PATHWAYS TO BETTER MENTAL HEALTH

Overcoming barriers, exploring reform, creating constructive solutions
AUSTRALIAN MOSAIC

The magazine of the Federation of Ethnic Communities’ Councils of Australia (FECCA)

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CONTENTS

04 A MESSAGE FROM THE FECCA CHAIR
   Joseph Caputo OAM JP

06 A MESSAGE FROM THE FECCA DIRECTOR
   Gulnara Abbasova

08 FRAMEWORK FOR MENTAL HEALTH IN MULTICULTURAL AUSTRALIA – TOWARDS CULTURALLY INCLUSIVE SERVICE DELIVERY
   Hamza Vayani

11 MENTAL HEALTH, PEOPLE FROM CALD BACKGROUNDS AND THE NDIS
   The Hon Susan Ryan AO

14 CONTRIBUTING LIVES, THRIVING COMMUNITIES
   David Butt

17 TRANSCULTURAL MENTAL HEALTH SERVICES IN MULTICULTURAL AUSTRALIA

20 ESTABLISHING A MENTAL HEALTH SERVICE IN A REMOTE ABORIGINAL COMMUNITY
   Arthur Papakotsias

23 DRAMA QUEENS: LGBT MENTAL HEALTH
   Monique Hameed

26 MENTAL HEALTH STIGMA – INFLUENCING HELP SEEKING BEHAVIOUR IN CALD COMMUNITIES
   Penny Antonopoulos

30 THE CASE FOR SPECIALIST MENTAL HEALTH SERVICES FOR REFUGEE SURVIVORS OF TORTURE AND TRAUMA
   Forum of Australian Services for Survivors of Torture and Trauma

33 MEDICAL PLURALISM: SUPPORTING CO-EXISTING DIVERSE THERAPEUTIC TRADITIONS IN MENTAL HEALTH
   Dr Ruth De Souza

37 BUILDING RESILIENCE IN TRANSCULTURAL AUSTRALIANS – THE BRITA FUTURES PROGRAM
   Elvia E. Ramirez

41 MENTAL HEALTH REFORM, PRIMARY HEALTH CARE NETWORKS AND THE CALD COMMUNITY
   Sebastian Rosenberg

44 CONNECTING CULTURE AND CARE: REACHING OUT TO VULNERABLE CALD COMMUNITIES
   Tea Dietterich

47 JOURNEY TO RECOVERY
   Vicki Katsifis

50 LIVING WITH MENTAL ILLNESS IN A MULTICULTURAL COUNTRY
   Lily Wu

51 ‘HAVE A LEMON, MAKE LEMONADE’: IN SUPPORTING MENTAL HEALTH RECOVERY
   Nevena Simic

52 HOW WORKING WITH NCCCCWG HAS HELPED ME AS A MULTICULTURAL MENTAL HEALTH CARER ADVOCATE
   Angela Rao

53 THE IMPORTANCE OF ADVOCACY FOR PEOPLE WITH MENTAL HEALTH ISSUES FROM CALD BackgroundS
   Sonia Di Mezza
Welcome to the 2015 spring edition of our Australian Mosaic magazine. This edition focuses on mental health in diverse communities.

We have partnered with Mental Health in Multicultural Australia (MHiMA) — a project funded by the Australian Government Department of Health. MHiMA aims to provide a national focus for advice and support to providers and governments on mental health and suicide prevention for people from culturally and linguistically diverse (CALD) backgrounds.

I would also like to extend my thanks to Mental Health Australia (MHA) that has recently taken on the MHiMA project. Mental Health Australia is the peak, national body representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all. We look forward to MHA’s engagement with the multicultural sector and working with them on tackling mental health issues in CALD communities.

With the significant proportion of Australia’s population born overseas, it is crucial that there are services and programs specifically tailored to meet the mental health needs of our culturally and linguistically diverse communities. Research in Australia indicates that people from CALD backgrounds have greater risk of mental illness than people from non-CALD backgrounds (particularly in older age groups), and are also less likely to seek help. Organisations and projects such as MHiMA are working to fill the gaps in research, programs and services for CALD Australians.
There is also a number of barriers for some CALD people with regards to seeking help for mental health issues. For many migrant groups, there is strong stigma attached to having a mental health issue. This, in turn, can lead to an individual denying that a mental health issue exists, and subsequent delays in diagnosis and assistance. Some CALD people may not understand the gravity of a mental health issue and that there are varying degrees of mental health illnesses.

