Leaders Forum on Mental Health and CALD Communities

This summary was prepared for the Mental Health Commission of NSW to support the development of the Strategic Plan for Mental Health in NSW 2014 – 2024

October 2014
Welcome to Country, Aunt Millie Ingram

Opening remarks by the John Feneley Mental Health Commissioner:

- There is a strong need to support, foster and grow the community and the smaller communities that makes up the larger whole.
- Need to remain in contact with the communities and that this will be the first of many such conversations taking place.
- Provided overview of the NSW MHC, the deputy commissioners
- Objective is whole of government and whole of community and how the Commission will function and operate
- There is a need to establish services which meet the current needs but we will need to have services which can be modified for the first and second generations of people so services can adapt to meet the changing needs of it community.
- What is the intention of the forum: (To identify): What is standing in the way of making change, what do you want the commission to influence to make changes and what supports are required out of this presentation.

Presentation of Centre Manager, Maria Cassaniti: Setting the scene.

- Maria provided a comprehensive summary of the issues from a macro through to a micro and personal story point of view.
- There is a need to consider that mental health and wellbeing is complex and multilayered. It is difficult to develop or apply only one type of strategy to the overall population. The strategy needs to be adaptive and flexible enough to meet the different sections of the community
- In order make real change, we need to work in partnership across the sector and the community to make real sustainable change.

Presentation by Vicki Katsifis, Mental Health Consultant

- People's perceptions of mental health impacts on the individuals relationship and participation in the community
- There is shame and stigma in the community and the individual will isolate themselves from their families and therefore use of traditional services.
- CALD communities are under-researched and there is a need to hear more stories of lived experience.
- There is a challenge of the different values and social standards.
- Experience of racism and discrimination, experience or exposure to torture and trauma experiences.
- There is a need to work with religious leaders and community leaders in order to address issues of mental health and a need to engage different religious and spiritual contexts in providing services to CALD individuals and considering this in the treatment plan. The consumer stories need to discussed further with religious leaders to understand where the religious leader has helped and where they have needed better mental health literacy.
- There is a need to use bilingual workers, use of interpreters, and recognising that there are differences between older and young generations.
- It was mentioned that we need to understand the carers cultural background and where there is a difference between the carer and consumer and the difficulties this
can also present particularly because the carer may not be considered or recognised in the treatment process.

- There is a key role for consumers to have a space to speak and to be heard.

Discussion facilitated by Sebastian Rosenberg, NSW Mental Health Commission (MHC)

Session One – The NSW Mental Health Strategy

Key question: What is the CALD community perspective focus on life course, journeys and the overarching themes?

Role of the MHC and the NSW Mental Health Strategy, Policy issues

- As many services are now being contracted to the private sector, what is the relationship between the MHC, the federal government and contractor sector? How do we ensure collaboration between different sectors?
  SR response: MHC has autonomy to negotiate with different sectors of government. Issues about the way to collaborate. What are the incentives to collaborate and share rather than to work in competition? Organisations often set up to deal with certain parts of the body and particular needs. Need to work more with employers and employment services.

- Many plans over the years, but can people on the ground see change and is that change supported? Plan will be aware of why things have not been sustained in the past. This is at the centre of this process. Must discuss what services may not be funded to allow funding for those services that will address these issues.

- Commission’s job to serve as a repository for information about what works

- What processes are going to be used in sending out this message after the strategic plan? What avenues will be used?

- Is it about communities or the system? How do we achieve change without more services funding etc. Services have to change to address this.

- What is the process beyond the strategic plan? Community education needs to spread the word.

- Concern about the direction of the day – how is this leading to the development of the strategic plan?

- Importance of accurate data collection

Meaning of life course in CALD communities

- Rather than a linear life course, family centric life course is more relevant to CALD.

- Migration and refugee experiences are significant events across the life course and need to be considered when using this model

- Along the life course some periods don’t exist in some cultures e.g. adolescence.

- Limited utility of some of the terms used by the MHC such as recovery, agency and autonomy
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- The difference between intercultural issues, young people more acculturated. Contrast between culture of carers (parents) and young people. Need to look at dynamics of family and culture of family.
- Acknowledge that migration itself is a process of loss, importance of intergenerational issues. Impact of individual events.
- Issue of loss/grief and trauma. These issues can be intergenerational and impact on subsequent generations.
- Journeys can be seen as having a westernised medicalised base.
- No mention of specialised communities, or diversity or uniqueness of individual.
- Life journey is a good start as recognised as it is inclusive of first second and third generation.
- Concern for CALD LBGTQI, whose specific needs are not addressed, which does no justice to either CALD group or LBGTQI.

