

Latrobe City CALD Communities' Access to Mental Health Service Mapping and Scoping Project

June 2014

Commissioned by the Department of Health
Gippsland Region



Acknowledgements

We gratefully acknowledge the support of the Departmental of Health Gippsland staff, Latrobe City staff, representatives of CALD communities, service providers, faith community representatives and interested persons for their time, information and ideas.

Conducted by:

Mind Australia and Gippsland Multicultural Services

Project Staff:

Milan Poropat (Mind Australia)
Md Tahseen Qadeer (Gippsland Multicultural Services) and
Belinda Gooding (Mind Australia)



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ACSO	Australian Community Support Organisation
CAC	Community Advisory Committee
CALD	Culturally and Linguistically Diverse (Background)
CAMHS	Child and Adolescent Mental Health Services
DH	Department of Health
DALY	Disability Adjusted Life Years
FaPMI	Families where a Parent has a Mental Illness
FECCA	Federation of Ethnic Communities' Councils of Australia
GMS	Gippsland Multicultural Services
GP	General Practitioner
HACC	Home and Community Care
LCHS	Latrobe Community Health Service
LGA	Local Government Area
LRH	Latrobe Regional Hospital
MCHC	Maternal and Child Health Centers
MCHN	Maternal and Child Health Nurse
MHCSS	Mental Health Community Support Services
MHiMA	Mental Health in Multicultural Australia
MIF	Mental Illness fellowship
PAG	Planned Activity Groups
PDRSS	Psychiatric Disability Rehabilitation Support Services
PTSD	Post-Traumatic Stress Disorder
SEIFA	Socio-Economic Indexes for Areas

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Executive summary

This project has been a collaborative effort between Mind Australia and Gippsland Multicultural Services (GMS) funded by Department of Health. The project's aim was to investigate the level of access of Culturally and Linguistically Diverse (CALD) communities to community based mental health services in Latrobe City, including their understanding of mental health, knowledge and use of services, identify the barriers that have led to current low levels of service usage, and propose strategies and recommendations to address these.

The project used qualitative research principles to explore the issue of CALD communities' poor access to mental health support services. Literature search, semi structured interviews and focus groups have been used. The focus was on various key informants in the CALD communities, service providers, faith community leaders and interested individuals in the Latrobe LGA. The project team found a pattern of underuse of mental health support services in the Latrobe City area consistent with experiences in other areas of Victoria and in some other service sectors.

GMS has undertaken a range of interviews and focus group discussions with different community people from South Sudan –Dinka tribe, South Sudan -Nuer tribe, South Africa, Russia, Philippines, Nigeria, Italy, Greece, China, Bosnia and Bangladesh. The CALD respondents reported a range of mental health issues experienced by CALD community members within their communities including bi polar, schizophrenia, post-traumatic stress disorder and depression. However, due to cultural, religious and other stigma, CALD community people interviewed indicated a common tendency not to disclose experiences of mental illness outside the immediate family or community, or to seek supports from services. On the other hand, as they have very limited or do not have any information of service providers in this field, there is a very limited capacity to seek and use mental health support services, even where willing. Therefore, a large number of mental health issues go undiagnosed or untreated, and present only when mental health issues experienced pose a significant risk to themselves or others.

All Mental Health Community Support Services (MHCSS) providers reported low levels of CALD community use of their support services, except in a few isolated instances where particular strategies have been used to improve access. These were mostly targeted outreach educational and health promotion approaches, sometimes using people from the target CALD community to deliver the programs.

Inadequate cultural competency within mental health community based services is another key barrier faced by both CALD community members interviewed and service providers. There seemed little active outreach to increase access, and limited skill of personnel in the use of language services and cross cultural communication, and a lack of policy and procedure within agencies to ensure cultural competency as an embedded, systemic and core process.

The project identified a high demand for the mental health services, particularly amongst high-risk groups such as those from newly emerging refugee and humanitarian background communities, but lack of a proper interface between CALD communities and mental health services continues to result in low access levels. A high level of trust needs to be built between CALD communities and service providers to develop sustainable helping relationships as well as increase awareness of mental health and wellbeing.

Clinical mental health services reported in some areas reasonable use of services by CALD communities. One of the project conclusions is that the link between clinical and community mental health support

services needs to be strengthened so that CALD clients can be more frequently referred on to community mental health services.

Information in various community languages was not easily accessible nor widely distributed. Therefore, information about services targeting identified end users and in various formats that is widely available should be considered.

The Latrobe LGA has endeavoured to embrace cultural diversity in a range of ways, which includes the implementation of a Cultural Diversity Plan and Cultural Diversity Committee at Latrobe City, and the Latrobe Settlement Committee which brings key stake holders together to identify issues and gaps and address these and is convened by Latrobe City.

However the service sector as it relates to CALD communities is at best fragmented and uncoordinated.

It is further characterised by a diverse range of CALD communities that range from post war migrants to more recent arrivals representing skilled migration, refugee and asylum seeker streams. The project team was frequently reminded that the CALD community is not homogeneous as the time of arrival, the reasons for migration, the cohesiveness or divisions within each particular group have a marked impact on the nature of their needs and ways of addressing these.

The literature on CALD communities' access to services suggests a number of approaches , which have proved effective. Local approaches were identified along suggestions that came out of the interviews, focus groups and project team deliberations that will be suggested for implementation.

The strategies for consideration are grouped into four key areas:

- Department of Health
- Systems
- Service Delivery and
- General information and/or further areas of Exploration.

Strategies for consideration to increase CALD community access to mental Health Community Support Services in Latrobe

Department of Health

Catchment based resource information and MHCSS promotion

Following community mental health support services recommissioning, Australian Community Support Organisation (ACSO), is in a good position to take responsibility for keeping resource information up to date on services relevant to people with mental health issues, their carers and families. This information could be available to the service network and be easily copied for clients as required.

Taking the opportunity of the new service system being implemented, promotion information on MHCSS in Latrobe could be made available in brochure or poster form in major community languages for wide distribution especially to local GPs and other primary health service outlets, Maternal and Child Health Centres (MCHC), schools and faith communities.

Service Delivery

CALD liaison officer or Cultural Advisor position

Many ideas from the respondents, the project group and the literature have a better chance of fruition if a resource is focused on the issue of CALD communities' access to MHCSS. A CALD liaison officer or Cultural Advisor position could be auspiced by GMS for an initial 12 month period to work between CALD communities, clinical, community and multicultural services in Latrobe. They could facilitate cultural competence training for MHCSS, link with CALD portfolio holders in services and link with CALD community leaders. The Cultural Advisor could explore the various ideas in this report that would help increase CALD community access to MHCSS.

Community Education

There are two focal points worth exploring: reaching out to particular CALD communities and targeting carers in order to increase CALD MHCSS access.

Community Education workshops provided by Latrobe Regional Hospital's Mental Health First Aid and the local adaption of the process developed by Mind in Narre Warren (originally targeting the Sudanese community).

Providing community education targeting CALD carers may be a way of both supporting carers and also reaching out to people from CALD backgrounds with a mental illness not currently accessing services through options such as LCHS Carer Respite Funding or Mind's fee for service four session program

System

Latrobe CALD Reference Group

In order to support the CALD liaison officer position a reference group representing CALD communities, clinical, community and multicultural services in Latrobe could be formed. There is already a good deal of support for services coming together to focus on CALD communities access to services as expressed in the focus group for services and interested persons during the project.

The reference group could be part of a broader engagement strategy with various CALD community leaders.

Some form of recompense to participating community leaders (honorariums or in kind) may need to be considered to recognise providing their time and expertise to the system.

CALD Community access to MHCSS as a standing agenda item

The Gippsland Mental Health Alliance through, its chair expressed a commitment to have CALD community access to services as a regular agenda item. Part of the action plan may be to develop a planned approach to ethnic media with stories, interviews and information on mental health concerns and services throughout 2014-15.

CALD access to MHCSS monitoring

Following Recommissioning, Mind Australia has responsibility for Catchment-Based Planning. As part of that responsibility it could focus on monitoring rates of access by CALD communities and feeding the results to the relevant stakeholders.

Further Areas for Exploration

Cultural Competence

For the system to work effectively for CALD communities, agencies need to be culturally competent. That commitment needs to be underpinned by:

- developments of cultural competence plans underpinned by an implementation plan for 2014-15
- utilisation of the Cultural Competency tool (adapted from the Gippsland HACC Cultural Competence tool) for review and action planning of their cultural competency plans
- budgeted commitment to cultural competence training for all staff
- prioritising CALD staff appointments and CALD student placements
- inclusion of a review of staff cultural competence within their staff appraisal frameworks, and
- Agency management reviewing their CALD case numbers at least six monthly in comparison to the Latrobe demographic profile.

As part of their cultural competence, agencies may need to consider alternate marketing of services to CALD communities in terms of appropriate language (i.e. “mental illness” vs “emotional wellbeing”), images in brochures and agency decoration (posters and paintings/murals) reflecting Latrobe’s cultural diversity.

The Department of Health can as part of the contract monitoring processes regularly monitor the achievement of the implementation plans.

Agency CALD portfolio holder positions

Some organisations have used a whole agency approach to CALD communities’ access to service consideration. Whilst that is a preferred approach, agencies could consider appointing a CALD portfolio holder in their organisation. The role has to have clear support from and reports to senior management, have a role in capacity building within each agency, be responsible for distributing relevant resource and training information on CALD issues, monitor the cultural competence action planning implementation six monthly and liaise with the Latrobe CALD liaison officer proposed previously.

Networking

Agencies could explore co-location of services as a strategy to increase access to MHCSS by CALD communities by association a less “stigmatised” service and improve case coordination between services.

Invitation of multicultural services into existing Mental Health networks would also strengthen the service system for CALD communities and increase understanding of issues by both sides.

In order to increase referrals by clinical services to MHCSS it is important that all MHCSS agencies ensure they participate in the S2S (Service to Service referral forwarding) and E shared case planning (PCP service coordination) systems. This would go some way of ensuring stronger links between clinical and acute services with MHCSS.

Given the nature of Latrobe City communities, there is a good opportunity for MHCSS to forge stronger links with GPs, Latrobe Settlement Committee, Latrobe Cultural Diversity Committee, LRH Primary Mental Health and Community Development as another way to ensure CALD community clients improve access to MHCSS.

Background to the study:

People from a culturally and linguistically diverse (CALD) backgrounds have a significantly lower level of access to mental health care and support than general population in Latrobe. This results in much greater responsibility being placed on family members to care for their loved ones without adequate support or education. The government has reviewed this issue and refocused its attention to promote better mental health and wellbeing and to improve awareness of suicide prevention in culturally and linguistically diverse communities¹.

Victoria is the most culturally and linguistically diverse state in Australia and its makeup is constantly changing. This diversity presents many challenges to health service providers. There is incredible diversity between and within communities with differences based on language, ethnicity, faith, age, gender, migration streams, length of residency and status. Diverse communities can comprise established arrivals, refugees and humanitarian entrants, new and emerging communities². Almost a quarter of Victoria's population was born overseas while 43.5% of Victorians were born overseas or have a parent who was born overseas. Victorians come from over 200 countries, speak over 180 languages and dialects and follow over 110 religious faiths. Since 2001, the number of languages spoken in Victoria has increased from 200 to 400 in 2006². Census 2006 recorded 5784 members of the migrant population in Latrobe City. According to the report, "New Arrivals to Gippsland Project 2012" in Latrobe City as of 2010-2011, 846 new settlers arrived. However, that report identified that the health barriers for CALD communities were mostly attending medical specialist appointments, especially when these are in Melbourne, and not understanding the health system and expectations about diet, food, body image and western lifestyles. CALD communities reported their members often not understanding medicines prescribed by doctors and how often to take them. The report also indicated that the services were not addressing the Maslow's Hierarchy of Needs well due to a lack of resources/funding/support services. (i.e. basic needs like food, shelter, safety, health, financial security need to be met first before other higher order human needs).

This project has the specific focus of examining the existing barriers and perceptions of CALD communities about accessing the mental health services in Latrobe City. The Department of Health Gippsland region is concerned that mental health service providers have repeatedly reported low levels of service request by from CALD communities and have implemented a few strategies that made much of a difference to the problem. It appears that for governments ensuring equity of access to relevant services by all sections of the community is a high priority.

Project Objective:

The overarching objective of the project was to identify the gaps, barriers and to some extent attitude of CALD communities towards mental health services in Latrobe City, and propose strategies to address identified gaps.

Specifically the aims of the project were to:

¹ Fact Sheet- Mental Health Services for CALD communities, Department of Health and Ageing

² Culturally and Linguistically Diverse Communities -Resource Kit, Dental Health Services Victoria.

- scope the current resources in Latrobe city that support CALD communities and what support they provide around mental wellbeing and mental health to their user groups
- identify engagement strategies to increase awareness of mental illness and resources
- Identify strategies MHCSS could employ to open engagement with and service pathways for people from a CALD background

The Key Project Questions

1. What are the main barriers to access the mental health services?
(E.g. lack of information, unavailability of services, stigma etc.)
2. What information do agencies have on CALD communities?
3. Where are the service gaps for CALD communities?
4. What is working in improving access to services?
5. What do agencies and the service system need to do to improve access to mental health support services in the city of Latrobe?

Operational Definitions:

CALD Communities: For the purpose of the project, the definition of CALD community is limited to new migrants, well settled, refugees, family and skill stream migrants. The following definitions have been adopted from GMS (Gippsland Multicultural Services) to be able to construct the structure of this study.

A. A migrant chooses to leave his/her country and settle in another country

B. A refugee is a person who has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or social group membership. A refugee must be either unable or unwilling to return to his/her country of origin

C. An asylum seeker is a person seeking protection

D. Migrants – Skilled – likely to continue in smaller but steady numbers. Less barriers to service access, although family members may need assistance. Occupations in Latrobe City include Health professionals, engineers, accountants and others.

E. Migrants – Family stream – high dependency on sponsor. Varying levels of access barriers. Backgrounds include Thai, Chinese, Filipino and others. Likely to continue in ongoing pattern.

F. Refugees & Humanitarian entrants – primary entrants and as secondary movement from metro areas. High needs and complex service access barriers. Presently significant numbers of Sudanese, others include Syrian, Iraq, Sri Lankan, various. Possible movement of Afghan Hazara into area as secondary settlement

Methodology:

The project team used a qualitative approach to the investigation (see Anne Bowling 2002)³. The main tools were face to face or telephone interviews using one of three semi structured interview schedules (Appendices 3, 4 and 5).

Potential respondents were nominated by the area Department of Health representatives, Latrobe City Coordinator Community Strengthening, and the Project reference group.

The Project reference group was made up of the CEO of Gippsland Multicultural Services (GMS), researcher employed by GMS, Area Manager Mind Australia Gippsland, Project Officer employed by Mind Gippsland and the Mind Service Development Manager.

The potential respondents broadly divided into:

- representatives of various CALD communities, that live in the Latrobe City area,
- representatives of service providers in the primary health, mental health clinical and community agencies
- people representing various faith communities where CALD communities belong in large numbers
- individuals from various state and federal departments,
- and other community informants that were thought to have contact and insights into various CALD communities of Latrobe City.(See Appendix 6)

The study was divided into two focus areas:

- understanding the CALD communities' perspective, which GMS took the lead as they have strong existing links with CALD communities in Latrobe, and
- mental health support service providers and other relevant informants that Mind workers focused on.

The team was successful in speaking with most people so identified, however there were a number of targeted respondents whose participation was not able to be secured in time. In all, 32 people were interviewed and two other respondents submitted emailed responses to the interview schedules and questions sent out.

The project team ran two focus groups toward the end of the project in addition to the interviews. These were a focus group for CALD community representatives and a group of local service providers and other persons in significant contact with Latrobe CALD communities.

The purpose of these groups was to explore the findings and hypothesis of the project team, and to engage in discussion and deepen understanding of the issues identified. It was also to consider the draft report recommendations, especially identifying any interest in any ongoing processes that ought to be put in place to improve access by CALD communities to Mental Health Community Support Services (MHCSS).

³ Bowling, Anne, (2002) RESEARCH METHODS IN HEALTH-Investigating health and health services, Second edition Open University Press, Philadelphia.

The Department of Health representatives met with Mind representatives regularly throughout the project to support its completion, monitor progress and provide direction as needed.

The final report was presented to the Department of Health for consideration and any ensuing action.

