I'm with the consumer, there's more communication going on, and it helps break down that barrier, because I already have a rapport with that consumer. (CAS 8)*

### 6.5.2 Main theme 7: Strategy

“Strategy” (strategies for effective comorbidity service) incorporates eight sub-themes which are key suggestions for improved comorbidity service, as summarised in Table 6.7.

**Table 6.7: Sub-themes and internal components of “Strategy”**

<b>VII Main theme: Strategy</b>	<b>Internal components</b>
1) Wraparound	Wraparound service – one-stop-shop, on-the-ground input, co-location, community hubs
2) Reachable	Reach the unreached <ul style="list-style-type: none"> <li>○ Mobile population</li> <li>○ Visibility in community</li> <li>○ Ngangkari</li> </ul>
3) Components	Aboriginal and mainstream services with preventive, promotive and tertiary health services for comorbidity – practical challenges for future service
4) Educate	Individual consumer education to include family and their related community Education empowers decision-making and educating

	<p>in an appropriate manner</p> <p>Modes of education through advertisement and word-of-mouth</p>
5) Engage	<p>Engagement a two-way process fostered by trust</p> <p>Engagement with services is essential</p> <p>Barriers to engagement – language, custody, confidentiality</p>
6) Trust	<p>Trust enhances communication for service implementation</p> <p>Language to build trust</p> <p>Barriers – child protection issues</p>
7) Include	<p>The right to decision-making</p> <p>Giving responsibility to make individual choices</p>
8) Moving forward – addressing breakpoints	<p>Breakpoints</p> <ul style="list-style-type: none"> <li>○ Location</li> <li>○ Disconnection</li> <li>○ System</li> <li>○ Coordination of referrals</li> <li>○ Aboriginal/non-Aboriginal divide</li> </ul>

### 6.5.2.1 Wraparound services (Hub)

All participants said it is essential to replace the current referral system with a well-resourced, local, needs-based “wraparound” MH-AOD service in line with on-the-ground feedback from service providers and consumers:

*It would be great to see a wraparound service where you know you can go get everything met at once. In an ideal world that would be great ... the way I can see it would be is basically all of government services would change to hubs and then have workers in each one and each hub will have all those service providers in. (CMS 4)*

*All I can see is that we should use services differently. It is not rocket science. At the very least it should be sort of community mental health and drug and alcohol services in the same building... (CMS 3)*

*... in terms of capacity, think about location of services. (CMS 1)*

*A one-stop-shop for our mob, we need to have them in our services. Instead of taking all these consumers to that clinic, that clinic, that clinic [points*



fingers around], *have it here. We need to be done in our services. We need more workers. We need psych nurses. We need psych health workers. We need the psych clinics run from our office, well, within our clinics. So there is option for our people. Our people can make a choice; either go to a white mainstream service or come to our service. ... We need our voices out there with these decision-makers and our community people need to have their voices too. ... Stop restricting us health care workers. (CAS 8)*

*Actually having Aboriginal workers to work and have the ability to work across drug and alcohol and mental health. Having people co-located, maybe if that can happen. (CMS 2)*

### **6.5.2.2 Reach the unreached**

All participants accentuated the importance of providing services that Aboriginal people could reach easily, particularly children; the need for greater service visibility in the community; the issue of a mobile lifestyle as a barrier to treatment and follow-up; and the need for traditional Aboriginal healers to be fully involved in MH-AOD services to reach those Aboriginal consumers who need holistic cultural healing and/or do not trust mainstream treatments (largely medication):

*Us being in the community more often is the only way to be more visible to the Aboriginal community. (CMS 6)*

*A small part of my role is actually going out and trying to get more fellas aware of services. (CMS 4)*

*Look at the safety of the children, domestic violence ... because a lot of child abuse and stuff like that when alcohol and drugs are involved. (CAS 9)*

*It would be fantastic to get some Aboriginal healers down here and see some of our people. It would mean a lot to them. ... (CMS 6)*

*... Aboriginal Ngangkari attached to it, Aboriginal workers or cultural awareness training. (CMS 7)*

### **6.5.2.3 Components of a MH-AOD service**

Having suggested what they thought could be the ideal solutions to service problems,

participants began to critically analyse these as workable practice components of a dedicated MH-AOD service:

*If you separate the units and break them out to where all the hubs ... you'd be breaking down that network, you'd be breaking down their resources ... it is hard. (CMS 4)*

*Having a stand-alone service, I don't think that you can to be honest. There is no one service that covers all of the problems. It should not be all under psychiatry. (CMS 6)*

*I think we have to be co-located with the drug and alcohol workers. I think people need to be trained and skilled enough to be able to do that work. (CMS 2)*

Some argued that a mandated service could help consumers “get in the door” by giving them information about strong links to services around their area. “Intense case management” would be an “ideal way of doing it”, with a centralised service “out in the community”:

*One-stop hub for information, so you used to be able to go there and say, “Look I've got these issues”, and they'd be able to refer you to people. And say, “Ok, look, you need to go see this person, this person, this person”. “I'm homeless”. “Ok, you need to go see homeless gateway, you need to go see these shelters over here”. (CMS4)*

#### **6.5.2.4 Education and Hope**

*They need to be encouraged as life is good after you give things away. (CMS 7)*

Participants commonly stated the need to educate individuals, family, extended family and community about MH-AOD comorbidity and available services:

*Talk about how that affects the person, talk about transition from hospital to home and then to services. Talk about how you get services. Talk about community and rehab. Talk about assistance, talk about grief and loss, and talk about advocacy, that's part of the services. (CMS 4)*

*There needs to be some sort of approach to the communities that they live in, maybe helping them to retain, to get back their pride. Their pride! [stresses the word]... we are individualistic, we don't look at the family, the culture or the expanded family community. So if we start to broaden our outlook, actually address community ... (CMS 5)*

*We can give the person a sense of, "Oh okay, what you're telling me I've got some idea about. This is what we can do". ... Try and get a cooperative approach happening. (CMS 6)*

*Put some posters up in reception area so that they can identify. ... With Aboriginal people it's like, once someone hears about something, they will talk about it to everyone and it will get around the community, the "Bush Telegram", the "Nunga Grapevine". ... (CMS 4)*

*I did up a little pamphlet and ... put it in little strategic places like in the schools, shopping centres, Aboriginal health in the hospital, library, second hand shop next door. So you advertise your service. ... it's a hard ride. (CMS 7)*

#### **6.5.2.5 Engage**

Participants emphasised consumer engagement must be a two-way process, dependent on mutual trust, as shown in the following example of how a MH-AOD clinician managed to engage with two brothers to ensure the best outcome for both:

*... I was in ED and this ... it was a good outcome for a bad situation. This guy was really short and skinny, massive drinker and he was going to die. His liver was shot and he was still drinking a high journey, he wanted to drink himself to death. Then his brother came in – 6ft 4in, build proverbial muscles everywhere and he was a builder, and he came to me and he was almost threatening me, "You will do something". I sat him down and I said, "Look, this is the situation. Your brother knows that he is dying from this and he is happy to die. He would rather die drinking than having the prospect of not drinking and you paying his bills and doing all of those sort of stuff, all you've done is free him up money for drink". So, I sat him down with his brother and went through the story again and the older brother, the*

*skinny one said, “Yeah, that’s exactly how it is. I want to keep drinking. I know I’m going to die ...” and the younger brother went, “Aah, okay. I can live with that. You’re getting no more money from me, but you can come over to my house any time and have a meal”. Because I said that, “Don’t just cut him off and say, ‘That’s it, finished with you’, leave it open, invite him over for a meal ... not a problem. You won’t be drinking at my house”. The younger brother came to the acceptance and that was a beautiful thing because he had been struggling for years. (CMS 6)*

Engagement can be a complex challenge:

*One family, the child is not with the mum and dad because they have an alcohol problem, so the child is with the grandpa. I’ll try to engage with the mother and father, but I’ll support the grandparents because they’ve got the child. ... (CMS 7)*

*It’s not like they don’t want to tell you anything, it’s just that they are frightened it’s going to get around to the rest of the community. (CAS 9)*

*Young fellow, isolated, family cannot deal with him, he’s only like 26, 27 ... will just go “Yes, yes, yes, yes, yes” and he won’t accept support. ... He’ll accept it if it’s from Aboriginal services, but ... [silence. Says with sigh]. (CAS 8)*

Participants also stressed the importance of not enforcing service protocols when trying to engage with consumers, and of using consumer-appropriate language:

*Just talk ... is a better way of doing things than formal criteria. Know what their standards are and what they want. It is hard because it is so varied in terms of the way they behave. (CMS 6)*

*... we’ve got Aboriginal families who moved down here from traditional lands and it could be English could be their fourth or fifth or even more removed language, and so language could be a huge issue. (CMS 4)*

*We sat and followed the yarn for a little time. I used some language words that he knew and that rapport was created straight away ... that doctor was saying ... the last six weeks he’s been there he hasn’t talked to anyone, so*

*there's that cultural thing there, he wouldn't respond to any questions from the doctors or anything, but while the Aboriginal worker was with him, he was telling all the information they needed. (CAS 8)*

#### **6.5.2.6 Trust**

Participants could not stress strongly enough the importance of trust and its links with communication and understanding:

*... they think sometimes that they are the only people that's got those problems and if you can relate to them well then they will trust you and will tell you anything you want to know. (CMS 7)*

*A lot of Aboriginal people get very scared when they are unwell, but just by saying some words or reminding them of connection to community, connection to land, connection to people/family that makes a bond, it creates a bit of a trust [stresses the word] with a lot of our people. (CAS 8)*

Participants also emphasised the link between cultural awareness and building trust:

*For trust a lot of education still needs to go and cultural awareness still needs to be incorporated in mental health, and in comorbidity, as the biggest thing in the Aboriginal community is cultural validation. (CMS 4)*

#### **6.5.2.7 Include consumers as decision-makers**

All participants spoke about the importance of understanding Aboriginal consumers' preferences in any new comorbidity care structure, thus empowering them to make decisions:

*He says, "I don't want you coming to my house". "Fine... come into the office". So they come into the office and they start telling me their story and then you listen ... (CMS 6)*

*Mostly Aboriginal consumers will want to speak to Aboriginal people. ... Because they feel comfortable doing that. ... what will happen is that when the non-Aboriginal worker is there they will say a story but when the non-Aboriginal person leaves the room you get the real story ... and then as an Aboriginal consultant have to tell the non-Aboriginal worker what they've actually said when they weren't there. ... So to me a service that is on-the-*

*ground with their community, community able to have a bit of say about how they receive that service and what sort of service they get. (CMS 2)*

There are situations where consumers can make their own decisions, however certain services or institutions may question their choices. Clinicians and workers need to work with Aboriginal consumers to honour their choices while meeting service requirements:

*The Courts, Families SA or child protection ... give your orders to do certain things. So, rather than “doing”, try to paraphrase or break down what's required of them, help them to see that this is the way you access your child ... (CMS 7)*

### **6.5.2.8 Moving forward – addressing service breakpoints**

Participants identified “breakpoints and gaps” (see Table 6.8) that form barriers to the availability and accessibility of a dedicated MH-AOD service. They also identified opportunities for action.

**Table 6.8: MH and AOD clinicians’ and workers’ perspectives: Five factors affecting access and quality of care for MH-AOD issues**

<b>1. Breakpoint</b>	<b>2. Widening gaps</b>	<b>3. Opportunities for filling the gaps</b>
<b>Location</b>	<p>Availability of MH and AOD services is limited due to casual or part-time contracts for many clinicians and workers</p> <p>Services were located in different localities</p>	<p>Provide specialised comorbidity service in the northern regions of Adelaide with improved transportation</p>
<b>Disconnection</b>	<p>People with mild to moderate comorbidity conditions often were not able to access services and their issues became chronic and complex. This is particularly so with MH or AOD services</p> <p>Consumers experiencing comorbidity care problems were unable to access services from hospital or non-hospital sectors</p>	<p>Establish a one-stop service with dedicated comorbidity clinicians and workers</p>

<b>System</b>	<p>Clinicians and workers identified that there is not a single service providing holistic AOD and MH comorbidity care</p> <p>This made Aboriginal consumers, clinicians and workers to run-around looking for services, with many consumers not getting any services at all</p> <p>It was harder for individuals with little or no extra money to support their transport costs, treatment and capacity to be admitted for comorbidity care</p>	<p>Ensure uncomplicated policy for services and guidelines for clinicians and workers in practice, and support for Aboriginal consumers to access</p>
<b>Coordination of referrals</b>	<p>Communication was a challenge between siloed services leading to service duplication and comorbidity consumers missing needed services</p>	<p>Due to high numbers and frequent referrals, any coordination between services was very difficult</p> <p>Having a supported, facilitated pathway to comorbidity service provision is essential</p>
<b>Aboriginal and non-Aboriginal divide</b>	<p>Participants recognised that Aboriginal people have cultural beliefs and worldviews of health and health care that can differ from those held by non-Aboriginal people</p>	<p>Cultural respect and culturally-safe care by inclusion of Aboriginal clinicians, workers, Ngangkari and choice of using Aboriginal and mainstream MH-AOD services</p>

#### 6.5.2.8.1 Location

Participants identified that many consumers fall through service gaps – distance and disconnection between services, lack of transport, homelessness, “living rough” in parklands, difficulty coordinating across multiple services and Aboriginal cultural issues – which are exacerbated by unavailability of a dedicated, accessible, local MH-AOD service, including a detoxification program.

#### 6.5.2.8.2 Disconnection

Currently, comorbidity care is haphazard or absent due to disconnected MH and AOD “silo” services and practices with extended waiting periods. Difficulties in travelling between MH and AOD services for family to visit consumers is also a problem. Lack of

holistic comorbidity care by MH and AOD services contributes to no continuity of care, adequate follow-up and monitoring, leading to consumers having regular relapses and crises. This is the vicious cycle of repeated, disconnected, short-term MH *or* AOD care, emergency/acute hospital contact, family distress, and deteriorating health, social and emotional wellbeing, and worsening comorbidity.

#### 6.5.2.8.3 *System*

The mainstream health service system is at odds with the Aboriginal community's concept of health and illness. Three needed strategies were identified: 1) incorporating Aboriginal medicine and healers into Aboriginal-specific services; 2) preventive, promotive and educative services for young people and adults; and 3) a reliable, robust comorbidity service approach (increased numbers of beds, clinicians and workers, and consumer education) to stop the vicious cycle of comorbidity, particularly among children:

*Then we see the importance of children's centres and those sorts of holistic services for families with young children to help promote the development of children, support their families. (CMS 1)*

#### 6.5.2.8.4 *Coordination of referrals*

Participants recognised that the common practice of referrals between MH and AOD services for consumers with MH-AOD problems created difficulty in developing direct, interpersonal relationships between clinicians and workers, consumers and services. Work overload impacted on levels of trust, service duplication and difficulty determining "who does what". Higher level policy (operational level) was seen as a solution by the clinician and worker participants.

#### 6.5.2.8.5 *Aboriginal and non-Aboriginal divide*

The establishment of good rapport and trust was identified as essential for MH-AOD care. Participants acknowledged they could only work to establish trust if appropriate intercultural understanding was recognised and provided. They explained that familiarity with Aboriginal culture is essential and suggested cultural training for all clinicians and workers, and other staff.

## **6.6 Conclusion**

This exploration of MH and AOD clinicians' and workers' (Aboriginal and non-Aboriginal) experiences and perspectives highlights "no dedicated MH-AOD service"



within the Salisbury and Playford LGA region, including for Aboriginal people, and that services need to be culturally-appropriate. Participants identified the urgent need for holistically-integrated, accessible, on-the-ground MH-AOD services. Recognition of the challenges and suggested improvements for providing capable, local MH and AOD health care for Aboriginal consumers and families affected by MH-AOD comorbidity provides a starting point for better service and practice development for treatment responses and outcomes. The next chapter reports support service staff's perspectives.

## 7 Findings III – Perspectives of Support Service Staff

### 7.1 Introduction

Support service staff play a major role in assisting consumers to access MH and AOD services. They help consumers reach and approach services, and get connected to clinicians (**reach + approach + connection = access**). This chapter explores the perspectives of five staff from two mainstream (coded SMS<sup>23</sup>) and two Aboriginal-specific (coded SAS<sup>24</sup>) ancillary support services through individual interviews and one couple interview (SAS-C<sup>25</sup>). Four participants were Aboriginal and one was non-Aboriginal. They lived in the Salisbury and Playford LGA region, and had a wide range of experience working with Aboriginal people with acute and chronic MH-AOD comorbidity and related issues.

### 7.2 Thematic framework

The overarching thematic framework used in the previous two chapters also provides the framework for presenting these findings. The three overarching themes remain constant but ‘Practice’ replaces main theme 6 (‘Need’). The sub-themes and their components vary, reflecting the support service staff’s different roles, perspectives and language from those of the Aboriginal Consumer Advocates, and MH and AOD clinicians and workers (see Figure 7.1). Participants’ contributions are in block italic quotations.

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<sup>23</sup> SMS = Support Mainstream Service Staff (personal interview )

<sup>24</sup> SAS = Support Aboriginal Service Staff (personal interview)

<sup>25</sup> SAS-C = Support Aboriginal Service Staff – Couple interview

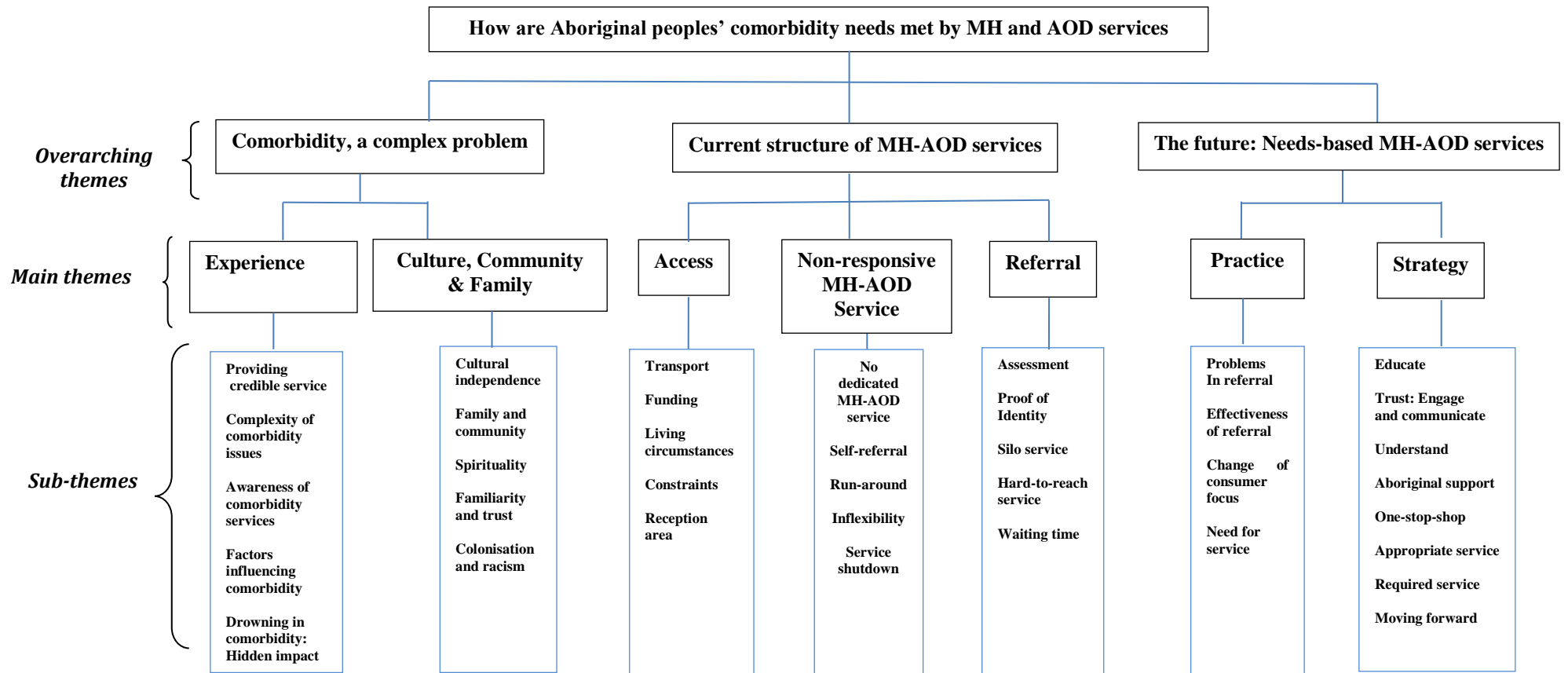


Figure 7.1: Thematic framework of comorbidity service needs: Support service staff

### 7.3 Overarching theme 1 – Comorbidity, a complex problem

“Comorbidity, a complex problem” encompassed the main themes “experience” (with a focus on credible service and comorbidity awareness), and “culture, community and family”, emphasising cultural understanding, respect and sensitivity.

#### 7.3.1 Main theme 1: Experience

Support service staff’s perspectives related to “experience” are discussed under the five sub-themes summarised in Table 7.1.

**Table 7.1: Sub-themes and internal components of “Experience”**

<b>1. Main theme: Experience</b>	<b>Internal components</b>
1) Providing credible service	Staff assist throughout the comorbidity journey Organisation working alongside consumers who are connected well
2) Complexity of comorbidity issues	Comorbidity affects the individual’s holistic health Common coexisting issues Spread of consumers
3) Awareness of comorbidity services	Staff unaware of other related services People not familiar with service (visual thing)
4) Factors influencing comorbidity	Kids from dysfunctional family Habitual “quick” drinking
5) Drowning in comorbidity: Hidden impact	Heavy burden and comorbidity cycle <ul style="list-style-type: none"> <li>○ Police</li> <li>○ Gaol</li> <li>○ Death</li> </ul>

##### 7.3.1.1 Providing credible service

Staff believed they played an essential role in providing credible service by promoting communication, and providing health information and access to outreach services for continuity of care:

*I work to assist the rural and remote Aboriginal people that come down for treatment ... to ensure that they know what's happening, they're being treated appropriately and they're feeling okay about their treatment. (SAS – C 13)*

*... we have got to lift our own credibility as individuals and as an organisation. (SAS 12)*

*Some of them go to the parks, and some go ... to the primary schools, I reckon they're pretty well connected you know, they go to the swimming centres ... on school holidays. ... (SAS – C 13)*

*We've had a couple of patients for 'hospital at home' and that worked brilliantly. (SAS – C 13)*

### **7.3.1.2 Complexity of comorbidity issues**

Staff revealed that many Aboriginal consumers who need to access MH and AOD services commonly have a range of complex comorbidity issues that require holistic care rather than just treatment for one MH issue, or AOD or physical symptoms:

*Alcohol, mental health, homelessness, disabilities ... Consumers are spread through mental illness and drug and alcohol problems, and they are people walking around undiagnosed. ... Heavy drug users ... mix alcohol and drugs ... some may be on mental health medication. (SAS 12)*

*Pancreatitis – that type of thing as a result of over-indulgence in alcohol, so they're coming in with pancreatitis but that's just a symptom of their holistic health needs. (SAS – C 13)*

An Aboriginal participant working in a mainstream support service expressed concern about the indignity people experienced arising from their untreated comorbidity:

*A lot of this stuff that they are using today, it's bringing us down. ... get them fixed and make them happy. (SMS 10)*

### **7.3.1.3 Awareness of comorbidity services**

Lack of awareness of available local MH and AOD services amongst staff from Aboriginal and mainstream support services and Aboriginal consumers was seen as a major issue. This required more education by the available services for the Aboriginal community and staff about treatment and support programs, and how to access these. This would avoid poor MH and further deterioration of AOD comorbidity:

*Am not particularly sure of what service or specific services that they provide, I am sure if there is but we have to go into it and know what's around. (SAS 12)*

*A lot of Aboriginal people don't think about crisis places anyway. They ... just wander off by themselves. I've got grandkids coming down saying, "I'm a drug addict", you know, I'd like to say, like, "Ring up crisis care and they could put you somewhere for the night at a safe place". (SMS 11)*

A support worker highlighted the experience of getting to the doctor's for depression. They stressed the importance of clinicians being more aware of the reason for the consumer's poor MH instead of treating them automatically with prescribed medication:

*... you go to the doctor now and say, "I'm depressed", and he'll give you a tablet. That's only going to make you more depressed and the sides of some of those drugs ... are suicidal. (SMS 10)*

#### **7.3.1.4 Factors influencing comorbidity**

Knowing about a consumer's whole life situation to identify comorbidity causal factors was deemed essential for effectively managing treatment and support:

*Dig a little bit deeper to find out the reason why he's into that negative behaviour. (SMS 11)*

An Elder from the mainstream support service recollected that binge drinking stemmed from the past when Aboriginal people developed the habit of "quick drinking" to avoid detection and arrest:

*The fellas get drunk out in the scrub ... when they get that drink, they just gulp it down for the sake of getting drunk. Getting rid of it quick. ... The younger generation sort of follow the same footsteps ... It's just like it's in their genes ... (SMS 11)*

Staff also identified boredom as a key factor in alcohol and drug use:

*They're sitting in there doing nothing. They're drinking more alcohol. They're getting on with the drugs and of course ... Kids see it and they think, "Oh that's deadly" ... It will go from down to down. (SMS 10)*

### **7.3.1.5 Drowning in comorbidity: Hidden impact**

Staff described the inter-generational impact of comorbidity as “horrific”, with ongoing cycles of comorbidity linked to lack of places at rehabilitation and detox services, leading to increasing contact with police, gaol time, family disrespect and death:

*I know a lot of the people because they're picking them up all the time ... We'd help him out a lot but then he'd go home and face the same issues that he'd come and tell us ... He passed on because he needed a rest ... didn't give up on his family, but he gave up on himself; he had to for him. (SAS – C 13)*

*Some of the fathers there, they've been in and out of gaol all their life and ... some of the kids say, “I don't want to be like my father. ... Gaol bird! That's no life”. We have to strengthen the father into the men and we've got to straighten them from an early age. (SMS 10)*

*Yeah, 95% of the Aboriginal people in gaol because the judge won't give them bail. So, you have to have a very, very, strong support to be bailed. ... When a person is not able to get help for his combined problems, where do you think that he will end up? ... Dead [long silence]. (SMS 11)*

They identified the compounding issue of police needing an appropriate understanding of, and respect for, Aboriginal cultural norms, which appeared lacking:

*Police carrying on like a Star Wars ... they're shining torches in every room in the house at 4 o'clock every morning. There are people ... running away and don't know what to do. (SMS 11)*

### **7.3.2 Main theme 2: Culture, community and family**

The five sub-themes of “culture, community and family” are summarised in Table 7.2.

**Table 7.2: Sub-themes and internal components of “Culture, community and family”**

<b>II. Main theme: Culture, community and family</b>	<b>Internal components</b>
1) Cultural independence (Uniqueness)	Respect Aboriginal culture Culture integrated with country Aboriginal people understand and work with it better
2) Family and community	Harmony of service with family and community
3) Spirituality	Go to Ngangkari in Port Adelaide (outside north of Adelaide study region) to get spiritual service Church influence
4) Familiarity and trust	Some non-Aboriginal staff are not familiar with Aboriginal ways
5) Colonisation and racism	AOD puts people back to colonisation Racism and how to overcome it How it is interrelated

### **7.3.2.1 Cultural independence: Uniqueness**

Recognition of the link between Aboriginal health and wellbeing and belonging to Country, as well as respect for Aboriginal culture, Aboriginal people and Aboriginal Australia led Aboriginal staff to emphasise Aboriginal culture’s uniqueness. They raised the need for “cultural independence”; to acknowledge “Aboriginal Australia”, and to embed this in service structures and practices for the future wellbeing of all Australians:

*When they come here, embrace our culture, we are the oldest, religious culture in the world. We’re older than Egypt. We’re older than any other in the world. Embrace our culture and learn from us. (SMS 10)*

*We need our cultural independence. The major problem is those services are not there. (SMS 11)*

Aboriginal staff were deeply concerned about fading Aboriginality amidst the projection of Australia as multicultural:



*They don't know what culture is anyway, getting the respect back to our people is the main thing, and don't see them as that less, don't disregard the community. Respect the culture! (SMS 10)*

### **7.3.2.2 Family and community**

Aboriginal staff spoke about “information exchange”, “knowledge transition” and sharing health care services to include families, not just individuals, to foster community wellbeing:

*Work with their families to create harmony and talk to the family about what type of services are out there and inform them what type of service we are providing to the individual. ... Meeting their family and community that they wouldn't have met for a while, so it's all about social interaction. ... Do cultural programs, art and reading type programs with them. It helps to integrate our consumers back into the community. (SAS 12)*

### **7.3.2.3 Spirituality**

All staff recognised the importance of spirituality in Aboriginal culture. They recognised traditional Aboriginal healers (Ngangkari) as an essential service, stressing the importance of respecting consumers' choice of spiritual beliefs but also the need for religious institutions to work with health services to achieve the best consumer outcomes:

*I do not know if there are any other groups out here [silence]. Ngangkari, the ones we go to is at Port Adelaide. (SAS 12)*

*A youngish woman, came in, didn't really want to be here [mainstream health service name removed] and didn't really want to be in the ward, so spent a fair bit of her time in one of the courtyards. We sat out there with her and had a yarn ... and told her what we could do with like referrals to wellbeing team and [name of health network]. So she listened to us and that was okay. Then we saw her again, and she said that she didn't want any of our services or referrals done because she had been speaking to her church and the church had told her that she could find the strength within and that she should do that first ... the church had a bigger influence than we had. ... We followed up a couple of times ... gave our contact number if she chose*

*then to follow that up ... [silence] ... we don't have any issue with [name of church removed] but as long as it's helping her. (SAS – C 13)*

#### **7.3.2.4 Familiarity and trust**

Staff talked about how they developed familiarity and trust through talking to Aboriginal people in the community without pressuring them to come into a service:

*You might not want help if you're having too much alcohol, you may not want help today, but tomorrow you might, so here's a little card, or give us a call, or here's my card, you know, ring me up, sort of thing. (SAS – C 13)*

*... if you want to interact, you've got to build their trust first and that could take a while. ... Some won't devour it straight away because they don't think that they trust us. We need that trust for them to tell us what their issues are and then we'll work from there. ... That could take a couple of days, it could take a month. ... Eventually that person will come ... feel more comfortable with that person they've built up that trust and rapport with them. (SMS 10)*

They stressed the need for Aboriginal staff to facilitate familiarity in a short time, which helps them work together better:

*Having Aboriginal people work with Aboriginal people because we have that information about families. So we already have the step in their door. (SAS 12)*

*Over the years they have had a lot of Aboriginal workers in there and I found that a lot of them provide support for Aboriginal consumers that come in, but with mainstream agencies, they have their own process and a lot of Aboriginals have left because they totally disagree with (it) and the way they provide a service specifically to Aboriginal people. (SMS 11)*

#### **7.3.2.5 Colonisation and racism**

Aboriginal staff stressed the harsh impact of colonisation on Aboriginal people (past and present) and its influence on MH-AOD comorbidity. They pinpointed underhand, ongoing racial discrimination and suggested ways to overcome it:

*I think it's because of how our Aboriginal people, being taken off their land, dispossessed, it all goes back to way back ... [knocks table]. When you're taken away, your language and your culture, your dreaming ... then they got all this like alcohol and now the drugs ... [a big sigh] ... it just puts us right down and it will never change until I think they pay respect to our people and give us a bit of responsibility. ... David Gulpilil, he said ... on the video, he then had a Mugabong and he said, "You fella brought in the alcohol, you brought in the drugs, you brought in this ... We never had none of it". (SMS 10)*

*Don't forget Australia is a very racist country and ... haven't made a great deal of change up until now. You still have pockets of racism and sly racism ... they look at you differently ... or they serve a white fella before you, sort of "Get at the end of the line" sort of thing. ... we put up with on a day-to-day basis. (SMS 11)*

*When I look at things like racism ... You can't teach the people who grew up with those things, you've got to go for the kids in the schools; teach the young kids in the school the Aboriginal background. ... The kid goes home and says, "Mum, dad, this Aborigine come in today, he done this and he done that, I learned a lot from him". What do you think that father will do? ... He's not going to hurt that young kid's feeling ... that may have changed his way of thinking. ... Aboriginal Studies ... should be compulsory ... (SMS 10)*

## **7.4 Overarching theme 2 – Current structure of MH-AOD care**

“Current structure of MH-AOD care” comprised the three main themes “access”, “non-responsive service” and “referral”.

### **7.4.1 Main theme 3: Access**

The influencing factors for, and potential barriers to, accessing services emerged under five sub-themes, summarised in Table 7.3.

