Multicultural Mental Health Plan 2008-2012

Summary  The Multicultural Mental Health Plan 2008-2012 is the strategic statewide policy and service delivery framework for improving the mental health of people in NSW from culturally and linguistically diverse backgrounds.

Although this policy applies to Board Governed Statutory Health Corporations Justice Health is the only Board Governed Statutory Health Corporation that is required to comply.

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Distributed to  Public Health System, Ministry of Health, Public Health Units
Audience  Mental Health Services
MULTICULTURAL MENTAL HEALTH PLAN 2008-2012

Purpose of the Policy

The *NSW Multicultural Mental Health Plan 2008-2012* is a strategic state-wide policy and service delivery framework aimed at improving the mental health of people in NSW from Culturally and Linguistically Diverse (CALD) communities.

Mandatory Requirements

The full list of requirements of all parties is set out in Section 6 (Page 22-28) of the accompanying document.

Roles and Responsibilities

**NSW Department of Health – Mental Health and Drug and Alcohol Office**

- Appoint people with clinical and policy expertise in multicultural mental health on key strategic advisory bodies.
- Consult with educational bodies providing mental health courses to ensure that they incorporate CALD issues/perspectives
- Seek to ensure that CALD mental health awareness is included in the development of any relevant training/educational resources.
- Collate, evaluate, document and promulgate CALD specific GP models of shared care initiatives across NSW Area Health Services.
- Ensure that a CALD focus is included in relevant Tenders and Funding Agreements.

**Area Health Services**

- Complete a Mental Health Implementation Plan that includes clear lines of accountability for reporting and planning for multicultural mental health. The plans will identify and address multicultural mental health strategies at various levels
- Designate a senior key position with responsibility for the oversight of the development, implementation and monitoring of their Multicultural Mental Health Plans.
- Establish Multicultural Mental Health Consultative Groups/initiatives that include the participation of consumers, their carers and families, in order to monitor quality of services.
- Seek to use interpreters with persons from CALD communities during assessment to help ensure a culturally appropriate diagnosis and case management

Professor Debora Picone AM
Director-General
Foreword

The NSW Multicultural Mental Health Plan 2008-2012 is the strategic state-wide policy and service delivery framework for improving the mental health of people in NSW from Culturally and Linguistically Diverse (CALD) communities.

This Plan was developed after extensive consultation, and reflects current and emerging trends across our communities. It aligns with relevant initiatives including:
- A New Direction for NSW: The State Plan;
- A New Direction for NSW: The State Health Plan;
- NSW: A new direction for Mental Health 2006; and

The Plan is a seminal document that synthesises epidemiological issues with the mental health challenges within CALD communities. This knowledge underpins a strong reform agenda for multicultural mental health at all levels of care, as well as ensuring responsive consultation with the CALD communities.

The Plan reflects and complements national and state policy directions and planning for multicultural mental health. It recognises that a comprehensive model of service delivery for multicultural mental health includes a range of services such as health promotion and prevention programs, early diagnosis, assessment and treatment services and care planning, to cultural consultancy and training and education.

Over the next four years, NSW Area Health Services in metropolitan, regional, rural and remote areas will further develop models of mental health care and service provision that reflect the local demographic profile. Each model will aim to ensure access to culturally competent mental health services.

The Plan identifies five key strategic directions for enhancing mental health care in CALD communities:
- Integrated policies that guide informed and data driven planning processes.
- Renewing a focus on education, prevention and early intervention.
- Delivering culturally inclusive and responsive mental health services.
- Enhancing cultural competencies in mental health service delivery.
- Promoting culturally inclusive research, evaluation and innovation.

The key actions outlined in the Plan are underpinned by several existing programs. These programs include large services like the Transcultural Mental Health Centre (TMHC) and the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), as well as several other initiatives such as Bilingual Clinical Consultation and Assessment Services, the Transcultural Rural Remote Outreach Project and the CALD Children and Families Mental Health Project.

The Rees Government is committed to delivering equitable and accessible mental health services that directly respond to the diversity and needs of people living in NSW.

John Della Bosca MLC
Minister for Health

Barbara Perry MP
Minister Assisting the Minister For Health (Mental Health)
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>i</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>2</td>
</tr>
<tr>
<td>2 Strategic Framework</td>
<td>3</td>
</tr>
<tr>
<td>2.1 Strategic Priorities</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Principles</td>
<td>3</td>
</tr>
<tr>
<td>2.3 Targets</td>
<td>4</td>
</tr>
<tr>
<td>3 The Policy and Planning Context</td>
<td>5</td>
</tr>
<tr>
<td>3.1 National Policies</td>
<td>5</td>
</tr>
<tr>
<td>3.2 State Policies</td>
<td>6</td>
</tr>
<tr>
<td>3.3 Ethnic Affairs Priorities Statements</td>
<td>8</td>
</tr>
<tr>
<td>3.4 Role of Transcultural Mental Health Services</td>
<td>8</td>
</tr>
<tr>
<td>4 Factors impacting on Multicultural Mental Health</td>
<td>9</td>
</tr>
<tr>
<td>4.1 Diversity</td>
<td>9</td>
</tr>
<tr>
<td>4.2 Migration &amp; Settlement</td>
<td>10</td>
</tr>
<tr>
<td>4.3 Consumer, Family &amp; Carer Participation</td>
<td>11</td>
</tr>
<tr>
<td>4.4 Promotion, Prevention &amp; Early Intervention</td>
<td>11</td>
</tr>
<tr>
<td>4.5 Service Access</td>
<td>11</td>
</tr>
<tr>
<td>4.6 Primary Care Sector and General Practitioners (GPs)</td>
<td>12</td>
</tr>
<tr>
<td>4.7 Cultural competence of mental health services</td>
<td>12</td>
</tr>
<tr>
<td>4.8 Research and Evaluation</td>
<td>13</td>
</tr>
<tr>
<td>5 Specific Population Groups at Risk</td>
<td>15</td>
</tr>
<tr>
<td>5.1 Infants, Children, Young People and Families</td>
<td>15</td>
</tr>
<tr>
<td>5.2 Women</td>
<td>16</td>
</tr>
<tr>
<td>5.3 Carers and Families</td>
<td>17</td>
</tr>
<tr>
<td>5.4 Older People</td>
<td>17</td>
</tr>
<tr>
<td>5.5 Refugees and Survivors of Torture and Trauma</td>
<td>18</td>
</tr>
<tr>
<td>5.6 Regional, Rural and Remote Areas</td>
<td>19</td>
</tr>
<tr>
<td>5.7 People in contact with the Criminal Justice System</td>
<td>20</td>
</tr>
<tr>
<td>6 Implementing the Strategic Framework for Multicultural Mental Health</td>
<td>22</td>
</tr>
<tr>
<td>6.1 Strategic Priority: Integrated policies that guide informed and data driven planning processes</td>
<td>23</td>
</tr>
<tr>
<td>6.1(a) Policy Integration</td>
<td>23</td>
</tr>
<tr>
<td>6.1(b) Data Driven Planning</td>
<td>23</td>
</tr>
<tr>
<td>6.1(c) Reporting and Accountability</td>
<td>24</td>
</tr>
<tr>
<td>6.2 Strategic Priority: Renewing the focus on education, prevention &amp; early intervention</td>
<td>24</td>
</tr>
<tr>
<td>6.3 Strategic Priority: Achieving culturally inclusive &amp; responsive mental health services</td>
<td>25</td>
</tr>
<tr>
<td>6.3(a) Assessment, Diagnosis &amp; Management</td>
<td>25</td>
</tr>
<tr>
<td>6.3(b) Mental Health Partnerships</td>
<td>26</td>
</tr>
<tr>
<td>6.3(c) Support &amp; Participation</td>
<td>26</td>
</tr>
<tr>
<td>6.4 Strategic Priority: Enhancing cultural competencies in mental health</td>
<td>27</td>
</tr>
<tr>
<td>6.5 Strategic Priority: Promoting culturally inclusive research, evaluation, and innovation</td>
<td>28</td>
</tr>
<tr>
<td>6.5(a) Research, Evaluation &amp; Applied Knowledge</td>
<td>28</td>
</tr>
<tr>
<td>6.5(b) Evidence-based Models of Care &amp; Best Practice</td>
<td>28</td>
</tr>
<tr>
<td>7 Accountability</td>
<td>29</td>
</tr>
<tr>
<td>Acronyms</td>
<td>30</td>
</tr>
<tr>
<td>APPENDIX 1 Acknowledgements</td>
<td>31</td>
</tr>
<tr>
<td>APPENDIX 2 Multicultural Mental Health Achievements to Date</td>
<td>32</td>
</tr>
<tr>
<td>References</td>
<td>34</td>
</tr>
</tbody>
</table>
SECTION 1

Introduction

People migrate to Australia from approximately 140 different countries around the world, building Australia's cultural, religious and linguistic diversity. NSW is one of the most culturally and linguistically diverse communities in Australia, with 16% of our community being born overseas from Non English Speaking Backgrounds (NESB). Diversity creates a range of influences that impact on an individual's general and mental health status. These influences can extend beyond first generation migrants to subsequent generations born into CALD communities.

Understanding the role of culture and the socio-economic, religious, political, linguistic and familial frameworks from which individuals and their communities operate is essential to the effective assessment, diagnosis and treatment of mental illness. Recognising diversity is also critical to effective planning processes and services, especially for achieving equitable access and outcomes.

In 1998, the first NSW multicultural mental health policy, Caring for Mental Health in a Multicultural Society, was released. It placed the needs and rights of people from CALD communities onto the mainstream mental health agenda and initiated much needed reforms. The policy was an important acknowledgement that the mental health sector needed to respond to the mental health needs of a culturally, linguistically and religiously diverse society.

In 2003, the Framework for Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia and the National Mental Health Plan 2003–2008 were released. The Framework aimed to promote mental health across multicultural Australia, in particular the needs of CALD communities. The Framework aimed to:

- prevent the development of mental health problems and mental illness;
- reduce the impact of mental illness on CALD individuals, families and communities; and
- assure the rights of people from CALD communities with a mental illness.

In 2006, the NSW government released NSW: A new direction for mental health, a five-year plan outlining how mental health services will provide earlier and better access to a broader range of services. The plan identified four areas of effort:

1. Promotion, prevention and early intervention across the lifespan.
2. Improving and integrating the care system.
3. Participation in the community and employment, including accommodation.

The five-year plan also recognised the needs of people from CALD communities.

These policy initiatives have all informed the development of this Plan. The Plan also relies on a population health approach methodology to ensure a holistic approach that incorporates the development of evidence-based interventions that meet the needs of CALD communities.

