MHiMA
Mental Health in Multicultural Australia

Introductory guide

Framework

for **Mental Health** in **Multicultural Australia**

Towards culturally inclusive service delivery

MHiMA
Mental Health in Multicultural Australia

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Framework for Mental Health in Multicultural Australia:
Towards culturally inclusive service delivery

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Overview

The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery **(The Framework) has been developed to help services evaluate their cultural responsiveness and develop action plans to enhance their delivery of services to CALD communities as part of core business.**

The Framework is mapped against legislation, policies and plans. Its implementation will assist organisations to fulfil their existing safety, quality and accreditation requirements. The Framework offers an ongoing process of assessment and development.

The Framework consists of three integrated components:

1.	Organisational Cultural Responsiveness Assessment Scale (OCRAS)	The OCRAS is based on the *National Cultural Competency Tool (NCCT) for Mental Health Services (2010)* which includes eight cultural competency standards. The OCRAS assessment scores are used to guide organisations through the development of an individually tailored action plan.
2.	Implementation guides	The action-oriented implementation guides consist of four key outcome areas with associated indicators and strategies to help organisations identify what they can do to enhance their cultural responsiveness. The outcome indicators have been developed for both organisations and individual workers and are ranked at three levels of achievement.
3.	Resources and information	Resources and information to assist organisations and individual workers to build their knowledge and skills in the provision of services for culturally and linguistically diverse consumers, carers and communities. These resources include best practice examples, five key concept sheets, a knowledge exchange centre and links to useful policy documents and websites.

Introduction

This introductory guide is an overview of the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* (The Framework), developed by Mental Health in Multicultural Australia (MHiMA).

The Framework is an important tool for mental health services operating in all sectors. The Framework enables mental health services to evaluate their cultural responsiveness, enhance delivery of services and work in partnership with CALD communities.

It is a web-based, action-oriented system aimed at both organisations and individual workers which can be accessed online at **www.mhima.org.au**

This introductory guide provides an explanation about why the Framework is an important tool for mental health services. The Framework consists of three integrated components which are:

- **The Organisational Cultural Responsiveness Assessment Scale (OCRAS)**
  The OCRAS is based on the *National Cultural Competency Tool (NCCT) for Mental Health Services (2010)* which includes eight cultural competency standards. The OCRAS assessment scores are used to guide organisations through the development of a customised organisational action plan.

- **The action-oriented implementation guides**
  The guides consist of four key outcome areas with associated indicators and strategies. The four key outcome areas are:
  - Consumer, carer and family participation
  - Safety and quality
  - Promotion, prevention and early intervention
  - Workforce.

  The action-oriented implementation guides assist organisations and individual workers to identify what they can do to become more culturally responsive. Outcome indicators and strategies have been developed for both organisations and individual workers with three levels of achievement 'Entry', 'Developing' and 'Advanced'.

- **Resources and supporting information**
  The resources and supporting information will assist organisations and individual workers to build their knowledge and skills in developing mental health service provision that is culturally responsive. The resources and supporting information include good practice examples, five key concept sheets, a knowledge exchange and links to useful policy documents and websites.
- The key concept sheets are the theoretical underpinnings of the Framework. They are:
  - Cultural responsiveness
  - Risk and protective factors
  - Culturally responsive practice
  - Consumer and carer participation
  - Recovery and cultural diversity.

The Framework is mapped to legislation, policies and plans. As such its implementation will assist mental health services to fulfil their existing safety, quality and accreditation requirements against both the *National Standards for Mental Health Services (2010)* and the *National Safety and Quality Health Service Standards (2012)*. The Framework offers an ongoing process of assessment and development that is built into existing quality activities.

Rationale

"...what we increasingly know about the mental health of the general Australian population, we do not know about culturally and linguistically diverse communities in Australia."

What the data says

There are considerable gaps in data and information on the prevalence of mental illness in people from CALD backgrounds and their experiences with the health system. Data collection systems used by mental health services are often not adequately equipped to capture data on cultural and linguistic diversity. In addition, CALD populations are not often included in national mental health research.[1] At a national level, there is limited monitoring or reporting on the status of mental wellbeing in CALD communities, the level of service access or mental health outcomes.

Despite these gaps and limitations, there is some data available indicating that the mental health experiences and outcomes of first and second generation immigrants, refugees, asylum seekers and their families are different to those of other Australians. In particular, the data tells us that:

- Generally immigrants, refugees and asylum seekers have lower rates of mental health service utilisation than the Australian-born population[2]. Barriers to access include greater stigma about mental illness in some CALD communities, language barriers, cultural misunderstandings, and limited knowledge of mental health and available services when compared with the Australian-born population. These barriers make it harder for people from CALD backgrounds to access mental health services when needed, resulting in higher acute and involuntary admissions.
- People from CALD backgrounds are over-represented in involuntary admissions and acute inpatient units and are more likely to be exposed to quality and safety risks. These risks include misunderstandings and misdiagnosis and they are often a result of language and cultural barriers.[3]
- Other factors contributing to increased risk of mental health problems in CALD populations include low proficiency in English, loss of close family bond, racism and discrimination, stresses of migration and adjustment to a new country, trauma exposure before migration, and limited opportunity to fully utilise occupational skills. Factors that appear to be protective of mental health include religion, strong social support and better English proficiency.[4]
- Suicide rates for first generation immigrants generally reflect the rates in their country of birth while the rates for subsequent generations of immigrants tend to become more reflective of the rates for the Australian population. Research indicates that strong family bonds, religion and traditional values are associated with lower suicide risk.[5]
- Refugees and asylum seekers are at greater risk of developing mental health problems and suicidal behaviours than the general Australian population. Prolonged detention is associated with poorer mental health in asylum seekers, particularly among children.[6]

A culturally diverse future

Population projections are clear. Immigration, including a significant humanitarian intake, will be a continuing major contributor to Australia's future. This creates an even more pressing need for mental health services to respond in culturally inclusive ways.

Multicultural Australia

Australia is a multicultural country with over a quarter of Australia's population being born overseas and more than 200 languages spoken.[7] Migration patterns have changed in the past 15 years and there is now a significant increase in the number of immigrants arriving from non-English speaking countries. As Australia's cultural diversity continues to grow, so does the need for mental health services to be more responsive to the diversity in their local communities ensuring greater access and equity in service delivery for CALD communities.

Increased cultural diversity brings a range of approaches to understanding and explaining mental illness and mental wellbeing. Cultural beliefs about what constitutes mental illness and how to respond to it will affect how immigrants and refugees display distress, explain symptoms, seek help and whether or not they will choose to access health services. Understanding mental illness as a health problem that requires medical treatment is a western concept that can seem strange or even threatening to some immigrants and refugees.[8] Health professionals who try to understand and work with differing cultural views about mental illness will more successfully engage with CALD consumers and communities and achieve better mental health outcomes.[9]

Australia is a signatory to the United Nations Convention Relating to the Status of Refugees (1951) and the Protocol (1967) and as such accepts refugees from a range of countries every year. Refugees are often very vulnerable and can be at higher risk of developing mental health problems because of their pre-migration and migration experiences, which can include torture, trauma, detention, poverty and loss of family and community.[10] When providing mental health care to refugees, mental health services need to be aware of the added complexity of the experiences of refugees and the importance of the Program of Assistance for Survivors of Torture and Trauma (PASTT) as a key strategy in the delivery of specialist mental health services to refugees.

Australian Mental Health Policy context

As a multicultural nation, Australia's mental health policies and plans contain principles promoting cultural responsiveness. However, as there has been limited evaluation of the implementation of these policies in relation to CALD populations, it is not possible to determine if there have been improvements in mental health outcomes in CALD communities over time. Available information suggests that there are still barriers for CALD communities when accessing mental health care.

Australia's mental health care system includes reporting and monitoring mechanisms that provide an annual snapshot of mental health activity. There are also a number of mental health policies and plans designed to promote cultural competency. Although current policies and plans provide a vision for what needs to be done, they don't always provide strategies or indicators to assess how improved cultural competence can be achieved and tracked over time.

