Building the case for reform – The experiences of people from refugee and CALD backgrounds negotiating the mental health system, who are at risk of developing or have severe and persistent mental health conditions.

2014

Mater UQ Centre for Primary Health Care Innovation in partnership with:

- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
- Queensland Transcultural Mental Health Centre (QTCMHC) and
- Harmony Place

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Executive Summary

The Mater UQ Centre for Primary Health Innovation, based at the South Brisbane Campus of Mater Health Services is the lead organisation for this project. Partner organisations include Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Harmony Place and Queensland Transcultural Mental Health Centre (QTCMHC) which are all based and engaged in service delivery in the Greater Metro South Brisbane Medicare Local (GMSBML) region.

The project's key objectives are to identify and better understand system gaps and barriers to culturally responsive mental health care in the GMBSML region, for people from CALD and refugee backgrounds with or at risk of developing severe and persistent mental health conditions.

This report outlines barriers identified through consultation with a range of service providers, community representatives, consumers and carers in the GMSBML region, and makes recommendations for systems change and immediate improvements. Guidelines have been developed for service providers, through a 'Tip Sheet' to increase access and engagement of clients from CALD and refugee backgrounds to their services.

The barriers identified at the Client/Community level are cultural perceptions of mental illness, treatment and stigma, collectivist cultures and confidentiality and knowledge about services and how to access them. **The barriers identified at the service provider level are** lack of use of an interpreter, approach of the mental health professional, lack of family and community involvement. **The barriers identified at the systems level are** lack of required and appropriate mental health services, service Integration, mental health assessment tools, funding for Interpreters, cultural competence and diverse workforce, and social and economic deprivation, including visa determination processes impacting on asylum seekers.

The recommendations at the Client/Community level include delivering community education programs and developing a 'Mental Health Pathway Resource' for Community Leaders. **The recommendations at the Service Provider level include** addressing interpreter issues, focusing on training in cultural competence, adapting the approach of mental health professionals, involving family and community (with permission), implementation of organisational policies. **The recommendations at the System level include** innovating and integrating mental health programs and services, increasing cultural competence and a diverse workforce, resolving some interpreter issues, and addressing social and economic deprivation.

Key strategies to address 'lack of fit' between the local mental health system and people from CALD backgrounds with severe and persistent mental health conditions are recommended for implementation.

Part 1: Overview

Introduction

This project investigates the growing gap in culturally responsive mental health care for people from culturally and linguistically diverse (CALD) and refugee backgrounds in the Greater Metropolitan South Brisbane Medicare Local (GMSBML) region. Current barriers are mapped and strategies for change are recommended.

The project is underpinned by consumer engagement, to ensure the responses and best practices identified are CALD client focused. The inequity in mental health care for people from refugee and CALD backgrounds is well documented both in terms of their mental health and in relation to access and quality of care received.

Accessing the mental health system can be challenging in general. For people from CALD and refugee backgrounds, particularly those with or at risk of developing severe or persistent mental health conditions. This challenge is exacerbated by the cultural differences and understanding of mental illnesses, the language barriers, the pre-migration experiences and the challenges of having to adjust to a new and different country.

Understanding mental illness as a health problem that requires medical treatment is a western concept that can seem strange to some people from CALD communities. To respond to the needs of culturally diverse people, mental health services need to understand their CALD communities, and engage with them in partnership, to deliver services that are culturally responsive.[1]

The project's key objectives are to identify and better understand system gaps and barriers to culturally responsive mental health care in the GMBSML region. Based on these findings the project makes recommendations for systemic changes, to improve service providers' ability to respond appropriately to the mental health care needs of people from CALD and refugee backgrounds, particularly those with or at risk of developing severe or persistent mental health conditions. The project also makes recommendations to enable mental health clients, their families and community leaders and representatives, from CALD and refugee backgrounds, to better navigate into and around the mental health system. Facilitating equity of access is a high priority.

[1] Multicultural Mental Health in Australia http://framework.mhima.org.au/framework/supporting-tools-and-resources/key-concepts/culturally-responsiveness

Project Partner Organisations

This project was a collaboration between four organisations with a long history of service provision to CALD populations, and partnership innovation in the GMSBML region. The partners included:

- Mater UQ Centre for Primary Health Innovation organisation (lead organisation)
- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
- Harmony Place
- Queensland Transcultural Mental Health Centre (QTCMHC)

Methodology

Conducted between April and August 2014, this project consulted across the spectrum of stakeholders in CALD, refugee and mental health related services in the GMSBML area. Representatives from various CALD and refugee communities were consulted, along with a range of service providers, including *GMSBML*, General Practice, mental health professionals and clinicians from community organisations and Queensland Health, *Access to Psychological Services* (ATAPS) providers, ten Partners in Recovery (PIR) organisations, and other relevant organisations.[2] Nine community representatives known collectively as the *Greater Brisbane Refugee Health Advisory Group,* employed by the Mater UQ Centre for Primary Health Care Innovation, were key community consultants. These representatives were originally from Congo, Liberia, South Sudan, Eritrea, Somalia, Burundi, Burma and Afghanistan. The Refugee Mental Health Sub Group acted as an advisory group to the project.

The project was largely exploratory and used primarily qualitative research techniques including face to face semi structured interviews, focus groups and questionnaires. Multi-phase design and snowballing techniques provided opportunities to identify and communicate with a rippling circle of relevant stakeholders. Each research phase answered and raised questions and built on insights previously gained.

The Background

Greater Metropolitan South Brisbane Medicare Local (GMBSML) region is home to 43 per cent of Queensland's CALD population and 68 per cent of the state's refugee population.[3] Over 170 different cultural groups are represented. 27.9 per cent of residents were born overseas, higher than the national average (20.5%), and more than double the Queensland average.

[2] For a full listing of the organisations consulted, see Appendix 1.
[3] GMSBML 'Whole of region needs assessment' (May, 2014) http://gmsbml.org.au/about-us/our-organisation/

Of the 30,025 humanitarian entrants granted permanent residency in Queensland between 1991 and 2014, 53.1% reside within the GMSBML region. Their countries of origin are primarily Sudan, Afghanistan, Burma, Somalia, Burundi, Iraq, Iran, Pakistan, Former Yugoslavia, and Bosnia-Herzegovina. The largest refugee settlement areas in the GMSBML region are Woodridge, followed by Moorooka, then Annerley.

The number and diversity of CALD and refugee communities residing in the region presents many challenges to health service providers. Challenges include working with the diversity of language, ethnicity, faith, migration streams, and length and status of residency.

The Context

Pre-migration torture and trauma and post-migration acculturation stress are recognised as risk factors to poor mental health outcomes in this population group.

"People from CALD communities may experience significant levels of psychological distress, particularly related to war and conflict, and the disruption of being separated from family and friends. Approximately 25 per cent of refugees have been physically tortured or have experienced severe psychological violation prior to arriving in Australia. The resettlement process may also impact on mental health and wellbeing."[4]

People from CALD backgrounds have lower rates of *voluntary* mental health care when compared with the general population. They are over-represented in the group of people who are treated involuntarily or admitted for acute inpatient care. This suggests that CALD populations are more likely to access mental health care only when they become acutely and seriously unwell.[5]

Findings from this project support previous studies which have identified that:

"CALD communities generally have low levels of knowledge around mental health issues/illness, are more at risk of developing mental health issues, are less likely to receive needed care than the general population and have a lower rate of participation in health promotion, prevention and treatment programs" [6]

There is widespread government recognition that people from CALD backgrounds have a significantly lower level of access to mental health care. State and National legislation seeks to protect people's right to non-discrimination and equal access. Some work has been done

[4] Beyondblue on the Department of Immigration and Citizenship's discussion paper on 'Access and equity: Inquiry into the responsiveness of Australian Government services to Australia's culturally and linguistically diverse population'

[5] Multicultural Mental Health Australia (MMHiA) http://framework.mhima.org.au/framework/supporting-tools-and-resources/key-concepts/culturally-responsiveness

[6] *Stepping out of the shadows*: Promoting acceptance and inclusion in multicultural communities in Queensland. (2010) Queensland Transcultural Mental Health centre, Queensland Government

in Queensland to overcome barriers to engagement[7], however this cohort continues to face barriers which prevent them having equitable access to mental health services, supports and information.