CALD community focus method

Primary Information sources

This part of the study was qualitative in nature. Initially developed questionnaires were field tested with the community and with agencies and adjusted.

For the CALD communities' part, data has been collected using interpreters as required and the research worker conducted interviews directly the English speaking migrants.

Male and female key informants representing groups from South Sudan, Nigeria, Russia, Philippines and Bosnia were interviewed face to face using interpreters as necessary. A total number of six interviews has been conducted based on a semi-structured questionnaire. The CALD focus group discussion was also conducted with community representatives from South Africa, Philippines, South Sudan (Nuer speaking), Bangladesh, Italy, Greece, China and the Philippines. In addition, GMS interviewed a key informant from Foundation House.

Secondary Information sources

Secondary Information sources involved the literature review as well as data from different agencies, interested groups and individuals was collected and collated.

Data Interpretation and Report Writing:

CALD data were analysed according to GMS organisational policy and procedure.

Timeframe of the study:

The project was conducted over a 12 week period (see Appendix 1).

Latrobe CALD community perspectives

Description of CALD Community representatives interviewed

Average age of the respondents was 45 and highest was 65. Lowest age of the respondent was 28. On an average the respondents lived in Latrobe City is five years. Longest stay by one of the respondent was more than 20 years and shortest stay in Latrobe is 3 months. The language spoken at home is Nuer, Bosnian, Bengali, Italian, Russian, English, Uroba, Mandarin mostly but some of the families they speak English as well as their partners are Australians.

Experience and Knowledge of accessing any health facilities in Latrobe City

Respondents indicated their community members have the knowledge to access the medical services available in Latrobe City. For emergency community people have the knowledge to use "000" and most of them prefer to go to Latrobe Regional Hospital. For minor or regular health issues people have the preference to go their General Practitioner, and some indicated a preference to see a General Practitioner from their community. Most of the community people reported that they are satisfied with services provided by service providers but sometimes some of the clinics or General Practitioners do not use interpreter services, preferring to use a bilingual family member. This presents difficulties especially

for the elderly and for the newly arrived from refugee and humanitarian backgrounds. Long wait times in emergency department also seem to be a big frustration for many.

Understanding and perception of mental health issues

The most common understanding of the word “stress” was that it makes people ill and disoriented. However, the most common theme arising from the perception of mental illness is emotional, physical and mental disorder of a person demonstrated in their behaviour, which is quite unusual. Respondents indicated that members of their community had mental illnesses including bi polar, schizophrenia and Post Traumatic Stress Disorders. Unemployment, frustration and trauma arising from experiences of war and persecution were the major causes of mental illness identified by community members interviewed, whilst some women also spoke about the effects of family conflict and breakdown, and isolation. One of the expressions from the respondent was:

“Another thing is counselling here is totally different than that our traditional counselling because counsellors are here professional and trained. They help clients to cope with situation and actually to help with a way forward. However, they do not give any solution to a problem as they think the clients are expert to their problem. But when we come to our traditional counselling we come as a community.”

Stigmas associated with mental health within community settings

In many conversations, what came out is that many people in the community do not want to talk about mental health issues. If it is disclosed then it may negatively affect the individual and people may call him/her “crazy”, so there is a common tendency to hide the illness. Respondents stated that in many cases, the families refuse to take medication and they believe that they are ok. Some of the communities are collective, rather than individualistic, such as the South Sudanese, and respondents indicated that they might come together to pray for the wellbeing of those experiencing mental health issues. All indicated that community members feel a strong sense of shame and avoid disclosure of any family members having mental illness. Even depression or Post-traumatic disorder patients in the community are heavily stigmatized and they are seen as “crazy”. Some spoke of being annoyed with doctors who sought mental health issues when they had presented with physical health symptoms. Sometimes stigma is also associated with personal beliefs and experience to manage a mental health patient. One of the respondents said:

“My husband, he has pension for mental illness from Vietnam war, He always in spring or autumn has got some problem like he is very angry and shouts....I know how to manage him for not being aggressive, I know how to handle him and I just let him alone, initial three years it was very hard but slowly I have adapted and know how to manage him after long 11 years. Even when my children comes I tell them do not touch your father and I will take care of him. I will not go to Doctor for him for this. However, in my husband’s case when my son bought a psychiatrist my husband was so angry and asked the doctor not to come here again. Afterwards all my communication with Doctor is finished.”

“We have people in our community who are suffering from mental illness but general situation is in my community background or culture there is a tendency to hide the problem if anyone having a mental problem and if you want to assist him/her, he/she may tell you “No I am alright and I have no problem” but when you look at him/her you will see that this person is dealing with something but they will tell “no I am fine and ok”.

“Many will choose not to go to the hospital because of the stigma. Many prefer to go out of Gippsland, prefer anonymity”.

CALD Community perception of demand for mental health issues and awareness of existing community based options.

Very few community people are aware of mental health services offered by the Latrobe Regional Hospital (LRH) at Traralgon. Community members interviewed indicated there was a potential strong demand for mental health services due to issues being experienced within their communities, but very little understanding and awareness was provided of community based services and how to access these. Many community members knew about “Lifeline” but have a very general perception of it providing telephone counselling. Only one respondent said she had heard about MIND but was not able to explain what is their role in the community.

“There are some other programs of lifeline that they call crisis management through phone and our community people are not comfortable with that as language is a barrier. So this is only organization that I am aware of and if you are having mental illness and crisis that you go to them. What I know so far, people who are close to me, I know from experience, if you do not build trust and friendship, relationship it is hard to know the particular problem.”

Service navigation as an access barrier

Service navigation within the community and within an organization has been identified as a significant problem, especially where there is also a language barrier. CALD community members are faced with a plethora of services that they have often had little or no previous experience of, and are unfamiliar with the use and benefit of these. Respondents indicated that they prefer to access services where they can easily engage with a trusted person, and find complex intake and triage systems to be an additional barrier. Community people do not like to go to the hospitals unless they are forced by circumstance because of different cultural and religious reasons such as food at hospitals, language difficulties, perceptions within the community about having problems. Service navigation was seen as a barrier both in locating the right service within the community, and in then finding the right supports and service type within a service. One of the key respondents said:

“Services have to come to community rather than we go to them”

Barriers towards accessing mental health services

Ranges of barriers were identified, which included-

- No knowledge of services
- Difficulties in navigating complex challenging service systems
- Services lacking capacity and skill in utilising language services as needed

- Services lacking capacity to provide culturally responsive services, and to understand the cultural backgrounds and experiences of CALD community members
- Inclusivity of services
- The importance of “word of mouth” amongst and within communities, and therefore if mental health services are not known and trusted by community leaders and key members, they will not be promoted and recommended and referred to within communities.
- A lack of trust and reluctance to access and disclose mental health issues due to fear of stigmatisation.
- Reliance by services, on printed and written materials, when some CALD community members may not be literate in their first languages, particularly amongst those from refugee and humanitarian backgrounds.

“Partly stigma, partly awareness. Back at home, people would try to just solve the problem, if they don’t have a job, then they would look for work or go to the church, rather than seek

“People will not want to talk about mental illness until it’s at crisis point”

Services, faith communities and interested persons perspectives

Consultations with Community Mental Health Service Providers (CMHSS)

All services agreed that the CALD communities were not accessing services anywhere near the proportion they represent in the total Latrobe community. Less than 5 % was the most frequent figure we heard as a notional figure for CALD clients use of services. Interestingly one service indicated that they had reasonable use of their service by CALD communities; however, upon further probing it became apparent that the percentage was under 3%. Service providers may not have a working knowledge of the proportion of the Latrobe population from a CALD background. All the services indicated that they were ready and available and saw all people who requested service and when people from different cultures approached services, the practice of workers intentionally accommodated the cultural differences particular to that specific client. Many services espoused person-centred approaches. It appears that there is no active filtering out of CALD clients, however there was no evident proactive seeking of CALD clients needing support. Part of that was explained by the services being usually at capacity so the focus is organisationally on those using services rather than those that are not requesting service. Furthermore the active promotion of service could be accompanied by even greater demand which may not be easily accommodated leading to the strategy backfiring. That is the CALD members overcoming their reticence to use services coming forward then finding there is a long waiting period. This would be communicated back to their communities of reference reducing the likelihood of further referrals.

There was no indication that services had a rigorous or systemic approach, such as ongoing evidence based comparison of service user data compared to demographic data, agency requirements to analyse

non service usage of special needs groups such as CALD and develop access strategies, internal monitoring of staff usage of language services compared to client languages spoken at home, etc.

Cultural issues, views of mental illness; knowledge of the service system; help seeking behaviour

These are critical in the way notions of mental illness and mental health are understood and reacted to by particular CALD communities. It is clear that each ethnic group that has arrived in Australia brings with it its own cultural understandings and preparedness to utilise services that are available. It needs to be remembered that the CALD community is not a homogenous whole, and whilst there are significant differences between CALD communities in their understanding and reactions to mental illness, there are also group and individual differences within groups. Therefore, no one size fits all solution is likely to work and a person centred approach is crucial.

Most CALD communities are family oriented and communitarian in contrast to the more individualistic philosophy of the Australian community in general. This may be more pronounced in the early phases of settlement as survival and organising the basic needs (as Maslow's hierarchy of needs dictates) takes precedence over other concerns. The host community may be experienced as hostile or at least foreign and incomprehensible, pushing members back to self-reliance on family the community as a whole, and their own leaders and elders. Faith connections tend to be very important for sources of meaning as well as social support and identification. The rate of assimilation and acculturation also is likely to play a part in participating in service use that approximates that of the general population. It would be safe to posit from this that the more isolated and insular the group the less likely it is to access services. Conversely, the more open and integrated the group the more likely it is to behave like the rest of the community in relation to service usage.

Other issues identified in the literature are concepts about mental illness, whether it is treatable, what it means to the individual and their family and whether services are known and trusted.

Various CALD communities have a high level of stigma and shame associated with mental illness as outlined in the literature section and the Latrobe CALD community respondents answers. Some view it as demonic possession, result of bad karma, a result of a curse, consequence of bad character and so on. It is not visible as physical illness may be (e.g. a broken arm) and so it does not evoke the sympathy and understanding that a physical illness might. There are also implications that it "may be willed" somehow by the person, (it is not that they are not able to look after themselves or to cope but the person is not willing to try or put in the effort.) Mental illness is seen as in "the person's head", so ought to be subject to personal control. The person with the mental illness thus brings shame to the family and as a result is "hidden" or protected within the bounds of the family and community. If they are not able to look after themselves they are seen as not able to marry, have a family or cope on their own. There have been reports from the Barwon region NDIS trial that a small number of elderly parents, mainly from the rural parts of that region have been coming forward concerned about the future of their son or daughter with a mental illness when they die. In most of these cases the family has not sought any assistance from services before, and the person is not in the system at all. It was hypothesised that such a scenario is likely also in the city of Latrobe particularly with the more established CALD communities. The actual situation and possible extent of such an issue was not able to be established in this project but remains an area for future research and planning.

For higher prevalence disorders like depression for example, help seeking behaviour is less likely if the problem is perceived as something the person should handle themselves. They feel shame about it, have

not used counselling or support services before and do not know anyone who has or do not have any positive feedback about a service or professional as being helpful.

It was surprising to learn that most services in the system were not fully familiar with all the services each organisation provided for people with mental illness. Therefore, it is not surprising that the general community and people with mental illness in particular find it difficult in navigating the system. Specifically the Mental Health Community Support Services were not widely known by the CALD community leaders.

One could expect that the refugees and asylum seekers would have escaped war, famine, torture, severe deprivation, loss of family, friends, country, social role etc. which are all great challenges to people's mental health. Therefore, they should be prioritised for service access by the system designed to assist people with recovery.

These risks to mental health can be counter balanced by peoples' will to survive, their resilience, forbearance and desire to build a new life in a new country, through the support of their family, reference community and the host community.

We frequently heard from service providers and CALD community leaders that typically families try to cope on their own until a crisis requires engagement with the tertiary part of the system. Clearly this would not be the optimal way to set up the service inflows. The negative of the above scenario is that the strain on the family becomes very high and unmanageable, the person with the mental illness is likely to feel traumatised by the situation becoming out of control and the service system is likely to be experienced as frightening, and controlling. Hardly the way to ensure recovery. One of the community service providers commented that the acute admissions are frequently a revolving door experiences for CALD persons (this applies to others as well).

Zhang⁴ et al. study into risks of readmission into acute inpatient facilities found that nine variables were related to the risk of readmission. Six of these variables increased the risk of readmission, including history of previous frequent admission, risk to others at the time of the index admission and alcohol intoxication. Importantly they found that more active and assertive treatment in the community post-discharge decreased the risk of readmission. The quality of care within the acute services was important but not statistically significant in relation to the risk of readmission. The study did not separate out CALD community risks of re-admission, however other studies have shown that people from CALD communities are more likely to be involuntarily admitted to acute facilities and stay longer than other groups. Therefore, the findings are particularly relevant as they point to assertive and effective support in the community as vital in reducing readmission and by implication levels of distress for CALD patients and their families and carers. Potentially preventing inpatient admissions may be more cost effective and less traumatic for the patient and the family and once an admission is needed active and assertive community support can reduce the likelihood of readmission.

⁴ Zhang J¹, Harvey C, Andrew C. "Factors Associated with Length of Stay and the Risk of Readmission in an Acute Psychiatric Inpatient Facility: A Retrospective Study", *Aust N Z J Psychiatry*. 2011 Jul; 45 (7):578-85.

Faith communities' perspectives

"... there have been hundreds of studies that have found religion is a protective factor against depression and a helpful factor in recovery from depression. As well as the religious faith helping, belonging to a religious community can help in recovering from depression. Social support from a religious community is very helpful in recovery".⁵

Most respondents noted that for CALD communities their faith and religious beliefs are a strong part of their culture, their identity and their centres of worship a source of support and celebration. Several faith communities we interviewed indicated an active attendance at services by CALD community members, use of material relief occasionally, formation of groups (young mums etc.), participation in the wider church life and making a positive contribution to the general community. The faith communities are a point of networking and information sharing and are a potential target for any community education campaigns.

There were not too many observations of serious mental illness, overall. The representatives did their best to help directly with various needs (mainly material assistance with newer arrivals) and pointed people to services. They did not have a thorough knowledge of Latrobe services and some noted that unless there was a known or trusted person at the service being referred to, the person concerned was reluctant to take up the suggestions.

Schools were also noted as providing great support to young people with their own issues or supporting students whose parents had a mental illness.

Some programs targeting CALD students were particularly effective in engaging their parents as well.

The Traralgon Catholic church had developed a good link between recent arrivals and the primary school. A number of support groups have been established and are working well.

The Traralgon St Vincent's de Paul Society provides a lot of practical assistance, food parcels, clothing material goods and initial setting up houses with furniture and furnishings. It is supported by all the denominations in the area and is a good point of information. It was commented that the Sudanese are pretty independent and only come when they have a genuine need and do not like becoming dependent. The Society estimated that between 30 to 40% of their clients have a mental illness.

One respondent noted that some groups are overly reliant on their faith providing a resolution to their mental health issues.

MHCSS Intake and Assessment Pilot Project

The clinical leader of the MHCSS Intake and Assessment Pilot Project reported that in four month pilot period to the end of March 2014 there were no CALD referrals at all and the referrer groups were about half self-referred and the other half from clinical mental health.

It is of concern that no CALD referrals were registered in the pilot period as one of the working assumptions of the team was that if help seeking directly was restricted due to various barriers (self-referral) then the entry into the MHCSS is likely via clinical services. According to this information, this is not the case.

⁵ Christina Comely Psychologist , Health Share Website May 2014

The other entry points may be via the acute services like clinical mental health services and the Flynn Unit of Latrobe Regional Hospital, that is after the person has experienced an acute episode and may have experienced a stay in residence either voluntarily or involuntarily.

Focus Group with Service providers and interested persons

This part of the method was one of the last steps in data gathering. We anticipated the group reflecting on our findings, deepening the analysis of barriers and engaging with consideration of strategies to increase access by CALD communities in Latrobe. This was a very constructive meeting. There was appreciation of, and agreement with the reported findings from CALD community representatives, agencies, faith communities and interested persons.