**Table 7.3: Sub-themes and internal components of “Access”**

<b>III. Main theme: Access</b>	<b>Internal components</b>
1) Transport	Enables assessment Used for run-around Some services provide it
2) Funding	Funding a major drawback; inequitable Money spent incorrectly Cutting funds (political game)
3) Living conditions	Living circumstances Mobile lifestyle Knowledge of staff and how to support
4) Constraints	People (Shy/timid) Aboriginal representation
5) Reception area	Reception makes the consumer either accept or reject service Be encouraging

#### **7.4.1.1 Transport**

Staff highlighted the benefits of providing transport in terms of enabling a healthy staff-consumer relationship. This relationship develops through fostering informal counselling and assessment in a car, in the office or in the person’s house, and enabling staff to “keep on top of” consumers’ appointments while emphasising that having to get public transport to access services is a barrier to care:

*Public transport is the main issue. If you can get the transport up and running for them then they will tend to use it. ... They use a lot of the services out there to get them from A to B, pick him up and bring him in. ... It all depends if you’re already hooked up to the service. ... Try and make it easy for that consumer to get to those various appointments. (SAS – C 13)*

#### **7.4.1.2 Funding**

Staff saw lack of funding and inequitable funding as major drawbacks in providing the level and variety of culturally-appropriate MH and AOD services required to meet people’s needs:

*Our agency here is only a fee for service agency at this point. Pay per hour and we deliver our service per hour. ... No funding at all – Na! ... There are services that have money for it but still do not provide it or don't know how to link-in with Aboriginal people to get to their services. (SAS 12)*

*It's not culturally-appropriate... all the services out there in the community, they've all gone because all their money has gone mainstream and it's not right. (SMS 11)*

Mainstream staff highlighted funding duplication, resulting in service overlap by similar agencies. Cessation of dedicated Aboriginal organisations was also happening:

*Overlapping is all about funding. Some might come in and take that kid and say, "Okay" ... they put it down to statistics and say, "Yes, we got so many, then we got our quota for our funding and that's it". ... I think it's going right back to 60 odd years this government and the government before ... (SMS 10)*

#### **7.4.1.3 Living circumstances**

Staff highlighted the impact of living conditions on Aboriginal children today and the need for services to address all lifestyle facets together, not just MH and AOD:

*Look at circumstances where kids come from – and think about where their parents come from – and where their parents come from – and where their parents come from ... tru, tru, tru, tru, tru [points one after another]. (SMS 10)*

*Consumers, they need to be supported from accommodation, transport, advocating for them at meetings etc. to other agencies, to sit down and talk with their issues. (SAS 12)*

Aboriginal staff from Aboriginal-specific and mainstream support services explained the importance of understanding and working with consumers' transient and mobile lifestyles:

*I think with a reasonably transient sort of situation they may be at friends' house and go to another facility for treatment, although they may not live*

*here or they be staying with relatives in a different area and some people go from this area straight into the big hospital. (SAS – C 13)*

*That's what they (non-Aboriginal people) call us "walkabout". Everybody goes, nobody sat around in their little Wurlis<sup>26</sup>, there's all this trading, doing stuff ... seasonal movement. Don't call it "walkabout", that's a white man's term. They can be quite rude at times, hmm, hmm. [After a pause laughing] (SMS 10)*

Staff also expressed the benefits of understanding consumers' family and community as necessary for selecting and providing appropriate services:

*Most of our Aboriginal workers understand and know the individual consumer. They understand the family. If they don't, someone else will who already has that knowledge ... will go with them and show the way. (SAS 12)*

#### **7.4.1.4 Constraints**

Shyness and "shame" (related to having poor MH, AOD use and MH-AOD comorbidity), Aboriginal representation and living conditions (see above) were identified as the key constraints to Aboriginal consumers' health-seeking behaviour and access to services:

*Aboriginal people are too shamed to even think that "I have got a mental illness or a drug and alcohol problem", and so they wouldn't go. (SAS 12)*

*Even today, an Aboriginal in line from up in the bush, they're still a little bit timid and intimidated by where they're going. ... I may as well go for Aboriginal, okay, well they [mainstream service non-Aboriginal staff name removed] said, "Let's talk about that". I said, "Where's the Aboriginal officer?" "I'll do it", staff [mainstream service non-Aboriginal staff name removed] said, "because we haven't got one". The service is not there. (SMS 11)*

*I know everyone can go and read a book, everyone can go and do this and go and do that, they can go out into the community and spend one or two*

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<sup>26</sup> Wurlis are the camps in which traditional Aboriginal people lived

days out there, and say, “Yeah! They represent the Aboriginal people” [a big laugh]. How would they [non-Aboriginal staff name removed] represent? They don’t know [silence]. (SMS 10)

Other constraining factors staff emphasised were:

...**Waiting times**, not knowing the services, services that don’t open their doors for Aboriginal people. Maybe some specific service that they don’t want ... (SAS 12)

#### 7.4.1.5 Reception area

All the staff stressed how the reception area determines service approachability and acceptability, and must be welcoming, encouraging and culturally-appropriate:

The reception is one that will either accept you or kick you out the door and that has happened in a lot of cases. ... Some reception will see them as a very shy person, so they won’t sort of act in a friendly manner to encourage them to provide that extra service for them. (SMS 11)

#### 7.4.2 Main theme 4: Non-responsive service

The main theme “non-responsive service” incorporated five sub-themes as summarised in Table 7.4 with their internal components.

**Table 7.4: Sub-themes and internal components of the theme “Non-responsive service”**

<b>IV. Main theme: Non-responsive service</b>	<b>Internal components</b>
1) No dedicated MH-AOD service	Available services have wide gaps Less staff Services out of the region No service (No specialised Aboriginal comorbidity service, Hard-to-reach mainstream services, No services for parkland and traditional people)
2) Self-referral	Asking for service
3) Run-around (long process),	Long process – makes run-around Run-around as no service Run-around is time consuming (leading to forgetfulness to loss of interest)

4) Inflexibility	Rigid rules Too many non-Aboriginal workers
5) Service shutdown (unsustained service)	Stopping of service – Aboriginal program taken away Closing Aboriginal service Community meeting stopped/ Health check-up stopped

#### **7.4.2.1 No dedicated MH-AOD service**

Staff analysis of available services identified that there is “no dedicated comorbidity service” in the Salisbury or Playford LGA region for consumers with MH-AOD:

*No I don't think ... Hmm! [silence, looks sad through window]... There's always gaps, always. I think it's a bit like anything, you don't know what's around until you need it; get them there, not just refer them. (SAS – C 13)*

*At present there isn't, and not a lot of services. ... There just aren't enough services out there that can work with those people or do not want to work with them. (SAS 12)*

Staff focused on the lack of MH-AOD services for Aboriginal people camping in parklands, who would have to go to services outside the Salisbury and Playford area if they needed help:

*See them in a park and they might be feeling ok, and say, “Look, I need some help with this”, or “I'm feeling crook”, and with that they might take them in, and say, “Ok, we'll pick you up tomorrow”, but I don't think ... [no words – silence – looks sad]. See there's the other clinic out at [place of service removed], which is sort of [...silence] ... I mean, people can walk in, they have walk-in clinics. (SAS – C 13)*

They discussed the lack of permanent full-time Aboriginal employees in Aboriginal-specific services and the lack of capacity of available on-the-ground services (“not culturally-appropriate”) to cater for comorbidity:

*You see “goonyas”<sup>27</sup> now sort of go mainstream ... We're not really for that until they're ready to accept us as members of the community. They make it*

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<sup>27</sup> ‘goonyas’ refers to non-Aboriginal people



*very hard for us ... We still want to stick to ourselves ... We've been around for a while. There's those traditional people that's coming down here and I feel so sorry for them because they don't know where to go ... (SMS 11)*

Staff also suggested what a MH-AOD service should be:

*Just a place to sit down and relax ... talk without being laughed at ... a place where consumers and workers feel comfortable. The workers can share their info and consumers can share their info too and their stories. There are not a lot of places around like that too. (SAS 12)*

#### **7.4.2.2 Self-referral**

Staff explained self-referral as individual consumers taking responsibility to recognise they have a problem and to seek help through accessing and receiving appropriate information and MH-AOD services:

*Mental health and stuff like that, depending on the patient, obviously if they come in, they are given information for alcohol and drug rehabilitation. ... it is then up to (them) to request that. (SAS – C 13)*

#### **7.4.2.3 Run-around (long ineffective process)**

Staff highlighted the long, drawn-out, complex process of them running around to various services to try and do a “patchwork referral job”. This involved trying to assist consumers access comorbidity care, including detox rehabilitation services that were outside their familiar areas and getting into hard-to-reach localities:

*You can't get into the places like [name of specific service removed] and all of them, you have to go through the courts system or something to get through to [name of specific service removed]. (SAS – C 13)*

*(Consumers) don't like going from place to place anyway. They like a one-stop-shop ... (SMS 10).*

*It's like going to the doctor. You go to the doctor and he prescribed you this. You say, “Ok, I want to go and see another doctor and get another second opinion”, so you go there and he says, “No you don't need that drug, you need this drug”. You might go and see another one, no hang on, “I'm worried about these drugs”, and they probably say, “Nah! Nah!” (SMS 10)*

Staff said by the time consumers had done the running around, they had forgotten what they were there for, lost interest and received no service.

#### **7.4.2.4 Inflexibility**

Rigid access and client criteria rules, including age limits, area of care, work timing, service location and presence of only non-Aboriginal staff were identified as barriers to Aboriginal people accessing the MH-AOD services they needed:

*Rules are fairly rigid .... An elderly consumer ... mobility was quite weak and they couldn't get around very well, so you get in touch with domiciliary care and we really do need one of those gophers so this person can get around and have a little bit of independence. But because of the age group ... **you're pretty well left out in the dark** ... You've got to be a certain age. (SMS 11)*

*They [mainstream services] do not encourage Aboriginal people to come to them. Have too many non-Aboriginal white people working there or have no cultural awareness, no cultural competency. (SAS 12)*

A significant problem concerned young people growing past a certain age. The rigid eligibility criteria for access to the patchwork of services according to arbitrary determination of age, coupled with different age criteria depending on types and models of funding sources, led to consumers falling through the gaps:

*... if you're over that age of 21 you can't come in. ... they're out in the streets and there's a bigger population of 21s to 25s. Where's the places for them? (SMS 10)*

#### **7.4.2.5 Shut down of services / programs**

All the staff spoke animatedly about service shutdowns due to “unsustainability”, highlighting the closing of much needed local Aboriginal outreach, support and after-care services staffed by Aboriginal MH or AOD clinicians and workers. Skills training, employment programs and consumer-driven initiatives had all gone:

*They used to have those meetings where the community met with the police and they stopped that, but this was about 7–8 years ago, but I think it needs to happen again. I think it should be in north, south, east and west. ... Years*

*ago, the Prime Minister made some silly decisions in relation to Aboriginal people and one of those was to shut down Aboriginal organisations. ... all the millions of dollars that ... earmarked for Aboriginal organisations, it was then all handed out to Christian organisations ... so they've got all this millions of dollars for Aboriginal programs, yet they don't have any Aboriginal workers in there. I know for a fact that [Christian organisation name removed] has only got one... (SMS 11)*

*There used to be an incentive to do a well-health check ... with mental health or alcoholic abuse or whatever. We'll pick up everything within that well-health check; they go to parks and all of that. But they stopped that \$30 incentive now, so I don't know how people are getting their health checked. (SAS – C 13)*

Staff critically analysed service delivery benchmarks and found that they, too, were unsustainable.

### **7.4.3 Main theme 5 – Referral: Fishing for Nunga places**

Support service staff highlighted the influential role of referral, which is discussed under the five sub-themes summarised in Table 7.5

**Table 7.5: Sub-themes and internal components of the theme “Referral: Fishing for Nunga places”**

<b>V. Main theme: Referral: Fishing for Nunga places</b>	<b>Internal components</b>
1) Assessment	Need in-depth assessment Acting physical (Medication vs Drugging) Aboriginal way of assessment
2) Proof of Aboriginal identity	Origin of Aboriginal identity in service: John Howard Process and importance of getting identity Issues related to identity (Duplicity, Misuse)
3) Silo service	Acute problems taken care of (but not early/at risk stages of comorbidity) Services working in isolation from each other
4) Hard-to-reach service	Fishing for Nunga places – constant referrals Referrals not easy – hard to coordinate

	Duplicity
5) Waiting time	Delay in contacting consumers Long waiting hours ruin the staff's time too

#### **7.4.3.1 Assessment**

Staff described the need to find out as much as possible about consumers – background, social determinants of health, MH and medical history – by interviewing family members as well as consumers so as to understand consumers' problems and make appropriate referrals:

*Do they know about his living circumstance, which is more important? I don't think they do. ... there's no family history or anything like that. (SMS 11)*

They seemed distressed that some service practices, such as medicating people experiencing acute MH-AOD comorbidity on entry with no apparent assessment, were culturally inappropriate and prevented gaining a full history:

*I had to take a young lad over to [name of health service removed] and the first thing they did, when they put him through those doors, is they drugged him. I thought, (Wow, that's terrible. How come they can't just talk to somebody ...) (SMS 11)*

#### **7.4.3.2 Proof of Aboriginal identity**

Aboriginal staff explained that the Australian Government had introduced proof of Aboriginal identity criteria to benefit from community service entitlements. Aboriginal community people must repeatedly undergo an embarrassing, complex process of applying to the Legal Rights Commission or other designated Aboriginal organisation for this proof:

*A lot of European fellas, they're starting to say they hate Aboriginal people and using the service. Some of the places where you go, you got to turn around and prove you're Aboriginal. (SMS 10)*

Aboriginal identity is essential to access certain local Aboriginal specialised programs. Aboriginal staff have been asked to show their proof of Aboriginality when, as private people, they go to contact services:

*Proof of your Aboriginality, you must have proof. You've got to prove you're an Aboriginal person. ... John Howard ... who was the Prime Minister ... made a blanket ruling. All Aboriginal people around Australia have to fill in an Aboriginality form. ... What I find quite disturbing is that you can't photocopy that and use it for the next time. You have to have an original every time ... It can be quite difficult because there are a lot of fair Aboriginal people these days ... (SMS 11)*

#### **7.4.3.3 Silo service**

Interviews revealed that each individual service espouses its own service philosophy and model of care, resulting in the situation that “they work in isolation” (SAS 12). Staff explained that holistic care for people with complex MH-AOD needs is absent when “only” the presenting problem is recognised and treated, leaving the possible cause (e.g. co-existing high risk alcohol consumption) unaddressed:

*Obviously their acute care ... they get straight up but the other issues take too long because ... the holistic health area is not always treated. ... I can see consumer suffering with social issues at home. ... if we start to address this issue, then the medical problems will probably decrease or mental problems will probably decrease. ... I think a lot of them run into each other too. (SAS – C 13)*

#### **7.4.3.4 Hard-to-reach service**

Staff explained that services were “hard-to-reach” and referrals were hard to coordinate and implement effectively. Referrals for coexisting AOD, MH, homelessness and related disability services for one consumer, for example, could create confusion and a constant referral process.

*When people come with mental health or alcohol problems, we cannot work with them but we can refer them on to another agency that does have funding to look after them. (SAS 12)*

*The services are overlapping. Then they go to another one and that person might say, “No, you got to be doing this”, and then they go and do this, and then that's confusing a lot too. (SMS 10)*

Due to siloed services, demarcation of services and specialist practices (e.g. MH or

AOD), staff are required to try to advocate for the most appropriate services. They also take consumers to appointments:

*... [name removed] network group, they'll help them and take them to appointments, and [name of Aboriginal-specific service removed] will pick them up, but that's only if you go to their clinic. But hmm [long silence], they haven't got a service for alcohol, but they can refer people on ... (SAS – C 13)*

Staff stressed that while having too many types of services involved for one consumer can result in duplication of resources, connecting consumers to a particular MH or AOD service initially highlights the hard-to-reach aspect of the process, particularly in seeking available services that are both relevant and culturally-appropriate for Aboriginals:

*We tap into a lot. We tap into about 5 or 6, maybe even more, depending on where the people come from. ... Depending on the referral itself, if they haven't got the staff, that's the problem. So we fish around and look for the Nunga places. ... (SMS 10)*

*I would get a lot of consumers coming in here; a lot of consumers aren't hooked up to the service. (SAS – C 13)*

#### **7.4.3.5 Waiting time**

Staff appraised service waiting times pessimistically, stressing that waiting time constrains consumers' timely and much needed access to MH and AOD services. It also prevents them from doing their own work; it impacts their capacity to manage their time and workloads effectively:

*They might say, "I really need some help to reduce my alcohol consumption", so the nursing staff [clears throat] refer to AOD services but to be honest, I don't know how quickly an AOD worker would contact that person ... (SAS – C 13)*

*I don't think anything these days is automatic. I think there is still that process, "Stand in line and we'll get around to you when your number's up". It could take a long period – even a few months before you're seen and*

*then it might only be just for a short while, just to sort of get you on the book. And then it's just a long, drawn-out process [silence]. (SMS 11)*

## **7.5 Overarching theme 3 – The future: Needs-based MH-AOD service**

The overarching theme “The future: Needs-based MH-AOD service” revealed by the support service staff’s data comprised the main themes “practice” and “strategy”, with a major focus on addressing the service gaps arising from differences between current practice and consumers’ real service needs.

### **7.5.1 Main theme 6: Practice**

“Practice” incorporates the four sub-themes summarised in Table 7.6.

**Table 7.6: Sub-themes and internal components of the theme “Practice”**

<b>VI. Main theme: Practice</b>	<b>Internal components</b>
1) Problems in referral: Service complexity	Referral to appropriate service Frequent referral Coordination complexity
2) Effectiveness	No service, so referred Number of referrals Repeating stories – frustration
3) Change of consumer focus	Aboriginal-specific to mainstream – Multicultural
4) Need for service	Need more services, better services and increased capacity of Aboriginal-specific services

#### **7.5.1.1 Problems in referral – service complexity**

Staff re-emphasised their practice issues arising from the very complex referral system, particularly “hunting around” for available spaces in Aboriginal-specialised services; a complex task given the number of agencies needed to address comorbidity issues, and the level of cooperation and coordination needed for continuity of care:

*Lots of referrals... it's not easy, I don't think it's easy, I don't know [silence] ... (SAS – C 13)*

*Coordination, linking these services, was it easy? (researcher)*

*Not really. Well it shouldn't be. It depends on the liaison person. If they've experienced various things with previous consumers ... what that person should do is then link in with various other organisations to have something ... put in place for when they need it ... again, so make those relationships, build those linkages and then the service for that individual may be a lot easier. (SMS 11)*

### **7.5.1.2 Effectiveness**

All staff spoke about the ineffectiveness of the referral system and its implications – referrals are only effective with consumer input and staff need to assist consumers who find it difficult to attend appointments as the first step:

*We refer them to other organisations around here to help them out with their drug and alcohol issues, mental issues ... (SMS 10)*

*If you get into the drug services, you have to get referred to them drug and alcohol, gambling, or whatever, you know, specialist appointments. We refer to them, they don't actually have it there, but they have the ability to refer on, as we pretty much all do. (SAS – C 13)*

*We may refer on to [name of alcohol treatment service removed], AOD service and other agencies that can sort of help them with those sort of issues. (SAS 12)*

Aboriginal support staff stressed that reaching the specialist services and referral processes is “only paperwork”. Consumers must overcome barriers to accessing services caused by physically running around finding services and constantly repeating their stories:

*The services that they provide are with papers which tell their stories over and over again; they don't want to do that so they don't go back. (SAS 12)*

Mainstream staff said continual referral, not difficulty getting the needed service, was the biggest “pain” for consumers:

*You know what we found out, those young fellas, they are sick of repeating the story after story after story, the same story all over again. (SMS 10)*



### **7.5.1.3 Change of consumer focus**

Staff expressed their frustration with policies and a service system they saw as transferring the focus on Aboriginal services to a focus on multicultural services, thus continuing Aboriginal Australians' invisibility. Their long-standing and poor social determinants of health require restructuring and funding of the service system to address the as yet unmet need for culturally-appropriate, dedicated MH-AOD services:

*A couple of years ago a representative from the African community was invited to our day and there was 40 staff from our organisation. The African man turned around and said, "I'd like to let you know a bit about our African community and what issues that we are facing now". He said, "Our kids are getting harassed by the police. We can't stand around. Our kids can't stand around in a mob of about 5. We have issues with employment. We find it hard to get a job. We're having problems with our housing ...." He went through everything there and he complained about what was going on in the community and what the Australian communities were perceiving on them. I didn't want to say anything because we invited him to the thing, but when he left, I had 40 staff looking at me. I turned around and said, "Isn't that funny?" They said, "What do you mean?" I said, "What he was complaining about is what we've been trying to fix for over 200 years". I said, "We got coppers harassing our kids. We've got no employment. We are having housing issues ... and he's got the cheek to come in and complain from Africa" [widens eyebrow]. I came home and I said, "Yeah, we are in a third world country, you go out and have a look in the community and see how it is". (SMS 10)*

*I understand now that [name of a politician removed], since he come into the top seat, he sort of left Aboriginal behind a little bit, but prior to that he was doing a lot for Aboriginal people. They play that political game all the time. (SMS 11)*

### **7.5.1.4 Need for service**

These staff identified a high need for more and easily accessible, culturally-appropriate local services in general, and MH and AOD in particular, as well as more publicity to let consumers know about them:

*Aboriginal population is increasing ... so if the numbers are increasing you should cater for the numbers. (SMS 11)*

*Provide bigger and better services and programs for our consumer group, especially the ones that are with mental illness, drug and alcohol. ... More culturally-appropriate, which do not have a waiting period, not in 2 or 3 months' time. (SAS 12)*

There was scepticism about the rate of Aboriginal consumers actually linked to services; the number and type of services did not match the real need:

*Our work mob think, consider it as a high rate [long breath, sigh], I don't think it's a higher rate. ... None of us can save the world, but if we put one person or a couple of people back on track, you've achieved something in your life. And that person will have more respect for you and then they'll bring up their kids and all that in the same way. (SMS 10)*

*Break down the cycle of problems, yeah we need more services. (SAS 12)*

### **7.5.2 Main theme 7: Strategy**

The eight sub-themes identified as suggested strategies for implementing appropriate services to meet consumers' needs are summarised in Table 7.7.

**Table 7.7: Sub-themes and internal components of the theme "Strategy"**

<b>VII. Main theme: Strategy</b>	<b>Internal components</b>
1) Educate	Educate kids, family and community Education is two ways – educate culture Mode of education – Nunga grapevine program, compulsory cultural education
2) Trust: Engage and communicate	Consumers, staff and organisations Lack of engagement – outcomes
3) Understand	Understand the Aboriginal way of learning – watch, listen, learn Understand Aboriginal culture Understand consumers 'inside out'
4) Aboriginal support	Community and cultural links Support more than advocacy –walking with consumer

	Support consumers to see mainstream services Aboriginal model of care Mentors for young people
5) One-stop-shop	All services together Within the reachable living region Mobile clinics
6) Appropriate service	Ongoing planning – little action Culturally-appropriate – no stigma Aboriginal staff Cultural competence Appropriate specialists
7) Required service	Components of dedicated comorbidity service
8) Moving forward – addressing breakpoints	Breakpoints <ul style="list-style-type: none"> <li>○ Service capacity</li> <li>○ Increasing illness burden</li> <li>○ Communication</li> <li>○ Connection</li> <li>○ Cultural safety</li> </ul>

### 7.5.2.1 Educate

All staff noted education as a key strategy for enabling access and effective delivery of appropriate comorbidity services that meet Aboriginal people’s complex needs, starting with preventive MH-AOD education and compulsory cultural awareness education in all schools and service organisations:

*It all comes down to education. Educating the young kids, educating the families, the father and the mother, and education in the community and educating all the go passers. (SMS 10)*

*Run programs for the kids, try and get that education and also that knowledge at young level. (SAS – C 13)*

*We find that when we work with other (non-Aboriginal) agencies we do cultural awareness training not as a sit down and talk ... the whole organisation needs to be provided with one-on-one type training. (SAS 12)*

Some advised that two-way communication, with listening a vital skill, is the most effective form of education, and the “Nunga grapevine” is the most effective

promotional tool:

*Whether it's the doctor or nurse or counsellor, listen even to the psychiatrist. I go into the psychiatrist and I'll listen in on what they're saying but then give my opinion too on the consumer because I know the consumer pretty much well. (SAS 12)*

*I think it's relatively simple because the Nunga grapevine is very, very, powerful media. You just have to ask somebody and somebody will tell you. ... It's a very good way of communicating. (SMS 11)*

Some were disillusioned by the non-impact of cultural awareness training:

*We train everyone ... but there's no outcome ... for them ... Only Aboriginal people were doing it. (SMS 10)*

*Sometimes that's even difficult, people will just go through the motions just for the sake of still keeping their job. ... their attitude is still the same ... (SMS 11)*

#### **7.5.2.2 Trust: Engage and communicate**

*If they want to tell us straight out, they would, some don't, some do. (SMS 10)*

Staff discussed engagement as a fundamental element of good MH-AOD service provision in terms of individual consumer engagement with services. Staff spoke about the importance of engagement for developing trusting relationships through which to address an individual's and family's expressed need for cooperation for better outcomes; **lack of engagement = poor outcomes:**

*... there were not enough hours put in to work with [X]. He was put into an accommodation place which was not appropriate ... The consumer did not like having other non-Aboriginal people telling him what to do like a kid. That impacted on his stability and his ability to live in the community. It comes down to making decisions around what is best for the consumer but [no engagement] has made him bound himself into the street again and back in gaol. (SAS 12)*

*They [organisations' names removed] certainly tell you when you ask for information, they will tell you what organisations that you need to go to and ... who the Aboriginal person that works in there is and the best person to get help from. (SMS 11)*

### **7.5.2.3 Understand**

Aboriginal staff insisted on the benefits of unique Aboriginal ways of communicating, knowing and understanding; a system of gathering and analysing evidence of problems equating to **watch + listen + learn = understanding:**

#### **Watch**

*Look at the elections now. No one [stresses the word] talked about Aboriginal issues, but they had an Aboriginal person standing up next to them, so? [silence] (SMS 10)*

#### **Listen**

*Well you'll see ... we never said a word because we couldn't understand each other, the half caste gang and they [tribal people] tell you what you're looking for. (SMS 10)*

#### **Learn**

*One amazing thing, there's a bloke who started talking and he said he went out with my uncle, went out bush and we were out there for a very, very, very long time and that old fella didn't even say a word to me, and he was wondering, "Why won't he talk, why won't he talk to me, why won't he talk to me?" he was saying, and then it clicked to him [clicks finger]. He said, "Hang on, this is a way of teaching me: watch, listen, learn. Don't go talking, just watch, pick it up. That's the way of teaching them". (SMS 10)*

They stressed the need for staff to learn about consumers by listening to their stories:

*Know the consumer inside and out so that they can encourage them to do the right thing in order to get better. (SAS 12)*

They also emphasised the need for all services to improve staff cultural awareness and cultural consultancy through formal and informal training to help staff understand certain situations:

*One day I was working in the clinics ... and went around there and knocked on the door. No-one answered, dog was going off [barking], the door was open, could hear a baby crying. When he did come to the door and let me in, there was only him there. He was about 80 something eh, and he was babysitting a little baby like that and no-one else was in the house, they were all gone ... When I went back I told my boss ... “Yeah, he shouldn’t be looking after the little one”. What if he dropped dead and no one there for the little baby ... He was the patriarch of that family and that was his role to look after that little fellow. (SAS – C 13)*

#### **7.5.2.4 Aboriginal support**

Aboriginal-specific staff said other Aboriginal workers came in to help with consumers from “the lands”<sup>28</sup> to foster understanding, if they knew the consumer and the service well enough, while a mainstream service Aboriginal worker said non-Aboriginal staff do not have the cultural or community links to work effectively with Aboriginal people from far away:

*We can understand each other and we do the same things, our instincts tell us about things. We ... just got to sit and listen and look, and we know what’s going on. (SMS 10)*

*Non-Aboriginal persons will only focus on what they are skilled to do. If you had an Aboriginal person there that can advocate for that individual, you’ll get them coming back and seeing that this place does help. (SMS 11)*

Aboriginal staff highlighted Aboriginal consumers’ diverse needs, re-emphasising the importance of informed choice of service and supporting consumers’ ability to access it:

*Lot of fair Indigenous consumers you know, got Aboriginal blood in them, and they sort of go to their own doctors. A lot of people that can’t get to the doctor, we’ll help them get to the doctor. (SAS – C 13)*

Aboriginal staff from an Aboriginal-specific service insisted on support through the Aboriginal model of care, going out to consumers and establishing a service tailored to

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<sup>28</sup> clients from “the lands” means traditional people from remote communities

the community's needs:

*If he [consumer's name removed] didn't have that support, he would have fallen by the wayside ... but he's got people going and checking up on him and the network. (SAS – C 13)*

*Talk to that person that walks past you every day. Say good day, stop and listen and talk to them, and learn a bit about them and their culture. (SMS 10)*

Staff repeatedly stated the value of having many Aboriginal staff in services and called for support for “mentor type” support for young people; a “walking with the youth” approach to develop personal responsibility:

*Any younger they might have to have some sort of circumstance where they are accompanied by someone older too. (SMS 10)*

#### **7.5.2.5 One-stop-shop**

There was the common suggestion that a local “one-stop-shop” for dedicated MH-AOD services was needed. Based on consumers' real comorbidity care needs, it could be “like a shelter” (SMS 10) in a familiar, central location:

*Really do need an organisation, one-stop-shop, in Elizabeth where Aboriginal people can go and ... they know they feel safe. ... Not ... in the city because the city is a horrible place for Aboriginal people to get to – I think it should be in north, south, east and west. (SMS 11)*

*That would be quite good, like satellite, so they're wherever they are; they're in Playford so they're Playford. So let's say one in Salisbury ... (SAS – C 13)*

Staff addressed the necessity of designing a mobile service as part of a one-stop-shop to cater for Aboriginal people camping in parklands:

*Mobile clinic will come, or that person will know, that mobile clinic will be here on Tuesday, whatever day, you know, and I think the mobile side of things is really good. (SAS – C 13)*

### **7.5.2.6 Appropriate service**

Aboriginal and mainstream staff highlighted the need for appropriate service delivery for Aboriginal consumers, but Aboriginal staff stressed that planned future services never get past the planning stage; they never eventuate:

*We have been involved in the negotiation around services providing for Aboriginal people. It is still going through the planning process. (SAS 12)*

Staff from the Aboriginal-specific services emphasised the need for adequate future MH-AOD services that would be culturally-appropriate, would not stigmatise consumers and would sustain employment for Aboriginal staff in Aboriginal-specific mainstream services:

*It should be a place where we can provide a culturally-appropriate service or program that consumers who suffer from mental illness, drugs and alcohol can come, sit down and relax too, where they are not feeling scared and they want to interact. (SAS 12)*

*There needs to be more workers in the bigger government organisations, non-Aboriginal organisations. There needs to be lot more Aboriginal people ... more training in cultural awareness and competence. (SAS 12)*

Mainstream staff stressed the need to ensure consumer access to specialist MH-AOD clinicians and workers who could provide appropriate treatment for consumers' comorbidity care needs:

*There really needs to be somebody taking him under his wing and sort of, a psychologist or psychiatrist or someone, so they can dig a little bit deeper to find out the reason why he's into that negative behaviour. (SMS 11)*

### **7.5.2.7 Required service**

Staff pinpointed the following elements required to build service capacity to meet consumers' real needs. These intended essential elements of services will assist, support and facilitate successful dedicated MH-AOD service implementation:

#### **1. Combined comorbidity service**

*Why can't they turn around and couple MH and AOD service things on community and get people out there to work it? (SMS 10)*



2. Culturally-safe accommodation

*Teach people to do it all, even up in house stations that was taken from them back in the home lands. (SMS 10)*

3. Transport

*You need a transport section as well to be able to transport individuals. (SMS 11)*

4. Walk-in clinics

*Have walk-in clinics open all around the place, and more teams. (SAS – C 13)*

5. Dry-out centre [AOD withdrawal service name removed]

*Dry-out clinics and all of that. (SAS – C 13)*

6. Aboriginal medicine

*Have a Ngangkari; should have a mental health service there. (SMS 11)*

7. Support service

*Put as much support services as you possibly can and an Aboriginal crisis care group; that would be good. (SMS 11)*

8. Crisis care

*Crisis intervention unit focusing on depression and self-mutilation and suicide. (SMS 11)*

9. Aboriginal health workers

*... appropriate Aboriginal health workers and skilled health workers, that they're not just put on to make the place look pretty; make life easier for them. (SMS 11)*

10. Outreach service: comorbidity education

*Pockets of outreach services around that could assist consumers. ... around to parks and you know, going to schools, that does spread the word, but there's always room for more. (SAS – C 13)*

### 7.5.2.8 Moving forward – addressing service breakpoints

Support service staff identified five breakpoints and widening gaps that undermined Aboriginal people’s access to good MH-AOD care. These are summarised in Table 7.8. Staff stressed that mandated, organisation-level operational strategies that meet consumers’ real MH-AOD care needs are necessary. These are presented as “Gap filling: Opportunities for implementation”, which are to be made available on-the-ground.

**Table 7.8: Support service staff perspectives: Five factors affecting access to, and quality of care for MH-AOD issues**

<b>1. Breakpoint</b>	<b>2. Widening gaps</b>	<b>3. Gap filling: Opportunities for implementation</b>
<b>Service capacity</b>	Service inability and unwillingness to address comorbidity – maze of referrals  No wellbeing pathway for consumer’s self-empowerment	Locally-available comorbidity service: easy to access – one-stop-shop  After-care: Establish self-empowerment wellbeing strategy pertaining to consumer’s goals
<b>Increasing illness burden</b>	Individual’s comorbidity affects their family’s wellbeing	Inclusion of family in services’ comorbidity care
<b>Communication</b>	Difficult to exchange information when English is not the consumer’s primary language  Misunderstanding of medical terminology	Use simple, easy to understand words  Aboriginal translation service  Educate the community about comorbidity and its health care
<b>Connection</b>	Many local people are not connected to services and remain undiagnosed  Rigid rules do not fit with consumers’ needs	Trustful, unbroken service  Evaluate service feasibility based on consumer’s need
<b>Cultural safety</b>	No appropriate understanding of the community’s needs  People feel threatened	Incorporate Aboriginality into the service structure: Aboriginal healing  Assist and empower people

#### 7.5.2.8.1 Service capacity

When approaching services for help for MH-AOD issues, consumers must currently navigate a maze of referrals and experience run-around between disconnected services

for “bits” of treatment. Specific MH services treat only MH issues; specific AOD services treat only AOD issues, with few being easily accessible to Aboriginal people. Staff succinctly advised that local MH service capacity must expand with an AOD component, and vice versa. Service incapacity for accessibility in terms of having long waiting times also created serious service gaps, with consumers giving up and remaining distressed while continuing to experience their improvised lifestyles. Even if a consumer managed to access the services they needed, once treatment finished there was no “wellbeing pathway” to help them recover and become productive community members; again, they were heading into a recurring cycle of probable relapse, then treatment, then relapse.

#### *7.5.2.8.2 Increasing illness burden*

The foremost impact of MH-AOD comorbidity on an individual is its harsh effect on them, their family and community, who all become trapped by the increased burden of illness and the need for care. However, mainstream services tend not to involve Aboriginal family or community in consultation or problem solving to seek solutions, so they have insufficient knowledge of MH-AOD to assist them to understand and care for Aboriginal people experiencing this comorbidity. Family and community needs, as well as individual needs, must be considered.