GMSBML region is 'home' to several 'specialised' services for CALD communities and/or people from refugee backgrounds. These organisations provide resources and training to mainstream government and community service organisations in addition to direct clinical and support services.

Some key agencies working with CALD and refugee communities in relation to mental health, have the following roles:

- **Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)** works only with people from a refugee background and refugee like experience who are presenting with symptoms related to their past torture and trauma experiences.
- **Queensland Transcultural Mental Health Centre (QTCMHC)** provide additional bi-cultural consulting services to support mainstream mental health services.
- **Harmony Place** have a Partners in Recovery (PIR) Program which at this stage provides 'specialised' CALD services on behalf of the 10 PIR providers in GMSBML, but may not always be geographically available to clients or may not be consulted by other PIR organisations.

Because these 'specialised' CALD and refugee organisations are intended to value add to, not in any way replace mainstream mental health services, access and equity to mainstream mental health services remains extremely important to people from CALD and refugee backgrounds who are at risk of developing or have severe and persistent mental health conditions.

Part 2: Findings - Mapping the Barriers

A number of gaps and barriers to access and equity of mental health services for people from CALD and refugee backgrounds have been identified through project consultation in the GMSBML region. The term 'barrier', as used in this report, refers to something which restricts the use of health services. Findings largely confirm previous studies [8] [9]about barriers to the use of health services among CALD communities.

7 http://www.qld.gov.au/web/community-engagement/guides-factsheets/cald-communities/introduction/barriers.html

[8] Potential barriers to the use of health services among ethnic minorities: a review (2005) Emmanuel Scheppersa, Els van Dongenb, Jos Dekkerc, Jan Geertzend and Joost Dekkere

Barriers and Recommendations have been divided into three levels of perception or impact, for ease of discussion in this report. These will be referred to as the 'Client/Community level', 'Service Provider level' and 'Systems level'.

The barriers identified at the Client/Community level are:

1. Cultural perceptions of mental illness, treatment and stigma
2. Collectivist cultures and confidentiality
3. Knowledge about services and how to access them

The barriers identified at the Service Provider level are:

4. Lack of use of an interpreter
5. Approach of the mental health professional
6. Lack of family and community involvement

The barriers identified at the Systems level are:

7. Lack of required and appropriate mental health services
8. Service Integration
9. Mental Health Assessment Tools
10. Funding for Interpreters
11. Cultural Competence and Diverse Workforce
12. Social and Economic Deprivation

Barriers: Client/Community level

1. Cultural perceptions of mental illness, treatment and stigma

The most common barrier to accessing help, identified from the client and community perspective, is the different cultural beliefs and explanations of mental illness. These perceptions are strongly influenced by experiences of people in their country of origin and the stigma associated with mental illness. They strongly affect people's acceptance of an illness and can create reluctance to seek help.

"Back home, they view mental health issues as 'crazy' and 'violent' so that is why they don't want to access any mental health service – they are afraid of that stereotyping." – Community Consultant

[9] Te Pou (2010). *Developing culturally responsive services for working with refugee youth with mental health concerns.* Auckland.

"Back home, if people have a mental illness, they just wander into the jungle and never come back. Nobody knows anything about it and don't know how to help." - Community Consultant

Beliefs about the value of treatment and the possibility of recovery through treatment is also strongly influenced by what people have experienced in their country of origin.

"People think about treatments in their country of origin such as being tied to a bed and so they don't want to get help here". - Community Consultant

"People have a fear of the mental health system – once you get in, you are done and you never come out and the system will change that person for the worse. There is a fear that they will be given an injection and you will turn into a zombie and not recover." - Community Consultant

There is often a lack of knowledge in the community about the causes of mental illness. Communities may blame the unwell individual for the illness.

"Her husband thinks the condition is not a sickness but it is something that is caused by the freedom given to women in Australia. He never believed his wife has a problem… He asked "Why did you make the problem … the children have to suffer." - Community Consultant

These perceptions are compounded by the extreme stigma associated with beliefs about mental illnesses and the shame and guilt associated with it.

"People believe that mental illness is caused by something you did wrong, punishment from a previous life… or it might be that someone is doing voodoo with you." - Community Consultant

"A doctor is the last one you will talk to, especially if you're mentally unwell. " - Community Consultant

This can cause clients to be reluctant to accept that there is a problem, that they need psychological help, and that treatment will be helpful.

"Patients are reluctant to take medication as it may be seen as a 'weakness' " - Psychologist

"There is sometimes a lack of commitment to regular appointments so that treatment can be thorough and follow up can occur" - Psychologist

"Cultural and spiritual beliefs may limit their desire to identify mental illness and seek help" - PIR Support Worker

Cultural perceptions about symptoms may be expressed in ways which could result in a missed or wrong diagnosis.

"The patient was talking about 'an elf in the room' but later I found out that this often talked about in their culture and it was not a hallucination but a metaphor" – GP

And the stigma of a mental illness, even if treated will often continue after treatment.

"Even if a person has been admitted to a mental health hospital, they will always be viewed as 'mental'. The community will continue to stigmatize them, even if they recover, they will still view them as 'mental'." – Community Consultant

2. Collectivist cultures and confidentiality

Many people from CALD communities come from more collectivist cultures than mainstream Australia, which is considered 'individualistic'. This has implications for help seeking, and how individuals and family want to be involved in health care. This is challenging for health professionals who are governed by privacy and confidentiality legislation.

This can be frustrating for people from CALD backgrounds who trust and respect close extended family and often want their support and involvement, which is not always offered by service providers.

"Confidentiality can be a barrier when clinicians don't explore options available to get support in the community because they have not got consent from the client to do this, even when it may be beneficial for the person to get support." - Community Consultant

3. Knowledge about services and how to access them

People from CALD and refugee backgrounds can have difficulty identifying and accessing appropriate services or 'get lost' in the system. They may also feel disrespected by referral, appointment and assessment systems.

"I experienced someone who needs help but I don't know how she can get help." Community Consultant

"When clients do not present to booked appointments there is a lot of frustration by providers" Service Provider

When appropriate professional services cannot be accessed, people may be influenced by clinically uninformed recommendations and stories from friends and family members.

"Some women talk to each other and give wrong information about taking medication. For example, I overheard a woman saying to another that if you feel sick, don't take the

medication for depression, that the doctors give you as it makes you crazy." - Community Consultant

Barriers: Services Provider level

4. Lack of use of interpreters

Culturally appropriate and responsive care cannot exist without professional interpreting services. One of the strategies in the *Queensland Cultural Diversity Action Plan* completed in 2014 states that:

A key element to ensuring equality of opportunity for every Queenslander is their ability to communicate effectively in English or to have access to language support when needed.[10]

However, underuse of professional interpreters continues to impose overwhelming barriers for people with no or low levels of English language proficiency, to access and engage effectively and safely with services. Many people from CALD backgrounds struggle to express feelings, ask questions or represent themselves. In response to this challenge service providers sometimes bypass the clients, communicating instead with a family member, or request a bi-lingual caseworker to interpret. Sometimes CALD clients are suspicious about using interpreters due to concerns about confidentiality. However it is always important for clinicians to explore how using a professional interpreter can work for their client, and resist the temptation to use family members, bi-lingual workers or support people to interpret.

"For people who have limited English it is hard to express problems to a health professional." - Community Consultant

Following are some reasons proposed for service providers not engaging professional interpreters: lack of information about how to access interpreters, confidence to work effectively with interpreters, and the additional cost and time associated with engaging professional interpreters.

"Limited English makes engagement more difficult and requires much more time" - PIR Support Facilitator

Local measures are being taken in GMSBML to train workers in the importance and use of interpreters, ie: 2014 education sessions facilitated by *Ethic Communities Council of*

[10] Queensland Cultural Diversity Action Plan
http://www.datsima.qld.gov.au/resources/datsima/culturaldiversity/publications/cdp-action-plan-final.pdf

Queensland (ECCQ).[11] *However,* such training reaches only a small number of service providers. The majority who miss training may continue not to use interpreters, unless information and education can come to them.