On a national level, there is limited reporting on the implementation of these policies and plans in relation to CALD populations. The Framework seeks to overcome some of these limitations.

The Framework is mapped to existing Commonwealth, State and Territory legislation, policies, plans and frameworks in mental health services, suicide prevention and multicultural affairs. In particular, it is closely aligned with the *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009 –2014* and *The Roadmap for National Mental Health Reform 2012–22*. It is also mapped against current standards for Australian mental health services, including the *National Standards for Mental Health Services (2010)* and the *National Safety and Quality Health Service Standards (2012)*.

The Framework is aligned to, and consistent with these policies and standards in order to assist organisations to fulfil their existing safety, quality and accreditation requirements. This approach has been designed to enable organisations to incorporate the work they do on the Framework within their existing quality and accreditation activities so that it is an ongoing process and not an 'add on' activity.

In addition the Framework assists mental health services to identify and address access and equity barriers. This aligns with the ongoing commitment of successive governments across Australian jurisdictions towards an inclusive multicultural Australia.

Using the Framework

The Framework is designed to turn principles into actions.

The purpose of the Framework is to improve service delivery for CALD consumers and carers.

It translates principles and standards into clear, practical and achievable strategies that can be implemented at an organisation's own pace. It also fully adopts the principles underlying the *Fourth National Mental Health Plan (2009)*.

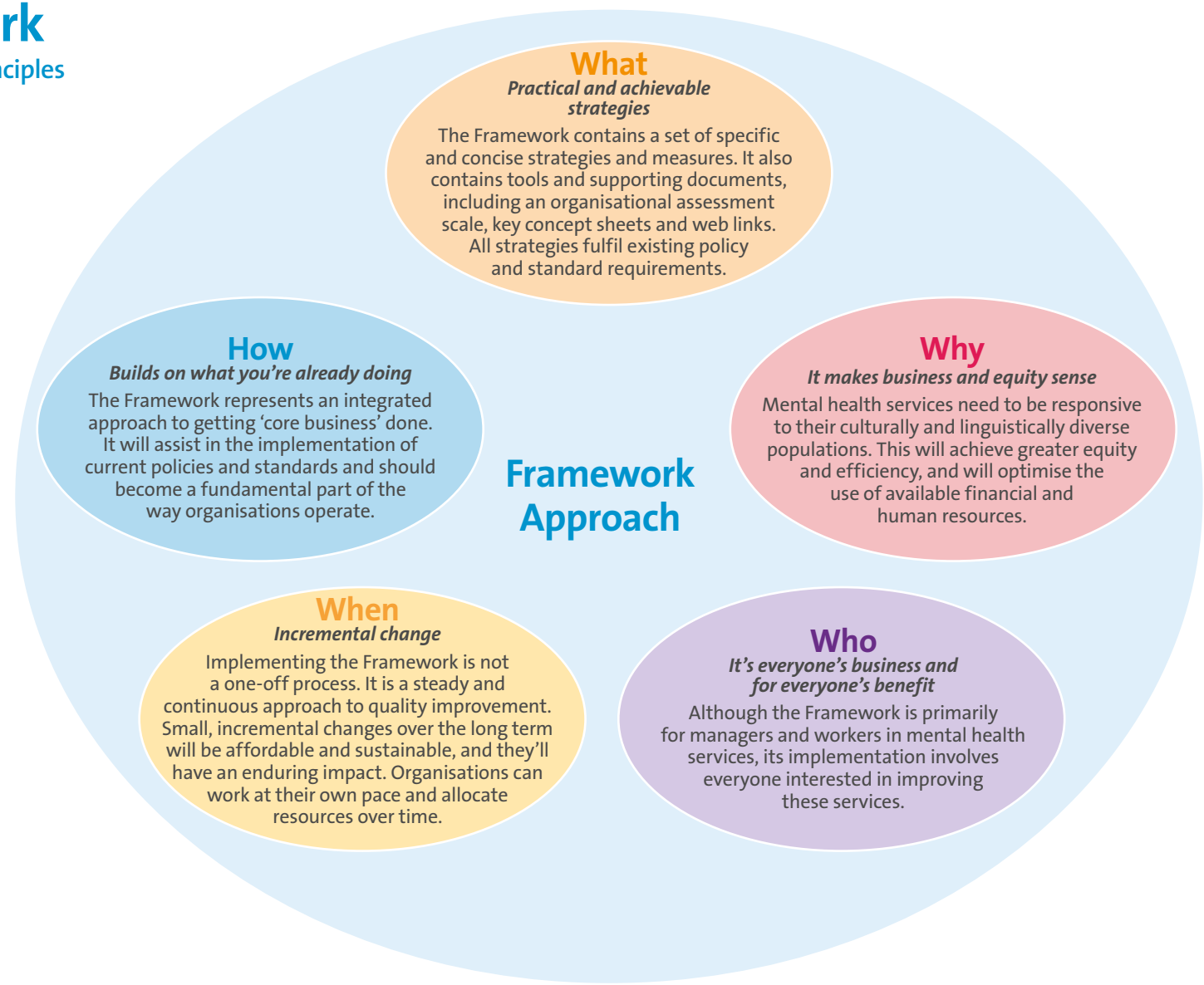
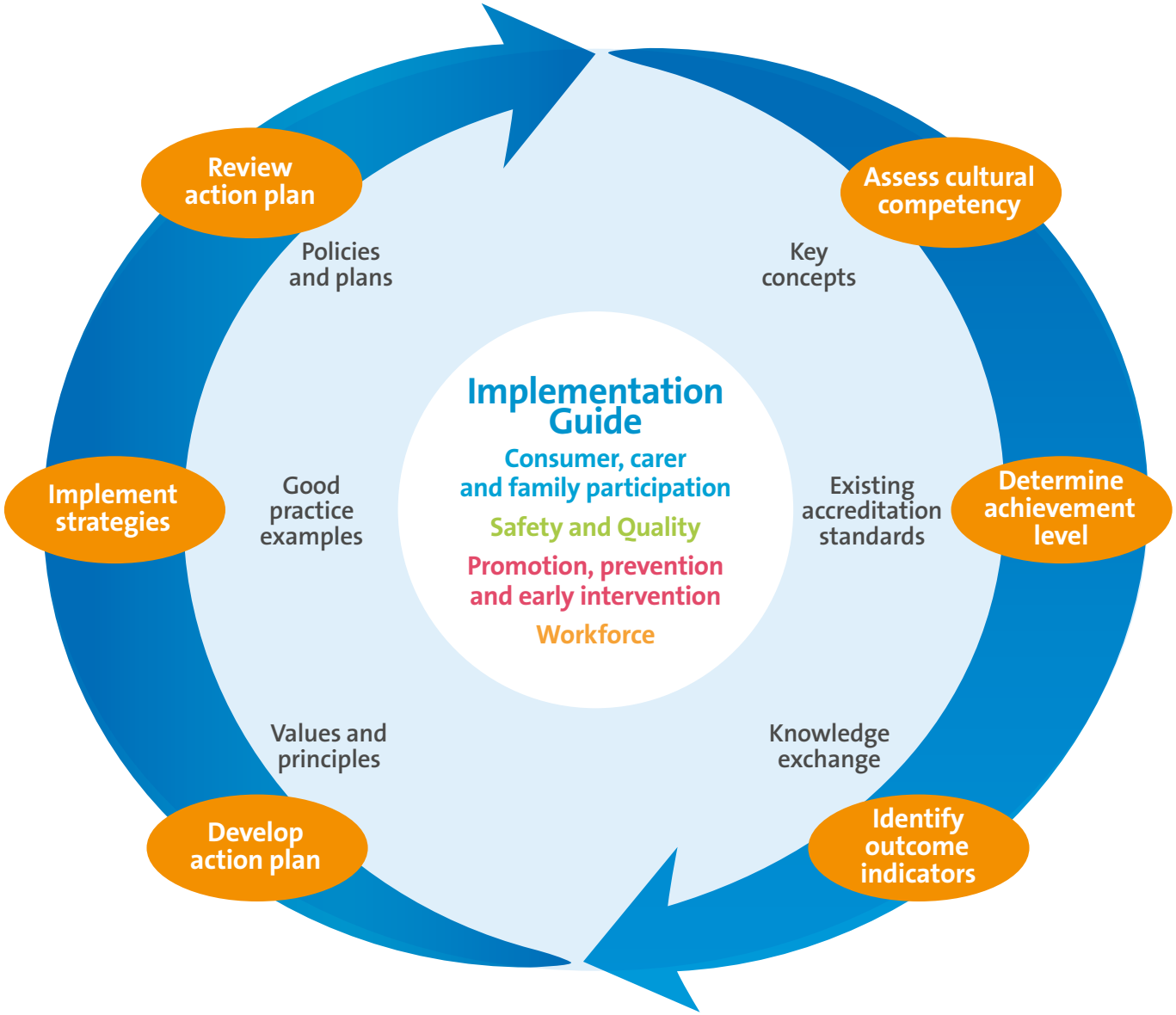


Figure 1: Framework approach



The Framework is primarily for managers of organisations to be used as part of their existing quality programs and accreditation.