#### *7.5.2.8.3 Communication*

Lack of appropriate and understandable information exchange was identified as contributing to communication errors, particularly for Aboriginal people when English was not their primary language or literacy was an issue. This created a barrier to, and a gap in, MH-AOD consumer education, which staff felt could be improved by using visual aids to get the message across.

Ineffective communication was also apparent with medical staff using medical jargon with Aboriginal consumers. Even those consumers who had English as their primary language had problems understanding the jargon, which impeded clinicians’ capacity to effectively explain medical diagnoses or medication prescriptions. This led staff to call for Aboriginal language translators in all services.

#### *7.5.2.8.4 Connection*

Many consumers remained undiagnosed and not connected to the MH-AOD services they needed. Those who were connected faced barriers to receiving effective treatment, for example service operating times and demarcation (division of services, situated in

different localities) between particular services. These barriers denied them access even during crises and resulted in a huge gap in service for both consumers and staff, who felt their ability to support consumers was seriously compromised.

Essential factors for providing good, accessible health care were identified as developing trust, engagement, reliable connections between staff and consumers (not too many staff in the service), and providing reliable, robust service rather than continuing the vicious cycle of repeated, unhelpful referrals to, and between, services.

#### *7.5.2.8.5 Cultural safety*

Aboriginal staff believe they have unique skills, community connections and knowledge about how to work with Aboriginal consumers in culturally-respectful, safe and inclusive ways. To do this effectively, they called for use of traditional Aboriginal healers (Ngankaris) in acknowledgement of Aboriginal people's holistic concept and experience of health and wellbeing. They also stressed the necessity of involving family and community in an individual's MH-AOD care. Both Aboriginal and non-Aboriginal staff recognised the practical need to work together in an "intercultural space", providing Aboriginal consumers with service choice.

## **7.6 Conclusion**

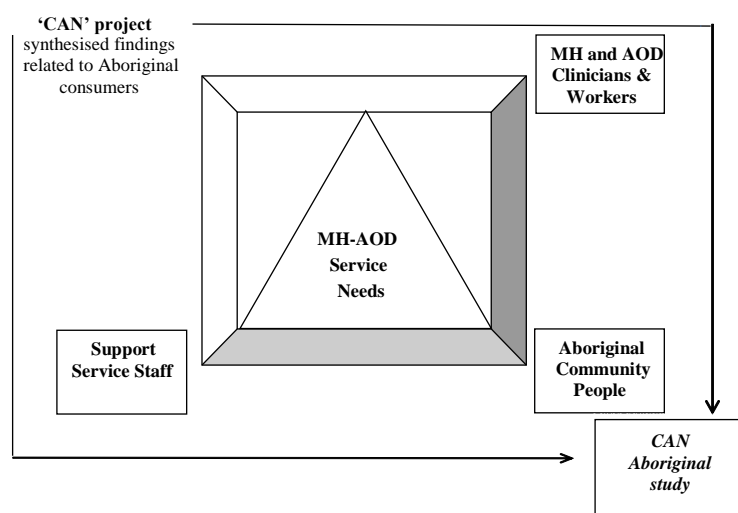
The findings presented in this chapter have highlighted the barriers to service and the service gaps that have resulted in Aboriginal MH-AOD needs going unmet. There is no dedicated specialist MH-AOD service. Staff reiterated the importance of services and programs addressing MH-AOD comorbidity together, rather than continuing the fragmented system of referrals between specialist MH or AOD services for one or other type of issue. They suggested strategies to achieve MH-AOD care, most notably a local one-stop-shop incorporating MH, AOD and other comorbidity services working together to provide holistic comorbidity care, after-care and follow-up. The next chapter further explores the breakpoints (barriers) and widening service gaps in its synthesis of the triangulated findings from the Aboriginal Consumer Advocate's, MH and AOD clinicians' and workers', and support service staff's data with the *CAN project* data.



## 8 Synthesised Findings – Perspectives of Aboriginal Community People, Service Staff and the *CAN Project*

### 8.1 Introduction

This chapter presents the synthesised qualitative findings of the *CAN Aboriginal study* presented in three previous chapters with the *CAN project's* survey (quantitative) findings. Triangulation was considered the best strategy for confirming the findings, and estimating the spectrum of the Aboriginal community's MH-AOD service needs and possible implementation strategies (see Figure 8.1). This chapter identifies strategies that work well and areas that need improvement in order to provide the most appropriate services to meet Aboriginal consumers' MH-AOD care needs.



**Figure 8.1: Spectrum of synthesised triangulated findings: Perspectives of Aboriginal community people, MH and AOD clinicians and workers, support service staff and the *CAN project's* findings**

The analytical framework of the qualitative data used in chapters 5, 6 and 7 (see Figures 5.1, 6.1, 7.1), with the overarching themes “Comorbidity: A complex problem”, “Current structure of MH-AOD care” and “The future: Needs-based MH-AOD service”, is used to present the synthesised triangulated findings.

## 8.2 The CAN project findings

As mentioned earlier, this *CAN Aboriginal study* is an offshoot of the wider *CAN project*, which scoped all the government and non-government MH, AOD and support services in the study region, and carried out two surveys. Survey I involved MH-AOD clinicians and workers. Survey II involved support service staff. Initial scoping detected 70 services/programs but only 29 with the potential to serve MH-AOD consumers aged 12 years and over were situated locally. Others offered “in-reach” services for people in the study region but were located outside the region. There were no Aboriginal adult and adolescent-specific MH-AOD services/programs. Most of the 29 local services offered MH services or programs only, while four offered AOD services. Nearly 60% of consumers registered in the MH and AOD services/programs had MH-AOD comorbidity. Table 8.1 presents all relevant Aboriginal data from the *CAN project*.

**Table 8.1 Interrogated relevant findings from the CAN project**

	<b>MH and AOD Services</b>		<b>Support Services</b>	
<i>Prevalence (%) of consumers with comorbidity</i>	Mean (%)	SD	Mean (%)	SD
Mainstream	60.0	30.8	32.3	20.7
Aboriginal	61.9	25.6	42.1	28.5
<i>Assessment timeframe (months) for consumers experiencing MH-AOD comorbidity</i>	Mean (months)	SD	Mean (months)	SD
Mainstream	4.7	3.1	-	-
Aboriginal	6.5	4.8	-	-
<i>Do you provide “cultural competency training”?</i>	Yes	%	Yes	%
Mainstream	4	44.4	37	82.2
Aboriginal	26	61.9	2	100
<i>MH Consumer exclusion from services</i>	Yes	%	Yes	%
Mainstream	0	0	0	0
Aboriginal	5	8.6	0	0
<i>AOD Consumer exclusion from services</i>	Yes	%	Yes	%
Mainstream	3	5.3	0	0
Aboriginal	6	10.5	0	0

<i>Provision of triage service</i>	Yes	%	Yes	%
Mainstream	10	17.2	-	-
Aboriginal	45	77.7	-	-

<i>Percentage of services providing assertive care</i>	Yes	%	Yes	%
Mainstream	3	5.4		
Aboriginal	20	35.7		

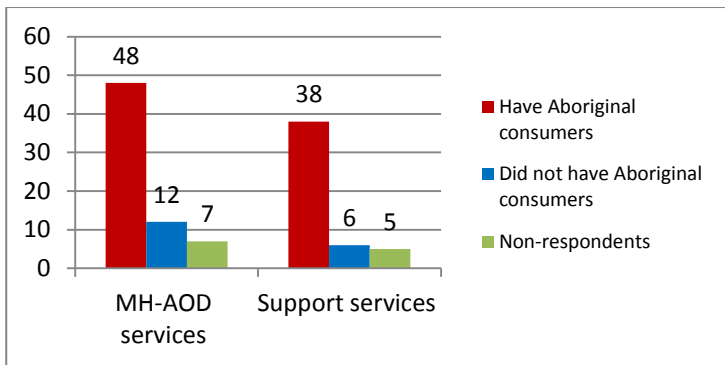
	Very confident (%)	Somewhat confident (%)	Somewhat less confident (%)	Not confident (%)	Don't know (%)
<i>Level of clinicians' and workers' confidence in dealing with comorbidity care</i>					
Mainstream	5	13.3	0	1.7	80
Aboriginal	20	50	10	0	20

The following section presents the carefully checked and synthesised (*interrogated*) relevant findings of the *CAN project* with the findings from the *CAN Aboriginal study*.

### 8.3 Participants

***CAN project:*** Staff from 67 MH and AOD services who were involved in caring for, and supporting consumers experiencing MH-AOD comorbidity participated in the wider *CAN project* Survey I. They reported that Aboriginal consumers accessed only 48 of these services, while 12 reported no Aboriginal consumers and seven services did not respond to this question. Workers from 49 support services participated in the *CAN project* Survey II. They reported that Aboriginal consumers accessed only 38 of the services. Six support services had no Aboriginal consumers and five did not respond (Figure 8.2) to this survey question. This signifies that not all services are being used by Aboriginal people, although they are all available for all consumers. This informs us that services need to take action to implement culturally-appropriate care; to “walk the talk”, which means implementing services according to local people’s needs. This finding strongly reiterates that it is not only a service that is necessary for people, but a culturally-appropriate service for Aboriginal people to access.





**Figure 8.2: Number of services with Aboriginal consumers – CAN project**

**CAN Aboriginal study:** Participants included 19 local Aboriginal people (ACA), nine non-Aboriginal and Aboriginal MH or AOD clinicians and workers (CMS and CAS), and five non-Aboriginal and Aboriginal support service staff (SMS and SAS).

## 8.4 Overarching theme 1 – Comorbidity, a complex problem

Synthesised findings from 1) Aboriginal Consumer Advocates (ACA)<sup>29</sup>, 2) MH and AOD clinicians and workers (CMS and CAS)<sup>30</sup>, and 3) support service staff (SMS and SAS)<sup>31</sup> data in the *CAN Aboriginal study* illustrate the commonality of their concerns. The *CAN project Survey I*, like the *CAN Aboriginal study*, indicated that there were no MH-AOD services in the study region. All were either MH or AOD services. This is likely to have exacerbated untreated MH-AOD issues and their consequent impact on individuals, families and communities, as identified in the *CAN Aboriginal study* interview findings.

### 8.4.1 Experience of unmet comorbidity care

Synthesised findings emphasised that all groups of participants in the *CAN Aboriginal study* acknowledged comorbidity as a major but unaddressed service issue; and that consumers were “drowning in comorbidity”. Broad discussion occurred when parents, siblings and spouses shared their deep frustration about the difficulty of trying to access services for their loved ones’ MH-AOD problems. Similarly, on-the-ground staff and workers also discussed difficulties in providing appropriate services for people with MH-AOD problems because the MH and AOD services for each individual problem

<sup>29</sup> ACA refers to coding for Aboriginal Consumer Advocates (local Aboriginal people)

<sup>30</sup> CMS refers to coding for Mainstream services’ MH or AOD clinicians and workers; CAS refers to coding for Aboriginal services’ MH or AOD clinicians and workers

<sup>31</sup> SMS refers to coding for Mainstream support service staff; SAS refers to coding for Aboriginal support service staff

were different. MH and AOD clinicians and workers, and support service staff remarked that more than half of Aboriginal consumers linked with their services had comorbidity issues, a situation commensurate with the 60% prevalence of consumers with comorbidity reported in the *CAN project* survey data.

All groups identified the connection between unmet comorbidity service needs and consumer wellbeing. They stressed the importance of a trusting, respectful, relationships-based approach to comorbidity service provision. MH and AOD clinicians and workers, and support service staff called for deeper investigation into consumers' care needs, social determinants, living conditions and cultural background when assessing them for comorbidity treatment, which aimed to rebuild their overall health and wellbeing. They saw this as crucial to avoiding endless cycles of comorbidity and related harm. Support service staff emphasised the need for an educational, preventive approach to raise awareness about comorbidity and the availability of comorbidity services that address inter-generational comorbidity-related family dysfunction, violence and death.

#### **8.4.2 Culture, community and family**

Understanding the uniqueness of Aboriginal culture and working in culturally-respectful ways in culturally-safe environments were seen as essential for encouraging Aboriginal consumers to access comorbidity services and engage with comorbidity treatment. All three participant groups shared concerns about MH and AOD services that excluded families from involvement in consultation about an individual's care. They raised the issue of language, believing that a lack of Aboriginal translators and Ngangkaris (Aboriginal healers) intensified consumer and family exclusion. Some participants from all three groups stressed the need for cultural competency training for all staff to ensure culturally-safe and welcoming places. This would encourage consumers, their families and community members to come for assistance. It would help to develop trusting relationships and working together to achieve positive comorbidity treatment and care outcomes.

The *CAN project* survey data revealed that more Aboriginal-specific than mainstream MH and AOD services provided this cultural competency training for their staff but this accounted for only 61.9% and 44.4% of participants respectively. Support services, however, provided staff with cultural competency training at much higher

rates, with 100% in Aboriginal-specific services and 82.2% in mainstream services (refer back to Table 8.1).

## **8.5 Overarching theme 2 – Current structure of MH-AOD care**

All participant groups in the *CAN Aboriginal study* highlighted the complexity of the current health system's MH-AOD care structure. They focused on the major issues of access to service, and non-responsiveness to the complexity of comorbidity due to inefficient referral systems and no dedicated MH-AOD service. This is also illustrated in Table 8.1 in long assessment timeframes, consumer exclusion from services, far from ideal cultural competency training and limited assertive care in MH and AOD services, pointing to a consequent run-around for consumers and service staff.

### **8.5.1 Access**

All groups identified the physical location of MH and AOD services as a practical barrier to access, raising issues of transport and consumers missing appointments. The MH and AOD clinicians and workers, and support service staff emphasised the importance of providing transport for Aboriginal consumers, not only to get them to appointments but also to provide an opportunity to “yarn” about MH-AOD problems in a relaxed conversational context. This would enable them to gain valuable information about consumers' life circumstances to aid with assessment. Support service staff regretted that existing resources for transport were seriously insufficient and under threat.

All groups commented on the problems of separate services, which provided different bits of MH-AOD care (either MH *or* AOD, or other services) due to distinctly different philosophies, therapeutic models and operational criteria. This forced consumers to run around seeking appropriate care. The *CAN project* survey data on consumer exclusion from these services reinforced these findings, as illustrated in Table 8.1. Aboriginal MH and AOD clinicians and workers identified that 8.6% of MH consumers and 10.5% of AOD consumers were excluded from services depending on the primary focus of their illness. These figures were much higher than those identified by mainstream MH and AOD staff (0% MH consumers excluded and only 5.3% AOD consumers).

Other issues affecting Aboriginal consumer access to services identified by

Aboriginal Consumer Advocates and support service staff included stigma associated with MH and AOD problems; fear of culturally disrespectful, inappropriate service environments and treatment; feelings of shame (for example having no money for transport or medication, or needing to ask for help); and lack of appropriate support to connect them with services.

### **8.5.2 Separate MH and AOD services non-responsive to MH-AOD needs**

Major agreements among all three participant groups were that there were no dedicated MH-AOD services in the Salisbury and Playford LGA region. Self-referral, run-around, service “boundaries” and “inflexibility” prevented consumers from connecting with the services they needed. Program unsustainability and shutdown due to restrictive work hours coupled with inadequate and short-term funding prevented continuity of care.

The Aboriginal Consumer Advocates emphasised that essential components for Aboriginal wellbeing were missing. There were no services for children under 16 years of age overnight or on weekends; MH and AOD assessment, referral and treatment were rushed; a generalised approach to care made Aboriginal-specific health care needs invisible; there was no family involvement; and staff did not build a culturally-respectful rapport with consumers. The Advocates felt the current system did nothing more than meet service targets and hand out medications as a quick fix; it did not listen to consumers or address their individual health needs. They expressed anger at the MH and AOD services’ “propaganda” about what they provided compared with the actual lack of delivery. They saw this as nothing but “lip service”, particularly in relation to the self-referral system for consumers with MH problems, whom the Advocates identified as either too ill or lacking the confidence to approach a service. Although the current system had a documented Aboriginal mental, social and emotional wellbeing framework, and an AOD framework, implementation of these was not mandatory. Advocates felt this was particularly lacking in links between MH services and gaol, where most Aboriginal people are first diagnosed with MH or AOD issues. However, they acknowledged that staff tried their best within the current service structure’s constraints and models of care.

The MH and AOD clinicians and workers, and support service staff talked in terms of people’s lack of awareness of MH-AOD creating difficulties for self-referral. They also talked about consumers feeling unwelcome when seeking help from culturally-

inappropriate service settings. Support service staff, who took an educational approach to the MH-AOD issues and care that people experienced, commented that if someone came to the MH service with MH-AOD issues, they were only given information for AOD rehabilitation. It was up to the individual to request that service. This reflects the *CAN project* data, which showed a disproportionately high number of MH services and low number of AOD services, with neither pro-active in addressing people's MH-AOD effectively, thus perpetuating run-around (refer back to Table 8.1). Consumers and families who were unaware of appropriate MH-AOD services faced a complicated pathway, made more difficult by rigid entry criteria and service rules. This situation led to the run-around they experienced from many services when seeking appropriate MH-AOD care. They also knew of problems for staff when trying to link people to other relevant services.

All groups saw rules governing “service work” times as problematic. The restriction of service operating hours to Monday to Friday between 8.30am and 5pm left consumers with no service after hours or on weekends, unless they could attend the local hospital emergency department. Interestingly, the *CAN project* identified that some services had links to telephone triage services for MH (refer back to Table 8.1) but there was no MH-AOD triage and no face-to-face contact. MH triage personnel categorised potential consumers based on their own judgement of the severity of the MH or AOD problem from their phone conversation. They then referred callers to what they decided was the required MH service or elsewhere. The *CAN project* Survey I support service staff (77.7%; n=45) reported that a high proportion of Aboriginal-specific services had a triage service while most mainstream services did not. Support service staff from the *CAN Aboriginal study* identified a long string of callers to this telephone service, resulting in extended waiting times with prolonged, pre-recorded telephone voice messages. They also emphasised the fact that every few years these services were resurrected with no improvement.

### **8.5.3 Referral: Fishing for Nunga places**

Referral is the route through which consumers are encouraged to access the specialist MH-AOD services they need. The *CAN Aboriginal study* found that Aboriginal Consumer Advocates, MH and AOD clinicians and workers, and support service staff described referral as a long, drawn-out process with specialist MH services not raising AOD issues within the first few interviews, thereby slowing referral to AOD services.

All groups identified frequent “handballing” of consumers from one service to another. The *CAN project* survey data found that it took nearly four to six months to complete a thorough MH-AOD assessment (refer back to Table 8.1), thus making it extremely hard for consumers to reach the services they needed and causing many to stop trying.

All participant groups identified the silo nature of MH and AOD services as a major influence in extending the service referral, access and assessment processes. The fragmented nature of this service provision coupled with differently-located services hindered communication between services and led to duplication. These barriers added to consumer and staff frustration as people seeking help were given the run-around, referred-on when accessing the next service and receiving the same advice as they received from the previous service. Advocates identified this as a service “gap” that swallowed consumers.

Also frustrating for consumers was having to repeat their story again and again to different services due to lack of effective referral and cross-service communication. Support service staff suggested assessing and treating MH and AOD together would shorten and simplify the referral, transport and appointments process. Complex and inadequate referral processes made it hard for consumers to reach much needed MH-AOD services and many walked away.

Overall, fishing for Nunga places in Aboriginal MH and AOD-appropriate services was a complex and frustrating process for consumers, clinicians, workers and staff, resulting in lost trust and missed opportunities for getting help when in need. These are the disheartening effects of widening service gaps.

## **8.6 Overarching theme 3 – The future: Needs-based MH-AOD service**

Synthesis of the data from all three *CAN Aboriginal study* participant groups in relation to this third overarching theme revealed a unified call; recognition of the urgent need for, and implementation of, local, easily-reachable, available, holistic, culturally-appropriate and dedicated MH-AOD services in the Salisbury and Playford LGA region (Table 8.2). All three groups suggested some kind of integrated “one-stop-shop” MH-AOD service as a key strategy to meet this missing health care need.

### 8.6.1 Need/Practice

The Aboriginal Consumer Advocates strongly believed that good health is a right and responsive health care is a requirement. They identified an urgent need for dedicated, culturally-appropriate, locally-based MH-AOD services that included follow-up and after-care service to assist consumers to heal and reintegrate into their communities. They also expressed the need for choice of service, with Aboriginal consumers being visible and treated respectfully in mainstream as well as Aboriginal-specific services. The MH and AOD clinicians and workers, and support service staff similarly expressed the urgent need for a dedicated MH-AOD service to accommodate Aboriginal consumers' and their families' unique cultural needs rather than this population being forced to integrate into a generalised multicultural service. Their suggested focus was more on work practice issues and better outcomes. They wanted to see an end to the ineffective referral system, which they identified as largely responsible for the run-around that prevented consumer access and the gaps that prevented continuity of care.

These needs complement the *CAN project's* Survey I and Survey II findings related to "assertive care"<sup>32</sup>. Significantly less than 50% of the participants surveyed provided this type of care. Only 35.7% (n=20) of Aboriginal services participants said they provided assertive care and 25% (n=14) did not, while 19.6% (n=11) were unsure about it. In the mainstream services, only 5.4% (n=3) provided assertive care, 10.7% (n=6) did not and 3.6% (n=2) were unsure (refer back to Table 8.1).

The groups of MH and AOD clinicians and workers, and the support service staff in the *CAN Aboriginal study* identified the need for Aboriginal support staff to assist consumers to access MH-AOD care, and for outreach services to meet transient and hard-to-reach Aboriginal consumers' needs in the region. Thus, although all three participant groups had a slightly different focus, all were united in identifying the critical need for dedicated MH-AOD services; a need confirmed by the *CAN project* findings.

### 8.6.2 Strategy

All three participant groups in the *CAN Aboriginal study* called for a "one-stop-shop" as a major service model to ensure provision of holistic MH-AOD care in one location that

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<sup>32</sup> Assertive care is a service skill that enables continuity of care by taking an overview of the consumer's whole care journey.

would be accessible to consumers in their local area. The MH and AOD clinicians and workers called this a “wraparound” service. All three groups also called for all staff to undergo cultural training and training in MH-AOD care to enable them to provide care for these issues in the same service. They discussed instances of AOD staff being unable to cope with MH consumer behaviours and MH staff refusing to treat AOD consumers. This was due to different service models and staff and professional backgrounds, and the necessity for drug-free MH treatment environments.

These views complement the *CAN project* findings about staff confidence in dealing with MH-AOD (refer back to Table 8.1), which also imply the need for evidence-based training for MH and AOD clinicians and workers to better provide effective MH-AOD care. The survey results show that half of the Aboriginal-specific service staff (50%) felt only “somewhat confident” while 10% felt “very confident” in caring for people with MH-AOD. Only 5% of staff in mainstream services felt “very confident” and 13.3% felt “somewhat confident”.

The MH and AOD staff calls for “proactive” care rather than “reactive” care recognise the need for training to give staff the confidence to act appropriately in the changing context of on-the-ground need. They also reported the need for changes at policy and organisational management levels to incorporate on-the-ground staff and consumer participation in decision-making about MH-AOD care practice.

The fact that the *CAN project* survey results showing that more than 60% of existing MH or AOD specialist service consumers have MH-AOD comorbidity adds urgency to the *CAN Aboriginal study’s* participants’ calls for service providers to listen and respond to consumers, and to respect their needs. This was reported as an essential strategy in designing and implementing new MH-AOD care services and consumer pathways to recovery. Participants stressed that this strategy must incorporate after-care programs to develop life and employment skills, and provide ongoing Aboriginal support to lessen the likelihood of relapse. Without this respect and support, certain Aboriginal consumers could not engage consistently or develop the mutual trust required for successful, holistic MH-AOD service delivery. All three groups also identified education about what MH-AOD comorbidity is and the implementation of MH-AOD services as a major strategy.

The synthesised findings for “Need/Practice” and “Strategy” offer hope that there



could be determined staff action and support for change, with a combined vision of local and holistic “one-stop-shop” MH-AOD services:

*For many years we cried to get detox house but no one listens to us, and no one wants to hear us. We talk about it for many years, specifically for Aboriginal people. (Kaurna Elder)*

### **8.6.3 Moving forward – addressing service breakpoints**

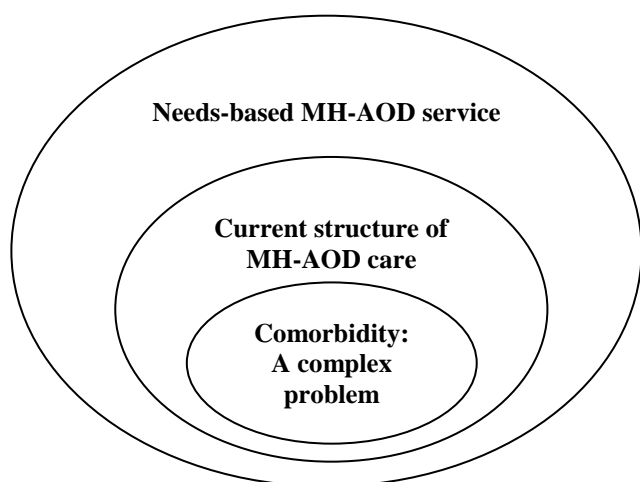
The service breakpoints, widening gaps and gap filling strategies (implementation) identified for each participant group are similar in regard to the need for needs-based, dedicated MH-AOD services. Differences amongst the three groups were limited to the way each categorised the same issues, perhaps reflecting the particular issues of greater or lesser importance to them in their particular roles. A synthesis of these is presented in Table 8.2, with “Opportunities for strategic implementation” that informed the recommendations listed in Chapter 10.

**Table 8.2: Synthesis of findings linking CAN Aboriginal study findings with CAN project data for “Moving forward”**

Moving forward	CAN Aboriginal research			CAN Findings
	Breakpoints	Widening gaps	Opportunities for strategic implementation	
Aboriginal People: Aboriginal Consumer Advocates (ACA)	Locality Divided services system Longevity Language	No MH-AOD service Run around Not Aboriginal-friendly Unsustained service No Aboriginal language translators	Local one-stop-shop MH-AOD dedicated service Available Aboriginal-specific & mainstream services Sustained funding Inclusive communication	No, ACA in CAN project
MH and AOD clinicians and workers (CMS, CAS)	Location disconnection System Coordination of referrals Aboriginal & non-Aboriginal divide	Limited service – different locations No consumer access No dedicated comorbidity service Service duplication Cultural gap – little respect	Local, dedicated comorbidity service One-stop-service with specialised staff Uncomplicated comorbidity care policy Supported comorbidity care pathway Include Ngankaris Service choice	Triangulated CAN project Survey Results (Table 8.1)
Support service staff (SMS, SAS)	Service capacity increasing illness burden Communication Connection Cultural safety	Unable to address MH-AOD – referrals “maze” MH-AOD impact on families English not primary language Complex medical terminology Undiagnosed consumers Rigid service rules Cultural misunderstanding	Local dedicated MH-AOD service After-care Family inclusion MH-AOD education Aboriginal translators Unbroken service Incorporate Aboriginality – healing focus	Triangulated CAN project Survey Results (Table 8.1)

## 8.7 Conclusion

The most telling factor from the synthesis and triangulated findings is the remarkable consistency in the overarching themes derived from all data regarding: 1) Comorbidity: A complex problem; 2) Current structure of MH-AOD care; and 3) Needs-based MH-AOD service (see Figure 8.3). This consistency was further enhanced by consistent main themes within each overarching theme, leading to the conclusion that there is an urgent need for a dedicated MH-AOD service in the Salisbury and Playford LGA region of northern Adelaide. We also conclude that sustained implementation of culturally-appropriate services is fundamental to successful Aboriginal MH-AOD service outcomes.



**Figure 8.3: Three key factors affecting MH-AOD health care**

The major findings show that it is essential to involve Aboriginal community people along with MH and AOD clinicians and workers, and support service staff in ongoing consultation to identify the best strategies for assisting them to effectively respond to Aboriginal consumers' and carers' MH-AOD health care needs. Service effectiveness in providing holistic MH-AOD care to individuals, families and whole communities depends on really listening to, respecting and acting on consumers' expressed needs and their situation. It also depends on understanding factors such as cultural beliefs about health and wellbeing, social and emotional determinants of mental and physical health, and the inter-generational impact of colonisation, all of which strongly influence MH-AOD and its impact on lives.

These findings have shone a light on what is needed and what is possible. As part of

the PAR processes of validating the findings, we invited the participating Aboriginal Consumer Advocates, MH and AOD clinicians and workers, and support service staff to attend a “CAN Aboriginal workshop” to learn from, consider and confirm the findings. We then invited them to make recommendations from the study, including development of a strategic pathway for needs-based MH-AOD care. As detailed in the next chapter, this generated great hope that these recommendations could, and would, be actioned.



## **9 Confirmation of Findings with Participants – CAN Aboriginal Workshop**

### **9.1 Introduction**

This chapter reports on the final cycle of PAR, where the participants (Aboriginal Community Advocates, staff from specialist MH and AOD services, and support service staff) were invited to a workshop along with members of their wider community. This was to present the findings and possible recommendations for the participants to confirm, refute or agree on to come up with the most appropriate solutions to best meet the Aboriginal community's MH-AOD service needs.

This chapter represents a response to my personal concerns about the ethical dimensions of the mutual research relationship I shared with the Aboriginal community, and they with me, in writing-up the research as a thesis on comorbidity (MH-AOD) service implementation. It presents an open debate about Aboriginal preferences for MH-AOD care by discussing the fifth and final research area – a workshop to consider and confirm the study findings, and determine recommendations regarding the best way to implement MH-AOD services for the benefit of the Aboriginal community.

Throughout this study, I have been mindful of Aboriginal Australians' cultural identity in multicultural Australia, and have been required to talk with a diverse group of Aboriginal and non-Aboriginal colleagues, sharing their ideas, challenges and strategies. I felt privileged and excited by this opportunity to learn from the diverse major participating Aboriginal and non-Aboriginal groups' and invited stakeholders' expertise.

### **9.2 Method**

The idea of holding a workshop to consider the study's preliminary findings was first presented to the AWP for their comments. I used their suggestions and the decision was made to invite Aboriginal and other workshop participants' feedback, as well as confirming our interpretations of the synthesised findings during the workshop. Those unable to attend would be sent a record of the workshop's participants, format, discussion and recommendations via their choice of post or email. My role involved

planning, implementing and evaluating the workshop – organising email and telephone communication, an agenda, meetings and recording of minutes. Data coding of the workshop discussion and recommendations would involve identifying the data source, discussion, planning meetings, emails, conversations, telephone calls, personal meetings, postal communication, and the workshop proceedings and deliberations.

### **9.2.1 Bringing together the *CAN project* partners with the *CAN Aboriginal study* partners**

Reconnection of partners was crucial in this phase of the research, and so all partners were invited to participate in the workshop. Those who participated in workshop planning (n=19) were named the “CAN Aboriginal Workshop team” (meeting minutes from 9.4.2014 and 15.5.2014). They came from four distinct networks: 1) AWP members (n=10), including Kaurna Elder Aunty Coral Wilson; 2) the AHCSA (n=2; 1 Aboriginal and 1 non-Aboriginal); 3) the CAN team from the University of Adelaide (n=4 non-Aboriginal members); and 4) key support persons (n=3). I was the co-facilitator, with the above-named team as co-researchers for this part of the study. We agreed on the title “CAN Aboriginal Workshop” and designed the workshop as a platform whereby Aboriginal people’s opinions of the preliminary findings would be considered and discussed. Their voices would be heard, respected and valued, and the focus would be on the study’s processes and outcomes (recommendations) as important hallmarks of collaboration.

### **9.2.2 Stakeholder and participant collaboration**

The “CAN Aboriginal Workshop” brought consenting participant Aboriginal Consumer Advocates, Aboriginal and non-Aboriginal MH and AOD clinicians and workers, and support service staff together with other stakeholders, including relevant invited health and education professionals, clinicians and researchers. All played an important role in the workshop as participants, supporters or partners (“spreading the word”).

The workshop was a transparent collaboration process, valuing participants’ different areas of involvement while maintaining individual confidentiality in the findings. Planning the workshop mirrored the nature of participation in the whole PAR study. It demonstrated friendliness, trust and close, purposeful, professional relationships.

## 9.3 Envisioning the workshop

### 9.3.1 Knowledge-sharing: Recognition of the wider community's needs

The Aboriginal Kurna Elder and AWP members, as co-researchers, spoke specifically about the importance of creating a “fair play ground” in which all information is acknowledged and respected. Their viewpoint, combined with my concerns about the dominance of mainstream knowledge in health systems, led this research as a whole and underpinned the workshop design; it was linked to the principles of *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (Ungunmerr-Baumann, 2002). The model of collaborative practice that allowed us to share knowledge for decision-making throughout the whole research process was also employed in the workshop planning, development and delivery.

The Kurna Elder envisaged holding a workshop to present the entire research work to all relevant stakeholders, thereby sharing the project appropriately with a wider audience, including representatives of the wider community. We knew there would be constraints, for example setting, presentation style (a ten-minute time slot with a “punchy” powerpoint presentation) and time for discussion. Recognising this helped us to design a time-efficient program in which we enacted *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) broadly while addressing Aboriginal health research ethics guidelines. The workshop's knowledge-sharing focus aimed to highlight the reality of MH-AOD issues on-the-ground and to frame pragmatic ways to meet the Aboriginal community's MH-AOD service needs. We saw the workshop as an integral part of the whole PAR process, not as an add-on.

### 9.3.2 Reflect, discuss and plan

Workshop planning began when Kurna Elder Coral Wilson, Professor Charlotte de Crespigny (Principal supervisor and *CAN project* leader), Dr Rosie King (non-Aboriginal Senior Research Officer, Aboriginal Health Council), Mr Robert Dann (Aboriginal man on the Aboriginal Health Council) and I had a reflective conversation about the research process and the complexities of running an Aboriginal health workshop. I liaised between the CAN team and the CAN Aboriginal Workshop team. We decided we needed to undertake strategic network-building with people interested in transforming the research findings into approaches to MH-AOD services in a wide range of community settings.