The Plan focuses on improving service delivery and workforce practices. Success will require strong partnerships between NSW mental health service providers, CALD consumers of mental health services and consumers’ families and carers, in order to:

- Promote broad awareness of consumer rights;
- gain equitable access to appropriate services and information; and
- Provide the opportunity to participate at all levels of care.

The Plan builds on existing service capacity to document the mental health needs of CALD communities and to effectively assess, manage and coordinate care and treatment. Measurement and performance reporting on service access and mental health outcomes is critical. The Plan emphasises that this needs to be achieved in collaboration with general health and mental health services; consumers, carers and their families and GPs; other government agencies; specialist transcultural mental health services; bilingual mental health workers; and the non-government sector, including multicultural and ethno-specific agencies.
SECTION 2

Strategic Framework

2.1 Strategic Priorities

The *NSW Multicultural Mental Health Plan 2008–2012* builds on the work of *Caring for Mental Health in a Multicultural Society* 1998. The five strategic priorities for multicultural mental health are:

- Integrated policies that guide informed and data driven planning processes.
- Renewing a focus on education, prevention and early intervention.
- Delivering culturally inclusive and responsive mental health services.
- Enhancing cultural competencies in mental health service delivery.
- Promoting culturally inclusive research, evaluation and innovation.

Critical to these five priorities is the continued integration of multicultural mental health issues into the mainstream mental health agenda. Success will require support at the highest levels, as well as commitment to stronger leadership to advance multicultural mental health at broader State and Area Health planning levels.

An Action Plan drives the achievement of these five strategic priorities. The Action Plan details short, medium and long-term milestones that are all subject to monitoring, reporting and evaluation. Implementation will be monitored and reported on through Departmental and Area level reporting and planning processes, as well as the Ethnic Affairs Priority Statement (EAPS) process.

2.2 Principles

The seven principles underpinning this plan are:

1. Understanding, valuing and strengthening diversity is intrinsic to everyday service planning and delivery and is to be reflected in the development of responsible public policy.

2. CALD communities have the right to participate at a service planning and delivery, evaluation and decision-making level relevant to their own mental health.

3. A population health approach to mental health in CALD communities acknowledges the importance of culture and pre- and post-migration experiences in determining risk and protective factors across the life span.

4. The concept of cultural transition, which is that the mental health needs of CALD communities vary over different phases of the migration and settlement process, is clinically significant.

5. CALD communities demonstrate great strength and resilience that needs to be recognised and enhanced by the mental health sector.

6. A commitment to building the capacity of the mental health service system to ensure it is responsive to, and inclusive of, the whole community regardless of cultural, linguistic, religious and social backgrounds.

7. The complexities and the diversity of experiences, cultural, linguistic and religious backgrounds and needs and skill base, all impact on clinical care and practices.

The further development of a culturally competent workforce and culturally appropriate mental health services is fundamental to achieving positive mental health outcomes for CALD communities. It requires the strengthening of partnerships across the health, NGO and community sector and with consumers, their families and carers.
2.3 **Targets**

This Plan targets:

- People from CALD communities at risk of developing mental health problems.
- People from CALD communities experiencing mental health problems across their life span, with particular reference to children, young people and their families, the ageing population, refugees, people who have experienced displacement and/or torture and trauma and people from rural and remote areas.
- Families and carers of people with mental health problems.
- Principal mental health service providers who provide direct services to CALD communities.

**National Standards for Mental Health Services**

The National Standards for Mental Health Services (MHS) represent an important opportunity to improve the quality of mental health care in Australia. Standard 7, which is set out below, addresses cultural awareness in a mental health service setting.

### Standard 7: Cultural awareness

The MHS delivers non-discriminatory treatment and support which are sensitive to the social and cultural values of the consumer and the consumer’s family and community.

7.1 Staff of the MHS have knowledge of the social and cultural groups represented in the defined community and an understanding of those social and historical factors relevant to their current circumstances.

7.2 The MHS considers the needs and unique factors of social and cultural groups represented in the defined community and involves these groups in the planning and implementation of services.

7.3 The MHS delivers treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.

7.4 The MHS employs staff or develops links with other service providers/organisations with relevant experience in the provision of treatment and support to the specific social and cultural groups represented in the defined community.

7.5 The MHS monitors and addresses issues associated with social and cultural prejudice in regard to its own staff.

7.6 Documented policies and procedures exist and are used to achieve the above criteria.

7.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.
SECTION 3

The Policy and Planning Context

This Plan reflects significant changes, directions and priorities in both National and State strategic policy and planning frameworks that target the needs of the CALD communities. Together, these frameworks support a coordinated National and State government approach, based on a population health methodology, to ensure the delivery of responsive and inclusive mental health services across NSW.

3.1 National Policies

National Policy | Context Point
--- | ---
National Standards for Mental Health Services 1996 | The National Standards for Mental Health Services emphasise the protection of individual rights, principles of access and equity and participation of consumers in all aspects of their mental health care, recognition of the role of carers, provision of cross-cultural training and education and collection of data and information.

National Mental Health Plan 2003–2008 | This Plan built on and consolidated the Commonwealth priorities and reforms initiated by the respective National Mental Health Plans. Accordingly, it “provides a national policy and implementation framework for a coordinated national approach to improving Australia’s mental health”. This is achieved through linkages with other sectors including housing, employment, justice, welfare and education. The Plan has four themes:
1. Promoting mental health and preventing mental health problems and mental illness.
2. Increasing service responsiveness.
4. Fostering research, innovation and sustainability.

Framework for implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia | This Framework was a first, in that it complemented existing mainstream mental health policy and focused on issues pertaining to service responsiveness, the promotion of mental health, prevention of mental illness, capacity building, culturally inclusive research, and program sustainability. The Framework aimed to:
1. Promote the mental health of all people from CALD communities.
2. Prevent the development of mental health problems and mental illness within CALD communities.
3. Reduce the impact of mental illness on CALD communities.
4. Assure the rights of people from CALD communities with mental illness.

Mental Health Statement of Rights and Responsibilities 1991 | This document identifies the main rights and responsibilities of everyone involved in the area of mental health in Australia today. This includes the rights of consumers, carers and advocates, service providers and the community. Each stage of the mental health spectrum is addressed from prevention, assessment, diagnosis, treatment and rehabilitation. Rights and responsibilities upon admission to a mental health facility or community program are covered, as well as the main mental health standards and legislation.
### 3.2 State Policies

<table>
<thead>
<tr>
<th>State Policy</th>
<th>Relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A New Direction for NSW: The State Plan</strong></td>
<td>The NSW State Plan lists five priorities for the next 10 years: 1. Rights, respect and responsibility. 2. Delivering better services. 3. Fairness and opportunity. 4. Growing prosperity. 5. Environment for living. The State Plan acknowledges the many opportunities created by the drive and ambition of immigrants who settle in NSW each year. It specifically addresses the importance of providing more effective mental health services to enable CALD people with a mental illness to more fully participate in the community and gain employment.</td>
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<td><strong>A New Direction for NSW: The State Health Plan</strong></td>
<td>The State Health Plan reflects the health priorities in the NSW State Plan, <em>A New Direction for NSW</em>. The Plan draws on priorities in the Council of Australian Governments’ national health reform agenda as well as extensive research and consultation with consumers, health professionals and other stakeholders. This NSW Health Plan will guide the development of the NSW public health system towards 2010 and beyond.</td>
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<td><strong>NSW Health Caring for Mental Health in a Multicultural Society 1998</strong></td>
<td>This Plan:  ■ Highlighted key areas of need and issues impacting on the management of the mental health problems of CALD communities.  ■ Identified gaps impeding equitable service provision for CALD communities.  ■ Identified priority areas in direct response to the real mental health need in the CALD communities.  ■ Provided funding for specific services, projects and multilingual resources.</td>
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<td><strong>NSW: A new direction for Mental Health 2006</strong></td>
<td>This five-year plan outlines how the NSW Government will invest and reform mental health services to ensure the right care is provided at the right time. It has four focus areas: 1. Promotion, prevention and early intervention across the life span. 2. Improving and integrating the care system. 3. Participation in the community and employment, including accommodation. 4. Better workforce capacity. The Plan balances hospital focussed care with community care, and commits to building stronger links between the public, private and community services, between hospitals and GPs and between the State and Federal Governments.</td>
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<td><strong>Select Committee Inquiry into Mental Health Services in NSW December 2002</strong></td>
<td>This inquiry highlighted many areas in mental health that required further attention including issues affecting older and young people, carers, and multicultural and indigenous issues. Recommendations included the need to:  ■ Identify consumer and carer perceptions of CALD communities and offer support to their carers.  ■ Increase access to appropriately trained health care interpreters.  ■ Develop cross-cultural training programs that require the participation of mental health professionals and staff.  ■ Develop GP programs that will increase their knowledge of the range of public mental health service options available to CALD communities.</td>
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<td>State Policy</td>
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<td><strong>NSW Interagency Action Plan for Better Mental Health</strong></td>
<td>There are a number of government agencies with responsibilities for responding to the needs of people affected by mental illness. There is scope to improve the responsiveness of, and coordination between these agencies and their services, particularly in the following three areas:  1. Prevention and early intervention.  2. Community support.  3. Emergency responses.</td>
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<td><strong>NSW Mental Health Act 2007</strong></td>
<td>This Act:  ■ Provides for the care and treatment of mentally ill and mentally disordered persons;  ■ Aims to facilitate treatment primarily on a voluntary basis, but involuntarily where necessary to protect the person or others from serious harm;  ■ Requires that any restriction on the liberty of patients and any interference with their rights, dignity and self-respect is kept to the minimum necessary in the circumstances;  ■ Promotes the intention that the age-related, gender-related, religious, cultural, language and other special needs of people should be recognised;  ■ Aims to ensure that the rights of patients and their carers to be informed and to participate in treatment decisions, are respected to the maximum extent possible; and  ■ Provides that treatment services are to be designed to assist people with a mental illness or disorder to live, work and participate in the community.  The Act makes specific provision for the use of interpreters in formal medical assessments and at magistrates’ inquiries and Mental Health Review Tribunal hearings. It also requires that all reasonable efforts be made to ensure that information about legal rights and other entitlements is given in the language, mode of communication or terms that persons are most likely to understand.</td>
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<td><strong>Community Relations Commission &amp; Principles of Multiculturalism Act 2000</strong></td>
<td>This Act establishes the four principles of multiculturalism as a State policy (refer to breakout box on this page). It requires all public authorities to embed these principles in “the conduct of their affairs and made it the duty of the chief executive officers of each public authority to ensure that the provisions of the policy were carried out”.</td>
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**The Four Principles of Multiculturalism:**

**Principle 1:** All individuals in NSW should have the greatest possible opportunity to contribute to and participate in all aspects of public life in which they may legally participate.

**Principle 2:** All individuals and institutions should respect and make provision for the culture, language and religion of others within an Australian legal and institutional framework where English is the common language.

