Trish Nagel
MBBS, PhD, FRANZCP, is Consultant Psychiatrist, TEMHS, and Senior Lecturer, Flinders University, Menzies School of Health Research, Darwin, Northern Territory. trish.nagel@nt.gov.au

Carolyn Thompson
Cert III Community Service, BITE, AssocDipCommMgmtDev, is Senior Indigenous Research Officer, Healing and Resilience Division, Menzies School of Health Research, Darwin, Northern Territory.

Motivational care planning

Self management in indigenous mental health

Background

Detection and treatment of mental illness in indigenous communities is often complicated by cross cultural difference, social complexity and comorbid disorders.

Objective

This article discusses the development of self management skills in mental health, with particular reference to the use of brief interventions in remote indigenous communities, and highlights qualitative findings of a recent study which sought to integrate these interventions into a practical approach to treatment.

Discussion

Shifting to a self management and recovery orientation of mental health services has proven to be challenging. The challenges to autonomy and ownership of treatment plans are even more manifest for indigenous people. Therefore, there is a need to focus on effective and efficient brief interventions that promote self management.

■ **Self management is a broad set of strategies designed to help individuals with chronic conditions make day-to-day decisions about their illness.[1] Training patients with chronic disorders to self manage their disease has been shown to improve outcomes in both physical and mental illness.[2,3] However, in time and resource poor remote and rural settings, there is clearly a need to focus on brief interventions that not only promote self management, but are also both effective and efficient.**

A number of brief therapies have been used successfully, alone or in combination, to enhance self management skills. These include: motivational interviewing (MI), brief interventions, goal setting and problem solving therapy (PST). Shifting to a self management and recovery orientation of mental health services in general has proven to be challenging.[4] The challenges to autonomy and ownership of treatment plans are even more manifest for indigenous people where racism persists and miscommunication abounds.[5,6]

Motivational interviewing

Motivational interviewing is widely used as an adjunct to treatment for substance misuse with successful results.[7]

Brief interventions

Brief interventions are a collection of techniques that include motivational interviewing, as well as feedback to patients of likely adverse consequences of drug use, self monitoring of use, developing a contract for future use, providing strategies to cut down drug use, and regular follow up. A systematic review and meta-analysis of primary care indicated that brief alcohol intervention was effective in reducing alcohol consumption.[8]

Table 1. Summary of five most frequent responses in each category[12]

Strengths	Worries	Goals	Steps
Good tucker	Family worry (I do things which worry my family)	Cut down on alcohol/marijuana use	Family support
Hunting/fishing	Family self harm	Worry about family (family do things which worry me)	Change in use of alcohol/marijuana
Family	Sadness	Hunting/fishing	Go hunting/fishing
Dance (traditional dancing linked with ceremony)	Smoking	Work	Cultural activity (such as sitting down with elders)
Exercise	Too much alcohol/marijuana	Culture (such as learning ceremony, weaving baskets)	Seek work

Problem solving therapy

Problem solving therapy has been described as the most accessible form of psychological intervention for primary care practitioners.[9] It provides a framework for coping with ongoing life stressors by encouraging the patient to identify specific problems and then formulate specific solutions. A recent meta-analysis showed that PST was effective, although further research was needed to clarify which conditions might maximise its effectiveness.[10] This approach emphasises patient self management and autonomy, encourages patient centred solutions, and requires little training or ongoing supervision.

Goal setting

Goal setting is another important strategy for care planning and self management. Collaborative goal technology, for example, uses principles of goal setting and motivation in a structured approach to treatment of people with chronic mental illness. It draws on goal setting theory and identifies key aspects of successful goal setting as:
• feedback
• commitment to the goal (which is enhanced by self efficacy and viewing the goal as important)
• task complexity (the complexity matches patient ability), and
• situational constraints (the goal is achievable).[11]
The development of the Australian Commonwealth Government's Better Access initiatives, and the focus on goal setting within General Practitioner Mental Health Care Plans, is an important step toward improved outcomes.

Self efficacy

An 'active ingredient' of self management therapies, and a key predictor of success in problem solving and self management, is self efficacy – the belief in one's capability to make change. The high prevalence of emotional distress in indigenous communities, and the limited access to services in rural and remote settings, demand that as GPs, we make every clinical moment count. No care plan will succeed without the motivating factors of personal meaning and personal empowerment. The challenge to GPs working with indigenous patients is to work in partnership with indigenous practitioners, patients and their families wherever possible, and to discover the personal meaning that will drive successful behaviour change.