The language barrier and lack of knowledge of systems, also impacts on carers:

"The wife had a huge English barrier and absolutely no understanding about how to help her husband." – Community Consultant

While there are some bi-lingual GPs and clinicians in the GMSBML area their resources are limited, demand outstrips supply, and there is concern that these clinicians will 'burn out' due to over referring to their practices and services.

5. Approach of mental health professionals

A 'business model' associated with primary health care can be perceived as impersonal. The authoritative or 'distant' way in which health care personnel, including administrative staff, sometimes approach clients can result in shame and discomfort for the client, and impact on rapport building.

"When a GP says "What can I do for you?" it is like a brick wall goes up. Doctors need to ask questions to build rapport such as "How are you feeling? Do you have pain? Have you taken any medicine for it? People feel like the Doctor should ask questions about the problem, rather than ask what they can do for them, when they don't know…" - Community Consultant

The issue of language choice, terms and labels used in mental health, has been raised repeatedly by community representatives and service providers.

"Medical language can be a barrier for a consumer. It is hard to understand when you are "outside the system" so simple language needs to be used." – Service Provider

Words such as "mental" and "counselling" are perceived as stigmatising by people from CALD backgrounds and service providers.

"Clients feel that a referral to an allied health professional means they are 'mad'. Caseworkers urge clients to seek "psychological help" but we need to use words that stress that a counsellor can 'help problem solve', or 'cope with stress', instead of using words like mental illness." - Service Provider

[11] Learning Objectives included – Understanding and managing the dynamics of culture and cultural difference in a clinical environment; developing communication strategies for effective engagement with refugees; and effective use of professional interpreters and utilising TIS.

Project findings support research[12] which shows that communities' perception of mental illness and its treatment are often based on traditional beliefs and practices such as rituals performed by witch doctors, animal sacrifice, or beliefs in traditional healers. If a service provider ignores the cultural explanations, beliefs, and spiritual and traditional practices about mental illness, this can act as a barrier to building rapport and formulating appropriate treatment, based on respect and trust.

"Some traditional healings may work and some have seen that and think it might work for some people, but not all but it is important to be considered as a real option." - Community Consultant

6. Lack of family and community involvement

Service Providers neglecting the influence of immediate and extended family is seen as a barrier to clients from CALD backgrounds accessing and engaging with ongoing support from the mental health system. Some clients may not want family or community involvement, but GPs and clinicians need to continually assess if this will be useful and if so, to build trust with an individual's support networks, with clear client consent, to provide stable ongoing support.

"The family may be the only ones that the patient trusts and feels comfortable with to give information to the Doctor, or the family may try to hide the mental health issues even more. It depends on each case." - Community Consultant

"If you get a family member involved, with consent, the GP will get more information because of the trust." - Community Consultant

Although it is important not to assume that individuals from a CALD background will want to be linked with their ethnic community, not asking the question poses a barrier. Community members, such as liaison workers, volunteers, formal and informal leaders are important resources, who facilitate trust between the service and the client and provide monitoring and support. Clinicians need to be aware that there may be some ethnic community networks that will assist with a person's recovery.

"When you start a conversation with the consumer, you can ask who the key people in the consumer's life are and who they want to involve. This may be family, religious leader, community leader and you can engage those people then, to support the consumer." - Service Provider

"The people she trusted in the community helped her by giving advice about handling problems and showing her what to expect in this country and offering new strategies how to cope with it. This helped to make her feel stronger and she felt supported and believed she can handle it in the future". - Community Consultant

12 http://www.adec.org.au/images/Conversations_with_new_communities_about_mental_health_updated.pdf

Barriers: Systems

7. Lack of required and appropriate mental health services

There are broad ranging systems gaps in mental health services for people from CALD communities who are experiencing severe and persistent mental illnesses. The following comments indicate the concern of workers in the GMSBML region, who feel increasing pressure to 'do something' with decreasing resources.

"There are limited places to send people for an ongoing service for those with severe mental illness in the community."– Service Provider

"Now there are fewer options. It drives me to despair. ATAPS is a struggle, it is early days for PIR… The public health system is dealing with 3% of mental health issues…. There are fewer bulk billing GPs…. "– Service Provider

"There are limited referral points and limited bi-lingual psychologists or counsellors. " – Service Provider

"Mental health is a "desperate space", where everything has "fallen apart" for clients with severe mental health issues, so we hope that PIR helps, as people from CALD backgrounds with mental health issues are the clients with the most complex needs. "- GP

Partners in Recovery (PIR) and *Access to Allied Psychological Services (ATAPS)* are national mental health programs available to people with persistent mental health problems. However appropriateness of service provision has been cited as a barrier to people from CALD backgrounds. The 'western model' of PIR and ATAPS, and the 'business model' of primary health care are considered a 'bad fit' for CALD communities.

ATAPS[13]

There are approximately 130 ATAPs providers, mainly Psychologists, working in the GMSBML region. Referred clients are usually seen within two weeks, or 72 hours after a suicide attempt or self-harm incident. A TIS interpreter can be used, however it is understood that due to budget limitations an interpreter is provided on a case by case basis. Project participants expressed concerns about barriers imposed on people from CALD backgrounds due to program inflexibility around interpreters, number of sessions, and lack of remuneration for additional clinician time required when working with CALD clients.

[13] The **Access to Allied Psychological Services (ATAPS)** program delivers short-term, goal-oriented psychological support for financially disadvantaged people and families. These services are for individuals who are experiencing common mental health disorders of mild to moderate severity. However, individuals with more severe illness whose conditions may benefit from focused psychological strategies may also be provided with services at the discretion of the Mental Health Services team.http://gmsbml.org.au/programs-and-services/mental-health/access-to-allied-psychological-services-ataps/

"Due to not being able to see clients who require interpreters under 'Better Access' ATAPS is really the only option.... and there are many barriers in ATAPS… GPS are reluctant to make ATAPS referrals due to paperwork… & ATAPS has to make limited funds stretch" - ATAPS Provider

"Given that ATAPS is essentially for hard to reach, marginalised groups… - more flexibility in how ATAPS consultations are delivered would be welcome, as marginalised groups typically do not fit the traditional business model." – ATAPS Provider

"Generally more sessions are required [because] "CALD/refugee/asylum seeker clients need more follow up… more time is required to build rapport & trust" – Service Provider

Partners in Recovery (PIR) [14]

Partners in Recovery (PIR) is a relatively new program. Service Providers are enthusiastic about the potential of PIR to address gaps in culturally responsive mental health care for people from CALD backgrounds. However many organisations have not had any direct contact with PIR providers to date, and do not understand exactly what services PIR provides.

PIR supports people with severe and persistent mental health issues, along with their carers and families. *GMSBML* facilitates PIR through partnership with 10 non-government organisations.

PIR works with people to:

- access clinical services appropriate to their needs
- access community support and related services
- coordinate services to meet their needs
- encourage a journey of recovery

The newness of PIR presents a barrier because it takes time for GPs and services to engage with a new program.

"to watch it and see if it is going to stay. There is no point spending the time engaging and then finding out that it has lost funding or changed." - GP

"We hope that PIR helps. As people from CALD backgrounds with mental health issues are the clients with the most complex needs… but we have anxiety about referring as we don't really know how it works and if it works well. - GP

[14] *Partners in Recovery (PIR)* http://gmsbml.org.au/programs-and-services/mental-health/partners-in-recovery

Clinical and CALD community services do not yet feel connected to PIR, due to the need for PIR promotion and integration at a systems level.

8. Service Integration

There is abundant good will, support and effort given to networks and integration between organisations, service providers, communities and individuals in the GMSBML region. The mental health and CALD/refugee related organisations are a labyrinth of interconnected committees and partnerships, forums and events which achieve remarkable outcomes for their clients. The following gaps and barriers in service integration were hard to identify because organisations and individuals in GMSBML demonstrate a high regard and level of respect and understanding for each other.