**Principle 3:** All individuals should have the greatest possible opportunity to make use of and participate in relevant activities and programs provided or administered by the Government of NSW.

**Principle 4:** All institutions of NSW should recognise the linguistic and cultural assets in the population of NSW as a valuable resource and promote this resource to maximise the development of the State.
3.3 Ethnic Affairs Priorities Statements’ Standards Framework

The Ethnic Affairs Priorities Statement (EAPS) program is the system used for implementing the principles of multiculturalism in NSW government agencies. The system requires Chief Executives from each Area Health Service to have a current multicultural/EAPS Forward Plan and report on it to NSW Health and the Community Relations Commission for a Multicultural New South Wales.

Multicultural/EAPS Forward Plans identify timeframe, performance measures and responsibilities for programs and services. Each Forward Plan correlates to an EAPS Standards Framework criterion and performance levels. There are five activity areas:

a) Planning and evaluation;
b) Program and service delivery;
c) Staffing;
d) Communication; and

e) Funded services.

To fulfil the goals of the EAPS program, Area Health Services (AHS) are expected to bring EAPS forward planning into alignment with their corporate and business planning processes.

An annual or biannual evaluative process informs Area Health EAPS Standards Framework reports. The reports are submitted to NSW Health and the Community Relations Commission for assessment and inclusion in the Community Relations Report, which is tabled in Parliament each year. An overview of EAPS implementation progress is also included in each AHS Annual Report.

3.4 Role of Transcultural Mental Health Services

Specialist transcultural mental health services provide a high degree of expertise in the provision of assessment, treatment and support, as well as the development of state-wide initiatives. These services are primarily delivered, with state-wide capacity, by the following:

- Transcultural Mental Health Centre (TMHC);
- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) via direct clinical services and programs and the NSW Refugee Health Service;
- Area Multicultural Health Coordinators;
- Area based bilingual mental health workers;
- Area Mental Health Services with high concentrations of people from CALD backgrounds; and the
- NSW Health Care Interpreter Services.

Innovative work is also being conducted by a number of non-government organisations (NGOs) and by facilities such as specialist children’s hospitals.

It is important that mental health services continue to work collaboratively with bilingual/bicultural staff and community based services in order to share and develop transcultural mental health expertise, programs, resources and information. These partnerships facilitate the sharing of clinical knowledge and expertise and enhance culturally competent assessment, diagnosis, management and recovery processes. They drive the development of best practice in the critical area of early detection and treatment.

It is critical to ensure that NGO participation is acknowledged and supported. Many NGOs are frontline providers of services targeting the mental well being of CALD communities. Peak multicultural and ethno-specific organisations are often the first point of contact. Strengthening the partnerships between mainstream mental health service provision and NGOs is therefore critical to successful implementation.

The NSW Health, Mental Health and Drug & Alcohol Office, has funded a partnership with the NSW Transcultural Mental Health Centre to review and enhance the Mental Health Outcomes and Assessment Tools and processes to become culturally accurate, acceptable to diverse communities, and meaningful to consumers and carers. This project canvases suggestions from front-line mental health clinicians, consumers and carers of CALD communities, bi-lingual / bi-cultural mental health professionals, professional health care interpreters, and other key parties. Input has been collected from sources across the life span, from rural and metropolitan areas, and from the inpatient and community sectors. The review process is producing concrete, practical revisions and addenda to MHOAT documentation, clinician guidelines, and training materials. It also gives new insights into the use of standard measures in multicultural NSW.
SECTION 4

Factors impacting on Multicultural Mental Health

This section outlines the key factors that impact on the delivery and accessibility of culturally competent mental health services. The eight factors are summarised in the diagram below:

4.1 Diversity

Immigration continues to be the main source of population growth in NSW and Australia. According to the Australian Bureau of Statistics 2001 Census, NSW, the largest state in Australia, has the highest number (1,020,421) of people born in a non-English speaking country (16%). Settler arrival statistics from the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) indicate that in 1993-94 people from 153 different countries arrived in NSW to settle. By 2003-04, this number increased to 171 countries. Relevant NSW facts include:

- 18.1% (1,197,071) of all NSW residents speak a Language Other Than English (LOTE) at home.
- 16.1% of the total NSW population were born in a non-English speaking country.
- 8.5% (536,172) of Australian-born people living in NSW have both parents born overseas.
- 9.5% (599,189) of Australian-born people living in NSW have one parent born overseas.
- 2.9% (182,972) of the total NSW population arrived since 1996 and were born overseas from a non-English speaking country.

“Immigration continues to be the main source of population growth in Australia.”
The most common languages other than English spoken at home as a percentage of LOTE speakers in NSW are:

- Arabic (12.2%)
- Cantonese (10.1%)
- Italian (8.1%)
- Greek (7.5%)
- Vietnamese (5.7%)
- Mandarin (5.5%).

The fastest growing languages include Mandarin, Hindi, Indonesian, Assyrian, Punjabi, Tamil, Persian and Korean. The countries from which the greatest increase in migration has occurred since 1996 are Iraq, South Africa, India, China and Korea. There have been significant proportional increases over the last five years in speakers of Mandarin, Hindi, Indonesian, Assyrian, Punjabi, Tamil, Persian and Korean.

Area demographics change over time in response to immigration policies, settlement and resettlement trends, and global events. These changes need to be monitored at a State and Area level as they can have a substantial impact on the profile of mental health needs of specific Areas and the development of relevant policies and services.

4.2 Migration & Settlement

While studies indicate that immigration alone is not associated with an increase in mental health problems, some aspects of the immigration and settlement experience may place particular stressors on an individual or community's mental health and wellbeing. Some of these stressors may be migration related such as:

- Pre- and post-migration experience;
- Life long settlement experience;
- Immigration status;
- Past experiences of war, torture and trauma;
- Past experience of other forms of human rights violation;
- Consequences of any trauma experienced by parents being transmitted to their children; and
- Voluntary versus involuntary migration.

Other stressors may be directly related to the settlement experience such as:

- Age at the time of migration;
- Years of residency in Australia;
- English proficiency;
- Nature and length of detainment in immigration detention centres;
- Access to community, social and family support networks;
- Financial, housing and employment status;
- Discrimination and racism;
- Changes in family dynamics and/or roles within the family unit;
- Loss of status, identity and self esteem;
- Access to social and health services; and
- A sense of disempowerment.

In addition to these factors, settlement issues and community needs may vary considerably between larger more established communities, refugees, and small and emerging communities.

Culture is also a dynamic attribute. As newcomers come into contact and become more familiar with Australian society, they gradually integrate some aspects of Australian culture into their own. For effective intervention, it is essential to consider these cultural transition processes.

In contrast to the more negative experiences of the settlement process, some migrants have very strong family and community bonds and demonstrate great strengths and resilience in the adaptation to their new homeland. It is important to recognise and build on these strengths in clinical interventions and the implementation of innovative and creative prevention and promotion initiatives.

“Culture is not a static attribute but a dynamic one.”
4.3 Consumer, Family & Carer Participation

A recent study found that consumers and carers from CALD communities are often:  
- Unaware of the availability of services and how they work;  
- Lack the knowledge necessary to access services; and  
- Need better access to translated information, support, training and education on their roles and rights.

Language and cultural barriers, including cultural attitudes towards mental illness, present significant obstacles for CALD communities, especially when seeking access to mental health services. These factors impede their right to participation and adversely affect their ability to seek early assistance for mental health issues that can delay initial and ongoing care.

The needs of consumers and carers from CALD communities have not always been well integrated into mainstream consumer and carer advocacy organisations. They experience particular barriers to participation in their health care, policy, planning, service delivery and related evaluation and decision-making processes. Efforts to engage CALD communities in these processes needs to be supported by appropriate educational initiatives, as well as improved consultation, knowledge and systemic support.

4.4 Promotion, Prevention & Early Intervention

Mental Health programs today focus on promotion, prevention and early intervention. This development was driven by the recognition of the "increasing prevalence of mental health problems and disorders and by evidence of effective initiatives and services."x

Unfortunately, the shortage of ethnicity data on the incidence and prevalence of mental health problems and disorders in CALD communities complicates any precise determination of CALD community mental health needs, including promotion, prevention and early intervention.

The pattern of utilisation of mental health services by people from CALD communities is significantly different to the general community. People from CALD communities are less likely to use mental health services voluntarily, often present late at a time of crisis and are more likely to be hospitalised on an involuntary basis.x This is generally due to the following issues:

- Lack of knowledge about mental health problems/illness;
- Cultural differences in interpreting mental illness;
- Expectations in the management of mental illness; and
- The lack of appropriate service delivery models and staffed services.

The most significant factor behind these issues is the difficulties that people from CALD communities can encounter in understanding and communicating their mental health needs, as well as varying perceptions of symptoms and problems associated with mental illness.

These issues are of particular concern when specific health status data is examined. The Australian Institute of Health and Welfare reports that people born in non-English speaking countries account for 14% of people with mental disorders.xi Based on population figures, it is likely that more than 15% of people from CALD communities live with depression.xii This highlights the need for people from CALD communities, and relevant health professionals, to have access to appropriate information and services.xiii This is also problematic. In a search of 15 websites on depression, Griffiths and Christensen (2002) found "an extremely limited amount of information specifically targeted at CALD consumers and carers."xiv As noted by the researchers, the "presence of early accessible depression information increases the likelihood of a more accurate diagnosis".

4.5 Service Access

The most significant barriers for CALD communities seeking to access mental health services are:

- Lack of accessible interpreters and translators (exacerbated in rural and remote areas).
- Lack of diverse interpretation services (there are ongoing difficulties servicing the increasing diversity of languages spoken by CALD communities, especially newly arrived and smaller groups).
- Shortage of interpreters and translators trained in mental health.
- Limited awareness of, and access to, information on mental health services.
- Limited CALD consumer and carer participation in all aspects of mental health care.
- Low levels of mental health literacy in CALD communities.
Limited health promotion, prevention and early intervention strategies that specifically target CALD communities.

Stigma and shame attached to mental illness. This may result in avoidance of GPs and mental health services, withdrawal and extreme isolation and loneliness. By the time some families do get help the situation has increased in severity, complexity, and impact.

Limited multicultural resources and programs, skilled bilingual/bicultural mental health professionals and culturally competent mainstream mental health workers across all Area Health Services.

Lack of established infrastructures and social support networks within some CALD communities.

Existing models of mental health care are generally limited in the nature and extent to which they accommodate the needs of CALD communities.

Current service infrastructures can create barriers to access.

NSW Health’s Transcultural Rural & Remote Outreach Project is a collaboration between the Transcultural Mental Health Centre and the Centre for Rural and Remote Mental Health. The Project works in partnership with rural Area Health Services and local government and NGO’s in Griffith, Coffs Harbour, Tamworth and Dubbo. The aim is to develop demonstration models of service delivery that enhance the cultural responsiveness of rural mental health services for CALD populations.