Workers can use the Framework to guide reflection and improvements in their individual practice.

While there are separate processes for organisations and individual workers to develop their cultural responsiveness, both systems are aligned.

The Framework is used within a quality framework of assessment, planning, implementation and evaluation. This will enable mental health services to gradually work through the continuum of cultural responsiveness.

Implementing the Framework is not intended to be a one-off process. Rather, it is a continuous approach of building and enhancing culturally responsive systems and practices that will result in sustained and positive change. Mental health services using the Framework will also be able to more effectively meet accreditation standards as the Framework is aligned to the *National Standards for Mental Health Services (2010)* and the *National Safety and Quality Health Service Standards (2012)*.

Figure 2: The Framework – continuum of cultural responsiveness

Practical steps to using the Framework

The Framework is designed to engage with the mental health sector in two distinct ways:

- On an organisational wide basis in relation to delivery of culturally responsive care and practice.
- With the workforce at an individual worker level to enable individual reflection and delivery of culturally responsive care and practice.

The Organisational Cultural Responsiveness Assessment Scale (OCRAS)

The OCRAS builds on the National Cultural Competency Tool (NCCT) for mental health services released in 2010. It is specifically designed to support the development of culturally responsive practice at an organisational wide level.

The OCRAS is a web-based assessment tool that generates scores based on responses provided to eight cultural competency standards. The scoring system is based on the work of Carole Siegel's (2011) three stages of cultural competency. The first stage is the implementation of administrative elements; this includes developing organisational commitment and engagement to cultural competency. The second stage is engagement in activities that help build an understanding of the local community. The third stage is about direct clinical care.

Scores are generated against each cultural competency, which are totalled for an overall score. The OCRAS helps organisations identify which outcome areas in the *Organisational Implementation Guide* are most appropriate to include in their own tailored action plan.

Each outcome indicator also provides strategies, good practice examples and an understanding of how they are linked to national accreditation standards.

Organisations develop and implement an action plan at their own pace and they can re-assess their progress at any stage using the OCRAS.

All organisational online records in the OCRAS are maintained in a secure and confidential environment. The online record of an organisation is only available to the nominated registered user in an organisation. Completion of the OCRAS will generate one total score that will be accessible by MHiMA in a de-identified manner. Aggregate de-identified organisational scores will be used by MHiMA to map uptake and change. Scores will not be used to compare organisations or regions and will only be used for MHiMA's future planning and improvement of the Framework.

MHiMA provides ongoing advice and support to registered users of the Framework at any stage as requested. Registered users are encouraged to actively share good practice examples for the benefit of everyone which they can submit to MHiMA for uploading to the online Framework website.

The following tables provide a quick step by step guide of how the Framework is intended to be used by the mental health sector either on an organisational-wide basis or as an individual worker:

Use of the Framework as an Organisation	
Step 1	Organisations complete the online OCRAS. On completion the organisation will receive an *Assessment Score Report Card* via e-mail to the registered user. This report provides a diagnostic of the organisation's current level of cultural responsiveness based on the eight cultural competency standards. Receipt of the *Assessment Score Report Card* is the first stage of completing the OCRAS.
Step 2	The *Assessment Score Report Card* should be read in conjunction with the *Organisational Implementation Guide*. This guide includes indicators and strategies to improve organisational cultural responsiveness. It also includes links to resources and information to guide the development of a customised organisational action plan. Development of an action plan is the second stage of completing the OCRAS.
Step 3	Once organisations have fully completed the action plan in the OCRAS, an e-mail of the completed *Action Plan Report Card* is sent to the registered user. The action plan becomes the basis for ongoing monitoring and evaluation of organisational progress in improving cultural responsiveness. Following implementation of the action plan, Step 1 should be recommenced. On completion of Step 1, organisations will be able to measure and review progress in improving their cultural responsiveness.

Use of the Framework as an Individual Worker	
Step 1	Individual workers should review their practice in line with the achievement level for each of the four outcome areas in the *Workforce Implementation Guide*.
Step 2	The *Workforce Implementation Guide* includes indicators and strategies to assist individual workers to reflect and consider ways in which they can improve their practice in delivery of culturally responsive care as part of a process of continued professional development. Individual workers can then prioritise areas for professional development and can identify useful strategies to enhance their cultural responsiveness.

Additional Framework resources for organisations and individual workers

- Five key concept sheets that provide important theoretical underpinnings to improve cultural responsiveness
- Online links to relevant legislation, policies, standards and other useful web based resources which will be maintained and kept up-to-date
- Australian based good practice examples
- An online knowledge exchange centre which includes useful literature in the form of publications and open-access journal articles.

Levels of achievement

The Organisational and Workforce Implementation Guides have three levels of achievement that align with outcome indicators and practical strategies to improve cultural responsiveness.

The three levels of achievement are:

Entry	Entry-level achievement is expected of mental health services and individual workers in the public, private and community-managed sectors as detailed in the *National Standards for Mental Health Services (2010)*. This level reflects an awareness and understanding of culturally responsive mental health service delivery and practice, and a commitment to further development. Organisations and workers may have demonstrated occasional examples of good practice but an integrated approach still needs to be developed.
Developing	Developing-level achievement reflects a proactive approach to the implementation of culturally responsive practices. Organisations and individual workers at this level demonstrate culturally targeted approaches and strategies, specialist skill development in culturally inclusive practice and the integration of cultural responsiveness into systems and practice. Achievement at this level reflects a move away from 'one-off' examples, towards an approach that allocates time and resources to create sustained change.
Advanced	Advanced-level achievement is achieved when organisations and individual workers are considered leaders in the field of cultural responsiveness and mental health service delivery and practice. Cultural responsiveness is integrated and embedded as core business, and routine evaluation informs service improvements to meet the needs of CALD consumers and carers.

The Framework provides organisations with a pathway to work through a continuum of cultural responsiveness via an ongoing process of organisational assessment, implementation and outcomes review. It provides service managers with the tools to improve organisational cultural responsiveness and it provides individual workers with strategies to facilitate culturally inclusive practice.

Key outcome areas

Consumer, carer and family participation

Participation from consumers and carers leads reform and improves mental health services. It benefits organisations, consumers, carers and families. CALD consumer and carer participation generally lags behind mainstream levels.

The creation of culturally inclusive participation opportunities will extend the benefits of participation to CALD consumers, carers and families, producing more equitable outcomes.

Safety and quality

Safety and quality practices underpin all mental health service activities. Despite the current governance frameworks and standards, CALD consumers receive poorer quality of care and are more likely to be exposed to adverse safety risks.

The implementation of quality and safety standards in a culturally inclusive way, results in CALD consumers and carers experiencing improved safety and quality.

Promotion, prevention and early intervention

Promotion, prevention and early intervention are key components of contemporary mental health policy and plans. Programs with a broad focus generally do not engage CALD populations. These types of programs may fail to reduce health inequalities or may even increase existing inequalities.