Engaging with CALD communities

- Changes in migration patterns affect how to define and work with communities. We tend to frame groups in terms of language and country of origin however there are different stages of migration (e.g. post war versus recent migration) for different communities with different perspectives. Have to engage in different ways with different sectors of communities.
- Have to fundamentally change access issues, community based approaches so need to gain an understanding of each community
- Important to identify community leaders and build relationships that can facilitate engagement with communities
- Stigma needs to be addressed at a community level (e.g. community project that produced a play for the Greek and Macedonian communities that presented the experiences of family/carer, served to demystify the issues in the community)
- Certain things that work and work on different levels. What works within certain communities and within certain areas? A lot of knowledge currently wasted.
- Danger in talking about CALD communities alone, there is a whole system that caters for everyone. There is a danger of boxing CALD communities, we need to recognise that CALD are part of the larger community and the whole mental health sector has to address these issues. Systems need to be set up that caters for CALD populations, system needs to welcome CALD as part of that whole.
- Build bridges between generations – children and grandparents.

Service provision

- The mental health system operates during business hours, one of the issues is that mental illness is not limited to business hours, however many services are not available on weekends. TMHC etc. looking outside that model. We need to design wider system that is flexible outside business hours.
- Essential nature of partnerships, working together to address gaps and local issues that come out of this. Housing for refugees and new migrants, need to coordinate inter-agencies to address these gaps in services.
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- Need to look at the way that stigma and shame get in the way of accessing mental health services
- We need consistency of funding for those services that have been proven to work.
- Need to look towards other interventions outside medical model (community health) keeping people well and out of hospital. Engage with and partner with spiritual leaders to help people from CALD backgrounds.
- Need for practical linkages between employment and education services.
- Importance of early intervention.
- Importance of peer support, run by or facilitated by CALD groups – for themselves, among themselves.
- Best practice – identify packages that work.
- Need for respect towards spirituality in CALD communities to help people with mental illnesses.

Session 2: Expanding our knowledge of what mental health means with CALD communities of today. What are the priority areas for mental health and wellbeing for CALD communities?

Information resources and community education/health promotion

- Consumers need information about services provided in their language that is cultural sensitive and distributed in a culturally relevant way.
- CALD consumers and carers can be employed to share stories to destigmatise illness.
- Importance of good ongoing messages that are repeated over and over again, rather than a one off campaign.
- Information needs to be easily accessible; pamphlets, radio, interpreters, TIS should be mandated. Translated info needs to be priority, on a range of topics that impact on mental health.
- Need multifaceted marketing strategies to market to multicultural communities.
- Importance of bilingual bicultural workers, educating communities. Involving and ongoing education of GPs. Community forums targeting particular communities, promoting wellness and talking about symptoms.
- Educating police important as well, police need to be aware how intimidating their presence can be for some communities e.g. refugee groups.
- Educate communities about how to engage with the mental health system in Australian and how that might differ from system in their country of origin. The egalitarian nature of the Australian health system is very different from some countries.
- Community need to know what services are available. Community forums to inform communities of what services are available.
- Need to share and use existing information, importance of knowledge exchange, to balance innovation and building on existing knowledge. MH commission as knowledge exchange centre.
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- More bilingual / bicultural mental health workers - in terms of health promotion. Due to funding cuts and lack of career paths - using casual workers makes services inconsistent.
- Marketing strategies across services and sectors.
- Effective communication across state and shared consistency communication of innovations.
- Mental health literacy needs to be addressed. Importance of bilingual community educators.

Early intervention and addressing stigma

- Addressing stigma and shame, particularly for families e.g. plays that addressed these issues, witnessing other people’s life stories made people more able to address their own issues.
- Health promotion; individuals, families and communities receiving information that destigmatises having a mental illness and reaching communities before mental illness becomes evident.
- Use people experiencing life stresses as an opportunity for early intervention, with GPs, community and other key workers etc.
- In ethnic communities people may go to GPs for a variety of reasons outside specific health issues.
- How can we support rural and regional areas? Need to help people settle well into the community, especially in rural areas.
- CALD consumer context; preventative measures, rather than reactive measures. Service outreach to people when they are well, looking for early signs of illness

CALD Access to Services

- Carers; making sure there is universal access to mental health promotion and mental health education services for family and carers that is consistent across different areas, so that people throughout the state are able to access best practice services.
- We need more resources, more people on the ground to enable people to know how to access the system. People who can show how to actually do it.
- Need to improve primary care – gatekeepers to service provision.
- Intergenerational conflict in mental health perceptions and understanding of mental illness in families, across generations. Young people born in Australia see mental health differently than parents.
- Creating more accessible services, more comprehensive for different language groups, recognise diversity within CALD groups, flyers in other languages.
- Clearer pathways about accessing services. New programs and players, it is no longer clear who is responsible for what. Mapping of how people can access the system. Clearer advice about where people should go. System is a problem.