4.6 Primary Care Sector and General Practitioners (GPs)

Patterns of service use indicate that the majority of people from CALD communities access their GPs as the primary source of treatment, advice and management. Only a small proportion with a diagnosable mental disorder receive specialised treatment through public mental health services. While this trend may be more pronounced in CALD communities, it is also true of the general community. According to some researchers, “under-recognition of mental health problems amongst immigrants treated in general practice may be a factor accounting for the low referral rates of ethnic minorities to specialist mental health services.”

Given that GPs are the primary source of contact for people from CALD communities, the need to support and engage with GPs, specifically with information on detection and treatment, is of critical importance. Given also their propensity to seek out GPs who speak their language, the pool of bicultural/bilingual GPs and overseas-trained GPs also requires additional support in providing services to consumers with mental health problems.

4.7 Cultural competence of mental health services

When people from CALD communities access a mental health service they may experience difficulty using the service and obtaining culturally appropriate clinical assessment and interventions. Mental health problems for people of CALD communities can be complex in their presentation and intervention and management requires specialist transcultural knowledge and skills. Cultural differences influence the conceptual and experiential dimensions of mental health and illness and these differences need to be accommodated in mental health service provision.

The expression and presentation of problems is further compounded by the significant relationship between physical and mental health needs. This needs to be more clearly understood as people from CALD communities can present with physical symptoms that are not always recognised or diagnosed as mental health problems especially at the early onset stage, including the perinatal stage.

The National Standards for Mental Health Services stipulate that mental health services deliver treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.

Diversity in the local population needs to be reflected in the skill base and composition of the mental health workforce. The need to build on the skill base of the mainstream mental health workforce to ensure they work cross culturally is critical. There is also a need to maintain and protect existing bilingual resources and expand these resources to support the growing diversity of newly arrived and emerging language / cultural groups.
The attainment of culturally competent mental health services requires focus at the policy, consumer, community and service delivery levels.\textsuperscript{xvi} The policy level includes policy and program development, planning, resource allocation, data and evaluation and reporting. The consumer and community level includes community education, mental health literacy enhancement, consumer and carer participation and support options. The service delivery level includes a culturally competent workforce, workforce development, mainstream and specialist transcultural mental health programs, consultation protocols and processes and links with communities and data collection.

The multicultural mental health sector recognises the need to standardise practices for cross cultural training and determine core cultural competencies required by mental health workers to work effectively. Cross-cultural mental health training needs to be conducted in a coordinated, structured, consistent and systematic way and targeted to meet the varying needs of the workforce and service mix. Training is also essential in order to transfer the skills of transcultural/torture and trauma mental health specialists to mainstream mental health workers.

A culturally competent framework will achieve better mental health outcomes for people from CALD communities. It can also be an effective accountability and quality improvement measure; “effective cross cultural assessment necessitates the clinician operating within a culturally competent context, paying attention to communication, respect for patients’ beliefs, values and attitudes”\textsuperscript{xvii}

4.8 Research and Evaluation

Culturally inclusive research is essential in order to develop the evidence base underpinning service delivery models and clinical practices for CALD communities. Currently, there is difficulty in accessing epidemiological data on the mental health status of CALD communities. More evidence is required on the:

- Outcomes of clinical interventions and treatments;
- Preference for service location and type;
- Explanatory models of illness across cultures; and
- Treatment responses to different groups.

In mainstream research the most common exclusion criteria for sample selection in Australian studies is “subjects with an inadequate knowledge of English”.\textsuperscript{xviii} One outcome from such exclusion is that the research fails to be representative of the whole community. The research results cannot be generalised to the CALD community with any degree of validity. A review of research publications / grants indicates that research dealing with non-English speaking population groups comprised only 2.2% of published articles and attracted only 1.5% of competitive research grant funding.\textsuperscript{xix}

As a consequence, there is limited evidence about:

- Effective clinical practice and interventions for specific CALD communities;
- Mental health prevalence data for CALD communities, including new, small and emerging communities to inform service delivery, promotion, prevention and early intervention initiatives. (note the National Mental Health Survey data includes limited findings for the CALD communities due to small sample sizes);
- Best practice service delivery models, including community-oriented initiatives;
- Differing concepts of positive mental health across CALD communities and how these concepts translate into clinical care and program development;
- Development of performance indicators that measure the success of multicultural initiatives and programs;
- Management of mental illness by bilingual GPs and quality of therapeutic outcomes.

In an environment of increased accountability, the availability of data to develop and inform valid performance measures for CALD communities is essential. This will require an incisive understanding of the available data, validity, reliability, and gaps as well as a review of current data collection systems.

In light of the lack of evidence-based research on the mental health of CALD communities, the need to document and recognise the value of innovative projects, qualitative data, and anecdotal information available in the community and NGO sector, is critical for improving insight and understanding.

The Mental Health Service monitors its performance …and utilises data collected to improve performance as part of a quality improvement process.

\textit{(National Standard for Mental Health Services 7.7)}
Often, evidence based practice has been established through the funding of pilot programs. To date, many pilot projects have been evaluated in an adhoc manner, rather than using empirically sound methodologies. This has resulted in difficulties in validating best practice and also risks duplication of resources and funds over time. An empirical approach will ensure valid data is collected, analysed and published in appropriate journals. It will also attract experienced researchers, expanding the current body of knowledge. Success requires strong and substantive links with relevant research institutions and universities.

Related issues with completed pilot projects include:

- An ongoing gap in local service delivery.
- The pilot project has raised unrealistic expectations in the local community.
- Service delivery is not sustained past the duration of the pilot project.

In an environment of increased accountability, the availability of data to develop and inform valid performance measures for CALD communities is essential.

Clearly there is an ongoing need to establish and validate evidence based best practice. The funding pre-conditions of innovative pilot projects need to include resources and criteria for sound evaluation. Success can then be validated and best practice sustained across relevant components of the mental health system.
Within the CALD communities there are particular groups ‘at risk’ because they require a high level of cultural competence by service providers and/or specific interventions, collaboration and support. These groups are illustrated below:

### Specific Groups at Risk

- Infants, Children & Young People
- Women
- Carers & Families
- Regional & Remote Populations
- Refugees & Torture & Trauma Survivors
- Older People

### 5.1 Infants, Children, Young People and Families

This population group includes first and subsequent generations of children and young people, post migration, experiencing mental illness, those caring for parents with a mental illness and those with dual diagnosis of a mental illness and substance use disorders or a mental illness and intellectual disability.

In 2001, the ABS Census reported a total of 34,956 children aged 12 years and under living in NSW who spoke a language other than English at home. According to the Census, the top nine languages spoken by this group are Arabic, Cantonese, Vietnamese, Mandarin, Korean, Greek, Turkish, Hindi and Japanese.

Children and young people from CALD communities can experience specific mental health problems arising from pre- and post-migration experiences, including:

- Changes in family roles/dynamics;
- Issues arising from living between two cultures;
- Lack of understanding of mental illness within the family;
- Impact of religion;
- Parental expectations of young people;
- Societal expectations of young people;
- Domestic violence;
- Child abuse;
- Psychological disorders;
- Exposure to war and associated trauma;
- Intergenerational conflicts;
- Identity formation; and their
- Experiences of education/employment, racism and abuse.
In addition, there are particular challenges for infants, children and young people from refugee backgrounds, including:

- Impact on attachment;
- Inadequate/interrupted parenting;
- Separation from loved ones; and
- Guilt about surviving/leaving families.

Specific immigration related problems such as ‘anticipatory stress’ also affect the emotional well being of unaccompanied minors, children who have experienced periods in detention and previous Temporary Protection Visa holders.

Sexual health for young people is also an often-overlooked need. Disruption can cause confusion about sexual behaviour and identity. Young women who have had refugee experiences need information and support to address their sexual health needs as they may have experienced or have been exposed to sexual violence.

Young people who have had refugee experiences can have increased vulnerability to the use of drug and alcohol as a form of self-medication. These problems can develop into dual diagnoses and more complex problems. It is necessary for mental health and child and adolescent services to ensure the availability of culturally appropriate support and assistance to effectively meet the needs of this group of young people.

The Framework for Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia 2004 notes that ‘Depending upon the resilience and resources of the young people, such life changes… may result in increased risk of suicide, increased vulnerability to drug and alcohol problems, anxiety, depression, distress and poor self esteem which may be hidden by withdrawal, or alternatively, aggressive and acting out behaviours.’

Research also indicates that young people from CALD communities are unlikely to seek help as they perceived help-seeking as a sign of weakness…lacked trust in agencies and services; lacked understanding of the services being provided; …had issues of confidentiality; and felt disloyal to their family’.

Studies indicate that, for children and young people from CALD backgrounds, exposure to risk will significantly depend on support structures and access to resources and resilience. All these factors make this group more vulnerable to marginalisation and alienation.

This Plan is complemented by the draft NSW Health plan Building a Secure Base for the Future: NSW Mental Health Service Plan for Children, Adolescents and the People who Care for Them (soon to be released). The draft document recognises this particular CALD population group and the importance of integration of approaches.

5.2 Women

Despite the diversity of CALD communities, women as a population group share a number of factors that can adversely impact on their mental health, including:

- Settlement difficulties such as limited English language proficiency;
- Grief and loss;
- Racism and discrimination (cultural and religious);
- Social isolation and change in family dynamics and roles that contribute to family stress;
- Occupational segmentation;
- Unemployment and/or low income;
- Conflict between traditional and new norms / values.

These factors increase women’s risk of depression, anxiety and distress.

Refugee families are at greater risk of developing psychological problems. For many refugee families traditional parenting practices may be disrupted. Issues such as a possible history of violence, trauma, sexual abuse, chronic physical illness, feelings of guilt or acute anxiety about family members left behind may result in associated specialised mental health needs. Refugee women may not present themselves to specialist torture and trauma services and the related trauma may not be dealt with on immediate settlement and may resurface later in life.

Pregnancy can be a challenging period characterised by heightened stress and recurrence of past mental health issues. Between 2000 and 2004 approximately 20% of women giving birth were from non-English speaking countries. In 2004, 15.6% (13,135 babies) of mothers giving birth were from the Middle East, Africa and Asia. NSW Health, under the umbrella of the
NSW Families First Whole of Government Strategy, has developed a program that identifies families at risk of, or with, mental health problems early in pregnancy. Primary health care professionals including midwives, general practitioners and child and family nurses routinely screen women for specific risk factors including significant recent stressors, past history of trauma, abuse and mental illness including depression, current domestic violence and drug and alcohol problems.