Mainstream mental health providers & 'specialised' CALD/refugee service providers

When considering service Integration for people from refugee and CALD backgrounds, who are at risk of developing or have severe and persistent mental health conditions, we are challenged by a system which responds to this cohort through at least three different and overlapping sectors (mental health, CALD/ refugee services & other community services). Given this complexity it is not surprising that there are some gaps and barriers in service integration. Whilst there are many examples of cohesion, effective communication & service partnerships there are some indications that *"the mainstream services and CALD are siloed and could share knowledge more".*

There is also confusion between mainstream mental health and 'specialised' CALD/refugee providers about service roles & limitations.

"There are specialised services working with CALD or refugee communities, but working with people with chronic & persistent mental illness is not part of their role, in all cases." - Service Provider

Part of the confusion seems to be around mainstream services perceiving CALD and refugee services as 'alternative' rather than 'specialised' mental health services.

Emergency Departments, Acute Care & Post Hospital Care

Service providers noted problems associated with clients' ability to express the full extent of their mental health problems *"at Emergency Departments (EDs), leading to a 'revolving door' where they never get past ED" or who are experiencing extreme distress but do not have a diagnosis.* A further barrier was identified with "*access for clinical mental health support after multiple Emergency Department (ED) presentations for suicide".* Also 'Acute crises' were reported when people were taken to Acute Care in hospitals, as the *only available option,* (particularly in association with negative visa outcomes). Such cases have

been called a 'situational crisis' *"even if they take them for a day, they will be released with limited community mental health care".*

"Mental health programs need to be flexible enough to work with people from CALD backgrounds who don't have a diagnosis." – Service Provider

9. Mental Health Assessment Tools

The assessment process has been identified as a significant potential barrier to clients receiving quality mental health care. Best practice implementation of health assessments for people from CALD and refugee backgrounds needs more time, respect and effective cross cultural understanding and communication. The nature and use of assessment tools are also seen as posing barriers. There is concern that mandatory use of particular assessment tools in some circumstances can be detrimental to the wellbeing of people from CALD/refugee backgrounds and may lead to misdiagnoses. For example:

- *"Mandatory and routine use of The Kessler Psychological Distress Scale (K10) by settlement caseworkers, administered by untrained workers, on newly arrived refugee families [is not appropriate]" – Service Provider*
- "The *Camberwell Assessment tool does not work for us… it doesn't cover [any assessment about]the trauma of three daughters missing…." – Service Provider*
- Inappropriate assessment tools may contribute to people from refugee backgrounds being put into the *"too hard basket. [They may be] tagged with Borderline [Personality disorder], rather than [exploring the impact of] trauma [and] depression". – Service Provider*
- *"…if you want to access a mental health services you need a diagnosis. It is very difficult for those from refugee backgrounds and asylum seekers – especially people who have experienced trauma and may have mental health symptomology. They shouldn't have to be individually pathologised to get access. By diagnosing them this can prevent recovery – need to alter view to see it as a 'reaction' to trauma which needs support, but not through a diagnosis imposed." – Service Provider*

10. Funding for Interpreters

Free interpreting services through the Translating and Interpreting Service (TIS National) are available to GPs, Medical Specialists, some specialised services and Pharmacists, but largely unavailable to allied health providers. The exclusion of allied health professionals from 'free' Interpreter services is a monumental barrier to people from CALD backgrounds requiring mental health services.

At a local level some additional interpreting services are available on a case by case basis, funded through GMSBML to ATAPS allied health service providers, but not as yet for all PIR organisations.

For General Practice working across two or more *Medicare Local* areas a referral to ATAPS for a client from a CALD background is more complex, because funding for interpreters is different between *Medicare Local* areas, each which manages a separate ATAPS service.

Despite the difficulties of access, all service providers who contributed to the project have emphasised the importance of using professional interpreters.

"It is unbelievable that we would ever expect somebody to access a service, without access to an interpreter." - GP

However, in some cases clinicians who are eligible to access 'free' TIS Interpreters choose not to, due to the time and costs associated with engaging professional Interpreters.

"Consultations via interpreters take twice as long, there is no recognition of this for the providers ; currently many GPs do not bother using an interpreter and the quality of MH Care Plans is poor" - ATAPS Provider

Some clinicians, particularly Pharmacists, do not know that they are eligible for 'free' TIS interpreting services.

"Pharmacists don't really know they have access, which is serious - language differences lead to wrong medication & misdiagnosis which creates much bigger problems for people in the long term & puts pressure on the mental health system." - Service Provider

11. Cultural Competence and Diverse Workforce

At a systems level cultural competence related barriers are associated with gaps in the implementation of policies and frameworks to improve organisational cultural responsiveness and cultural workforce diversity.

There are insufficient culturally responsive knowledge, skills and resources within mainstream services. - Service Provider

"Clinicians often don't see the need for a systemic approach…Mainstream mental health workers may not consider family, community, systems, past – this is a real barrier… Organisations and clinicians need to consider a multicultural framework." – Service Provider

Staff turnover is considered an ongoing challenge for *Queensland Health* in terms of building cultural competence. CALD / Multicultural training needs to be mandatory for mental health workers. However, there is uncertainty about who would deliver state wide mandatory training. *Queensland Health* is now divided into *Health Service Districts* each with its own responsibility for making decision about training and whether to employ *Multicultural Mental Health Coordinators* or not.

12. Social and Economic Deprivation

People from CALD communities may be faced with social and economic barriers due to their experiences of settlement and acculturation, lack of or lower paid employment due to language issues, and the impact of past torture and trauma. Asylum seekers living in community detention, or on bridging visas also face work and study restrictions and have ongoing stress about an uncertain future. Economic barriers to accessing mental health services are associated with the cost or perceived cost of mental health services, transport costs, and distance to services. People from CALD backgrounds experience difficulties navigating the mental health system *"to receive referrals for psychological services"* and difficulty of finding *"bulk-billing GPs that are willing to book an interpreter and spend the time required with this client group*." *– Service Provider*

"If a refugee person has no work permit and has limited financial support this results in isolation and escalation of mental health issues" - PIR Support Facilitator

"There is a fear that the cost of the doctor or hospital will be a lot because of their visa and children may be taken away from them, so they don't ask for help." - Community Consultant

"Some women are unable to prioritise appointments over childcare or employment responsibilities… Access with transport is hard and there are trust issues because of negative experiences in the past." - Service Provider

Asylum seeker clients presenting at hospitals' Acute Health Care or Emergency Departments are being assessed as having a *'situational crisis' rather than a diagnosable condition.* These people are often experiencing extreme stress and crisis associated with immigration related final determination processes leading to re-detention or deportation. The dire limitation of care options available to this group is alarming, particularly given the substantial risks of self-harm and suicidal behaviour. People in these situations are often not admitted to an inpatient unit, due to a lack of diagnosis, but they desperately require care.

Part 3: Recommendations

The following recommendations have been strongly communicated and endorsed throughout the project consultation process with a range of service providers, community representatives, consumers and carers in the GMSBML region. The three levels of classification used to explore barriers has been maintained: the 'Client/Community level', 'Service Provider level' and 'Systems level'.

Recommendations: Client/Community Level

The following recommendations to address Client and Community level barriers are made to increase access and engagement to mental health services for people from CALD backgrounds in the GMSBML region.

1. **Deliver Community Education Programs**
2. **Develop a 'Mental Health Pathway Resource' for Community Leaders**

1. Deliver Community Education Programs

Recommendation: Deliver Community Education Programs that address the fears of stigma and treatment and provide opportunities to discuss and accept concepts of illness and health. These programs for community members need to be designed and delivered in partnership with trusted community representatives in a way that is non-stigmatising.

"Our community needs to know about mental education or information… before it is not too late…" Community Consultant

"Deliver information through community 'health' sessions (for women especially) so they know how to seek help, about the early signs of mental illness and strategies to deal with this, Information about medication – how could it help, what might the side effects be, is it worth a try?" –Community Consultant

Education programs need to address beliefs that mental illness is caused by something they did wrong, or is punishment from a previous life.