Many CALD people may be unaware of services that are available, such as counselling or therapy. Even when CALD people are aware of services, and seek help, there may not be culturally appropriate information and services offered. There may be fear of being misunderstood by mental health providers (such as counsellors or therapists) due to professionals being unaware of cultural norms and values. Further, there are assumptions around the cost of such services, which may preclude people from culturally diverse backgrounds from accessing such services.

Some people may feel that their employment may be at risk if they are known to be seeking help for mental health problems, or that finding a job in the first place will be harder. Experiences of trauma as part of the migration experience and/or time spent in detention centres may contribute to the higher risk of mental health issues in our CALD communities. We are particularly concerned about the higher risk of suicide for these population groups.

At FECCA, we are committed to working with the Australian Government, members, stakeholders and the community to support better health, including mental health, in CALD communities. We believe educating communities about the importance of early intervention, to prevent further harm or progression of an illness, is essential. We need to ensure that communities know about services, their accessibility and costs, as well as availability of language services to support CALD people when they are at risk of, or facing, a mental health issue.

I hope that the range of articles comprising this edition helps our readers better understand the complexities of mental health, cultural barriers for seeking assistance, and ways that our communities can learn more to help their members. My thanks to MHIMA for partnering with us on this important edition.
A MESSAGE FROM THE FECCA DIRECTOR

One of the strongest themes coming from the articles in this edition dedicated to mental health in multicultural Australia is the importance of partnerships; of working together to achieve great outcomes.

Our partner in this edition of Australian Mosaic is Mental Health in Multicultural Australia (MHiMA). Hamza Vayani, the National Project Manager, discusses in his article the Framework for Mental Health in Multicultural Australia and the three integrated components organisations use while working with the Framework. Hamza notes that the Framework helps providers to see how culturally responsive they are, and he also considers future possibilities for the Framework.

The Disability Discrimination Commissioner, and Age Discrimination Commissioner, the Hon Susan Ryan AO, considers the importance of supporting CALD people with disability appropriately and ensuring their dignity. We have addressed barriers for CALD people in these pages before; Susan focuses on the potential extra barriers CALD people with psychosocial disability may face, such as possibly only being able to live in an institution with limited access to advocacy and support services. This would limit their freedom to make choices.

David Butt, the CEO of the National Mental Health Commission, writes of the findings in relation to CALD people in the Commission’s review into mental health services in 2014. It is encouraging to read that the Commission found a high degree of consensus about the way they were heading with the system, and including major stakeholders such as MHiMA and the Federation of Ethnic Communities’ Councils of Australia (FECCA) in the development of system changes to promote good mental health and wellbeing.

Transcultural Mental Health Services (TMHS) have provided mental health service delivery for over 20 years, in four states. This article ties together the information from MHiMA and the National Mental Health Commission, particularly reflecting on the potential in mental health service delivery reforms, and the important role that TMHS plays, especially for CALD communities.

I hope you will enjoy the article from Arthur Papakotsias, the CEO of Neami National. Arthur tells of a partnership with Neami National and the Sunshine Health Service Aboriginal Corporation, working together in the region east of Katherine, NT, using a mix of traditional Indigenous culture and mainstream medicine. A joint project based in Ngukurr required staff to work with huge diversity; 7 language groups and 50 family groups in a very remote community, which has few services, and particularly lacking in specialist mental health support services. You will sense Arthur’s pride in the partnership and how everyone involved learned from each other working in this collaboration.
Also facing challenges in discussing and dealing with mental health issues are young CALD LGBTI women, and the reflections from the Multicultural Centre for Women’s Health illustrate the success of a project called Our Voices, Changing Cultures. Using storytelling approaches and theatre techniques to cover topics, including the role of culture and wellbeing, provided a safe place for women in the project to talk openly about their mental health. The development of this small community provides hope for empowering the young women participating.

Penny Antonopoulos writes about the impact of help seeking behaviours of CALD people with mental illness and their families and carers, and identifies the barriers to accessing mental health services. Again, there is a focus on the importance of partnerships and how individual cultures must be appreciated and understood by people delivering mental health and other services.

It is estimated that about 45,000 people who are survivors of torture and trauma have settled in Australia over the last decade. The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) provide a response to the needs of refugee survivors of torture and trauma. The article makes a case for a specialist service response for people of refugee backgrounds as they are more likely to have trauma related mental health issues than other migrant populations or the general population. FASSTT is a network of eight not for profit agencies which provide this specialist care.

Dr Ruth De Souza has provided us with a fascinating insight into the importance of understanding the cultural context when treating mental illness. The strong message from Ruth is that there is no single way to do anything and no one has all the knowledge; we must work together.