5.3 Carers and Families

CALD carers and families can encounter a range of issues while caring for a relative or friend with a mental illness. A study conducted by Schofield in 1998, concluded that:

- Higher levels of unmet needs were identified among carers from CALD communities than in other carer populations.
- Access to information about services was significantly lower for carers from CALD communities.

Schofield also found that ‘lack of information about the medical condition…role change and financial burden’ impacted on carers’ wellbeing. Other carer emotional responses reported were: grief, loss, guilt, anger, helplessness, depression and fatigue, family conflicts and loss of contact with social networks. These responses can be exacerbated by the fact that carers from CALD communities fail to identify themselves as carers because they perceive this role to be a part of daily life.

Another study highlighted similar pressures on families as primary care providers. Issues included inadequate emotional and social support and respite care. The study’s survey of carers indicated that their two main health problems were physical injury and emotional stress. Both of these problems can be prevented with responsive support and information.

To overcome these issues, it is imperative that the development and implementation of specific CALD carer support initiatives be incorporated into the NSW Family and Carer Mental Health Program.

5.4 Older People

The population of older people in Australia is becoming increasingly diverse in terms of cultural and linguistic background, according to a report by the Australian Institute of Health and Welfare. Entitled Diversity among older Australians in capital cities 1996–2012 the report concludes that the proportion of older people aged 65 and over from CALD communities will increase from 18% in 1996 to 23% by 2012. This equates to a 66% increase over the 15-year period, compared to a 23% increase for older people born in Australia. Furthermore:

- 12.2% of the total NSW population is 65 years or over and 20% of the total NSW 65 years and over population are from CALD backgrounds.
- 15% of the total CALD population in NSW is 65 years and over.

- 43% of the total CALD population in NSW (65 years and over) reported speaking English not well/not at all.

In Sydney, the increase in the 65 years and over population is even more marked. In 1996 there were 110,000 older people from CALD backgrounds living in Sydney, about a quarter of the city’s total older population. By 2012, this number is projected to increase to 190,700, or to around one-third (34%) of older people, representing a 73% increase in this population. (p.6) The biggest growth will be in the Greek, Lebanese, Vietnamese and Croatian older communities.

This has a number of implications for mental health services. For example, according to McDonald and Steel, ‘While immigrants of NESB up to the age of 64 years have lower or similar rates of suicide compared to the overall community, immigrants aged 65 years and over have significantly higher rates’.

There are particular stresses experienced by older people from CALD backgrounds that vary according to years of residency in Australia, health status and pre- and post-migration experiences including experiences of war, torture and trauma:

- Grief and loss, particularly loss of a spouse, one’s hopes and aspirations, nostalgia for the country of origin, vocational status and physical illness/frailty are significant issues for this cohort.
- Reduced English language proficiency and regression to first language is common, which may require an increased focus on the provision of language specific services.
- Settlement related issues such as a breakdown in the traditional family unit and their role within this unit, intergenerational conflict, sense of disconnection with family and children, impact of the lack of family and social support structures and increased levels of cultural, social and geographic isolation and loneliness can place a significant emotional burden on this population group.
With the ageing CALD population, as is common with the general ageing population, various mental health problems requiring specialist mental health care are emerging. These include dementia, under-recognition and treatment of depression, somatisation of symptoms, resurfacing of earlier traumatic memories and increased rates of depression and suicide especially with older men. It is recognised that while there is relative under-treatment of depression in all populations, older people are very vulnerable. Health care providers will need to improve recognition of symptoms which can be presented or described differently by older people and, at times, fail to be diagnosed as mental illness.

This group has an additional vulnerability, experiencing further difficulty accessing and negotiating the complex array of aged care programs and mental health services. The NSW Health Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005–2015 recognises these particular issues and will provide the planning and service delivery framework to address them.

5.5 Refugees and Survivors of Torture and Trauma

The refugee population is growing in numbers, becoming more diverse and geographically dispersed in NSW, particularly through the Australian Government’s current Refugee and Special Humanitarian Program’s emphasis on Africa.

In the five-year period from 2001 to 2005, over 16,000 refugees settled in NSW. Five major source countries contributed nearly 75% of the total humanitarian entrants in this period. These countries were:

- Iraq – 4,314
- Sudan – 3,878
- Afghanistan – 1,934
- countries of the Former Yugoslavia [not otherwise specified] 1,030
- Iran – 815

Emerging source countries for humanitarian entrants include Sierra Leone, Liberia and Myanmar (Burma). Refugees originating from countries in Africa now comprise nearly 50% of the intake to NSW. It should be noted that country of birth does not always reflect ethnicity or language spoken.

In the same five-year period (2001–2005), nearly half of the refugee groups settling in NSW were aged less than 20 years, this constitutes a total of over 8,000 children and young people.

The three Local Government Areas (LGAs) of Fairfield, Liverpool and Blacktown were the settlement destination of 50% of these humanitarian entrants. Another 25% settled in Auburn, Parramatta or Holroyd LGAs. While around 80% settled in either Sydney West or Sydney South West Area Health Service locations, small but significant numbers settled in rural and regional areas such as Newcastle, Wollongong and Coffs Harbour. These latter settlement patterns have implications for local mental health service provision.

Refugees have suffered threats to their lives, loss of or separation from family members, loss of social networks, possessions, connection with their homeland, culture and traditions, and changes to family roles. These events can impact on their psychosocial development and adaptation in a new country. Many women, in particular refugee women from African countries, are now heads of large families, which can contribute to family stress. Additional issues may arise for young people and children. Torture and trauma experiences can have adverse affects on parents, as well as mental health consequences for their children.

Pre-migration trauma, post-traumatic environment and post-migration stress are recognised as predictors of increased vulnerability to mental health problems. Two of the identified risk factors for Post Traumatic Stress Disorder (PTSD) are cumulative trauma and past psychiatric history. In addition, ‘age, language proficiency, social and economic diversity and fear of repatriation appear to be influential in preventing recovery from PTSD and other forms of psychosocial distress in refugees and asylum seekers’. Certain cultural factors including ‘religious faith, a sense of commitment to a political cause and psychological preparation for torture all appear to provide some protection against adverse psychological consequences.’

The research suggests there are higher rates of mental disorders in refugees compared with the general population. Furthermore, asylum seekers displayed over three times the risk of being assigned to a “high” depression, anxiety or PTSD category compared to immigrants, partly due to the post-migration stressors relating to the asylum seeker process.

There is a lack of data about refugees accessing mental health services. This is attributed to the absence of a migration status measure in routine health service data collection. Nor is this population group identified in population surveys of mental health status. This is attributed to the population’s high mobility, lack of home telephones, language barriers and marginalisation.
The Longitudinal Survey of Immigrants to Australia (DIMIA 2002) contains data from two cohorts of over 11,000 migrants. Compared with persons who migrated under other visa categories, humanitarian entrants: had poorer self-assessed health status over the previous four weeks; and were more likely to display psychological distress based on the GHQ-12. (VandenHeuvel A & Woden M. New Settlers have Their Say – How immigrants fare over the early years of settlement.)

Many refugees are members of very isolated, small and emerging communities, with limited support networks and community infrastructures. Access to appropriate information, bilingual health professionals (including GPs), interpreters, and/or traditional methods of mental health care is lacking. These factors further restrict refugees’ choices in health care. It is noted that refugee settlement is often located in urban fringe areas that generally have less services, infrastructure and a less well-established CALD community.

Mental Health service providers need to support and enhance service models that address the needs of refugees in regional, rural and remote areas. Increasing the understanding and knowledge of issues affecting this population group and the impact on service provision will require enhanced cross-jurisdictional and cross-agency planning.

Furthermore, a number of asylum seekers living in the community do not have access to Medicare. It is important that the principle of providing mental health services to people regardless of their residency or visa status be upheld.

5.6 Regional, Rural and Remote Areas

Regional, rural and remote areas are characterised by small and geographically dispersed concentrations of a number of different CALD communities. A number of these are experiencing a small increase in the number of people from CALD communities. Settlement patterns in NSW have changed over the last ten years, with more refugees first settling in regional and rural areas. This trend has been encouraged by both federal immigration/population policies and state planning policies. The trend is likely to increase as established refugee communities become sponsors for people under the Immigration Special Humanitarian Program.

Persons of CALD heritage living in rural and remote communities may experience a greater sense of isolation due to the lack of a critical mass of people from their culture in their area. Current initiatives are strengthening services to enhance cultural safety, are promoting outreach to encourage access, and are increasing clinical capacity to ensure equity for CALD consumers and families in rural NSW.

The Regional Area Health Services with the highest numbers of people who were born overseas in a non-English speaking country are Illawarra (12%); Central Coast (4.9%) and Hunter (4.5%). The rural Area with the highest number of people born in a non-English speaking country is the Greater Southern Area Health Service (10.5%).

There is an expanding body of literature about the challenge of delivering quality health to non-urban populations. Access to mental health services in regional, rural and remote areas by CALD communities remains disproportionately low. Key issues include:

- Compounded cultural isolation due to low critical mass;
- Restricted employment opportunities;
- Exposure to often unwelcoming and/or intolerant attitudes;
- Restricted access to professional (clinical) supervision in the rural mental health sector;
- Poorly developed networks for service delivery;
- Lack of bilingual mental health workers and locally based trained interpreters; and
- Limited community infrastructures.

“…the difficulties experienced in targeting and servicing the specific needs of the CALD population in regional, rural and remote areas in NSW are even more pronounced due to the lack of critical mass of ethnic communities.”

Improvement in service delivery requires the commitment and development of appropriate infrastructure, funding resources and building service capacity of mental health staff to deliver culturally competent services.
5.7 People in contact with the Criminal Justice System

This population comprises all individuals who come into contact with the criminal justice system. Justice Health provides health services for all adolescents and adults within a correctional setting in collaboration with the Department of Corrective Services and Department of Juvenile Justice. Currently in NSW, there are approximately 9200 adults in correctional settings (20,000 new receptions per year) and 320 young people in detention (3500 new receptions per year).

Individuals who come into contact with the criminal justice system often have complex psychosocial needs, high mental health and substance abuse issues, higher levels of general health needs and complex and multiple trauma histories including deprivation, neglect and abuse histories. Many have experienced educational and work difficulties, impaired intellectual functioning, and adverse economic and social backgrounds. Individuals from CALD backgrounds may experience ongoing discrimination, stigmatisation and individual and institutional racism. In detention settings, which are often traumatising, conflicts and clashes are often culturally based.

NSW Department of Corrective Services 2005 census data indicates that, 81% of women and 75% of men were born in Australia of whom 30% of women and 22% of men respectively, had one or more parents who were born overseas. Data indicates that country of origin for the current offender population is:

- 22.5% – Australian
- 3.2% – Vietnam
- 2.8% – New Zealand
- 1.9% – United Kingdom
- 1.5% – Lebanon
- 1.1% – China.

