Developing mental health rehabilitation services in a culturally appropriate context: an action research project involving Arabic-speaking clients

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Abstract

The present study illustrates the efforts by a community mental health service to restructure the Mental Health Rehabilitation Program to meet more adequately the needs of the Arabic-speaking population. It was discovered that the principles of mental health rehabilitation theory are inherently Anglo-Australian and not suitable for the Arabic-speaking population. Action research methodology was used as a tool to drive the changes necessary to implement effective mental health rehabilitation across cultures. Two new culturally relevant programs were developed, staff attitudes to rehabilitation were changed and assertive strategies were introduced to alter clients' attitudes and perceptions about mental health rehabilitation.

Introduction

It was observed that Arabic-speaking clients used only acute and case management components of the mental health service (at a rate proportional to their representation in the total community), and were virtually absent from any involvement in the mental health rehabilitation program. Funding was therefore obtained from the National Mental Health Reform and Incentive (Transitional) Program, to investigate why Arabic-speaking clients did not use the mental health rehabilitation program and to introduce changes to improve the level of utilisation.

Literature review

Minas (1992; 1996) reported a generally higher prevalence of mental disorders among migrants from Non-English Speaking Backgrounds (NESB) than among Australian-born communities or among English Speaking Migrants (ESB). He also noted a consistent pattern of under-utilisation of inpatient and community mental health services in NESB groups. This latter finding was also reported by Zigouras (1993), who attributed it to lack of knowledge of the service, inappropriate

staffing or programs, and lack of referral from hospitals. It is recognised that NESB clients are more likely to live with their families, and hence more attention needs to be paid by mental health services to work with spouses, parents and other family members of NESB groups (Minas 1996, Zigouras 1993).

Mental health rehabilitation services are designed to address the specific disabilities within individuals, which may result from mental illness, and to improve role performance within living, learning, working and social environments (Anthony 1993). At the time of commencement of the project, the mental health rehabilitation program was broadly following the rehabilitation approach described by Farkas, Cohen and Anthony (1988). It contained the elements of individual assessment and goal setting; and individual and group programs which were aimed at social, communication, domestic, leisure, vocational and self-care skills enhancement. It also contained symptom/stress management, problem solving and community awareness, family education and support, and liaison with community organisations.

It was apparent that the current program was not meeting the needs of the Arabic-speaking group of clients in the service, as was evident from their non-attendance. Whilst it is recognised that there are differences within individuals with similar levels of disability in terms of their readiness to engage with rehabilitation programs (Anthony 1996), it seemed unlikely that this explanation could be ascribed to the whole group of Arabic non-attendees. This led the management of the service to seek understanding of what might be the issues for the group and to embark on organisational change in response to these.

It was recognised that the tool to drive organisational change must be participatory in order to engage staff in what is essentially a modification of their work practice (Tobin, Dakos and Urbanc 1997). In many community-based mental health services, there is a culture of professional autonomy. Hence the introduction of new concepts, even when accompanied by strong staff development opportunities, do not automatically lead to changes in clinical practice (Kavanagh 1994). These changes require implementation of new models of service delivery. The action research methodology has been demonstrated to be a useful tool for this type of change, in organisations (Prideaux 1993), in community based mental health services (Tobin, Dakos and Urbanc 1997), and in psychiatric rehabilitation services (Rogers and Palmer-Erbs 1994). It was considered to be appropriate for use in this project.

Service context

Canterbury is a geographically defined district in inner western metropolitan Sydney with a population of approximately 90,000. The 1991 census by the Australian Bureau of Statistics (ABS) showed that 65.6 per cent of the population were from a Non-English Speaking Background (NESB), and did not speak English at home. One of the most common language groups was Arabic, which accounted for about 25% of the total population.

The Canterbury Community Mental Health Service is a multicultural mental health service. Services provided include intake and assessment, 24-hour crisis management, case management, counselling and psychotherapy. Approximately 800 clients were registered with the service and active at the time of the project in 1995/6. One hundred of these clients were participants in the community mental health rehabilitation component. None of the 100 clients were from the Arabic-speaking community.