The group identified that language proficiency is an issue for many newer CALD communities like the Sudanese especially the older men. There were also issues with younger people being more independent than their parents/elders were used to, and this led to conflict between generations. Lack of employment and understanding of health and support systems were issues confronting the newer CALD communities. Residual beliefs by local communities that “they get provided with everything by government” generated some resentment toward these groups. This observation resonated with the Victoria Police comments that there is some underlying fear and anxiety especially toward the new arrivals (Sudanese community youth in particular) as they “look different”. These were barriers to fuller participation in community life and access of services. It was noted that many refugees had no experience of a developed support systems in their countries of origin or in refugee camps and found the multiple appointments and different helping roles overwhelming and incomprehensible. The group also identified that there were barriers within CALD communities – notions of mental illness different to the host community (i.e. Western notions of mental illness and mental health) trust issues toward authority figures and the helping professions, lack of understanding of support systems and how to access these and how to utilise them effectively for their own benefit. The older CALD communities had their own support systems, reliance on family and their ethnic clubs and groups. Stigma and shame having a family member with a mental illness, remains and is a major barrier to seeking assistance until things get to a crisis point.

Outreach approaches appear to be working (e.g. School nursing service and refugee nursing service)

Planned group activities are particularly attractive to the older CALD communities experiencing Alzheimer’s and dementia associated mental health issues. Latrobe Community Health Service (LCHS) Respite service coordinator reported 47% utilisation by CALD communities of organised groups. GMS provide Home and Community Care (HACC) funded culturally responsive Planned Activity Groups (PAGs)for over approximately 150 older CALD Latrobe residents a week. The group thought that an ongoing network focusing on CALD issues in accessing mental health support services would be constructive and help resolve these concerns in time.

Demography of the communities at Latrobe City

The population of Latrobe City was 72,397 in 2011⁶. The population is projected to increase by 9% which is 4.2% less than Gippsland in general and 6.6% less than Victoria’s rate of growth from 2011 to 2021⁷. The

⁶ Estimated Resident population Latrobe 2011 Source: AUSTRALIAN BUREAU OF STATISTICS, 2011 Census of Population and Housing.

population distribution will change with an overall ageing demographic with 65+ year olds increasing by 47.2% which will be 7.9% greater than Victoria over that 20 year period.

Avoidable Mortality Standardised Rate Ratios for Latrobe⁸ show suicide is 40% above Victorian average. There are strong links between suicide rates and rates of mental distress.

Latrobe also has almost the worst DALY rate in Victoria. The DALY rate is Disability Adjusted Life Years⁹ per 1,000 population and has been age standardised. Rank is the relative position of the LGA in an ordered list of the 78 LGA's in Victoria (1=Best Health Status, 78=Worst Health Status) Latrobe ranks 77th for males and 76th for females out of 78 Victorian LGAs!

Life expectancy¹⁰ for males in Latrobe is 77.0 compared to Victoria 80.4 years, and for females is 82.2 years compared to Victoria 84.5 (in 2007).

The Socio-Economic Indexes for Areas (SEIFA) ranks areas in Australia according to relative socio-economic advantage and disadvantage. Moe-Newborough to Morwell area is in the first decile and is therefore among the most disadvantaged areas in the State. Churchill –Traralgon area is in the fourth decile indicating it is less disadvantaged than Moe but still highly disadvantaged compared to more than half the Victorian areas. Yallourn- Glengarry is in the fifth decile so just below the middle statistical areas of Victoria in terms of socio-economic disadvantage.

Victorian population Health Survey 2008¹¹ reports that Latrobe is fairly similar to the rest of Victoria in terms of alcohol consumption, physical activity, overweight and obesity, and nutrition (although females met dietary guidelines for vegetable intake compared to both males and Victoria). Latrobe is better than Victoria slightly in terms of psychological distress. People in Latrobe have much higher rates of smoking than Victoria.

⁷ Projected Estimated Resident Population Latrobe 2011- 2021 Department of Health Last updated: 22 October 2012

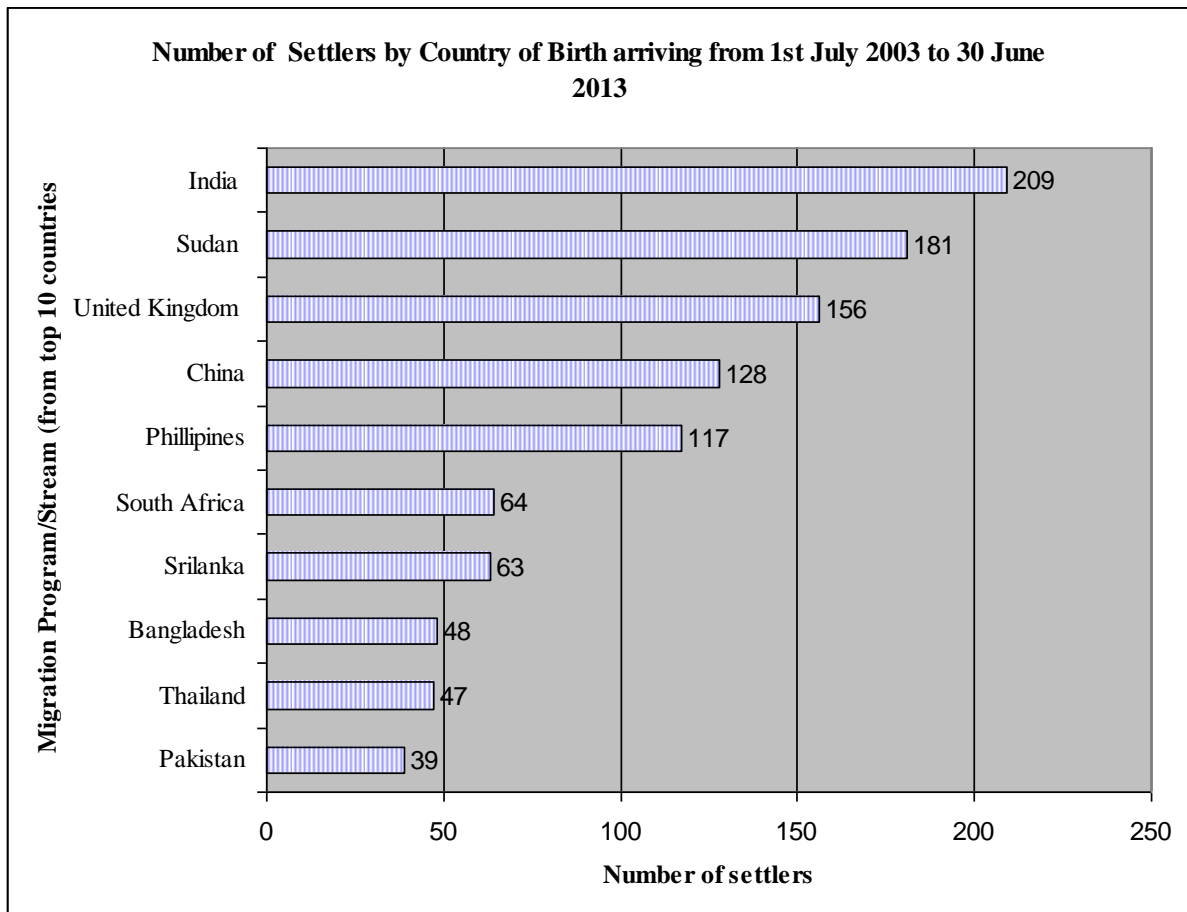
⁸ Avoidable Mortality Standardised Rate Ratios 2002-2006 (Department of Health), Health online website.

⁹ Department of Human Services, 2006, 'Victorian Burden of Disease Study: Mortality and Morbidity in 2001', Melbourne: Public Health Group, Rural Regional health and Aged Care Services, Victorian Government Department of Human Services.)

¹⁰ Health status of Victorians, Source: <http://www.health.vic.gov.au/healthstatus/le.htm>

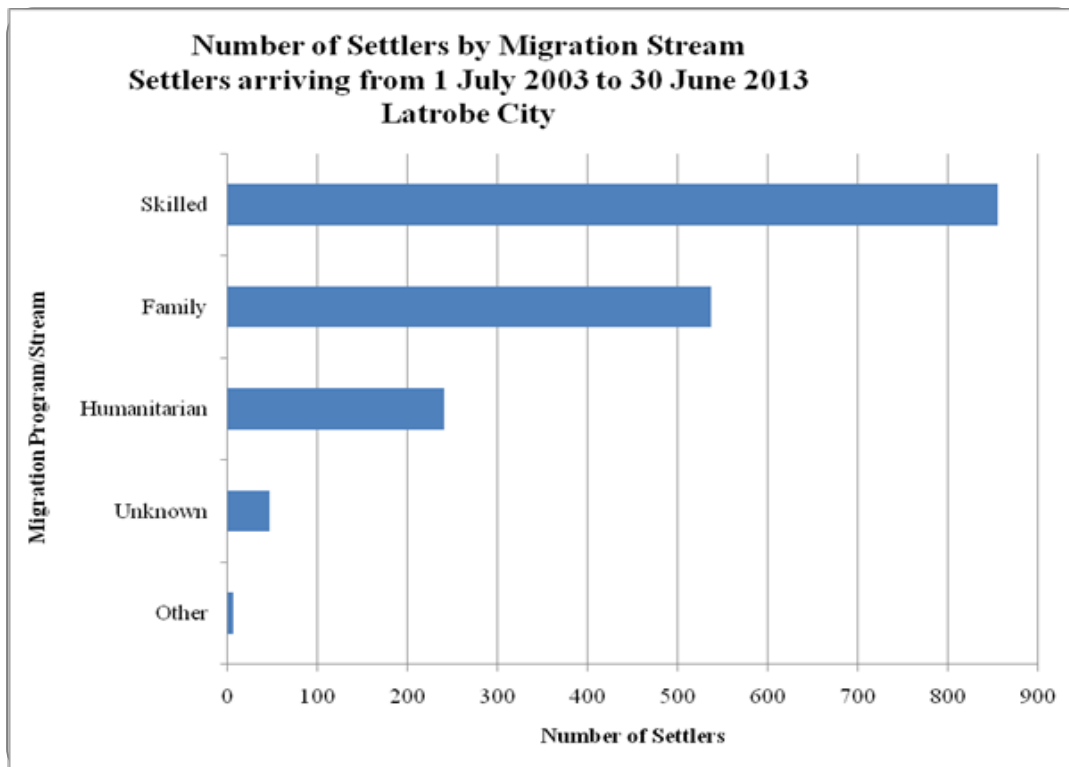
¹¹ 2008 Victorian Population Health Survey at www.health.vic.gov/healthstatus/vphs.htm

Figure 2: New arrivals – Country of Birth



Source: Department of Immigration and Citizenship Settlement Database.

Figure 3: New arrivals – Migration stream



Source: Department of Immigration and Citizenship Settlement Database.

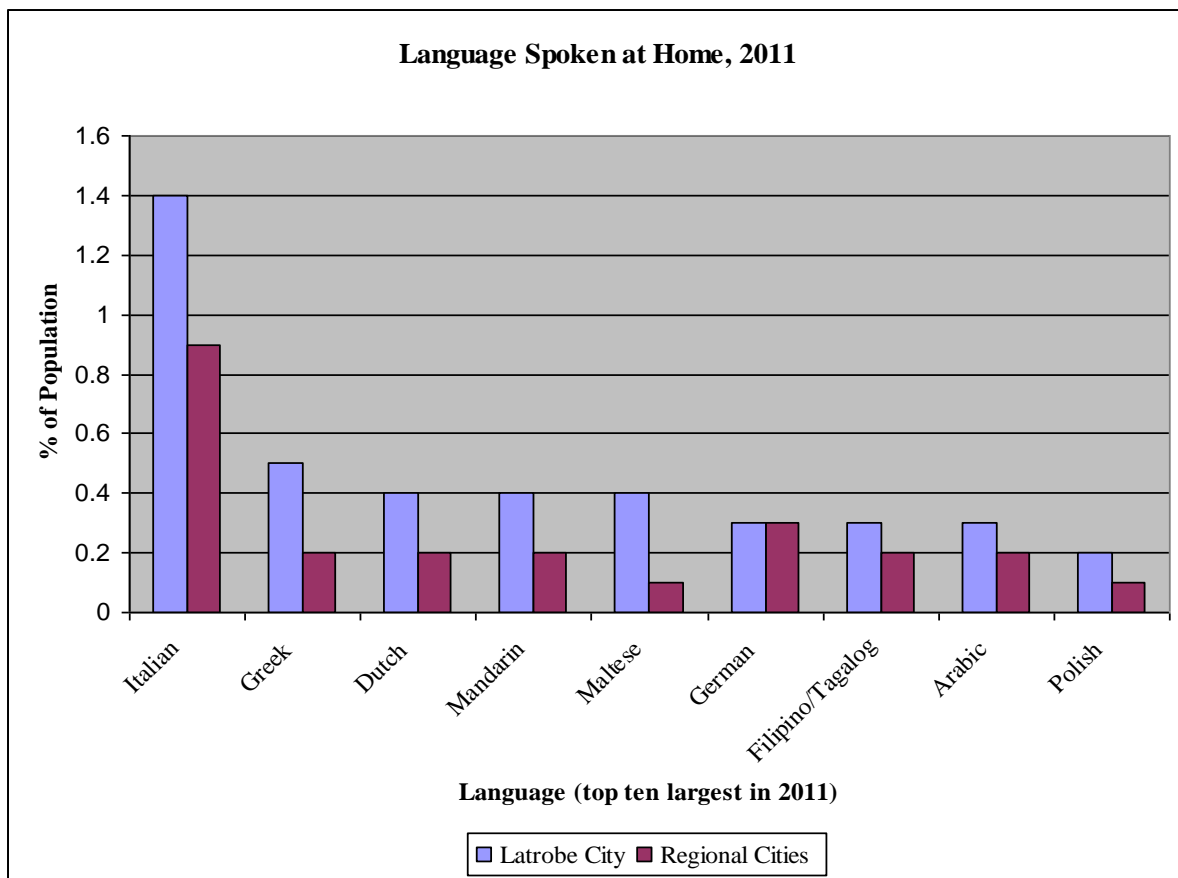
The recent arrivals vary from skilled migration stream, to humanitarian, refugee and asylum seekers.

The Settlement Database captures only the primary location of new arrivals, however does not capture “secondary movement” effectively, being those residing in Latrobe City, who have first settled in Melbourne or elsewhere, and then relocated to a second location. In particular, the South Sudanese are a mobile community and the above data significantly under represents community numbers. The skilled stream to Latrobe is greater in total numbers of the other streams combined.

Skilled migrant stream people have better work and settlement prospects and generally fit well and integrate into the community. However, the dependant relatives of skilled migrants experience high levels of isolation and under employment.

The other streams it is likely will have particular mental health needs particularly relating to Post Traumatic Stress Disorder (PTSD) following experiences in their country of origin as well as in transition steps to Australia.

Figure 4: Established CALD communities



The greatest increases in the spoken languages of the Latrobe City population between 2006 and 2011 were those speaking Arabic (+151 persons), Mandarin (+132 persons), Dinka (+104 persons) and Nuer (+98 persons). The greatest decreases in spoken languages during this timeframe were those speaking German, Polish, Maltese and Dutch. This corresponds with the ageing of the older migrant groups. Latrobe has a greater proportion of non-English speakers from various ethnic groups than Victorian regional cities in general.

Country of Birth data identifies where people were born and is indicative of the level of cultural diversity in Latrobe City. The mix of Country of Birth groups is also indicative of historical settlement patterns, as source countries for Australia's immigration program have varied significantly over time.

Table 2: Country of birth – regional changes 2006 to 2011.

Country of birth	Number	%	Regional VIC %	Number	%	Regional VIC %	Change 2006 to 2011
	2011			2006			
Netherlands	784	1.1	0.6	841	1.2	0.6	-57
Italy	716	1.0	0.6	752	1.1	0.7	-36
Germany	552	0.8	0.5	574	0.8	0.5	-22
Malta	407	0.6	0.1	449	0.6	0.1	-42
Philippines	361	0.5	0.3	288	0.4	0.2	+73
China	270	0.4	0.2	124	0.2	0.1	+146
India	252	0.3	0.4	100	0.1	0.2	+152
Sudan	198	0.3	0.1	0	0.0	0.0	+198
Greece	132	0.2	0.1	135	0.2	0.1	-3
Poland	129	0.2	0.1	161	0.2	0.1	-32
Malaysia	113	0.2	0.1	97	0.1	0.1	+16

Source: Australian Bureau of Statistics, Census of Population and Housing 2006 and 2011. Compiled and presented by .id, the population experts. Excludes countries with less than 0.2% of the total population and English speaking countries. (Usual residence data).

