

INDIGENOUS MENTAL HEALTH

Tools and methodologies for investigating the mental health needs of Indigenous patients: it's about communication

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Objective: *To undertake a needs analysis to determine the quality and effectiveness of current mental health services to Indigenous patients within a health district of Southern Queensland. The present study focused on identifying gaps in the service provision for Indigenous patients. Tools and methodologies were developed to achieve this.*

Method: *Before commencement of the needs analysis, a review of related national projects was completed. The needs analysis entailed the development and distribution of two separate questionnaires. A major priority of the questionnaire for Indigenous patients was ensuring that effective communication and cultural respect was achieved. A steering committee of both Indigenous and non-Indigenous experts collaborated on this. The second questionnaire was for employees of the mental health service. Both questionnaires were designed to provide a balanced perspective of current mental health service needs for Indigenous people within the mental health service.*

Results: *The predominant issue that emerged and underpinned all the results was communication.*

Conclusions: *The present study has developed and used procedures for undertaking research involving Indigenous people. It has shown the importance of involving Indigenous people to help ensure successful communication, compliance and cooperation by Indigenous mental health patients.*

Keywords: *Aboriginal and Torres Strait Islander, communication, cultural awareness, Indigenous Australians, mental health.*

The National Aboriginal Health Strategy¹ highlighted the necessity for any health programme to be developed, owned and evaluated by local communities. Unless this occurs, community participation is unlikely and benefits will be minimal. Despite the strategy, mental health in Indigenous populations is still highly problematic as shown by subsequent publications. (*Note: To avoid misunderstanding and in keeping with cultural sensitivity, throughout the present paper we refer to Aboriginal and Torres Strait Islander people collectively as Indigenous Australians.*)

During the 1990s, three major national reports included issues related to Indigenous mental health services. These were the report arising from the Royal Commission into Aboriginal Deaths in Custody,² the Burdekin Report on Human Rights³ and the 'Ways Forward' document.⁴ All reports acknowledge the need for increased and improved mental health services for Indigenous people and identify significant shortfalls in existing services.

The report resulting from the Royal Commission into Aboriginal Deaths in Custody² made a number of recommendations specifically linked to Indigenous mental health as did the Burdekin Report,³ which looked at central issues affecting the mental health of Indigenous people, including their historical experience and the consequences of colonization. Both reports found that many mental health professionals have little understanding of Indigenous culture and society, resulting in frequent misdiagnosis and inappropriate treatment. It was concluded that mental illness among Indigenous Australians cannot be understood in the same terms as mental illness among non-Indigenous Australians because of their unique culture and their experience as a dispossessed people.

The 'Ways Forward' report⁴ followed the National Aboriginal Mental Health Conference in 1993, and incorporated many of the insights and recommendations supported by Indigenous participants at the meeting. It noted a high level of unmet need and that Indigenous people perceived mainstream health services as failing them. The report called for services that took into account the holistic value of health, spiritual and cultural beliefs.

The most recent publication regarding Indigenous mental health outlines the development of a pilot mental health service in Geraldton, WA.⁵ The authors identified inadequate management of those with mental illness in addition to many underlying factors impacting on the mental health of Indigenous people.

Similar surveys assessed the effectiveness of mental health service delivery to the ACT Indigenous community⁶ and the Northern Rivers Mental Health Service, Tweed Heads.⁷ Problems identified in these studies included a lack of Indigenous consultation into the project development, generalized questionnaires and limited resources. Findings in both studies were non-specific and focused only on current service deficits rather than including possible options for improvement.

Reforms undertaken within the Queensland Mental Health Service in a district of Southern Queensland recognized that cultural issues were of significant concern to Indigenous patients. Consequently, a major initiative commenced in 1999 to review the cultural safety of Indigenous people accessing the District Mental Health Service (DMHS). Cultural safety refers to making sure that cultural difference is respected. The purpose of the review was to assist with implementing the State and National Mental Health policies and plans that provided the framework for the reform of Mental Health Services throughout Australia and guided significant changes to the way mental health services were organized and delivered in this district of Southern Queensland.^{8,11}

The rationale for this project was twofold: (i) to identify issues in service delivery; and (ii) to develop strategies to facilitate the implementation of national and state policies for Indigenous mental health service delivery at a local level.