Our consultations resulted in the Kurna Elder suggesting we host the workshop in the northern region of Adelaide and that the workshop design must meet local participants' preferences and priorities in confirming consumers' MH-AOD service needs. We offered a platform to meet the research participants again and share knowledge of reflective action to devise a feasible pathway for MH-AOD service implementation. Thus, the workshop was initiated as a forum where Aboriginal and non-Aboriginal members from the local Aboriginal community and service provider staff could come together to positively discuss existing issues and work together for appropriate future service delivery. Salisbury Council became a partner during this joint hands-on planning process, offering to provide catering.

### **9.3.3 Developing a workshop planning team**

Initially, we invited all the co-researchers to be involved in planning the workshop. Over a few months, a small but growing group of people met at various locations. Each planning group member connected with a wider group of people and facilitated knowledge-sharing to and from the workshop planning meetings. This led to a wider group of practitioners and community members expressing an interest in participating in the workshop and research findings. Together, we developed a non-hierarchical planning group based on democratic knowledge-sharing, equality and respectful, transparent communication. Each person was recognised as bringing their unique knowledge, skills and expertise (integrating fresh and salt water), which were shared in a large swirling *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) pool. The resulting collective knowledge (foam) helped create a unique responsive, purposeful workshop.

We used the analogy of the workshop as a “wheel”, with our reflective discussion meetings as the “hub” and wider local on-the-ground Aboriginal people's involvement as the “rim”. As the wheel turned, it took us further along our journey, the focus of which was meeting MH-AOD service needs.

### **9.3.4 Roles and responsibilities: Teamwork**

Mr. Robert Dann and Dr. Rosie King from AHCSA would facilitate the workshop. The Kurna Elder and I planned to co-present the study's findings. Each AWP member became a self-appointed chairperson of each group discussion.

All members of the CAN Aboriginal Workshop team became involved beyond usual

work and personal commitments in a no blame, no guilt “collaborative-empowered” way of working. If a team member could not complete a task, they let another team member know and someone who had the time, energy and expertise took over. We recognised each other’s value as well as our complex lives with many personal, professional and family commitments. We learned flexibility in holding meetings and following processes, enabling space for creativity while meeting deadlines and adhering to the workshop work plan.

### **9.3.5 Aboriginal-preferred way of knowledge-sharing: Moving towards the vision**

Each person in the CAN Aboriginal workshop team shared their priorities and visions for the workshop. Generally, all agreed on the importance of networking, awareness, learning and skill development in PAR. Intended outcomes were participative mutual learning from each other and taking action after the workshop. Throughout the planning process, we kept in mind the priority of creating a respectful space in which to listen to each other and learn from one another through self-reflective practice. This collective focus assisted us to formulate a vision for the workshop, which we advertised in an advance flyer (see Appendix 9). Once the *CAN project* team and executive partners had endorsed our vision, we started planning the integrated process of “look and listen, think and reflect, collaborate and plan, consult and act” both individually and together (see Methodology chapter). Our aim was to build a culturally-safe PAR platform for workshop participation, based on respect and social justice.

### **9.3.6 A culturally-respectful, safe and cost-effective venue**

As an element of the PAR cyclic method and in the interests of upholding our social justice approach by including all who wished to participate, we lobbied for a fee-free event supported by additional sponsorship from Salisbury and Playford local councils to enable people to attend. The CAN team, CAN Aboriginal Workshop team, AWP members, Kaurna Elder and I networked successfully to secure sponsorship and a suitable venue.

Finding a culturally-respectful and safe, affordable, geographically appropriate venue was essential. Our priority was to find a venue that was easily accessible via public transport and with low-cost or free car parking. The CAN team, AWP, Kaurna Elder and I had existing relationships with the City of Salisbury and were referred to the

Morella Community Centre in Parafield Gardens. I took photos of the venue (with consent), which I gave to the CAN Aboriginal workshop team to assess its suitability. They appreciated the wide meeting room and garden, which was ideal for yarning/small group work, and recommended the Centre as the right place for the workshop. Making decisions about the workshop organisation and venue was indicative of the empowerment of the AWP members because their views were respected and represented in the planning decisions. The Morella Community Centre leadership offered to sponsor the venue cost and the City of Salisbury sponsored high tea and a healthy lunch for all workshop participants. These sponsorships were greatly appreciated. We have maintained a formal partnership with both sponsors.

## **9.4 The workshop program**

The workshop program reflected our intention to accommodate diverse knowledge-sharing and learning styles by using short presentations and longer interactive group sessions, as well as yarning circles for informal talking in smaller groups (Wingard, 2001; Bessarab, 2010). Yarning circle/circular learning is recognised as a traditional Aboriginal Australian learning/teaching style (Santoro, 2011). We allowed time for networking and group discussions to enable people to talk together and use the workshop as a strong platform for their constructive knowledge-sharing. We aimed to ensure that every participant could relate to at least one workshop presenter<sup>33</sup> and what he/she said. Accordingly, we included local younger and older Aboriginal and non-Aboriginal participants, partners and those working in communities, universities, and health and education services relevant to the project in each discussion group (see Appendix 10, “Community Report”).

### **9.4.1 Welcome, acknowledgement and knowledge-sharing facilitators**

The Kaurna Elder gave a traditional welcome to Country and introduced the CAN AWP members, explaining how our team worked, and described the Aboriginal-preferred “walk along way” to guide me in this project. We explained that culturally-respectful Aboriginal ways are embraced within the ethical concepts of social justice, equity and acknowledgement that Aboriginal knowledge is equally as important as academic knowledge (see Chapter 2).

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<sup>33</sup> Presenters were the AWP members who chaired each of the small workshop discussion groups

Since the AHCSA was the official CAN partner, AHCSA representatives were partners in this *CAN Aboriginal study* and, as discussed, Robert Dann and Dr. Rosie King from AHCSA, who were members of the CAN Aboriginal Workshop team, collaboratively planned and facilitated the workshop with us. Robert and Rosie discussed how participants could learn from each other through deep listening (*Dadirri*; Ungunmerr-Baumann, 2002) and two-way action learning (*Ganma* [Yunupingu & Watson, 1986, in Muller, 2012] and PAR). Professor Charlotte de Crespigny, leader of the *CAN project*, presented an overview of the wider project in her keynote speech. The Kaurna Elder and I then jointly presented the research findings.

Ms Joanne Else, an Aboriginal woman from the northern region of Adelaide and an AWP member from CAN partner Northern Adelaide Medicare Local then spoke. She introduced the findings and draft recommendations. She talked through an “Aboriginal cultural lens”, reflecting on the real life situation of an Aboriginal person affected by MH-AOD comorbidity.

There were then three, ten-person discussion groups, with two AWP members chairing each and a scribe noting group members’ deliberations in relation to the findings and draft recommendations for action regarding MH-AOD service provision (see Appendix 10, report recommendations).

Throughout the workshop conversations and interactions, participants could hear and see the application of the PAR processes, for example the active involvement of the advising AWP members guiding this research from the beginning to completion. AWP-member activity enabled workshop participants and CAN partners to reflect on the on-the-ground research carried out by CAN Aboriginal team members.

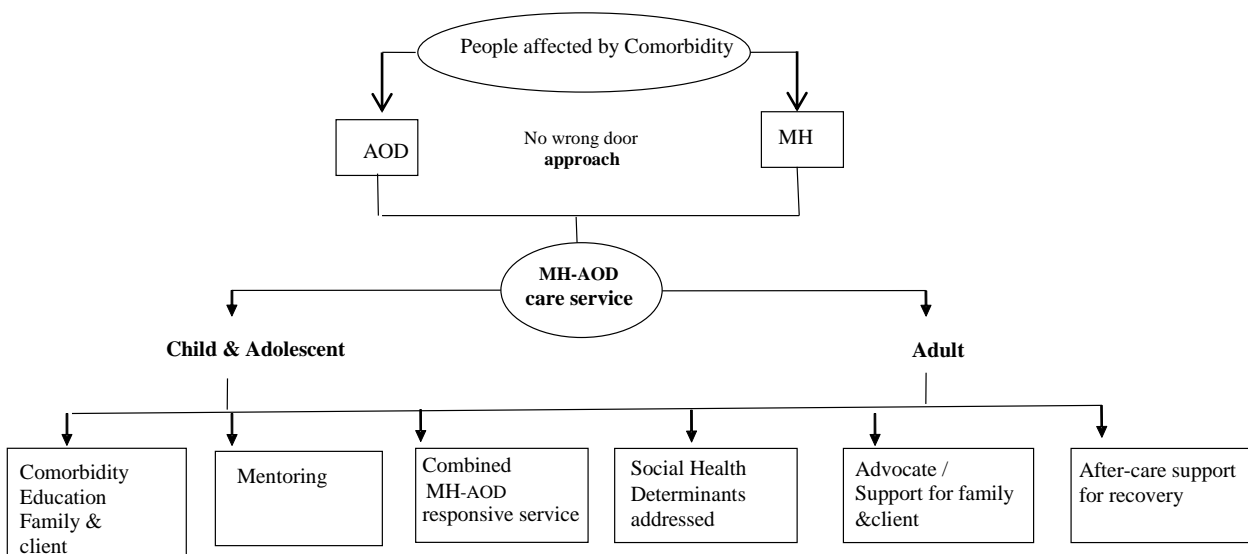
The workshop participants discussed major recommendations for culturally-appropriate, accessible and local MH-AOD services. Discussion group members talked about each recommendation in order of colour coding; red, green and blue respectively.

- 1. Providing integrated (combined) culturally-appropriate MH-AOD services in the local area.**
- 2. Addressing the social determinants affecting Aboriginal people’s health with MH-AOD.**
- 3. Having specialist MH-AOD staff, teams, service partners and advocates in the local area.**

They discussed each recommendation in relation to three main categories: Priority Actions; Priority Considerations; and Priority Need to Improve (see Appendix 10). They agreed that there was an urgent need to implement culturally-appropriate MH-AOD services.

## 9.5 Workshop outcome: A MH-AOD service model

Workshop participants confirmed the MH-AOD service model generated from the findings (Figure 9.1).



**Figure 9.1: Pathway to meeting MH-AOD service needs**

### 9.5.1 Strategies for implementing learnt knowledge in practice

In the yarning circles (small group work), participants highlighted the importance of knowledge learnt from the study and workshop discussions about MH-AOD service needs, and how they would apply this for their daily lives, workplace practice and in community health settings. Many shared how they try to work in ways that enable Aboriginal people’s ownership of programs, research and service implementation. They emphasised listening and reflected that most services are willing to listen if presented with a clearly-designed, workable service pathway. They discussed working respectfully using critical reflection of people’s circumstances as an ongoing need.

## 9.6 Need for Aboriginal and mainstream service collaboration

Ways of improving Aboriginal people’s easy access to Aboriginal culturally-appropriate

health services by acknowledging the diversity of Aboriginal culture were discussed. The necessity for mainstream services to liaise strongly with Aboriginal services so that Aboriginal people retain their choice of accessing a uniquely Aboriginal service or a mainstream service was also discussed at length. Workshop participants spoke about renewed interest in collaborative practice and participative approaches among Aboriginal and mainstream services, which they could see working in their workplace and community. They felt an approach should be made to the government about the ways of working with Aboriginal people, highlighting successful programs and projects, and those that should be actively implemented. Introducing combined health services, equating with the community's informed acceptance of required dedicated MH-AOD services, was a significant talking point. All participants highly recommended a service based on their real needs and advised that interconnecting AOD and MH services to become MH-AOD services is crucial. There was general consensus that the local Aboriginal community's input into evaluating current services for future service development and implementation is essential.

### **9.6.1 Concerns**

One of the major concerns aired in the workshop was the need for sustained availability of Aboriginal-specific MH-AOD services with a choice of mainstream MH-AOD services. Participants considered the uniqueness of an Aboriginal place amidst the mainstream realm highly important. The need for increased flexibility and easy-to-reach community-based services was emphasised due to the compromised health of people with complex MH-AOD issues and the importance of providing culturally-sensitive service.

Some workshop participants said that at the beginning of this project they were unclear about what "comorbidity" meant, but now, having gained an understanding of comorbidity terminology (MH-AOD), they could try to inform services about their real needs. Even so, their voices remained unheard because the health system was structured to address only MH *or* AOD *or* another health issue.

Listening to the workshop discussions, a non-Aboriginal workshop participant reflected that her organisation provided no cultural training. She discussed the need for an in-depth, knowledge-sharing approach between all health services.

Participants were concerned about the significant impact of unmet health needs on

Aboriginal people having to run around in search of appropriate health services, constantly repeating their stories to various services that had no apparent concern for the social determinants affecting their health. Services had their own philosophical boundaries and showed no apparent interest in change.

Another concern was possible lack of action after workshops such as this. It is not easy to convince people, services and health systems to take action to move forward despite well-supported ideas. Participants were deeply committed to taking steps to progress towards implementation of MH-AOD services.

### **9.6.2 Unexpected outcomes**

Many participants liked the participatory methodological aspect of the research because it did not restrict the scope and range of consultation. The workshop, as an integral part of this method, enabled “healing-up” connections and a deeper sense of wellbeing. Some local Aboriginal members met and got connected with their kin and friends through their attendance. A young Aboriginal person met an Elder at the end of a session and they continued to yarn (talk). The Elder reconnected the young person with their extended family from the past. An Aboriginal man shared the story of being raised in youth accommodation where the Kaurna Elder used to mentor him. An Aboriginal woman and a staff member shared their vision with each other about “the other side” of services. They had never met before but this workshop provided a platform for them to connect and share their views and knowledge.

The workshop discussions, consultations, event and resultant messages regarding Aboriginal people’s involvement in the PAR process deeply reflected this community’s vital interest in taking action to ensure the provision of the dedicated MH-AOD service they envisioned.

### **9.6.3 Cultural approval to use Ganma with PAR through Dadirri**

At the end of the workshop, after watching me over a three-year period, the Aboriginal people accepted this research. They suggested that I could use *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) as a guiding approach with PAR and manifest *Dadirri* (Ungunmerr-Baumann, 2002) in my own way. This “cultural approval” was very significant to me, my supervisors, mentors and fellow research team members. It was a major event because throughout this research I was concerned about using the PAR concept without seeking the wider community’s approval. Now we had “walked our

talk” and endorsed *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) in a way approved by Aboriginal people.

## **9.7 The workshop outcome**

### **9.7.1 AWP members’ reflection**

I invited AWP members to share their experiences of being partners with the research team, working collaboratively to plan, consider preliminary findings, and implement and evaluate the workshop. I thanked members and participants respectfully, and they emailed back to me to express their gratitude and respect for our work. The Kaurna Elder/co-researcher and I then presented our collective experiences of planning, managing, implementing and evaluating the workshop outcome to the *CAN project* research advisory team at a committee meeting.

The CAN advisory team members comprised diverse project partners and representatives from service providers and the Aboriginal community. The workshop committee indicated that the workshop had met its goal and exceeded their expectations. They discussed unexpected outcomes, such as the reconnection of Aboriginal people with family and friends, as a “light bulb” moment for non-Aboriginal people to suddenly understand the depth of collaboration within the wider Aboriginal community. The invigoration of on-the-ground staff, who were struggling to meet complex consumer needs in their workplaces, also impressed them. They appreciated the importance of retaining pride in, and respect for, Aboriginal Australians’ knowledge. In a joint meeting with CAN team members, the advisory group reflected on this *CAN Aboriginal study* that offered them capacity-building opportunities to increase knowledge and skills in areas they would not usually undertake in their work with non-Aboriginal consumers.

The CAN and AWP team members put their efforts into attending planning meetings and assisting me. They appreciated that this workshop was well organised and attracted a larger-than-usual group. The shared wellbeing and demonstrations of respect and equality in participants’ interactions reflected ethically-appropriate research. It was important to have two people, the Kaurna Elder and I, coordinating the team and ensuring ongoing consultation to keep the PAR process on track.

The CAN team also appreciated shared leadership, with different group participants



and AWP members taking the lead at appropriate times. This collaborative process enabled Aboriginal and non-Aboriginal members to connect with, and support, each other. Sharing knowledge democratically and openly, rather than in competition, was a highlight. All felt they owned the process, shared the vision and could accept another's contribution in a team.

### **9.7.2 My experience of partnering with co-researchers**

My experience as a co-researcher throughout this project was a major transition phase in my life. I have undergone a huge learning curve. I continue to learn from this experience, and discuss my thoughts and new knowledge with like-minded people. The PAR process of “look and listen, think and reflect, collaborate and plan, consult and act” provided a safe and effective research framework, assisting us to work collaboratively and creatively. Developing a partnership between the CAN team, people involved in this research and AWP members was challenging, particularly when the people involved already had other plans, agreements and priorities. I developed the skill of gently yet firmly holding the cooperative process together, ensuring tangible and pragmatic outcomes within the planned timeframe while encouraging *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) knowledge-sharing to emerge.

Working alongside the Kaurna Elder, I learned how to create and maintain a truly collaborative space, and promote harmony while meeting deadlines and budgets. I learnt the benefits of holding a group of people together, but not too tightly, and facilitating information sharing by valuing everyone's opinion, experience and input.

### **9.7.3 Synergy between Aboriginal knowledge and PAR**

The process of planning, implementing and evaluating the workshop, and being involved with each cyclic process of PAR enabled Aboriginal knowledge and PAR to progress together to implement action learning. Prior to the workshop, very few local Aboriginal people had been involved in considering and informing service provision and models. There had been no specific focus on Aboriginal concerns regarding comorbidity. Attending the workshop enabled all the Aboriginal members within the CAN team to explain precisely their issues and processes to the Aboriginal community. Links continue between the CAN Team and the AWP post-project. Growing links between people who now know and trust each other to collaborate across cultures devolved to inform the creation of culturally-safe services. Our process of the revolving

“look and listen, think and reflect, collaborate and plan, consult and act” cycles worked just as well for organising a local workshop as it did for the whole study.

## **9.8 Summary**

The workshop affirmed the study process, findings and recommendations in a wider context, thus legitimising the research. It created new dynamics, more comfortable lines of communication and greater connection among all who attended.

The outcome exceeded the intent, with participants activating new partnerships and practice strategies with the aim of establishing a needs-driven, dedicated MH-AOD service in Adelaide’s northern regions based on Aboriginal ways of doing things and the Aboriginal community’s expressed needs.

The next chapter discusses strategies for developing MH-AOD services and the type of system that will be able to meet the Aboriginal community’s expectations and needs.



## **10 Discussion and Conclusion: Meeting Aboriginal People's MH-AOD Service Needs**

### **10.1 Introduction**

This chapter discusses the research findings and their implications for the future development and delivery of local Aboriginal MH-AOD services in the Salisbury and Playford LGA region. This is particularly pertinent given there is little knowledge about the research issue, as revealed in the extant literature and confirmed by the CAN Aboriginal Kurna Elder, co-researchers and participants. Clearly, Aboriginal people's need for locally-accessible and culturally-appropriate MH-AOD care has not previously been explored from *their* perspectives or experiences, especially in the context of their very poor physical, psychological, social and emotional health and wellbeing.

The PAR methodology, through its reflective-action cycles of “look and listen, think and reflect, collaborate and plan, consult and act”, in conjunction with the Aboriginal concepts of *Ganma* (mutual knowledge) (Hughes, 2000) and *Dadirri* (respectful listening) (Atkinson, 2002), enabled production of new, legitimate, valued Aboriginal knowledge, and recommendations and implementation strategies for future planning and design of MH-AOD services in northern metropolitan Adelaide. The evidence from the research data, compiled by the Aboriginal Kurna Elder, co-researchers, community members, service providers and the researcher from the study participants' views, is clear; there is an unmet, urgent need for improvements in MH-AOD care for Aboriginal people in the form of local, flexible and easily-accessible culturally-appropriate “one-stop-shop” MH-AOD services. Participants' suggestions for ways to meet this need in terms of future pathways to locally-available, culturally-appropriate, sustainable MH-AOD services for Aboriginal people in the study region have been synthesised into the recommendations presented in section 10.5.

### **10.2 The importance of determining comorbidity service needs through PAR and critical praxis**

Over at least 15 years, a confusing, disconnected, complex and frequently changing array of federal and state government policies, strategies and funding arrangements have

been directed towards delivery of MH-AOD services but seldom are people with MH-AOD treated effectively, regardless of whether they seek help from MH or AOD services or programs. This is remarkable in that MH-AOD comorbidity is recognised as a prevalent cluster of MH-AOD chronic conditions requiring holistic, integrated treatment and support responses. This study highlights poor communication, cooperation and collaboration between disparate government and NGO MH and AOD services as barriers to Aboriginal MH-AOD consumers and their families receiving effective MH-AOD services and programs. Most concerning is that there are no identifiable dedicated Aboriginal MH-AOD services or programs in the current health system (Gray, Saggars, et al., 2010; Kowanko et al., 2012; Wilkes et al., 2014). Yet siloed services exist which, if they cooperated, could together provide a comprehensive network of much needed integrated MH-AOD services.

The PAR approach used in this research to seek solutions to this untenable MH-AOD situation achieved the research aims of determining the MH-AOD service needs of Aboriginal people aged 12 years and over living in the Salisbury and Playford LGA region; identifying and devising strategies to “stop the run-around” for those people through local, culturally-appropriate, on-the-ground service; and making recommendations for holistic, coordinated MH-AOD care. Its direct consultation and engagement with the Aboriginal Kaurna Elder and AWP co-researchers, Aboriginal Consumer Advocates, Aboriginal and non-Aboriginal MH and AOD clinicians and workers, and support service staff as well as other key informants demonstrated the power of collaboration and partnership to fully engage people in sharing their knowledge, experience and advice about on-the-ground realities of MH-AOD needs and services in the study region. This was the first time participants had experienced consultation or inclusion in decision-making, despite documents highlighting their importance (de Crespigny, Emden, et al., 2004).

Critical praxis by the researcher and Aboriginal co-researchers focusing on participants’ experiences and perspectives brought about deeper understanding and identification of essential components of the content and meanings within participants’ stories about comorbidity and service issues. Primarily, services need to consider Aboriginal consumers’ and families’ overall wellbeing, not just “treatment”. This approach is supported by existing literature on non-Aboriginal people’s MH-AOD comorbidity service requirements and very limited Aboriginal-focused research

(Kowanko et al., 2012). Those studies found that involvement of consumers and family members in decision-making regarding therapy was essential, and would be a requirement of Aboriginal consumers and families. Collaboration and partnership between MH, AOD and Aboriginal services and workers are needed for delivery of coordinated, holistic MH-AOD services.

### **10.3 Closing the gap between MH and AOD services**

Participants' perspectives in this *CAN Aboriginal study* reveal wide gaps between MH and AOD “siloes” services that people seeking, or being referred for, comorbidity help fall through. The data clearly indicate that MH and AOD services have yet to recognise and respond effectively to MH-AOD comorbidity. Their different therapeutic and operational philosophies, policies and practices are barriers to providing the holistic, integrated, culturally-appropriate, approachable and easily-accessible MH-AOD treatment and support that MH-AOD consumers and their families need. Participants called unanimously for a local, “one-stop-shop” MH-AOD service, set up in accordance with consumers' and their families' expressed needs – ask people what they need, and respect and act on their input – to overcome the current gaps. All participants agreed that implementing integrated MH-AOD services, which recognise consumers' diverse health needs, depends upon utilising shared, collaborative knowledge that provides the experiential evidence at the heart of a needs-based MH-AOD care model.

#### **10.3.1 Respect, listen and act in accordance with the voices “on-the-ground”**

The MH and AOD clinicians and workers, and support service staff appreciated the opportunity to be heard in the hope of generating change and closing the MH-AOD service gap for Aboriginal people. Both groups were frustrated that service leaders did not listen to, recognise, validate or include their front-line, on-the-ground knowledge in decision-making about MH-AOD service delivery.

MH and AOD clinicians and workers advocated for a “no wrong door” service in which MH-AOD consumers would not be turned away from either MH or AOD services according to their primary diagnosis or rigid service rules. Instead, all services would have comorbidity and cultural competency-trained staff so whichever service a consumer accessed, they would receive appropriate MH-AOD treatment. If a service could not provide holistic MH-AOD care, staff would assist in maintaining links with

other essential services and implementing a strategic pathway for full MH-AOD care. There would be no gap.

Clinicians and workers also advocated for long-term contracts to overcome Aboriginal consumers' loss of trust when skilled workers moved on. They intend to manifest PAR, with *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (Ungunmerr-Baumann, 2002), in the MH-AOD care system to improve care for Aboriginal consumers experiencing MH-AOD comorbidity; implement collaborative working partnerships by seeking and respecting consumers' and families' involvement in their care, and putting into practice their knowledge of the requirements for a needs-based MH-AOD service; and seek change in health service management practice by asking management to collaborate and form partnerships with front-line, on-the-ground MH and AOD clinicians and workers in decision-making for delivery of culturally-appropriate, needs-based MH-AOD care for Aboriginal people in the study region.

Support service staff emphasised that while services identified the high need for locally-available, dedicated MH-AOD care, this need was often overlooked in the complexities of service delivery. They felt trapped between recognising the local community's MH-AOD care needs and the fragmented care delivery system resulting from a top-down decision-making process uninformed by those "doing the job" in the community. They advocated for bottom-up decision-making, which recognises, respects and utilises workers' knowledge and experience of consumers' expressed needs. Implementing both bottom-up and top-down management processes would provide better informed, inclusive and supported organisational policy, resulting in action to replace the "lip service" from current policies, strategies and frameworks such as the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* and the *Statement of Intent to Close the Gap* (Pulver et al., 2010, p. 34). Despite these frustrations, this research shows that MH and AOD clinicians and workers, and support service staff perform incredible work in a complex environment.

#### **10.4 Future pathways to holistic MH-AOD care**

Despite their current MH-AOD service needs not being met, Aboriginal people appreciated that clinicians and workers tried to meet their needs and MH-AOD comorbidity-related situations as best as possible in the "broken" system of referrals and "run-around". However, too often Aboriginal people experienced negative attitudes

from front-line or other staff, leaving them feeling disrespected and hopeless. They walked away and became “invisible”. The comment “because we are a minority, we’re not a priority” (ACA – FG 10) sums up Aboriginal Australians’ ongoing struggle for “visibility” as equal members of Australian society deserving equal consideration in the health care system.

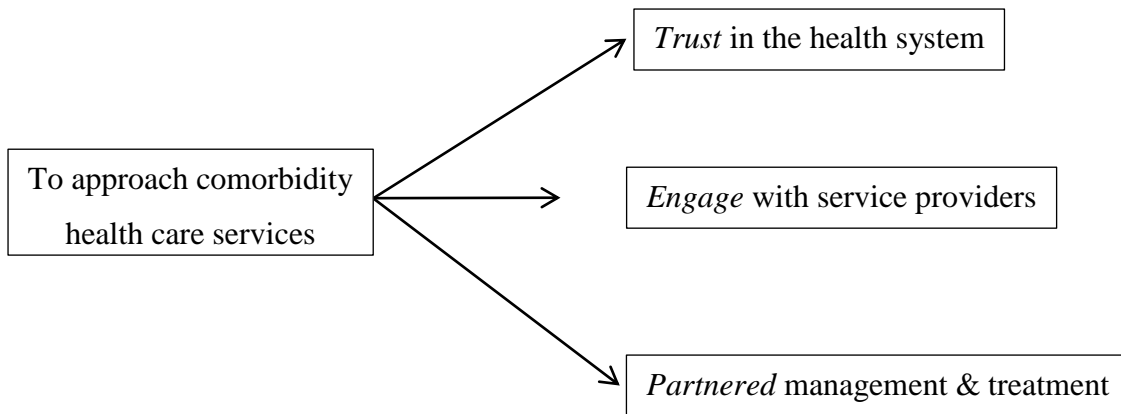
In light of this background, the PAR process highlighted the importance of working respectfully and collaboratively with local Aboriginal community people. They felt valued and encouraged to tell their stories, and focused on meeting real needs instead of on failure; they appreciated being fully included in the research process as self-empowering and countering some of the destructive effects of colonisation. The research was cathartic in as much as it gave them the opportunity to create an AWP with the power to decide how to organise their team to make recommendations about ways to effectively address MH-AOD service needs for their local area. They were adamant that a locally-based MH-AOD service designed to meet their needs would necessarily involve their ongoing partnership in decision-making at the planning, implementation, evaluation and management stages in the future.

#### **10.4.1 Trust, collaboration and partnerships: Communication as a vital tool**

The importance of trust, engagement and partnership in the complex interrelationships needed for effective MH-AOD care echoed through participants’ stories. Consumers need to trust services in order to approach them. Engagement between the consumer and clinician is essential for consumer connection to services (de Crespigny & Talmat, 2012). Continued partnerships between different services, consumers, MH and AOD clinicians and workers, and support service staff are essential for consumer compliance with management and treatment, as illustrated in Figure 10.1.

Trust, engagement and partnership cannot be built without culturally-appropriate communication. The findings showed a communication breakdown between Aboriginal consumers who did not speak English as a first language and services’ staff, many of whom spoke no Aboriginal language. Aboriginal participants were frustrated by a lack of cross-cultural communication. Clinicians need to understand Aboriginal people’s cultural interpretations of medical conditions, and use appropriate language to ensure meaningful, two-way discussion about medication, treatment and management.





**Figure 10.1: Elements needed for consumers to approach and receive comorbidity services**

Clear, culturally-appropriate communication was identified as essential during assessment, which requires understanding the consumer’s environment to identify supportive factors and risk factors that may affect their health and wellbeing. Despite detailed history-taking, there is a need to collaborate with those who have had recent contact with the consumer to gather missing details about their MH-AOD behaviours. More Aboriginal translators are needed to overcome communication barriers during this critical stage in providing MH-AOD care, during which the consumer’s personal experience must be valued through deep listening. Similar to Flatau et al. (2013), MH and AOD clinicians and workers suggested using Aboriginal consumers’ closest relatives or Aboriginal staff members known to consumers to fill this vital gap.

Participants also identified communication breakdown as precluding Aboriginal consumers from health promotion education and MH-AOD awareness training to develop a shared consumer and service staff understanding of MH-AOD-related issues (Butler, 2005), implying service management tokenism.

#### **10.4.2 Understanding the uniqueness of Aboriginal culture**

The uniqueness of Aboriginal culture was recognised as a major element in providing, accessing and fully engaging in MH-AOD service and treatments. Participants’ comments confirmed Gray et al.’s (2014) stand that effective interventions in multicultural mainstream communities cannot be directly transferred to Aboriginal health services due to the need to respect, and practice within, Aboriginal-specific cultural ways. The major difference between Aboriginal-specific and mainstream services is family inclusion, a key culturally-oriented manifestation in Aboriginal-specific services and an essential element of MH-AOD care. The evolving concept of

Aboriginal services as multicultural services was seen as a threat to Aboriginal consumers' unique needs (NACCHO, 2014).

However, participants warned against culturally stereotyping consumers by assuming they will behave in a certain way because they are “from the Aboriginal community”. Although sensitivity to cultural difference is important, individual differences must be prioritised (Deady et al., 2013). A holistic, “healing” approach to MH-AOD care incorporating acknowledgement and understanding of the ongoing effects of colonisation, racism and exclusion, which are associated with poor social determinants of health and MH-AOD comorbidity, was emphasised as the way to address future consumer-centred, culturally-safe MH-AOD service. All participants indicated that involvement in the PAR process was a step towards healing their historical scars. They associated healing with re-engaging consumers with appropriate MH-AOD services through strengthening and improving service provision.

#### **10.4.3 Early intervention**

This research has identified the urgent need for MH-AOD services for children aged 12–16 years because these do not exist in the study region and it is known that early intervention is especially beneficial for young people (Howard, Stubbs et al.2008), prevents worsening of MH-AOD issues and provides long-term benefits (Volkow, 2008; Deady et al., 2013). Any future MH-AOD services must make provision for early assessment and intervention for this neglected, highly vulnerable group.

#### **10.4.4 Easy access**

Coordination of the currently disconnected, individualised services was not seen as the answer to the lack of effective MH-AOD care. Participants clearly identified assessing and treating MH-AOD in one place, with “no wrong door” approach and fully integrated services as the best solution, with holistic MH-AOD assessment and care of consumers with AOD issues attending MH specialist services and vice versa. Services must demonstrate efficacy of treatment for complex comorbidity (NIDAC, 2014) to be truly accessible. Also, consumers' complex MH-AOD needs should never be seen as a deterrent to the provision of appropriate comorbidity services (Mills et al., 2012); a situation in which services are *available but not accessible*. Participants called for outreach services to ensure accessibility for Aboriginal people experiencing MH-AOD comorbidity who were living in parklands or otherwise unable to reach MH-AOD

services in specific locations.

Support for the family and community, as well as the consumer, in responding to complex MH-AOD issues was identified as an accessibility issue. Lack of appropriate support for family members of consumers experiencing MH-AOD comorbidity despite repeated requests for help (Lee, Harrison, Mills, & Conigrave, 2014) is a barrier to accessing services.

Service opening times was another major access barrier raised by participants. Business hours only service equates to no service. Participants requested that future MH-AOD services provide 24/7 accessibility.

#### **10.4.5 Developing sustainability**

Strengthening and improving service provision was seen as complex in an unsustainable MH-AOD care environment. Funding cuts resulting in removal of essential after-care services, such as an employment program (Mental Health Commission, 2011), short-term clinician and worker contracts, short-term projects and “bits” of service pose challenges to providing effective MH-AOD services. High staff turnover in Aboriginal health services adds to the lack of continuity of care. Some participants likened the situation to consumers “taking a health care journey towards a closed door health service”. Participants underscored the immediate need for workforce development, ongoing support, knowledge-sharing and partnerships between all MH-AOD service stakeholders as strategies to implement sustainable MH-AOD services in all organisations; a common call that remains unaddressed (Gray et al., 2008; Allan, 2010; Wilson et al., 2010). Several Aboriginal health reports comparing short-term Aboriginal-specific health programs with longer-term mainstream programs found the Aboriginal-specific services were the first to stop functioning due to removal of funding in an attempt to combine them with mainstream services.