CALD respondents gave their estimations of the numbers of people in their communities, some by number of individuals, and some by number of families. This is depicted below as approximate estimates.

Table 3: Estimated number of families and individuals by ethnic group in Latrobe.

Ethnic Group	Approximate number of Families/individuals
South Sudan Dinka community	50 (families)
South Sudan Nuer Community	500 (Individuals)
South Africa	40-50 (Families)
Russia	12 (families)
Philippines	100 (families)
Nigeria	15 (families)
Italy	50-100 (families)
Greece	20-30 (Families)
China	20-30 (Families)
Bosnia	30-40 (Individuals)
Bangladesh	10-20 (Families)

The individuals selected for interview reflect the census data and Settlement database data of the key backgrounds in Latrobe City and key newly emerging communities.

Older CALD communities

The population distributions by age cohort indicate clearly that the more established post war migrant groups are much older than the general population and certainly than the more recent arrivals. This has implications for the kinds of mental health support services that need to be provided. The older groups suffer from age related mental ill health, there is also a notable increase of depression, and PTSD as a result of their contemporaries' health problems keeping them at home, going into nursing homes or dying off. This is seriously disrupting the formerly strong mutual support networks. One of the Ukrainian groups has gone from 60 members 7 years ago to 19 today! This pattern is evident in other older groups. Their children are in their 50's and their affiliation to ethnic clubs is not as strong as their parents. As noted in other parts of the report, the traumas of their WWII experience appear to be surfacing with advancing years, reduction of physical activity and busyness that may have kept such memories at bay. This is combining with reduced support. Unsurprisingly this scenario is likely to lead to increased rates of depression and other symptoms.

We have been informed that at both a commonwealth level (e.g. National Respite for Carers Program, Community Visitors Scheme, Aged care assessment Service and other services) and state level (e.g. HACC) these issues for ageing CALD communities both in Latrobe and more broadly have been well identified and addressed. The Community Partners Project was specifically aimed at developing awareness by CALD communities of aged care options and of aged services of CALD backgrounds. HACC is seen as the "best practice" example of ensuring CALD service access.

Recent arrivals

The Sudanese are the most recent large group of refugees to have settled in the valley in large numbers. They are predominately Christian however are not a homogenous group as they represent different tribes and languages. One respondent noted that the Sudanese have a generally fatalistic attitude and say, "God will take care of this..." in reference to illnesses and life burdens. This makes it a bit difficult to promote active recovery from mental ill health. She has adapted her communication to take into account the cultural norms of this group to good effect.

Literature Review

Australian Government Policy

Australian Government, in recognising that the people from a CALD background have a significantly lower level of access to mental health care and support,¹² fund the Mental Health in Multicultural Australia (MHiMA) project to provide a national focus for advice and support to providers and governments on mental health and suicide prevention for people from CALD backgrounds.

They also fund Access to Allied Psychological Services (ATAPS) programme targeted to give priority to population groups that have particular difficulty in accessing mental health treatment in the primary care sector, including people from CALD communities.

The Department of Health (federal) funds the Programme of Assistance for Survivors of Torture and Trauma (PASTT). Through this programme it funds providers to deliver mental health and other support to permanently resettled humanitarian entrants who are experiencing psychological and/or psychosocial difficulties resulting from their pre-migration experiences of torture and trauma. (This is only a sample of federal government funding relevant to CALD communities mental health).

National Standards

The new National Standards for Disability Services have been adopted in 2013 and include an important definition of Cultural competence¹³:

"Cultural competency – the term 'cultural competency' describes individuals and organisations with a set of behaviours, attitudes, knowledge, skills, practices and processes which enable effective work in cross-cultural settings. It is more than cultural awareness. It means that individuals and organisations are proactive, rather than responsive, regarding cultural diversity to ensure effective and relevant service delivery or supports". (p.5).

The Federation of Ethnic Communities' Councils of Australia (FECCA) presented to the Australian Government the [Multicultural Access and Equity: Strengthening connections between communities and services](#) report (June 2013).¹⁴ The Australian Government accepted the Panel's recommendations in full,

¹² Fact sheet: Mental health services for people of culturally and linguistically diverse (CALD) backgrounds, <http://www.dss.gov.au/our-responsibilities/mental-health/programmes-services>

¹³ National Standards for Disability Services, http://www.dss.gov.au/sites/default/files/documents/12_2013/nsds_web.pdf

¹⁴ *Multicultural Access and Equity: Strengthening connections between communities and services*

which includes the Multicultural Access and Equity: Respecting Diversity, Improving Responsiveness framework. This framework requires all Government agencies to develop an Agency Multicultural Plan (AMP). The outcomes sought are effective engagement and communications with CALD communities and equitable outcomes for CALD clients. Adequate consideration of CALD clients' needs is an essential element of a fair service delivery system.

While the Australian Government committed to a policy of Access and Equity in the late 1970s, various reviews paint a worrying picture for example:

"FECCA's 2012–13 consultations show that after over 30 years, there is still inequality. There is still a gap between good policy intent and actual service delivery." (ibid. P.2).

In summary the report recommends that that government funded services need to ensure that CALD Australians are aware of government services, through having:

- sufficient information in languages other than English via a variety of formats
- that language training and interpreter services are used by agencies especially Job agencies
- that Government websites be translated into community languages
- that cultural competency training is provided to all frontline staff, and
- that liaison officers be appointed to work between service providers and CALD communities.

Beyondblue¹⁵ submission on the Department of Immigration and Citizenship's discussion paper on 'Access and equity: inquiry into the responsiveness of Australian Government services to Australia's culturally and linguistically diverse population' focussed on the high prevalence mental health disorders of depression and anxiety. The submission notes that:

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

The submission notes that current programs and services for people from CALD communities pose significant barriers to seeking help for mental health services.

These barriers include:

- stigma associated with mental illness
- lack of knowledge about available services
- GP referral patterns
- cost of services
- language and cultural barriers
- differences in cultural explanations and perceptions surrounding mental health.

FECCA June '13.

¹⁵ <http://www.beyondblue.org.au/> Submission Access and Equity Feb 2012

The submission urges the development of targeted strategies, which address these barriers to seeking help by people from CALD communities. It argues for a much stronger level of authority of government agencies to ensure implementation of the Access and Equity Strategy and Framework.

Victorian Government policy Framework

The Psychiatric Disability Rehabilitation Support Services (PDRSS) Reform Framework Consultation Paper: Consultation Report¹⁶ notes that:

“Respondents recognised the reforms offered a significant opportunity to improve responsiveness to population diversity (e.g. CALD, Aboriginal people and refugees) as part of the core business of PDRSS provision.”

Clearly, the recommissioning is intended to bring this about and the direction received endorsement from the then PDRSS sector.

Quoting from its Health Information website:

“The Government recognises the importance of ensuring that Victorians from culturally and linguistically diverse backgrounds (CALD) have full and fair access to health services.”¹⁷

As part of that commitment the government has instituted the cultural responsiveness framework.¹⁸ This framework is designed to improve and extend the cultural responsiveness performance of Victorian health services.

It specifies six standards and improvement measures for culturally responsive practice.

Standards for cultural responsiveness

Standard 1

A whole-of-organisation approach to cultural responsiveness is demonstrated

Standard 2

Leadership for cultural responsiveness is demonstrated by the health service

Standard 3

Accredited interpreters are provided to patients who require one

Standard 4

Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices

Standard 5

CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis

¹⁶ PDRSS Reform Framework Consultation Paper: Consultation Report www.health.vic.gov.au/mentalhealth/pdrss-reform/index.htm

¹⁷ Victorian Government Health Information website.

¹⁸ <http://www.health.vic.gov.au/cald/cultural-responsiveness-framework#docs>

Standard 6

Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness

Health services are required to develop and submit a Cultural Responsiveness Plan covering at least a three year planning cycle to the Quality, Safety and Patient Experience Branch.

The brief exploration of federal and state government policy clearly recognises the need for equitable access by CALD communities and strongly intends that this be achieved.

The concept of Need

There are varying definitions of need in the literature (see Table 1 and Figure 1).

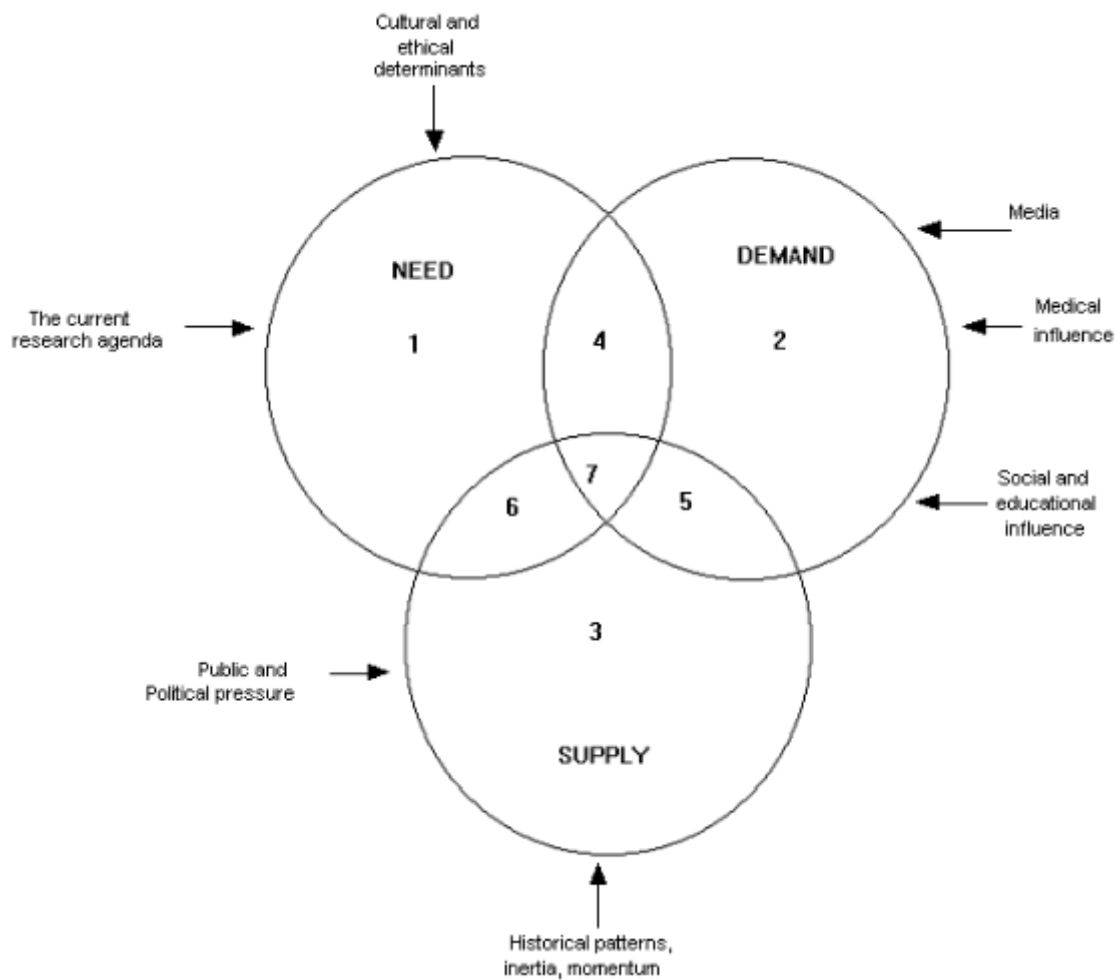
Table 1: Bradshaw's 4 types of social need¹⁹

Type of need	Definition	Examples
Normative need	Need that is defined by experts. Normative needs are not absolute and there may be different standards laid down by different experts.	Vaccinations, a decision by a surgeon that a patient needs an operation
Felt need	Need perceived by an individual. Felt needs are limited by individual perceptions and knowledge of services.	Having a headache, feeling knee pain
Expressed need (Demanded need)	Felt needs turned into action. Help seeking.	Going to the dentist for a toothache
Comparative need	Individuals with similar characteristics to those receiving help.	Compiling an at risk registrar of babies in need of specialist treatment based on characteristics which have been associated with handicap in the past

The project examined Normative need, namely the assumption by policymakers that similar populations require a similar level of service, in this case mental health support. It also explored Comparative need where CALD communities are assumed to have similar prevalence of Psychiatric conditions to the general population. In fact most experts in this field would posit that the incidence of mental illness and various forms of psychological distress are likely to be much greater depending on the type of migration experience e.g. refugees and asylum seekers have usually experienced high levels of conflict, displacement and trauma in countries of origin and refugee camps which can be exacerbated by an unwelcoming and alien environment and resulting in high levels of PTSD).

¹⁹ Bradshaw J. (1972) "A taxonomy of social need." in McLachlan G (ed.) Problems and progress in medical care. Seventh series NPHT/Open University Press.

Figure 1: Need, demand and supply: influences and overlaps



Source: Stevens A, Raftery J, Mant J. An introduction to HCNA.
<http://www.hcna.bham.ac.uk/introduction.shtml>

According to Stevens²⁰ et al, there are overlaps between need, demand and supply, resulting in seven different fields (eight if you include an external field - where services are neither needed, demanded, nor supplied).

- Field 1: Services are needed but not demanded or supplied
- Field 2: Services are demanded but not needed or supplied
- Field 3: Services are supplied but not demanded or needed
- Field 4: Services are needed and demanded but not supplied
- Field 5: Services are supplied and demanded but not needed
- Field 6: Services are needed and supplied but not demanded
- Field 7: Services are needed, demanded and supplied

For the present study Field one seems the most appropriate. There is an assumption that services are needed but not demanded or supplied at least in the manner acceptable to the target groups.

²⁰ Stevens A, Raftery J, Mant J. An introduction to HCNA. <http://www.hcna.bham.ac.uk/introduction.shtml>

This has been confirmed, if we take the experience of the service providers and other informants into account. In that the services are needed but are not sought out nor supplied in a manner that these become accessible or acceptable. The policy direction is proposed to be toward Field seven where the services are needed, demanded by members of the CALD community and supplied in a manner that is skilled, inclusive and acceptable. This speaks to both cultural sensitivity and more importantly cultural competence of service providers.

Prevalence of mental illness in CALD communities

Minas et al²¹ questioned whether we have accurate prevalence rates for CALD communities. They caution that studies which purport to show that CALD communities experience higher rates of mental illness are small and not having a comprehensive database to check against may be inaccurate. None the less their conclusion is that in all likelihood when more rigorous prevalence records are created in Australia CALD groups are likely to have higher incidence of mental illness than the general population especially for selected groups that had faced great trials and traumas before arriving in Australia.

The report found that rates of depression, anxiety and post-traumatic stress disorder were between three and four times higher among Tamil asylum seekers in Australia, for example, than rates among other immigrants. Young refugees in general have an increased risk of depressive symptoms.

The report also notes that the rates of suicide are quite variable between immigrant communities. Understanding both risk factors and protective factors within each community is vital in order to design appropriate prevention and early intervention strategies.

Research on CALD community access to mental health services

An investigation by Stolk, Minas and Klimidis²² of mental health service use by Victorians from non-English-speaking countries (NESC) found that whilst they comprise 20% of Victoria's population, they comprise only 13% of community clients and 15% of inpatients. Typically, people from Non English Speaking Backgrounds (NESB) present late in the course of a disorder; experience more diagnoses of psychoses, more frequent contacts, inpatient admissions were more likely, more involuntary admissions and longer inpatient stays.

A study²³ into barriers to service by Sudanese refugees showed that these included language barriers, financial handicap, lack of health information, not knowing where to seek help, and poor understanding of how to access health services. Most refugee families established connections with community cultural, social and religious groups of their own ethnic background soon after arrival in Australia. These groups provide the new arrivals with information on local resources, health and education services, and provide key connections to the institutions of the host community.

²¹ Harry Minas, Ritsuko Kakuma, Lay San Too, Hamza Vayani, Sharon Orapeleng, Rita Prasad-Ildes, Greg Turner, Nicholas Procter, Daryl Oehm, "Mental Health Research and Evaluation in Multicultural Australia: Developing a Culture of Inclusion" Mental Health in Multicultural Australia (MHIMA) 2013

²² Stolk, Yvonne, Minas, I Harry & Klimidis, Steven (2008) Access to Mental Health Services in Victoria: A Focus on Ethnic Communities Victorian. Transcultural Psychiatry Unit, Victoria. (available VTPU website)

²³ Mohamud Sheikh-Mohammed, C Raina MacIntyre, Nicholas J Wood, Julie Leask and David Isaacs Barriers to access to health care for newly resettled sub-Saharan refugees in Australia MJA • Volume 185 Number 11/12 • 4/18 December 2006.