"They thought "someone did the punishment, someone did the voodoo with you." – Community Consultant

Approaches[15] [16]to demystify mental illness within ethnic communities have succeeded by engaging large numbers of the community and exploring attitudes to mental illness in a safe way. QTMHC has implemented many prevention and early intervention initiatives. The '*Stepping Out of the Shadows: Promoting acceptance and inclusion in multicultural communities in Queensland Program*[17] aims to reduce stigma around mental illness in multicultural communities in Queensland. It is a recommendation that this program be delivered in an ongoing way, through an optimal combination partnership between multicultural and mental health service providers.

A best practice approach like the Ethnic Communities Council of Queensland *CALD Chronic Disease Program*[18], could also be trialled, whereby Multicultural Health Workers guide people through complex health systems, provide cross-cultural expertise to both health practitioners and members of the family, and promote early intervention information.

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[15] Ilse Blignault, Lisa Woodland, Vince Ponzio, Dushan Ristevski and Suzanna Kirov "Using a multifaceted community intervention to reduce stigma about mental illness in an Australian Macedonian community" Health Promotion Journal of Australia 20(3) 227 – 233. Published: 01 December 2009

[16] Patrycja Toczek, "Demystifying Mental Health in Ethnic Communities: Multicultural Mental Health Project Evaluation, Australian Polish Community Services (APCS): www.apcs.org.au

[17] http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/initiatives.asp

[18] The Ethnic Communities Council of Queensland http://www.eccq.com.au/what-we-do/health/chronic-disease/

2. Develop a 'Mental Health Pathway Resource' for Community Leaders

Recommendation: Support CALD community networks to develop a 'mental health pathway resource' with information about service options and how to access them. This will increase access to information and services prior to and during a crisis. This is particularly relevant for men, who may be less likely to attend a 'Community Education Program', but rely on their local support networks.

It is recommended that resources enable community leaders to navigate the mental health system, or find ways to gain support for themselves or a community member. The development of this resource is best done in partnership with community representatives from high population ethnic communities.

Recommendations: Service Provider Level

The following recommendations to address Service Provider level barriers are made to improve opportunities for service providers' to respond appropriately to the mental health care needs of people from CALD and refugee backgrounds. A Service Providers 'Tip Sheet' to increase engagement between mental health services'[19] and people from CALD backgrounds has been developed, to assist services to implement some of these recommendations.

1. **Address Interpreter issues**
2. **Focus on training in cultural competence**
3. **Adapt the approach of mental health professionals**
4. **Involve family and community (with permission)**
5. **Audit and develop organisational policies**

1. Address Interpreter issues

Recommendation: Services need to use professional interpreters, not family members or bi-cultural workers, to improve the quality of the conversation, build trust and rapport, and provide the client with clear and correct information.

"She had a good relationship with her GP. She trusted her GP so she told her GP everything and accepted her advice. When there is trust and they feel that the GP is showing interest to them. If they find a good GP they will stay there forever!" – Community Consultant

Some clients may have concerns about the ethnic and political background of interpreters, which can impact on information sharing. However using a professional interpreter to communicate effectively is essential. Using a telephone interpreter instead of an onsite

[19] See Appendix 2

interpreter is an option, if the client has concerns about confidentiality. Service providers can book an interpreter using the word "confidential", instead of a client name and should always consider if a particular gender is more appropriate.

In discussion about maternity services one organisation explained that it ensures *" that we have identified the correct language preference of the woman, with the right interpreter and that includes female only interpreters at all times."*

2. Focus on training in cultural competence

Recommendation: Focus on cultural competence training and accessing information about the refugee and migration experience, to increase service providers' confidence and competence and implement organisational policy development.

GMSBML needs a region wide cultural competency in health implementation plan [20], to ensure cultural competency occurs at all levels of the service for all staff, through training in the use of accredited interpreter services, cultural awareness and knowledge about the refugee experience, and working with survivors of torture and trauma.

3. Adapt the approach of mental health professionals

"Provide a culturally appropriate service by building a relationship of trust"
"Being aware of the symbols of 'power' such as a uniform, stethoscope and desk and negating stigma around social issues."
"Go that extra step, which will make navigating the Australian health system that much easier for example assisting with booking scans and other appointments, choosing times that are good for women such as within school hours, introductions to each other and other services to ensure handover of information and service provision." – Service Provider

Recommendation: Distribute the 'Tip Sheet: Tips to increase the cultural responsiveness of mental health services for people from CALD backgrounds in Queensland'[21] and 'Tip sheet 2: 'Tips for using interpreters with people from CALD backgrounds and mental health services in Queensland'[22] to service providers and make it available on the GMSBML

The 'Tip Sheet: Tips to increase the cultural responsiveness of mental health services for people from CALD backgrounds in Queensland' covers the following topics:

1. Use an interpreter
2. Create a welcoming and respectful environment
3. Watch your language!
4. Access translated information
5. Respect cultural beliefs
6. Issues to consider when involving family
7. Consider involving a community or spiritual leader
8. Train all staff (including reception staff) in cultural awareness, trauma and the impact of migration
9. Work with bi-cultural workers or cultural consultants
10. Consider flexibility of your service
11. Organisational policy
12. Employ a diverse workforce
13. Refer client to a group

To read the full Tip Sheets, see Appendix 2& 3 of this report.

website. The cultural responsiveness resource was developed through this project by collating advice from community representatives and services. It can be used in various training environments, including forums hosted by GMSBML.

4. Involve family and community (with permission)

Recommendation: Services need to be aware of the benefits of involving families and community support people in mental health appointments and care. Clinicians should offer to refer and link to family and ethnic communities, with permission from the client, at key times, including entry to the service, during treatment, and especially at discharge from hospital.

"Clinicians should ask direct questions to client to gain permission on discharge to liaise with community leaders/support people regarding recommendations after discharge. This communication with the ethnic community from mental health system can ensure that they know when and how they can support the person, on release." – Community Consultant

"When they discharge a client from an inpatient unit they could include a PIR worker to ensure follow up happens (eg: make an appointments with GP and link with community) and ensure they can overcome the ongoing barriers to getting help." - Service Provider

Intensive support at the right time is seen to prevent a client's mental health from deteriorating.

"When the person is receiving treatment, and being discharged, bring in additional community support at that time so that the community can work to support the person, at the same time as they are getting treatment and getting better (to prevent them being admitted again)." – Community Consultant

5. Audit and develop organisational policies

Recommendation: Promote the use of *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*[23] and the *Organisational Cultural Responsiveness Assessment Scale (OCRAS)*, to guide organisations through the development of an individually tailored action plan, make organisation wide changes, and ultimately enhance their cultural responsiveness.

Service providers could also consider appointing a CALD portfolio holder in their organisation[24]. Such a role needs clear support from and reports to senior management, contributes to capacity building, is responsible for distributing relevant resources and training information on CALD issues, and monitors the cultural competence action plan.

[23] The National Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery http://framework.mhima.org.au/framework/index.htm

[24] Latrobe City CALD Communities' Access to Mental Health Service Mapping and Scoping Project -June 2014

Recommendations: Systems Level

To address the identified gaps and barriers and improve access and quality of mental health care for people from CALD backgrounds in the GMSBML area, the following recommendations are made for systems interventions and change.

1. **Develop mental health programs**
2. **Service Integration**
3. **Cultural Competence and Diverse Workforce**
4. **Address Interpreters Issues**
5. **Address Social and Economic Deprivation (with particular attention to Asylum Seekers)**

1. Develop mental health programs

Recommendation: Create more flexibility in the ways mental health programs, including ATAPS are delivered to the CALD community client group. This could include:

- additional sessions for CALD clients, required to build rapport & trust
- engagement of professional interpreters
- recognition & remuneration for bi-lingual workers as essential to ATAPS treatment team

Recommendation: Develop **PIR** roles and functions to provide a culturally appropriate service through "innovative solutions to ensure effective and timely access to the services and support required by patients with severe and persistent mental illness with complex needs"[25] such as people from CALD backgrounds.

The following overview of what General Practice needs from PIR may assist *GMSBML* to develop PIR roles, functions and services for enhanced integration and communications between PIR service providers and all the organisations involved in providing mental health care for people with severe and persistent mental illness.