Strategies suggested by the *CAN Aboriginal study* participants to address the issues of inadequate and unsustainable MH-AOD services, as discussed in chapters 5,6 and 7, and the synthesised findings with the wider *CAN project* in Chapter 8, point to future pathways for locally-available, culturally-appropriate and sustainable MH-AOD services. These are itemised in the recommendations section (10.5) of this chapter.

An integrated service pathway is achievable with ongoing collaboration and partnership between government and non-government, and mainstream and Aboriginal-

specific health services working along similar organisational lines. Essential elements include: responsiveness to local communities' MH-AOD service needs; provision of appropriately trained MH-AOD care clinicians, technicians and support staff to increase consumers' willingness to access comprehensive, holistic, culturally-appropriate 24/7, easily reachable MH-AOD care services and comply with treatment (Cairney et al., 2015); formalisation of health care service management procedures; and embedding commitment to policies and procedures that address consumers' real needs in working arrangements at implementation level.

## **10.5 Recommendations: Aboriginal MH-AOD service improvements and implementation in the Salisbury and Playford LGA region**

Having applied PAR combined with Aboriginal knowledge (West et al., 2012), “mutual knowledge-sharing” (*Ganma*) (Hughes, 2000; Kelly, 2008), consistent “listening” (*Dadirri*) (Creative Spirit, 2012) and an audit trail (Robinson, 2003), the trustworthy partnership between the University of Adelaide *CAN project* team and this *CAN Aboriginal study's* AWP ensured the development of an overarching strategy for MH-AOD service implementation that incorporates all suggested strategies to meet the Aboriginal community's MH-AOD service needs. These strategies have been synthesised and summarised to produce the following recommendations for future MH-AOD service best practice and their implications for service development and delivery.

### **1. Implement integrated MH-AOD care: A “one-stop-shop”**

There is an immediate, essential need to integrate MH and AOD services to provide effective MH-AOD care. All organisations delivering health services governed by federal, state and private sectors should support this integrated service model.

#### ***Implications***

The associated MH and AOD services need to be co-located, for example within a hospital, primary health care centre or community centre. When a consumer approaches the services, they can receive immediate MH *or* AOD, or MH-AOD treatment in the same building (as illustrated in Figure 5.5). A consumer can be screened, assessed, treated and provided with a follow-up strategy, all in one location. This cost-efficient

MH-AOD service model can reduce system complexity and service overlap, thus minimising service gaps.

## **2. Improve communication between service organisations**

Appropriate two-way communication between Aboriginal-specific and mainstream MH and AOD services, and support services needs to be implemented in consultation with consumers and in consideration of their individual needs.

### ***Implications***

Aboriginal consumers and families can only achieve lasting changes for better health and wellbeing through mutual communication among MH-AOD care-related service organisations and themselves.

## **3. Support and retain skilled staff who have built trusting relationships with Aboriginal people**

Experienced staff who have earned the community's trust through working with Aboriginal consumers must be retained, mentored and supported. Updating necessary skills and ongoing education about various aspects of MH-AOD care should be incorporated into staff training, based on consumers' health needs.

### ***Implications***

The quality of service acknowledged by Aboriginal people must be sustained. This means making time for experienced staff to share their knowledge with new professionals to help them provide effective care; "train the trainer".

## **4. Recognise knowledge for evidence-based service**

Consumer and staff knowledge requires equal acknowledgement with biomedical knowledge of MH-AOD, particularly in MH-AOD care settings.

### ***Implications***

Ongoing service evaluation and effectiveness will depend on ongoing partnerships with the local community. Unmodified medico-scientific knowledge cannot sufficiently address and respond to the deep-rooted historic, social and economic factors that underlie the health disparities experienced by Aboriginal community people.

## **5. Involve Aboriginal people and service staff in meaningful contributions to policy-making and implementation**

Involve and represent Aboriginal people, and MH and AOD clinicians and workers, and support service staff influenced by MH-AOD service policy in policy decision-making to ensure MH-AOD care structures are in touch with consumers' genuine MH-AOD care needs.

### ***Implications***

Respectful consultation with local people and staff will enable development of appropriate national and state level policies for responsive action and appropriate implementation.

## **6. Recognise health education, health promotion, self-empowerment and self-management strategies**

Incorporate regular, consistent MH-AOD awareness, prevention and health promotion programs in hospitals, schools, workplaces, parklands and community gatherings, delivered by a mobile MH-AOD service team.

### ***Implications***

Health promotion will provide Aboriginal community people with self-empowerment and self-management. It is a step towards reconciliation that will make them visible in the MH-AOD care system and lead to improved MH-AOD outcomes.

## **7. Develop a pathway for early MH-AOD intervention**

Make information about MH-AOD care and how to approach MH-AOD services readily available. Make services available, easy to reach and easy to approach. A community centre adjacent to, or within, a hospital would enable an early consumer approach and early identification of MH-AOD issues to prevent consumers' susceptibility to the effects of MH-AOD.

### ***Implications***

Currently hard-to-reach services will be made easily reachable as people access easy-to-reach community centres in hospitals to gain information about available services and understand how to approach them.

## **8. Integrate engaged partnership processes into MH-AOD health care**

Establish ongoing partnerships with local community leaders, Elders and local

Aboriginal community people to foster the success of MH-AOD services and programs, and ensure services and health care centres reach their service provision targets.

***Implications***

Aboriginal culture remains strong. Without engaged partnerships between services and Aboriginal community people, programs and services will fail.

**9. Implement strong links between MH-AOD services and support services**

Establish strong, transparent links between all MH-AOD services and related support services.

***Implications***

All organisations involved in MH-AOD care need a mutual goal. Appropriate strategic information systems need to be established so that each organisation is acquainted with the core business of all related services, and protocols for action in specific situations are known to all. Support services and their linked networks, as an important means of reaching so-far-unreached populations, play a vital role in meeting the Aboriginal community's extant MH-AOD service needs.

**10. Enable choice of Aboriginal-specific and mainstream services**

Establish better resourcing and funding for Aboriginal-specific services to meet Aboriginal people's need for locally-available, Aboriginal-specific services as well as mainstream services.

***Implications***

Lack of funding and resources is closing Aboriginal-specific MH-AOD care programs. If Aboriginal-specific services disappear, Aboriginal people who require them will be forced to either assimilate into mainstream services that do not meet their needs or miss out on health care.

**11. Commit to closing the widening gap with substantial networks**

Urban, rural and remote health services need to be encouraged to work in partnership to create substantial health service networks to close widening MH-AOD service gaps. A collaborative network linking gaols with MH-AOD services is urgently needed.

***Implications***

Aboriginal Australians will continue to suffer health inequalities and higher rates of MH-AOD and its effects (including incarceration) if this recommendation is not

adopted.

### **12. Recognise the importance of healing in health care: Build trust**

Building trustworthy relationships between local Aboriginal community people and MH-AOD services is needed urgently. Acknowledging an individual's abilities, skills and needs is part of the process of healing from the devastating effects of colonisation.

#### ***Implications***

This recommendation, if implemented, will begin to remove Aboriginal people's fears of culturally unsafe and unhealthy contact with MH-AOD services, thus reducing barriers to access.

### **13. Implement culturally-appropriate models of practice**

Local Aboriginal community people need to be incorporated into MH-AOD services to educate staff and management about cultural safety and respect, and to address health professions' practices and attitudes when responding to individual consumers' cultural needs.

#### ***Implications***

A cultural practice model, recognising the diversity of Aboriginal culture, will develop culturally-appropriate environments in all MH-AOD services, opening greater access for Aboriginal consumers.

### **14. Establish a sustainable MH-AOD care system**

It is recommended that an unbiased commission be initiated to check the usefulness and sustainability of MH-AOD services, and suggest ways to increase sustainability.

#### ***Implications***

Unsustainable, short-term "bandaid" funding for non-government services and programs, and frequent government service re-structuring and re-focusing continue to reinforce distrust among referral and other services, and consumers, and cause high staff turnover with a loss of expertise and community engagement. Reliable and sustainable MH-AOD services would regain trust by being able to fulfil service commitments, stimulate service networks and service Aboriginal consumers affected by MH-AOD, as well as retaining competent staff.



## 10.6 Conclusion

This study has demonstrated that a collaborative PAR model can become the basis for developing sustainable MH-AOD service delivery strategies through seeking and valuing input from everyone involved. It has also shown that Aboriginal and non-Aboriginal people can be active partners in rebuilding Aboriginal Australians' social and emotional health wellbeing. Their suggestions for MH-AOD comorbidity care demand respect and action.

Linking this research with the *CAN project* was necessary in terms of triangulation and synthesis of findings from the *CAN project* surveys, which involved questions regarding Aboriginal service provision. Findings from the CAN scoping study and resultant local *CAN directory* (2014) enabled engagement, communication and negotiation with relevant services in the study region pertinent to MH-AOD service delivery. The findings and recommendations of this *CAN Aboriginal study* are reflected in, and supported by, key recommendations of the wider *CAN project* (see Appendix 13).

Before concluding, the research strengths, challenges and limitations must be addressed.

### 10.6.1 Strengths, challenges and limitations of this research

The PAR partnership approach was a major strength in achieving the research aims. It enabled development of a culturally-respectful and safe research partnership between me, as researcher, the CAN Aboriginal Kurna Elder-community researcher, AWP members (as co-researchers) and wider CAN research team, which facilitated collaborative action to successfully implement each stage of the research. Ongoing transparent communication helped build trust between the Aboriginal and non-Aboriginal research group and community members, which encouraged and empowered all participant groups to inform us about the need for, barriers to, and best ways to improve MH-AOD services for local Aboriginal people in the Salisbury and Playford LGA region of South Australia. This broad consultation enabled identification of the elements needed for developing successful MH-AOD services. Thus, the PAR partnership, reflecting critical praxis as methodological empowerment of Aboriginal people, was crucial to the study's success.

A significant challenge was the need to respond to an Aboriginal participant's

personal issues while addressing the collective needs of diverse Aboriginal participants and stakeholders, but the Kaurna Elder and AWP co-researchers guided me through it.

Seeking and gaining approval from multiple ethics committees also proved challenging. Recruiting adults who were consumer advocates for Aboriginal minors 12 years of age and over, and affected by MH-AOD comorbidity, entailed a slight modification of the research wording to more accurately indicate that the intention was to include *only Aboriginal adults* who could advocate; no children would be involved.

The main limitation was researching MH-AOD service access issues in a particular region, thus disallowing generalisability. However, transferability of the research processes and findings is probable, as demonstrated in Table 4.2 (audit trail; also see Appendix 7). The second limitation was not researching government perceptions of MH-AOD service issues for planning and allocating longer-term, non-competitive funding to services based on pertinent performance criteria, not just numbers. This is an important area for future research.

### **10.6.2 Moving towards better MH-AOD services**

The development and implementation of sustainable MH-AOD care has long been a high priority of governments and communities seeking to promote better health and wellbeing of people with recurring and chronic illnesses, including MH-AOD disorders. In the ten years between the *Australian Integrated Mental Health Initiative* (AIMhi) (2005) and today, people with MH-AOD comorbidity have continued to fall through widening gaps between government and NGO MH and AOD services and programs. International and national calls to “close the gap” in Aboriginal and non-Aboriginal health disparities go unheeded in relation to MH-AOD comorbidity among Aboriginal Australians. The findings from this study, complemented by the larger *CAN project* findings (Cairney et al., 2015), confirm what other researchers have reported elsewhere; the lack of MH-AOD services is costing lives, using precious resources, and impacting on services, consumers, families and whole communities with very little change. They also show that MH-AOD services remain disconnected, making coordination for appropriate care difficult, despite the *National Comorbidity Initiative* (AIHW, 2005) to improve coordination of MH and AOD services and treatment outcomes.

Today, as I conclude this thesis, I cannot find any new, reported official strategies for MH-AOD service changes for the Aboriginal community. Therefore, moving towards

better MH-AOD services as identified in this research requires the establishment of effective, collaborative service pathways to meet the broad needs of Aboriginal consumers with serious MH-AOD issues. Existing MH and AOD services need to integrate and work collaboratively as dedicated MH-AOD services to improve service delivery. This action will stop the run-around and prevent consumers from falling through the service gaps. It will also prevent staff from falling through service delivery gaps in the current complex system.

Furthermore, the establishment of a needs-based MH-AOD service would offer potential benefits in terms of early diagnosis, standardised treatment protocols and care pathways, addressing AOD and MH conditions as related MH-AOD issues. Empowering consumers through respect for, and inclusion of, their knowledge of their complex MH-AOD service needs, including their sociocultural background, would provide services with greater insight into real service needs to improve MH-AOD care.

Lastly, in moving towards better MH-AOD services, the researcher and Aboriginal co-researchers took steps during the study to inform, empower and prepare the local Aboriginal community, MH and AOD clinicians and workers, and support service staff to understand the particular service needs of Aboriginal youth and adults affected by MH-AOD comorbidity. MH, AOD and comorbidity resources were provided at local community health fairs and expos, and information was disseminated throughout participant engagement. MH-AOD resources, practice guidelines and specialist education were provided to GPs, allied health professionals and emergency department nurses. At government level, an Aboriginal-specific AOD seminar was held with the SA Department for Premier and Cabinet. The *CAN project* ran five workshops to discuss research outcomes, one of which was a specific “CAN Aboriginal workshop”, which enabled research participants to come together with other stakeholders, including relevant invited health and education professionals, clinicians and researchers, to discuss and verify the *CAN Aboriginal study*’s findings, and work together to develop implementable strategies for better MH-AOD services.

In conjunction with the wider *CAN project*, this research offers uniquely new, comprehensive knowledge and guidance on developing MH-AOD services for Aboriginal people in the Salisbury and Playford LGA region of South Australia. Change has already begun, as evidenced by acceptance of the *Can Aboriginal Community report* by Nunkuwarrin Yunti through AHCSA, which will be presented to the Social

Development Committee of the South Australian Parliament for deliberation. An Aboriginal woman from the AWP, inspired by this research, has started higher studies in Aboriginal Health and Law. She became motivated to increase her knowledge to help her people. Also, an Aboriginal man from the AWP is undertaking PAR similar to this research to meet service needs other than MH-AOD in the Salisbury and Playford LGA region. The groundwork has been done to encourage consumers, staff and policy-makers to work together towards initial and ongoing service integration and sustainable program implementation.

This study has succeeded in raising the current system's awareness of Aboriginal community people's MH-AOD service needs. Together with the wider *CAN project* outcomes, this outcome has enabled us to move forward with the *CAN project* team to address the MH-AOD service needs of the broader community and provide a guide to implementation.

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## **Appendices**

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# Appendix 1: Ethics Approval Letters



RESEARCH BRANCH  
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND  
INTEGRITY

SABINE SCHREIBER  
SECRETARY  
HUMAN RESEARCH ETHICS COMMITTEE  
THE UNIVERSITY OF ADELAIDE  
SA 5005  
AUSTRALIA  
TELEPHONE +61 8 8313 6028  
FACSIMILE +61 8 8313 7325  
email: sabine.schreiber@adelaide.edu.au  
CRICOS Provider Number 00123M

5 September 2012

Professor C de Crespigny  
School of Nursing

Dear Professor de Crespigny

**PROJECT NO: H-2012-088**  
***The comorbidity service (mental health and alcohol and drug) service needs of  
Aboriginal people (12 years and over) living in Salisbury and Playford local  
government areas, Adelaide***

I write to advise you that the Human Research Ethics Committee has approved the above project. Please refer to the enclosed endorsement sheet for further details and conditions that may be applicable to this approval. Ethics approval is granted for a period of three years subject to satisfactory annual progress reporting. Ethics approval may be extended subject to submission of a satisfactory ethics renewal report prior to expiry.


**The ethics expiry date for this project is: 30 September 2015**

Where possible, participants taking part in the study should be given a copy of the Information Sheet and the signed Consent Form to retain.

Please note that any changes to the project which might affect its continued ethical acceptability will invalidate the project's approval. In such cases an amended protocol must be submitted to the Committee for further approval. It is a condition of approval that you immediately report anything which might warrant review of ethical approval including (a) serious or unexpected adverse effects on participants (b) proposed changes in the protocol; and (c) unforeseen events that might affect continued ethical acceptability of the project. It is also a condition of approval that you inform the Committee, giving reasons, if the project is discontinued before the expected date of completion.

A reporting form for the annual progress report, project completion and ethics renewal report is available from the website at <http://www.adelaide.edu.au/ethics/human/guidelines/reporting/>

Yours sincerely

 Dr John Semmler  
Acting Convenor  
Human Research Ethics Committee

29<sup>th</sup> August 2012

Mrs Hepsibah Jebaraj  
School of Nursing  
University of Adelaide  
North Terrace  
ADELAIDE SA 5005

Dear Mrs Jebaraj



Research Secretariat  
Level 2, Samuel Way Building  
72 King William Road  
North Adelaide SA 5005  
Tel 08 8161 6390  
Tel 08 8161 6521  
www.wch.sa.gov.au

**Re: The comorbidity service (mental health and alcohol and drug) service needs of Aboriginal people (12years and over) living in Sallsbury and Playford local government areas, Adelaide. REC2487/6/15 (HREC/12/WCHN/22; SSA/12/WCHN/24)**

I refer to your letters dated 14<sup>th</sup> and 17<sup>th</sup> August 2012 in which you responded to matters raised by the WCHN Human Research Ethics Committee at its June 2012 meeting. I also note approval of the study by the Aboriginal Health Research Ethics Committee in its letter dated 7<sup>th</sup> August 2012. I am pleased to advise that your protocol has been granted full ethics approval and meets the requirements of the *National Statement on Ethical Conduct in Human Research*.

This letter constitutes advice on ethical consideration only. You must not commence this research project at a SA Health site until separate authorisation from the Chief Executive or delegate of that site has been obtained through a Site Specific Assessment (SSA) request.

I note that you have provided a signed Confidentiality Agreement and Department for Communities and Social Inclusion (DCSI) Police Clearance for non-WCHN staff involved in the study. If in the future, the study involves other non-WCHN staff or students, a signed Confidentiality Agreement will be required and, if they visit any WCHN site or access identifiable patient information, a DCSI Police Certificate provided to the Ethics Committee and the Human Resources Department. The study may proceed on this proviso.

I remind you approval is given subject to:

- immediate notification of any serious or unexpected adverse events to subjects;
- immediate notification of any unforeseen events that might affect continued ethical acceptability of the project;
- submission of any proposed changes to the original protocol. Changes must be approved by the Committee before they are implemented;
- immediate advice, giving reasons, if the protocol is discontinued before its completion;
- submission of an annual report on the progress of the study, and a final report when it is completed. It is your responsibility to provide these reports – without reminder from the Ethics Committee.

Approval is given for three years only. If the study is more prolonged than this, an extension request should be submitted unless there are significant modifications, in which case a new submission may be required. Please note the approval number above indicates the month and year in which approval expires and it should be used in any future communication.

If University of Adelaide personnel are involved in this project, you, as chief investigator must submit a Human Research Approval notification form online at <http://www.adelaide.edu.au/ethics/human/guidelines/> within 14 days of receiving this ethical clearance to ensure compliance with University requirements and appropriate indemnification.

TAMARA ZUTLEVICS (DR)  
CHAIR  
WCHN HUMAN RESEARCH ETHICS COMMITTEE



Government  
of South Australia  
SA Health



**Human Research Governance Office (TQEH/LMH/MH)**

Basil Hetzel Institute  
DX465101  
The Queen Elizabeth Hospital  
28 Woodville Road  
Woodville South SA 5011  
Telephone: 08 8222 6929

11 January 2013

Prof Charlotte de Crespigny  
School of Nursing  
The University of Adelaide  
Adelaide, SA  
5005

Dear Prof de Crespigny

**HREC reference number:** HREC/12/WCHN/22

**SSA reference number:** SSA/12/TQEHLMH/113

**Project title:** The comorbidity service (mental health and alcohol and drug) service needs of Aboriginal people (12years and over) living in Salisbury and Playford local government areas, Adelaide.

**RE: Site Specific Assessment Review**

Thank you for submitting an application for authorisation of the above project. I am pleased to inform you that authorisation has been granted for this study to commence at the following site:

- Lyell McEwin Hospital (LMH)

The following conditions apply to the authorisation of this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval to this project:

1. Notification of extensions to ethics approval granted by the lead HREC are to be provided to the Research Governance Officer.
2. Notification of completion of the study at LMH is to be provided to the Research Governance Officer.
3. Confidentiality of the research subjects shall be maintained at all times as required by law.
4. Researchers are required to immediately report to the Research Governance Officer anything which might warrant review of site approval of the protocol including serious or unexpected adverse effects on LMH participants;

Should you have any queries about the consideration of your Site Specific Assessment form, please contact me on 08 8222 6929 or [geh.ethics@health.sa.gov.au](mailto:geh.ethics@health.sa.gov.au)  
The SSA reference number should be quoted in any correspondence about this matter.

Yours sincerely

ALISON BARR  
A/Research Governance Officer (TQEH/LMH/MH)



10 September 2012

Ms H Francis  
University of South Australia  
School of Nursing  
3<sup>rd</sup> Floor, Eleanor Harold Building  
Frome Road  
Adelaide  
SA 5005

Dear Ms Francis,

**Reference: The comorbidity needs of Aboriginal people (12 years and over) living in Salisbury and Playford local government areas, Adelaide**

Thank you for your recent application to the Anglicare-SA Research Ethics Committee for your research project "The comorbidity needs of Aboriginal people (12 years and over) living in Salisbury and Playford local government areas, Adelaide".

I am pleased to advise that the Committee has considered your application, and has granted approval.

Please be aware that it is a condition of this approval that you provide the committee with a final written report at the completion of your study, including a summary of the findings and recommendations.

The Committee wishes you well with your research and looks forward to a successful outcome.

**Dr Ian Goodwin-Smith**  
Acting Chair  
Research Ethics Committee

hope



Clinical Governance Unit  
SA Ambulance Service  
216 Greenhill Road  
Eastwood  
SA 5063  
Telephone: (08) 8274 0339

Mrs Hepsibah Sharmil Francis Jebaraj  
School of Nursing  
University of Adelaide  
3<sup>rd</sup> Floor Eleanor Harrold Building  
Frome Road  
Adelaide SA 5005

5 March 2013

Dear Hepsi

**RE: SITE SPECIFIC ASSESSMENT - AUTHORISATION**

Project title: Comorbidity service needs of Aboriginal People

SSA reference: SSA/13/SAH/16

Site Name: SA Ambulance Service

Thank you for submitting the site specific assessment (SSA) form for this project

Following a review of the SSA form and attachments, and noting the research protocol was ethically approved in full by the SA Health HREC, I am pleased to advise that your project is now authorised.

Please note the following conditions of authorisation:

- Authorisation is limited to the site/s identified in this letter only.
- Project authorisation is granted for the term of your project outlined in Section 9 of the SSA, or until the project is complete (whichever date is earlier). Should you require an extension to this timeframe, please submit an amendment to the SSA with a brief justification.
- The Coordinating Principal Investigator is responsible for notifying the institution via the Research Governance Officer of any changes to the status of the project within a timely manner, including discontinuation or withdrawal of the study at the named site, or changes to the scope of the project including the participants, research staff, site resources or other governance matters affecting the site.
- The study must be conducted in accordance with the conditions of ethical approval provided by the lead HREC, and in conjunction with the standards outlined in the *National Statement on Ethical Conduct in Human Research (2007)*.
- The Coordinating Principal Investigator must ensure regular (at least annual) progress reports are submitted. These progress reports should be submitted directly to the Research Governance Officer.

- A copy of this letter should be maintained on file by the Coordinating Principal Investigator as evidence of project authorisation.

Should you have any queries regarding your project authorisation please do contact me.

Yours sincerely

**Melanie Thorrowgood**  
**RESEARCH GOVERNANCE OFFICER**  
**SA Ambulance Service**

## Appendix 2: Letters of Introduction from Supervisor



### Letter of Introduction

Dear .....

This letter is to introduce Hepsibah (Hepsi) Francis Jebaraj who is a nursing candidate in the School of Nursing at The University of Adelaide. As proof of identity she will have a student card with her photograph on it.

Hepsi is involved in a research project to determine the service needs of Aboriginal people (12 years and over) with mental health and alcohol and other drug (comorbidity) problems living in Salisbury and Playford LGAs, Adelaide. She would be very grateful if you could volunteer some time to assist in this research by participating in an interview or focus group to discuss this topic. Time requirements would be one hour for an interview and two or more hours for a focus group on three to five occasions.

You are assured that any participant information provided will be maintained with strict confidentiality and will not be identifiable in the project report, thesis or any other publications. You are free to discontinue your participation at any stage or decline to answer any questions.

As Hepsi intends to audio record (digital recording) the interviews and focus groups, she will require your consent on the form attached to audio record and utilise this recording or notes in preparing the project report, thesis or publications, on condition that any identifying information or your name will not be revealed.

Any further enquiries or concerns about this project should be forwarded to:

Charlotte de Crespigny  
Phone 0434019403  
charlotte.decrepigny@adelaide.edu.au

Yours sincerely

Charlotte de Crespigny  
Professor of Drug and Alcohol Nursing Joint Chair  
School of Nursing, The University of Adelaide, Australia 5005

## Supervisor's Introductory Letter to Aboriginal Community of Salisbury and Playford Areas



### 'Stopping the run-around' Comorbidity Action in the North (CAN)

#### *Information Sheet*

#### *Aboriginal Community of Salisbury and Playford Areas*

At some stage in their life, one in five Australians will experience a mental illness such as depression (including grief and loss) or anxiety. Many experience mental illness as well as alcohol or drug problems, a combination known as Comorbidity. Aboriginal people also experience mental health and alcohol or drug problems, and Comorbidity.

Getting help easily for Comorbidity problems is necessary for people to be supported in their healing. Comorbidity care for Aboriginal people needs to be easy to receive, culturally-safe and provided locally by mental health and drug and alcohol services.

Over the next two or so years, the CAN team is engaging with local mental health and drug and alcohol services, and the general community in the Salisbury and Playford areas. This includes the Aboriginal community and people from refugee and non-English speaking backgrounds. We will be asking mental health and drug and alcohol services, other relevant services such as GP, emergency, housing and welfare services and the community what treatment and support is available for young people and adults with Comorbidity. Once we have this information, the CAN team will work with the community members and services to consider what else is needed for the provision of accessible, acceptable and culturally-safe Comorbidity care in the Salisbury and Playford areas.

In order to be effective, the CAN team needs to regularly consult with the local Aboriginal community, be advised by them, and work with them on the issue of Comorbidity care provision. We need to find out from them the Comorbidity service issues faced by other local Aboriginal people aged 12 years and over, and their families. To this end, the CAN team is forming the **CAN Aboriginal Working Party**.

The **CAN Aboriginal Working Party** will meet with the CAN team to discuss the issues associated with Comorbidity services and advise the team. We hope that the Working Party will guide and assist us in reaching out to other Aboriginal community members who are willing to tell us their stories about seeking and receiving

Comorbidity services in their local area. We also want to learn the views of the Aboriginal Community on how local mental health and drug and alcohol services could better meet the needs of Aboriginal people with Comorbidity.

The **CAN Aboriginal Working Party** needs 6 local Aboriginal men and women from their community in the Salisbury and Playford area. We do not require members to have experienced mental health, alcohol and drug Comorbidity themselves. However, we do ask that members are willing to speak for others (no names) who have experienced Comorbidity issues, and have needed to seek help and Comorbidity care.

When the **CAN Aboriginal Working Group** has been formed, we will meet soon to discuss how we can work well together, how often we need to meet and what action plan we need for the next 12 months.

We will meet at the **CAN Office, 63 Commercial Road, Salisbury** at a time convenient to the members.

Ms Coral Wilson, Aboriginal Cultural Advisor and Community Researcher, Hepsi Francis, CAN PhD student and Mel Cairney, *CAN project* Coordinator will arrange the meetings, transport and refreshments for members.

**Feel welcome to call**

**Hepsibah Francis    mobile    0426 095 641**

**Mel Cairney            mobile 0404 467 763**

Yours sincerely

Professor Charlotte de Crespigny and Professor Cherrie Galletly  
Co-Leaders of the *CAN project*

## Appendix 3: Aboriginal Working Party (AWP)

### Support letter from Aboriginal Working Party members



28.5.2012

To whom it may concern

Dear Sir/Madam

**Re: Support and guidance by the Aboriginal community this project being conducted by for Hepsibah Sharnil Francis Jebaraj**

This letter confirms support and guidance by the CAN Aboriginal Working Party members for Hepsibah Sharnil Francis Jebaraj for the research project titled *Determining the comorbidity service needs of Aboriginal people (12years and over) living in Salisbury and Playford local government areas at Adelaide*, which is a sub-project of the parent research project *Stopping the run-around: Comorbidity Action in the North (CAN)*.

Yours sincerely

**Ms Coral Wilson**

Aboriginal Kaurna Elder, Cultural Advisor and Community Researcher

**Paul Elliott**

Chair - Aboriginal Family Support,  
Alcohol Prevention Project Officer, Aboriginal Health Council

**Joanne Else**

Closing the Gap Outreach Project Officer  
Northern Adelaide Division of General Practice

**Trevor Wanganeen**

Closing the Gap Outreach Worker  
Northern Adelaide Division of General Practice

**Mandy Brown**

Indigenous Arts and Cultural Engagement Officer  
Country Arts SA.

**Lisa Warner**

Aboriginal Project Officer, YWCA

**Robert Taylor**

Aboriginal Dads Worker  
Salvation Army Communities for Children, Ingle Farm

# Aboriginal Working Party meeting minutes

*Purpose: Discussion for the CAN Aboriginal Workshop*

30<sup>th</sup> March 2014

CAN Office

30 Gawler Street, Salisbury

2.30 pm to 4.30 pm

## Minutes

### 1. Present

Coral Wilson, Joanne Else, Trevor Wanganeen, Jodus Madrid, Robert Taylor, Mel Cairney, Janet Kelly, Hepsi Francis

### 2. Apologies

Mandy Brown, Lisa Warner, Charlotte de Crespigny, Trevor Warrior, Paul Elliott, Frank Wanganeen

### 3. Discussion

Points of discussion	Description	Amendments
1.Acknowledgement	'Aunty' Coral Wilson acknowledged Kaurna land.	The meeting started with on table service of fruits, snacks and refreshment.
2.Previous minutes of meeting	Previous Aboriginal Working Party Members (AWP) meeting: 26 <sup>th</sup> March 2014	The previous minutes were accepted by the members <ol style="list-style-type: none"> <li>1. The previous minutes were emailed to AWP members</li> <li>2. Handouts of previous minutes distributed</li> <li>3. Agenda of current AWP meeting was given</li> </ol>
3. Sharing of Information	Charlotte's Health	Auntie Coral told the group that Charlotte will be going for Chemotherapy, but will still be available via email and phone. Members send their regards to Charlotte
4.Workshop agenda	21 <sup>st</sup> May Wednesday (9.30am to 12.30 am)  Venue: Morella Community Centre, 90 Kings Rd, Parafield Gardens SA 5107  Aboriginal community members, key	Invitation: Three coloured versions to <b>enable choice of printing</b> depending on whether the printer can print in colour or not. <ol style="list-style-type: none"> <li>1. Full colour with black background and red, yellow and white letters and logos/ Aboriginal flag</li> <li>2. Full colour with Light brick colour with black letters and black and white logos/flag or coloured logos/ Aboriginal flag</li> <li>3. White only background with</li> </ol>



	informants, staff participant and CAN team members	black letters, and black and white Aboriginal logos/flag  Facilitators: Rosie King and Robert Dann Scribe: Margaret Bowden <i>CAN project</i> over view: Charlotte de Crespigny Findings: ‘Aunty’ Coral & Hepsi Recommendation and its importance: Joanne Else  Joanne Else and Hepsi will be visiting Morella Community centre before 19 <sup>th</sup> May to have a look at the infrastructure.  Expected participants : 30 to 40  Refreshment and light lunch sponsored by Salisbury council
5. Workshop proceeding plan discussion	Group discussion floor plan	The visual floor map for the small group discussion was discussed. Each recommendation will be discussed for 30 minutes.
6. Nominees to chair each group discussion	Three nominees with extra three extra members	Nominated chair persons  Group 1: Joanne Else & Trevor Wanganeen Group 2: Trevor Warrior & Paul Elliott Group 3: Jodus Madrid & Robert Taylor (Jodus may be an apology) if so Frank Wanganeen
7. Group discussion	The major recommendations with activity	Recommendation 1: Providing integrated (combined) comorbidity services in the local area  Recommendation 2: Address the social determinants of health  Recommendations 3: Having specialist comorbidity staff and advocate  Prompting questions for each recommendation were discussed, reviewed and modifications suggested by the group (Appendix 1)

8. Any other related business	How to start and complete the workshop.	<p>The group suggested two additional agenda items:</p> <p>At the beginning of the workshop define comorbidity.</p> <p>At the end of the workshop finish up with a Yarning circle (for debriefing and any other comments).</p>
9. Chapter writing	Working document	Hepsi is writing the findings chapter in ongoing consultation with 'Aunty' Coral
10. Vote of thank	A thank note	<p>Hepsi thanked everyone for their continued support, guidance and mentorship</p> <p>Next meeting: 21<sup>st</sup> May 2014 for the workshop and on 19<sup>th</sup> May Hepsi will meet members at their workplace to give them the printed copy of the working sheet of the workshop</p>

# Appendix 4: Participant Information Sheet



## Participant Information Sheet

**Project Title:** The comorbidity service needs of Aboriginal people (12years and over) living in Salisbury and Playford local government areas, Adelaide.

[A sub-project of 'Stopping the run-around: Comorbidity Action North']

(CAN project)

### Invitation

We wish to invite you to participate in this research project. The aim is to understand, and make recommendations on the design, development and delivery of local, easy to reach and culturally appropriate services for Aboriginal people (aged 12 years and over) who experience combined mental health *and* alcohol or other drug problems, and who live in the Salisbury and Playford (Elizabeth) region.