Culturally tailored programs produce better outcomes for CALD communities and facilitate equitable access to programs and services.

Workforce

Culturally inclusive policies, practices and programs can only be effectively implemented through a culturally responsive workforce. Cultural responsiveness is directly linked to health outcomes and it is therefore important that the Australian mental health workforce has the skills to work effectively with our diverse population.

A culturally responsive workforce is able to provide culturally and clinically competent mental health care in their local communities.

Outcome area 1

Consumer, carer and family participation

Consumer and carer participation is one of the most important changes within the mental health sector and has strongly influenced the way mental health services are delivered *(Department of Human Services, 2009)*. When services better reflect the needs of consumers, carers and families they achieve better quality and safety health outcomes and increased client satisfaction. Strong evidence supporting the value of consumer and carer participation has become a central tenet of policies and plans.[11] The set standards and benchmarks are outlined in the *National Standards for Mental Health Services (2010)*.

Participation needs to be meaningful and involve consumers, carers and families across the full spectrum of health care, from policy development and legislation through to service delivery and evaluation. CALD consumer, carer and family participation varies across jurisdictions, and generally lags behind mainstream participation. Language barriers may restrict access and cultural differences in the notions of participation and consumer rights may reduce engagement of CALD consumers, carers and families in traditional consumer participation activities.

It is important that opportunities for the participation of CALD consumers, carers and families be specifically developed in consultation with CALD communities, elders and leaders. The creation of culturally inclusive participation opportunities will enable mental health services to be more responsive to the needs of CALD consumers, carers and their families and enhance knowledge about mental health services within local CALD communities.

Family is included in this key outcome area as CALD consumer and carer participation acknowledges that many cultural groups are collectivist. Family involvement is integral to facilitating participation and recovery.

Safety and quality

Safety and quality practices underpin all mental health service activities. There are governance frameworks in place to ensure high standards of clinical performance, risk management, clinical audits, ongoing professional development and processes to manage adverse events.

All health services, including mental health services, are guided by standards such as the *National Safety and Quality Health Service Standards (2012)*. Health services are routinely assessed against these standards through accreditation cycles. Mental health services are also guided by the *National Standards for Mental Health Services (2010)*, which are designed to be used through regular accreditation cycles.

Despite these standards, CALD consumers are over-represented in involuntary admissions and acute inpatient units[12]; receive poorer quality of care than the majority of the population[13]; and are at risk of errors and incidents leading to potentially serious clinical consequences as a result of language and cultural differences between service providers and consumers and carers.[14]

Quality and safety standards must be implemented in a culturally inclusive way rather than being seen as an add-on. This will result in improved safety and quality of mental health services for CALD consumers. The challenges of sound safety and quality practices are whether they can be applied equally to all Australians, including those of CALD background.

2 Outcome area

Outcome area 3

Promotion, prevention and early intervention

The importance of mental health promotion, prevention and early intervention is well established[15] and is a key component of current policies and plans.[16]

Unless programs are culturally tailored they are unlikely to have the desired outcomes. Culturally tailored health programs produce better outcomes and better access to services for culturally diverse populations than do generic population-based interventions.[17] International experience also suggests that broadly-focused approaches may fail to reduce health inequalities and may even increase existing inequalities.[18]

Strong collaborative approaches are required to ensure promotion, prevention and early intervention is effective and produces the desired outcomes. As such, agencies and groups from the multicultural sector and services in health, education, employment, housing, immigration and justice need to work together. Collaborative approaches to implementing culturally and linguistically responsive programs ensures that CALD consumers, carers and families are able to access and are more actively engaged with their mental health care.

Workforce

Australia requires a mental health workforce that is able to respond to the diversity of the Australian population. To achieve this outcome, strong leadership is needed to build an informed, skilled, flexible and reflective workforce. The *National Mental Health Workforce Strategy (2011)* identifies that the most appropriate strategy for building workforce capacity is cultural competency training, rather than brief awareness sessions.

The Framework aligns with the *National Mental Health Workforce Strategy (2011)* and the *Fourth National Mental Health Plan (2010)* by making workforce development one of the four key outcome areas. Key strategies include building skills and knowledge to develop and retain a culturally competent workforce.

Cultural competency has been shown to be directly linked to better health outcomes for CALD consumers.[19] It requires the workforce to go beyond cultural awareness to being culturally responsive. The integration of cultural responsiveness into clinical and other training programs ensures that cultural competency is embedded into the required skill-set of the mental health workforce.

Key stakeholders in building a culturally competent workforce not only include mental health services but also the Australian Health Practitioner Regulation Agency (AHPRA) and specific peak professional bodies and universities. The Framework will enable these key stakeholders to better support mental health services by embedding cultural competency as an important requirement for every worker.

4 Outcome area

Conclusion

MHiMA is pleased to present the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* and sees it as a cornerstone in the enhancement of mental health services for CALD consumers, carers and their families. The vision is that mental health services in the public, private and community-managed sectors utilise the Framework as an ongoing quality improvement process that guides them through the journey of building culturally responsive services.

Next steps

MHiMA encourages everyone to visit the Framework website (**www.mhima.org.au/framework**) and explore all that it has to offer both organisations and individual workers.

MHiMA is available to support and advise organisations in using the Framework and implementing strategies. This includes phone (**1300 136 289**) and email support (**framework@mhima.org.au**)

Footnotes

1. *Garrett, Dickson, Whelan, & Whyte, 2010; Stolk, Minas & Klimidis, 2008*
2. *Blignault & Eisenbruch, 2008; Correa-Velez, Sundararajan, Brown, & Gifford, 2007; Hassett & George, 2002; Youssef & Deane, 2006*
3. *Divi, Koss, Schmaltz, & Loeb, 2007; Johnstone & Kanitsaki, 2005, 2006; Pirkis, Burgess, Meadows, & Dunt, 2001; Stolk et al., 2008; Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2011*
4. *Alizadeh-Khoei, Mathews & Hossain, 2011; Chakraborty, McKenzie, Hajat, & Stansfeld, 2010; Reid, 2012; Sawrikar & Hunt, 2005*
5. *Burvill, Armstrong & Carlson, 1983; Kliewer, 1991; McDonald & Steel, 1997; Morrell, Taylor, Slaytor, & Ford, 1999*
6. *Silove, Austin, & Steel, 2007; Silove & Steel, 1998; Silove, Steel, McGorry, & Mohan, 1998; Ziaian, de Anstiss, Antoniou, Sawyer, & Baghurst, 2012*
7. *Australian Bureau of Statistics, 2012; Cully & Pejoski, 2012; Queensland Health, 2010*
8. *Kleinman & Benson, 2006*
9. *Kleinman & Benson, 2006*
10. *Davidson, Murray & Schweitzer, 2008*
11. *Department of Human Services, 2009*
12. *Pirkis et al., 2001; Stolk et al., 2008*
13. *Johnstone & Kanitsaki, 2005, 2006*
14. *Johnstone & Kanitsaki, 2005, 2006*
15. *Department of Health and Ageing, 2012*
16. *Department of Health and Ageing, 2009, 2010; The Council of Australian Governments, 2012)*
17. *Blignault, Woodland, Ponzio, Ristevski, & Kirov, 2009; Sun, Tsoh, Saw, Chan & Cheng, 2012*
18. *Jones, Trivedi & Ayanian, 2010*
19. *Australian Institute of Health and Welfare & Australian Commission on Safety and Quality in Health Care, 2007; Bird, 2008; Divi, Goss, Schmaltz, & Loeb, 2007*

Glossary

Based on the National Standards for Mental Health Services (2010) unless indicated otherwise.

Access: Ability of consumers or potential consumers to obtain required or available services when needed within an appropriate time.

Access and equity: The Australian Government aims to achieve fairer and more accessible government services and programs through its Access and Equity strategy, which seeks to promote fairness and responsiveness in the design, delivery, monitoring and evaluation of government services in a culturally diverse society (Department of Immigration and Border Protection 2013).