The rehabilitation centre had a staff of psychologists, occupational therapists, social workers and psychiatric nurses. It provided a day program, an evening social and leisure component, a work program, accommodation and intensive community support activities.

The aims of the project were (1) to understand what were the barriers preventing Arabic-speaking clients from utilising the mental health rehabilitation program, and (2) to implement strategies to reduce these barriers, thus improving utilisation of rehabilitation services by this client group.

Method

Engagement of mental health staff

The project was overseen by a steering committee, which comprised of the Area Director of Mental Health, Clinical Manager of the service, Co-ordinator of Rehabilitation program, representative staff of the service, the Arabic-speaking bilingual mental health counsellor and the Arabic-speaking project officer. It was impossible at the commencement of the project to interest Arabic-speaking consumers in participation in the steering committee. Thus consumer input to the project was obtained by direct consultation between consumers and their families and the project officer.

All staff from both the case management and rehabilitation programs of the mental health service were involved in a regular review of the findings at various stages of the project. A monthly staff meeting was the forum for this continuing discussion. At these meeting the findings from interviews with staff, consumers and families, and external referrers were outlined, and their meaning for staff, and the implications for service change were debated in an iterative way. For example, the early realisation of inadequate understanding within the Arabic speaking community of the concept of rehabilitation, resulted in the development of simple educational materials for the project officer to use with consumers and families. This encouraged initial engagement of interest by the mental health rehabilitation program staff. Once engaged, these staff were able to achieve greater flexibility in the organisation of the supported work program. This allowed the trialling of the young Arabic-speaking men's group.

Identification of the cohort

Fifty Arabic-speaking clients of the mental health service who had long term mental illness were identified from case files. They were all receiving mental health case management and had some level of chronicity in their illness or disability. Of the 50 clients, 34% (17) had a diagnosis of schizophrenia; 12% (6) had bipolar affective disorder; 28% (14) had a major depressive disorder and 26% (13) had miscellaneous diagnoses. On the basis of disability or role dysfunction, they were thought to have a potential need for rehabilitation. The three major needs groups were determined from discussions with consumers. These were (i) young men with schizophrenia who required a work role (N=13); (ii) women with either schizophrenia or affective disorder who required recreational and social support activities (N=10); and (iii) families who requested education and support services (N=8). These were the foundation for the development of the trial programs.

Understanding of the reasons for non-engagement

Semi-structured interviews were conducted with approximately 50 consumers, 30 family members, 10 referring agents (including primary care doctors and private specialist mental health providers), three Arabic community leaders and 15 community mental health staff. The goal of these interviews was to assess the current levels of understanding of mental health rehabilitation, its relevance to Arabic-speaking clients, and their stated reasons for non-engagement. The Arabic-speaking project officer conducted the consumer and carer interviews in the homes of the consumers and in the offices of external referrers. Notes were recorded during these interviews, and contents presented to the steering committee. In addition, the interviews were used to provide information to consumers and their families. The concepts of mental health disability, convalescence, and recovery were explained in simple terms so that consumers and their families could understand the potential benefits of participating in rehabilitation programs.

Strategies to engage clients in the existing program

Arabic-speaking clients were actively encouraged to participate in the existing rehabilitation service by the project officer. The project officer provided clients with immediate responses to queries and concerns. In order to obtain their involvement in the existing program, she accompanied each potentially interested client to the rehabilitation centre on at least three occasions to promote engagement with the non-Arabic-speaking staff. This attendance at the centre enabled participation in work-based activities. It was agreed that social rehabilitation and leisure components of rehabilitation could be conducted in consumers' homes or community venues such as coffee shops, according to consumer preference.

Trialling of new approaches

Small pilot programs were trialled in response to the findings as they unfolded. These included development of young men's groups, a family education and support group, and women's interest discussion and support group. These initiatives could only be trialled in small groups and were time limited within the resources of this project.