Service provision

- Need to recognise the diversity within CALD communities, not all people within particular communities have the same beliefs and understanding.
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- Education of service providers about traditional interpretations of health and mental health.
- Responsibility of services to address CALD communities as core population not an add on. Change of attitude in communities can only be achieved by working with whole community.
- Realise that CALD often present late to services.
- Recognise the influence of social isolation and mental health issues in out of hospital settings such as schools and workplace.
- Recognise factors outside the medical model i.e. such as spiritual factors etc.
- Child and Adolescent issues priority – services not always responsive to this group, especially when parents don’t speak English or from different culture.
- Adjustment, not only an issue for refugees, but all migrants. Recognition of personal resilience.
- Importance of addressing physical health problems for those with mental health issues.
- Peer approach, bilingual workers in community settings. Importance of bilingual recruitment.
- Training of clinicians. Actually asking people what is going on – explanatory models, narrative therapy.
- Understanding culture is not just language.
- Communities not necessarily heterogeneous, different sub groups and different generations exist within each community.
- Use of creative therapies.
- Recognition of the impact of the migration experience and impact of racism.
- Case management that support continuity of care.
- Service fragmentation an issue.
- Peer workers and culturally competent workers; people are able to access mental health plans to see psychologists but cannot access interpreters, so seeing a psychologist is pointless. Public services can access HCIS, however it is more difficult for those in private practice.
- Greater use of technology, take advantage of video conferencing opportunities and using TIS more effectively.
- Hidden carers, not recognised when not in contact with service providers. They may not necessarily identify as being a carer, yet need support.
- Importance of stable housing for recovery.
- Need to understand and address life course of trauma
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Data collection and research

- Inconsistency in recording of data about CALD mental health. Community based services where data is collected, leading to inconsistent levels of collection and nature of data.
- Data doesn’t show the number of CALD patients using service – so we need common data to understand how to address CALD health.
- Performance data for services, needs to account for CALD
- Redirecting minimum dataset COB, LSAH, interpreter needed, date of arrival, migration program. Experiences of adolescents from CALD – with implications for data collection for Australian born.
- Data matching, data integrity and accessibility.
- Data captures COB but ignores language and culture and culture and language of carers.
- Need to identify new and emerging communities.
- Research on migration history of communities
- Some communities lack of awareness and acceptance of mental illness means they don’t engage with services and are never identified in mental illness data.
- Research – importance of data collection; a huge gap in collection of data about mental health.
- Literature review needed to assess the evidence around CALD mental health.
- Need to have standards that force research to address the whole community, not just those whom it is easy to research i.e. CALD included in all research. Make it mandatory so that funding is dependent on it.
- Econometric modelling on the impact of preventative health specific to CALD.
- Consideration of this should happen at the beginning of the process. What is the evidence base as otherwise will be perceived as special needs group. What is the research agenda to support this?
- Be aware of being able to do CALD research and the development of methodologies that facilitate CALD input

Policy/ systemic issues

- We need to do things differently for change to occur. Money is being taken out of mental health, rather than going in to mental health. Amount of money in NSW for multicultural endeavours is one quarter of those in Vic. Mobilise diverse communities politically and as social movements.
- Policy regarding refugees, NSW mental health plan needs to take this into account. We have created a situation that increases risk of mental health issues for refugees which needs to be taken into account when planning services.
- Information collected but not tabulated across system. We focus on dollars not on mental health standards, which focus clinicians work on outcomes for people rather than numbers e.g. number of people using services. Medicare funding for mental health and measure how people get better is linked to dollars not people’s lives. Need time to get better outcomes for CALD communities and this is not acknowledged with this approach. We should be comparing ourselves to other
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countries with similar population diversity and adopting these methods. When money is tight groups do not work collaboratively across services.