### What do we mean by 'Comorbidity'?

In this research we are using the word 'comorbidity' when someone has or had a *combination* of mental health problems such as depression, anxiety or strange thinking (psychosis) *as well as* problems with alcohol and/or other drugs including medicines such as pain or poor sleep. For some people this sort of comorbidity may also include problem gambling.

### What do we mean by *Aboriginal Consumer Advocate*?

In this research we are using the words '*Aboriginal Consumer Advocate*' for local Aboriginal community members and workers who agree to talk to us about the local comorbidity service needs of other Aboriginal youth and adults with comorbidity who they know or provide services locally.

### Who is doing this research?

Hepsibah (Hepsi) Francis is a registered nurse undertaking her PhD at the University of Adelaide, School of Nursing. Hepsi is a research team member of the wider project called "*Stopping the run-around: Comorbidity Action in North*" (CAN). Her PhD research is focussing specifically on the local comorbidity service needs of Aboriginal people aged 12 years and over who live in the Salisbury and Playford (Elizabeth) region. Hepsi is mentored, supported and guided by a respected Aboriginal Kurna Elder/Community Researcher, the CAN Aboriginal Working Party, whose members are local Aboriginal community members and workers, three PhD supervisors and the CAN research team. The Aboriginal Health Council of SA (AHCSA) is a formal partner of the CAN project and supports this project.

### Who suggested I may like to be involved in this research?

Member of the CAN Aboriginal Working Party, another local Aboriginal person or key informant advising this project has suggested that you or someone you know may be willing to take part in this project. We are therefore welcoming you to share your knowledge and experience about the local comorbidity service needs of other Aboriginal people you know who have (or have had) comorbidity due to their combined mental health *and* alcohol or other drug problems, and possibly problem gambling.

### How can I be involved?

#### 1. Local Aboriginal consumer advocate (Interview or Focus group)

As an Aboriginal community member you are invited to participate in a confidential interview or focus group comprising up to 5 other Aboriginal people. This is because as a local Aboriginal community member you may know of and be willing to speak

about the local comorbidity service needs of other Aboriginal people (youth and adults) with comorbidity, which may include problem gambling.

**Interview:**

- o *Who will conduct the interview, how long will it take and where will it be?*

PhD Researcher and Aboriginal Kurna Elder/Community Researcher will be together at your interview. It will take up to 1.5 hours including meeting each other and having light refreshments. Your interview will be held at a date, time and local place suitable to you.

**Focus group:**

- o *Who will be at the focus group, how long will it take and where will it be?*

PhD Researcher and Aboriginal Kurna Elder/Community Researcher will be together at your focus group discussion. It will take up about 1.5 hours including meeting each other and having light refreshments. Your focus group will be held at a date, time and local place suitable to you and other members.

[or]

**2. Local Aboriginal or non-Aboriginal worker (Interview)**

As an Aboriginal or non-Aboriginal worker we welcome you to talk to us about the local comorbidity service needs of Aboriginal people (youth and adults) with (have or had) comorbidity, which may include problem gambling.

**Interview:**

- o *Who will conduct the interview, how long will this take and where will it be?*

This would involve a confidential, personal interview with PhD researcher and the Aboriginal Kurna Elder/Community Researcher. It will take up to 1.5 hours including meeting each other and having light refreshments. Your interview will be held at a date, time and local place suitable to you.

**What about my local travel expenses?**

We can reimburse your local transport costs to attend your interview or focus group, on receipt of your fare. Alternatively we can provide you with return bus or train tickets before your attendance at your interview or focus group. If public transport is not suitable for you we can organise with you how your travel needs can best be met before your interview or focus group. Free parking will be available, including parking for people with disability.

**Your participation is voluntary and confidential**

- Participating in this research is voluntary. If you decide to take part and then later change your mind, you are free to withdraw at any stage without giving a reason. Any personal information you give us such as; your name, family background, where you live or work will not be shared with any person, other than members of this research team, or service provider/employer
- All recorded information will be safely stored in secure files of the University of Adelaide for 15 years (as per Australian code for the responsible conduct of Research, National Health and Medical Research Council). This information will then be permanently destroyed through confidential document procedures.
- Your information will remain confidential except in the case of a legal requirement to pass on personal information to authorised third parties. This requirement is standard and applies to information collected, both in research and non-research situations. Such requests to access information are rare, however we have an obligation to inform you this possibility.

### Recording your voice during your interview or focus group participation

- If you agree, your voice will be recorded on a digital voice recorder by the PhD researcher during your interview or focus group conversation. If you do not want your voice recorded the PhD researcher will take written notes instead.
- If you agree to have your voice recorded, your words will be converted to a written version after your interview or focus group participation.
- Following your interview or focus group discussion your information (either recorded or written notes) will be checked by both the PhD researcher and Aboriginal Kurna Elder/Community Researcher to ensure that your information was correctly documented, understood and agree on by both.
- The written version of your voice recording will then be kept in a secure document in a code protected computer of the University of Adelaide, for up to 15 years (as per Australian code for the responsible conduct of Research, National Health and Medical Research Council). It will then be destroyed through confidential document procedures.
- Any details that might identify you, your family, where you live or work will not be revealed (spoken or written) to any other community members, other people or service providers/employers. The PhD researcher, Aboriginal Kurna Elder/Community Researcher, PhD supervisors and CAN Research Project Coordinator may have access to your information but will all adhere to this confidentiality policy.

### Will I be informed about the outcomes of this research?

After all interviews and focus groups are completed and the information has been analysed we will be holding a *local workshop*. You will be invited along with other local Aboriginal community members, workers, members of the CAN Aboriginal Working Party, AHCSA representative of the CAN Project Advisory Committee, CAN research team members. At the workshop the audience will be presented with the findings for consideration and work together to make recommendations based on the findings, with the focus on improving the design, development and provision of culturally appropriate local comorbidity services for Aboriginal youth and adults.

Following the above a community report will be written, and talks will be held to inform local Aboriginal community groups and relevant service providers to ensure they too are informed. [Please indicate how you would like to receive the community report]

If you would like to know more about this research and/or are interested in taking part in an interview or focus group please contact Hepsi on  
Mobile: 0426 095 641 or Email: [hepsibah.francisjebaraj@adelaide.edu.au](mailto:hepsibah.francisjebaraj@adelaide.edu.au)

### For other information and correspondence

<b>Hepsibah (Hepsi) Francis PhD Candidate</b> University of Adelaide School of Nursing, Adelaide 5005 Mobile: 0426 095 641 Email: <a href="mailto:hepsibah.francisjebaraj@adelaide.edu.au">hepsibah.francisjebaraj@adelaide.edu.au</a>	<b>Mel Cairney</b> CAN Research Project Co-ordinator, 63 Commercial Road, Salisbury Mobile: 0404 467 763 Email: <a href="mailto:imelda.cairney@health.sa.gov.au">imelda.cairney@health.sa.gov.au</a>
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### If you have any concerns please contact any of the people below

Principal Supervisor	Second Supervisor	Third Supervisor
Charlotte de Crespigny Mobile 0434019403 Email: <a href="mailto:charlotte.decrespigny@adelaide.edu.au">charlotte.decrespigny@adelaide.edu.au</a>	Cherrie Galletly Phone: 82698144 Email: <a href="mailto:cherrie.galletly@adelaide.edu.au">cherrie.galletly@adelaide.edu.au</a>	Janet Kelly Mobile 0428 891286 Email: <a href="mailto:janet.kelly@flinders.edu.au">janet.kelly@flinders.edu.au</a>

# Appendix 5: Consent Form



Appendix:

Code No:

## CONSENT FORM FOR PARTICIPATION IN RESEARCH

*Project Title: 'The comorbidity service (Mental health and Alcohol and Drug) needs of Aboriginal people (12years and over) living in Salisbury and Playford local government areas, Adelaide'.*

Researcher: Hepsibah Francis (PhD Research Candidate)

Aboriginal Kurna Elder/Community Researcher: Ms Coral Wilson

Supervisors: Prof. Charlotte de Crespigny, Prof. Cherie Galletly, Assoc. Prof. Janet Kelly

I agree that for this research project I will take part in *Focus Group*   
*Interview*

(Please x one box)

1. I have read (or have read to me) the invitation and information sheet and my consent is voluntary.
2. I understand the purpose of this research and my involvement may not be of direct benefit to me.
3. The aims and details of this research have been explained to me including the nature of my participation, expected time it will take, and my questions have been answered to my satisfaction.
4. I understand that I have the opportunity to bring a family member or friend to support and discuss my participation in this research.
5. I understand that privacy and confidentiality of any information I provide will be safeguarded as explained in the Participant Information Sheet, except where there is a requirement by law for it to be divulged.
6. The interview or focus group in which I participate will only be digitally voice recorded if I consent for this to occur. Should I prefer not to have my voice recorded, I understand that written notes only will be taken instead.
7. If I have agreed to the voice recording I understand that I can ask for the recording to be stopped at any time, in which only written notes will then be taken.
8. I understand that I can withdraw my involvement in this research at any time or stage without any disadvantage to myself, and without needing to explain why.
9. I understand that I will not receive any payment for participating in this research.
10. I understand that I will have the opportunity of receiving a copy of the draft findings from my interview or focus group participation for my own confirmation, and if need be, I can request any corrections to errors of facts or interpretation.

Preferred name of the participant: .....

Signature..... Date

*I certify that I have explained the research project to the participant and consider that he/she understands the aim of the research, what is involved by participating, and freely consents to participate*

Signatures of Researcher and Aboriginal Kurna Elder/Community Researcher

Researcher..... Date

Aboriginal Kurna Elder/ Community Researcher..... Date

# Appendix 6: Semi-structured Interview/Focus Group Guide

## Semi-structured Interview/Focus Group Guide

### Note

These interviews will be conducted as a conversation. Open questions will be used to elicit information from participants, and these are the styles of mirror questions that will be used. In the conversation, if the required information emerges in relation to another particular question, then it will not be asked again.

### Group A – Aboriginal Consumer Advocacy (Interview / Focus Group)

### Opening Conversation

*In our project we are focusing on what happens for people with combined problems of mental health, alcohol and drugs (which we are calling **comorbidity**). We are very interested in what you can tell us about what happens when Aboriginal people, children, youths and adults with comorbidity try to seek specialist care or treatment for this problem in this local area*

### I. Interview Details

1. Code name/number:
2. Date:
3. Time:

### II. Demographics

1. Post code:
2. Age:
3. How many people do you live with:
4. Daily activity: (Grandmother/granddad//mother/father/carer/guardian/worker/others .....)

### III. Semi-structured Interview Guidelines

1. Can you tell a brief story about an Aboriginal person you know who has needed treatment for their combined mental health *and* alcohol or drug problems (comorbidity)?
  - What mental health problems did they have?
  - What alcohol or drug problems did they have?
  - Were there also other health problems, e.g. problem gambling or physical illness?

2. Can you tell us what services exist locally for Aboriginal children, youth and adults with such problems?
  - How do they come to know about these services?
  - How do they access these services?
  
3. Can you tell us how local services respond to Aboriginal people seeking care for their combined problems of mental health and alcohol/drug?
  - You were talking about xxx, can you say more about these issues.
  
4. Can you tell us how this person gets to the service from where they live?
  - Mode of transport
  - How often it is required to go
  - Accompanied by family member
  
5. Has the person you are talking about been referred to another service?
  - If yes, why do you think this happened
  - Were they refused any services
  - Do you believe they were treated differently because they are Aboriginal?
  
6. Where else do they go to seek help for these problems?
  - Why do they go there xxx?
  
7. What might be preventing an Aboriginal person from receiving helpful specialist services for their mental health *and* alcohol / drug problems (comorbidity)?
  
8. Can you describe what understanding mental health or drug and alcohol workers have had about the life circumstance of the Aboriginal person you know?
  - About their
    - Family situation
    - Cultural connections
    - Role in their family and community
    - Support networks
    - Social circumstances, e.g. housing, transport, employment
    - Economic background
  
9. What would you suggest to the workers of these services on appropriate care for Aboriginal people?
  
10. What helps Aboriginal people to get the care for mental health *and* alcohol and other drug problems?

**Closing Conversation:** Is there anything else you would like to talk about?



## **Group B – Service Providers** (Interview)

### **Opening Conversation**

*In our project we are focusing on what happens for people with combined problems of mental health, alcohol and drugs (which we are calling **comorbidity**). We are very interested in what you can tell us about what happens when Aboriginal people, children, youths and adults with comorbidity try to seek specialist care or treatment for this problem in this local area*

### **I. Interview Details**

1. Code name/number:
2. Date:
3. Time:

### **II. Demographics**

1. Post code of service:
2. How long have you been working with Aboriginal people?  
----- months/years
3. What does your health service offer Aboriginal people?
  - How long has the service been in existence?
4. Approximately what % of the clients in your service are Aboriginal people?

### **III. Semi-structured Interview Guidelines for Health Care Staff**

1. Please can you describe some common MH and AOD problems that an Aboriginal person may have, who presents to your service?
  - Can you tell us how important it is to know about the living conditions of the client?
2. When the Aboriginal person with combined mental illness, alcohol and drug problems (comorbidity) seeks help, what assistance would they receive from your service?
  - You were telling about XXX, then what happens?
  - How do people find about the availability of services?
  - How do they get access to these services?
3. What services are available locally for Aboriginal children, youth and adults?
  - How do the mental health and alcohol and drug services link to provide comorbidity care?
  - How do the services determine who is responsible for what?

- Who takes the lead responsibility for comorbidity care for a client?
4. In your opinion, do you think Aboriginal clients are receiving sufficient and appropriate care for coexisting problems of mental health, drug and alcohol problems (comorbidity)?
    - If yes, what services do you know that are culturally-appropriate for Aboriginal people?
    - If no, why not?
  5. Are the clients referred to other services?
    - Why are they referred?
    - What are the criteria to refuse a service for a client?
  6. Where else might Aboriginal people go to seek help for comorbidity problems?
    - Why do clients go there?
  7. Are there any barriers that an Aboriginal person faces in receiving services locally?
    - Mode of transport
    - Supporting person / family member
    - Sustainability of service
    - What else could be done to improve access to your service
  8. How does the staff communicate information about delivery of services to their client?
    - Are the clients well informed about their overall comorbidity treatment?
  9. If a new health service was to be established for Aboriginal people with comorbidity
    - What sort of service do you think should be considered?
  10. Can you tell us a brief story about a client you know with comorbidity who sought care / treatment locally?
    - What worked well
    - What didn't work well

**Closing Conversation:** Is there anything else you would like to talk about?

## **Telephone conversation guideline for inviting potential participants if they wish to participate in an interview or focus group for this research**

### **The comorbidity service needs of Aboriginal people (12 years and over) living in Salisbury and Playford LGAs, Adelaide.**

A sub-project of the *Stopping the Run-around: Comorbidity Action in the North*.

**Researcher:** Hello, this is Hepsibah (Hepsi) Sharmil Francis Jebaraj, I am a research candidate, XXX has given me your contact telephone number. Are you free to talk, will it be okay for me to talk with you now please?

**Participant:** ----

**Researcher:** The aim of this project is to understand the treatment needs of Aboriginal people aged 12 years and over, and find ways of improving local mental health and alcohol and other drug comorbidity services that can better meet their need, in the Salisbury and Playford areas.

We are interested in what you understand is happening for other Aboriginal people and will not be asking you to talk about personal issues or experiences.

May I ask if you would be interested in participating in your choice of an interview, or focus group discussion with other Aboriginal people for this research. An Aboriginal Kaurna Elder who is the community researcher working with me will be present with us at that time.

**Participant:** ----

**Researcher:** We would find a local place, date and time that suits you, and can help you with local transport if that is useful. We will offer you light refreshments at that time. The interview or focus group discussion will take about 1 and ½ to 2 hours of time respectively. If so, could you please let me know when you would be free to participate?

**Participant:** ----

**Researcher:** (If agreed) Thank you for agreeing to participate in this project. Would you prefer me to organise transport for your travel for this purpose?

**Participant:** ----

**Researcher:** Have you got any preferred place or site for our interview/focus group

sessions to be organised?

*Participant:* ----

**Researcher:** Thank you so much for this, I shall organise our meeting as such.

## **Appendix 7: Audit Trail**

### **Audit Trail Journal Entry**

*When*

Tuesday 18 June 2013 at 3 pm

*Where*

In yarning room at an Aboriginal-specific service

*Who*

An Aboriginal person

*Who was with us*

An Aboriginal Working Party (AWP) member

*How long*

1 hour

#### **The practicum of interview**

It was a cold day and interview started with a hot cup of coffee and sultana biscuits. The atmosphere of the area for our conversation was comfortable for the participant, as the participant chose the venue. The room was wide for us to move around, with bright wide open windows, where the trees, the land and the mud were a visual treat. We found our chair to sit side by side and the Aboriginal Working Party member said she would do her work on one side of the room while we held our conversation. She said she would join us as and when required. Just the presence of the AWP member made a lot of difference; it enhanced the participant to be connected with me. We spoke at ease and with familiarity, as if we knew each other for a very long time. The participant expressed interest for the interview to be voice recorded. I was able to take the direction of the interview in accordance with the semi-structured interview guide. I did not have to look down at each question. I used prompts from content of participant's talk. Though we were recording the voice, I listened carefully to the participant's expression, gesture, tone of voice. For the participant to talk fluently, I did not interrupt by giving hints in completing the sentence of conversation. This enabled the participant to have relaxed conversation and not a rushed talk. This also allowed me to realise the reality and have insight into their experience of the impact of comorbidity. When the participant told about their felt comorbidity issues, rather than moving on to the next question, I used expressions like "Hmm...that must be hard...". This led the participant to mull on the context of comorbidity and it enhanced the depth of the interview.

#### **Content**

The participant spoke of the practical needs of the comorbidity problem; the orientation of available health services and the run-around that they have in seeking an appropriate comorbidity service. People are running between these services and finally they fall onto the ground with a tragic broken life. One issue that was quite instrumental was

children were taken away from the families affected with comorbidity. It was highlighted that families were not given prior information on seeking help for comorbidity. Rather, the health system waits for people to have issues to get worse and then finally services take children away. Again, the issue of separation is yet another nexus that impacts their wellbeing.

A generalised monopoly of disconnected services is not good enough. The participant really emphasised that healing of the health system is important for understanding and healing comorbidity issues of Aboriginal community members. The participant also said that the needs of Aboriginal people are diverse depending on their situation. It was identified that there is 'no comorbidity service' in northern Adelaide where many Aboriginal people live.

### **Other comments**

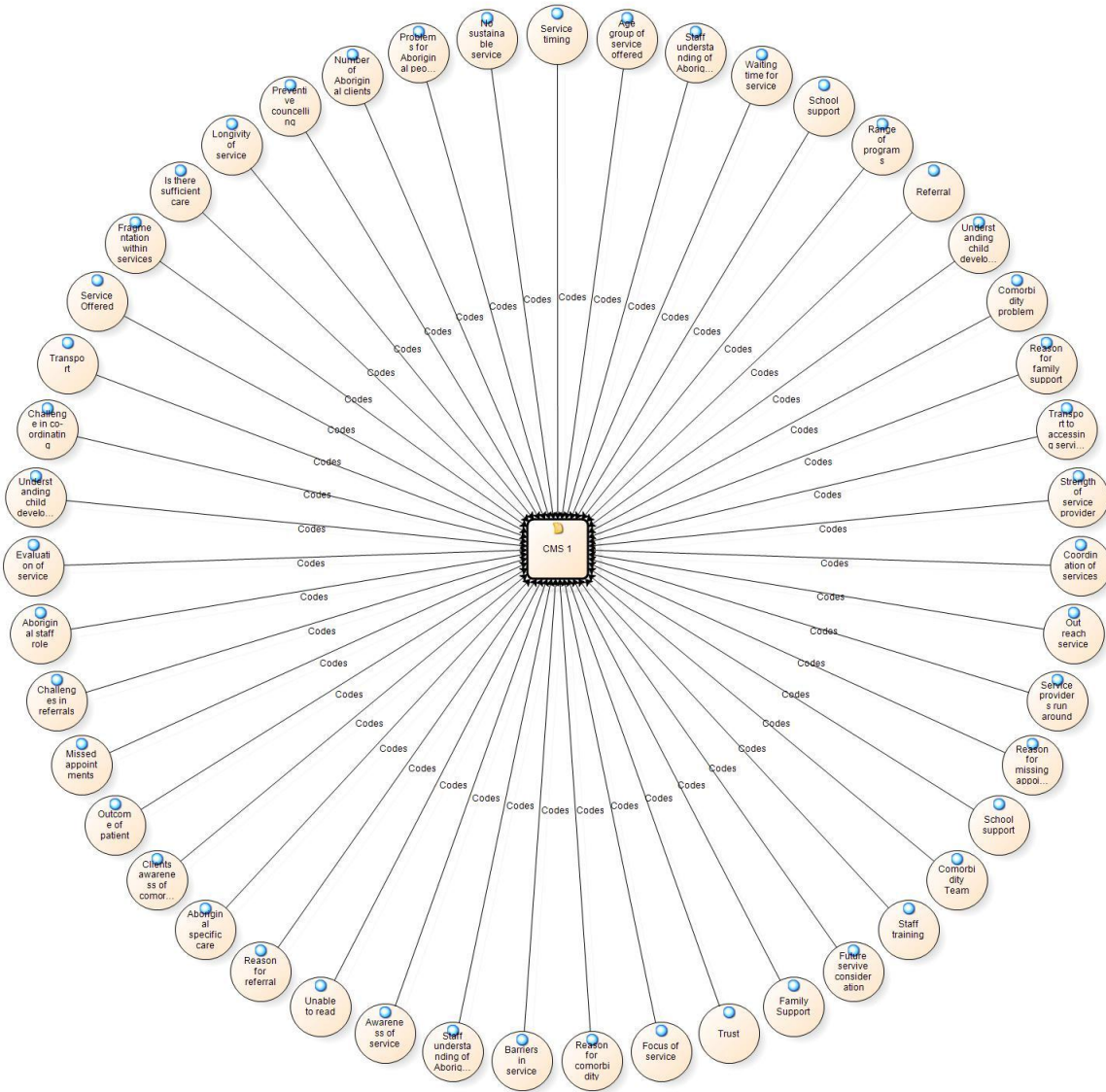
I asked the participant how the transcribed interview should be sent, via email or postal mail. The participant asked me to listen to the recorded interview and to share my thoughts about our conversation.

### **Follow up**

I carefully listened to the interview and put my thoughts in my reflective journal. I rang the participant after three days and shared my thoughts about the interviewed conversation. I sent the copy of the transcript with my reflective thoughts as a researcher's notes. It was appreciated by the participant.

# Appendix 8: Thematic Analysis

Excerpt of thematic analysis using qualitative software (NVivo 10): first participant



**Extracted content analysis from NVivo for paper and pen method, for discussion  
with the co-researcher Kurna Elder**

**First Node**

1 Comorbidity Problem

<Internals\\Aboriginal Consumer Advocate\\ACA 1> - § 2 references coded [0.96% Coverage]

Reference 1 - 0.22% Coverage

They've got that comorbidity that you talk about. They've got the drugs and alcohol issues, they've got the sexual abuse attached to it and on top of that they've got all the other illnesses that are medical.

<Internals\\Aboriginal Consumer Advocate\\ACA 2> - § 1 reference coded [1.18% Coverage]

Reference 1 - 1.18% Coverage

They called her condition schizophonia – what is schizophonia? She was drinking and she was smoking marijuana and there was a history of speed with her past boyfriend and she has had a lot of abuse in her life from her mother and stuff and the girl was – it was like they broke her spirit and she was very quiet and she didn't think there was anything wrong with her.

<Internals\\Aboriginal Consumer Advocate\\ACA 3> - § 1 reference coded [3.67% Coverage]

Reference 1 - 3.67% Coverage

I know actually about mental health. But I know a lot of Aboriginal people with mental health problems. I think I had a nephew who had mental health problems – it was very traumatic for his mother and I suppose his father.

<Internals\\Aboriginal Consumer Advocate\\ACA 4> - § 1 reference coded [5.06% Coverage]

Reference 1 - 5.06% Coverage

We on medications and different doctors and they confused me and until one doctor said you're entitled to compensation, what would you do with it? And I just said joking what bungy jumping and sky diving, which I wouldn't do, I'd reinvest it and they let me out,



I went missing, they continuously put me on treatment orders, I'm allergic to the medication they forced me on, I've got side effects from it and people have died mixing their medications with psychiatric medications.

<Internals\\Aboriginal Consumer Advocate\\ACA 6> - § 3 references coded [1.17% Coverage]

Reference 1 - 0.42% Coverage

Violence, the alcohols and all those things, and look at our chronic health, most people have died at 50 – 50 if they're lucky. So are breeding out and dying out. Which was the original intention of colonisation policy

Reference 2 - 0.40% Coverage

These kids have withdrawn themselves off drugs. Slowly but surely through smoking yandi (which is marijuana) occasionally, that's still better than they were – to understand the power of Ice is quite frightening.

Reference 3 - 0.35% Coverage

Mental health issue is probably the first precursor to comorbidity. Just depending on far – not too far down the track. Give them a little bit longer and they would have been addicted.

<Internals\\Aboriginal Consumer Advocate\\ACA – C 7> - § 1 reference coded [1.74% Coverage]

Reference 1 - 1.74% Coverage

There are a lot of issues that our people, Aboriginal people, are faced, especially with the problem that we have with alcohol and drugs within our community. I mean a lot of our mental health issues that we face in our community are alcohol and drug related.

<Internals\\Aboriginal Consumer Advocate\\ACA FG 10> - § 2 references coded [1.17% Coverage]

Reference 1 - 0.08% Coverage

Alcohol and drugs.

Reference 2 - 1.08% Coverage

*It's too much drugs down on the street. It's too much – we thought we had to drink, then the drugs came along, now with the drink it was hard there at that time, now it's the drugs that's hard now. And the drugs bring in the drink as well*

## Appendix 9: CAN Aboriginal Workshop

# **STOPPING THE RUN-AROUND**

## **Comorbidity Action in the North (CAN)**

*Comorbidity = people with 'combo' mental health and alcohol / drug problems*

### **WORKSHOP REPORT**

**21 May 2014**

#### **Authors**

Hepsibah Francis J

Coral Wilson

Charlotte de Crespigny

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## **Aboriginal Working Party (AWP) members**

Coral Wilson

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Jodus Madrid

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Mandy Brown

## **Acknowledgements**

### *Acknowledgements and respect to traditional custodians of the Kurna country*

Our deep appreciation to the *CAN project* ‘Stopping the run-around: Comorbidity Action in the North (CAN)’, from which this ‘Stopping the run-around’ research is an important component.

We sincerely thank the Australian Research Council Linkage Grants Scheme for offering funds to the University of Adelaide for the *CAN project*, and the major co-funded linkage partner SA Mental Health. In addition, we acknowledge our joint partners Northern Adelaide Medicare Local, Aboriginal Health Council of South Australia Inc, University of South Australia, South Australian Network of Drug and Alcohol Services, and Salisbury Council.

Our earnest gratitude to all the participants and support members of this ‘Stopping the run-around’ research for their valuable contribution, shared knowledge and good will, and for their immense contribution.

## **Contents**

Introduction

Overview of findings from ‘Stopping the run-around’

Group discussion

Discussion questions and responses

Key finding areas and recommendations

Workshop wrap-up

Appendices

## **Introduction**

The Comorbidity Action in the North (CAN) workshop titled ‘Stopping the Run-around’ was held on May 21 2014 at the Morella Community Centre, Parafield Gardens, in Adelaide’s northern metropolitan region. Convened by members of the CAN Aboriginal Research Project Team, it aimed to bring local Aboriginal community members, workers, services and key stakeholders together to hear about the project and its findings to date, consider the key recommendations, and talk about what is needed for accessible and acceptable local comorbidity services for Aboriginal people aged 12 years and over. A total of 30 participants attended in response to the invitation (Appendix 3). All participants received an agenda (Appendix 1) and an information sheet (Appendix 2).

Mr Robert Dann and Dr Rosie King facilitated the workshop. They began by welcoming all who attended. Robert asked participants if they consented to having their photographs taken and used in publications about the *CAN project*. Everyone gave their consent. Kurna Elder and CAN co-researcher Aunty Coral Wilson then acknowledged that the workshop was being held on Kurna Lands, and explained that the Kurna people were custodians of the Kurna plains. She also explained the spiritual relationship of the Kurna people with the land and its waters, and welcomed everyone to Kurna Land.

Hepsibah (Hepsi) Francis Jebaraj, PhD Student and workshop organiser thanked the Kurna people and the Land, and made a special welcome to Aunty Coral, who had worked with her on the project over three years, acting as her guide through the Aboriginal community and mentor in Aboriginal culture. Hepsi and Aunty Coral thanked all members of the CAN Aboriginal Working Party (AWP) and the *CAN project* team for their work. Aunty Coral warned about the uncertainty of the life of the project – “you don’t know how long it will last” – and stressed the importance of services being culturally-appropriate and placed where Aboriginal people need them: “sometimes you cannot go mainstream”.

Professor Charlotte de Crespigny gave an overview of the *CAN project*, emphasising that 70% or more of people with mental health problems also have drug and alcohol problems. She mentioned the large team of partners who had come on board as part of

the *CAN project*, aiming to make a change in comorbidity health care, and the two key researchers (Hepsi undertaking the Aboriginal focus of the research, and Miriam Posselt undertaking the refugee focus). She explained that the project resulted from government recognition of the Salisbury and Playford region as one of the poorest in Australia and that funding for on-the-ground research was needed. She stressed that “what is happening in the Aboriginal community is also happening in the wider community”, sharing her personal experience. Charlotte emphasised that “cultural respect is essential”, and thanked Aunty Coral and the AWP for their valuable input. She stressed the need to understand what comorbidity is – “a combo of mental and physical problems” – by listening to individual voices and respecting their knowledge. She ended by acknowledging Aunty Coral’s position as a researcher and cultural advisor in the University of Adelaide School of Nursing.

### **Overview of findings from ‘Stopping the run-around’**

Aunty Coral and Hepsi discussed the finding that a comorbidity service for people aged 12 years and older is badly needed in the northern metropolitan region of Adelaide. Currently there is no such service. Aunty Coral introduced the findings by sharing her thoughts about the need for new health services to keep up with the changes in society, and for Aboriginal people to acknowledge the problems and have input into what types of services there should be to treat the problems:

*The northern area has gone without for years and now is a good time to do it because the drug and alcohol abuse age is getting younger and younger. ‘Comorbidity’ – I had never heard the word before starting to work in the School of Nursing. We didn’t want to accept that sort of stuff in the community because we didn’t know about it. Now we’re researching what services are available. We only had alcohol back in my day – we didn’t have drugs. Alcohol was seen as a poison in the community – it caused fights, poverty, scheming...*

*Hepsi and I went and had a meeting with the community to find out what services they needed. Staff from the community organisations wanted these services available in the northern areas. I think once we can get services in the north we can get them everywhere. It’s about time. We used to run away from people with these problems but now it’s becoming worse with drugs as well – it’s our people, we need to know.*



Hepsi thanked Aunty Coral, the project's co-researcher, for her guidance; the AWP members for their input; her PhD project supervisors Professor Charlotte de Crespigny, Professor Cherrie Galletly, and Dr Janet Kelly; Ms Imelda Cairney, the overall *CAN project* coordinator; and Helen Murray and Margaret Bowden for their support. She then talked about the way the research was done and findings to date. She explained that action research was chosen so the researchers could work with people to address real issues as people on-the-ground experienced them. The research into what services are available in the northern region revealed very good single services but no comorbidity services; people had to go into the city (Adelaide) to access comorbidity services, which was very difficult financially and transport-wise. Hepsi spoke about *Ganma* (Yunupingu & Watson, 1986, in Muller, 2012) – the strengths of the people involved in introducing her into the Aboriginal community – and people's commitment to attend all meetings. A major finding was that staff and people said when clients presented with comorbidity, they were referred to other services. Both staff and people were “running around”: there were too many “boundaries”. People were falling through service gaps due to the referral system and lack of comorbidity services in the northern area. Undiagnosed comorbidity was also identified as a problem.

Hepsi described the impact of comorbidity in terms of people giving up on themselves, which led to family dysfunction and loss. She used the case study of an Aboriginal woman with alcohol and drug issues to illustrate the fact that “we cannot force people into treatment”, and also misunderstandings about comorbidity and Aboriginal culture. The woman was too drunk to move so the police were called. Their reaction was to put her in gaol but her family got her into hospital for detox. However, after she went home she started drinking alcohol again and refused to go for treatment because she did not know the people who would be driving her; she needed more support from people she knew and closer services. Hepsi pointed out that it is human nature to want to use what is around us, otherwise we “just won't bother”.

Aunty Coral then talked about her long experience sitting on the Nunga Court, working with people with comorbidity problems, and her suggestions for strategies to address the comorbidity issue once people came out of gaol. She expressed her frustration that her suggestions for some solutions had been ignored “for 20 years”:

*I can't save the world; none of us can. If we put even one person back on track we've achieved something. They will respect you and they will bring up their kids in the same way. ... There has been nothing around for them. ... I have been suggesting for a long, long time to have 'bail houses' but it hasn't happened. People need somewhere they can go and get treatment after they come out of gaol – somewhere they can change through support. Often when they come out there's no support so they get back on the drink and drugs. ...The only place they get off the drink and drugs is in gaol. There has been no real support for people with comorbid problems and their kids are following in their footsteps. What can you do? I'll retire when you give up the drink and drugs!*

Aunty Coral ended by sharing her hopes that this project will give support to people “so their families and their kids can do something for their futures”.