Data indicates that the number of adults coming into contact with the mental health services within this population group have the following country of origin:

- 88.46% – Australia
- 9.45% – born overseas
- 2.09% – failed to identify the country of birth

In a recent 2005 demographic survey of adults in gazetted beds at Long Bay Hospital, 23% were from CALD backgrounds.xi

The 2001 Mental Illness Among NSW Prisoners’ Report found that the rate of mental illness of prisoners is 30 times higher than that of the general population. It also concluded that the prevalence rate for any psychiatric disorder amongst prisoners born overseas from a non-English speaking country is less (66%) than those born in Australia (81%).

In August 2005, a review of the MH-OAT census data of ambulatory patients in Justice Health found that 22% of patients aged 55 to 64 years were born overseas and 31% of patients aged over 65 years were born overseas. Older first time offenders receive longer sentences due to the seriousness of the crime committed.

Adolescents in detention are another extremely vulnerable group with high levels of intellectual impairment, educational difficulties, mental health issues including conduct and substance use disorders as well as possible exposure to abuse, neglect and deprivation histories. As a group, they are exposed to racial harassment, dislocation and separation from significant others, high levels of parental imprisonments, separations, absent parent/s, and living on the streets. In the population of young people in a detention setting there is limited data identifying the country of birth of parents.

In 2003, the NSW Department of Juvenile Justice and Justice Health conducted the NSW Young People in Custody Health Survey. The sample consisted of 242 young people in custody (76% of all available young people in custody). The survey identified that 15% of young offenders were born overseas and were from a CALD background (Oceania 6%; Asia 5%). The Survey does not provide details of the nature of offences committed or if they vary between young offenders from a CALD background.

The survey also indicated:

- People who spend time in refugee camps have a higher rate of incarceration.
- The three most prevalent disorders were Conduct Disorder, Substance Abuse Disorder and Adjustment Disorder.
In order to meet the particular mental health needs of this population, the following areas require strengthening:

- Improved access to bilingual/bicultural resources and interpreter services.
- Delivering culturally appropriate assessment, management and care.
- Meeting specific cultural needs such as food and religious requirements.
- Increasing staff cultural competency.
- Enhancing the use of court diversion, post release, and community based services.
- The collection of ethnicity data to enhance planning, appropriate service development and implementation.
SECTION 6

Implementing the Strategic Framework for Multicultural Mental Health

This Plan details the strategic direction for a five-year action agenda to enhance the delivery of mental health services to people from CALD communities. It provides a framework to enable NSW Area Health Services to develop localised multicultural mental health plans. The five inter-related strategies are summarised below:

1. Integrated policies that guide informed and data driven planning processes.
2. Renewing a focus on education, prevention and early intervention.
3. Delivering culturally inclusive and responsive mental health services.
4. Enhancing cultural competency in mental health service delivery.
5. Promoting culturally inclusive research, evaluation and innovation

These five strategic priorities set the parameters for a range of initiatives with clear measurable outcomes and longer-term impact as on the right.

Implementation & Measurement

The key driver will be the NSW Multicultural Mental Health Plan Implementation Committee, with executive support from MHDAO. Implementation and measurement will also reference relevant Multicultural Mental Health Consultative Groups/initiatives including AHS Mental Health Plans and the Ethnic Affairs Priority Statement forward planning processes and reporting. The four key performance measurement points are illustrated below.
6.1  **Strategic Priority: Integrated policies that guide informed and data driven planning processes**

This priority drives systemic and sustainable process changes that enable the integration of multicultural policies and multicultural mental health initiatives at international, federal, state and local levels. Implementation will improve access, continuity and quality of care and safety for CALD consumers, carers and their families. Challenges include improving the information management systems, the governance structures as well as overall accountability for multicultural mental health initiatives.

Successful implementation involves initiatives across three inter-related areas:

a)  Policy Integration;
b)  Data Driven Planning; and
c)  Reporting and Accountability.

### 6.1(a)  Policy Integration

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<th>Initiative What we will do:</th>
<th>Implementation How we know what’s changing:</th>
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</table>
| a)  Area Health Services (AHS) complete a Mental Health Implementation Plan that includes clear lines of accountability for reporting and planning for multicultural mental health. The plans will identify and address multicultural mental health strategies at various levels. | NSW Health and AHS integrate multicultural issues in corporate and business planning processes, mental health plans and policies.  
- Documented in AHS Multicultural Mental Health Implementation Plans. |
| b)  AHS designate a senior key position with responsibility for the oversight of the development, implementation and monitoring of their Multicultural Mental Health Plans. | Designation completed and contact details promulgated to MHDAO, AHS and NGOs.  
- Designation documented in AHS Multicultural Mental Health Plans. |
| c)  AHS establish Multicultural Mental Health Consultative Groups/initiatives that include the participation of consumers, their carers and families, in order to monitor quality of services. | Area based Multicultural Mental Health Consultative Groups/initiatives and networks are appropriately established.  
- Documented in AHS Multicultural Mental Health Plans. |
| d)  MHDAO appoint people with clinical and policy expertise in multicultural mental health on key strategic advisory bodies. | MHDAO appoints a CALD representative on the Clinical Advisory Council. |

**IMPACT:** Multicultural policies, planning and program processes are integrated with mainstream mental health services.

### 6.1(b)  Data Driven Planning

<table>
<thead>
<tr>
<th>Initiative What we will do:</th>
<th>Implementation How we know what’s changing:</th>
</tr>
</thead>
</table>
| a)  NSW Health State-wide Services and AHS commit to improving the collection and analysis of ethnicity data items, including accessibility. | Relevant ethnicity data items are developed and included in existing and new data collection systems.  
- AHS collation and analysis of ethnicity data for inclusion in reporting and planning processes. |
| b)  MHDAO and AHS record, analyse and report on ethnicity data. | MHDAO monitored completeness and quality of ethnicity data collected by AHS. |
| c)  South East Sydney Illawarra Area Health Service (SESIAHS) will develop and implement a project aimed at improving the collection and quality of mental health ethnicity data. | SESIAHS completed and evaluated ethnicity data collection pilot project. |
| d)  Use the Mental Health Clinical Care and Prevention (MH-CCP) to review and update population data to meet the service needs of CALD communities. | MH-CCP review has estimated population needs and level of demand for mental health services by CALD population. |
| e)  Justice Health scope and address gaps in ethnicity data collection, client needs, service provision, carer support and cultural competency of staff. | Scope completed, documented and disseminated to relevant stakeholders. |

**IMPACT:** Improved collection and analysis of service utilisation data for CALD communities to inform State and Area planning at all levels.
### 6.1 Reporting and Accountability

**Initiative**

<table>
<thead>
<tr>
<th>What we will do:</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) MHDAO, AMHS and state-wide specialist transcultural mental health services develop evaluation frameworks and performance and outcome measures to monitor progress in multicultural mental health.</td>
<td>Evaluation frameworks documented in AHS Plans (including Implementation Plans).</td>
</tr>
<tr>
<td>b) Reporting and planning for multicultural mental health in Mental Health Service Agreements and existing Area reporting frameworks.</td>
<td>Reporting and planning documented in MH Service Agreements and evidenced in relevant AHS and state-wide specialist transcultural reports.</td>
</tr>
<tr>
<td>c) InforMH to monitor the completion of MH-OAT outcome measures for CALD consumers across AMHS.</td>
<td>InforMH monitoring completed, documented and dissemination to relevant stakeholders.</td>
</tr>
</tbody>
</table>

**IMPACT:** Improved monitoring, reporting and accountability for multicultural mental health across the mental health sector.

### 6.2 Strategic Priority: Renewing the focus on education, prevention & early intervention

This priority focuses on renewing the mental health sector's focus on education, prevention and early intervention initiatives that are culturally and linguistically sensitive. It is about delivering culturally and linguistically appropriate information to individuals, families and communities on mental health, in particular the prevention of health risk behaviours. This will broaden knowledge and awareness of:

- Risk and protective factors around mental health problems in CALD communities; and
- Early signs and symptoms of mental health problems in CALD communities.

**Initiative**

<table>
<thead>
<tr>
<th>What we will do:</th>
<th>Implementation</th>
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</thead>
<tbody>
<tr>
<td>a) MHDAO and AHS use their partnerships and service linkages with consumers (carers and family), primary health care services, key state-wide specialist transcultural mental health agencies and CALD community representatives/organisations to inform the development of mental health promotion initiatives that are culturally and linguistically appropriate.</td>
<td>Information and mental health education needs of the CALD population are identified.</td>
</tr>
<tr>
<td></td>
<td>Development and distribution of culturally and linguistically appropriate mental health material (state-wide services and NGOs).</td>
</tr>
<tr>
<td></td>
<td>Documented in AHS Multicultural Mental Health Plans and the EAP reporting process.</td>
</tr>
<tr>
<td>b) MHDAO consult with educational bodies providing mental health courses to ensure that they incorporate CALD issues/perspectives</td>
<td>Educational bodies such as The Institute of Psychiatry incorporate CALD awareness / education components into relevant courses.</td>
</tr>
<tr>
<td>c) MHDAO seek to ensure that CALD mental health awareness is included in the development of any relevant training/educational resources.</td>
<td>CALD mental health awareness incorporated in all relevant training/educational resource.</td>
</tr>
</tbody>
</table>

**IMPACT:** Promote positive mental health to strengthen CALD communities, reduce stigma, build resilience and ensure people know where to get help.
6.3 **Strategic Priority: Achieving culturally inclusive & responsive mental health services.**

This priority is the impetus for improving access to culturally inclusive and responsive assessment, diagnosis and treatment mental health services. It will enable mental health services to more effectively and efficiently respond to the mental health needs of CALD consumers, their carers and families. It focuses on the importance of transcultural skills as core to effective service provision in NSW and the need for adequate strategies to bridge language barriers.

Successful implementation involves initiatives across three inter-related areas:

a) Assessment, Diagnosis and Management;

b) Mental Health Partnerships; and

c) Support and Participation.

