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Two way approaches to Indigenous mental health training: Brief training in brief interventions

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Abstract

This study aimed to train health care professionals in a mental health assessment and care plan package designed for Aboriginal clients and carers and to evaluate the training and the package. The package has been developed over two years of consultation and encourages a collaborative, culturally appropriate approach to mental health assessment and care planning using motivational counselling techniques and relapse prevention strategies. Seventeen workshops were delivered in a range of settings to 261 service providers between 2006 and 2008. The training used the tools developed through the AIMhi 'Story Telling Project' and included multimedia resources, and activities designed to bridge the cross cultural and literacy gap in remote communities, including role play and skills practice. The training was well received and pre- and post-workshop evaluations show that participants found the workshops interesting and useful, and significantly improved in their confidence in assessment and communication, and their knowledge of early warning signs and treatment. The findings suggest a need in both the Indigenous and non-Indigenous workforce for further training, in both undergraduate and postgraduate settings, and in specialist and primary care.

Keywords

Indigenous mental health, mental health literacy, primary health care, social and emotional wellbeing, program evaluation

Introduction

In 2003-2004, Indigenous males and females were up to twice as likely to be hospitalised for mental and behavioural disorders as other Australians (Australian Bureau of Statistics, 2005) and recent comprehensive health surveys suggest high rates of mental distress in the community. The Western Australian Aboriginal Child Health Survey (Zubrick, Silburn, Lawrence et al., 2005), for example, indicated that 20.5 percent of 12-17 years old Aboriginal young people were at high risk of clinically significant emotional or behavioural difficulties.

Indigenous peoples from remote communities have particular difficulty accessing specialist services given issues of distance, language, and literacy (Bailey, Siciliano, Dane et al., 2002; Brock, Acklin, Newman et al., 1999; Cass, Lowell, Christie et al., 2002; Eades 2005). Furthermore, Indigenous peoples often have a

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different world view which further challenges accurate and sensitive assessment and treatment. They do not necessarily distinguish between wellbeing and 'physical' health or 'mental' health or 'cultural' or 'spiritual' wellbeing; instead, they have a 'whole of life' view (National Aboriginal and Torres Strait Islander Health Council, 2003).

The health workforce, which is predominantly non-Indigenous, is poorly equipped to meet these challenges: 'The health system, overall, does not provide the same level and quality of care to treat illness for Aboriginal and Torres Strait Islander peoples and is so culturally inappropriate or inadequately resourced that their needs cannot be met' (Australian Health Ministers' Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, 2004, p. 5). In the current context of increasing evidence of high prevalence of mental distress, there is a particular additional need and imperative to resource and train the mental health workforce.

Health professionals working across cultures have a responsibility to understand the dynamic relationship between mind, body and spirit, so as to accurately address the whole of health, and there is a need to blend traditional and modern ways of understanding and treating illness in order to develop services which are appropriate to Indigenous peoples (Kirmayer, Simpson & Cargo, 2003; McLennan & Khavarpour, 2004; Murray, Bell, Elston et al., 2002; Roxbee & Wallace, 2003; Trudgen, 2000).

While an understanding of Indigenous perspectives of mental illness, wellbeing and resilience is fundamental to delivery of effective mental health promotion programs and effective treatments, there has been little available to assist in service provider training. In 2003, a remote service provider survey in the Northern Territory (Nagel, 2006b) revealed that strategies for education of clients and carers were limited, and there were few culturally appropriate information resources available (Nagel, 2005).

The Australian Integrated Mental Health Initiative Northern Territory (AIMhi NT) has been working in a participatory action framework to explore mental health promotion strategies and treatments and to translate these to service provider training, and resources (Nagel, 2006a, 2006b; Nagel & Thompson, 2006a, 2007). This paper describes the findings of the evaluation of a series of training workshops delivered between 2006 and 2008 for service providers.

Method

Workshop development

The core AIMhi NT research team comprised three investigators. The principal investigator, a non-Indigenous psychiatrist, has lived and worked in the NT for more than twenty years. The two Indigenous associate investigators were a female Aboriginal Mental Health Worker (AMHW) of Walpiri-Gurindji heritage from an area south-west of Katherine, who works as a researcher and a part time service provider, and a male Indigenous research officer who is a Larrakiah (Darwin area) traditional owner. The content and format of training resources were informed by engagement with local Indigenous practitioners in a participatory action research model (Nagel & Thompson, 2007). These findings were then adapted through a collaborative process with stakeholders, and incorporated into a workshop which included video, flip chart and manuals.