Hepsi then introduced Ms Joanne Else to talk about the priority recommendations. Joanne also spoke of her personal experiences and also her experiences working at Northern Medicare Local to underline the major recommendation that there must be comorbidity services on-the-ground and especially for “kids”. She emphasised that there are no services for people under 16 years of age; a situation that sees many in the juvenile justice system because children with comorbidity are at high risk of getting into crime. Joanne also stressed that “health must be first and foremost in the justice system”; there is a need for a change of focus towards health. The major issue must be “a duty of care” and “confidentiality is a must”. Referring to the case study Hepsi mentioned, Joanne stated it was “reprehensible” to send six police cars for an alcohol problem and that it may have been unsafe for the woman to go to treatment. Again this demonstrated the need for a health approach rather than a punitive judicial approach. She spoke of Aboriginal people’s extra needs, such as cultural issues, and therefore the need for an Aboriginal workforce to work with them. She also talked about the need for outreach workers, more Aboriginal support, joint Aboriginal and non-Aboriginal care teams working together and sharing knowledge, and more education about the reasons for comorbidity, such as inter-generational oppression. While mentioning that the co-service arrangement at the Northern Medicare Local is the closest to a comorbidity service in the area, Joanne made it clear that it is not one.

## Group discussion

Participants were divided into three groups of ten for the discussion. The AWP members chaired each group. They initiated all group members to communicate and contribute as much as possible. The three major findings discussed were:

1. **Providing integrated (combined) culturally-appropriate comorbidity services in the local area.**
2. **Addressing the social determinants affecting Aboriginal people's health with comorbidity.**
3. **Having specialist comorbidity staff, teams, service partners and advocates in the local area.**

These key findings areas were colour-coded respectively as red, green and blue. The discussion was scribed on chart paper. The discussion was embraced so enthusiastically that it was difficult to keep to the time schedule.

## Questions for group discussion and responses

### Key finding area 1

#### Integrated culturally-appropriate comorbidity services in the local area

### Recommendation

#### a. The needed comorbidity services

Priority Actions	Priority Considerations	Priority Need to Improve
One-stop service <ul style="list-style-type: none"> <li>○ Use existing services: Hospital, community-controlled, Community health centres</li> <li>○ Comorbidity education, housing, employment, health</li> <li>○ Healing centre: Social determinants on comorbidity</li> </ul>	Choice of Main Stream and Aboriginal-specific service  Central location: Service to be situated in key area  Open tent community events <ul style="list-style-type: none"> <li>○ Access for workers and families to promote knowledge</li> </ul>	Gap in services between ages 12-18 years   12-16 years  Services working in silos <ul style="list-style-type: none"> <li>○ Clients are seen as too hard basket</li> </ul>
Detox Centre  Youth Service  24/7 crisis point Outreach services	Strengths-based family approach services <ul style="list-style-type: none"> <li>○ Holistic Approach</li> </ul> Grass roots education on comorbidity prevention  Better information of service to	Coordination in referral: <ul style="list-style-type: none"> <li>○ Not passing the bucket of responsibility</li> </ul> Communication between services so people don't fall between the gaps  Jobs are not sustained  Accommodation: need appropriate Aboriginal housing

After-care employment guidance	the community	for mental health clients
Aboriginal Health Clinic		
Appropriate referrals: Links to other agencies		

**b. Types of therapy or treatment that works best for Aboriginal people**

Priority Actions	Priority Considerations	Priority Need to Improve
Motivational Therapy	Access to comorbidity physicians with no prolonged waiting time	No CBT (CBT is ineffective): Westernised services don't match cultural needs
Music Therapy	Referrals to be done within reasonable time – immediate	Systematic change needed
Group work	All service to be culturally-appropriate for Nunga people	Programmatic services are 'Band-Aid'
Talking Circles		
Narrative Therapy		
Aboriginal traditional healers		
Family wellbeing		

**c. What needs to happen to make this possible?**

Priority Actions	Priority Considerations	Priority Need to Improve
Governments need to listen to the people dealing with comorbidity in their lives	Aboriginal people are over studied, over researched - Just do it: implement the service need	Modification in Arts and other programs - sick of colouring
Address Racism: People who are racist make choices detrimental to people they serve	Make sure research is followed with action	Strong people on-the-ground: Strong Boards - Influential Management, having strong people to guide projects and programs (Elders, GPs)
Training to think 'on-the-ground' service - time to debrief	People coming into projects must be passionate - not 'Just a Project'	Confidentiality
Ongoing comorbidity awareness and preventive education in schools: Liaise with High Schools and Primary Schools	Evidence-based: Recognition that every day and every case is different	Elders' input
Ongoing evaluation: To know what's happening with students and on-the-ground consumers to act early	Top to bottom: Cultural respect / Understanding	
	Funding	
	Educate staff to treat all clients with respect	

	Reduce conflict between staff and clients	
--	---	--

## Key finding area 2

### Addressing the Social determinants affecting Aboriginal people's health with comorbidity

#### Recommendation

##### a. Empowerment strategy would help people to gain control over their lives?

Priority Actions	Priority Considerations	Priority Need to Improve
<p>Cultural activities: Walk the Journey” with consumers</p> <p>Families and person empowered</p> <ul style="list-style-type: none"> <li>○ Have a support person available: Give people choices</li> <li>○ Families feeling safe to access services</li> </ul> <p>Accountability across board: Input from client to help selves</p> <p>Build trust: How: Trust comes with competency</p> <ul style="list-style-type: none"> <li>○ Engage outreach health workers</li> </ul> <p>Sitting around fires: Around games</p> <p>Local government access to federal</p>	<p>Not taking kids away if families ask for help</p> <p>Care for children so adults can access service</p> <p>Education and re-education in schools on risk of comorbidity</p> <ul style="list-style-type: none"> <li>○ Plant seed to empower</li> <li>○ Encouragement</li> <li>○ Students need cultural awareness around mental health</li> </ul> <p>Practical supports</p> <ul style="list-style-type: none"> <li>○ Providing alternative positive activities for adults</li> </ul> <p>Convenient Transport</p> <ul style="list-style-type: none"> <li>○ Local accessible services</li> <li>○ Service close to public transport</li> <li>○ Outreach transport to be provided</li> <li>○ Should have transport for all services</li> </ul>	<p>Challenge the norm</p> <p>Client-centered care</p> <ul style="list-style-type: none"> <li>○ Cultural identity</li> </ul> <p>Don't make promises: Be open and transparent</p> <p>More Social Support Groups: Empower each other</p> <p>No wrong door: Culturally-appropriate and adequate support through stages to self-employment</p> <p>Appropriate mental health care plans</p> <p>Appropriate use of language: simple easy to understand terms</p>

**b. Self-management strategies that work best for Aboriginal people with comorbidity**

<b>Priority Action</b>	<b>Priority Consideration</b>	<b>Priority Need to Improve</b>
Camping: Accessing country for healing  Traditional Law  Social groups - support group  Phone friends and Aboriginal-specific phone service  Aboriginal churches	Kinship connections and Support  Family conferences: Working with family, significant others and community  Role of comorbidity worker/mentor: Elders supporting young people to learn respect	Daily plan: Not just for the person but the whole family  Home visits Self-formulate strategy  Cultural reaffirmation

**Key finding area 3**

Having specialist comorbidity staff, teams, service partners and advocates in the local area

**Recommendation**

**a. Specialised comorbidity staff is needed**

<b>Priority Actions</b>	<b>Priority Considerations</b>	<b>Priority Need to Improve</b>
Multi-disciplinary teams: <ul style="list-style-type: none"> <li>○ Traditional healers</li> <li>○ Mainstream health staff</li> <li>○ Aboriginal-specialised Aboriginal &amp; non-Aboriginal staff</li> <li>○ Having clinicians who understand Aboriginal people</li> </ul> Yarning team: going out to the families	Comorbidity Trained Staff <ul style="list-style-type: none"> <li>○ Cultural awareness</li> <li>○ Staff dedicated to Aboriginal community</li> <li>○ Aboriginal staff in all areas and non-Aboriginal staff who are committed to Aboriginal health</li> <li>○ Identified Cultural Safety comorbidity workers</li> </ul> Respectful networking for staff: <ul style="list-style-type: none"> <li>○ Aboriginal workforce in areas for mental health, allied health, nutrition, outreach workers, drug &amp; alcohol specialists</li> </ul>	Education - Train health professionals in Aboriginal culture as part of overall education  Staff retention: skilled staff treat them well with respect  Appropriate and adequate comorbidity trainers  Aboriginal workforces  Gateway: Burnout for Aboriginal staff <ul style="list-style-type: none"> <li>○ Workers stand in the gap</li> <li>○ Support group for Aboriginal people in the workforce</li> </ul>

**a. Available location of comorbidity staff**

Priority Actions	Priority Considerations Best way for people to get to the type of services they need	Priority Need to Improve Yarning circle
<p>All the community health services</p> <ul style="list-style-type: none"> <li>○ Dedicated comorbidity services</li> <li>○ Aboriginal-controlled services,</li> <li>○ Liaison and home care</li> <li>○ Mainstream, Emergency, Primary, community health care</li> <li>○ Supported accommodation</li> <li>○ aged care, youth services, GP, Justice, schools</li> <li>○ Vocational education</li> <li>○ community mental health services</li> </ul> <p>Regional town hall meetings</p> <ul style="list-style-type: none"> <li>○ Need to be at community</li> </ul>	<p>Not a one size fits all:</p> <ul style="list-style-type: none"> <li>○ Model for remote and</li> <li>○ Model for urban</li> </ul> <p>Maintain safe culturally-sensitive place, especially for people from remote areas</p>	<p>Even when white fellas want to do right thing they're not given the opportunity</p> <p>Service gaps: Clients dropped out of services</p> <p>Nurture processes: Ask people what steps need to be taken to help them in treatment</p> <p>Make sure facilitators have understanding of real world situation - Need Aboriginal cultural knowledge</p>

**Workshop wrap-up**

At the end of the group discussion, Charlotte and Hepsi thanked everyone for their commitment in attending, and stressed that participants' voices would be kept in writing up the discussion. They acknowledged the work of families in looking after their members as well as looking after other families. Charlotte then thanked Hepsi, Aunty Coral and Mel for their efforts in organising the workshop, and Robert and Rosie for facilitating it.

Aunty Coral closed the workshop with some final wise words:

*You have to go to workshops to meet friends and relations to talk about what needs to be talked about. You need to lay the foundation for people to come to the workshop.*

Aunty Coral presented attendance certificates (Appendix 4) to all participants. Hepsi gave a final thank you to Aunty Coral and the AWP members for helping her to establish a “flexible and helpful connection with the Aboriginal community”, and informing her of “how to conduct the research” with their people. Hepsi again acknowledged participants’ commitment to the workshop, knowing that they had another commitment as well. She thanked Aunty Coral for being her interpreter through the “step-by-step process” of connecting with the Aboriginal community and of the whole project. She ended the workshop by emphasising the importance of sustainability strategies in working effectively with Aboriginal people and providing comorbidity services:

*It is essential to have more than one person in an agency with the necessary knowledge so if they leave others can continue to provide the necessary services.*

Robert, Rosie and Charlotte closed the workshop. Participants were advised they would all receive a copy of this report. Everyone who did not have to attend the second commitment continued the discussion casually while eating the healthy lunch. We thank the Salisbury Council for sponsoring the high tea and Lunch provided on the day and Morella Community Centre for sponsoring our use of the venue.





## Appendix 1: CAN Aboriginal Workshop Agenda



### **‘Stopping the run-around’: Comorbidity Action in the North (CAN)**

*\*Comorbidity is when people have combined mental health and drug and alcohol\**

### **‘CAN’ Aboriginal Workshop Agenda**

**May 21<sup>st</sup> 2014**

**9.30 am to 12.30pm**

**Morella Community Centre, 90 Kings Rd, Parafield Gardens SA 5107**

**Purpose: Consideration of the findings from the CAN Aboriginal project<sup>34</sup>**

Workshop Facilitators: Ms Rosie King and Mr Robert Dann, AHCSA

Time	Sessions	Presenters
9.30 am	<b>Brief Introduction and ‘housekeeping’</b>	Mr. Robert Dann and Ms Rosie King
9.35 am	<b>Welcome Welcome to the Kurna Country</b>	Ms. Coral Wilson, Kurna Elder and CAN Co-Researcher
9.40 am	<b>Introductions: CAN Aboriginal Working Party (AWP) and CAN project team</b>	Ms. Coral Wilson, Ms Hepsi Francis
9.45 am	<b>Overview: CAN project</b>	Prof Charlotte de Crespigny
9.50 am	<b>Overview of Aboriginal Project findings</b>	Ms Coral Wilson, Ms Hepsi Francis
10.55 am	<b>Priority recommendations</b>	Ms Joanne Else
10.00 am	<b>Morning Refreshments</b>	
10.15 am	<b>Introduction of key findings area</b>	Mr. Robert Dann and Ms Rosie King
10.20 am	<b>Small group work on key recommendations</b>	<i>Chair for each group:</i> Group 1: Joanne Else & Trevor Wanganeen Group 2: Trevor Warrior & Paul Elliott Group 3: Jodus Madrid/Frank Wanganeen & Robert Taylor
10.50 am	<b>Key findings area 1:</b> (20 min) Group discussion (10 min)	
11.20 am	<b>Key findings area 2:</b> (20 min) Group discussion (10 min)	<i>Scribes for each group:</i>
11.50 am	<b>Key findings area 3:</b> (20 min) Group discussion (10 min)	Ms Margaret Bowden, Ms Helen Murray, Ms Hepsi Francis,
12.00 pm	Certificate distribution	Ms Coral Wilson
12.30 pm	Thank you note	Ms Hepsi Francis
12.31 pm	<b>Wrap up</b>	Mr Robert Dann and Ms Rosie King

<sup>34</sup> Referred to throughout this thesis by its title of ‘Stopping the run-around’

## Appendix 2: Workshop information sheet



### **‘Stopping the run-around’: Comorbidity Action in the North (CAN)**

*\*Comorbidity is when people have combined mental health and drug and alcohol\**

#### **‘CAN’ Aboriginal Workshop: Information Sheet 2014**

**The Team:** Prof Charlotte de Crespigny, Prof Cherrie Galletly, Ms Imelda Cairney, Dr Janet Kelly, Dr Rosie King, Mr Robert Dann, Ms Coral Wilson, Mr Paul Elliot, Ms Joanne Else, Mr Trevor Wanganeen, Mr Trevor Warrior, Mr Jodus Madrid, Mr Robert Taylor, Mr Frank Wanganeen, Ms Mandy Brown, Ms Lisa Warner, Ms Hepsibah Francis Jebaraj

**The Start:** In August 2011 the CAN Aboriginal project<sup>35</sup> commenced as part of the CAN wider project. The parent project’s Aboriginal community researcher Elder Ms Coral Wilson and Hepsi (Hepsibah) a PhD student of University of Adelaide consulted the local Aboriginal community members and formed the Aboriginal Working Party. This was the Aboriginal research team who has been working together throughout this research project.

**Funding:** This research project has been funded as a part of the *CAN project*. The University of Adelaide has been awarded funds for the *CAN project* through the Australian Research Council Linkage research program, and co-funded by SA Mental Health as the major linkage partner. This 3 year Aboriginal CAN research study is auspiced by The University of Adelaide as lead organisation and additional partners being the Northern Adelaide Medicare Local, Aboriginal Health Council of South Australia Inc, University of South Australia, South Australian Network of Drug and Alcohol Services and Salisbury Council.

**Background:** In Australia many mental health (MH) and alcohol and drug (AOD) services continue to treat people with MH or AOD problems depending on the primary focus of the particular service. Commonly this leaves those with combined MH and AOD (comorbidity) being referred back and forth between these services rather than

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<sup>35</sup> Referred to throughout this thesis by its title of ‘Stopping the run-around’

being holistically treated. This contributes significantly to their poorer prognosis and outcomes, and is particularly problematic for Aboriginal people whose overall social, physical and mental wellbeing is significantly challenged.

**Aim:** To determine the mental health, alcohol and drug comorbidity service needs of Aboriginal people 12 years and over. The Aboriginal people and relevant ‘on-the-ground’ service providers were consulted for the future design and delivery of culturally-appropriate local comorbidity services in the Salisbury and Playford local government areas of Adelaide.

**Working together:** Using Participatory Action Research (PAR) we consulted and engaged Aboriginal leaders, community advocates and staff of mental health, alcohol drug services and support services. To explore the issues and barriers to Aboriginal people receiving comorbidity services locally. Through the process of mutual collaboration the researcher engaged with a Kaurna Elder to ‘walk together’ and empower local Aboriginal community members and on-the-ground staff. This collaboration ensured that we were able to work together to share information and find effective solutions to barriers that prevent Aboriginal people from receiving culturally-appropriate, local comorbidity services.

**What was found:** Currently there is no single service to treat comorbidity problem. The disconnected MH and AOD services treat clients between them. There is seriously poor access to approachable MH-AOD services locally. Aboriginal people want choice of mainstream and Aboriginal-specific comorbidity services. People need culturally-appropriate comorbidity services that involve family. There is a high need for prevention, health promotion, education and early treatment services regarding comorbidity for young people and adults.

**Where from now:** The findings are both specific to Aboriginal people and triangulated with the findings of the *CAN project*. Based on these results the CAN team has worked in partnership with the local Aboriginal community and services to consider and learn from the findings and make priority recommendations for future improvements in the design, access and delivery of suitable models of care by local comorbidity services for this significant, yet so far neglected population.

### Appendix 3: Workshop invitation

There were 3 differently coloured versions of the same invitation: although these may look slightly different they contain the same information.

We have offered a choice so they can be downloaded more easily and printed in either colour or black and white.

1. Full colour with black background and red, yellow and white letters, and logos/ Aboriginal flag



**'STOPPING THE RUN AROUND'**  
**Comorbidity Action in the North**  
**'CAN' Aboriginal Research Project Team**

*\*Comorbidity = people with 'combo' mental health and alcohol /drug problems*

**YOU ARE INVITED TO THIS IMPORTANT WORKSHOP.....**

**WHEN** **MAY 21<sup>ST</sup>** FROM **9.30am to 12.30pm** ... THEN **LIGHT LUNCH**  
*\*registration by 9.15am\**

**ATTENDEES** LOCAL ABORIGINAL COMMUNITY MEMBERS, WORKERS, SERVICES, KEY STAKEHOLDERS

**AGENDA** **Hear about the project & findings & consider the key recommendations**  
TOGETHER FOR ACCESSIBLE AND ACCEPTABLE LOCAL COMORBIDITY SERVICES FOR  
ABORIGINAL PEOPLE AGED 12 YEARS AND OVER

**WHERE** MORELLA COMMUNITY CENTRE, 90 KINGS RD, PARAFIELD GARDENS  
**YOUR PARTICIPATION IS VALUED. NUMBERS ARE LIMITED. CALL**  
**HEPSIBAH (HEPSI) BY 14<sup>TH</sup> MAY. MOBILE 0426 095 641**

2. Full colour with light brick colour with black letters and black and white logos/flag, or coloured logos/ Aboriginal flag.



**'STOPPING THE RUN AROUND'**  
**Comorbidity Action in the North (CAN)**  
**CAN Aboriginal Research Project Team**

*\*Comorbidity = people with 'combo' mental health and alcohol /drug problems\**

**YOU ARE INVITED TO THIS IMPORTANT WORKSHOP.....**

**WHEN:** **May 21<sup>st</sup>** from **9.30am to 12.30pm** ... & then light lunch  
*\*registration by 9.15am\**

**ATTENDEES:** LOCAL ABORIGINAL COMMUNITY MEMBERS, WORKERS, SERVICES, KEY STAKEHOLDERS

**AGENDA:** **Hear about the project & findings & consider the key recommendations**  
Together for accessible and acceptable local comorbidity services for  
Aboriginal people aged 12 years and over

**WHERE:** Morella Community Centre, 90 Kings Rd, Parafield Gardens.  
**Your participation is valued.** Numbers limited. Call Hepsibah (Hepsi) by May 14<sup>th</sup>  
mobile 0426 095 641

3. White only background with black letters, and black and white Aboriginals/flag.

**'STOPPING THE RUN AROUND'**



**Comorbidity Action in the North (CAN)  
CAN Aboriginal Research Project Team**



*\*Comorbidity = people with 'combo' mental health and alcohol /drug problems\**

**YOU ARE INVITED** TO THIS IMPORTANT WORKSHOP.....

**WHEN: May 21<sup>st</sup> from 9.30am to 12.30pm ... & then light lunch**  
**\*registration by 9.15am\***

**ATTENDEES:** LOCAL ABORIGINAL COMMUNITY MEMBERS, WORKERS, SERVICES, KEY STAKEHOLDERS

**AGENDA:** Hear about the project & findings & consider the key recommendations  
Together for accessible and acceptable local comorbidity services for  
Aboriginal people aged 12 years and over

**WHERE:** Morella Community Centre, 90 Kings Rd, Parafield Gardens.  
**Your participation is valued.** Numbers limited. Call Hepsibah (Hepsi) by May 14<sup>th</sup>  
mobile 0426 095 641

**Appendix 4: CAN Aboriginal Workshop certificate**



*Certificate of Participation*

Presented to

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Given in appreciation for attendance at the 3 hour workshop

***Comorbidity Action in the North (CAN)***

***CAN Aboriginal Research Project***

***'Comorbidity service needs of Aboriginal people in Salisbury and Playford LGAs'***

21 May 2014  
Morella Community Centre



21 May 2014

Professor Charlotte de Crespigny

Date

Ms Coral Wilson  
CAN Aboriginal Community researcher

Ms Hepsibah Francis Jebroj  
PhD Student for CAN, University of Adelaide

adelaide.edu.au

seek LIGHT

## **Appendix 10: Community Report**

### **CAN Aboriginal study Community Report**



**February 2015**

#### **'CAN' ABORIGINAL STUDY**

A sub-project of the wider 'CAN' project

H. Francis, C. Wilson, C. de Crespigny, C. Galletly, J. Kelly, I. Cairney

**COMORBIDITY ACTION IN THE NORTH: '*STOPPING THE RUN-AROUND*'**

## **What is comorbidity?**

When people experience more than one health problem it is called comorbidity. ‘Comorbidity’ in this research refers specifically to a mental health (MH) disorder combined with alcohol and other drug (AOD) misuse (MH-AOD), including illicit drugs and overuse of legal medications.

Many people experience MH-AOD problems, and experience difficulty with taking medication and repeatedly attending hospital for emergencies. Having MH-AOD can affect an individual’s health and wellbeing, putting them at high risk of homelessness, suicide, increasing drug use, poor physical health, increased stress and violence. It is estimated that 40–60% of people with a mental health problem are commonly affected with coexisting substance misuse.

## **Project background**

This Aboriginal project is part of a wider project titled ‘*Stopping the run-around: Comorbidity Action in the North (CAN)*’. Its purpose was to develop strategies for consumer-focused comorbidity services for all people living in the Salisbury and Playford areas. The *CAN project* team worked with existing MH and AOD services to find on-the-ground solutions for improved comorbidity services<sup>36</sup> for all consumers. The *CAN Aboriginal study* began in response to the concerns of Aboriginal community people and AOD and MH service staff who work with, and for, the Aboriginal community in the northern regions of Adelaide.

## **Aim**

This research aimed to identify issues and develop strategies to stop the run-around for Aboriginal community people who seek comorbidity care. In particular, it strove to develop strategies for comorbidity care to be delivered locally by local government and non-government MH and AOD services, and to better meet the needs of Aboriginal people aged 12 years and over with coexisting MH and AOD problems (comorbidity).

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<sup>36</sup> The term ‘comorbidity services’ refers to mental health, drug and alcohol services, agencies and programs that recognise when people have comorbidity and facilitate appropriate care for their combined problems.



The focus was the Salisbury and Playford local government areas in the north of Adelaide, South Australia.

### **Ethics approval**

A very comprehensive ethics approval process was undertaken involving many meetings and discussions with Aboriginal health research leaders and ethics committees. Ethics approval was given by the Aboriginal Health Research Ethics Committee (AHREC), Queen Elizabeth Hospital, Women's and Children's Hospital, the Human Research Ethics Committee - The University of Adelaide, Anglicare and SA Ambulance. Letters of support and site-specific assessments were received from all relevant managers of the health service sites included in the research. All data was managed in accordance with the National Health and Medical Research Council (NHMRC) guidelines.

### **Guiding principles (How we did this: Methodology)**

The local Aboriginal community involvement in this research partnership ensured that the research was respectful, collaborative and culturally-appropriate. A collaborative participatory action research (PAR) approach was used. This involved working closely with Aboriginal leaders, community advocates and relevant service providers to explore the issues and barriers to Aboriginal people receiving comorbidity services locally. The research involved repeated cycles of 'look and listen, think and reflect, collaborate and plan, consult and act' in conjunction with the Aboriginal concepts of *Ganma* (mutual knowledge-sharing; Yunupingu & Watson, 1986, in Muller, 2012) and *Dadirri* (respectful listening; Ungunmerr-Baumann, 2002). Careful attention was given to respecting a range of Aboriginal, community and staff voices, and providing space for deep knowledge-sharing. Our intention is that this research does not end with the findings but empowers individuals and communities to take control of their future.

### **The mentorship of a Kurna Elder and Aboriginal Working Party**

Working closely with Aboriginal community members and staff was a crucial part of this project. Aboriginal people were involved in all aspects of the research process as respected research partners. An Aboriginal Kurna Elder was the cultural advisor and co-researcher who engaged community and mentored researchers on how to work

collaboratively with local Aboriginal community people and staff. She guided and assisted researchers to connect with local Aboriginal people living in Salisbury and Playford, leading the research activity in a culturally-appropriate way. An Aboriginal Working Party (AWP) made up of local Aboriginal people offered guidance throughout the study. Together, we ensured that local people could participate and that a truly collaborative approach was taken to the research.

Community meetings, data collection, networking, negotiation and telephone communications were arranged at times to suit people's commitments and suggestions. Discussions occurred at a time and place suitable for Elders, community members and service providers. Four interlinked strategies were developed: meetings with Aboriginal community people; meetings with AOD and MH service staff; meetings with support service staff; and discussing workable strategies with all three groups, converging together in a workshop.

### **In-depth qualitative data linked with the wider *CAN project***

In-depth conversation style interviews and focus groups were used to gain a deeper insight into comorbidity care. Conversations from interviews, storytelling, field journal and network meeting documents were used. This provided a wider and deeper understanding (range of views) about comorbidity service needs and implementation strategies.

We recognised the importance of understanding the whole, complex picture of Aboriginal community people's real comorbidity care needs, and the cultural issues influencing access to care and care provision. We also sought the opinions and experiences of MH, AOD and support service staff regarding their consumers' needs, as well as their own services' needs, to ensure successful delivery of appropriate comorbidity care. The data from this Aboriginal project was compared and contrasted (triangulation) with the wider *CAN project* to enable us to clarify meaning, confirm the findings and substantiate the trustworthiness of the outcomes of 'Stopping the run-around'.

### **Major findings: No dedicated MH-AOD service**

The Aboriginal project uncovered three major areas of concern: 'Comorbidity: A complex problem'; 'Current structure of comorbidity care; and 'The future: Needs-

based comorbidity service'. The key finding in all three of these areas of concern was that there was no dedicated comorbidity service providing local, holistic comorbidity care.

The current structure consisted of isolated bits of comorbidity services, some treating MH issues only, others treating alcohol issues only, and others treating other drug issues only, with NO SERVICES addressing comorbidity of MH and AOD issues and their contributing factors as a whole. Aboriginal people reflected on their experience of the current service. They felt that services are very complex and fragmented, making it difficult to receive care. They said the comorbidity service system needs healing and emphasised the need for a responsive comorbidity service. They stressed the need for action now, saying there had been ENOUGH LIP SERVICE and there was a NEED FOR REAL SERVICE, operating in accordance with established Aboriginal health policies that were committed to sustainable comorbidity service implementation.

### **The reality of 'run-around'**

The Salisbury and Playford areas are not without specialist services. There are mainstream services and Aboriginal-specific services governed by federal government, state government or non-government organisations. Currently, the MH and AOD interventions are only provided as a single service-focused pathway. Consumers with MH-AOD issues have to approach the MH service or the AOD service, or both, or perhaps an associated service, resulting in a very complex and uncoordinated path to recovery and wellbeing. The Aboriginal community people, and the MH and AOD clinicians and workers, and support service staff all stated that this is not convenient or useful for people with MH-AOD.

Overall, there is a higher utilisation of MH and AOD services with poor outcomes than with good outcomes. Better screening, monitoring and assessment techniques for more effective treatment are needed to improve comorbidity service consumers' overall health outcomes. Evaluating service effectiveness requires understanding more about consumers' comorbidity care issues in their real world.

Although organisations may work in collaboration, each different service operates as a distinct silo and consumers are referred to and fro between several services to access comorbidity care. Services are often located in different areas within and beyond

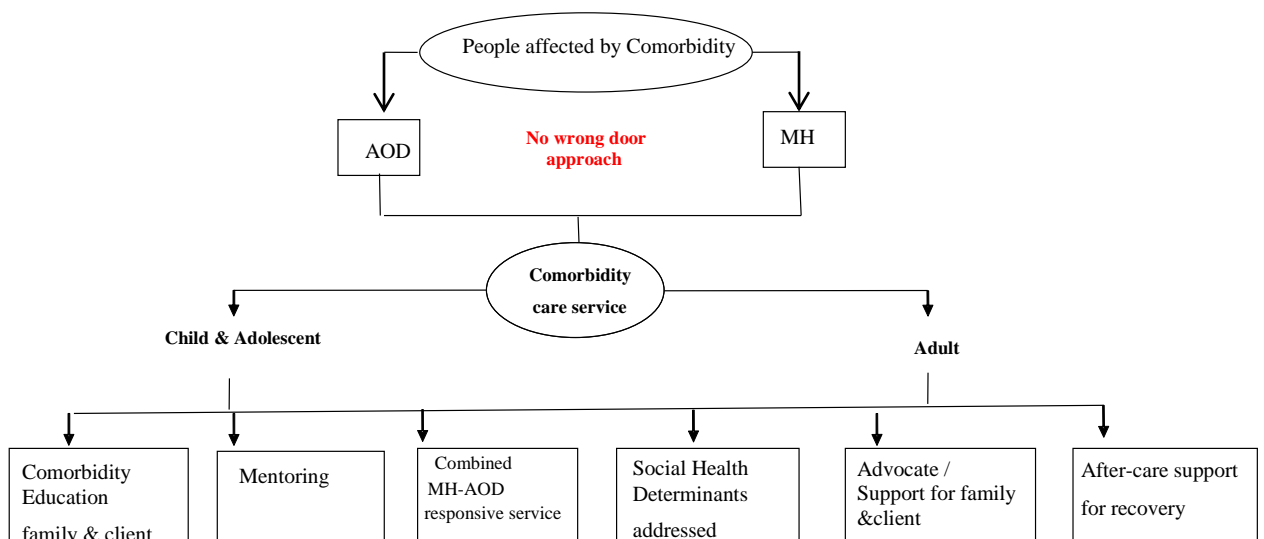
the Salisbury and Playford areas, requiring consumers to travel significant distances, often while unwell. This disconnection also makes it difficult for families and friends who are trying to assist with comorbidity care, and for staff who are trying to support consumers, and provide them and their carers with education about comorbidity.

These findings – that consumers have to ‘run-around’ to access the services they need – are both specific to Aboriginal community people and the broader findings of the wider *CAN project*. To confirm the findings, we invited the wider local Aboriginal community people, MH and AOD clinicians and workers, and support service staff to attend the ‘CAN Aboriginal workshop’ and suggest feasible recommendations. This confirmed the strategic pathway of a needs-based comorbidity service model, providing insight into how culturally-appropriate comorbidity services should occur.

## Recommendations ®

### *‘Stop lip service, need real service and stop the run-around’*

Recommendations for the required form of comorbidity services were the first priority because everyone agreed that it was essential for them to understand the best way to make the needed services available. Each recommendation explains how to implement it and the importance of implementing it to give a better understanding of the most appropriate way to deliver comorbidity service.



**Figure 1: Pathway to meeting MH-AOD service needs**

### **1. ® Implement integrated comorbidity care: A ‘one-stop-shop’**

There is an immediate need to integrate AOD and MH services as comorbidity services to provide a “no wrong door” service to people with comorbidity. All organisations delivering health services governed by federal, state and private sectors should support this integrated service model for MH-AOD care to stop the run-around.

*How to do it:* The associated MH and AOD services need to be located next to each other, for example within a hospital, primary health care centre or community centre. When a person with comorbidity approaches the services, they can receive immediate MH-AOD treatment in the same building. A person should be screened, assessed and treated in one location, and provided with a follow-up strategy. This cost-efficient comorbidity service provision model would reduce system complexity and service overlap, and thus minimise service gaps.

### **2. ® Improve trustful communication between Aboriginal-specific and mainstream service organisations**

Appropriate two-way communication between Aboriginal-specific and mainstream comorbidity services needs to be implemented in consideration of each consumer’s individual needs.

*How to do it:* Aboriginal people and families can only achieve lasting changes for better health and wellbeing through mutual communication. If a consumer prefers to have a reliable family support person involved in their care, the comorbidity care system should respond accordingly. This will assist the consumer to follow the treatment to achieve a better outcome.

### **3. ® Support and retain skilled staff who have built trusting relationships with Aboriginal people**

Experienced staff who have earned the community’s trust through working with Aboriginal consumers must be retained, mentored and supported. Updating necessary skills and ongoing education on various aspects of comorbidity care should be incorporated into staff training, based on consumers’ health needs.

*How to do it:* The quality of service acknowledged by Aboriginal people must not be lost. Staff who have earned the Aboriginal community’s trust should be supported and their valuable skills-based service quality must be taught to others in the services. The ‘train the trainer’ practice model, which is effective for capacity building, should be

used to enable experienced staff to share their knowledge with new professionals to help them provide effective care.

**4. ® Involve Aboriginal people and on-the-ground service staff in meaningful contribution to policy making and implementation**

Aboriginal people and health service staff affected by health service policy should be included in policy decision-making. This is to prevent health care structures that are out of touch with their consumers' genuine comorbidity care needs.

*How to do it:* Respectful consultation with local Aboriginal people and staff is needed to develop appropriate local, state and national level policies for responsive action and appropriate implementation.