Trial Program 1: Young Arabic-speaking men who had schizophrenia

A rehabilitation program consisted of six-education/support group meetings run jointly by the project officer and a rehabilitation staff member. These groups provided information about mental illness and rehabilitation, and described the functions of rehabilitation in preparing people for recovery from mental illness. Questions were answered and mutual support from other group members occurred.

Trial Program II: Arabic-speaking women who had affective illnesses

Ten women with major depression and/or bipolar disorder participated in an ongoing informal social support group, initially facilitated by the project officer. At the completion of the project the group was meeting without staff support and awaiting long term facilitation from the service to move towards a more rehabilitation focus.

Results

Reasons for non-engagement identified

From the consumers' perspective, there were three main clusters of explanations. First, mental health rehabilitation as a concept appeared to be poorly understood by the families of consumers. It was associated with stigma and shame, and hence families did not support attendance. Second, there was poor understanding of the goals of rehabilitation within the consumer group. Many perceived attendance at activities outside the Arabic community environment as culturally inappropriate. Third, Arabic-speaking consumers had adopted a long-term sick role, which was accepted within their family and local community. For the young men in the group, the non-work associated activities of the rehabilitation program were not attractive to them.

The external health providers (general practitioners, private psychiatrists and psychologists) suggested that Arabic-speaking clients refused referral to mental health rehabilitation services because of high levels of denial of mental illness, lack of knowledge of what mental health rehabilitation is and how it is provided, and a general level of mistrust of government services.

The community based mental health staff (case managers) described hesitancy in making referrals to mental health rehabilitation because of beliefs that the service was culturally insensitive, and hence not appropriate for Arabic-speaking clients. Reasons for inferring cultural insensitivity included the program providing mixed gender groups inappropriate to the religious beliefs of the client group, and that they were provided in English.

Changes in short-term client participation rates achieved

Of the 13 young men with schizophrenia, four men joined the rehabilitation supported work program; three men entered the waiting list for this program and nine men commenced an ongoing informal leisure activities group. For the group of young men who had previously not been able to attend any functions outside their immediate family, this was considered to be a significant early achievement.

Changes in staff attitudes and cultural awareness achieved

Rehabilitation staff achieved a greater understanding of the cultural issues that impact on mental health rehabilitation. They had been unaware that the service they provided was culturally inappropriate for Arabic-speaking clients. It had been incorrectly assumed by some of the staff that overcoming a language barrier by the use of interpreters was synonymous with providing a culturally sensitive service. Through this project, it was acknowledged that an Anglo-Australian rehabilitation goal of achieving independence from the family may be inappropriate for some Arabic-speaking consumers. Activities of daily living such as cooking and maintaining an independent flat came to be understood as culturally unacceptable to many young Arabic men. The project officer's Arabic background enabled her to understand these cultural norms and her ability to communicate this understanding to staff was influential in bringing about changes to the program.

A change in attitude occurred among the staff of other parts of the mental health service. Neither the Arabic-speaking bilingual mental health counsellor nor clinical case management staff had a clear grasp of the aims and objectives of the mental health rehabilitation program. In response, efforts were made to improve verbal and written communication about rehabilitation to staff

from other parts of the service. Thus, written policies regarding referrals were altered, and more formal staff education about rehabilitation occurred.

Identifying limitations to organisational change

Although pilot programs were developed and staff demonstrated willingness to make the incremental service alterations as described, major organisational change was impeded by the perceived multiple demands on the program and the lack of sufficient resources to meet those demands. There was an inability on the part of senior management to prioritise NESB rehabilitation above more generic rehabilitation approaches. Thus, the cultural changes occurred only at the marginal level. For example, much of the early engagement of the consumers and their families occurred as a parallel activity run by the project officer with minimal input from the program staff. Whilst this was useful to demonstrate the principles of Arabic culture in relation to mental health rehabilitation, it did not alter the fact that within a largely NESB community, mental health programs continued to be provided from within the dominant Anglo-Australian cultural paradigm.