"We need CLEAR information about what the PIR program is, eligibility criteria and how to refer, up to date pathways, so that GPs are aware of programs available and when programs change. This helps build the GPs confidence in the system and confirms that it is working.

[25] http://gmsbml.org.au/programs-and-services/mental-health/partners-in-recovery/

It should be a main role of the PIR worker to keep multiple workers informed of what is happening in the client's life. As a GP I need someone who can ensure that my patient shows up to my consultation and shows up at the right time to a hospital appointment. For example if a client has a hospital appointment, a letter (through a PIR worker who is coordinating care) to know which health issue was dealt with, which hospital department they visited would be useful. CALD clients may not have the language skills or if they are dealing with mental health issues, not remember what happened and where, so it is very important for a worker to feed this information back so that the GP can continue to manage the patient.

Part of PIR worker role should be to feed information to all workers involved in patient the case …and follow up to communicate with client, hospital and practice.

PIR workers should not just link but have an educational role to let organisations know that they need to communicate with each other (GPs and services) and have ongoing role with coordination and facilitate patients/enabling them to get to appointments. PIR worker is an 'enabler'. " - GP

Recommendation: Develop PIR to its full potential through flexibility, innovation and sustainability and use it as a 'pilot' for cultural competency and service integration strategies, which may be used as an exemplar for other programs and organisations in GMSBML.

- Consultation between GMSBML and PIR organisations and workers about strategies to provide services for people from CALD backgrounds with severe and persistent mental health problems.
- Develop & promote PIR as a best practice service partnership model for integrated mainstream & CALD/refugee specialised care
- Implement GMSBML PIR wide cultural competency approach - *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*[26] and the Organisational Cultural Responsiveness Assessment Scale (OCRAS)
- Develop and formalise policies and procedures around best use of the services of specialised CALD organisations which are also PIR service providers
- Use and monitor the effectiveness for PIR of a *b*i-cultural workers model such as that used by Harmony Place
- Develop effective links with CALD & refugee communities for improved awareness and de-stigmatisation
- Use innovative workforce developments such as staff exchanges and student placements to enhance sustainability of cultural competence and service integration
- consult with GMSBML service providers (GPs, Qld Health etc.) to identify transition points in the mental health system where clients are 'getting lost' (eg: on release and

[26] The National Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery http://framework.mhima.org.au/framework/index.htm

follow up after hospitalisation) and formalise protocols for PIR to fill the gaps and streamline communications between clients and service providers

2. Service Integration

Recommendations for PIR led service integration initiatives are interrelated with program development and as such have been included in the above section: *Development of mental health programs*

Recommendation - Address confusion between mainstream mental health providers and 'specialised' CALD/refugee providers about organisational roles & limitations, through established partnership committees and forums with the support of GMSBML.

Recommendation – Address waiting lists for mental health specialists and counselling at some CALD and refugee specialised agencies, by working with primary health care in a partnership that manages the needs of people at risk of developing or have chronic and persistent mental illness.

This could include ensuring adequate communication flows back to referring GPs and GPs are engaging on an ongoing basis including being kept informed about the progress of the referral (assessment, referral out and discharge summary). This will also facilitate escalation of referral to clinical specialist if indicated.

3. Cultural Competence and Diverse Workforce

The literature and local service providers suggest that the strategic positioning of Bicultural Health Workers (also known as multi ethnic teams and Cultural Support Workers), with an awareness of ethnicity, in the system can improve the cultural capacity of workforces and promote education and cross cultural understanding within and between organisations. However, with trauma recovery it is important to note the inappropriateness of using bi-cultural workers in some situations where clients prefer to build trust through with a worker NOT from their own background.

Bilingual case managers are small in number, but make a unique contribution to culturally responsive mental health service delivery.[27]The Office of Public Service Commissioner has produced a *Guide to attracting and hiring a diverse workforce*[28].

Recommendations: Implement cultural responsiveness framework regionally and acknowledge and formalise the role of *Bicultural Support Worker.*

[27] *Key findings from the Project Cultural Responsiveness in Specialist Mental Health Services: Service Development as a Component of a Capacity Building Project. (2011) Victorian Transcultural Psychiatry Unit*
[28] www.opsc.qld.gov.au/publications

The following outcomes focussed recommendations could be implemented locally in the short term:

- GMBSML-wide implementation of *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery (*MHiMA) and the Organisational Cultural Responsiveness Assessment Scale (OCRAS) using PIR as a 'pilot'. For such an initiative to evolve effectively at a regional level 'buy-in' will be required from all government and community mental health and CALD related services in the GMSBML area.

- *"Employment of a CALD specific social worker through GMSBML to assist in primary health care settings" – Service Provider*

- Document effectiveness of Bi-Cultural Worker models in GMSBML (eg: abovementioned PIR proposal) as basis for wider implementation

- *"Promote a multi-cultural model – build trust through people from many different cultural backgrounds….. It is not always appropriate to use bi-cultural workers." – Service Provider*

- Investigate availability of formal training and qualifications for Bi-Cultural/Multicultural Health Workers and determine whether promotion of qualification will benefit achieving status for Bi-Cultural Workers under Medicare

The following recommendations cannot be implemented locally, without government action:

Alter status for Bi-Cultural under Medicare to be the same as Indigenous Mental Health Providers (acknowledging that not all clients will wish to include a Bi-Cultural Worker in their care) - *We strongly advocate for the role of bilingual worker to be given the same status under Medicare as indigenous mental health providers.– ATAPS Provider*

- broaden definition of "family" and role of extended family and community for people from CALD and refugee backgrounds, in government policies and legislation (eg: Queensland Mental Health Act 2000)

4. Address Interpreter issues

The following systems level recommendations are made to address interpreter related barriers in GMSBML.

- Clarify policies and procedures for use of Interpreters within Queensland Health, ATAPS and Partners in Recovery programs

- Provide user friendly and easily accessible information and links about using interpreters on the GMSBML website
- Provide comprehensive and sustainable *"training for health professionals to know how to work with professional interpreters,* in association with implementation of the recommended GMSBML-wide organisational cultural responsiveness framework

Some systems level interpreter issues are funding and technology related, and beyond the capacity of the GMSBML region to directly address.

Recommendations: The following recommendations require government action and are documented to demonstrate project participants' strong advocacy for their implementation.

- Free national TIS interpreting services for allied health providers in primary health care
- payments to service providers for additional time required to engage and work with Interpreters (payment linked to actual interpreter use to incentivise the use of professional interpreters rather than others)
- allow practitioners to re-engage the same Interpreter when dealing with mental health issues, for continuity – *enable practitioners to book a specific interpreter through TIS (without signing an indemnity form, for appointments that build trust with patient - GP*
- *"Provide training for interpreters in mental health" – Service Provider*
- Investigate TIS voice recognition system that *"doesn't recognise English with an accent"*

5. Mental Health Assessment Tools and Data Documentation (Minimum CALD dataset)

Recommendation: Fund partnerships to research the use of appropriate non-language based mental health assessment methods for CALD communities such as the current research partnership undertaken at Milpera State High School. (See text box below).

- *"We need experts to advise on which mental health assessment tools are best" (GP)*
- *"We need the development of a culturally responsive assessment tool to replace CANSAS" (PIR)*

A 3 year research partnership between Queensland University of Technology (QUT), the Australian Catholic University and Milpera State High School is, in addition to other research projects, investigating the use of a non-language based assessment test, the CTONI-2 with students from refugee backgrounds. The project aims to validate that the non-language based test is a reliable measure to assess student well-being, which impacts on the learning process, and considers a range of protective factors and stressors such as trauma and acculturation, so that students can then receive the proper assistance required to address some of these barriers to learning.

Recommendation: Ensure that CALD relevant data is collected and used to inform and develop the evidence base, and thus improve the effectiveness of mental health services for people from CALD backgrounds.

Ethnicity data and 'date of arrival' need to be collected in documentation for people from CALD backgrounds as the exclusion of key CALD variables, such as ethnic details, in government funded data collections is counterproductive. [29] The capturing of 'Country of birth' rather than ethnicity data *"is not indicative of people's experience and disguises differences"* - *Service Provider*

6. Social and Economic Deprivation

Recommendation: Reduce people 'getting lost in the system' and experiencing isolation by providing information about low and no cost mental health care in GMSBML for people from CALD and refugee backgrounds.