A Workforce Development Working Party was established in 2006 and met by phone and email over three months. One face to face workshop was held in the development phase of the training. The training is described in detail in the manual and available on the AIMhi website (www.menzies.edu.au/AIMHI). While the format of the training changed somewhat according to the composition of the group, the level of skills and professional training, the content was relatively consistent.

Description of the program

Seventeen workshops of between two hours and two days duration (average duration of eight hours) were conducted between June 2006 and March 2008. Most (14 out of 17) workshops were invited by the organisations, which included government health services, tertiary training institutions and non government services. The course was delivered as two hour, half day, full day and two day training. This flexibility was recommended by the Working

Party and took into account the competing priorities of practitioners. Each participant received an accompanying training package for use during the course. The content is described in a course book in the '*Yarning About Mental Health*' training manual (Nagel & Thompson, 2006b) and covers the following topics: care planning, early warning signs, goal setting, risk assessment, mental state examination, and medication. The same instructors (TN and CT) taught all the courses, with some taught by one instructor, most with two and some with one or two Indigenous male Mental Health Worker co-trainers.

Ethical considerations

This project received the required ethics approval of the Menzies School of Health Research and Department of Health and Community Services Joint Ethics Committee. Qualitative data (such as direct quotes) have been de-identified to ensure anonymity.

Evaluation

The evaluation reported here was carried out with the first 261 course participants who gave informed consent. These participants were given questionnaires to self-complete at the beginning of the first session of the course (pre-workshop), and at the end of the last session (post-workshop). The pre-workshop questionnaire included sociodemographic characteristics of participants as well as experience, training, and current client load. Participants were next asked about confidence in assessment and treatment of Indigenous peoples with mental illness and knowledge of causes, treatment and early warning signs of mental illness. Knowledge and confidence were rated on a scale 1 (lowest) to 9 (highest). They were also asked to assess their own practice in terms of partnership with Indigenous peoples, treatment and causes. Participants were also asked whether or not they had been exposed to AIMhi training resources before. The post-workshop questionnaire presented the same questions with additional questions rating the course itself in terms of usefulness, interest, and building of partnerships.

Analysis

Wilcoxon Signed-Rank tests were used to compare pre- and post-workshop scores of confidence and knowledge. Qualitative data were grouped into categories and analysed according to themes.

Results

Participants' characteristics

Two hundred and sixty one service providers across three states participated in 17 workshops. The most common role identified was that of nurse (see Figure 1). Of the 56 participants who described their role as 'other' 10 were carer advocates, 10 were counsellors and other role descriptions varied from managers to support workers to trainees.

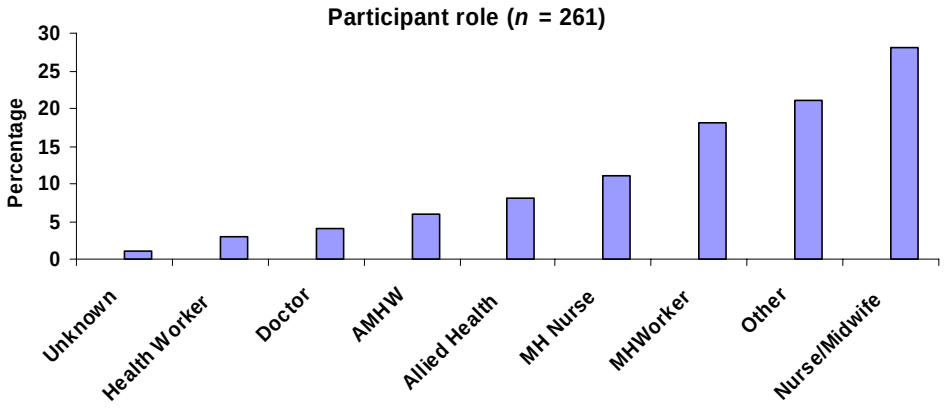

Figure 1. Participant role

Table 1. Participants' self-reported workplace experience and training

Experience and training	*n*	*(%)*
Number of clients currently treated		
0-5	112	*(43.1)*
6-10	42	*(16.2)*
11-20	32	*(12.3)*
>20	51	*(19.6)*
Unknown	23	*(8.8)*
Length of training in mental health		
< 2 weeks	84	*(32.3)*
2 weeks to 3 months	49	*(18.8)*
> 3 months	113	*(43.5)*
Unknown	14	*(5.4)*
Years of experience working in Indigenous mental health		
< 2 years	144	*(55.4)*
2-5 years	41	*(15.8)*
> 5 years	63	*(24.2)*
Unknown	12	*(4.6)*
Work in partnership with Indigenous colleagues		
None	54	*(20.8)*
Little	45	*(17.3)*
Some	64	*(24.6)*
Most	49	*(18.8)*
All the time	48	*(18.5)*

