Case Study 1: Margaret

Case Study Information

You are about to head to the airstrip after a quiet and unremarkable outreach clinic at Morgan’s Lagoon, your second visit to the community (the first was even quieter). It is 4.00pm and the pilot wants to get off well before last light. The nurse on duty, Tracy, approaches you and relates that an elderly Aboriginal woman, Margaret, wants to talk to “the head doctor”, adding that she doesn’t think that Margaret has a “mental problem”. She adds that Margaret is a frequent attendee at the clinic, a “big worrier” and that the biggest worry is her adult children. Margaret had been in the clinic earlier in the day, but had not raised anything about mental health issues. Tracy comments that the community had been informed that the specialist was only going to be in the community this day and that Margaret could have come earlier if her issue was important. Tracy kindly offers to “settle her down” instead of seeing you so that you can get into the air early.

Outreach

Fly in / fly out outreach clinics to remote communities are not ideal means to provide services. For residents of these settings, the alien nature of such practice is compounded by the high turnover of practitioners, particularly when this complex work is allocated to registrars who are necessarily short term.

Indeed the same problems beset primary care and, in this instance the primary care nurse is herself an agency employee with probably a less than full understanding of local issues and knowledge of community members. It is not surprising that, on your first visit there were few presentations, or that this person has presented late in the day. There may well have been lengthy discussion after your first visit and Margaret may well have been “checking” you out when she came to the clinic earlier in the day.

Although Tracy is trying to be helpful while there may well be some pressure because of the approaching last light, allowing Margaret to be put off risks more than missing a mental health issue. It may well also reinforce doubts about the degree to which health care service workers care about community members. Indeed there is a long history in Australia of medical practitioners involvement in discriminatory, race-based practise – for instance in the treatment of leprosy and sexually transmitted infections – the legacy of which remains real in many areas of remote Australia.

Even if a consultation with Margaret is necessarily short, it is important as recognition of Margaret’s problems, an affirmation of her needs and as a building block in developing a relationship with this community. Be sure that discussion about you and how you have responded to people’s needs will continue after you have left.
You thank Tracy and inform the pilot that you will be a little longer. You introduce yourself to Margaret and explain what your role is, letting her know that you have only 15 minutes and that you are very sorry that you can’t spend longer, but that you want to at least start the process of figuring out how you can be of help. You tell her that you will make sure you have plenty of time when you return in two weeks to talk with her more and add that you are willing to talk with her on the phone between now and the next visit as well.

Margaret looks about sixty, but is, in fact, a decade younger. She is reasonably dressed and groomed, but has long-healed scarring about her left eye and near her lip. Her speech is careful and though you know English is her second language, you find she is articulate and clearly a thoughtful woman. “Doctor, it’s my daughter Mona and her man Josiah,” she explains, adding, “I want someone to tell them they got to stop this fighting and drinking”.

### Generational Differences

Margaret has raised multi-generational concerns and has presented a picture of the trans-generational consequences of alcohol. She is of the first generation to encounter unrestricted access to alcohol as young adults around the 1970s and her healed scars probably bear testimony to a time of heavy drinking and its behavioural consequences.

Among Indigenous people generally, the proportion of drinkers is less than among non-Aboriginal and/or Torres Strait Islanders, but the proportion of drinkers who consume at high levels – both males and females – is higher. Elevated morbidity and mortality rates from accidents and injuries, particularly among young adults, reflect alcohol-related behavioural disinhibition. However, about one third of Aboriginal drinkers eventually give up drinking, usually during or after their fourth decade and this may have been the case for Margaret. This is usually done without formal treatment and most commonly is a result of health issues (often mediated by a health practitioner who is able to personalise the health consequences in a compassionate and caring way), or concerns about family – particularly the birth of grandchildren.

Margaret would have been raised in a fairly stable and structured environment (her parents would have been non-drinkers in a society in which prohibition was still in force). The social turmoil of the 1970s when she was a drinking young adult probably impacted her role as a parent and she may feel despair and powerless about the drinking of her daughter. Indeed, she may feel a sense of failure and guilt as a result of having been drinking during pregnancy. Of course, at the time of her pregnancy with Mona, nobody would have been discussing alcohol effects on pregnancy, but over the last five years this has been widely discussed. There is now a degree of understanding and a large amount of misunderstanding across Indigenous Australia about foetal alcohol effect and Foetal Alcohol Syndrome, which are now recognised to be substantially more common among Aboriginal births. The concern has been heightened by changes in patterns of alcohol consumption through the 1990s in which binge drinking by girls and young women became more common as did the use of a wide range of other substances (including petrol sniffing, particularly in remote settings).
Health Status

There is a human rights agenda in relation to health, due to the vast inequity between Indigenous and non-Indigenous health status. In many cases Aboriginal and Torres Strait Islander groups do not receive the same consideration or access to basic rights such as housing, education and health care enjoyed by the rest of the population. Aboriginal and Torres Strait Islander children in particular need to grow and develop with knowledge of their history with an unqualified assurance for their future in society with the provision of a safe and nurturing environment supported by their community. Healthy Aboriginal and Torres Strait Islander communities are important for all of Australia.