There are notable differences between CALD communities rate of usage of mental health support services, Minas²⁴ reports that particularly

“... Vietnamese and other Asian communities, access public mental health services at less than half the rate of the general population. It seems unlikely that this is because of lower rates of mental illness in these communities.”

Minas concludes that:

“A person with mental illness who does not speak fluent English may or may not have access to an interpreter, and will generally not have access to psychotherapy, rehabilitation and social support programs.”(ibid.)

The Queensland government has done a great deal on the access issues by CALD communities and have published helpful guides to overcoming these.²⁵

Peter Westoby²⁶ provides a critique of the Western approach to service provision to refugees and demonstrates the effectiveness of a community development approach in response to Sudanese accusations of neo-colonial methods of ‘service delivery’. He urges the utilisation of the insider perspectives of Sudanese refugees in contrast to outsider professional perspectives. In other words, to develop any needs statements in target group’s terms. This requires a creation of a safe space to make sense of the new settlement context for the refugees and the community development worker orienting themselves towards facilitation and discovery of the resources of culture, community and power within the refugee community.

Expanding on the community development approach, Susan A. Rans’ Hidden Treasures²⁷ showcases examples of building community connections for people usually seen as disadvantaged by mainstream society. One of the key approaches is identifying what “gifts and talents” people have and using “community connectors”, those people who seem to naturally know everything about their communities and what is going on, link these talents with groups or places where they are needed. The vignettes illustrate the power of belonging and contributing which result in personal growth and development of the people concerned and in the case of persons with mental illness concomitant reduction of symptoms. This approach has parallels with the recovery model used by MHCSSs but at a communal rather than individual level. Most CALD communities are communitarian, so this approach would seem appropriate to the task of improving mental health of these communities.

²⁴ Minas Harry Minas: (October 2013) <http://theconversation.com/getting-the-facts-about-refugee-and-migrant-mental-health-in-australia-18902>

²⁵ <http://www.qld.gov.au/web/community-engagement/guides-factsheets/cald-communities/introduction/barriers.html>

²⁶ Peter Westoby, Developing a community-development approach through engaging resettling Southern Sudanese refugees within Australia, <http://cdj.oxfordjournals.org/>

²⁷ Susan A. Rans, Hidden Treasures : Building Community Connections by Engaging the Gifts of : People on welfare, People with disabilities, People with mental illness, Older adults, Young people, Asset Based Community Development Institute, School of Education and Social Policy, Northwestern University 2120 S. Campus Drive, Evanston, IL 60208-4100.

Understanding CALD communities in relation to mental health

J. J. Luntz²⁸ collated information on a project undertaken by all Child and Adolescent Mental Health Services (CAMHS) in Victoria between 1999 and 2000. The project aimed to increase the responsiveness of Victorian CAMHS to CALD communities. As part of the process each of the fourteen Victorian CAMHS was required to conduct an internal and an external mapping exercise with a unique CALD community in their catchment. The external mapping exercise involved the CAMHS discovering which ethnic communities lived in their catchment area, and to contact the ethno-generic, ethno-specific and mainstream agencies who work with these communities. Each CAMHS then chose one community and learnt about its history; reasons why members left the country of origin; migration (and especially refugee) experiences; languages spoken; spiritual and religious beliefs and ways of explaining physical and mental health problems. In particular, participants were asked to consider the mental health needs of children, adolescents and their families and the implications of these for accessing CAMHS. To choose a community to profile required clinicians to meet and develop a dialogue with community agencies with whom they had previously had little, if any, contact.

Luntz states in her summary:

“The Western framework for thinking about mental health/mental illness is not shared by many of the communities” (p.5).

There were many positive spin offs for the particular CAMHS and the CALD community they engaged with as well as for CAMHS a service sector overall. Much learning occurred by participant clinicians and better access was achieved for CALD clients.

The project illustrates a possible method of Latrobe MHCSSs collaborating in engaging with particular CALD communities in Latrobe City.

Cross and Singh²⁹ study of mental illness in a culturally and linguistically diverse society concludes that people from CALD backgrounds are disadvantaged by the marginalization and stigmatization associated with mental illness, often exacerbated by that culture’s attitude to mental ill health, and the access and utilization of services that are not adapted (culturally competent) to the various communities that need them.

Approaches to demystify mental illness within ethnic communities

Blignault et al (2009)³⁰ undertook a two phase study targeting the Macedonian community in south-east Sydney in order to address service underutilisation. The first phase engaged a large number of the community exploring their attitudes to mental illness. They used the findings of the first phase to design a multifaceted community intervention to reduce stigma and improve mental health literacy. The intervention involved delivering targeted education programs to key individuals and groups within the

²⁸ J. J. Luntz, 2000. Child and Adolescent Mental Health Services Increasing Cultural Sensitivity to Children and Adolescents from Culturally and Linguistically Diverse Families

²⁹ Wendy Cross; Charanjit Singh (2012). Dual vulnerabilities: Mental illness in a culturally and linguistically diverse society. Contemporary Nurse: Vol. 42, Advances in Contemporary Health Care for Vulnerable Populations, pp. 156-166.

³⁰ Ilse Blignault, Lisa Woodland, Vince Ponzio, Dushan Ristevski and Suzanna Kirov “Using a multifaceted community intervention to reduce stigma about mental illness in an Australian Macedonian community” Health Promotion Journal of Australia 20(3) 227 – 233. Published: 01 December 2009

community. Unsurprisingly in phase one, participants cited negative views about mental illness, negative attitudes and discrimination towards people with mental illness, and concerns about confidentiality as the main reasons for failing to seek care early. In Phase two, more than 90% of those who provided written feedback indicated that the community and workplace education sessions had given them a better understanding of mental illness and its impact. This is a promising methodology if direct action with Latrobe CALD communities is accepted from our recommendations.

Another very interesting project was undertaken by Patrycja Toczek³¹ of the Australian Polish Community Services in collaboration with Arabic, Chinese, Macedonian and Cambodian workers. Each worker was employed by their respective ethno specific welfare organisation. They had thus an excellent understanding of their communities and a high level of trust. Each worker developed an investigation as well as information strategy about mental illness that they implemented with their respective communities.

This Multicultural Mental Health Project was targeted at de-stigmatising mental health issues among target communities, raising awareness and improving access to mental health services prior to situations reaching crisis point. The project workers collaborated to provide support and direction to each other and the project, whilst addressing the issues in a culturally and linguistically appropriate manner, thus respecting the differences as well as the similarities for each community. The project achieved its aims and reached very large numbers of the respective CALD communities. This project provides illustrations of engagement with particular CALD communities, understanding their reference points in relation to mental illness and delivering via multiple modalities useful information that de-stigmatised mental illness and also gave information on multiple options to obtain timely and effective assistance.

In the process of carrying out the project interesting insights were gained by the research team into these five CALD communities

They found that Arabic and Cambodian people experiences high levels of PTSD. The Cambodian community indicated that mental illness brought shame on family. Severe emotional disturbance and mental illness indicated one of the following: possession by malicious spirits, bad karma, punishment for misdeeds in past lives, inherited bad luck, witchcraft or upsetting of family ancestors. They believed that people with mental illness are not able to look after themselves or others. The solution was to seek spiritual healing from a Buddhist temple, or if Christian, from a priest. When comparing traditional ways and western ways they expressed concerns about side effects of medications, person sleeping too much, not doing anything, no longer 100% and essentially changed.

The social stigma surrounding mental illness has implications for the person, their families, future prospects of marriage and compromising the degree of contributing to the family and community.

This was a very different reaction to that of physical illnesses.

Chinese community broadly expressed a stereotypical view of mental illness as unpredictable and possibly dangerous to self or others. Media influenced views about people with severe mental illness as extreme, violent and unpredictable.

³¹ Patrycja Toczek, "Demystifying Mental Health in Ethnic Communities: Multicultural Mental Health Project Evaluation, Australian Polish Community Services (APCS): www.apcs.org.au

Macedonian community did not see mental illness as an authentic illness. It brought a burden and shame for the family. The individual was seen as to blame. The Macedonian youth came across as more knowledgeable than older people about mental illness and where to get help.

Polish community had an overrepresentation of older Polish migrants in mental health services. (See Drozd et al. (2004))³². Evert (1996)³³ found that Polish people were overrepresented in admissions to psychiatric facilities in comparison to other CALD communities.

For the Polish community, church, family community clubs, interests, educational pursuits, pleasant environments and social networks reduce depression.

On the risk side for depression, reactions to war (older Polish migrants) lowered hopes and expectations, seeking answers, ruminating on past tragedies becoming loners and isolating themselves increase depression symptoms. This underscores the importance of social support services targeted at these ageing CALD communities.

In all five communities, help seeking tended to be initiated following family members becoming unmanageable or in a crisis.

*“People who talk about mental health problems risk being ostracised by their family and community”
(P 16)*

For older Poles the effects of war experiences, and past trauma are often suppressed for many years, leading to depression and PTSD as well as risk of suicide. Scant knowledge of service options is a factor. However, 30 % reported they would seek help from their GP (Mackiewicz, 1996)³⁴.

Overall observations were that the CALD communities strongly orientated to their own welfare bodies. These, however did not necessarily have a fully developed understanding of mental illness or pathways to obtain assistance. Therefore, a partnership between multicultural services and mental health service providers is an optimal combination.

In spite of the stigma and other negative reactions, all five CALD communities were generally supportive of people with mental illness.

Professional Education programs on culture and CALD communities

Don Gorman and Wendy Cross³⁵ chapter on Cultural Issues in Mental Health (part of health education text) provide an excellent overview of best practice with CALD communities in health settings. They outline that Anglo Celtic cultures classify health and illness into quite definite categories based on physiological understanding of health and disease. Whereas many CALD cultures do not distinguish between physical and mental health and may also incorporate the idea of health of the whole community and the land the community is attached to. Gorman and Cross note several studies that indicate the level

³² Drozd, E., Szczepanska, E. & Wiench, M. (2004). The understanding and prevalence of Depression in the Polish community. Australian-Polish Community Services: Melbourne. <http://www.apcs.org.au>

³³ Evert, H. (1996). Polish community mental health profile: a guide to clinicians and service providers. Victorian Transcultural Psychiatry Unit, Melbourne.

³⁴ Mackiewicz, G. (1996). Forgotten fragments: the significance of the Polish war experience. Australian Polish Community Services: Melbourne.

³⁵ Don Gorman and Wendy Cross, “Cultural Issues in Mental Health”
eprints.usq.edu.au/18144/5/Gorman_Cross_Ch21_2011_SV.pdf

of acculturation being strongly associated with levels of service use. In other words, the more acculturated a person from a CALD background to the host community the more likely they are to utilise available services and vice versa. (See Neff & Hope 1993)³⁶ This has big implications for this study, as newer CALD communities coming into Latrobe are unlikely to be very aculturalised partly as a factor of time and partly because of cultural differences to the host community. Clearly to improve service access to such communities more than improved information on services will be needed.

Examples of good practice and resources

The following examples are not exhaustive but illustrative of what the project team learned about some services in Latrobe. There are many other examples of services that the project had not had the opportunity to explore in detail and therefore outline.

Mental Illness Fellowship (MIF) and Mind

MIF Wellways program is an excellent example of engaging the CALD community and training the CALD representatives to deliver the program to the particular group. It empowers the representatives and provides them with confidence and skills; ensures the message is culturally appropriate and delivered to maximise impact. The method as well as the content of the program ensures maximum buy in by the target group and therefore maximum impact. It is part of MIF's Cultural competency agency wide approach and reflects a community development philosophy.

Another example is Mind Australia's Narre Warren program developing a long-term strategy in engaging with the Sudanese community in that area. It has involved placing a staff member in the local Learning hub increasing low-key exposure. This person has linked with the local Sudanese community leaders and through that, contact began deepening her understanding of the culture around health, mental health and spiritual meaning important to that community. The communities deep faith in God, a somewhat fatalistic attitude to life, distrust of western approaches to mental health were woven together into a community education presentation that used rocks and pebbles and lots of pictorial representations in a PowerPoint presentation to a large gathering to symbolise worries and burdens (avoiding mental illness language), and inserting messages that God works through the various helping professions to help people and how to seek and ensure assistance. It has been a long process but is bearing results like acceptance of the Mind worker by the community, help seeking behaviour and clearly increased access to services.

Families where a Parent has a Mental Illness (FaPMI)

Is an excellent state wide initiative (in Gippsland auspiced by the Latrobe Regional Hospital) that has two positions funded by the Department of Health that work with mental health services, community organizations, consumers, carers and families, and other service providers to improve the way support is provided to families and children aged 0-18 where a parent has a mental illness.

³⁶ Neff J. A. & Hope S, K, (1993) "Race/Ethnicity acculturation and Psychological Distress: Fatalism and religiosity as Cultural Resources" *Journal of Community Psychology* 21 (1) 3-20.

Headspace

We were informed that Sudanese young people for instance come in large numbers into Headspace because there is internet access available. This creates an opportunity for health and other professionals to be present in a low key way and assist as needed. The new Headspace CEO will be prioritising access to young men and CALD community.

Koori Co-Op

Koori Co-Op Ramahuck's Nindedana Quaranook also provides a drop in facility to their target group. One of the LCHS representative observed that few Koori and ATSI people frequent LCHS comparatively to the Co-op suggesting that the open door drop in nature of the service there presents no barrier to access compared to the formality of appointments, form filling that go with a more westernised service delivery method.

SNAP

Snap uses the Optimal Health Program (formerly known as Collaborative Therapy).³⁷ It is a therapeutic framework for working with individuals in order to help them achieve optimal health outcomes balancing physical, psychological and social health and wellbeing. The program helps participants to understand the factors that have an impact on their mental health and develop the skills they need to achieve and maintain optimal health.

It shifts the focus from 'illness' to 'health' and from being 'dependent' on to being 'supported by' services.

The Optimal Health Program has three core components:

- Education – the factors that influence mental health
- Coping Strategies – actions and strategies that are effective in helping manage and reduce stress
- Skills Development – a range of skills, tools and techniques that help manage stress and achieve long term optimal health.

The program is generally delivered in a group setting, but can also be delivered individually, over eight or nine weekly sessions.

Tipping Foundation and Headway Gippsland

Both agencies who service people with a disability reported high proportions of CALD communities using their services. The specialist nature of their services to their target populations seems to remove barriers to service. GPs are an important referral source for both organisations. The initial entry point is non stigmatising and this increases the likelihood of service uptake.

Latrobe Community Health Service (LCHS)

LCHS is a large and important provider of health and community services. Its wide range of primary health and aged care services engages effectively with a broad cross section of the Latrobe population. The mental health support part of its work thus is engaging more effectively with CALD communities than

³⁷ Reference <http://snap.org.au/models/collaborative-therapy/>

stand alone or specialised MHCSSs. (following Recommissioning of MHCSS LCHS will no longer be a provider of MHCSS).

LCHS also has an active and effective CALD recruitment policy. This approach increases the likelihood of CALD communities using LCHS even if their particular ethnic group is not on staff. Some of the respondents from LCHS indicated that the engagement with CALD communities is variable across the multitude of CALD communities, and that they have to continue trying to engage proactively with all CALD communities. Overall, several Latrobe Community Health Service respondents felt that CALD communities do access their services relatively frequently. Planned activities and respite in particular seem to have high levels of uptake and participation especially by the CALD elderly. A slight down side to the LCHS size is that their various services can refer internally and may not actively enough refer and engage with external organisations.

Latrobe City Council and general community

The Council auspices the Latrobe Settlement Committee, the Cultural Diversity committee, promotes community cohesiveness via events and employing various staff positions to promote community development and harmony. The council funds various groups to run events and festivals and supports community service organisations. It also undertakes planning for the whole community.

Community venues

Similarly, access to target communities can be obtained in neutral venues like soccer, basketball, and other sporting and cultural venues/clubs, faith communities, Centrelink, GPs practices, cultural and community events, shopping centres, neighbourhood houses and so on. In other words reaching out to where those communities regularly interact with each other or the general community could be effective. This may require a low-key community development approach rather than the formal approach of most professional agencies. GMS reported that if they wanted, say the Sudanese community to receive an important message or information they have organised to speak at a Sunday church service with the support of the priest (an identifiable community leader).