The evidence for effective treatments in indigenous mental illness is sparse and there are few guidelines to support the clinician's decision making framework. A recent study in remote indigenous communities sought to integrate these models into a practical approach to treatment.[12] The study design and outcomes are reported in more detail elsewhere.[14–16]

The study

The study was conducted by the Australian Integrated Mental Health initiative (AIMhi) in the Northern Territory and was designed to explore the effectiveness of a self management intervention in indigenous mental health. It was conducted in two remote indigenous communities in the NT where traditional lifestyles are changing in response to a range of dominant societal influences.[12] The study used a mixed methods design. The initial qualitative phase of the study focused on understanding local perspectives of mental health through collaboration with local Aboriginal mental health workers (AMHWs). These perspectives were then incorporated into a brief intervention, which was compared with 'treatment as usual' using an 18 month repeated measures design, with randomly allocated early and delayed treatment groups.

Qualitative data were gathered concurrently with the randomised controlled trial and integrated into the final analysis.[3,17] The qualitative data allowed the opportunity to understand personal experiences of patients and AMHWs (ie. the 'emic' or insider's viewpoint), and provided rich description of their local context. This understanding was used to promote engagement, motivation and meaningful care plans.

The study recruited 49 indigenous patients with mental illness and 37 carers. The average age of participants was 33 years; participants were diagnosed with psychotic and depressive illnesses; 40 out of 49 participants used alcohol or marijuana; and most were psychologically dependent on one or the other or both of these substances.[12]

The brief intervention

The brief intervention consisted of two treatment sessions 2–6 weeks

apart and integrated problem solving, motivational therapy and self management principles. Local AMHWs and carers were engaged in treatment wherever possible. The key cultural adaptations were threefold: focus on family; 'whole of life' approach to strengths and stressors through exploration of 'spiritual and cultural', 'physical', 'social and family', and 'mental and emotional' domains; and the use of a supporting pictorial tool. The average length of treatment sessions was 50 minutes.

The first step in the intervention involved discussion about important and supportive family members, and the second and third steps involved review of participant strengths and stressors by looking together at pictorial tools. The final goal setting phase explored one or two goals, and steps to those goals, which were immediate, circumscribed, achievable, and relevant to that person.

The second session, 2–6 weeks later, reviewed the progress to goals, explored barriers to goal achievement, and developed new strategies as appropriate. Two brief psychological education videos were shown in each session with distribution of matching handouts.

Table 2. Words and stories used to describe worries which take away strength[12]

'Nowadays wrong food…doing wrong things we forgot our cultural ways... too much grog and gunja… families not close… bring back old ways' (H, I)
'That mortuary (totem) pole shows how the stories are passed down from the elders to the children to teach them how to behave. Nowadays we can't pass those stories on because life has changed and the old people don't know how to teach those kids... and the mortuary pole is broken' (B–F)
'Yeah… all that past. About my people… about going out hunting and the corroborees …and everything that we used to have… all that have been faded away. That kept me strong in my life' (H)
'Big problem… wrong way marriage… kids not respecting their elders' (B–F)
'She should get a job… she only walk for gunja' (A)
'It makes me strong that I gave up drinking and drugging nearly 4–5 years now' (J)
'Back in my time when I used to see my people spearing each other to death alcohol destroyed my people and then gunja was introduced later on... alcohol and petrol sniffing in my time… that would take my strength away I used to see people fighting each other' (H)
'Need to close club or put it away from town… have a four can limit' (B–F)
'Helping my clients and my people in this community… bush medicine it helps but it's not enough. We haven't got the right tools. That's why we need nonindigenous medicine to come and help us there as well' (H)
'Thinking... awake all night… even during the day I would stay inside all the time. That affected me really inside of me – it was really… bad' (H)
'I don't know how I got sick but by looking it was relationship problem and family humbug as well it's like when kids see their parents when they fight the kids they come into the stage where they can't handle themselves that's when the mental health illness gets developed inside of them' (H)
'How did it begin? Through my mental illness I had a bit of a problem that I wasn't working, and I kept bludging on other people – that make me more sick. And especially the drug and alcohol got me causing that – so I have suffered from manic depression and mental illness' (J)
'Big problem with jealousy between men and women if they are all at the club' (B–F)
'If that person doesn't want that story to go round, if she hears that stories been going round this community she'll get upset and her family and his family will go along asking and people and that problem will get bigger and bigger' (H)
'All things on top of you whatever the problem is deep inside small problem that you want to try and get at… holding you up' (H)
'How it affected me… like I tried to harm myself a couple of times. I even overdosed myself with anything, trying to get rid of myself. It's all those bad things that came into my life that really affected me, and I didn't know that I had this depression within me. The way it affected me was my appetite. I wasn't eating enough food… I wasn't sleeping at night. Thinking... awake all night… even during the day I would stay inside all the time. That affected me really inside of me – it was really… bad' (H)
'Like I feel really scared like someone is doing a lot of threats on me, like someone is cursing me, you know. I had a lot of things in my mind – that I gonna self harm to myself' (J)
* A–K represent 11 individual informants – 10 mental health workers and one patient

