Author's response to reviews

Title: Working Together for Mental Health: Evaluation of a one-day mental health course for NGO service providers.

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Author's response to reviews: see over
Thank you for your review of our manuscript. We appreciate the time taken to consider the manuscript and think that the issues raised have resulted in greater clarity in this revised draft. We have addressed the reviewers comments in the revised manuscript submitted with this letter. We have also included below a point-by-point response to the concerns raised by the reviewers. We look forward to hearing from you regarding this response to your review of our article.

Yours Sincerely

Pam Grootemaat and Cathie Gillan.

Authors Response to First Review

Reviewer: Paul S Appelbaum

1. The title does not seem to be accurate. Although this is portrayed as a course for NGO service providers, in fact only 53% of the sample worked for NGOs. It would better be described as a course for human services providers, or some similar term, which would more accurately capture the full nature of the sample.

We have changed the title of the article and deleted reference to NGOs. The title now reads “Working Together for Mental Health: Evaluation of a one-day mental health course for human service providers.”

2. The tables in the paper, particularly Tables 3 and 4, are either not quite right or unusually difficult to make out. A footnote at the bottom says that positive responses include participants who either strongly agreed or agreed a little to positively worded questions and the converse with negatively worded questions. However, as I attempt to apply that framework to the individual items, I am not sure it always works. For example, in Table 3, Item 2, “people who have a mental illness are more likely than other people to be dangerous” is the probe, and it appears that, since this is a positively worded question, there is an increase in people believing that persons with mental illness are dangerous after the training. Yes, we know from the text that just the opposite is true. This has to be described much more clearly so people can make sense of these tables.

The tables have been reformatted to group together the questions that the course was designed to promote agreement with and those designed to promote disagreement. For example in Table 3, Item 2 has been placed in the lower section for questions that the course was designed to promote disagreement or strong disagreement with. The footnote has also been removed. The terminology referring to positively and negatively worded questions has been removed in the table and text as it was thought this may be confusing. This has been replaced with terminology indicating that there are questions which the course was designed to promote disagreement with and questions which the course was designed to promote agreement with. We hope that this clarifies our interpretation of the results.

Reviewer: Brenda Happell

1. My main criticism relates to the discussion of the results. The authors have attested to the success of the program by referring to the significant changes in attitudes and confidence etc. following completion of the program. They have almost ignored the fact that most of these positive developments are not sustained after three months.
Why do the authors think this has occurred and what do they believe could be implemented to prevent this happening in the future?

Our analysis of the results separated attitude testing from confidence and knowledge testing. While changes in attitudes were not detected our results show a significant improvement in participants self-reported level of confidence and knowledge which was maintained at three months. This distinction has been clarified adding a graph of the median attitude scores over time and the median confidence and knowledge scores over the three time periods.

Reviewer: Kamaldeep Bhui

1. This is a pre and post training comparison of ratings for capacity and confidence of participants to provide community services to people with mental health problems including their attitudes and beliefs about mental health problems. There is no direct measure of improvement in service user experiences or outcomes or family in experience and outcome.

We agree that this is a major limitation of the study and we have identified it as such in the discussion.

2. A 16-item instrument was developed from a number of existing questionnaires. How this was reduced to 16-items from 3 substantial questionnaires is unclear. The authors need to make some rationale for how this was done and why whether this process produced a robust instrument addressing the key domains of interest.

The rationale for the selection of the 16-items is now included in the methods, paragraph two under measures. We have also included a statement that only the face validity of the resulting 16-item instrument was considered.

3. Missing data were handled by assuming no change in scores. It might be appropriate for the authors to actually assess the impact of changes in directions opposite to those expected for those participants for whom data was missing. Sensitivity analyses here would be helpful to ensure that the findings are not simply due to conservative rates amongst those with missing data. The exact proportions of those with missing data also need to be specified.

An analysis of missing data has been added to the results as has the proportions of those with missing data. Some further analysis of scores looking at what impact of those with missing data would have had if they had answered in an overwhelming positive way and an overwhelming negative way. It was felt that this analysis would confuse and weigh down the results section so it has not been entered here but it has been added to the discussion. The authors felt that while assessing this impact was beneficial, the original analysis combined with an analysis removing all those with any missing data gave the strongest results.