Elvia Ramirez provides information about the BRITA Futures program, a group program designed to build resilience of CALD people in different age groups to help them more effectively deal with acculturation. Currently the program is mostly provided in Queensland, and Elvia reports that other States are interested in developing similar approaches.

Sebastian Rosenberg considers the possible reforms in mental health in Australia and how Primary Healthcare Networks (PHNs) should provide a ‘community mental health service’ which he sees as a gap in mental health service provision to date. Sebastian argues that PHNs are best placed to push for investment in properly researching, understanding, planning, delivering and evaluating multicultural mental health care in Australia.

We often hear a cry for quality interpreting and translating services for CALD people in Australia. Tea Deatrich of 2M language services agrees but adds other components that are important to consider — including that sometimes it is not necessary to translate everything. Sometimes it is appropriate to keep an English word or phrase in translated materials — and materials for mental health services must be framed in the right way.

The South Eastern Sydney Recovery College reported by Vicki Katsifis provides a new approach to mental health education. Vicki, who works as a peer educator, advises that some courses are provided in several community languages, and she hopes to see the Recovery College model all around Australia in the future.

We have been able to include a couple of consumer articles in this edition: Nevena Simic shares her own mental health journey to demonstrate how it has made her a more sympathetic social worker and culturally sensitive psychotherapist. Lily Wu tells us of her own recovery from mental illness and her current role in mental health work, with her greatest passion being about employment and educational programs for people living with mental illness.

Finally we have a couple of articles from two women who work with MHIMA, in different ways.

To Hamza and his team, our thanks for your collaboration on this informative edition about mental health and wellbeing, and for continuing to illustrate how important partnerships are to FECCA.
Hamza Vayani is national project manager for Mental Health in Multicultural Australia (MHIMA), which is an Australian government Department of Health funded project. Hamza is passionate about matters of health service access and equity in an ever increasingly multicultural Australia; that is part of an increasingly interconnected and globalised world. A central tenet of facilitating a cohesive, productive and engaged multicultural society is supporting the mental health and wellbeing of all Australians in a holistic way so that everyone can be the best they can be at ‘having a go’. It’s this spirit of ‘having a go’ that has kept Hamza feeling motivated, humbled and privileged to work with people from across a range of backgrounds both in Australia and from his home country of the UK where he served as a Commissioner on the Commission for Integration & Cohesion.

The Framework for Mental Health in Multicultural Australia was launched in April 2014. The Framework can be accessed at www.mhima.org.au/framework. It is an online practical resource that can be used by mental health services and workers across the continuum of care to evaluate and improve cultural responsiveness in delivery of mental health services for people of culturally and linguistically diverse backgrounds.

The Framework is aligned with current policies, plans and standards relevant to multicultural mental health and it is cross-referenced to the relevant standards and accreditation requirements. This approach means that the Framework can be integrated into ongoing organisational quality improvement initiatives and integrated into the continued professional development of mental health workers.
For organisations that use the Framework there are three integrated components which are outlined in an Introductory Guide. They are as follows:

The first component of the Framework involves completion of the Organisational Cultural Responsiveness Assessment Scale (OCRAS) with the involvement of a working group generally led by clinical governance or the leadership team of an organisation. The OCRAS is based on the National Cultural Competency Tool and National Mental Health Standards (2010). Completion of the OCRAS allows an organisation to collate evidence of what processes it has in place to be more culturally responsive and to identify gaps of what services can do better.

The second component of the Framework involves reviewing the OCRAS scores through a working group that involves clinical governance or the leadership team in an organisation working with staff to review the findings. Review of the OCRAS scores forms the basis for developing an action plan with agreed time bound actions to focus on two to three key priorities over a 12 month period. The scores generated are at three levels which are Entry, Developing or Advanced.

The third component of the Framework involves being able to access a range of supporting resources and information which can be used to inform the development of the action plan. Supporting resources and information include the Organisational Implementation Plan which includes various strategies and good practice examples that are provided at Entry, Developing or Advanced levels. Services can then set their actions to the level they are seeking to achieve in any given period. In addition there are 5 key concept sheets which include the theoretical underpinnings that form the basis of multicultural mental health.

The development of the Framework commenced in 2012 and concluded 18 months later. During the consultation phase the Framework was informed by literature, current mental health policy, transcultural mental health expertise and the involvement of consumers and carers from the MHIMA National Consumer & Carer Working Groups with a workshop to finalise content held at the National Mental Health Commission.