An Indigenous mental health needs analysis was developed by the DMHS in collaboration with the University of Queensland to determine the quality and effectiveness of mental health practice in relation to Indigenous patients. The project involved consultation among Indigenous mental health patients, their families, community members, staff within the DMHS, other key service providers and stakeholders, and enabled the development and recommendation of strategic directions for future Indigenous Mental Health Service Delivery.¹² The needs analysis served to identify strategic directions to improve mental health service delivery for Indigenous people accessing the service. At no time did the present study attempt to look at the prevalence of mental illness of Indigenous people, but focused on identifying currently unmet needs for Indigenous patients of the mental health service.

The aims of this needs analysis were to: (i) review the quality of current mental health service delivery to the local Indigenous community within the DMHS; (ii) gather information that assists in the development of culturally sensitive mental health service provision; and (iii) facilitate consultation with Indigenous patients, carers and communities, mental health staff and other key service providers in relation to future directions of Indigenous mental health service delivery.

The present paper describes the methods used and tools developed to undertake the assessment of these needs and presents the major finding of the study. The project received ethics approval before commencement.

Establishment of a steering committee

A Walaag (Mental Health) Steering Committee (consisting of psychiatrists, psychologists, Indigenous mental health workers, public health officers and nurses) was authorized by the DMHS to develop and oversee the needs analysis. The steering committee was charged with the responsibility of gathering views on current service provision as well as potential solutions to identified problems. The project secured appropriate resources, including staff time, to complete the project.

Identified geographical area for study

The DMHS area includes a city of approximately 100 000, in addition to a large area of surrounding rural communities and a number of smaller towns in south-east Queensland.

Target study groups

Two populations comprised the target study groups: (i) Indigenous participants, including patients (current patients of the Extended Inpatient and Acute Mental Health Unit), their families or carers (identified by the patient or treating team); and (ii) staff participants, all employees of the DMHS, including both clinical and non-clinical staff.

Questionnaire development

Questionnaires were developed through community consultation with local and regional Indigenous groups and the steering committee. For Indigenous participants, priority was given to achieving culturally appropriate wording and adapting the language so that it would be fully understood. This was accomplished in part through the review of previous surveys, and included information gained from a Dual Diagnosis Symposium.¹³ The questionnaires were piloted by patients and staff members and revised to ensure comprehension was acceptable.

Staff questionnaire recruitment and distribution

All data were collected over a 3 week period in a deidentified format. Staff questionnaires were addressed personally to all DMHS staff and included a stamped return addressed envelope. Posters in wards and in community hospital areas, presentation to business unit meetings and advertisements in hospital newsletters promoted the study and a reminder letter was distributed in the second week.

Indigenous questionnaire distribution

The project aimed for completion of the questionnaires by approximately 100 Indigenous participants. Indigenous research assistants were recruited from the DMHS and allowed to work on the project for 2 weeks. They administered the questionnaires personally with Indigenous participants (taking approximately 20 min). Indigenous research assistants worked in pairs within the community or alone if within the participating health service units or clinics. They wore an identification badge and provided ethics documentation when potential research participants were approached.

Research assistant training

Because of the importance placed on effective communication with the Indigenous participants, training was provided to the research assistants through a half-day session coordinated by two members of the steering committee who had experience in questionnaire administration and Indigenous mental health. Training issues included:

- background to the project and its objectives;
- the questionnaire – its history, types of questions, how to ask the questions and record the answers;
- identification of organizations for accessing participants;
- giving information about the project and seeking consent for the interviews;
- handling difficult situations;
- methods to minimize bias;
- record keeping; and
- the importance of maintaining confidentiality.

Indigenous participant questionnaire collection

Indigenous research assistants approached potential participants to explain the purpose of the study. Following review of the covering letter and provided consent was obtained, the assistant gave the participant the questionnaire to complete. Assistance was given only if requested (where literacy problems existed). Following completion, the participant sealed the questionnaire in an unidentifiable envelope. A copy of the covering letter and consent form were provided.

Data analysis

Results were analysed using SPSS to obtain frequency and descriptive data.

Of the 671 questionnaires distributed to DMHS staff, 164 were returned (24%); 65% of these were females. No data are available for the age range of the staff respondents.

Research assistants completed questionnaires with 126 Indigenous participants (41% female), all of whom complied with the request for participation. Of these 126 Indigenous participants, 45 (36%) were patients, the remainder representing family members or friends. There was a wide variation in age, ranging from 16 to more than 55 years. The majority (92.6%) identified themselves as Aboriginal, 0.8% identified as Torres Strait Islander and 3.3% as Aboriginal Torres Strait Islander. The remainder (3.3%) identified as being of South Sea Island descent and were included in the present study.