Asylum seeker: A person who has fled their own country and applied for protection as a refugee (Australian Human Rights Commission 2013).

Carer: A person of any age who provides personal care, support and assistance to another person because the other person has a disability, a medical condition, a mental illness or is frail (Mental health statement of rights and responsibilities 2012).

CALD: Culturally and linguistically diverse.

Consumer: A person who is currently using, or has previously used, a mental health service.

Cultural Competency/Responsiveness: A set of congruent behaviours, attitudes and polices that come together in a system, agency or those professions to work effectively in cross-cultural situations. Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services (Australian Government, NHMRC, 2006).

Cultural and Linguistic Diversity: Refers to the wide range of cultural groups that make up the Australian population and Australian communities. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. It is used to reflect intergenerational and contextual issues, not just the migrant experience (Australian Government, NHMRC, 2006).

Culture: A shared system of values, beliefs and behaviour.

Diversity: A broad concept that includes age, personal and corporate background, education, function and personality. Includes lifestyle, sexual orientation, ethnicity and status within the general community.

Glossary *Continued...*

Early intervention: Interventions that target people displaying the early signs and symptoms of a mental health problem or mental disorder.

Mental health: The capacity of individuals within the groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.

Mental health literacy: The knowledge and skills that enable people to access, understand and apply information for mental health (Canadian Alliance on Mental Illness and Mental Health, 2008).

Mental health professional: Refers to members of the workforce who are specifically trained in mental health and are expected to work to particular standards and/or meet registration requirements. In some cases, this term is used interchangeably with the term 'mental health worker'. (National Mental Heath Workforce Strategy, 2011).

Mental health service: Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

Mental health worker: A broad, generic term that encompasses people who work in mental health service delivery, regardless of role, training or qualifications (National Mental Health Workforce Strategy, 2011).

Mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Outcome: A measurable change in the health of an individual or group of people or population, which is attributable to interventions or services.

Prevention: Interventions that occur before the initial onset of a disorder.

Quality Improvement: Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers.

Racism: Racism is any act that involves a person being treated unfairly or vilified because of their race or ethnicity (Australian Human Rights Commission 2013). Institutional racism is that which, covertly or overtly, resides in the policies, procedures, operations and culture of public or private institutions reinforcing individual prejudices and being reinforced by them in turn (Australian Government, NHMRC, 2006).

Recovery: A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability.

Refugee: A person who is outside their own country and is unable or unwilling to return due to a well-founded fear of being persecuted because of their: race, religion, nationality, membership of a particular social group or political opinion (Australian Human Rights Commission, 2013).

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Framework for Mental Health in Multicultural Australia:
Towards culturally inclusive service delivery

MHiMA
Mental Health in Multicultural Australia

Key Concepts

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Version 1 – Released March 2014

MHiMA
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Key Concept 1

Cultural responsiveness

Version 1 – Released March 2014

Cultural responsiveness is an integral component of recovery-oriented service delivery and a critical consideration in improving the quality and safety of mental health services.

The new national ***Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*** (the Framework) helps mental health services achieve greater cultural responsiveness through an ongoing process of quality improvement. This is an important concept to enable mental health services to more effectively respond to the mental health needs of their local culturally diverse communities.

Why is it important to be a culturally responsive service?

Greater capacity to respond to Australia's growing cultural diversity

As Australia's cultural diversity continues to grow, mental health services need to understand and respond to changes in the local communities they serve. These changes include the arrival of immigrants and refugees whose values, norms, traditions, religious beliefs and social structures may vary from those of the broader Australian culture.

Cultural beliefs about what constitutes mental illness and how to respond to it will affect how immigrants and refugees seek help and whether or not they will choose to access services. Understanding mental illness as a health problem

Australia's growing cultural diversity

- The number of overseas-born Australians has increased from 23% of the total population in 2006, to 26% in 2011. Numbers of second generation migrants with at least one parent born overseas are significantly higher (43% in 2011 Census).
- The number of Australians who speak a language other than English increased from 16% of the total population in 2006, to 19% in 2011.
- The number of languages spoken in Australia has increased from 160 in 1996, to over 200 in 2011.
- Australia has experienced significant increases in the number of immigrants coming from non-English speaking countries between 2001 and 2011. For example, immigrants from India have increased by 200,000 people, and immigrants from China have increased by 176,200.

Australian Bureau of Statistics, 2012

that requires medical treatment is a western concept that can seem strange or even threatening to some people from culturally and linguistically diverse (CALD) backgrounds.

To respond to the needs of their culturally diverse communities mental health services need to firstly understand who their CALD communities are, and then engage with them in partnership to deliver mental health services that are culturally responsive.

Improve access

The National Health and Medical Research Council of Australia (2005) has recognised that:

"All Australians have the right to access health care that meets their needs. In our culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at every level of the health system – systemic, organisational, professional and individual."

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 and are more exposed to adverse quality and safety risks.

Some of the barriers for CALD people in accessing mental health services include:

- Lack of knowledge or understanding about mental health services
- Stigma related to mental illness or seeking help
- Concerns about confidentiality
- Language barriers
- Cultural misunderstandings
- Previous unfavourable or negative experiences with health or other services
- Concerns about being heard, understood or respected, especially in relation to their own explanation of their problem or issue.

Some of these barriers need to be addressed by changes in how mental health services operate while others require engaging and working with CALD communities to increase knowledge, decrease stigma and improve access.

Enhance equity, quality and safety

People from CALD backgrounds are more likely to receive poorer quality care than the general population, which may be partly due to language barriers and cultural differences between health care providers and consumers. These differences can result in miscommunication and misunderstanding leading to errors and incidents with potentially serious clinical consequences, sometimes even death.

Racism and discrimination from health care providers (intended or otherwise) also contributes to negative experiences for CALD consumers and can result in consumer mistrust and dissatisfaction with mental health services. This can lead to lack of compliance with treatment, disengagement from care and reduced willingness to access services in the future. All these factors can contribute to poor mental health outcomes.

What are the benefits of being a culturally responsive service?

When mental health services have good partnerships with the culturally diverse communities they serve, have addressed access issues by reducing barriers and improve equity of service delivery, they become more culturally responsive.

A culturally responsive mental health service can deliver:

- Better health outcomes for CALD consumers, carers and their families
- Greater access and equity for CALD consumers, carers and their families
- Improved quality and safety, and reduced rates of adverse incidents
- Better communication and understanding resulting in clearer expectations and improved compliance with treatment
- Higher consumer mental health literacy leading to appropriate help-seeking behaviour
- Greater consumer satisfaction and increased levels of trust, attendance and reduced re-admission rates
- More efficient use of resources leading to cost savings
- Compliance with national standards and accreditation requirements
- Improved public perceptions of the mental health service.

How can mental health services become more culturally responsive?

The evolution of a more culturally responsive mental health service requires organisational commitment and leadership, as well as an acknowledgement that it is an ongoing process. It cannot be viewed as a simple completion of a compliance activity with a fixed end point.

The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery (the Framework) is a national Framework that has been specifically designed for Australian mental health services under the current policy context.

The purpose of the Framework is to improve service delivery for consumers and carers from CALD backgrounds, ensuring equitable outcomes in access and quality of care. The Framework supports local continuous improvement practices and enables services to respond to the changing population demographics in their local catchment areas. Implementation of the Framework will not only assist services to fulfil current accreditation requirements, it will also facilitate safer and better quality services.

Useful readings

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Further information

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Key Concept 2

Risk and protective factors

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When providing mental health services to people from culturally and linguistically diverse (CALD) communities a range of additional risk and protective factors need to be taken into consideration. The factors that are particularly important are migration and acculturation, racial discrimination and equity, language acquisition, and refugee experiences. These factors are inter-related and can exacerbate the likelihood of a mental illness or conversely protect against the development of a mental illness.

The social determinants of health (including mental health) are the conditions of the social world that influence the health and wellbeing of individuals and groups. These conditions are shaped by the distribution of money, power and resources at personal, local, national and global levels. Health status is not merely the result of personal or individual factors, but rather is a complex interrelationship of social and economic factors which can mediate health and mental health. The determinants for mental health include education level, employment status, gender, ethnicity and socio-economic class.