The Framework was piloted across a number of mental health settings including an NGO organisation, a torture and trauma service, forensic mental health, acute inpatient and forensic mental health settings. It has since been rolled out at sites in New South Wales, Victoria, Queensland, South Australia and Western Australia. More recently there has been interest from one of the newly formed Primary Health Networks in using the Framework to guide the way they commission and coordinate mental health services to meet the needs of people from CALD backgrounds.

The early feedback on the Framework is that it has consistently enabled organisations to get a handle on how culturally responsive they are. It has got organisations to become practical in their focus to improving frontline care. For instance some services are reviewing their admissions forms to ensure CALD demographics are collected so that services can monitor levels of service access. It has got some services to revise and think through their use of interpreters as soon as possible after admission. In hospital settings services are thinking through discharge planning arrangements with community care providers that are working towards being more culturally responsive in their approach.
The Framework has also been showcased as part of an area mental health service Grand Round. In one mental health service it is now gradually being incorporated into key whole of service mental health initiatives to ensure that when service changes are made that considerations in regards to the needs of CALD populations are in integrated into whole of service planning from the outset rather than as an add on.

A key aspect of where many of these changes have been possible has been where there has been dedicated senior management support and access to support from state-wide funded transcultural mental health services as is the case in New South Wales, Victoria, Queensland and Western Australia.

As these practices keeping known and as improvements occur on a sustained and incremental basis so as to become embedded into routine practice services are being encouraged to share good practice examples. This serves the purpose of showcasing best practice and to assist other services starting out on their Framework journey to learn from other services and adapt strategies suited to their service context.

The Framework was also showcased at the May 2015 Royal Australian New Zealand College of Psychiatrists where a video explaining how the Framework has been used was also showcased.

The Framework could be further developed in terms of continued professional development being linked to accredited professional development of mental health workers. Also, with the revision of the National Quality & Safety Standards in Healthcare there may be opportunities for diversity to be incorporated on a cross cutting basis. This could enable the Framework to be integrated to incorporate access and equity considerations as a lens throughout various health accreditation requirements.

To conclude, the Framework has also been recognised in the National Mental Health Commission review into mental health services. Recommendation 17 of the review states: “Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different populations”. Widespread adoption of the Framework is included as a way to achieve this recommendation and for organisations to improve their cultural responsiveness. Progress on advancing this recommendation is important when considering opportunities around improving mental health services for CALD communities in the context of future reform of the mental health sector and the development of the 5th National Mental Health Plan.
MENTAL HEALTH, PEOPLE FROM CALD BACKGROUNDS AND THE NDIS

THE HON SUSAN RYAN AO

The Hon Susan Ryan AO was appointed as Australia’s first Age Discrimination Commissioner on 30 July 2011 for a five year term. Susan was appointed Disability Discrimination Commissioner in 2014, in addition to her responsibilities as Age Discrimination Commissioner. She commenced her new appointment on 12 July 2014. From 1975 to 1988, Susan was Senator for the ACT, becoming the first woman to hold a Cabinet post in a federal Labor Government. She served in senior portfolios in the Hawke Government as Minister for Education and Youth Affairs, Minister Assisting the Prime Minister on the Status of Women and Special Minister of State.

With Australia’s ratification of the Convention on the Rights of Persons with Disabilities (CRPD), the development of the National Disability Strategy, and the roll out of the National Disability Insurance Scheme (NDIS) well underway, we are now at an historic moment. Disability issues, and people with disability, have never been so prominent in Australian discourse. This presents a number of challenges, and more importantly, it provides opportunities.

The arrival of the NDIS recognises that the availability of high quality disability services, support and information is crucial to people’s ability to participate in society.

We know that access to support services is often a pre-requisite to someone with a disability being able to attend school, university or a training institute. The availability of support services is vital for some people to participate in employment and livelihood activities, and exercise independence in their private and public lives.

A foundation reform to the way disability services are provided include better information and support, so that people with disability can make informed choices and exercise control over their care and support. Choice and control in disability services is particularly important for people with mental health issues, in some circumstances can assist them in their recovery.

In my role as Age and Disability Discrimination Commissioner, I am committed to ensuring that people with disability are included in every way in our society and economy. Full inclusion requires the ability to exercise control and make choices about your own life. Freedom to make individual choices and full and effective participation are key principles of the Convention on the Rights of Persons with Disabilities, to which Australia has committed to implement, and which my work at the Australian Human Rights Commission supports.

Provision of support services, such as those available under the NDIS can and are being received positively by people with disability and...
supporting a real difference to people’s lives.