Table 3. Clinician rated progress toward goals between treatment sessions[12]

Progress toward goal (%, n=32)	None	Little	Some	A lot	Achieved
Goal 1	6	18	14	47	16
Goal 2	16	26	3	23	32

Table 4. Examples of goals and the steps needed to reach that goal

Goal	Step 1	Step 2	Step 3	Step 4
I want to do more fishing and hunting	Talk to my nephew about going hunting and fishing more	Save money for hand line	Walk to the beach once a week on the weekend	Hunt behind the airstrip with my brother on Saturday
Strategy	Family support	Hunting/finances	Hunting	Hunting/family support
I want to cut down gunja	Make up my mind	Talk to aunty	Say wait to friends, smoke less	Buy fishing line instead of gunja next pay
Strategy	Thinking differently	Family support	Limit use	Control spending/hunting/gunja
I want to learn more culture law	Sit with aunty	Talk old language with grandfather	Go to ceremony to learn	Teach children old language
Strategy	Culture/family support	Culture/family support	Culture	Culture/teaching children
I want to change medication	Go home and take medication	Check increased dose with nurse	Put reminder to take it on fridge	
Strategy	Mental health treatment	Mental health treatment	Mental health treatment	
I want to know more	Watch 'cross roads' DVD (about substance misuse)	Read flip charts		
Strategy	Knowledge	Knowledge		
I want to do more culture	Walk out bush and get pandanus leaves and dye	Make a mat or basket instead of playing cards	Ask at the shop or the women's centre about needles	Buy needles for weaving
Strategy	Culture	Culture	Culture	Culture

The four step intervention incorporated many of the principles of motivational interviewing. Empathy and rapport were established through a 'family map' and discussion of strengths. At the same time these two steps began the process of cognitive dissonance or discrepancy through contrasting the 'strengths' ('where the patient wants to be') with self identified stressors. The pictorial nature of the tool encouraged open questions and a nonconfrontational approach.

Study results

There was a high level of engagement and retention in the study. Seventy-four percent (35) of participants were followed up at the final assessment point 18 months later and 90% (44) received at least one treatment session. An average of three goals per patient were chosen over the course of two treatment sessions. The two most frequent goals chosen were 'cutting down' or 'stopping' alcohol or cannabis use, and changing 'family worry' or 'family humbug' (fights and arguments). An average of four steps was chosen to reach those goals. The most frequent steps chosen were 'family support', for example, 'talk to my nephew about going hunting', and changing alcohol or cannabis use, for example, 'buy food before grog'. These goals and steps reflected closely the strengths and worries reported by both patients and AMHWs (*Table 1, 2*).

A clinician rated assessment of progress at the second treatment session found that nearly one-third (32%) of patients had achieved their second goal after only one treatment session (*Table 3*). 'A little' progress recognised thinking and planning about making change, 'some' progress recognised completion of at least one step toward the identified goal, and 'a lot' of progress was noted if two or more steps were completed (*Table 3*). *Table 4* and the *Case study* provide more detail of the goals, steps and life changes that the participants were choosing to make.

Case study – Robbie's story

'Dad, Auntie, Katie Jean and Paula help to keep me strong. Strong things I like to do are to go hunting and fishing, to dance in Aboriginal ceremony, and do my hobbies like art and music.