Maternal and Child health Nurses

As reported by the CALD community representatives, the Maternal and Child Health Nurses (MCHN) are effectively accessed by the CALD communities. The service focus being on the baby/children' health and development so parents appreciate their input and do not feel threatened by the MCHNs.

General practitioners

It was reported that GPs also get a good representation of all groups in the community including CALD. It is worth noting that GPs from a CALD background appear to attract a disproportionately high number of CALD clients not necessarily from their own ethnic group only.

Outreach Services

The DEECD School Nurse and Refugee Nurse Service auspiced by LCHS are very accessible to CALD communities. It is the outreach nature of the services, instead of being available in a fixed facility and actually going out to the places where CALD communities live and interact that is the key to success.

Schools offer Mind Matters programs which support optimal student mental health and could be a vehicle for engaging families to seek assistance when necessary.

LRH Primary Mental Health and Community Development

The LRH Primary Mental Health and Community Development employ a Koori Liaison officer who is from a Koori background herself. They report that this has made a huge difference in engendering trust between LRH and the Koori community and opened doors for accessing their services and also very importantly “vouching for us”. The position is also helpful in helping staff develop a deeper and more sophisticated understanding of the Koori culture. We will assert, later in the report that a similar position at Latrobe focusing on the CALD communities would be equally beneficial.

Another portfolio responsibility is to provide mental health information to GPs. This gets included with a myriad other pieces of information that come across GPs desks. Also GPs tend to stay in the area for a relatively short time until they have fulfilled their visa and AMA requirements, and then they move to Melbourne or elsewhere in the state. The information flow has to be repeated and fairly frequent. This section of LRH repeats information circulation in six month cycles.

Overall CALD use of services is low compared to population proportion in Latrobe.

The Manager of LRH Primary Mental Health and Community Development was of the opinion that the referral pathways to mental health services can be circuitous. In LRH there is a single phone based triage. The focus is on low prevalence high impact disorders.

Clinical triage and all LRH MH programs have significantly increased the use of interpreters. He stated that the aim is to avoid reliance on family and friends acting as translators which could lead to conflicts of interest and critical distortions and misunderstandings.

LRH has done a good deal on cultural competence. Hospital policy is to employ CALD workers whenever possible. There are also many supporting resources on the web that practitioners can access increasing their cultural competence and sensitivity.

The Manager observed that in general CALD communities view mental health services with fear; the service providers are seen as “Authority”; evoking potential loss of autonomy and decision making over one’s life; some Sudanese patients expressed the fear that “they may take my children away”.

The networking is individually based which is a weakness of the system. Once the key person leaves a lot of knowledge and practice wisdom leaves with them. Need a more systematic imbedding of pathways and knowledge. MOUs are not enough. Service providers need to be participating in CALD community events, be seen and be known.

Latrobe Regional Hospital Community Input

LRH has established an active and effective Community Advisory Committee (CAC). It has recently revamped the CAC, with a number of new members from diverse backgrounds recruited to join the group to represents the diversity of the Latrobe Valley community.

The CAC has representatives from the Indigenous community, from communities new to Australia and from all the regions that the hospital services. The purpose of the CAC is to increase consumer, carer and community participation and input into all aspects of LRH service operations, planning and policy development (from LRH website).

Latrobe Regional Hospital Information booklet

The LRH “mental health Service-Information for Consumers, Families& Service Providers“ is an excellent resource that explains what services LRGH provides, explains MH Triage, Consumer and Carer consultant roles and contact details, outlines Primary Mental health and Community Development services and lists relevant MH promotion and self-help resources.

Latrobe Mental Health Networks:

The Recommissioning implementation is bringing changes to the makeup of service providers of MHCSS in Latrobe. There are several active networks that ought to be strongly supported. These are:

- Mental Health Consortia and networks include Gippsland Mental Health Alliance that includes Gippsland wide Community and Clinical service participants
- Centralised Intake and Assessment

In addition the Commonwealth through the Gippsland Medicare Local:

- funds Partners in Recovery Advisory Group includes agencies employing Support Facilitators through Gippsland Medicare Local
- funds Headspace (national youth mental health foundation) whose Consortia includes agencies that work with young people and who may or may not be experiencing mental health issues.
- leads an Advisory Group which includes Community Mental Health Providers lead by GML

Language Services Credit Line

This is an excellent Department of Health funded service available to all funded MHCSS agencies to access interpreting services when working with CALC community members. The guidelines can be accessed on the following link :

[http://docs.health.vic.gov.au/docs/doc/A258DF8BEDB06DEECA25796E001DE547/\\$FILE/Guidelines%20or%20DH%20LS%20Credit%20Line%20November%202013-v03.doc](http://docs.health.vic.gov.au/docs/doc/A258DF8BEDB06DEECA25796E001DE547/$FILE/Guidelines%20or%20DH%20LS%20Credit%20Line%20November%202013-v03.doc)

Foundation House for Survivors of Torture, Melbourne

It is an important resource for the refugees and asylum seekers in Latrobe. Their workers are prepared to come to the City and the organisation provides expert training modules for other agency staff.

Web based resources for associated conditions of some people with a mental illness

On the web there are valuable resources and listings that can help people experiencing mental health issues obtain assistance. Brain link, <http://staging.brainlink.org.au/service-finder-gippsland.php#> is a helpful guide for people with acquired brain injury and their family and carers.

Similarly, <http://www.vicdrugguide.org.au/> Produced by Fitzroy Legal Service lists relevant services throughout Victoria relevant to people with D&A issues. It would be good to have a similar ethno specific guide.

The State government provided Better Health Channel website covers all areas of health including mental illness, providing helpful information on conditions and getting appropriate assistance, <http://www.betterhealth.vic.gov.au> . Another excellent resource is the Health Translations Directory which provides information in a very large range of community languages and is designed for consumers as well as health practitioners.

One of the best resources is the comprehensive mental health providers' resource guide webpage www.mindhealthconnect.org.au/. Good as this guide is it is only available in English so those with poor or no English cannot use it.

Other Sectors successes

In this research, a number of sectors have been identified as having achieved significant change and outcomes in regards to reducing barriers and increasing CALD service access in Latrobe City. These are-

- Home and Community Care (HACC) services, Diversity Planning. HACC services are required to develop a Diversity Plan on an ongoing basis, identifying five special needs groups, of which CALD service users are one, and the HACC Diversity Advisor within the Gippsland region resource this process. HACC Diversity Plans are evidence based; management and the funding body monitor relevant and measurable documents and outcomes. This approach has driven ongoing change and improvement in HACC funded agencies in Gippsland for CALD service users. (http://www.health.vic.gov.au/hacc/downloads/diversity/gipps_diversity_plan.pdf)
- Maternal and Child Health Services. This service was identified by a respondent as having achieved change within the ways in which services are delivered in order to better meet the cultural needs of service users from CALD backgrounds.
- Latrobe Regional Hospital (LRH) – CALD portfolio. In response to access issues, LRH appointed a person/role within Customer Services to respond to issues of concern, ensure policy and procedure is understood and implemented. Whilst many organisations have a person whose role may include CALD services, often CALD clients are then allocated to that person within the agency. Such a person may also attend relevant training, and develop relationships with CALD communities, which is then lost if and when the person leaves the organisation. Within LRH, the customer services CALD role is a structural one, so that this person is responsible for addressing and service issues that arise in any part of the organisation, and for policy implementation.

Services are mostly Anglo. If there are people from your tribe there, who say "come over to our service", they will say "I know you and will come there". If there is no one from CALD backgrounds working there, if you have been unable to find work in the area also, how can you trust that these people can help and understand you?"

Services are mostly Anglo. If there are people from your tribe there. who say "come over to

Strategies for improved approaches to CALD communities

Increased understanding of the migration experience

There are general patterns that reflect most migration experiences; however, each migrant's journey is unique so understanding the general is no substitute for appreciating the particular. Some worthwhile reading is by Carlos Sluzki exploring migration and the disruption of social networks (1998)³⁸, and an article on migration and family conflict (1979)³⁹ where he outlines the general pattern of migration, impact on the family system and adaptation strategies needed to reduce the potential of conflict within the family induced by the migration experience. Workers would benefit from appreciating the relevant literature on this topic. Similarly many recent arrivals (refugees and asylum seekers) have experienced significant trauma in their countries of origin and in their transitional way stops along the way to Australia. These experiences are known to predispose persons to higher risks of mental ill health and compromise their adaptation to the new environment. Paradoxically, preoccupation with settlement issues are primary for refugees and asylum seekers necessitating attention to these concerns being repressed, hidden and postponed sometimes indefinitely. There have been reports that older people (e.g. Australian War veterans, older migrants escaping the horrors of WWII tend to open up and recall and speak about these traumatic memories as they get into their senior years. These appear to have been suppressed for much of their life.

Community development approach

Working closely with CALD communities to find out what their concerns are rather than putting forward what professionals think they need and in what manner to respond is also an effective method of engagement and ultimately breaks down barriers. Also, it needs to be kept in mind that communitarian cultures, and closely knit communities operate effective grapevines. A positive experience with an agency and/or a worker will quickly spread through that community for good or ill. So organisations that strive to be culturally competent, are flexible, offer appropriate services, remain responsive and helpful will become much more accessible.

Concerns about intergenerational conflict for recent arrivals has been noted as a high need to be addressed. Young people have money so are not as dependent on the elders and the family and may strive to find a sense of belonging with their Australian born peers, rejecting aspects of their parent's culture. They may then be seen as rebellious, experiment with the use of alcohol and drugs and labelled as hanging around in gangs when with other members of their own background. One of the workers reported the girls are becoming promiscuous and going out with older Australian men. The power shifts between men and women, that occur particularly when women become employed and the men remain unemployed are likely to warrant attention. Developing effective community education programs/interventions may prevent domestic violence and its sequelae.

³⁸ Carlos Sluzki (1998) "Migration and the disruption of the social network" Chapter in McGoldrick, M. ed.: Re-Visioning Family Therapy: Race, Culture and Gender in Clinical Practice. New York, Guilford Press

³⁹ CARLOS E. SLUZKI, M.D. Migration and Family Conflict in Family Process, 18(4):379-390, 1979

Reports from workers also suggest that many mental health issues are somatised. A vivid example was provided by a Mind worker. In this vignette, it is much more understandable and acceptable for a Sudanese mother to see a GP complaining of a stiffened/paralysed arm than to look at the underlying tragic issues and grief which related to the particular young woman. She had carried her child through a war ravaged area in her home country, losing her grip crossing a flooded river in the escape and thus losing her child altogether.

Direct funding options

Policy shifts in disability care like the NDIS point to the shift of the intended beneficiaries having direct control of the resources to assist them rather than facing a “services offered” approach where instead of individual tailoring of service response there is limited and sometimes inflexible range of options available as determined by agencies or associated professionals.

On the basis of equitable distribution of resources to all citizens entitled to a resource, it can be argued that direct funding to CALD communities in Latrobe is warranted as they in general underutilize community mental health support. Whilst in principle this seems like an appropriate option to consider, in practice there are issues relating to large numbers of small CALD communities in Latrobe and their potential lack of organisation or structure to accept and manage direct funding. Gippsland Multicultural Services could be an intermediary organisation in partnership with Mind to undertake a pilot project in Latrobe. The community development approach could be trailed with selected communities what their needs are in relation to mental wellbeing and what would help alleviate these. The Sudanese community could be a candidate given their predominately refugee status, recent arrival in Latrobe some organisational structure and relatively large number compared to most other new arrivals.

Cultural Competence

Community based MHCSS need to develop a comprehensive plan to ensure cultural competency at all levels of the service or agency.

The plan would include-

- a. a strategy, including professional development and training at all levels of the agency, to ensure staffs are competent in the assessment for and use of accredited language services.
- b. Cultural awareness and competency training for all staff.
- c. Development of knowledge within the agency about the refugee experience, working with survivors of torture and trauma, and the resources to assist staff in supporting and working effectively with survivors of torture and trauma.
- d. Policy development to ensure an embedded and systemic approach to cultural diversity, including induction, ongoing staff development, performance appraisal, management reporting processes, and staff position descriptions and responsibilities.
- e. The use of a cultural competency review tool, to be used on an ongoing or annual basis to measure progress and develop further planning.
- f. Ongoing work to ensure staff understand a range of various perceptions of mental health as framed by the diverse culture and faiths the individual may come from, and development of strategies that are inclusive of this range of beliefs in the recovery model utilised within mental health services.

Access

MHCSS will need to:

- a. develop ongoing and sustainable relationships between CALD communities and key personnel within community mental health services. This may include working closely with Gippsland Multicultural Services to develop links and relationships with community leaders and members, attending events, celebrations and other important times within the CALD community in Latrobe City, so that a profile, and relationships and trust are established.
- b. Undertake ongoing analysis of community based mental health service usage as compared to Latrobe City CALD demographics at a management level, including new arrivals trends and patterns, and the breakdown of arrival streams (Family stream, humanitarian, skilled), so that access strategies can be matched to an evidence based pattern of who is in the catchment area, not utilising services, and potentially have a higher need for community based support services.
- c. review of “inclusivity”, so that images, posters, printed materials, all provide a welcoming and inclusive environment for members of CALD communities.
- d. maintain ongoing work to raise awareness amongst targeted CALD communities about mental health and wellbeing and the role and availability of support services.
- e. and use language that avoids stigmatising individuals who may experience mental health issues but be reluctant to seek help.

Summary

From the literature review, it is clear that migrant groups across the globe have lower rates of access to mental health services than the host communities. The phenomenon may reflect:

- the priority being successful settlement first, for most migrants and refugees,
- the cultural differences between them and the host community around many matters but particularly around mental health,
- lack of knowledge of the service system,
- keeping problems within the family or cultural community,
- distrust of authority figures,
- lack of cultural competence of host country services, and
- the systems not being particularly flexible to accommodate a myriad of different cultures.

That appears to be the picture across Australia in that all literature examined for this study indicates widespread reluctance by CALD communities to utilise mental health support services except at crisis points which is not an ideal introduction to the helping system for anyone. Language difficulties, lack of adequate housing and jobs (settlement issues) appear to also hold back “acculturation” of some CALD communities. (This is not to promote assimilation of CALD communities, rather a sense of belonging to the broader community in general with the cultural diversity being respected and even celebrated.)

Government policy is explicit about equity of access for all citizens however it appears to be marked more by breach than compliance in the mental health sector overall at this stage.

Some excellent examples of engaging with CALD communities and demystifying mental illness have also been identified in the literature above. It is heartening to note the policy commitment and good will by governments, openness to engagement by service providers and projects which have used community development models of effectively engaging with CALD communities.

There are also many excellent examples of resources on the web relevant to mental health and CALD communities, quality training in cultural competence for staff and agencies. High bar service standards have been prescribed by governments (state and federal) requiring much better CALD access to health services and agency cultural competence being proactive and demonstrable.

We need to be careful not to characterise CALD communities as overly different from the mainstream. National Mental Health Commission research⁴⁰ has found that Australians feel they lack the most basic knowledge of mental illness, and that many 'don't know a single sign to look out for'. There is acknowledgement that most cultures do not know how best to deal with mental illness and suicide however given the prevalence of one in three Australians experiencing mental illness during their lifetime it is an important issue to be brought out into the open and treated like any other serious illness. The present study is conducted with a backdrop in the general community of general ignorance of mental illness and where to look for help.

During the project, one of the project workers was surprised at the low level of understanding about MHCSS within a community committee of interested and generally well informed citizens, council employees and agencies. It is hard to promote what is not known or understood!

Finally there is a great deal of interest and good will around the issue of CALD communities access to mental health support by service providers, funding bodies, interested peak interest bodies and academics.

CALD communities in Latrobe do not access mental health services anywhere near the rate of the general community. The LRH and LCHS services seem to have been more successful in effecting better access to their mental health services. Part of that is due to a deliberate strategy of employing CALD background staff, and following the prescribed Government mandated standard frameworks. The reasons CALD communities do not access mental health support services mirror the findings as outlined in the literature on the subject. That is one of the key factors to take into account to effect increased access to services. Namely information about services in language, images and forms that are culturally tailored, addressing the cultural beliefs about mental illness in a way that begins to align with effective approaches underpinned by belief and promotion of recovery and offering services in a more flexible manner more in tune with CALD communities' preferences.