- National Benchmarking standards for MH not being met, funding for psychiatry and allied health is inadequate. Not enough clinicians on the ground and so are unable to utilise the services such as interpreters that are available.
- Key is to develop a sense of ownership at all levels of the system. People who make decisions about funding need to have a sense of ownership of what goes on in the system. Needs to be built across agencies and government.
- TIS should be mandatory, as clinicians are not using it enough.
- Tap into partners in recovery program and make TIS easier to access.
- Weight services and resources according to complexity, with transcultural aspect being one of those. Cultural competence courses for all services, a cascade of education for service providers.
- Mental Health Commission well placed to influence KPIs in service level agreements with the Department of Health. LHDS need to collect data on CALD.
- Mental Health Line inaccessible to CALD communities when English is not spoken, need to be made accessible.
- Impact of government policy e.g. Temporary Protection Visas. Impact of practical things like visas and recognition of qualifications on CALD migrants.
- Funds need to be ongoing – programs and therapy are evaluated however there are no funds to implement projects.
- Importance of CALD representatives on policy and planning committees of peak bodies and organisations such as Medicare Locals, to upskill workers but also to have CALD professionals on these committees to ensure CALD perspectives included.

Session 3: Informing the development of the NSW Mental Health Strategy:

What is needed to support CALD communities’ mental health and wellbeing from the CALD consumer context?

Consumer participation

- Ensure CALD consumer participation is integrated into planning and service delivery, program design and evaluation
- Consumer committees, participation at all levels should be mandated. Asking consumers what else services can do for them, how services can best assist. CALD consumers should be at the centre of organisations such as TMHC and peak groups through Reference/Advisory Groups
- Consumers need a context to understand how to participate in service provision. They need to be educated about participation, have the vocabulary and framework to participate. Ask consumers specific questions.
- CALD consumer issues; mental health consumers especially CALD marginalised, need for active say for people in own care, more information and choice in model of
care in service delivery. CALD mental health consumers need to be centre of NDIS and not an afterthought.

- Establish regular multicultural consultative mechanisms such as stakeholder groups at the community level where information is shared in both directions

**Peer support**

- Dedicated positions in organisations for CALD peer support workers
- Appropriate training for CALD peer support workers and advocates so that they are well informed about mental health issues and skilled in providing mental health support

**Service provision**

- Greater focus on prevention and early engagement rather than reactive/ post-event intervention
- More community based and outreach services, so that consumers do not have to come to services, but are provided with services in their own local context
- Ensure consumers are actively involved in their own care, even if for CALD consumers this means delegating to family or trusted other
- MH Line service inadequate – operators do not know enough about mental health services

**Primary Care**

- A more holistic approach to care that includes greater coordination between mental health and primary health care as well as employment, housing and education services
- Increased awareness and promotion of CALD issues to GPs e.g. forums between community and GPs

**Information**

- Information about mental health and mental health services presented in languages and formats that CALD consumers can access and understand e.g. SBS radio and television, through GPs, newspapers, magazines and other ethnic media
- More information in appropriate languages and formats that describe how the system actually works and how to access services as well as information on rights and eligibility
- Information needs to be in more languages (not just the top ten), with greater depth and cultural sensitivity

**Policy/ Funding**

- Funding of greater number of sessions of psychological services by Medicare when an interpreter is used, as sessions with an interpreter can take longer
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- Free access to the Telephone Interpreter Service for allied health professionals working in private practice, such as psychologists. Although GPs can access TIS for free, psychologists in private practice pay for the service themselves.

What is needed to support CALD communities’ mental health and wellbeing from the CALD family and carer context?

*Increased support for carers*

- CALD carer support groups; social support groups for carers that include outings etc.
- Respite services for carers
- More information resources; information could be included in migration pack, publish personal stories of carers in own language, provide information for carers about their role, their rights, self protection and access to services
- Increased support for the children of people with a mental illness

*Service provision*

- Establish family based interventions, targeting the whole family
- More attention to cultural interface issues within different generations of families as well as intermarriage
- More services are required for carers of young people with a mental illness, including assessment, management and respite
- Ageing of population – need to prioritise services for those providing care for dementia sufferers
- Programs to assist the development of carer advocates
- Greater support for newly arrived families experiencing cultural transitions (e.g. FICT program)
- Establish telephone carer support line

*Recognition of whole family as carers*

- Expanded understanding of by service providers of who carers are - recognition that there may be multiple carers within a family and that service providers may have to engage with the whole family as well as others who are providing care, as they may be considered family when taking the carer role
- Inclusion of family in consumer recovery process
- Recognition that children may be acting as carers

*Training and Education*

- Increased training for religious and community leaders regarding mental health issues and developing leaders as ambassadors for mental health
- More training for psychiatric registrars about working with CALD families
- Fight stigma through education (plays, theatre, film) that bring communities together, reduce emotional isolation, create talking points within the community
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What is needed to support CALD communities’ mental health and wellbeing from the transcultural mental health service context?