**5. ® Recognise knowledge for evidence-based service**

Consumer and staff knowledge requires equal acknowledgement with biomedical knowledge of comorbidity, particularly in comorbidity care settings.

*How to do it:* Keep strong partnerships between service providers and local community to continuously evaluate how well services are working for Aboriginal community people.

**6. ® Recognise health education, health promotion, self-empowerment and self-management strategies**

Regular and consistent programs and events are required to raise awareness of comorbidity, disease prevention and health promotion in hospitals, schools, workplaces, parklands and community gatherings. A mobile comorbidity service team would be instrumental in delivering these.

*How to do it:* The industrious measures of health education, health promotion, self-empowerment and self-management strategies must be addressed in comorbidity care to address Aboriginal Australians' feelings of invisibility and disempowerment.

**7. ® Develop a pathway for early comorbidity intervention**

Information on comorbidity health care and how to approach comorbidity services needs to be made readily available. Access to services must be improved. A community centre adjacent to, or within, a hospital would enable early identification of comorbidity issues to prevent consumers' susceptibility to comorbidity's full effects.

*How to do it:* Hospitals and other related health services are the core places where people receive treatment for health issues. Therefore, provision of community centres in hospitals will enable people to gain information about available services and understand how to approach them. This will make currently hard-to-reach services easily reachable.

**8. ® Integrate engaged partnership processes into comorbidity health care**

Aboriginal culture must remain strong. Engaged partnerships between services and Aboriginal community people will help programs and services meet their needs.

*How to do it:* Establish ongoing partnership with local community leaders, Elders and local Aboriginal community people to foster the success of comorbidity services and programs, and ensure services and health care centres reach their service provision targets.

**9. ® Implement strong links between MH and AOD services and support services**

Strategic information systems need to be established so that each organisation understands the core business of other related services. The link between all comorbidity services and related support services must be strong and transparent.

*How to do it:* Mutual links between services are vital in meeting people's complex comorbidity service needs. For instance, if a severely ill person in the parkland needs help, the support service that assists homeless or displaced consumers as its core business should be informed. Support services are an important means to approach these so-far unreached populations.

**10. ® Enable choice of Aboriginal-specific and mainstream services**

Aboriginal-specific services need to be better resourced and funded. Aboriginal people require and prefer locally available Aboriginal-specific services as well as mainstream services.

*How to do it:* Aboriginal-specific and mainstream services should be culturally safe and respectful to counter the discrimination, racism and generalised multicultural practices Aboriginal community people currently experience. Aboriginal culture is diverse and there is a significant need for a cultural model of practice. However, in multicultural Australia, frequent measures are taken to dissolve Aboriginal-specific

specialised services and transform them into mainstream services. Such practices raise concerns among Aboriginal people that their culture is being diluted and continues to go unnoticed; a situation that does not help recovery from comorbidity.

### **11. ® Commit to closing the widening gap with substantial networks**

There is an urgent need to address Aboriginal community people's health inequalities and higher rates of comorbidity, and their effects. A collaborative network linking goals with comorbidity services is urgently needed. The inequalities will continue if this recommendation is not adopted.

*How to do it:* Urban, rural and remote health services need to be encouraged to work in partnership to create substantial health service networks to close widening comorbidity service gaps. All MH, AOD and support services need to make tight networks with all government and non-government organisations and sectors (eg police and corrections) so services can be linked and comorbidity can be diagnosed and treated effectively no matter where the consumer is.

### **12. ® Recognise the importance of healing in health care: Build trust**

There is an urgent need to build trustworthy relationships between local Aboriginal community people and health care service providers. Recognition of an individual's abilities, skills and needs is part of the healing process.

*How to do it:* Many Aboriginal people reported that it could be culturally unsafe and personally unhealthy to access, and work closely with, existing forms of health services. Transparent information about a strategic wellbeing pathway will enable people to know what the services are and how they are structured. It will enable services to understand, and work towards meeting, the individual's real comorbidity health care service needs.

### **13. ® Implement culturally-appropriate models of practice**

Local Aboriginal community people need greater access to comorbidity services.

Aboriginal consumers need to be incorporated into comorbidity services to educate staff and management about cultural safety and respect, and to address health professions' practices and attitudes when responding to individual consumers' cultural needs.

*How to do it:* Develop a cultural practice model, recognising the diversity of Aboriginal culture, to create culturally-appropriate environments in all comorbidity services.



#### **14. ⑩ Establish a sustainable comorbidity service system**

An unbiased commission must be initiated to check the usefulness and sustainability of comorbidity services, and suggest ways to make them sustainable. Unsustainable, short-term services and programs are not useful because they create distrust among consumers and cause high staff turnover. Short-term comorbidity services are a ‘bandaid’ for long-term problems; they do not help to treat problems from their core.

*How to do it:* It is essential that the Aboriginal-specific and mainstream health services (all health services, health personnel and governments) fulfil the commitments they make to Aboriginal community people regardless of changes in the health care system. If a promised commitment can no longer be met, active steps must be taken to find alternative solutions in consultation with the Aboriginal community. In particular, there has to be a collaborative network that links goals with comorbidity services. These steps will help close the widening gaps in inequality of Aboriginal health in Australia.

#### **Conclusion: Looking for a better future**

Aboriginal community people demonstrated a strong commitment to addressing the comorbidity service issue to achieve better health and wellbeing. They welcomed the opportunity to work together with local on-the-ground service staff. Respectfully sharing experiences and knowledge was the key to identifying the Aboriginal community’s comorbidity health issues and finding effective solutions to the lack of comorbidity care they experienced.

The key recommendation from the research partnership was to take action to implement locally available, culturally-appropriate comorbidity services in tune with the local Aboriginal community people’s real comorbidity service needs; a ‘one-stop-shop’ Taking action can be achieved through consultation (*‘always ask’*), collaboration (*‘in partnership’*) and construction (*‘act according to all partners’ knowledge and needs’*), as advised by the Aboriginal people and staff, formulated as:

#### **Comorbidity care need = Comorbidity services.**

Raising the current system’s awareness of the Aboriginal community people’s comorbidity service needs is one of this project’s achievements. Together with the wider *CAN project* outcomes, this outcome has enabled us to move forward together to address the comorbidity service needs of the broader community for service implementation.

## Appendix 11: Dissemination of Research

### Conference paper presentations

Francis H, Wilson C, de Crespigny C, Galletly C, & Kelly J. (2012a). *The Proposal: The comorbidity service needs of Aboriginal people (12years and over) living in Salisbury and Playford local government areas, Adelaide.*, School of Nursing Seminar Series, Faculty of Health Science, University of Adelaide: 27 March 2012

Francis H, Wilson C, de Crespigny C, Galletly C, & Kelly J. (2012b). *The Marginalised group: Aboriginal people with alcohol and psychiatric illness.* Paper presented at the Nurses and Midwives Research Symposium National Wine Centre, Gallery Room: 8 May 2012

Francis H, Wilson C, de Crespigny C, Galletly C, & Kelly J. (2012c). *In the age of complexity: Comorbidity Action in the North: Aboriginal project.* Paper presented at the Drug and Alcohol Nurses of Australasia, Australia's peak nursing organisation, Melbourne: 14 June 2012

Francis H, Wilson C, de Crespigny C, Galletly C, & Kelly J. (2012d). *Comorbidity action research in Northern Adelaide with Aboriginal people.* Paper presented at the Beyond 2012: Leading the way of Action, National Indigenous Drug & Alcohol Conference, Perth, Western Australia: 7 June 2012

### Publications: Reports

de Crespigny C, Cairney I, Francis H, & Wilson C. (2013). 'Stopping the run-around'; Comorbidity Action in the North. *AHCSA News, Aboriginal Health Council of South Australia Inc, PLAHS Celebrates 20 Years pp 22*: November 2013

Francis. H, Wilson. C, de Crespigny. C, Galletly. C, Kelly. J, Cairney. C, King. R, Dann. R, Bowden. M, Murray, H. (2014). Stopping the run-around: Comorbidity Action in the North. *CAN Aboriginal Study Workshop Report* (pp. 16). Salisbury, Playford local government areas of South Australia: The University of Adelaide.

Francis, H., Wilson, C., de Crespigny, C., Galletly, C., Kelly, J., & Cairney, I. (2015). Community Report for participants, services and wider community: 'Comorbidity Action in the North' Aboriginal Project (pp. 12). Salisbury, Playford local government areas of South Australia: The University of Adelaide.

### **Invited presentations**

Francis H, Wilson C, de Crespigny C, Galletly C, Kelly J, & Cairney I. (2012e). *CAN project: Comorbidity service needs of Australian Aboriginal consumers*. Paper presented at the E Conference, Webinar, Mental Health Professional Network, Working together. Working better, Oxford Brookes University, United Kingdom: 7 February 2012

Francis H, Wilson C, de Crespigny C, Galletly C, & Kelly J. (2013). *Ongoing consultation and collaboration: Our research with action*. Paper presented at the Beyond the Project, Research Conversazione Barr Smith South, School of Nursing, University of Adelaide: 25 July 2013

Francis H, Elliott P, Wilson C, de Crespigny C, Galletly C, & Kelly J. (2014). *'Stopping the run-around'; Comorbidity service needs of Aboriginal people, 12 years and over in Salisbury and Playford local government areas, Adelaide*. Paper presented at the Respect - Our Mob, Tandanya, National Aboriginal Cultural Institute, Adelaide: 14 March 2014

Wilson, C, & Francis, H. (2015). Outcome of the CAN Aboriginal study *Stop lip service need real MH-AOD comorbidity service in Northern Adelaide* (pp. 25). Unley: Adelaide: Aboriginal Health Council of South Australia.

### **Poster presentations**

Francis H, de Crespigny C, Galletly C, Kelly J, Cairney I, & Wilson C. (2013). Action Research: An approach of mutual partnership. In University of Adelaide (Ed.), *Faculty of Health Science 2013, Postgraduate Research Conference* National Wine Centre, Adelaide: 29 August 2013

Francis H, Wilson C, de Crespigny C, Galletly C, Kelly J, & Cairney I. (2014). Implementable Action Research: 'CAN' Aboriginal project determining the comorbidity service need. In University of Adelaide (Ed.), *2014 Faculty Postgraduate, Research Conference*. National Wine Centre, Adelaide: 25 September 2014

## Appendix 12: Posters


These Posters are reflective examples of the research work on how it evolved and developed with everyone's contribution. The first poster was done at the beginning. One Aboriginal Community member said "it is nice but better if colours of the land were portrayed, with pictures representing the message". I took their advice to make the second poster. They were really happy. One wanted this poster in his workplace to use with Aboriginal people.

### Poster 1: Poster at the early stage of the research

## Participatory Action Research: An approach of mutual partnership

Francis, H.<sup>1</sup>, de Crespigny, C.<sup>2</sup>, Galletly, C.<sup>1,2,3</sup>, Kelly, J.<sup>4</sup>, Cairney, I.<sup>1,2</sup> and Wilson, C.<sup>2</sup>

1. The University of Adelaide, 2. Adelaide Health Service, 3. Ramsay Health Care (SA) Mental Health Services and 4. Flinders University



Acknowledgment and Thanks to the parent "CAN" (Comorbidity Action in the North) project and to the Aboriginal Working Party members

#### Background

Comorbidity due to co-existing alcohol, mental health and drug problems have been associated with poor health and undesirable outcomes. Thirty percent to 90% of clients in mental health, alcohol and drug services experience combined problems of mental illness, alcohol and other drugs (Davis 2003). However many mental health and alcohol and drug services continue to treat people's comorbidity according to their primary service focus.

- o Commonly this leaves people with comorbidity being referred 'bounced' back and forth between these services rather than being offered integrated, holistic treatment.
- o Many missed opportunities for early and comprehensive interventions contribute seriously to exacerbation of mental and physical illness and social dysfunction.
- o This situation is very challenging for people in need, and imposes a severe burden on those affected by comorbidity, including their families, carers and community as a whole.
- o People's mental health and general wellbeing are likely to further deteriorate and they are more vulnerable from developing complications, crises and premature death that may have been preventable and could have been supported with appropriate treatment and conducive comorbidity services (Andrews, Henderson & Hall 2001).

This is particularly problematic for Aboriginal people whose overall health and wellbeing is significantly challenged. The latest statistics from the National Aboriginal and Torres Strait Islander Health Survey (2004-2005) has estimated that 82% of Aboriginal Population in South Australia experience high to very high psychological distress.

#### Objective

To determine the mental health, alcohol and drug comorbidity service needs of Aboriginal people 12 years and over. The Aboriginal people and relevant 'on the ground' service providers in the study region of Northern metropolitan Adelaide are being consulted as partners with the research team regarding the future design and delivery of culturally appropriate local comorbidity services.

#### Collaborative participation of co-researchers



This qualitative research project is informed through partnership and collaboration. Using participatory action research informed by critical theory, means that members of the local Aboriginal community are partners, co-researchers and participants with knowledge, experience and information regarding the topic of this research (Kemmis 2008).


The researcher is collaborating with a respected Kauma Elder, who is both cultural guide and co-researcher. Together the local Aboriginal Working Party (AWP) has been formed whose members are also co-researchers, comprised of local Aboriginal workers and community members in Salisbury and Playford local government areas.

Comorbidity services are required to offer comprehensive, interconnected models and pathways of care that are integrated and consistent with delivery of ongoing support and treatment in appropriate ways (Berry & Crowe 2009).

#### Reflective cycles of participatory action research


Participatory action research offers a framework for the necessary cyclical, reflective phases to identify the required comorbidity service needs through this framework of Look, Think, Act and Reflect process involving participating Aboriginal and non-Aboriginal advocates as research partners (Stringer 2007), are implemented in cycles. These phases of cyclical action provide inclusive, practical and culturally respectful means of engaging and involving people in seeking information (data), understanding that information and then formulating ways to solve problems affecting them.

#### Consultation of comorbidity service providers



Through the process of mutual collaborative approach the researcher has engaged with a Kauma Elder to 'walk together' and empower local Aboriginal community members and health workers as research partners. This collaboration aims to ensure that they are able to work together to share information and find effective solutions to barriers that prevent Aboriginal people from receiving culturally appropriate, local comorbidity services. To this end the researcher, Kauma Elder are 'walking together', engaging and empowering local Aboriginal community members and health workers as the Aboriginal Working Party members - research partners.

#### Action towards outcome



Consistent collaboration and involvement is an essential aspect of partnership model. Therefore the Aboriginal people are consulted with a decision making cyclical process of participatory action research


- o The Kauma Elder and Aboriginal Working Party members are regularly consulted by email, phone and ad hoc meetings. Through these mechanisms the researcher can seek advice and information on e.g. sampling matters and general progress. The data is collected and analysed jointly by the researcher and Kauma Elder.
- o Preliminary findings will be considered by Aboriginal working party members; and once agreed, by the wider Aboriginal and non-Aboriginal research team members. The Findings will then be presented to the research participants (workers and community advocates) at a purpose designed local workshop for consideration, and development of key recommendations.
- o The recommendations will focus on e.g. re-orientation and provision of local, culturally appropriate comorbidity services for Aboriginal people aged 12 years and over living in the study region.

This last reflective cycle ensures that the Aboriginal partners and participants have been able to engage in, be informed and inform others of the issues, processes and outcomes of this research for their families and wider community.

#### References

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Poster 2: Poster on the outcome of the research



## Implementable Research: 'CAN' Aboriginal project determining the comorbidity service need


A project of 'Comorbidity Action in the North' (CAN) 'Stopping the run around'  
H. Francis, C. Wilson, C. de Crespigny, C. Galletty, J. Kelly and I. Cairney  
E-mail: [francis@adelaide.edu.au](mailto:francis@adelaide.edu.au)

### Our Focus:

Comorbidity service needs of Aboriginal people (12 years and over) in the north of Adelaide at Salisbury and Playford local government regions.

**Comorbidity = combo of mental health and alcohol and drug problems (together)**


Seventy to 90% clients of mental health, alcohol and related services experience comorbidity (Dowdy, Teesson et al. 2013). If untreated marginalised Aboriginal clients are more vulnerable to complications, crisis and premature death (de Crespigny, Taimel et al. 2012). This causes cumulative physiological and psychological burden on individual, families and communities (Kelly, Dudgeon et al. 2009). Correct diagnosis is critical to ensure appropriate and effective treatment. It is often difficult to disentangle the overlapping symptoms of comorbidity making diagnosis and treatment complex (Volkow 2008). Ignorance of or failure to treat a comorbid disorder can jeopardise the client's chance of recovery. Appropriate health service is a national responsibility (Closing the Gap 2009)



### We worked together:


PAR, Dadimi & Ganma

**PAR:** Participation  
**Dadimi:** Deep Listening  
**Ganma:** Mutual Knowledge Sharing





### Local People's stories

Local Aboriginal people  
Staff Comorbidity Services  
Staff Support Services



### The findings:

This is what we found




We see a lot of Aboriginal people and a few of them are hooked up to the services" SAS 13  
There are people waiting around undiagnosed" SAS 12

### Impact of comorbidity:

Comorbidity cycle, imprisonment, death, dying



A massive, massive, (takes it) (in) impact on people" CMS 8  
He passed on (died) because he needed a rest...just needed some peace and quiet. That's what he said to us. He gave up! Didn't give up on his family; but he gave up on him as he had to for him" SAS 13



### Current services for comorbidity:

Complex with widening gaps

They're only interested in what they do and so that makes it a little difficult" SMS 11  
They work in isolation" SAS 12  
Stop your tip service and start actually giving us a service" ACA 8



### What is actually needed:

Future comorbidity services

Mental health, drug and alcohol service needs to exist" ACA 8  
We should have a service that looks at both (mental health, alcohol and drugs) but we don't actually have a service that looks like that" CMS 2

### How can we succeed:

Working together


The way I look at it too, I can't save the world. None of us can save the world, but if we put one person or a couple of people back on track you've achieved something in your life and that person will have more respect for you and then they'll bring up their kids and all that in the same way" SMS 10

### It isn't rocket science folks!

Integrated engaged partnership

So there is a lot of consistency with the findings of parent CAN project and specifically Aboriginal people want:

- Locally available integrated mental health, alcohol and drug 'comorbidity' services
- Choice of mainstream and Aboriginal specific comorbidity services
- Culturally appropriate comorbidity services that involve family



**Acknowledgements:** Aboriginal Working Party Members: Mr. Conal Wilson, Mr. Paul Elliot, Ms. Joanne Day, Mr. Trevor Wierzbicki, Mr. Trevor Wierzbicki, Mr. Robert Taylor, Mr. Paul Wierzbicki, Mr. Justin Madrig, Ms. Lisa Warner and Ms. Nancy Brown

**Reference:**

de Crespigny, C., Taimel, S., & Dudgeon, P. (2012). *Aboriginal people and mental health: A national responsibility*. Adelaide: University of Adelaide.

Dowdy, A., & Teesson, M. (2013). *Comorbidity in mental health: A national responsibility*. Adelaide: University of Adelaide.

Kelly, J., Dudgeon, P., & Kelly, J. (2009). *Aboriginal people and mental health: A national responsibility*. Adelaide: University of Adelaide.

Volkow, N. (2008). *Comorbidity in mental health: A national responsibility*. Adelaide: University of Adelaide.

## Appendix 13: CAN Briefing and Recommendations



THE UNIVERSITY  
*of* ADELAIDE

### ***'STOPPING-THE-RUN-AROUND': COMORBIDITY ACTION IN THE NORTH (CAN)***

An Australian Research Council (ARC) Project

#### **Briefing and Recommendations 2014**

When a person suffers from both a Mental Health (MH) disorder and a Drug and Alcohol (AOD) use disorder, this is called comorbidity. Comorbidity is common, and it can be difficult for people with comorbidity to find the right help. The federally funded *CAN project* took place over 4 years in the northern suburbs of Adelaide, engaged multiple government and non-government service providers and community groups, and investigated barriers and enablers to effective comorbidity services for people with comorbidity.

#### **A mother's voice – 'it's simple really, we need one door only for MH and AOD comorbidity care'**

As a mother who cares for her adult daughter affected by comorbidity, Margot O'Donnell asked that her words be expressed here. Margot was a member of the CAN Advisory Committee for 4 years and greatly contributed to our understanding of the experiences of consumers and carers.

"As parents and carers we are so frustrated with separate MH and AOD services - you have to have one problem or the other. This doesn't work for our loved ones or us. We need only one entry point - 'one door' – so our comorbidity 'story' only has to be told once. We need clinicians and workers to realise the suffering and complexity of comorbidity and that people need and deserve combination comorbidity assessment and treatments, and social support – they need to treat the whole problem. We remain disheartened by the continual MH and AOD service and practice gaps, and need this to change as soon as possible".

## **The CAN Recommendations:**

### **Recommendation 1 – recognition of comorbidity**

Co-existing MH and AOD comorbidity is to be formally recognised and responded to by governments, relevant authorities and personnel as a common, complex, chronic and relapsing disease requiring specific services to be established. These services are required to intervene early, reduce harm and support people’s recovery.

MH and AOD comorbidity is prioritised in state and commonwealth government policies, funding decisions and directions in order to improve the effectiveness and efficiency of MH and AOD services.

### **Recommendation 2 – comorbidity is core business**

Comorbidity is ‘core business’ of all government and non-government (NGO) MH and AOD services. MH and AOD service leaders, managers, ‘front-of-house’ personnel, clinicians, workers and students are trained to be professionally prepared, competent and capable in delivering comorbidity services.

### **Recommendation 3 – social determinants of health**

Governments, MH and AOD services, other relevant services and clinicians recognise and act to address the Social Determinants of Health which strongly influence the occurrence and experience of consumers’ comorbidity by impacting on their mental and physical health, and capacity and hope for recovery.

### **Recommendation 4 – “no wrong door” - stopping the referral run-around**

MH and AOD services organise their services away from ‘siloes’ service delivery and practice to delivering evidence-based “no wrong door” comorbidity service “its what we do”. Comorbidity care should be coordinated, networked and streamlined to ensure that any consumers who are affected, no matter which service they seek help from, will be assessed and treated appropriately. This ensures avoidance of multi-agency duplication of services, and consumers being referred on unnecessarily. Managers and staff of MH and AOD comorbidity services are supported and expected to cooperate and partner with each other, with other MH and AOD services and programs, and with key support agencies.

### **Recommendation 5 – ‘keeping the momentum’: sustainable government funding for the non-government sector**

A non-competitive funding and procurement model is required of government to enable NGOs to deliver a sustainable and skilled MH and AOD comorbidity workforce that can deliver evidence-based MH and AOD comorbidity services. This will enable these services to engage, maintain and assure consumer confidence and service improvements.

Funding cycles should run over a minimum of 4-5yrs.

Specifically allocated funding should be provided to NGO MH and AOD comorbidity services to support access to accredited interpreters for CALD and Aboriginal consumers and families.

#### **Recommendation 6 – evidence-based MH and AOD comorbidity services**

All MH and AOD leaders, clinicians and workers should be knowledgeable and competent in delivering evidence-based comorbidity services as their ‘core practice’.

All MH and AOD services should operate in accordance with Standard 2 of the National Health Quality Framework, providing programs that genuinely engage consumers, carers and the community.

Hospital avoidance programs should be systematically delivered by assertive community MH and AOD comorbidity teams, e.g. outreach/in-reach, step up/step-down pathways, relapse prevention, ‘home’ visiting care including home detoxification, consumer and carer group support, and community-based recovery services.

A 24 hour/7 day a week ‘first point of contact’ MH and AOD Comorbidity Assessment Clinic, immediately adjacent to or within each emergency department (ED), should be established urgently.

Local sobering-up and mobile assistance services should be reliably funded and have appropriately trained staff to deliver immediate safe care of intoxicated adults, youth and children; with transfer or referral to support services and specialists as appropriate.

#### **Recommendation 7 – culturally and age appropriate comorbidity services**

MH and AOD comorbidity services should be culturally-appropriate for:

- Aboriginal people and people from culturally and linguistically diverse (CALD) backgrounds.

- Young children, early teens and youth to 25 years.

- Older people, frail and disabled people.

Local MH and AOD comorbidity services should regularly engage with local Aboriginal, refugee and other CALD elders and community members.

#### **Recommendation 8 – trust**

Positive consumer engagement and outcomes are contingent on government and NGO MH and AOD comorbidity services building trust amongst consumers, families and the community. Trust is reliant on people’s easy access to known, accessible, competent and reliable “no wrong door” MH and AOD comorbidity services.

#### **Recommendation 9 – comorbidity workforce development**

Vocational Education and Training programs (VET), university, and continuing education sectors are strongly encouraged to include comorbidity as ‘core curriculum and content’ within their MH and AOD qualifications.



Accreditation of relevant undergraduate, postgraduate and short courses provided by VET and universities is contingent on evidence-based MH and AOD comorbidity curricula and student assessment.

Comorbidity services should utilise evidence-based comorbidity guidelines.

All MH and AOD workers should receive education and training so that they are capable and competent in delivering culturally-appropriate comorbidity services.

#### **Recommendation 10 – information & communication: services and community**

‘Frontline’ MH and AOD workers are able to build and maintain effective communication, information sharing, networking and problem solving through their regular attendance at ‘on-the-ground’ inter-agency gatherings.

A local generic Community Information and Referral Hub is developed that enables community members to access information, and learn where and how to access community services, including local MH and AOD comorbidity services.

Comorbidity Health Promotion is marketed locally (e.g. ‘Carnival in the North’, Drug Action Week, Reconciliation Week, Mental Health Week) and adequately supported by the MH and AOD sectors.

An easily accessible electronic and paper-based local MH and AOD comorbidity service directory is funded and supported by governments, and hosted and updated by local government; and hyperlinked to other reliable IT based ‘social media’ and websites, possibly based on the:

***2014 CAN Local Directory Mental Health and Alcohol and Other Drug Services for Salisbury and Playford:*** <http://blogs.adelaide.edu.au/nursing/2014/08/>

#### **Recommendation 11 – consumer inclusion and action**

A ‘grass-roots’ Comorbidity Action Network in Northern Adelaide (CANNA) is developed, adequately funded by governments and facilitated by local government, as a local community network and a dynamic ‘consumer voice’ to engage with government policy development, funding and other decisions regarding local MH and AOD comorbidity matters.

## **Briefing**

### **What is mental health and alcohol and drug comorbidity?**

Mental Health (MH) and Drug and Alcohol (AOD) comorbidity is a significant and prevalent *complex cluster of chronic relapsing illnesses*. Unrecognised and untreated, this comorbidity substantially impacts people's mental and physical health and social wellbeing, and significantly shortens their lives.

Research indicates about 70% of consumers with a mental illness and 90% of consumers with drug dependence have comorbidity requiring evidence-based comorbidity assessment, treatment and integrated care. The outdated 'siloes' approach of most MH and AOD services, according to their type of service, means that they only assess and treat people's MH **or** AOD disorders. As these consumers are not offered evidence-based comorbidity care and support for recovery, many experience worsening MH, AOD, general health, and social well-being through frequent relapses and crises, disability, and early death. This is despite international research and many government reports calling for a "no wrong door" approach to MH and AOD comorbidity service delivery for over a decade.

### **Background to the CAN research**

Between 2011 and 2014 the '*Stopping the Run-around*' Comorbidity Action in the North (CAN) research project investigated the barriers and facilitators to receiving mental health (MH) *and* alcohol and drug (AOD) comorbidity services for people aged 12 years and over, in northern metropolitan Adelaide. Led by The University of Adelaide, CAN's partners are: SA Mental Health, Aboriginal Health Council SA, Northern Adelaide Medicare Local, UniSA, City of Salisbury, and SA Network of Drug and Alcohol Services (SANDAS - peak body for the non-government [NGO] sector).

CAN undertook a regional scoping study of government and NGO MH and AOD services, including two surveys and multiple interviews with local service managers, clinicians, workers, consumer and community advocates. Throughout the project, representatives from local government and NGO MH, AOD and other health and social support services, consumers, and community advocates were consulted as key informants and advisors, including members of the local Aboriginal and refugee/CALD communities.

CAN was funded by the nationally competitive Australian Research Council (ARC) Linkage Grant Scheme, along with CAN's industry partner, SA Mental Health. The City of Salisbury has also been an important financial and in-kind contributor. Two PhD candidates were provided scholarships through the ARC grant. All CAN partners and associate partners have contributed significant in-kind expertise, personnel and resources.

### **CAN Research Team**

The CAN research team comprises prominent researchers, multi-disciplinary and multi-industry leaders, clinicians and community advocates, led by Professor Charlotte de Crespigny and Professor Cherrie Galletly from The University of Adelaide. The CAN Advisory Committee and CAN Aboriginal Working Party were key advisory bodies throughout the project whose members, along with all other participating groups, contributed to the formulation of the CAN Recommendations. **\*see names** of the CAN Research team, and contact emails of lead researchers, on last page.

## Why these CAN Recommendations?

Up to 90% of consumers of MH or AOD services in Australia and elsewhere have diagnoses indicating comorbidity. The high prevalence of comorbidity amongst the consumer base of these services means that both should be regarded as MH *and* AOD comorbidity services. The CAN findings from multiple sources confirm that despite strong international evidence regarding the *serious impact of comorbidity* on people's mental and physical wellbeing, their co-existing and complex conditions are typically treated separately. This common finding was confirmed in the CAN study region. Thus, the CAN findings reveal what is happening in northern Adelaide, and also confirm, support and extend findings of other Australian research into service provision for people with comorbidity.

## Who are the CAN Recommendations directed to?

The CAN recommendations need to be urgently and fully implemented due to the strong evidence base, likely transferability, and ongoing unmet consumer need. They are therefore directed to the relevant commonwealth, state and local government ministers, policy makers, authorities, heads of departments, service leaders, and health and human service personnel with responsibilities for the northern metropolitan Adelaide region. These recommendations are also relevant to South Australia as a whole.

## Selected Australian research and government reports

- 1) Australian Department of Health and Ageing. *Fourth National Mental Health Plan. An agenda for collaborative government action in mental health 2009–2014*. Commonwealth of Australia. 2009. Canberra.
- 2) Australian Government National Mental Health Commission. 2013. *A Contributing Life. The Australian Government 2013 National Report Card on Mental Health and Suicide Prevention*. Canberra.
- 3) Deady M, Teesson M, Mills K et al. 2013. *One person, diverse needs: living with mental health and alcohol and drug difficulties. A review of best practice*. NHMRC Centre of Research Excellence in Mental Health and Substance Use.
- 4) Manuel JI, Gandy ME and Rieker D. 2014. Trends in Hospital Discharges and Dispositions for Episodes of Co-occurring Severe Mental Illness and Substance Use Disorders. Administration and Policy in *Mental Health and Mental Health Services Research*, Feb 9.
- 5) Posselt M, Galletly C, de Crespigny and Procter N. 2013. Mental health and drug and alcohol comorbidity in young people of refugee background: a review of the literature. *Mental Health and Substance Use*. UK. 27 Feb.
- 6) de Crespigny C, Galletly et al 2011. 'Stopping the run-around': Comorbidity Action in the North. Successful submission to the ARC-Linkage Grant Program.
- 7) Alcohol and Other Drugs Council of Australia. *Policy Position – Comorbidity*, ADCA. October 2008, Canberra.
- 8) Teeson M, Slade T and Mills K. Comorbidity in Australia. Findings of the 2007 National Survey of Mental Health and Wellbeing, *Aust NZ J Psychiatry*, 2009, 43: 606
- 9) World Health Organization. *Global health risks: mortality and burden of disease attributable to selected major risks. 2009*. World Health Organization.
- 10) Kowanko I, de Crespigny C, Murray H et al 2009. Improving coordination of care for Aboriginal people with mental health, alcohol and drug use problems: progress report on an ongoing collaborative action research project. *Australian Journal of Primary Health*. 15(4): p. 341-347.
- 11) Roche A, Duraisingam V, Wang P and Tovell A. *Alcohol & Other Drugs, Mental Health & Comorbidity. A Training Review*. National Centre of Education and Training on Addiction. Flinders University | November 2008.
- 12) Holt, M and Australian Department of Health and Ageing. *Barriers and incentives to treatment for illicit drug users with mental health comorbidities and complex vulnerabilities*. 2007, Canberra: Australian Department of Health and Ageing. Viii, p 146.

### **CAN project Information**

**Funding:** Australian Research Council, SA Mental Health (NALHN) and City of Salisbury. Significant in-kind expertise, time and resources have been provided by The University of Adelaide and its partners. The *CAN project* would not have been possible without this support.

**Partners:** The University of Adelaide (lead), SA Mental Health, Northern Adelaide Local Health Network (NALHN), Aboriginal Health Council SA, Northern Adelaide Medicare Local and the University of SA.

**Associate Partners:** SA Network of Drug and Alcohol Services (SANDAS), City of Playford.

**Advisors:** Partners and Associate Partners; CAN Aboriginal Working Party and CAN Advisory Committee. Organisations represented in alphabetical order:

- Aboriginal Health Council, SA (AHCSA)
- Aboriginal Kurna Elder Cultural Advisor Ms Coral Wilson (with permission)
- Aboriginal Community Advocate - Joanne Else (with permission)
- Aboriginal Community Advocate - Paul Elliott (with permission)
- Anglicare
- Australian Refugee Association
- Child and Adolescent Mental Health Service City of Playford Local Government Area
- City of Salisbury Local Government Area
- Consumer/Carer and Advocate - Ms Margot O'Donnell (with permission)
- Department of Corrections, SA
- Disability SA
- Hepatitis SA
- Mental Illness Fellowship of SA
- NEAMI
- Northern Adelaide Mental Health
- Northern Adelaide Community Mental Health (refugee/new arrivals portfolio)
- Northern Adelaide Medicare Local
- SA Network of Drug and Alcohol Services (SANDAS) (peak NGO)

### **Chief Investigator/Leaders - Contact emails:**

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### **CAN team:**

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- 2) Professor Cherrie Galletly, University of Adelaide, NALHN (lead)
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- 22) Dr Tim Schultz, University of Adelaide
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- 25) Ms Nancy Whittaker, University of Adelaide.