The second set of factors relate to the service providers cultural competence, management policies and staff skill set, including use of language services, and proactive approach to engaging the CALD communities. As outlined in the body of the report, agencies focus naturally more on the people that are requesting services rather than those that are not presenting such as those from CALD backgrounds. A change of mindset is required where CALD communities' access is a high priority on a whole of agency basis, including reaching established targets and strategies such as appointing a well thought out position of CALD portfolio holders that will champion the issues of CALD communities' access to service and have

⁴⁰ Australian Government National Mental Health Commission: "Media Release" Wednesday 27th of February 2013

full management support. Training in cultural competence is vital to improve access patterns. Active outreach to particular CALD communities would facilitate trust building and lower barriers to entry along with an ongoing partnership relationship developed with GMS.

The third set of factors relate to the service system changes that are required in order to improve CALD communities access to mental health support services in a timely manner.

These are a system focus on improving access rates in Latrobe City. Better connections between services, clearer pathways between clinical and acute services and Mental Health Community Support services. The issue of CALD communities' service access should be a regular agenda item for all relevant networks. Beyond that, a position needs to be created to person to act as a liaison and resource person between CALD communities and service providers and supported by a representative Reference group, (including agencies portfolio holders and CALD community representatives) chaired by DH would move the issue forward.

There are various examples in the literature reported in this report that may be emulated by this group as projects to address the access issues.

DH can use its monitoring role of contracts to ensure agencies are developing cultural competence as prescribed by the national and state standards.

Following recommissioning, the way of accessing MHCSSs is via the centralised intake and assessment service which will be provided by ACSO. Active promotion of the new entry point into MHCSSs targeting GPs, other health professionals, faith communities, schools, community centres, social clubs and even sporting clubs would be opportune. The promotion could include information relevant to members of CALD communities on what is available and how to access it to help with mental distress, stress and trauma.

It could be argued that in terms of equity, that if a community group is not utilising what they are rightly entitled to use for whatever reason (services provided are not useful or relevant or comprehensible) then a direct funding allocation to such groups to manage the problems such funding is designed to address is supportable. A community development approach has a good deal of support in the literature and may be away of aiding CALD communities helping themselves in relation to mental illness and improved mental health. If there is any available funding DH could consider exploring this option as a partnership between one or more large recent arrivals groups in conjunction with GMS and MHCSS in Latrobe.

Information has been identified as a key to access. The comprehensiveness and accuracy of that information often suffers with time. The central triage could be charged with maintaining an accurate database of services and maintaining its accuracy.

Mind has the catchment-based planning function for Gippsland and one of its roles could be to monitor the service system as a whole in its effectiveness at increasing the access by CALD communities to services.

There are many examples of reaching into CALD communities by service providers recorded in this report alongside some excellent local efforts. The good work ought to be applauded and built upon and additional strategies trialled through collaborative projects with funding from DH or philanthropic sources.

Strategies for consideration to increase CALD community access to mental Health Community Support Services in Latrobe

Department of Health

Catchment based resource information and MHCSS promotion

Following community mental health support services recommissioning, Australian Community Support Organisation (ACSO), is in a good position to take responsibility for keeping resource information up to date on services relevant to people with mental health issues, their carers and families. This information could be available to the service network and be easily copied for clients as required.

Taking the opportunity of the new service system being implemented, promotion information on MHCSS in Latrobe could be made available in brochure or poster form in major community languages for wide distribution especially to local GPs and other primary health service outlets, Maternal and Child Health Centres (MCHC), schools and faith communities.

Service Delivery

CALD liaison officer or Cultural Advisor position

Many ideas from the respondents, the project group and the literature have a better chance of fruition if a resource is focused on the issue of CALD communities' access to MHCSS. A CALD liaison officer or Cultural Advisor position could be auspiced by GMS for an initial 12 month period to work between CALD communities, clinical, community and multicultural services in Latrobe. They could facilitate cultural competence training for MHCSS, link with CALD portfolio holders in services and link with CALD community leaders. The Cultural Advisor could explore the various ideas in this report that would help increase CALD community access to MHCSS.

Community Education

There are two focal points worth exploring: reaching out to particular CALD communities and targeting carers in order to increase CALD MHCSS access.

Community Education workshops provided by Latrobe Regional Hospital's Mental Health First Aid and the local adaption of the process developed by Mind in Narre Warren (originally targeting the Sudanese community).

Providing community education targeting CALD carers may be a way of both supporting carers and also reaching out to people from CALD backgrounds with a mental illness not currently accessing services through options such as LCHS Carer Respite Funding or Mind's fee for service four session program

System

Latrobe CALD Reference Group

In order to support the CALD liaison officer position a reference group representing CALD communities, clinical, community and multicultural services in Latrobe could be formed. There is already a good deal of support for services coming together to focus on CALD communities access to services as expressed in the focus group for services and interested persons during the project.

The reference group could be part of a broader engagement strategy with various CALD community leaders.

Some form of recompense to participating community leaders (honorariums or in kind) may need to be considered to recognise providing their time and expertise to the system.

CALD Community access to MHCSS as a standing agenda item

The Gippsland Mental Health Alliance through, its chair expressed a commitment to have CALD community access to services as a regular agenda item. Part of the action plan may be to develop a planned approach to ethnic media with stories, interviews and information on mental health concerns and services throughout 2014-15.

CALD access to MHCSS monitoring

Following Recommissioning, Mind Australia has responsibility for Catchment-Based Planning. As part of that responsibility it could focus on monitoring rates of access by CALD communities and feeding the results to the relevant stakeholders.

Further Areas for Exploration

Cultural Competence

For the system to work effectively for CALD communities, agencies need to be culturally competent. That commitment needs to be underpinned by:

- developments of cultural competence plans underpinned by an implementation plan for 2014-15
- utilisation of the Cultural Competency tool (adapted from the Gippsland HACC Cultural Competence tool) for review and action planning of their cultural competency plans
- budgeted commitment to cultural competence training for all staff
- prioritising CALD staff appointments and CALD student placements
- inclusion of a review of staff cultural competence within their staff appraisal frameworks, and
- Agency management reviewing their CALD case numbers at least six monthly in comparison to the Latrobe demographic profile.

As part of their cultural competence, agencies may need to consider alternate marketing of services to CALD communities in terms of appropriate language (i.e. “mental illness” vs “emotional wellbeing”), images in brochures and agency decoration (posters and paintings/murals) reflecting Latrobe’s cultural diversity.

The Department of Health can as part of the contract monitoring processes regularly monitor the achievement of the implementation plans.

Agency CALD portfolio holder positions

Some organisations have used a whole agency approach to CALD communities’ access to service consideration. Whilst that is a preferred approach, agencies could consider appointing a CALD portfolio holder in their organisation. The role has to have clear support from and reports to senior management, have a role in capacity building within each agency, be responsible for distributing relevant resource and training information on CALD issues, monitor the cultural competence action planning implementation six monthly and liaise with the Latrobe CALD liaison officer proposed previously.

Networking

Agencies could explore co-location of services as a strategy to increase access to MHCSS by CALD communities by association a less “stigmatised” service and improve case coordination between services.

Invitation of multicultural services into existing Mental Health networks would also strengthen the service system for CALD communities and increase understanding of issues by both sides.

In order to increase referrals by clinical services to MHCSS it is important that all MHCSS agencies ensure they participate in the S2S (Service to Service referral forwarding) and E shared case planning (PCP service coordination) systems. This would go some way of ensuring stronger links between clinical and acute services with MHCSS.

Given the nature of Latrobe City communities, there is a good opportunity for MHCSS to forge stronger links with GPs, Latrobe Settlement Committee, Latrobe Cultural Diversity Committee, LRH Primary Mental Health and Community Development as another way to ensure CALD community clients improve access to MHCSS.

Appendix 1. GANNT Chart

Activities	Feb-March				March-April				April to May			
	1 st week (Commen ced from	2 nd week	3 rd Week	4 th Week	5 th Week	6 th Week	7 ^{ht} Week	8 th Week	9 th Week	10 th Week	11 th Week	12 th Week
Background and Literature Search	■	■										
Prepare Draft Concept Paper		■	■									
Prepare Questionnaire		■	■	■								
Finalize Questionnaire					■							
Take Interview CALD communities						■						
Take Interview of Agencies						■						
Report Preparation										■		

Appendix 2. Consent form

Project title: Access to Mental Health Services by CALD Communities

Conducting Agency: Gippsland Multicultural Services

Contacting person: Lisa Sinha, Director, Gippsland Multicultural Services, tell: 51337072, email: lisa@gmsinfo.com.au

You are invited to take part in a study on the present situation of culturally and Linguistically Diverse communities in terms of identifying the mental health services and your understanding on mental health issues. This study is a part of collaborative project with Mind Australia funded by Department of health in Latrobe City. This study will help to understand to determine the need and required actions to be taken for serving the best interests CALD Communities in the field of mental health services.

What you will be asked to do: You will be requested to respond to a semi structure closed ended questionnaire to the best of your knowledge, experience and skills.

Risks and benefits: There are no anticipated risks to you if you participate in this survey, beyond those encountered in everyday life. Your contribution will assist service provider in determining the strategic approach to take towards the implementation of mental health services that will ultimately contribute to CALD communities well being.

Taking part is voluntary: Taking part in this study is voluntary. If you choose to be in the survey you can withdraw at any time without consequences of any kind.

Your answers will be confidential: The records of this study will be kept private. Any report of this study that is made available to the public will not include your name or any other individual information by which you could be identified.

If you have questions or want a copy or summary of the study findings: Contact Gippsland Multicultural Services at the email address or phone number above. You will be given a copy of this form to keep for your records. If you have any questions about whether you have been treated in an illegal or unethical way, contact Gippsland Multicultural Services.

Statement of Consent: I have read the above information, and have received answers to any questions. I consent to take part in the study.

Signature: _____

Appendix 3. Questionnaire for accessing barriers to Mental Health Services (Part One- CALD Communities)

Section One: Basic Information

- a. ID number:
 - b. Name of Respondent:
 - c. Date of Birth of respondent:
 - d. Profession:
 - e. Country of Origin:
 - f. Address of Residence:
-
1. When you migrated in Australia?
 2. How long you have been living in your present residential address.
 3. What Language do you speak at home?
 4. In your opinion, how many families from your community may be living in Latrobe City?
 5. What usually you do when you and/or your family members are sick or ill or having any medical emergency?
 6. In your opinion, What your community members usually do when they are having any medical issues?
 7. Have you heard of “mental illness or stress”?
 8. What do you understand by the word “mental illness or stress”?
 9. In your opinion or to the best of your knowledge have you ever heard of any one from your community has been suffering from mental illness or stress in last one year?
 10. Do you know anyone from your community has suffered or suffering from any sort of mental illness?
 11. Do you know which organizations are available to support you if you have any issue with your mental health or family well-being?
 12. In opinion, what possible steps may be taken by any of your community members when they encounter any mental health issues?

13. If you think that, anyone from your family members is suffering or has had any mental health issue then what would you do?
14. In your opinion, do you think there is a stigma associate with mental health in your community?
15. Do you feel comfortable when you hear that anyone is suffering from mental illness either in your family or in your community?
16. In your opinion, what may the barriers or obstacles to speak about mental health in your family or communities?
17. In your opinion, Do you think there is a strong barrier for a family from your community if they want to have access to any mental health service?
18. Have you ever heard of "MIND AUSTRALIA"?
19. Do you have any idea, Does any one from your community knows who to seek support you if you need a service for any mental health issues?

Appendix 4. Questionnaire for accessing barriers to Mental Health Services (Part TWO- CALD Organizations)

Section One: Basic Information

- a. ID number:
- b. Name of Organization:
- c. Name of Respondent:
- d. Position of Respondent:
- e. Length of service in current position:

1. What sorts of services does your organization provide?
2. Who are your prime/target service recipients?
3. Do you provide any specific services to CALD communities?
4. In your opinion are you aware of any services being targeted towards CALD communities?
5. Do your organization or according to your knowledge provide any mental health related services to CALD communities?
6. If your organization has experience to work CALD background population what is your general perception on services available for them? (prompt for service gap, barriers, challenges with regards to health or any mental health issues)
7. What is your opinion the common health/mental health issues suffered by CALD communities?
8. Are you aware of any agencies that provide mental health services specifically for CALD background populations?
9. What you recommend for better health/mental health services towards CALD communities or any comments/suggestion you would like to put forward?

Appendix 5. Semi structured interview for agencies and interested persons and groups

Date

Name

Role

Organisation

Contact details

1. Services provided (mental health related? Specific to CALD community?)
2. Can you tell me of any agencies that provide mental health services specifically for the CALD community?
3. Can you tell me of any service providers specifically for the CALD community in Latrobe City?
4. Have you any experiences, opinions and observations of the services provided for the CALD community in Latrobe City. (E.g. gaps, barriers, challenges)
5. What works, what does not work? (engagement strategies to increase awareness of mental illness and resources)
6. Do you have any ideas and/or strategies, for the community mental health services, to be more open/ accessible and acceptable to the CALD community in Latrobe City? (opening services pathways)
7. In your experience or opinion, what are the common mental health issues experienced by CALD communities?
8. Have you observed any attitude/views of the CALD community towards mental illness/health?
9. Who else should we talk to?

Appendix 6. List of respondents and focus group participants

ORGANISATIONS GROUPS AND INTERESTED INDIVIDUALS	
Disability Services	Centrelink
Coordinator W Tipping Foundation-Morwell	Multicultural service manager
Headway Gippsland-Moe	Victoria Police
	Victoria Police Community Outreach
Education and Training	Latrobe Regional Hospital Mental Health Services
Morwell Neighbourhood House	General Acute Bed Based Services- Mental Health S
Traralgon Neighbourhood House	Clinician, Forensic Specialist
Churchill Neighbourhood House	Manager, Primary MH and Community Development
Gippsland Employment Skills Training	Other Community Based Mental Health Services
Multicultural Services	CEO Headspace
Centre for Multicultural Youth	Senior Youth Worker Headspace
Berry Street- Unaccompanied Minors	
Faith Communities	PDRSS/MHCSS
Catholic Church Traralgon	CEO SNAP
Anglican Priest	Coordinator MIF Warragul
St Vinnie's Store Manager Traralgon	MIND Manager
President St Vincent de Paul Society- Traralgon Conference	CALD Community
Lavalla Catholic Secondary College Careers teacher	Bosnia
Latrobe City Council	Filipino
Coordinator Community Strengthening	Nigeria
Chairperson Gippsland Ethnic Communities Council	Russia
Latrobe Community Health Services	South Sudan Dinka
Manager Respite Services -LCHS	South Sudan Nuer
Clinical Lead-MHCSS Central Intake Pilot	Other
Refugee Nurse- LCHS	Community Liaison officer at Relationship Australia
Latrobe Settlement Grants Program- LCHS	Gippsland Centre Against Sexual Assault
Coordinator Creative House	Foundation House

CALD community representatives

Country of Birth	Gender	Age
South Sudan Dinka	Male	41
South Sudan Nuer	Male	32
Sudan Nuer	Female	52
South Africa	Female	63 Years
Russia	Female	60
Philippines	Female	56
Nigeria	Male	49
Italy	Female	58
China	Female	16
Bangladesh	Female	28
Bosnia	Female	30
Australia	Female	43

Participants in the services and interested persons focus group 16.5.14

Gippsland Multicultural Service CEO	Traralgon Neighbourhood House
Latrobe Regional Hospital	Student on placement (GMS)
Chairperson Gippsland Ethnic Communities Council	Area Manager Mind Australia-Gippsland
Latrobe City Council	Service Development Manager Mind Australia
LCHS- refugee nurse	Research Worker Mind Australia
LCHS – Latrobe Settlement Grants Program	There were in addition nine apologies.

Appendix 7. Resource listing for Latrobe

Gippsland Multicultural Services

Gippsland Multicultural Services Inc. is a community based organisation, assisting migrants and refugees in Gippsland through the provision of a range of services and programs that support the settlement and ongoing participation of our diverse communities in the Gippsland region.

We also provide a range of services to the wider community and service sector, including resources and training, and other services. Gippsland Multicultural Services now plays a major role in supporting our ageing CALD community members, both through the direct provision of a range of services, and also through assisting other aged service providers to better meet their needs.