I have seen the direct impact that the availability of appropriate and quality supports for people with disability can have, in breaking down barriers and opening up opportunities in the context of work.

Almost immediately after being appointed Disability Discrimination Commissioner last year, I conducted a National Disability Survey. I asked people with disability and their carers to name the most important human rights issues facing people with disability in Australia. Overwhelmingly, participation in society and access to employment were identified as the top priorities.

Addressing negative attitudes and stereotypes towards people with disability was also indicated as the most important employment and disability rights issue identified. From this input, I determined that the top priority in my work as Disability Discrimination Commissioner would be to work on supporting the improvement of employment opportunities for people with disability.

To support this priority, I am currently conducting a national inquiry into employment discrimination against older people and people with disability. This national inquiry, called *Willing to Work*, was requested by the Commonwealth Attorney-General Senator George Brandis. I am pleased to undertake such an important activity that so closely aligns to priorities identified by people with disability and their carers.

The importance placed on the need to improve access to employment is supported by the low labour force participation rates for people with disability in Australia. In 2012, the labour force participation rate for people with disability was 52.8%, compared with 82.5% for people without disability. This figure has changed very little over the past 20 years.

Employment rates vary among people with disability. People with sensory or speech impairment have the highest labour force participation rate at 56.2%. People with a physical restriction have the next highest labour force participation rate of 47.4%, while people with psychological disability have the lowest labour force participation rate at 29.1%. We know these low numbers are due to discrimination.

The issues related to the low labour force participation for people with psychological disability have also begun to emerge during consultations for the Willing to Work Inquiry. Employers are expressing that they sometimes lack the information, tools and confidence to support a person with a psychological disability at work. Often workplace flexibility such as job sharing and variable working hours, which can assist a person with a psychological disability, are not well understood as reasonable adjustments. Employers may feel more comfortable providing assistive technology or making the physical environment more accessible, compared with changes to work routine or hours. Changes can and should be made to support a person with disability at work, so long as it is reasonable and does not cause unjustifiable hardship on the employer.

Not providing this reasonable adjustment can result in discrimination which can deprive a person from a job, cause significant distress, and can prevent an employer from accessing the most talented staff available.

The effects of discrimination are compounded when disability intersects with other characteristics such as gender and ethnicity. For example, the employment rate among Aboriginal and Torres Strait Islander people with disability is significantly lower than among Indigenous people without disability.

We know that indigenous people with disability experience particular challenges when it comes to accessing services. Developing a system of service provision that addresses these challenges, especially in remote areas of Australia is also ahead of us. For example, orienting the scheme so that people living in rural and remote areas will have adequate access to services they require, including choice in service provision, will be necessary.

People from culturally and linguistically diverse backgrounds, and people with psychological disabilities face particular challenges, so it is crucial that the coverage of the NDIS is as broad as possible.
Organisations and projects such as Mental Health in Multicultural Australia (MHIMA) Multicultural Disability Advocacy Association (MDAA) and the National Ethnic Disability Alliance (NEDA) provide information, support and advocacy for people with disability from culturally and linguistically different backgrounds.

Ensuring dignity for people with disability from culturally and linguistically diverse backgrounds requires service providers and the community to understand the specific barriers and issues that they may confront.

A good start to addressing the barriers specific for people with disability from culturally and linguistically diverse backgrounds can be the provision of information in various languages or the delivery of services that are culturally respectful. But it must go further than this.

Appropriate support for people from culturally and linguistically diverse backgrounds must include a better understanding the different experiences, including political and religious, that an individual may have. A person with a disability may be from a family, or may themselves, have come from a country where there are limited or no supports for people with psychosocial disability. Their experience may be that people with psychosocial disability are only able to live in institutions with limited access to advocacy services and support services, and thus limited ability to exercise their freedom and make choices.

The services of the NDIS aim to deliver support which is tailored to respond to individual needs, giving people freedom to make choices. Greater individual choice and control is crucial to protecting and promoting the rights of people with disability, and as discussed, a foundation for the NDIS.

By ensuring people can exercise their human rights, through choice of the services they receive from the NDIS, we take further steps to a fully inclusive Australia. Recognising that people experience compounding barriers due to the intersection of disability and ethnicity is necessary to ensuring no one is left out. This massive new scheme will benefit all Australians, and those of us who are advocates must continually monitor developments so this big promise is delivered.
David Butt was appointed CEO of the National Mental Health Commission in January 2014. David has 30 years of experience in the health system, much of it at CEO and Executive level. Prior to his appointment to the Commission, David was Deputy Secretary of the Australian Department of Health from August 2011, head of Rural and Regional Health Australia, and the Commonwealth’s first Chief Allied Health Officer. This followed 15 years as CEO of three major health system organisations: Chief Executive of Australian Capital Territory (ACT) Health and Community Care, National CEO of Little Company of Mary Health Care (the Calvary group) and CEO of the Australian General Practice Network.