Things that take my strength away are arguing with my brothers about money, increased mood and energy, physical illness, family worries, violence, thoughts of self harm, and suicide.

Strong changes I want to make are to go hunting more with my Dad, and to work at the art centre. I want to talk to Dad about going hunting more, I want to talk to Nick at the art centre about stretching canvases, and I want to talk to Centrelink too, about working casual hours. And I want to stop arguing so much with my brothers about money, I want to stop borrowing and lending and keep my money in the bank'.

Follow up

At 6 month follow up Robbie reported that he had paid off his debts, and managed to stop fighting with his brothers over money. He had increased his hours of work at the art centre and was taking an exhibition of his artwork interstate. At the next visit he reported that he had sold three paintings for $1000 each and had put the money in the bank.

Figure 1. Four step intervention used in AIMhi training and resources
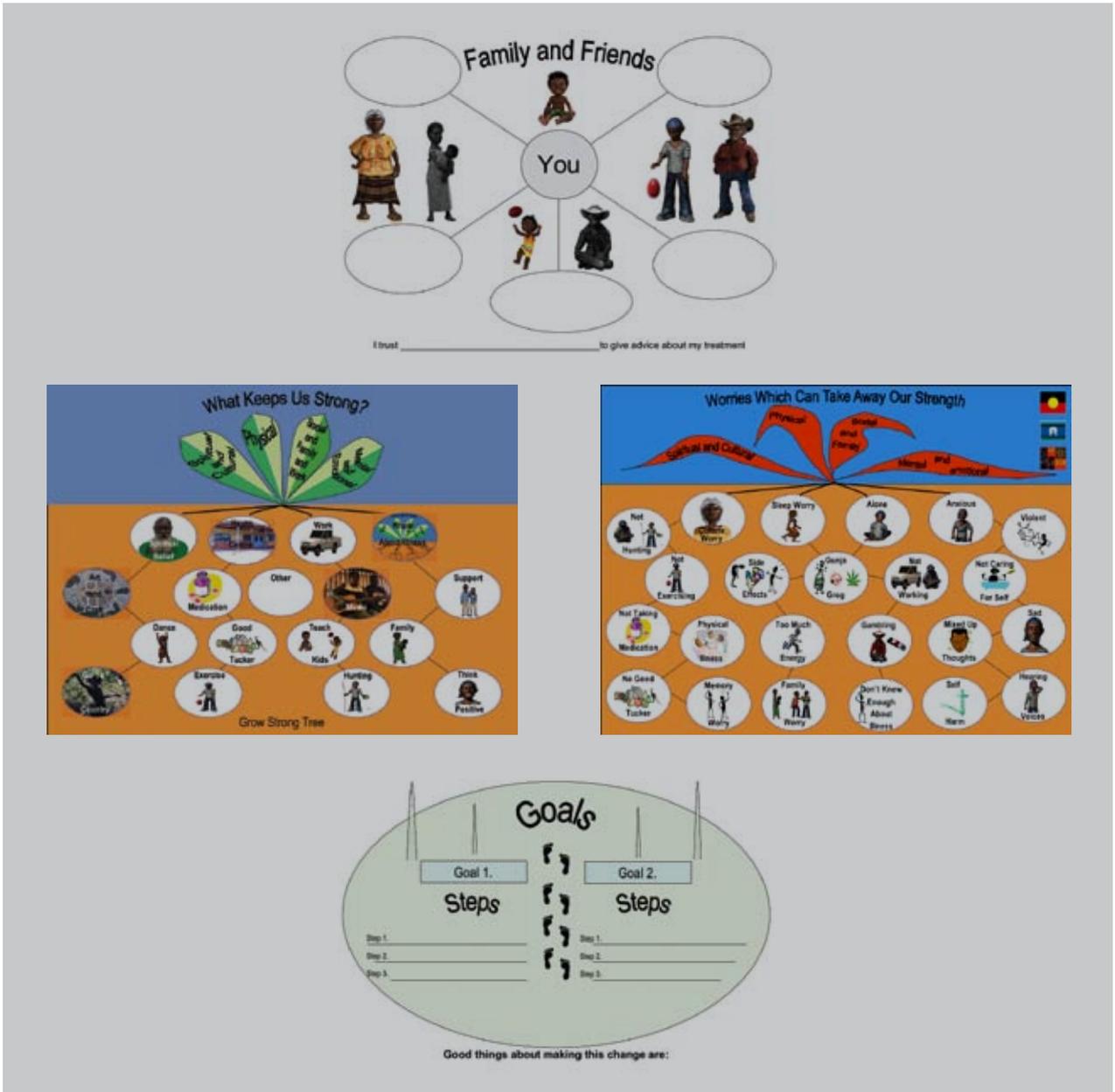
Discussion