100 - 102 Buckley Street Morwell Victoria 3840 Australia

Phone 03 5133 7072

Fax 03 5134 1031

<http://gmsinfo.com.au>

Centre for Multicultural Youth

The Centre for Multicultural Youth (CMY) provides services to and advocates for the needs of young people from migrant and refugee backgrounds.

c/- Anglicare Victoria,

65 Church Street,

Morwell VIC 3840

T (03) 5133 9998

F (03) 5133 9601

Gippsland Ethnic Communities Council

The GECC is a volunteer based non-profit organisation. Our volunteer members represent different ethnic groups in the community.

The aim of the Gippsland Ethnic communities' Council is to encourage understanding, develop goodwill and promote harmony within our culturally diverse community.

Contact Name: Dr Graham Dettrick or Dr Christine Lee

Chairperson GECC or Deputy Chairperson GECC

Postal Address:

PO Box 3492

Gippsland Mail Centre,

Victoria, 3841

Telephone: 03 51262091 (Chairperson)

Telephone 2: 03 51226714 (Deputy Chairperson)

Website: www.gippslandethniccommunitiescouncil.websyte.com.au

Main Website: <http://mc2.vicnet.net.au/home/gecc/web/index.html>

Berry Street- Unaccompanied Minors

Unaccompanied Minors Program After some months of negotiations, Berry Street has contracted with the Red Cross and the Department of Immigration and Citizenship to provide accommodation and care for a cohort of young people, all aged under 18 from the Christmas Island detention centre. The young people will be housed in what is known as "community detention" in houses in the community with 24 hour supervision and support. Housing has been established and staff have been appointed in Gippsland which will be

trialling this new program for Berry Street. Staff will include a team leader, 24 hour rostered support staff and case managers.

Morwell Office

37 Elgin Street
Morwell VIC 3840
t: 03 5134 5971
f: 03 5134 6673
e: morwell@berrystreet.org.au

Headspace

Headspace is the National Youth Mental Health Foundation. We help young people who are going through a tough time.

Headspace can help you with:

- General health
- Mental health and counselling
- Education, employment and other services
- Alcohol and other drug services.

99 Buckley Street
Morwell VIC 3840
Phone (03) 5136 8300
Fax (03) 5136 8333

Opening hours
Monday to Friday
9:00 am - 5:00 pm

emailheadspacecwg@gml.org.au

facebook<https://www.facebook.com/headspacecwg>

SNAP

SNAP Gippsland delivers psychosocial rehabilitation, recovery services and educative programs to adults with a severe and persistent mental illness, their families and carers. Our programs and services support individuals to self-manage, live well with their symptoms and participate as full citizens in their communities.

Contact Details

Head Office

265 Main Street
PO Box 635
Bairnsdale Vic 3875
Phone (03) 5153 1823
Fax (03)51526345
Email: emailbairnsdale@snap.org.au

Correspondence to: P.O. Box 635, Bairnsdale, 3875

Sale

Phone (03) 5143 0110
Fax (03) 5144 5749
Email: emailsale@snap.org.au
Correspondence to: PO Box 635 Bairnsdale 3875

Leongatha

3 Church Street
PO Box 272
Leongatha, Vic. 3953
Phone (03) 5662 5188

Fax (03) 5662 5288
Email: emailleongatha@snap.org.au
Correspondence to: P.O. Box 272, Leongatha, Vic. 3953
Gippsland Prevention and Recovery Care (PARC) service
Bairnsdale
Phone: (03) 5152 1233
Fax: (03) 5152 4544
Email: emailparc@snap.org.au
Correspondence to: P.O. Box 635, Bairnsdale, 3875

Mental Illness Fellowship

Mental Illness Fellowship Victoria is a member-based, not-for-profit organisation that works with individuals and families whose lives are affected by mental illness.

Our programs support people to bring about positive changes in their lives in the areas of employment and education, finding and keeping a home, improving physical and mental wellbeing, and strengthening relationships with friends, family and the community.

Our model of support brings together evidence from research with understanding of people's lived experience of mental illness. We work in partnership with people to assist them to identify their own needs and goals, and to support them along their individual pathways to recovery.

Our organisation was established in 1978 by families wanting to improve the services and information available to people affected by mental illness. Today Mental Illness Fellowship Victoria is one of Australia's leading mental health community support agencies, providing services to around 5,000 people a year, and reaching many more through advocacy and community education activities.

We deliver programs across metropolitan and regional Victoria, and in the Australian Capital Territory (ACT).

We aim to ensure that our services are culturally sensitive, meeting the diverse needs within our community. We recognise that people's cultural backgrounds, religious beliefs, gender and sexual identity can have an important part to play in their mental health.

Contact Details

Family Services & Day Programs
(03) 5622 4100
78 Albert Rd
Warragul VIC 3820

MIND

Mind Gippsland

1 Hoyle St
Morwell
Victoria 3840

Personalised Support Services

Mind Australia works to support people in their personal recovery from mental ill-health.

Some of the areas that people need help in could be:

- Managing the effects of mental ill-health
- Improving physical health
- Finding and/or keeping a job, or returning to education
- Building new friendships, and joining local activities
- Developing living skills such as cooking or managing money
- Addressing drug and alcohol use
- Finding suitable housing

The type and extent of services offered to an individual varies, depending on what they need and what else is available in the local community.

For further information contact Community Services Morwell on 03 5100 1000 or email info@mindaustralia.org.au

Residential Rehabilitation Services

Mind Australia's Residential Rehabilitation Services offer residential environments for people aged between 16 and 65 who have a mental health problem and need additional support. The residential experience enables people to work on their personal recovery and optimise their capacity to live independently in the community.

The following services are provided in your area:

- Residential Service Wannik Gunyah, Traralgon on (03) 5176 1800

For further information on these services email Mind on info@mindaustralia.org.au

Family & Carer Services

Mind Australia recognises the importance of families in the lives of many of our clients. We provide support to families that include a person with mental health issues.

For further information contact Community Services Morwell on (03) 5100 1000 or email info@mindaustralia.org.au

Group Support Services

Group Support Services provide opportunities for involvement activities in the general community. Groups are a place where clients can meet other people, develop friendships, give and receive peer support and learn new skills. Contact Mind's service centre, to get information about group support services and where they are run.

For further information contact Community Services Morwell on (03) 5100 1000 or email info@mindaustralia.org.au

Latrobe Regional Hospital

LRH is a purpose-built, 261-bed teaching hospital offering a suite of medical services from its Traralgon West location. Catering for a population of more than 240,000, the hospital treats close to 115,000 people every year, more than a quarter of them in our busy Emergency Department.

The hospital provides services in the areas of aged care, cancer care, elective surgery, maternity, rehabilitation and mental health. It runs eight community mental health centres across Gippsland and a Community Residential Care Unit for people with prolonged severe mental illness and associated disability.

Princes Highway,

Traralgon West,

Victoria, 3844

PO Box 424,

Traralgon,

Victoria, 3844

Telephone: 03 5173 8000

Fax: 03 5173 8444

Latrobe Valley Community Mental Health Service

Contact details: 20 Washington Street

PO Box 424

Traralgon Victoria 3844

Telephone 03 5128 0100

Facsimile 03 5128 0099

Mental Health Court Liaison Service

Moe Magistrates Court
First Floor, 53 Lloyd Street
PO Box 87
Moe Victoria 3825
Telephone 03 5127 4888
Facsimile 03 5127 8780

W Tipping Foundation

Improving quality of life for people with a disability, families, children, youth and older people across Victoria has been a priority for the EW Tipping Foundation for more than 40 years. The services we offer are specifically designed to assist Victorians in achieving greater independence while encouraging inclusivity and respect for the rights of all.

The Foundation offers a range of services through our subsidiaries HomeChoices, Vista Support and ReNew Services. While we operate offices throughout Victoria, not all services are available in all areas.

58-60 Commercial Road
Morwell VIC 3840
Tel: (03) 5135 4300
Fax: (03) 5135 4399

Headway Gippsland Inc.

Headway Gippsland Inc. is a community based support organisation for people with acquired brain injury (ABI) and their families.

Headway Gippsland provides support and information to people with ABI and families/carers.

Headway Gippsland works closely with other service providers, Governments and the media in ensuring the needs of our membership are heard and acted upon.

MAIN OFFICE

Chief Executive Officer: Marilyn Alborough
Email: m.alborough@headwaygippsland.org.au
Administration Manager: Dianne Mumford
Email: dmumford@headwaygippsland.org.au
ISP manager: Donna Walker
Email: dwalker@headwaygippsland.org.au

Office address

Shop 2, 55 Lloyd Street, Moe 3825
Phone: (03) 5127 7166
Fax: (03) 5127 2880
Toll Free: 1800 452 452

Open Monday to Friday 9am -5pm

POSTAL ADDRESS

P.O. Box 117, MOE VIC. 3825

EMAIL

hwABI@bigpond.net.au

WEBSITE

www.headwaygippsland.org.au

Relationship Australia

Relationships Australia is a leading provider of relationship support services for individuals, families and communities. We aim to support all people in Australia to achieve positive and respectful relationships.

We are a community-based, not-for-profit Australian organisation with no religious affiliations. Our services are for all members of the community, regardless of religious belief, age, gender, sexual orientation, lifestyle choice, cultural background or economic circumstances.

We offer services around the country that include counselling, family dispute resolution (mediation) and a range of family and community support and education programs.

Address: 1/42 Kay St, Traralgon VIC 3844

Phone : (03) 5174 1100

Hours Open 9:00 am - 4:00 pm

Morwell Neighbourhood House

48 – 50 Beattie Crescent, Morwell

(03) 5134-5488.

Traralgon Neighbourhood Learning House

Our Vision

The Traralgon Neighbourhood Learning House will provide a caring and supportive atmosphere where people in our community are encouraged to participate and learn.

Our Mission

Acknowledge and respond to community needs through the planning and development of programs in vocational, life skills and recreation areas; encourage the sharing of skills, knowledge and resources; provide personal support and information.

We Value

Teamwork – Respect – Honesty – Participation – Confidentiality – Individuality – Equality – Creativity – Tolerance – Humour

Our Staff

Our Office is staffed by 3 gorgeous girls,

- Jenny Poon - Co-ordinator
- Julie Callahan – Adult Education Officer
- Lynda Van Rossum – Receptionist

Kath Teychenne Centre

11 - 13 Breed Street, Traralgon Victoria 3844

Telephone: 03 5174 6199

Email: tnh@wideband.net.au

Churchill Neighbourhood Centre

The Churchill Neighbourhood Centre is a solely community based not for profit organization that, since 1981 has strived to meet the needs of the ever changing structure of the Churchill community.

Coordinator Henry Parniak

Board of Governance

Email: churchillncboardofgovernance@gmail.com

Phone: 5122 2955

Located Inside Churchill & District Community Hub

Office Hours

Mon - Fri 9.00am - 3.30pm

9 - 11 Phillip Parade

Phone 5122 2955

Email: churchillnc@bigpond.com

Gippsland Employment Skills Training

GEST is a registered training organisation accredited by the Victorian Registrations Qualification Authority to provide a wide variety of training from foundation level to skills deepening level.

GEST has highly qualified trainers and a career counselor all committed to work one-on-one with our clients to help them achieve their goals.

For more than 12 years GEST developed, coordinated and managed work experience programs for unemployed job seekers across Gippsland.

GEST is a major propagator and supplier to industry of native plants indigenous to Gippsland for regeneration and revegetation projects. A wide range of flowering natives is available for Landscapers and the general public.

After winning an "Innovation in ACE Learning" Award, GEST was successful in gaining a second CLP Grant. This involved new partners and a new retail outlet at 50 Della Torre Rd, Moe, selling vintage and retro goods.

Dept. of Employment, Education & workplace relations ph. 0419 516 460

GEST Moe

7 Anzac Street

Moe Vic 3825

Ph (03) 5127 4544

F (03) 5127 4693

E frontdesk@gest.com.au

Hours of Operation – Monday to Friday: 8:30am – 5:00pm.

RRR Emporium

50 Della Torre Road

Moe Vic 3825

M 0409 175 574

Ph (03) 5127 4544

F (03) 51 274693

E noreen@gest.com.au

Hours of Operation -Tuesday and Wednesday: 9:00am – 3:00pm

Catholic Church Traralgon

Groups for young parents

PARISH OFFICE 0351 742060

PARISH FAX 0351742981

PARISH EMAIL: st.michaels.traralg@bigpond.com

St Vinnie's Store Traralgon

Quality second hand goods

43 Kay Street, Traralgon VIC 3844

Contact Details

Telephone,(03) 5174 4026

Email traralgon.centre@sudp-vic.org.au

Catholic Diocese of Sale

Migrant Chaplain (Italian)

Sr Elizabeth Roberts MFIC

16 Wilson St,

Morwell.
Phone: 5134 2964
Email: eroberts@mficaust.org.au

Lavalla Catholic Secondary College

Lavalla Catholic College is proud of its provision of a Catholic Education that meets all the needs of the students and families in the Latrobe Valley. Through its network of three Campuses the College has innovative programs across all levels of the school that have been designed to engage students, build self-esteem and provide learning experiences that are fun and inspiring as well as relevant and rigorous.

Administration:

Coster Circle TRARALGON

Ph. (03) 5174 5272

Kildare Campus

Year 10-12:

Kosciuszko Street TRARALGON

Ph. (03) 5174 8111

St. Paul's Campus

Year 7-9:

Grey Street TRARALGON

Ph. (03) 5174 7355

Latrobe Community Health Services

81-87 Buckley Street

PO Box 960

Morwell

Victoria

3840

Phone. 1800 242 696.

Settlement Grants Program and Vulnerable Group Assistance Program - Casework and Referral

The Settlement Grants Program (SGP) is funded through the Department of Social Services to help new arrivals settle in Australia.

The Vulnerable Group Assistance Program is funded through the Department of Families, Housing, Community Services and Indigenous Affairs.

The Caseworker provides casework and referral services to all eligible clients. The Caseworker supports individual clients and families to overcome the challenges that they face in settling into Australia by providing them with information about Australia's systems, assisting them to access mainstream services, acquiring skills for everyday living and helping to build their capacity to independently solve problems when they arise.

The Settlement Grants Program

The Settlement Grants Program (SGP) Community Coordination and Development is funded through the Department of Social Services to help new arrivals settle in Australia.

The Program aims to successfully integrate eligible clients into the broader Australian community ensuring they are able to access and navigate mainstream services and achieve independence.

Refugee Health Nurse

The Refugee Health Nurse aims to increase the refugee access to primary health services by providing culturally appropriate services.

The RHN-

- Provides initial health and social needs assessments

- Facilitates and co-ordinates clients health care services e.g. General Practitioners, Community Dental Clinic, Hospitals, LCHS Counselling and Support Services and Allied health care services
- Provides health education and information to newly arrived refugees, individually or groups
- Resource for refugee health issues

Creative House

Creative House is a Psychiatric Disability Rehabilitation Support Service and is located at 49 Hyde Park Rd, Traralgon within a residential setting. Creative House has three permanent staff on-site comprising of a Coordinator and two Program Support Workers. Currently three volunteers are actively participating at Creative House. The program is supervised by the Manager Respite Services who is located at Buckley Street, Morwell.

Centrelink

Cnr Chapel Street & Elgin Street
 Morwell VIC 3840
 Postal Address
 PO Box 7800 Canberra BC ACT 2610

Vic Police Community Outreach

Multicultural Liaisons Officer Program

Victoria Police maintains a network of Multicultural Liaison Officers (MLO) based in a range of metropolitan and regional areas. These officers are responsible for:

- Assisting police with information and advice on policing diverse communities.
- Enabling culturally and faith diverse communities' access to Victoria Police services.
- Providing new and emerging communities with information on Victorian legislation and on the role of police in Victoria.

Community Engagement Support Team

Victoria Police Centre
 637 Flinders Street
 DOCKLANDS VIC 3008
 Phone: (03) 9247 5243 or 9247 5280
 Fax: (03) 9247 6963
 Email: multicultural.advisory.office@police.vic.gov.au

Gippsland Centre Against Sexual Assault

The Gippsland Centre Against Sexual Assault provides services within the Gippsland Region of Victoria to children and adults, both female and male, who have been sexually assaulted. The Centre also works with non-offending family members, partners, caregivers and support workers.

PO Box 1124, Morwell, 3840
 Phone: 03 5134 3922