Service provision

- Structured systemic responsiveness in mental health services delivery
- Greater flexibility, support and funding to allow effective service provision in rural areas
- Need to cater for the very different needs of different age groups and generations of migrants
- As the Australian community is becoming increasingly diverse transcultural mental health needs to be integrated into all mental health services
- Need to increase incentives for bi-lingual and bi-cultural workers who play a pivotal role, however are currently undervalued
- Difficult to maintain continuity of services in the context of changing resources
- Independence, responsiveness of state-wide services
- Structural barriers and capacity to implement strategy – require creative solutions

Promotion of services

- More effective promotion of services, so that consumers, carers and workers are aware of the services available and how to access and refer to them

Data collection

- Better data collection to identify not only ethnic background but other factors that affect service provision such as religion and spirituality
- Amend MH-OAT forms so that they collect more accurate data regarding CALD need for culturally and linguistically sensitive mental health services

What is needed to support CALD communities’ mental health and wellbeing from the mental health, community and peer support workforce context?

Training

- More training on working with culturally diverse communities and workers/colleagues in mental health services
- Training on culturally reflective practices and on cultural practices integrated into mainstream services
- Training for police, who are often at the forefront when a mental health crisis occurs – must learn to see beyond the law and order issue
- More transcultural training in undergraduate degrees for allied health practice
- Student placements
- Education for Medicare Locals
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- Papers on cross cultural issues integrated into mainstream mental health and health conferences
- Focus on continuous improvement of skills and information sharing

Systemic issues

- Build CALD related KPIs into service/ performance agreements with LHDs and establish strong reporting structures
- Services provided should reflect the cultural diversity of the areas in which they operate
- Establish minimum cultural competency requirements for mental health clinicians
- More affordable interpreter services in all contexts

Community

- Facilitate real community involvement in planning
- Educate the community on the importance of their voice
- Provide information in a variety of contexts such as schools, workplaces etc.

Partnerships

- Development strong and enduring partnerships across a range of mental health and community services
- Co-worker model as used in HIV response -

What is needed to support CALD communities’ mental health and wellbeing from the whole of community context?

- Education: continuous, balanced, lived life experiences, neighbourhood
- Representation in the media of the real cultural diversity of Australian society
- Greater tolerance of other cultures within minority communities
- Respite services
- More promotion of transcultural services
- More transcultural hospital services, especially in paediatrics – brief intervention is not enough
- Education programs on issues outside mental health such as physical health.
- Need for organisation such as Beyondblue for transcultural mental health to provide community education
- Ensure sufficient programs to reflect diversity when rolling out new programs
- Need a CALD specific mental health access line
- More translated information
- Social movement!
- Community acceptance that transcultural mental health is a legitimate area that is rightly funded and supported
Wrap up

Mr Pino Migliorino, Federation of Ethnic Communities’ Council of Australia

- First time we are hearing complete approach, what are the entry points, how to match our capacities
- The future is going to be about diversity. If we are going to overcome suspicion of self interest we need really good data to back up arguments.
- Personal stories have to be told, it is our role to assist in accessing those stories. Have to be brave enough to identify issues that affect mental health.
- Need to address research. Quality of data needs to be improved.
- Culture, language, life stage, we need to understand individual at all stages. Individuals need to be supported to voice this, many people see themselves as families, groups rather than an individual and services and clinicians need to recognise this. Person centred approach does not understand this.
- Carers are important, and we also have to understand what the community is. In this context need to address stigma and service access within the community.
- Priority areas; address stigma and shame, agenda has been set by beyondblue etc.
- Data is a priority - who is in community, their illnesses, impact of refugee policy which will have a huge impact, adolescent health, mental health in second generation groups, research agenda; research that does not address CALD should not be funded; hidden carers (30 percent in CALD), engagement, capacity and resources. Consumer and carer engagement to demand change, empower consumers.
- Greater structural capacity across the mental health system to address CALD. Early intervention skills across whole area in mental health, dementia.
- We are responsible to develop the capacity of CALD consumers to participate and make sure they are equipped to provide advocacy.
- Good consistent mental health promotion programs. Need to be able to target priority communities.
- Advocacy for equity.

Ms Maria Cassaniti, Transcultural Mental Health Centre

- Priorities – life course is a good way to view it, but needs to be matched up with migration timeline and what happens to first second and subsequent generations.
- We need to invest in early years.
- Establish an ongoing dialogue in the sector with the Mental Health Commission. Needs to be checks to ensure how change is happening on the ground and to understand if it is not working. Communities are growing and this has to be taken on board and recognised. Priorities need to be refined and taken forward.

Closing comments John Feneley, NSW Mental Health Commissioner