---

6.3(a) **Assessment, Diagnosis & Management**

<table>
<thead>
<tr>
<th>Initiative What we will do:</th>
<th>Implementation How we know what’s changing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Mental Health and Drug and Alcohol Office (MHDAO) initiate and resource a review of the cultural appropriateness of outcome measurement tools within MH-OAT, including initiatives such as the translation and validation of the SDS and K10.</td>
<td>Completion of the MHDAO Review of the cultural appropriateness of MH-OAT clinical modules. Outcomes include documentation, training, decision guide and promotion strategy.</td>
</tr>
<tr>
<td>b) Area Health Services (AHS) in consultation with CALD communities use the outcomes from the multicultural MH-OAT project.</td>
<td>AHS Multicultural Mental Health Plans</td>
</tr>
<tr>
<td>c) AHS seek to use interpreters with persons from CALD communities during assessment to help ensure a culturally appropriate diagnosis and case management.</td>
<td>AHS uptake of the multicultural components of the MH-OAT.</td>
</tr>
<tr>
<td>d) AHS ensure the appropriate utilisation of translated K10 form by clinicians for CALD communities.</td>
<td>Collection and analysis of interpreter utilisation data across Areas.</td>
</tr>
<tr>
<td>e) NSW Health to continue to provide core funding to clinical transcultural mental health services that specifically target refugee and CALD communities.</td>
<td>Increase promotion and use of the (15) translated K10 forms.</td>
</tr>
<tr>
<td>f) A documented trial of the Cultural Awareness Tool (CAT) trial by South East Sydney/Illawarra Area Health Service (SES/AHS).[xii]</td>
<td>Funds allocated for specialist transcultural mental health clinical assessment services.</td>
</tr>
</tbody>
</table>

**IMPACT:** Enhanced cultural appropriateness of the assessment, diagnosis and management of mental health problems of the CALD communities across the life span.
### 6.3(b) Mental Health Partnerships

<table>
<thead>
<tr>
<th>Initiative What we will do:</th>
<th>Implementation How we know what’s changing:</th>
</tr>
</thead>
</table>
| a) MHDAO collate, evaluate, document and promulgate CALD specific GP models of shared care initiatives across NSW Area Health Services. | ■ Advocate and support regular forums that build best practice through sharing experiences and models  
■ MHDAO access ethnic data collected by state-wide specialist transcultural mental health services, in particular TMHC and STARTTS.  
■ MHDAO completes Evaluation and disseminates to all AHS to support best practice. |
| b) All AHS commit to improving the collection of mental health data sets to record CALD specific partnership activities. | ■ CALD specific partnership activities including ambulatory code set.  
■ AHS Multicultural Mental Health Plans. |
| c) All AHS commit to improving their engagement with CALD communities, through:  
■ AHS Multicultural Mental Health Plans.  
■ EAPS Reporting Processes. | ■ Strengthening service linkages between mental health services, specialist transcultural mental health services, bilingual health workers and multicultural and NGO sector.  
■ Documenting, and referring to, local social networks, strengths and supports and community leaders.  
■ Increasing the use of cross-cultural consultants with CALD consumers in detection and treatment. |

**IMPACT:** Coordinated mental health services working in partnership with bilingual workers, specialist transcultural mental health services, consumers and carers, GPs, NGOs and multicultural agencies delivering enhanced clinical treatment and support to specific CALD communities.

### 6.3(c) Support & Participation

<table>
<thead>
<tr>
<th>Initiative What we will do:</th>
<th>Implementation How we know what’s changing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) All AHS commit to identifying ways of increasing the participation of consumers, their carers and family, in decision-making, service planning and delivery processes, including clinical care.</td>
<td>■ AHS Multicultural Mental Health Plans includes strategies for CALD consumers and carers.</td>
</tr>
</tbody>
</table>
| b) MHDAO continue to support and develop CALD Carer support initiatives and programs as part of the NSW Health Framework for Family and Carers of people with mental health problems and disorders. | ■ AHS Multicultural Mental Health Plans.  
■ EAPS Reporting Processes. |
| c) MHDAO and AHS / NGO Service Providers commit to providing a wider choice of support for CALD clients, including the adaptation of mainstream carer programs. | ■ AHS Multicultural Mental Health Plans.  
■ EAPS Reporting Processes. |
| d) MH-COPES should aim to include consultations with and feedback from CALD consumers during future project stages. | ■ MH-COPES targets CALD consumers and ascertains their experiences of mental health services and service evaluation issues. |
| e) MHDAO ensure that a CALD focus is included in relevant Tenders and Funding Agreements. | ■ Updated Tenders and Funding Agreements  
■ AHS Multicultural Mental Health Plans.  
■ EAPS Reporting Processes. |

**IMPACT:** Mental Health Services provide increased support and improved clinical care participation to CALD clients their families and carers.
6.4 Strategic Priority: Enhancing cultural competencies in mental health

This strategy sets the benchmark for ensuring that service capacity and capability works in a culturally competent manner. A key building block is optimal utilisation of bilingual mental health professionals. Cultural competency is also enhanced by:

<table>
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<th>Initiative</th>
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<tbody>
<tr>
<td><strong>What we will do:</strong></td>
<td><strong>How we know what’s changing:</strong></td>
</tr>
<tr>
<td>a) Assess AHS’s to ascertain:</td>
<td>■ Needs assessment completed and documented in AHS Multicultural Mental Health Plans.</td>
</tr>
<tr>
<td>Cross-cultural training needs of staff in mental health services;</td>
<td>Number of mental health staff that have undertaken cross-cultural training.</td>
</tr>
<tr>
<td>Define and develop competencies with reference to the NHMRC Guidelines on multicultural competency; and</td>
<td>Number of interpreters who have received mental health training.</td>
</tr>
<tr>
<td>Alignment with relevant national initiatives.</td>
<td></td>
</tr>
<tr>
<td>b) AHS’s include a cross-cultural component in all in-service training of mental health staff.</td>
<td>Documented in AHS Multicultural Mental Health Plans.</td>
</tr>
<tr>
<td>c) MHDAO and AHS’s promote the use of bilingual mental health professionals and interpreters for their language competency and understanding of the cultural and religious constructs impacting on client assessment and management.</td>
<td>Documented in AHS Multicultural Mental Health Plans.</td>
</tr>
<tr>
<td>d) MHDAO to ensure that the Integrated Perinatal Care Families (IPC) Training Package includes education on the impact of cultural diversity on birthing, parenting practices, and perceptions of mental health during the perinatal period.</td>
<td>Inclusion of a cultural component in the IPC.</td>
</tr>
<tr>
<td>e) MHDAO and AHS, in consultation with specialist transcultural mental health services, develop and implement innovative models that increase access by mental health workers to practical transcultural experiences (for example mentoring, supervision, cultural consultancy, work placements, cross cultural education including appropriate assessment and diagnosis).</td>
<td>■ Mentors, supervisors and cultural consultants with transcultural expertise are identified, promoted and utilised by mainstream mental health professionals.</td>
</tr>
<tr>
<td>innovative models/programs are established that provide access to transcultural expertise, information and consultancy. Documented in AHS Multicultural Mental Health Plans.</td>
<td>■ Completed and documented in AHS Multicultural Mental Health Plans.</td>
</tr>
<tr>
<td>f) Identify skilled supervisors/mentors working with people from CALD backgrounds to provide cultural consultancy advice to mainstream mental health workers.</td>
<td></td>
</tr>
</tbody>
</table>

**IMPACT:** Increased cross-cultural knowledge, experience and expertise in the mental health sector and increased skills transfer between specialist transcultural and mainstream mental health workers.
6.5 Strategic Priority: Promoting culturally inclusive research, evaluation, and innovation.

This strategy prioritises the need for more culturally inclusive research and evaluation that improves understanding, and informs the development of innovative and responsive models of care. Empirical research improves knowledge about the morbidity and prevalence of mental illness in CALD communities, as well as risk and protective factors. Particular focus points are the:

- Outcomes of clinical interventions / treatments;
- Preference for service location and type;
- Explanatory models of illness across cultures; and
- Treatment response.

Successful implementation involves initiatives across two inter-related areas:

a) Research, Evaluation & Applied Knowledge; and

b) Evidence-based Models of Care and Best Practice.

6.5(a) Research, Evaluation & Applied Knowledge

<table>
<thead>
<tr>
<th>Initiative</th>
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<tbody>
<tr>
<td><strong>What we will do:</strong></td>
<td><strong>How we know what’s changing:</strong></td>
</tr>
<tr>
<td>a) MHDAO will promote and support research at all levels that enhances existing baseline data and information on prevalence of mental illness in CALD communities.</td>
<td>MHDAO drive the research and production of a scoping paper on methodological issues arising in the multicultural research context.</td>
</tr>
<tr>
<td>b) MHDAO and relevant partners organise a NSW Mental Health Conference that focuses on recent research, evaluation and examples of best practice service delivery models of care for CALD population.</td>
<td>Multicultural mental health conference organised and papers promulgated.</td>
</tr>
<tr>
<td>c) MHDAO in partnership with the Transcultural Mental Health Centre, the Centre for Rural and Remote Mental Health, and rural Area Mental Health Services fund, develop and implement flexible, sustainable models of service delivery to CALD communities in rural and remote areas.</td>
<td>Increased number of transcultural mental health clinical services provided to regional, rural and remote areas.</td>
</tr>
</tbody>
</table>

IMPACT: Increased culturally inclusive research and evaluation that continually inform models of care and best practice for CALD communities.

6.5(b) Evidence-based Models of Care & Best Practice

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Implementation</th>
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<tbody>
<tr>
<td><strong>What we will do:</strong></td>
<td><strong>How we know what’s changing:</strong></td>
</tr>
<tr>
<td>a) MHDAO fund the Children and Families of CALD background mental health project to develop and promote evidence based clinical interventions and models of care.</td>
<td>An analysis of mental health issues and experiences of children and families from CALD backgrounds.</td>
</tr>
<tr>
<td>b) THMC evaluate the four-year pilot Transcultural Rural and Remote Outreach Project.</td>
<td>Evaluation completed.</td>
</tr>
<tr>
<td>c) MHDAO support and facilitate research projects addressing the needs of the refugee and CALD population, including publication in peer-reviewed journals.</td>
<td>AHS Multicultural Mental Health Plans.</td>
</tr>
</tbody>
</table>

IMPACT: Mainstream health services uptake of evidence based models and practices about CALD mental health issue detection, response, management, intervention, clinical care and support.
SECTION 7

Accountability

This Plan is a dynamic initiative that extends the progress achieved in multicultural mental health over the last decade. It provides a clear strategic framework driving future action that will improve and promote the mental health and well being of CALD communities. Implementation will occur in phases with clear documented performance measures that reflect the mental health needs of CALD communities.

Priority areas for improvement are data collection, a culturally competent workforce, accountability / reporting, consumer and carer participation, and prevention / early intervention. These are all critical for developing and sustaining culturally inclusive and responsive mental health services.

The reporting criteria for the Plan are:

- AHS reporting of client clinical outcomes through MH-OAT.
- Improved Departmental and AHS reporting against specific performance indicators including data collection that measures service access and service utilisation.
- Reporting and evaluation of key MHDAO CALD funded projects/initiatives.
- Qualitative reporting to Mental Health and Drug and Alcohol Office by MHDAO funded agencies.
- State and Area compliance with EAPS planning and reporting processes.
- AHS reporting to Mental Health and Drug and Alcohol Office on CALD strategies and initiatives as requested or through the Area Mental Health Service Agreements.
- Annual financial and program reporting.
- MHDAO reporting on state-wide policy and service development initiatives through relevant forums and mechanisms.