The National Mental Health Commission was established in 2012 to provide insight, advice and evidence on ways to improve Australia’s mental health and suicide prevention systems. We provide independent reports and advice to government and the community. Over the past three years, the Commission has worked hard to be a catalyst for change. We have listened to individuals, their families and supporters to understand their needs and drive forward change.

In 2014, the Commission was tasked to undertake a review of Australia’s mental health services and programmes. Our biggest report to date, Contributing lives, Thriving communities recognises that if we enable people to live contributing lives – to have relationships, stable housing, and to maximise participation in education, employment and the community more broadly – we will help build economically and socially thriving communities, and a more productive Australia. Within the report it is recognised that people from diverse communities may have a different experience of mental illness, be less likely to disclose symptoms, more likely to express distress in the form of physical symptoms, and less likely to seek treatment which they may feel is inappropriate. This builds on the findings of our 2013 Report Card, which reported on the discrimination and diversity of our cultural heritage and experience which shapes our beliefs, understanding and response to mental illness.
The review recommends a person centred approach and an integrated stepped care model that designs and wraps services around the needs of the whole person. To achieve this the focus of the mental health system will need to shift to community based services, primary health care, prevention and early intervention; and to better focus services on supporting individuals and families. Submissions to the review showed that problems experienced by people with mental illness are often dealt with in isolation.

The review also proposes a system which focuses on populations at a regional level, where, as far as possible, planning, service design, commissioning and service delivery are carried out locally. In particular the review recommends a stronger focus on the early years and a healthy start to life.

Gaps in culturally appropriate and competent mental health and suicide prevention programmes and services were confirmed in the review. That is why it recommended that evidence, evaluation and incentives be used to reduce stigma, build capacity and respond to the diversity of needs of different populations.

In the review, we describe how this can be achieved by:

- Exploring evidence based approaches to reduce stigma and discrimination, and low cost options on how to permeate these approaches throughout the community
- Engaging employers, schools, community organisations and workplaces to take part in local initiatives which improve both mental health understanding and behaviours and reduce stigma and discrimination
- Improving cultural responsiveness by supporting the widespread adoption of the ‘Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery’ as a tool to help organisations identify what they can do to enhance their cultural responsiveness
- Requiring Primary and Mental Health Networks (PMHNs) to partner with state-wide transcultural mental health services in New South Wales, Queensland, Victoria and Western Australia in planning and developing responses to local community needs; and with PMHNs in other states and territories to identify (or help to develop) alternative mechanisms
- Adopting clear and explicit equity-oriented targets for people from Culturally and Linguistically Diverse (CALD) backgrounds from multicultural communities to include in government funding agreements
- Extending the National Mental Health Commission’s Seclusion and Restraint Project to look at the specific factors which result in seclusion and restraint for vulnerable people (for example, communication problems resulting in misunderstanding and confusion that can arise from language difficulties and lack of access or use of interpreters).
Work previously prepared by MHiMA for the National Mental Health Commission, *Mental Health Research and Evaluation in Multicultural Australia; developing a culture of inclusion*, released in 2013, further substantiates the review’s recommendations. The 2013 report provided significant evidence of the need to advocate for a stronger culture of inclusion in Australian mental health research. MHiMA has also produced their own Framework for *Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*. This work has improved our knowledge of the mental health of immigrant and refugee communities in Australia and built a better evidence base for mental health policy and practice and mental health reform in multicultural Australia.

The review also recommends building workforce capacity, in particular improving supply, productivity and access to mental health nurses and peer workers. Peer workers play a vital role in the support and services for people with a lived experience of mental health issues and their families. In recognition of this, the Commission supported the Mental Health Peer Work Qualification Development Project. This project facilitated the development and rollout of the Certificate IV in Mental Health Peer Work. The resource materials that have been developed for teaching this qualification consider cultural competency and value a shared understanding of the person, their culture and their beliefs. These resources are freely available on our website.

Accordingly, the review calls for a mental health system that takes account of the vastly different needs of people, their mental health, social and emotional wellbeing, physical health and other determinants such as culture and a sense of belonging. People in all circumstances have the right to expect a just and fair approach and culturally competent mental health and suicide prevention services in communities. Mental health touches all of us, but the issue can be more challenging for people of culturally diverse backgrounds.