Recommendation: Provide more options for outreach and home visits, to address barriers such as transport costs and child care issues, which can result in missed appointments.

Part 4: Conclusion

Qualitative findings suggest that there are substantial gaps in culturally responsive mental health care for people from CALD and refugee backgrounds, at risk of or experiencing severe and persistent mental health conditions, in the GMSBML area. The project has consulted widely with clients and carers and drawn on the experiences of CALD/refugee and mental health service providers to map the local barriers which contribute to these gaps, and identify ways of closing gaps and improving the system.

Barriers have been categorised and expressed at different levels of perception and / or impact: 'Client', 'Provider' and 'Systems'. The process of barrier mapping has found significant flow-on between some barriers identified at the different levels. For instance a 'Client' 'shut out' by feeling that her cultural perceptions of mental illness have been ignored, may present as 'a missed appointment' for a service provider and again as a 'need for organisational level cultural competence training' at the Systems level. The barriers and problems of the client, service provider and the system impact on each other.

In order to achieve the project aim to enable systemic change in the GMSBML area, an outcomes focus has been adopted. Most recommendations emanating from the project will be actionable within the GMSBML area within a time frame of months rather than years. In response to consultation about identified barriers and suggestions for overcoming them,

[29] Minas et al. (2013) Mental Health Research and Evaluation in Multicultural Australia: developing a culture of inclusion

specific 'hands-on' recommendations have been made, and user-friendly guidelines and protocols developed to enhance appropriate mental health support and care for people from CALD and refugee backgrounds.

Key strategies to address 'lack of fit' between the local mental health system and people from CALD backgrounds with severe and persistent mental health conditions are recommended for implementation.

The following strategies for change and improvement have been selected from the comprehensive list of *Recommendations* contributed to by project participants because opportunities currently exist for their immediate implementation within the context of existing mental health referral pathways, partnerships and resources within the GMSBML area. They focus on building system capacity while giving voice to the consumer via stronger consumer engagement.

The strategies include:

- Acknowledge benefits of engaging people from refugee backgrounds ie: Community Consultants in design and delivery of mental health services through ongoing involvement in CALD community facilitated education and partnerships, to build mental health literacy, reduce stigma and dispel myths
- Support CALD community networks to develop a 'mental health pathway resource' with information about service options and how to access them, based on the recently developed 'Refugee Mental Health Pathways tool for GPs and Health Professionals'[30]
- Distribute or make available Tip Sheets for Service Providers (see Appendices 2 and 3) to assist services engaging clients from CALD backgrounds
- Clarify policies and procedures for use of Interpreters within Queensland Health, ATAPS and Partners in Recovery programs
- Create more flexibility in the ways mental health programs, including ATAPS are delivered to the CALD community client group including additional sessions for CALD clients and the importance of engaging of professional interpreters
- Develop & promote PIR as a best practice service partnership model for integrated mainstream & CALD/refugee specialised care
- Implement GMSBML PIR wide cultural competency approach, adopting - *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*[31] and the Organisational Cultural Responsiveness Assessment Scale (OCRAS)
- Use and monitor the effectiveness for PIR of a *b*i-cultural workers model (in some cases) such as that used by Harmony Place

[30] This tool was developed by the Greater Brisbane Refugee Health Service Providers Working Group (Mental Health Subgroup) and is available at http://gmsbml.org.au/programs-and-services/refugee-health/

[31] The National Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery http://framework.mhima.org.au/framework/index.htm

- Address confusion between mainstream mental health providers and ‘specialised' CALD/refugee providers about organisational roles & limitations

Appendices

1. Project Consultation List
2. Tip Sheet 1: ‘Tips to increase the cultural responsiveness of mental health services for people from CALD backgrounds in Queensland’.
3. Tip Sheet 2: ‘Tips for using interpreters with people from CALD backgrounds and mental health services in Queensland’.

Appendix 1: Project Consultation List

Project Partners:

- Harmony Place
- Mater UQ Centre for Primary Health Care Innovation
- Queensland Transcultural Mental Health Centre (QTMHC)
- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)

Project Advisory Groups:

- Greater Brisbane Refugee Health Advisory Group – Health Development Workers
- The Greater Brisbane Refugee Health Partnership Advisory Group – Mental Health Subgroup including:
  - Australian Red Cross
  - International Health & Medical Services (IHMS)
  - Mater Mothers Refugee Maternity Service
  - Mater Refugee Health Clinic
  - Mater Child and Youth Mental Health Service
  - Multicultural Development Association (MDA)
  - Queensland Health
  - West Moreton Oxley Medicare Local
  - World Wellness Group

General Practice

Consumers: via various organisations

Greater Metropolitan South Brisbane Medicare Local (GMSBML)

- ATAPS Service Providers
- Partners in Recovery (PIR) Partner organisations:
  - Access Community Services Ltd
  - Aftercare
  - Benevolent Care
  - Career Keys
  - FSG
  - Gallang Place
  - Institute for Urban Indigenous Health
  - Micah Projects Inc
  - Neami National
  - Richmond Fellowship Queensland
  - Stepping Stone Clubhouse
  - The Brook Red Centre

Tip Sheet 1: Tips to increase the cultural responsiveness of mental health services for people from CALD backgrounds in Queensland

1. **Use an Interpreter**

See Tip Sheet 2: Tips for using interpreters with people from CALD backgrounds and mental health services in Queensland.

2. **Watch your language!**

Medical language and talk of systems and referrals are hard to understand when you are "outside the system". Use simple language.

Use positive language and take time to connect with clients and carers. Use words like 'recovery' and 'wellbeing' (rather than 'Mental Health', 'mental' and 'illness') on buildings, doors and printed flyers. Talk about receiving help in the form of 'coping with difficulties' and 'managing stress'. Be aware of diverse cultural perspectives about recovery.

See MHiMA concept sheet: 'Recovery and Cultural Diversity' http://framework.mhima.org.au/framework/supporting-tools-and-resources/key-concepts/recovery-and-cultural-diversity

3. **Access translated information**

CALD consumers have lower levels of health literacy and it is important to ensure that they receive health information in their preferred language. Mental Health in Multicultural Australia [32] offer free translated resources for use by health practitioners working with individuals and families from culturally and linguistically diverse backgrounds.

4. **Respect cultural beliefs**

People have different perceptions and cultural understandings of the causes and treatments of mental illness and their expectations of health care. This can affect their acceptance of treatments. Communicate respectfully and listen to cultural and spiritual beliefs about causes and treatments. Incorporate these beliefs into the treatment – do not dismiss them.

[32] http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-resources

When working with CALD consumers with significant cultural barriers consider contacting the Queensland Transcultural Mental Health Centre[33] who provide state-wide consultation services via a pool of over 150 bilingual mental health workers and cultural consultants covering over 100 different languages to advise on managing cultural issues in mental health.

5. **Issues to consider when involving family**

Check if the client would like you to contact a family member that they trust to act as a support person. This will help you to build trust with the client and reduce isolation. Remember, some cultures are more collectivist than Western society and the notion of 'family 'is quite broad. Many clients may want to keep their issues private, due to shame and stigma, but it is worth asking the question. It is often critical to engage the family in the care of the consumer and many CALD families will benefit from psycho-education. In some family structures it is essential to engage the head of the household in order to work effectively with the family.

6. **Consider involving a community or spiritual leader**

Don't assume that people will want to be connected with their ethnic community, especially if they are experiencing a mental illness, due to heightened stigma and shame. Past experiences of torture and trauma can also affect trust.

However, do ask who the key people in the client's life are and who they want involved. This may be include a religious leader, an informal or elected community leader. This can be very beneficial for ongoing support, reducing isolation and recovery. Make this offer at different points of the treatment, as the client may initially refuse, but when the client has been receiving treatment, they may be more open to receiving support. Multicultural support agencies are often a good point of contact to connect with community leaders and elders.