There are currently high levels of morbidity and premature death in the Aboriginal population across all health indicators as compared with the non-Aboriginal population. From a developmental perspective, the cycle of ill health begins with maternal and infant problems, including obstetric complications, low-birth weight and failure to thrive. Children often suffer from chronic infections especially skin, respiratory, gastrointestinal and ear, nose and throat problems.

Chronic Otitis Media puts the child at risk of delays in speech and language development and impairs learning. Anaemia is a common problem throughout and may worsen significantly in adolescence, especially for women. High rates of diabetes, cardiovascular disease and chronic renal failure contribute significantly to premature death. Alcohol and substance abuse as well as head and other injury further compromise physical health. Some illnesses virtually wiped out in the non-Indigenous population are still prevalent, for example, bronchiectasis and rheumatic fever. Life expectancy remains 17-20 years shorter than the non-Aboriginal population.


Data from the 2004-05 NATSIH Survey found:

- Around two-thirds (65%) of Indigenous people reported at least one long-term health condition.
- Indigenous people in remote areas were less likely to report a long-term health condition than those in non-remote areas.
- Asthma was reported by around one in seven Aboriginal and/or Torres Strait Islanders (15%) in 2004-05.
- Around one in eight Aboriginal and/or Torres Strait Islanders (12%) reported a long-term health condition associated with the circulatory system, such as heart disease or hypertensive disease.
- One in eight Aboriginal and Torres Strait Islander people (12%) reported ear diseases and/or hearing problems in 2004-05.
- Indigenous people were more than three times as likely as non-Indigenous people to report some form of diabetes.
- Rates of kidney disease were much higher in the Indigenous population than in the non-Indigenous population.

Indigenous people were 1.3 times more likely than non-Indigenous people to have been hospitalised in the 12 month period.
Case Study Information (continued)

Margaret’s story begins and in the next fifteen minutes you identify that Margaret is herself abstinent, but used to be a heavy drinker. Her daughter and Josiah live with her along with several other relatives including Felicia, Margaret’s fifteen year old grand-daughter. Through this brief encounter you sense that Margaret’s major concern is Felicia, whose behaviour has been a concern. Margaret adds: “Doctor, I’m worried for all those grog babies – and I can’t look after more babies Doctor – I’m old woman now”.

The aeroplane pilot makes his presence known, tapping his watch. You apologise to Margaret, affirm the importance of the issues she has raised, explaining that you are going to try and make contact with her when you get back to base and that you will make sure there is time for you both to have a long discussion at your next visit. To your surprise Margaret appears extremely grateful thanking you in a somewhat formal, but clearly genuine manner. You get out just before last light.

### Premature Modality

The burden of premature mortality in Aboriginal Australia is such that Margaret belongs to a small group of surviving elders on whom, as a non-drinking woman, very significant demands and responsibilities fall – what has been called the “stressed out granny syndrome”. Margaret has alluded to this and it may well explain why she is a frequent clinic attendee and a “worrier”.

Although this may be speculation, taking this brief time to acknowledge Margaret is time well spent. You know that Margaret comes to the clinic almost daily. You plan to call the clinic and make time to speak with her on the phone. This is as much about emphasising your concern and affirming the importance of Margaret’s concern, as it is about gathering information. While telephone contact is less than ideal, in this community it is the only option and many Aboriginal people feel very comfortable talking by phone once they have made direct personal contact and have a sense of getting to know you.

### Alcohol

Indigenous patients are less likely to use alcohol, but more likely to do so dangerously. Rates of smoking are higher among Aboriginal people, being roughly double the national average.

Some trends, which have been noted, include:

1. Indigenous people are statistically less likely to use alcohol, but more likely to abuse it, if used.
2. Rates of smoking are higher among Indigenous people, being roughly double the national average.
3. Indigenous people are more likely to use inhalants, e.g. petrol, “chroming”. This is more common in remote communities.
4. In some areas, Aboriginal or Torres Strait Islander people may use kava.
5. In some areas, you may see people chewing wads of “native tobacco” or pituri. This is a stimulant similar to regular tobacco, with similar health risks. Its use is mostly confined to Central Australia, and is more common among women.
6. Substance abuse is usually comorbid with depression, chronic illness or post-traumatic stress disorder (PTSD).