People from CALD backgrounds consistently have higher levels, and greater numbers, of socially determined risk factors for mental health problems. People from CALD backgrounds also share some specific experiences that can make them particularly vulnerable. Experiences such as migration, acculturative stress, racial discrimination and equity, language barriers and refugee experience can all expose CALD populations to additional risk factors. Conversely strong protective factors are also seen in CALD communities including strong family and community support, connection with culture and faith, good English language acquisition, educational attainment, employment and economic opportunities.

Migration and acculturation

Acculturation is the process by which migrants adjust psychologically and socially to their new environment during settlement. The process of acculturation can be a long one but many people acculturate successfully achieving a good balance between their culture of origin and the culture of their new country.

For some the acculturation process can cause high levels of stress (acculturative stress) which is a significant mental health risk factor for this group.

The experience and extent of acculturative stress is influenced by a number of factors, including:

- Acculturation attitude
- Migration status including reasons for migrating
- Personality and cognitive factors, such as self-esteem
- Other personal variables, such as gender and age
- Cultural distance and differences between the host culture and the person's culture of origin
- External factors, such as the attitudes and responses to immigrants in the new society.

High levels of acculturative stress are associated with high levels of depression and increased levels of anxiety. The process of acculturation is rarely straightforward or short-lived. In fact, the effects of the migration experience can be long term and enduring. Effects may even be felt across lifetimes and generations. Increased levels of depression and anxiety are seen in second and third generation individuals with acculturative stress. Acculturative stress may arise due to intergenerational family and cultural conflict.

Addressing factors that prevent successful acculturation can help individuals and communities to achieve better mental health outcomes. The host culture has an important role to play in helping immigrants to acculturate by building a multicultural community that accepts and is inclusive of, cultural diversity and difference. Mental health services also need to look at how they provide culturally responsive services and promote cultural diversity.

Racial discrimination and equity

Racial discrimination is expressed both interpersonally and systemically and can have a significantly negative impact on the mental health and wellbeing of CALD people and communities.

People who experience racism and discrimination have higher levels of psychological distress, psychosis, depression and other mental health disorders. There is a clear link between belonging to a group that is stigmatised or discriminated against, and poor mental health, physical illness and academic underachievement. This is not only the case for those who experience direct interpersonal discrimination, but also relates to those who perceive that their group is the target of discrimination.

Discrimination can also reduce rates of participation in a wide range of social and community activities that are known to be protective factors for mental health. It can impact on participation in the workforce, local neighbourhood and community networks and social and friendship groups. It can also impact on access rates to services.

Social and cultural inclusion can counter the impact of racism and discrimination. Working in partnership with CALD communities and key stakeholders, mental health services can effectively identify local problems and real solutions. *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* (the Framework) provides mental health services with a good starting point to objectively review their organisation and build plans to become more culturally responsive. The ability to access appropriate health care services significantly impacts on health and wellbeing. Culturally inclusive mental health services have the potential to significantly improve mental health outcomes and consumer satisfaction for CALD consumers.

Language acquisition

A language barrier is a significant structural obstacle that can prevent people from accessing and receiving continuing mental health care, and attaining improved health status and outcomes. There is a strong association between language barriers and stress levels and instances of self-reported poor health. Those with low English language proficiency are more likely to seek assistance for mental health problems from primary care, rather than specialist providers. Language barriers may also limit or confuse communication about emotional and mental health problems, as the majority of the assessment and treatment options for mental illness are based on communication.

Stable and meaningful employment is a strong protective factor for mental health and wellbeing and language acquisition is associated with employment and underemployment. People with high levels of English are likely to experience greater levels of employment, more likely to experience employment commensurate with skills and qualifications and are more likely to be able to advocate for fair employment conditions. Furthermore education opportunities are available to those with suitable levels of English language proficiency.

Unemployment and underemployment impact on a person's sense of self-worth and creates greater economic hardship which contributes to an increased risk of mental ill health. Language acquisition also impacts on a person's ability to connect and engage with the local community including service providers, community groups, and neighbours. People who are proficient in the English language are going to be more easily able to access formal and informal supports thus reducing their risk of social isolation. Mental health services need to be particularly aware of the need to effectively address language barriers through good language services policies and also need to consider how to redress some of the social constraints for people with limited English.

The refugee experience

Refugees are among the world's most vulnerable people and they are also often highly resilient having survived through terrible experiences. The refugee experience can include witnessing or experiencing violence, abuse, imprisonment and torture. Refugees often face hazardous journeys, life in refugee camps and loss of, or separation from, family members. These traumatic experiences can have an impact on their mental health and wellbeing and may put them at increased risk of developing post-traumatic stress disorder (PTSD). Similarly, there is a strong link between witnessing violence and the development of PTSD in children. Mental health services need to be aware that while a refugee may have a trauma history they may not experience a resultant mental illness. Rather the stress resulting from settlement and acculturation may be more acute and problematic in helping refugees attain or maintain good mental health.

Refugees who experience mental health problems as a result of their trauma experiences need to be provided with culturally responsive treatment and care so they can go on to experience good mental health and engage fully with community life in Australia.

Useful readings

Australian Human Rights Commission. (2012). Face the facts: Some questions and answers about Indigenous peoples, migrants and refugees and asylum seekers. Sydney: Australian Human Rights Commission.

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Further information

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Key Concept 3

Culturally responsive practice

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All individuals have ways of explaining their mental health and wellbeing. The way an individual understands, explains and expresses their mental health or illness is known as their explanatory model. This encompasses beliefs about the cause, onset, nature and duration of the illness or distress, as well as beliefs about treatment, healing and recovery. An individual's explanatory model will influence their degree of distress, their behaviour and their response to distress. It will also influence their pattern of seeking help and their engagement and compliance with recommended treatments.

Mental health services and individual workers who work within them, will often have very different understandings and explanations of mental illness from consumers who are from culturally and linguistically diverse (CALD) backgrounds. Culturally responsive workers must seek to understand the illness experience of CALD consumers in order to gain their trust and respect, determine shared priorities, and plan and implement sensitive and effective intervention, treatment and recovery.

Assessment and diagnosis

Mental health professionals are trained in using the definitions and formulations outlined in the DSM-5 and ICD-10 to assess and diagnose mental illness. There is evidence, however, that these classification systems are based on ethno-centric assumptions, and that the syndromes and conditions they describe are not universal.

The DSM-5 includes a broad cultural formulation which can reduce the probability of assessment and diagnostic errors when used by mental health workers when they work with CALD consumers. However the cultural formulation should not be considered a checklist of how to perform a culturally competent assessment. Rather, it should serve as a guide for the mental health workers' exploration of cultural issues as part of the assessment. The cultural formulation can also be used to communicate assessment findings, assist mental health workers to reflect on their work, help build the therapeutic relationship and inform treatment planning.

During assessments, mental health workers should remain aware that culture is not synonymous with ethnicity, religious belief, nationality or language, and that cultural processes will differ within the same ethnic or social group. Mental health workers should not make assumptions about culture in relation to beliefs, understandings and traits. In some cases, culture may not be central to a consumer's presentation, and attention to cultural difference

can sometimes be interpreted negatively by consumers and their families. An approach that is respectful, sensitive and consumer (and family) centred can help avoid misunderstanding and misinterpretation. Mental health workers can also seek out advice from cultural consultants or community elders and leaders to help better understand what might be important or significant for a client and their family.

Language barriers

Language is also a significant factor in assessments. The risk of confusion or misunderstanding about feelings, emotions and experience of mental illness are significantly higher when these are expressed in a second language. The consumer's first or preferred language should always be used when conducting a mental health assessment. This can be achieved by working with an interpreter or a mental health worker who speaks the consumer's preferred language. Cultural consultants can also be involved if the consumer is agreeable. These consultants can assist or inform the assessment by providing an enriched understanding of the cultural components involved in the consumer's presentation.