By 2012, CALD consumers and carers will have significantly enhanced culturally inclusive mental health care. They will have greater access to, and more equitable provision of, mental health services. Success is the implementation of a shared vision of multicultural mental health that is core to every day work practices and responsibilities.
## Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHS</td>
<td>Area Health Service</td>
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<tr>
<td>AMHS</td>
<td>Area Mental Health Service</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CAT</td>
<td>Cultural Awareness Tool</td>
</tr>
<tr>
<td>COPMI</td>
<td>Children of Parents with Mental Illness</td>
</tr>
<tr>
<td>CRC</td>
<td>Community Relations Commission</td>
</tr>
<tr>
<td>DIMIA</td>
<td>Department of Immigration and Multicultural and Indigenous Affairs</td>
</tr>
<tr>
<td>EAPS</td>
<td>Ethnic Affairs Priority Statement</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>IPART</td>
<td>Independent Pricing and Regulatory Tribunal Review</td>
</tr>
<tr>
<td>IPC</td>
<td>Integrated Perinatal and Infant Care</td>
</tr>
<tr>
<td>K10</td>
<td>Kessler 10 – Self-reporting tool for Anxiety</td>
</tr>
<tr>
<td>LOTE</td>
<td>Languages other than English</td>
</tr>
<tr>
<td>MH-CoPES</td>
<td>Mental Health – Consumer Perceptions and Experiences of Services</td>
</tr>
<tr>
<td>MH-CCP</td>
<td>Mental Health Clinical Care and Prevention</td>
</tr>
<tr>
<td>MHDAC</td>
<td>Mental Health and Drug and Alcohol Office</td>
</tr>
<tr>
<td>MH-OAT</td>
<td>Mental Health – Outcomes and Assessment Tool</td>
</tr>
<tr>
<td>M/C</td>
<td>Multicultural</td>
</tr>
<tr>
<td>NES</td>
<td>Non-English Speaking</td>
</tr>
<tr>
<td>NESB</td>
<td>Non-English Speaking Background</td>
</tr>
<tr>
<td>NESC</td>
<td>Non-English Speaking Country</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government Organisations</td>
</tr>
<tr>
<td>RRR</td>
<td>Regional, Rural and Remote</td>
</tr>
<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td>SESIAHS</td>
<td>South Eastern Sydney and Illawarra Area Health Service</td>
</tr>
<tr>
<td>SMHSOP</td>
<td>Specialist Mental Health Services for Older People</td>
</tr>
<tr>
<td>STARTTS</td>
<td>Service for the Treatment and Rehabilitation of Torture and Trauma Survivors</td>
</tr>
<tr>
<td>TMHC</td>
<td>Transcultural Mental Health Centre</td>
</tr>
<tr>
<td>TPV</td>
<td>Temporary Protection Visa</td>
</tr>
</tbody>
</table>
Acknowledgements

The *NSW Multicultural Mental Health Plan 2008–2012* reflects the work of many individuals and organisations committed to improving the mental health of CALD communities.

NSW Health would like to thank all the members of the NSW Multicultural Mental Health Policy Reference Group for their guidance and advice in the development of the Plan.

**NSW Multicultural Mental Health Reference Group**

**Chair:**
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NSW Health, Centre for Mental Health (to May 2005)  
Mr. David McGrath  
NSW Health, Mental Health and Drug & Alcohol Office (from February 2006)

**Members:**
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Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)  
Ms. Sandra Bilson  
Formerly of NSW Health, Mental Health and Drug & Alcohol Office  
Ms. Maria Cassaniti  
Transcultural Mental Health Centre  
Ms. Rosa Droscher  
NSW Community Relations Commission  
Ms. Emanuela D’Urso  
Formerly of NSW Health, Mental Health and Drug & Alcohol Office (Secretariat)  
Ms. Franca Facci  
Multicultural Health Service, SESIAHS  
Ms. Angela Garvey  
NSW Nurses’ Association  
Ms. Meg Griffiths  
Multicultural Mental Health Australia  
Mr. Michael Kakakios  
NSW Health, Primary Health and Community Partnerships  
Professor Abd Malak  
Diversity Health Institute  
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NSW Refugee Health Service  
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Western Zone, SSWAHS  
Ms. Barbel Winter  
Multicultural Disability Advocacy Association

NSW Health would also like to thank the Area Mental Health Directors, InforMH, Area based mental health staff and multicultural health coordinators for their support for and commitment to the Plan. Special thanks also to the health agencies, other government agencies, key clinical and academic experts and community organisations.

A special acknowledgement to Ms. Emanuela D’Urso for her work and commitment in the development of this Plan.
APPENDIX 2

Multicultural Mental Health Achievements to Date

Information on mental health & mental health services to people from CALD background

- Development and provision of multilingual information and resources such as translations of:
  - The Mental Health Act (SWSAHS) in eight community languages;
  - The Mental Health Act: Patient Rights and Responsibilities (CSAHS and TMHC);
  - Healthy Kids – A Parent's Guide (TMHC);
  - Consumer Brochure Better Mental health Care for You in 15 community languages.

Research & Evaluation

- National Phone Survey of Mental Health and Wellbeing now includes some ethnicity and language components in the data collection systems in four languages.
- Consultations with key stakeholders in the transcultural aged care and mental health field to input into the Review of MH-OAT clinical modules to standardise clinical documentation of information.
- Development of the Multicultural Mental Health Assessment Tool (SESIAHS).
- Translation of the Kessler 10+ depression measure into 15 community languages. Further funding has been allocated for translations in a further 10 languages.

Supporting the role of GPs & other primary care providers

- TMHC Partnerships Project for GPs, MHS and NESB communities.
- Demonstration projects in Multicultural Community Shared Care with GPs.
- TMHC shared care collocation Project between GPs and bilingual counsellors.
- TMHC development of a module Cross Cultural Mental Health Care in General Practice.

Partnerships between mental health services, consumers, carers & NGOs

- Funding to TMHC for the Carers Support Project under the NSW Family and Carer Mental Health Program to develop a Carers Program to recruit and train carers of CALD background and establish carer support groups.
- Greek Community Development Worker Project with Schizophrenia Fellowship.
- Core funding to STARTTS for clinical services for torture and trauma survivors.
- Allocation of funding to TMHC for Consumer Initiatives.
- Funding for two-year TMHC Rural Outreach Mental Health Program to increase local awareness of issues and access to services affecting people of CALD background.
Enhancing skills & Capacity Building of Mental Health Professionals to work in a Transcultural Setting

- Development of an advanced module for School-link training program on depression and young people from CALD background.
- Specific Mental Health Course to increase the mental health literacy of Health Care Interpreters and bilingual counsellors and inclusion of cross cultural components in mainstream mental health courses conducted by Institute of Psychiatry.
- Cross cultural awareness courses conducted by a number of Area Mental Health Services.
- Psychology Intern Program established by TMHC.
- Mental Health and Drug & Alcohol Office funding of TMHC Clinical Services.
- SESIAHS has developed an Area based Multicultural Mental Health Action Plan.
- Six Area Health Services have established Multicultural Reference Group structures.
- $131,000 to TMHC for Suicide Prevention Programs.
- $205,000 over the last two years for Child Mental Health Program working with Westmead Children's Hospital.
- Funding to STARTTS for $90,600 for a Rural Outreach Work with TPV Holders.
- $600,000 to STARTTS for conduct of Clinical Sessional Services.
- Designation of a senior position in Mental Health and Drug and Alcohol Office to develop and coordinate mental health policy for people from CALD background.
- The ongoing employment of Bilingual Counsellors in the mental health area predominantly located in metropolitan AHS to reflect the demographic profile of the Areas.
- Fairfield mental health sector (SSWAHS), has developed a Bilingual Employment Strategy matching staff skills to the demographic profile in the Area.
- All metropolitan and regional AHS have an Interpreter Health Service.
- The ongoing existence of a NSW Multicultural Health Communications Service.
- Establishment of Mental Health and Drug & Alcohol Office Multicultural Mental Health Policy Reference Group to advise on the development of the Second Multicultural Mental Health Plan.

Promotion, Prevention & Early Intervention

- Support for the establishment of the Diversity Health Institute and assistance provided in this planning process.
- Mental Health and Drug & Alcohol Office established a network of key stakeholders to facilitate shared management of issues arising from the impact of the Iraqi war on the local Muslim population.
- TMHC conducted Prevention Programs for CALD communities.
- Community Awareness campaign to promote mental health of children, adolescents and young people in 15 community languages.
- Funding of $72,500 to TMHC for School Link Program.
- Development of component in Schoollink Advance Training Module on depression and young people from CALD background.
- TMHC Report: Keeping well: mental health promotion, prevention and early intervention for all.
References


viii Multicultural Mental Health Australia, National Ethnic Disability Alliance, Australian Mental Health Consumer Network & Commonwealth Department of Health and Ageing, Reality check: Culturally diverse mental health consumers speak out, MMHA, Parramatta, 2004


xii Extrapolated from Multicultural Mental Health Australia and beyondblue: the national depression initiative, Synergy No. 2, 2004 p.3.


xvi Cultural Competency is defined in the framework for the implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia as “The ability to see beyond the boundaries of (one’s) own cultural interpretations, to be able to maintain objectivity when faced with individuals from cultures different from (one’s) own and be able to interpret and understand behaviours and intentions of people from other cultures non-judgmental and without bias”.


xxv ibid.


xxviii Community Relations Commission For a multicultural NSW, The People of NSW – NSW 2003

xxix B. McDonald & Z. Steel, Immigrants and mental health, Sydney, Transcultural Mental Health Centre, 1997, p.149.


xxxi ibid.


Asylum Seekers are person who have applied for protection as a refugee and who have not yet received a decision.

Australian Bureau of Statistics 2001 Census data.

Justice Health, MH-OAT Census, September 2003

Tony Butler & Steven Allnutt: August 2004; Corrections Health Service Publication

E. Seah, F. Tilbury, B. Wright, R. Rooney, P. Jayasuriya, The Cultural Awareness Tool (CAT), Transcultural Psychiatry Unit, Curtin University & The Royal Australian College of General Practitioners WA research Unit, 2001. The CAT is aimed at providing practitioners with general guidance in how to manage clients with mental illness in a more culturally aware manner. This tool will guide practitioners in eliciting their CALD client’s understanding of the presenting problem, whilst conducting such an investigation in a culturally sensitive manner.

Cultural Consultancy – the provision of specialist transcultural advice and knowledge to mental health staff to enhance their ability to effectively work cross culturally, and the facilitation of appropriate assessment, diagnosis and treatment of CALD consumers.