The study findings suggest that goal setting is an acceptable self management strategy for indigenous mental illness and gives insight into the values of the patients in the study, and the strategies they chose for change.[12] The approach incorporated key principles of established brief therapies, while emphasising family and 'whole of life' strengths and stressors.

This intervention provides another resource for the 'tool kit' of GPs seeking to promote behaviour change in their patients. The findings have since been incorporated into publicly available tools, resources and training for both primary care and specialist practitioners (*Figure 1*).[18]

Summary of important points

- There is a risk that the overwhelming nature of indigenous social disadvantage and the complexity of illnesses can lead GPs to underestimate the value of individual action.
- Individual action and self efficacy, as represented by simple achievable steps and goals, may represent important and powerful enablers of change.
- The results of this study strengthen the evidence for brief interventions, which address comorbid disorders in an integrated approach. They can be effective, even in acutely unwell populations.
- The study also contributes a framework and tools to guide practitioners in culturally adapted assessment and treatment.

Resource

Nagel T. Auseinet – Recovery on-line toolkit. Available at http://auseinet.flinders.edu.au/toolkit/rec_exmpl.php.

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References

1. Jordan J, Osborne R. Chronic disease self-management education programs: challenges ahead. Med J Aust 2007;186:84–7.
2. Hibbard JH. Engaging health care consumers to improve the quality of care. Med Care 2003;41(Suppl 1):61–70.
3. Mueser K, Corrigan P, Hilton D, et al. Illness management and recovery: A review of the research. Psychiatr Serv 2002;53:1272–84.
4. Rickwood D. Recovery in Australia: Slowly but surely. AeJAMH 2004;3:1.
5. Eley D, Hunter K, Young L, Baker P, Hunter E, Hannah D. Tools and methodologies for investigating the mental health needs of Indigenous patients: it's about communication. Australas Psychiatry 2006;14:33–7.
6. Kowanko I, de Crespigny C, Murray H, Groenkjaer M, Emden C. Better medication management for Aboriginal people with mental health disorders: a survey of providers. Aust J Rural Health 2004;12:253–7.
7. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. Am J Health Promot 1997;12:38–48.
8. Bertholet N, Daeppen J, Wietlisbach V, Fleming M, Burnand B. Reduction of alcohol consumption by brief alcohol intervention in primary care: Systematic review and meta-analysis. Arch Intern Med 2005;165:986–95.
9. Hickie I. An approach to managing depression in general practice. Med J Aust 2000;173:106–10.
10. Cuijpers P, van Straten A, Warmerdam L. Problem solving therapies for depression: a meta-analysis. Eur Psychiatry 2007;22:9–15.
11. Locke E, Latham G. New directions in goal-setting theory. Curr Dir Psychol Sci 2006;15:265–8.
12. Nagel T, Robinson G, Condon J, Trauer T. An approach to management of psychotic and depressive illness in indigenous communities. Aust J Prim Health Care 2008;14:17–21.
13. Nagel T. Relapse prevention in Indigenous mental health. Darwin: Menzies School of Health Research and Charles Darwin University, 2008.
14. Nagel T, Thompson C. AIMHI NT 'Mental health story teller mob': Developing stories in mental health. Australian e-Journal for the Advancement of Mental Health 2007;6:2.
15. Nagel T. The need for relapse prevention strategies in top end remote indigenous mental health. Australian e-Journal for the Advancement of Mental Health 2006;5:1446–7984.
16. Nagel T. AIMHI NT Relapse prevention trial. Available at http://clinicaltrials.gov/ct/show/NCT00192582.
17. Stange K, Crabtree B, Miller W. Publishing multimethod research. Ann Fam Med 2006;4:292–4.
18. Australian Integrated Mental Health Initiative Northern Territory. AIMhi NT. Available at www.menzies.edu.au/AIMHI [Accessed August 2008].