The Commission would like to acknowledge the contributions made to the review. We found an extraordinarily high degree of consensus as to the directions to create a system which promotes good mental health and wellbeing and contributing lives and thriving communities. We are committed to working with our stakeholders, such as the Federation of Ethnic Communities’ Councils of Australia and Mental Health in Multicultural Australia, together with individuals, their families and supporters to enable our vision that all Australians achieve the best possible mental health and wellbeing.
Transcultural Mental Health Centres are state funded specialist state-wide services within public mental health services. They have been in operation in Perth, Sydney, Brisbane and Melbourne since the mid 1990’s and deliver a range of programs and services to improve the accessibility and cultural responsiveness of mental health services and programs. Transcultural Mental Health Centres work across the spectrum of mental health, the continuum of care and across all age, language and cultural groups. They deliver a mix of clinical and non-clinical services including clinical consultation and assessment, workforce education and development, promotion, prevention and early intervention programs, CALD consumer and carer engagement activities, and resource development.

With Transcultural Mental Health Services (TMHS) being at the forefront of frontline mental health service delivery for over twenty years, addressing the significant disparities in access and quality of care received by people from culturally and linguistically diverse (CALD) backgrounds in Australia, it is timely to reflect on achievements and opportunities ahead.

Firstly it is imperative that a distinction be made between multicultural and transcultural. As Australia becomes increasingly multicultural – in the profile of not only its mental health workforce but also the consumer, families and carer population it serves, the need to work transculturally is no longer desirable but crucial. ‘Multicultural’ describes not only those who provide but also those who receive. ‘Transcultural’, however, describes the process in which mental health services must work with multicultural client groups. The clinical dyad comprises the practitioner from a culture that is likely to be different to the one to which the client belongs. Together, the transcultural process is an endeavour to transcend cultural belief systems about mental health assessment and management in order to navigate to a common mid-point from where a collaborative partnership towards recovery.
may commence. TMHS have been the pre-eminent reference point for resources, training and clinical expertise in culture and mental health. Collectively they have delivered clinical services to well over 50,000 immigrants and refugees nationally and their promotion and prevention programs have delivered culturally tailored services to hundreds of thousands of people in Australia’s multicultural communities. Additionally, their workforce education programs are highly regarded and can be potentially scaled up for further reach via technology.

At the population health level, TMHS have also made a valuable contribution. Decades of experience of population health practice have demonstrated that the community’s health is determined by so much more than the quality and availability of health services. For CALD communities the social determinants of health are even more significant with many factors relating to migration and settlement experience resulting in socio-economic disadvantages in areas of employment, language, access to health and social services, racism and discrimination. It is well established that mental disorders, as with most other health conditions, arise from the interplay of biological, psychological and social factors [3].

The diversity of the Australian population necessitates public policy settings which ensure equity and access in the planning and delivery of health services. The recent review of mental health services and programs by the National Mental Health Commission acknowledged that “many people with mental health difficulties face compounding disadvantage with specific recognition of marginalisation of those from diverse cultural backgrounds” [1].

The Review’s recommendations in relation to responses for different population groups are welcomed with specific references to the adoption of the ‘Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery’ [2] as a tool to help organisations identify what they can do to enhance their cultural responsiveness; the requirement for PHNs to partner with state-wide transcultural mental health services in planning and developing services; and the adoption of clear and explicit equity-oriented targets for people from CALD backgrounds for inclusion in government funding agreements.

Transcultural Mental Health Services are well placed to make a valuable contribution to these developments, which if followed through, will potentially change the way people from CALD backgrounds engage with mental health services. From current ad hoc examples of good practice, mainly in the four states where TMHS currently exist, to long term sustained change across the spectrum of services and continuum of care, particularly if equity oriented targets are achieved in funding agreements which will significantly increase the funding base for specialist multicultural mental health services and programs.
For the past twenty years, TMHS have successfully engaged with the wide range of different ethno cultural groups reflecting the different waves of migration and patterns of resettlement influenced by changing economic and political pressures across the globe. Given the exposure to working transculturally with each wave of new arrivals, TMHSs are afforded invaluable opportunities every day to learn about different cultural idioms of distress and the cultural beliefs and values that may influence the presentation of a mental disorder from one culture to the next. The solid connections forged between TMHS and different community groups facilitate ongoing development of innovative strategies for cultural responsiveness and sensitivity in service delivery. These relationships are integral in the work of TMHS to reduce stigma, increase mental health literacy among CALD communities and maintaining an updated understanding of the mental health needs of these communities. The knowledge gained from these connections are valuable not only for ensuring that any training material developed by TMHS are context relevant, topical and applicable, but also to inform on policy at the state and national level on mental health issues pertaining to CALD communities.