Treatment, intervention and other remedies

An individual's explanatory model not only determines their beliefs about the cause of their illness, it also influences their help-seeking behaviour (whether or not they will seek help, what type of help they will seek and who they will seek it from). Attention must be paid to the consumer's expectations of the mental health service, the individual worker and each clinical encounter. Mental health workers should work with consumers and families towards a shared understanding of treatment goals and how they can be met. Treatment planning involves a process of negotiation, where differences are acknowledged and common ground is identified. When mental health workers and consumers can reach a respectful and shared understanding, the treatments offered will be more likely to be accepted and valued by consumers and their families.

Additional key strategies to use when planning and implementing mental health interventions with CALD consumers:

- Consider the involvement of workers, consultants or advocates who share the consumer's culture or language. Consumers often express a preference for treatment and benefit more from it, when someone from a similar cultural background provides it.
- Be flexible and adaptable. Choose interventions that are appropriate to the consumer, modify existing interventions to make them appropriate to the consumer's situation, and consider how to incorporate traditional therapies and treatments. Mental health workers may need to expand their view on what constitutes a mental health intervention and take on a range of roles, such as advisor, advocate, facilitator, broker or counsellor.
- Use a strengths-based approach. Encourage consumer competence and resilience, and help them identify their own strengths.
- Offer practical interventions and supports. These tangible and understandable interventions are highly valued by many CALD consumers, and can help to alleviate symptoms. Mental health workers may need to intervene, or provide or broker support across a range of areas including settlement, housing, social security, education or employment.
- Engage with families and communities, as these can be critically important in providing the consumer a wide range of practical, social or support options. Be aware of potential issues when involving families, however, such as intergenerational conflict, different levels of acculturation within families, and changes in roles and power relationships.
- When English is not the preferred language, always use accredited interpreters in treatment planning and delivery with CALD consumers, families and community supports.

CALD consumers and their families may seek multiple forms of treatment. In many communities, both traditional healing modalities and bio-medical approaches are sought simultaneously. There is often a high reliance on general practitioners, particularly bilingual general practitioners. Approaches that are jointly provided by mental health workers and traditional healers have yielded notable positive clinical outcomes, particularly among consumers who were resistant to bio-medical treatment options. Similarly, positive results have been seen from incorporating religious and socio-cultural components into standard psychotherapeutic treatment for religious consumers.

Mental health workers should aim to maintain a culturally responsive approach throughout treatment. There is increased potential for positive outcomes when interventions acknowledge the existence of the consumer's ethnicity and culture, express appreciation for it, and place the consumer's problem in a cultural context.

Organisational planning

When planning mental health services for CALD communities consideration needs to be given to the additional time and expertise required to undertake assessments and treatment so that language barriers can be overcome and cultural differences understood. In particular sessions conducted with interpreters can take at least twice as long as an assessment conducted with a client who has a high level of English. Furthermore some groups may have particularly complex needs that require further in-depth assessment and complex treatment. For example refugees with trauma histories may require additional assessment time for mental health workers to:

- Build trust and create a safe environment
- Understand the complexity of their presentation
- Explore the cultural differences in explanatory models
- Build a therapeutic alliance with consumer and their family and friends.

Useful readings

American Psychiatric Association, (2000). Diagnostic and Statistical Manual for Mental Disorders IV TR, Arlington, Virginia, American Psychiatric Association.

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The cultural formulation

Cultural identity of the individual

- Ethnic or cultural reference group
- Language abilities, use and preference
- Involvement with culture of origin and the host society.

Cultural explanations of distress

- Explanatory model – beliefs about cause, onset, nature and duration of the illness, and beliefs about treatment healing and recovery.

Cultural factors related to psycho-social environment and functioning

- Social stressors and supports
- Levels of functioning and disability.

Cultural elements of worker-client relationship

- Difficulties resulting from cultural differences, e.g. communication and language, relationship and rapport, reaching shared understanding.

Overall cultural assessment for diagnosis and care

- How culture impacts on diagnosis and care.

(adapted from American Psychiatric Association, 2013)

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Key Concept 4

Consumer and carer participation

Version 1 – Released March 2014

Consumer and carer participation with culturally and linguistically diverse (CALD) communities needs to be approached in a way that respects cultural differences and shows understanding of the needs of CALD consumers, carers and their families.

Consumer and carer participation with CALD communities needs to start with the mental health services actively engaging with their local CALD communities to build trust and tailored partnerships. Strategies for improving participation need to be multifocal and address jointly agreed goals.

Consumer and carer participation is a central principle in Australian government, state and territory mental health policies and plans. By comparison, very few consumers and carers from culturally and linguistically diverse (CALD) backgrounds are involved in mental health consumer and carer participation activities in Australia.

Participation involves a number of processes that facilitate contributions from consumers, carers and family members across a range of levels.

These include contributions at:

- The **personal** level: individuals, their families and carers are involved and have a voice in their own personal mental health care
- The **service** level: consumers and carers provide input into mental health service planning, development, delivery and evaluation
- The **system manager** and **corporate** levels: participation seeks to inform policy development and legislation.

It is important to acknowledge when seeking involvement from representatives from CALD backgrounds, to acknowledge that consumer and carer participation may be an unfamiliar concept. It may also be understood differently across diverse cultural groups. Many CALD communities don't typically consider the users of mental health services as 'consumers' with the associated rights of choice and self-determination. Similarly, the notion of 'participation' implies non-universal concepts such as individual rights and self-advocacy. The variety of mechanisms that are generally used to facilitate consumer and carer participation may not be accessible or applicable to CALD consumers, carers and their families.

It must also be recognised that participation is not an isolated social process, but one that occurs within, and is influenced by, community context. It is this community context that's particularly relevant to CALD populations.

Engaging CALD consumers and carers in participation

Participation in groups, networks and partnerships can deliver positive outcomes for all. However, this is least likely to occur amongst the most disadvantaged members of society. Particular attention must be paid to promoting and facilitating the involvement of these groups, or participation may have the unintended consequence of increasing social inequalities rather than reducing them.

Reports on the experience of CALD consumers in mental health care have highlighted consumer experiences of cultural insensitivity, institutional racism and culturally inappropriate care. Attempts to engage consumers and carers in participation within this current context, presents significant challenges. Insensitivity to the socio-cultural needs of CALD consumers and communities is identified as a key barrier to consumer and carer participation.

Additional barriers to participation include stigma and shame, differing explanatory models of mental illness, low levels of mental health literacy, and language barriers. Some of these barriers make voluntary access to mental health services unlikely, and consumer or carer participation even more unlikely. Efforts to engage CALD consumers and carers in participation need to address these barriers in innovative ways.

A critical first step is building trust with communities through community development. Participation can only occur when people feel comfortable talking about mental health and illness, and when mental health services develop their understanding of the needs of their local CALD communities. The development of dedicated strategies and partnerships targeting community engagement and improving mental health literacy can underpin successful participation.

Community engagement

Many traditional mechanisms for consumer and carer participation, such as formalised consumer advisory groups or representation on committees, fail to address the cultural context of mental health issues across CALD communities. Only limited outcomes can be achieved through group processes where participants have varying degrees of English language proficiency, and different understandings and beliefs about mental illness. One successful model for CALD consumer and carer participation has a focus on community engagement as its foundation. In this model, the mental health service actively engages with the community, rather than requiring community members or representatives to engage with the mental health service. Community engagement can occur with established community groups, community elders, leaders and mentors, targeted sections of communities, multicultural organisations or across communities as a whole. This type of engagement can assist mental health services to identify and understand how mental health issues are understood within CALD communities, help build trust between communities and services, increase mental health literacy, and identify culturally appropriate engagement strategies. These preparatory stages can lead to successful tailored partnerships and participation approaches.

Useful readings

Baker, A., Procter, N.G. and Szokalski, M (2013) Engaging with CALD communities to reduce the impact of depression and anxiety: A review of current evidence, Adelaide, University of South Australia, Sansom Institute for Health Research.