Sources: (Meadows and Singh, 2001); Curtin Indigenous Research Centre
Case Study Information (continued)

You have probably already provided significant help to Margaret. Indeed she seems to have settled and appreciated your willingness to listen and to allow silence rather than pushing with questions or rushing to recommendations. In fact, you have been reviewing the limited options available in your mind. You could try to meet with the family as a whole and address substance use in both of the younger generations – indeed you sense that this is what Margaret wants and that she sees this as being the authority of the doctor “telling” them to change their ways. You recognise that this is unlikely to be fruitful. You could try to meet with Mona and/or Josiah and explore their relationship issues – however you are also pessimistic about this approach without being able to address their substance use. You consider getting the Alcohol Tobacco Other Drug Services (ATODS) worker involved to follow up on their next visit – that might be useful. As Margaret resumes talking you reflect on her primary concern for her grandchild and her future great grandchildren and the need for them to have “strong” parents who are there for them.

You call Margaret and she seems very surprised that you have made the effort to make contact. She is profusely grateful and is at pains to emphasise that she will make sure she can come for a “good talk” when you return.

You arrive back in the community and Margaret is in the waiting room as you enter the clinic. There are several children bouncing around her and she brings the youngest of these into the interview room where you bring her a cup of tea. Over the course of the next hour you obtain a comprehensive history from Margaret.

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<th>Approach</th>
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<td>In general you should approach the situation as though you have something to offer, as does the patient, family and/or community, e.g. a two-way learning experience. Honesty is also important and if unsure about what to do in a situation, be open, ask and wait, instead of trying to bluff your way through. This is more likely to result in better communication. Sitting alongside or in a circle may be more comfortable and preferable to direct confrontation for some groups. Avoidance of direct eye contact may be part of respectful behaviour and should not be over-interpreted. Gazing together in the same direction may give an indication of social connection.</td>
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<td>Respect is shown through a commitment to being aware of and working through Indigenous protocol. Indigenous cultures are diverse and changing and all people have the right to be represented in a manner they approve and respect for you as an outsider may take time.</td>
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<tr>
<td>Indigenous people’s right to keep secret and sacred their cultural knowledge should be respected. Sacred and secret material refers to information that is restricted under customary law. All people have the right to maintain confidentiality about their personal and cultural affairs.</td>
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Case Study Information (continued)

After talking with Margaret, you discover that her real concerns are for her granddaughter Felicia who has been raised largely by Margaret and has recently started to hang out with a group of young males and females who use marijuana heavily. Several have already been evacuated to the regional hospital with acute psychotic episodes. Last year Felicia had been seen at the clinic on one occasion after an episode of petrol sniffing. Felicia will soon be old enough to drink at the canteen and Margaret tells you how she has seen teenagers in the community spiral out of control through binge drinking.

“I don’t want her to lose her future Doctor. She’s a smart girl and she’s got a chance to make something of herself and to help this community. If she starts drinking next thing she’s got a baby. And maybe then she’s got a grog baby. I don’t know what to do Doctor – I’m too old to help now. But I still worry for the young ones”.

Margaret seems to have settled her “worries” to some degree just by your willingness to listen and to allow silence rather than pushing with questions or rushing into recommendations. You review the limited options that are available to Margaret in your mind.

Further Reading

You recall reading Maggie Brady’s work about Aboriginal people who give up drinking and the importance of the authority of the doctor addressing specific alcohol-related health problems in a personalised and caring way. You also remember how family issues, particularly the birth of a grandchild, can be motivating. Perhaps these are means by which to engage Mona and Josiah. If so, Margaret’s primary concern, Felicia and the generation to follow, are indeed critical.

Another report comes to mind in which pregnant teens were interviewed about their knowledge of the effects of alcohol on pregnancy and their own drinking status. What seemed important in terms of their decisions to drink or not now that they were pregnant was not the amount of information they were able to recall (they had all had some information through the school and health systems) but the amount of drinking that was happening in their homes. What this meant was that the prospective grandparents’ choices in relation to lifestyle and alcohol consumption could have very significant consequences for the outcomes of the pregnancies of these teenage women.

Case Study Information (continued)

As the interview moves on you ask, “Why did you stop drinking Margaret?”

“I was sick doctor, with high blood pressure and diabetes and all sorts of things. Dr Lavery, he was a very good doctor, he cared about people and spent time with them, like you – he told me straight. He talked to me hard, but I knew it was because he was worried. He showed me all those tests and things. Showed me how grog was causing me to be sick, just like my husband who died from stroke. I listened to that doctor, he changed my life. I’d been drinking a long time and I also worried for Mona, she was drinking and was about to have a baby. I knew someone had to look after that baby, that’s Felicia.”