Discussion

Uncovering attitudes and beliefs

Consumers, carers, referrers and mental health staff had attitudes and beliefs, which mitigated against utilisation of mental health rehabilitation. However, what was not apparent to the management of the service was the diversity of these views and their additive effect. Mental health staff had made assumptions about the capacity of the rehabilitation program to deliver culturally appropriate services, and had acted upon those assumptions without overtly challenging their validity. In essence, an unconscious collusion had occurred between potential users and potential referrers which had resulted in non-utilisation. Challenging this collusion by providing alternative models appropriate for Arabic-speaking clients was therefore the major management task.

Incremental organisational changes

The organisational changes were brought about in stages. With commencement of early exploration of beliefs, a new understanding of the issues evolved, which in turn allowed the trialling of new programs to change aspects of the identified problem.

Increasing the utilisation of mental health services by culturally diverse communities in Australia has been an agenda of previous research (Minas 1996; Ziguras 1993). The present study is unusual in that it has specifically focussed on mental health rehabilitation. Providing a culturally appropriate mental health rehabilitation program for Arabic-speaking clients proved to be a difficult task. From this study, it is recognised that the application of mental health rehabilitation may be grounded on inherently culture specific principles. The philosophy of mental health rehabilitation emphasises individual goal setting and regaining of independent role functioning (Anthony 1996). A simple interpretation of these values was found to be inappropriate in the cultural context of Arabic-speaking clients, where independence from the family usually only occurs after marriage. In order to accommodate cultural diversity, the goals of rehabilitation may need to be adjusted or reinterpreted. Executing these changes to rehabilitation will present staff with both conceptual and practical challenges, which will require significant skill development.

The action research methodology proved helpful in overcoming some of the difficulties anticipated in initiating organisational change. At the beginning of the project, it was found that staff attitudes were an obstacle to service development. In the initial interviews to investigate reasons for non-engagement, communication was impeded by the defensiveness of staff. They felt they were being criticised for the lack of service responsiveness. In addition, some of the staff felt they were already working to maximum capacity with their current clientele. Hence, they were not receptive to the idea of increasing the range and cultural diversity of the program. The iterative process of uncovering attitudes and beliefs, and providing a forum for exploration of possibilities for change moved the group from defensiveness to collaboration. Similarly, the other stakeholders moved from disinterest in rehabilitation to engagement. The project was instrumental in raising awareness of the impact of cultural issues on rehabilitation. This attitudinal change produced a more flexible approach to the program, as was evident by the ability of staff members to engage the initial groups of consumers. These positive changes illuminate the capacity of action research to improve some aspects of service delivery.

The project did not enable the mental health service to achieve sustainable long-term change. A change in the Area Health Service boundary meant that the Area Director of Mental Health at the conclusion of the project was no longer in the position of crucial influence envisaged at its commencement. As a result, changes to the service were limited to what was within the control of the participating group of staff and did not impact on the prioritisation of resources available for culturally-sensitive rehabilitation. Such limitations are understandable in the context of the different interests and influence of the incoming leadership of the service. For this reason the follow up stages of the project were not completed and the long-term impact of the changes introduced cannot be described.

Conclusion

The present study has demonstrated that mental health rehabilitation services in 1995/6 were not adequately meeting the needs of Arabic-speaking mental health consumers. This finding may be applicable across various NESB groups. A large part of the difficulty with rehabilitation services in general is that the theory on which they are based on is inherently Anglo-Australian, and may be inappropriate for other cultural groups. The implications of this for further development of culturally sensitive mental health services are important. Despite difficulties related to leadership change, subtle yet significant improvements were made to the mental health rehabilitation service. It may be concluded that the action research methodology was useful to create an attitudinal change environment. The broader decisions of resource allocation and priority setting for cultural aspects of mental health service deserve further examination.

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