The predominant message that emerged from the needs analysis and that underpinned the results from both questionnaires was 'communication'. A series of questions dealt with issues of communication between mental health service staff and Indigenous participants. Sixty-four per cent (n = 29) of the patient participants indicated that they asked to be included in their treatment, yet 73% (n = 33) reported that they had no say in this. Furthermore, the majority (79%, n = 34) did not understand the information given to them about their illness. Table 1 illustrates the results of these and other questions dealing with communication issues and indicates a need for better communication in general and more inclusion of Indigenous patients and their families in treatment and care. Likewise, responses by family members and friends support the patient perceptions (Table 1).

When staff were asked if they believed the DMHS was meeting the needs of Indigenous people in the district, 53% responded 'yes', but when asked if the DMHS manages Indigenous people with cultural sensitivity, the most frequent response was 'sometimes' (42%). In contrast, when staff were asked to prioritize from a list of those strategies which would assist with meeting the mental health needs of Indigenous people, 'using language that Indigenous people understand' was chosen by only 9.3% (n = 12) and was ranked third out of nine options available. Strategies that were ranked higher included 'establishing more Indigenous mental health staff' (42%) and 'developing culturally appropriate information and policies' for Indigenous people (12%).

The present paper is part of a larger survey that looks at the mental health service needs of Indigenous people. It describes the procedure for undertaking this survey in two target populations, the Indigenous participants, including patients and their families, and the DMHS staff. The present study has developed procedures through an iterative process with patients for undertaking research involving Indigenous people. It has shown the need for appropriate input by them to assure successful communication and complete understanding of the questions necessary for this research. These efforts also ensure that Indigenous cultural concerns are respected and appropriate guidelines are adhered to in order to achieve successful compliance and cooperation by Indigenous participants. Attention to these, sometimes sensitive issues is likely to result in more valid research outcomes and a better understanding of the mental health service needs of Indigenous people.

Issues surrounding communication were a predominant finding and results show discrepancies in the views and perceptions of our two study groups regarding the mental health needs of Indigenous people. These discrepancies point strongly to a major gap in communication between mental health staff and Indigenous patients. This lack of communication is related to awareness of cultural practices and sensitivity to try to improve this situation.

Communicating with Indigenous mental health patients is problematic and consideration of the powerful link between communication and trust becomes a vital component of their care. This concurs with the view that although the last decade has seen a greater emphasis placed on communication with Indigenous patients in practice, the reality is that misunderstanding and miscommunication in mental health treatment and care is common and results in negative experiences for patients and carers.¹⁴ For example, the results showed over half of Indigenous patient participants asked to be involved in their treatment regime, yet of these respondents the majority reported that they had no say at all in their treatment. The perceptions of family members are in agreement and further suggest a significant communication problem requiring attention.

Likewise, these perceptions indicate that Indigenous mental health patients do not understand the information being provided to them, because it is in language they cannot understand. Staff agreed on this point, but did not rank it highly as a way of helping to meet Indigenous patient needs. This provides support for efforts to address this situation by adapting language, both written and oral, to adhere to cultural sensitivity and

understanding. The research methods followed in the present study have shown that attention to this important issue results in successful compliance and understanding among Indigenous participants.

The powerful link between communication and trust is a vital component of the well-being of Indigenous mental health patients.¹⁵ The present study has shown that effective communication and attention to cultural sensitivity can be achieved through collaboration with Indigenous people throughout the research process.

The present study is not without shortcomings. A recognized limitation is that the Indigenous participants comprised a convenience sample and represent not only mental health patients but family members also. This was necessary because of limited access to Indigenous participants. It should be noted, however, that the present study was successful in its attempt to involve Indigenous people in all aspects of the research process. As such, it has provided valuable albeit limited information to help improve mental health service delivery to Indigenous people.

Where to from here? The results presented have focused on the methodology and the predominant issue of communication in relation to the mental health needs analysis. The future direction of the present study and associated objectives include:

- formulation of a service improvement plan for the Indigenous mental health service;
- development of a model of service delivery that is effective and responsive to the mental health needs of the Indigenous communities; and
- cultivation of models of effective workplace support and cultural supervision for Indigenous mental health professionals.

Outcomes from this needs analysis have already been implemented by the DMHS and include the employment of more Indigenous mental health staff and holding an Indigenous Mental Health Conference in December 2004, with another planned for 2006.

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