Queensland Transcultural Mental Health Centre, (2006). A model for CALD consumer participation in mental health: A report on the multicultural consumer and community participation in mental health project, Brisbane, Qld Transcultural Mental Health Centre and Multicultural Centre for Mental Health and Wellbeing.

Romios, P., McBride, T. & Mansourian, J., (2007). Consumer participation and culturally and linguistically diverse communities: A discussion paper, Melbourne, Health Issues Centre.

Essential strategies

The following strategies for organisations can be a foundation for meaningful CALD consumer and carer participation.

Background and preparation

- Locate a suitable venue which is culturally appropriate and comfortable for CALD participants.
- Seek out, respect and value explanatory models of mental health and mental ill health that deepen understanding of how mental health and distress is understood and expressed; what people call this experience; when, how and why help is sought; and what CALD communities consider to be a good outcome.
- Be open to reframing terminology for diagnosis and treatment associated with mental ill health.
- Generate and deepen trust. Take into account personal and perceived stigma, shame, guilt and embarrassment.

Implement tailored engagement and communication processes

- Engage family members, informal supports, or the wider CALD community where appropriate in discussion and education about mental health and mental ill health.
- Discuss and negotiate culturally appropriate interventions with CALD communities as part of a two-way information exchange and capacity building activity.
- Consider and use alternative communication mediums such as online and virtual mediums. The anonymous nature of online support may be more appropriate for some CALD communities.
- Ensure information obtained from CALD communities is translated into action which is timely, meaningful and of benefit to community members.

Sustainability

- Use alternative communication mediums, e.g. fotonovela and pamphlets.
- Demonstrate ongoing respect and concern for the community; ensure the purpose(s) of engagement serve to benefit the community in some meaningful sense; and build in mechanisms for follow-up and sustained engagement wherever feasible.
- Recognise that to enable and achieve ongoing authentic engagement with CALD communities in the area of mental health often takes considerable time and thoughtful planning.

Further information

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MHiMA
Mental Health in Multicultural Australia

Key Concept 5

Recovery and cultural diversity

Version 1 – Released March 2014

Mental health services play an important role in supporting culturally and linguistically diverse (CALD) consumers in their recovery by reducing impediments and barriers, and creating opportunities.

To assist CALD consumers on the recovery journey, mental health services need to understand that recovery and its principles are not universal concepts and as a result may present challenges for mental health workers and CALD consumers.

Core principles underpinning recovery oriented practice responsive to the needs of CALD consumers:

- Recovery is a collection of processes that occur within a web of relations including the individual, family and community and is contextualised by culture, language, oppression and privilege, history and social determinants of health.
- Responsiveness to people from CALD backgrounds requires organisational capacity at different levels: systemic, organisational and practice.
- Recognising the diverse ways in which the concepts of mental health, mental illness and recovery may be understood by people from CALD backgrounds requires an awareness of the impact of the practitioner's own ethnocultural identity, as well as that of the organisation and service system.

The National Standards for Mental Health Services 2010 and *Australia's National Framework for Recovery-Oriented Mental Health Services* recognise that recovery is defined by the individual with the mental illness. It emphasises that recovery is about gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, achieving personal autonomy and social identity, achieving meaning and purpose in life, and having a positive sense of self.

Because recovery models take a client-centred approach they can be very effective in improving the lives of people from CALD backgrounds. For some cultures though the idea being individually focused is counter intuitive particularly in more collectivist communities. In addition for some cultures the concept of recovery from an illness is not a distinct concept as health and wellbeing are often on a continuum with ill-health. Thus for some CALD consumers a focus on recovery may be an unfamiliar approach. Finally for some CALD consumers the concept that a health professional is guided by the views and opinions of the consumer is a foreign one, thus taking a pro-active approach in their own recovery may be uncomfortable or even difficult.

A cultural perspective on recovery

CALD communities hold beliefs about the cause and nature of mental illness that are different to the beliefs held by mental health services and workers. Similarly, CALD communities may also have alternative ways of understanding and explaining mental wellness, wellbeing, healing or recovery. In addition some cultures do not always distinguish between physical and mental health. Thus, culturally inclusive and responsive mental health services need to take a broader understanding of the concept of recovery and listen to, understand and engage with their CALD consumers' alternative ideas about wellness.

Recovery traditionally tends to focus on the individual's experience and is often a reflection of individualist values inherent in western cultures. For many CALD consumers the experience or ways of understanding or explaining recovery is more about concepts of overall wellbeing or wellness, rather than the process of recovery itself, or that one recovers from a particular illness. Thus recovery is simply part of the continuum of health and ill-health.

Holistic explanations of recovery are therefore more relevant, understandable and applicable when working with many CALD populations. A holistic explanation of recovery is seen as a restoration of balance, equilibrium and wholeness. Similarly, ideas about health and healing are related to harmony and cohesion, rather than individual mastery and control. For CALD consumers, recovery may encompass change in a range of domains not just change in mental health symptomatology. These could include family relationships, community participation, and fulfilment of culturally prescribed roles and responsibilities, especially those that relate to family, religion and community.

Family and community

Healing occurs not only by reducing the distress of the individual, but also creating improvements in the health and functionality of the family and support network. Restoring, maintaining and strengthening connections play a significant role in healing and recovery, linking individuals, families, social groups and communities. At the broader level, this connection can promote an important sense of belonging, which can reduce the isolation and loneliness sometimes experienced by CALD consumers, carers and communities in relation to experience of mental illness and involvement with mental health services.

Recovery oriented services working with CALD consumers need to also focus on the wider needs of the family and community; and not only the individual with the mental illness. The trauma of mental illness and interaction with mental health systems may be experienced by individuals and immediate family, extended family, friends and in some cases, entire communities. This may be particularly apparent in small, closely-knit communities, especially where there is significant stigma attached to mental illness. Communities with high levels of previous trauma, for example refugees, may be even more vulnerable.

Assisting families and communities in the recovery journey can have significant impacts on the individual with the mental illness and people at risk of developing a mental illness. Working with communities can also reduce the stigma associated with a mental illness and increase mental health literacy reducing delays in seeking treatment.

The socio-political context of recovery

Social, economic and political conditions and processes can have either an enabling or inhibiting influence on recovery. A social justice perspective of recovery articulates that healing cannot occur in an environment that allows for discrimination, social exclusion, and inequity. The positive influence of social inclusion, a sense of belonging and of being needed cannot be underestimated particularly for people from more collectivist cultures.

Discrimination is a major barrier to recovery as it can limit people's access to treatment, support services, opportunities and the broader community. Therefore stopping discrimination by actively challenging stigma and championing respect, rights and equality for all is as important as providing treatment. The mental health sector is well positioned to develop an advocacy role in redressing discrimination, social exclusion and inequity for CALD consumers, carers and their families. Advocacy can bring about lasting, tangible and positive changes to the lives of CALD consumers, their families and communities.

Useful readings

Idsa, D. (2007). Cultural competency and recovery within diverse populations, Psychiatric RehabilitationJournal, 31 (1), 49.

Jacobson, N. & Farah, D. (2012). Recovery through the lens of cultural diversity, Psychiatric Rehabilitation Journal, 35 (4), 333.

New Zealand Government, Mental Health Commission (2001) Recovery competencies for New Zealand mental health workers, 1-7 and 87-91.

O'Hagan, M., (2004). Recovery in New Zealand: Lessons for Australia? The Australian e-Journal for the Advancement of Mental Health, 3 (1), 5-7.

Further information

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MHiMA

Mental Health in Multicultural Australia

MHiMA provides a national focus across Australia on issues relevant to CALD communities in relation to mental health and suicide prevention. We are committed to delivering practical and evidence-based advice and support to government, non-government providers, primary health care professionals, consumers, carers and their families.

Our vision is for an open and inclusive society committed to human rights and diversity in which everyone requiring mental health services is able to access culturally responsive services irrespective of cultural or linguistic background. MHiMA is committed to achieve this vision by developing effective and respectful collaborations across all sectors to address the mental health needs of Australia's CALD populations.