“Margaret, do you think that Mona and Josiah would come to see me if I wanted to talk to them about Felicia?”

“Of course Doctor – I already told them about you, how you called me up and talked and that”.

You have now spent an hour with Margaret, there is still no clear plan developed, but you sense that your relationship with Margaret and probably through her with the family as a whole has been put on a firmer foundation. There are several other people to see today, but the afternoon is free. Margaret agrees to go and talk with Mona and Josiah and to return with them in the mid-afternoon.

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**Multi-disciplinary teams**

Learning to be tolerant of uncertainty and gathering incomplete information directly from the patient/client is important, so it is essential to seek advice and guidance from family, community members as health decisions tend to be made by family or community and may be governed by gender-related cultural restrictions. In many instances it will also be considered more appropriate to talk to family or community members instead of the patient when discussing that patient’s situation.

Seeking corroborative history from staff and/or Aboriginal Health workers may also provide information, not only for current presenting symptoms but also of the person’s social history. Permanent staff that have lived in the community for many years will have an in-depth knowledge of what is happening with most of the community and can assist in developing a more global perspective.

A challenge to all mental health professionals is to determine how traditional or westernised the Aboriginal or Torres Strait Islander patient is and allow for enough flexibility in interview style to accommodate for the needs of each individual. It is helpful to be aware of a person’s history (cultural and personal) and any multiple losses together with your own personal prejudices and values.
At the appointed time both Mona and Josiah are in the waiting room. Again you introduce yourself, explain your role and organise a cup of tea for each of them. You acknowledge talking to Margaret and her concerns for Felicia. Mona and Josiah are both quick to agree with this, giving you an area of common concern and a focus for discussion. You talk about Felicia’s future, including being a mother, which her parents agree will probably occur in the next few years.

This gives the opportunity to raise the issue of the harm alcohol and other drugs can cause to pregnancies. “I’ve heard of that Doctor – grog babies – there’s some grog babies in this community here,” Mona says with Josiah nodding.

You take the time to talk about Foetal Alcohol Syndrome, explaining the particular risks for the pregnancies of young binge drinking women. Returning to talking about futures you ask about their visions for Felicia’s future and their thoughts about their own roles as grandparents. This approach allows them to see their own behaviour in terms of how this will influence Felicia and Felicia’s future pregnancies and also uses their very real concern as parents and prospective grandparents to allow them to begin considering their own drinking.

**Family**

Aboriginal mothers have a number of known risk factors during pregnancy and in the postnatal period for depression including loss and grief, substance misuse, domestic violence, and poor socioeconomic circumstances. Indigenous families and pregnant women are at particular risk of domestic violence and Aboriginal and Torres Strait Islander people are over-represented as both victims and perpetrators of all forms of violent crime in Australia.

As the Aboriginal population is now relatively young (40% of the population are aged less than 14 years) there are fewer adults to care for children and fewer elders to share their knowledge of health and healing. Many young people end up playing the role of carer for sick relatives.

Aboriginal children grow up in large extended families with lots of mothers, fathers and siblings. In Aboriginal kinship networks, sisters will be ‘mothers’ to each other’s children - the children will call each other brother and sister rather than cousin. Similarly two brothers will be ‘Father’ to each other’s children, but uncle to their sister’s children. In an Aboriginal society ‘uncle’ is a far more important role than in western society.

Case Study Information (continued)

“Mona, your mum told me about the problems she had with alcohol in the past and how it damaged her health. She also told me your father died from problems that drinking caused”.

“That’s right Doctor,” she says looking meaningfully at Josiah, “drinking causes problems for lots of people”.

You sense some potential difficulties in the air and choose to return the focus to their shared concerns about the future. You return to their health through discussion of their need to be strong and healthy grandparents and identify that Mona already has diabetes and Josiah is being treated for hypertension and intermittent gastritis. By the end of this session you feel that you have accomplished the primary task of developing a relationship based on a shared concern for the wellbeing of the family as a whole and of their daughter and prospective grandchildren specifically. They agree to come back to see you at the next clinic and also to have a “good, proper check-up” as well. You conclude the session by thanking them and commending them for talking so honestly.

Reflection

1. You organise for the local medical officer to undertake a full physical examination of Mona and Josiah. What examination will the medical officer most likely undertake and why?
2. What services and/or supports are likely to be available to Mona and Josiah to assist them in changing their behaviour?
3. What will you do to communicate your approach to this case to the other staff at the clinic?
4. What options are available to Felicia so that she has a “good future?”

References


Alice Morgan, Dulwich Centre Publications 2000


For more information on health outcomes for Aboriginal and Torres Strait Islander peoples go to: http://www.aihw.gov.au/publications/index.cfm/title/10234