Experience and training of participants

Most participants (59.3%) were involved in care of fewer than ten current clients (see Table 1). Almost half (43.5%) of those trained had more than three months of formal mental health training. Most (71.2%) had been working in the field of Indigenous mental health for less than five years. A little more than a third (38.1%) were either not working in partnership with Indigenous colleagues at all or only a little of the time, and 37.3% were doing so most or all of the time In summary, participants identified themselves as having mental health training but little experience and small case loads. Most (61.9%) were working in partnership with Indigenous colleagues at least some of the time.

Prior experience of AIMhi NT resources

AIMhi NT has developed flip charts, video resources and information sheets for psychoeducation. The information sheets covered five topics: depression, mania, psychosis, anxiety and medication. Most participants had not seen or worked with AIMhi resources. The information sheets were the most frequently identified resource. Seventy one percent had not seen the flip charts, 85% had not seen AIMhi videos and 68% had not seen the information sheets prior to the workshop. This confirmed that the workshops were the only exposure to the AIMhi information and training that most people had received.

Confidence and knowledge

Knowledge and confidence were assessed at baseline and again after the workshop (see Figure 2). Two participant evaluations were excluded from the analysis as they were incomplete. The average *confidence* scores at baseline were 3.8 for cross cultural treatment (the lowest of all baseline scores), 3.9 for assessment, and 4.4 for communication. The average *knowledge* baseline scores were 6.0 for recognition of early warning signs, 5.9 for treatment, and 6.3 for causes of mental illness. Pre- to post-workshop comparison of confidence and knowledge was conducted using Wilcoxon Signed-Rank analyses. Significant differences were found on all measures apart from 'knowledge of causes' which suggested that the workshop improved confidence in assessment (z = -7.524, Prob>|z| = 0.000) and communication (z = -6.988, Prob>|z| = 0.000), knowledge of treatment (z = -2.023, Prob>|z| = 0.043) and knowledge of early warning signs of relapse (z = -2-256, Prob>|z| = 0.024).

Workshop evaluation

The participants were strongly positive about the workshop experience (see Figure 3). Over 80% reported that the workshops were useful and interesting and likely to build partnership, confidence and knowledge. Workshop experiences were described as follows:

'Wonderful work – thank you for the workshop and all your work to formulate this package – most inspirational.'

'Fantastic – very useful practical tools for my remote practice, good skill development, great engagement and goal setting.'

'Fabulous! Really appreciate the wisdom and training style of all facilitators. The sharing of stories and practice was a privilege. Thank you!'