7. **Train all staff (including reception staff) in cultural awareness, trauma and the impact of migration.**

Cultural responsiveness education and training in mental health, focusing on working with people from CALD backgrounds increases skills and confidence for all staff at your organisation. Organisations offering training in Queensland are:

- Qld Transcultural Mental Health Centre (QTMHC) –practical applications for the mental health workforce focusing on enhanced clinical outcomes for CALD

[33] www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/

consumers via cultural responsive practice. Contact: (07) 3167 8333 or andres_otero-forero@health.qld.gov.au

- Qld Program of Assistance to Survivors of Torture and Trauma (QPASTT) – Offer a variety of workshops throughout the year, including introduction to the refugee and settlement experience and understanding the impact of trauma. They also offer a PD by Request Program to organisations or groups on a needs basis. Contact: Fernanda Torresi on (07) 3120 1525 or qpastt_training@qpastt.org.au
- Multicultural Development Association (MDA) – Offer training about 'Working with Refugees' Contact: (07) 3337 5400 or mailbox@mdaltd.org.au
- World Wellness group (WWG) – Offer training and workshops on a wide range of multicultural health and mental health topics. Contact: admin@worldwellnessgroup.org.au or refer to www.worldwellnessgroup.org.au
- Queensland Health – Multicultural Mental Health Coordinator Program – Offer training to enhance the capacity of mental health services to respond to the mental health needs of people from culturally and linguistically diverse (CALD) backgrounds. Contact: qtmhc@health.qld.gov.au or (07) 3167 8333

8. **Work with bi-cultural workers or Cultural Consultants**

Bi-cultural workers are an essential component of a culturally responsive service as they not only help to build trust to engage successfully with CALD consumers but also can inform on the cultural specific elements relating to a cultural assessment. Contact the Queensland Transcultural Mental Health Centre (07) 3167 8333 or email: tccs@health.qld.gov.au

9. **Consider flexibility of your service**

Consider your service model. Does it allow for outreach and home visits to overcome access barriers? Make sure the focus of the first appointment is on building trust and rapport, to make another appointment (rather than interrogating with a long list of questions). It will take time to gather all the information.

10. **Organisational policy**

Culturally responsive mental health services are led by managers who are aware of how organisational systems and policies impact on access and engagement of CALD clients. Policies need to be audited and reviewed so that staff are supported to implement strategies. Use the Mental Health in Multicultural Australia (MHiMA) framework The OCRAS is based on the National Cultural Competency Tool (NCCT) for Mental Health Services (2010) which includes eight cultural competency standards. The Organisational

Cultural Responsiveness Assessment Scale (OCRAS) is used to guide organisations through the development of an individually tailored action plan to make changes at the organisational level. Invite a speaker from QTCMH to give examples of using the framework, best-practice models and information about clinical consumer program. http://framework.mhima.org.au/framework/index.htm

11. **Employ a diverse workforce**

Regardless of the worker's own cultural background, gender or religious belief, an open approach and awareness of how this impacts on a client is valuable. Consider employing a variety of people (Eg: gender, cultural background and in some cases religion) to work with CALD clients as clients relate in different ways and may connect with a particular worker but don't assume that the client will necessarily want to work with a bi-cultural worker. It is especially important to employ female workers to work with female CALD consumers.

12. **Refer client to a group**

Reduce isolation so that consumers have connections and stigma is reduced. Partner to run a program or refer to organisations that run groups that are accessible to CALD consumers, Eg. The CALD consumer consultants at the Qld Transcultural Mental Health Centre run peer support groups for consumers ph 3167 8333 or email qtmhc@health.qld.gov.au

When clients are in hospital:

To ensure culturally appropriate support and care consider asking "What do you do in your culture that helps?" They may have specific cultural practices that they feel they cannot follow while in hospital and it is useful to find out what these are.

A woman is in the Mental Health Inpatient Unit and prays 7 times a day and refuses food and drink at meal times when the staff say "You need to eat". She speaks limited English. A female clinician is employed to request a female interpreter to have a respectful conversation to ask about her behaviour, culture and background. She finds out that the woman is a Muslim and praying 7 times a day is part of her religion. She is currently refusing food as it is Ramadan and she is fasting for a month, where she only eats halal food and no pork products when the sun sets.

Other Resources:

Multicultural Mental Health Website with resources for health workers
http://mhima.org.au

Cultural diversity: A guide for health professionals presents health and socio-cultural information on multicultural communities (including torture and trauma and issues for children, young people and women). It encourages health staff to actively explore cultural issues with patients and cautions against stereotyping.

Community Profiles for Health Care Providers is a practical tool that assists health care providers to better understand the health beliefs, pre-migration experiences, communication preferences and other aspects of their clients' culture. http://www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp

Ethnic Communities Council of Queensland 'What's working?' in the practice of service provision to people from culturally and linguistically diverse backgrounds. November 2012. http://www.eccq.com.au/wp-content/uploads/2012/11/Whats_working_research_reportv1.pdf

Additional tips for GPs: Shannon, P.J. (2014) Refugees' advice to physicians: How to ask about mental health. Family Practice. Vol. 00, No. 00, 1–5.

This tip sheet was developed as part of a project by the Mater UQ Centre for Primary Health Care Innovation in partnership with Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Queensland Transcultural Mental Health Centre (QTCMHC) and Harmony Place, funded by Greater Metro South Brisbane Medicare Local Partners in Recovery Innovative Fund.

Tip Sheet 2: Tips for using interpreters with people from CALD backgrounds and mental health services in Queensland.

NGOs: Check if your agency is eligible for free interpreting services and apply for a client code. www.tisnational.gov.au/Agencies/Frequently-Asked-Questions-for-agencies

Public Mental Health Service: Ensure staff are aware local booking processes via ISIS (interpreter service information system) Staff must be registered to use ISIS. www.health.qld.gov.au/multicultural/interpreters/ISIS_reg_frm.pdf

Check out the Queensland Language Services Policy and the Queensland Language services Guidelines. As a service provider in the region it would be useful to check out the action plans and see what the government departments in your area should be able to deliver to provide services to migrant and refugee communities.
www.datsima.qld.gov.au/datsima/cultural-diversity/publications/queensland-cultural-diversity-policy

Read the 'Training Resources for Working Effectively with Interpreters' developed by Victorian Transcultural Mental Health www.vtmh.org.au/resources/working-effectively-with-interpreters.html

When using an interpreter:

- Don't just use an interpreter, use an **appropriate** interpreters – Carefully consider ethnicity and gender
- Allow extra time and brief the interpreter.
- Speak directly to the client. Say "What is your name", not "What is her name?"
- Use simple language, without jargon and complicated medical terms that clients can understand
- Consider that people experiencing a mental illness may feel shame in front of an onsite interpreter and prefer a telephone interpreter (you can book this saying the name is confidential to protect the client's privacy even more).
- It is important to remember that if a family or individual does not take up the offer of an interpreter, it may be because of privacy concerns and they should be given the option of a phone interpreter.
- When you find an interpreter that the individual or family is comfortable with, try to use the same interpreter for all communications. It can be very difficult for the person and or their family to share very intimate details of their lives with a new interpreter every time you meet.
- Avoid using family, friends and Bilingual Staff as interpreters as there may be uncertainty about accuracy, impartiality and confidentiality.
- Don't use children as interpreters.

- It is a good idea to check with a client whether s/he prefers a male or female Interpreter. Female CALD clients will usually prefer a female interpreter.

More information:

Assessing the need for an interpreter
www.ceh.org.au/downloads/CEH_TipSheet2_Assessing_need_for_interpreter.pdf
Useful tips on how to conduct the interpreting session (Qld Health)
www.health.qld.gov.au/multicultural/interpreters/interp-tips.pdf
How to work with an interpreter onsite and on the phone (Qld Health)
www.health.qld.gov.au/multicultural/interpreters/how_to_work_int.pdf
Working with interpreters tip sheet (Centre for Culture, Ethnicity and Health)
www.ceh.org.au/downloads/CEH_TipSheet4_Working_with_interpreters.pdf

You Tube videos:

Hints and tips for working with interpreters
www.youtube.com/watch?v=Q4voquDnkbM
TIS National services for medical practitioners
www.youtube.com/watch?v=MXy-QF9GHyM

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