4. The scoring system, eg to produce scores of between 32 and -32 are 26 and -26 needs to be set out, although it is possible to discern this from the tables and instruments.

The scoring system has been revised for greater clarity in the text on page 7 of the manuscript.

5. The authors report that perceptions of adequate skills to support a client with mental illness improved following the course and indeed at follow-up. The authors obviously need to be aware that this perception may be to do with confidence immediately following the course, an experience, rather than actual improvements in capacity and skills that might be judged by their practice. Similarly, the statement that they would treat the needs of a client with mental illness in the same way as any other client needs to be put into context; this may be inappropriate in that there may be special needs that require assessment for people with mental health problems. I appreciate
the point they are trying to make, that the needs of people with mental health problems are not relegated due to stigma. The same can be said of the other findings. That is that these are perceptions and one could argue in either direction that they are the perceptions without any actual change in behaviour or which do not necessarily mean they are good outcomes.

The discussion has been revised to more clearly highlight that the detected changes in confidence and knowledge are perceptions and may or may not relate to the quality of service provided to people with a mental illness. The background section has also been revised to include more detail on why the course was developed and the key message of the course. The key message is that the support needs of people with mental illness are individual and based on abilities and disabilities not the presence of a mental illness per se. Following on from this, the professional skills of people working for human service agencies can be applied to support people with mental illness. These comments help to put the statement “I treat the needs of a client with mental illness in the same way as any other client” in context although the authors recognise that the wording of this question could be improved.

6. If there is any qualitative knowledge about the course and it changes practice in the workplace this would be useful to include as otherwise the findings can be dismissed as simply ones of perception rather than actual changes in practice.

There has been no systematic collection of qualitative data about the impact of the course for participants on work practice. However, the manuscript has been revised to include reference in the background section to anecdotal evidence that local mental health services were reporting better relationships with local human service agencies.

7. Throughout the paper the authors refer to “confidence” in capacity of people working outside of the health sector. I would question the word “capacity”. This could suggest either that they are more able in terms of taking on a greater volume of work, or that they are more skilled, or that they are simply more willing. The word capacity does not distinguish between these possibilities and these different meanings are conflated within the paper.

We recognise that for an international audience the term capacity may be ambiguous. We have therefore deleted references to capacity except in relation to question 26 which has ‘capacity’ in the wording. Replacing the terms ‘confidence and capacity’ is ‘confidence and knowledge’ or ‘confidence and ability’ as these more accurately summarises the overall themes of the third part of the questionnaire.

The term capacity building is frequently used in the Australian context and participants completing the survey would be familiar with the way we were using the concept (see http://www.health.nsw.gov.au/public-health/health-promotion/capacity-building/framework/index.html)

8. Some interesting finding in Table 3: immediately post the course a greater proportion of people thought that those who have mental illness were more likely to be dangerous and that people with schizophrenia can work in regular jobs. These are worth some comment.

The table presenting these findings have been revised. All findings are presented with the percentage of the desired response rather than the percentage of those that agreed with the statement. For the prompt around people with a mental illness being more likely to be dangerous, there was an increase in the number of people who disagreed but this was not maintained at follow-up. The discussion now highlights that for two questions there was a significant improvement at post-testing but not at follow-up.

9. Overall, the paper is important and of interest as it supports the NGO sector to provide mental health care. The NGO sector fills gaps in statutory service provision. Anything to support the NGO sector to do this is useful. However, as the paper is currently written, it raises more questions than it answers.
We have made additions and modifications to the manuscript that we hope clarify the questions raised for the reviewer.

10. I would ask the authors to specify in more detail the different components of the course, the teaching and learning methods used and difficulties encountered and examples of changes in practice using qualitative data to support their assertions. They then have to interpret their quantitative data with care, a revision of the paper adhering to these principles would produce a better paper suitable for publication.

The curriculum document has been included as an additional file and table 1 outlines both the content areas of the course and the teaching methods. Additionally, as previously mentioned, more detail has been provided about the need for the course and the message the course sought to convey to participants. The authors consider that adding this detail and context gives a better picture of the course and what the course might be able to achieve in one day.