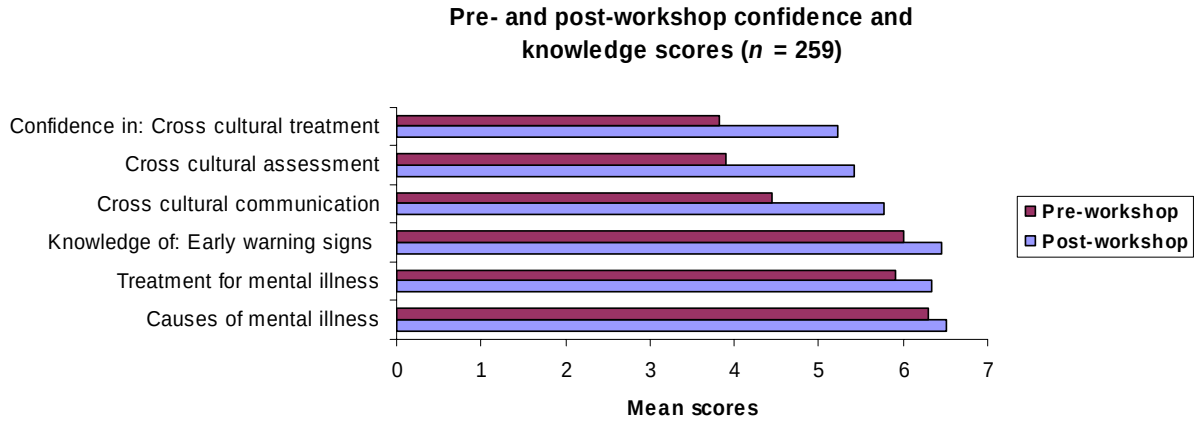

Figure 2. Pre- and post-workshop confidence and knowledge scores

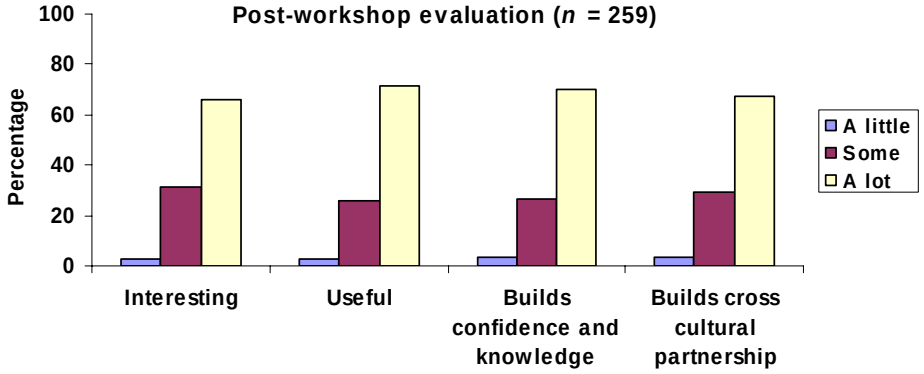

Figure 3. Post-workshop evaluation

Post-workshop comments

One hundred and seventy eight participants (68%) gave written comments in response to the question, 'Will you change your practice?' One hundred and fifty of these responses (84%) were clearly in the affirmative; for example:

'Very much so; I am excited about referring more patients to our Aboriginal Mental Health Worker – not just recognised patients with mental health problems but also others who may be at risk or need support and early intervention.'

'Definitely! I will be more involved in client-centered care instead of trying to find someone else to deal with the clients and their problems. Thank you.'

Twenty one of the responses (12%) were more equivocal; for example:

'I believe that this workshop and the AIMhi tools will be of some benefit and the development of the tool could be a dynamic process.'

'Subtly – more gently/more sensitive and less intrusive. We are all susceptible to mental illness as well as physical illness. Good reminder.'

Seven of the responses (4%) did not suggest a change in practice. Many of these responses nevertheless confirmed the approach to assessment and treatment outlined in the workshops by suggesting that the participant did not change because the principles of the workshop were already incorporated into their practice, for example:

'For me it rehashed a lot of knowledge and skills I already had.'

'Similar to my current practising now.'

Three month follow-up

Twenty two participants were followed up between 3 and 7 months later. Ten out of the 22 participants reported that they were using the flip charts and information sheets some or all of the time. While the small numbers at follow-up do not allow conclusions to be drawn about the translation of the training into practice, an example response to the question, 'Do you use the AIMhi resources?' was:

'Several times a day; really well thought out resources, presented beautifully, presenters were great; one of the best workshops I have ever been to.'

Discussion

This study reports the outcomes of brief mental health training developed through participatory action research in Northern Australia with Aboriginal Mental Health Workers and other stakeholders. The AIMhi training, delivered in flexible format to a range of different service providers, was assessed by participants as interesting and useful. The results show that the workforce attracted to the training tended to be inexperienced and low in confidence in assessment and treatment of Indigenous peoples with mental illness. Pre- to post-workshop scores showed significant improvement in confidence and knowledge related to Indigenous mental health, and qualitative data supported these positive outcomes. The overall findings indicate that a brief training of two hours to two days delivered in flexible format may have an impact on the capacity of the workforce to assess and treat Indigenous peoples with mental illness. The majority of participants reported that they will change their practice as a result of the workshops. The results do not show, however, to what extent the training is translated into practice or to what extent the effect of the training is sustained. Further research might confirm both sustainability and translation to practice, and seek to link the training with improved client outcomes. The findings suggest a need in both the Indigenous and non-Indigenous workforce for further training, in both undergraduate and postgraduate settings, and in specialist and primary care. The training and resources are publicly available through the AIMhi website (www.menzies.edu.au/AIMHI).

Acknowledgements

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