Engagement with community stakeholders is pivotal to the business of transcultural mental health. This involves representing the voice of transcultural mental health issues on relevant committees and steering groups to ensure that critical aspects of transcultural mental health are given due consideration prior to initiatives being funded or implemented.

TMHS are pivotal to mental health service reform as we move forward. In the wake of changing funding and services models and the ongoing devolution that is being implemented across Australia’s health system, the capacity for TMHS to facilitate the inclusion of those marginalised by language and culture within their state-wide jurisdictions must not be compromised. The collective strategic objective of all of Australia’s TMHS is to continue to work in unison for collective impact across the nation and at the many levels they do on a daily basis is vital for a mentally healthy multicultural Australia.


(This article is adapted from the article “Transcultural Mental Health Services at the Cross Roads”, Perspectives, May/June 2015, MHA)
Access to health support services for Indigenous Australians continues to be inadequate, with Indigenous Australians experiencing poorer mental and physical health compared with non-Indigenous Australians. Indigenous Australian adults experience significantly higher rates of high or very high levels of psychological distress compared to non-Indigenous adults. For young Indigenous people, rates of intentional self-harm are over 5 times the rate of non-indigenous young people. Two-thirds of Indigenous people live in regional or remote Australia where health services are harder to access.

This article describes an innovative partnership between two organisations, Neami National and Sunrise Health Service Aboriginal Corporation. The partnership focused on the provision of a program in a remote Aboriginal community to help improve the mental health and wellbeing of the community.

Neami National is a community mental health service supporting people living with mental illness around Australia to improve their health, live independently and pursue a life based on their own strengths, values and goals. Sunrise Health Service Aboriginal Corporation works to improve the wellbeing of the people in the region east of Katherine in the Northern Territory through mixing together traditional Indigenous culture and mainstream medicine.
In 2013, Sunrise approached Neami to support it to establish and deliver the Personal Helpers and Mentors (PHaMs) service in a remote Aboriginal community, Ngukurr in the Northern Territory. Ngukurr is an Aboriginal community three hour drive from Katherine in the Northern Territory with a population of approximately 1000 residents.

The Commonwealth funds the PHaMs services to provide increased recovery opportunities for people whose lives are severely affected by mental illness, by helping people to overcome social isolation and increase their connections to the community. PHaMs workers provide practical assistance to people with severe mental illness to help them achieve their personal goals, develop better relationships with family and friends, and manage their everyday tasks.

As part of the partnership, Neami agreed to train, coach, mentor and support Sunrise staff in the principles of the Collaborative Recovery Model (CRM) and apply these in a culturally appropriate way. The CRM underpins the delivery of all of Neami’s services. The model was developed over a number of years at the University of Wollongong and incorporates evidence of practices that have assisted people living with enduring mental illness. It is influenced by positive psychology, psychosocial rehabilitation principles, motivational interviewing and the stages of change model.

Neami together with Sunrise selected two Neami support workers to travel to the Ngukurr and support Sunrise staff. Due to the remote location and the difficulties in accommodation, the Neami staff worked in the Northern Territory for one week out of every month for 9 months from March to November 2014. The Sunrise staff were drawn from the community which gave the project a sense of local ownership.

Ngukurr, apart from being in a remote outback location, is also a culturally diverse place. This presented project staff with both challenges and rewarding experiences for learning and growth. Not only did staff work across the Indigenous / non-Indigenous cultural differences, but learnt about the diversity within the local Indigenous community in the area as well. For example, there are 7 different language groups and 50 family groups in the community. Like many remote Aboriginal communities in Australia, there is a lack of services in Ngukurr compared with larger towns. There are not many specialist services, especially specialist mental health support services. Additionally, basic life essentials like food can cost up to 50% more on average than in a metropolitan area.

This lack of services, in part, plays a role in the reduced wellbeing of the people in the community. Many people live in poor and overcrowded housing.
and are often hungry due to lack of money. The suicide rate is very high. Alcohol abuse is also substantial. These challenges are compounded by the impact of trauma on the people and the community.

However, despite these challenges the staff noted that there is still a sense of warmth in the community where people look out for each other. For example, although the community may not have the resources to improve their housing, they are concentrating on the relationships they have with each other and gaining a better understanding of their self and identity.

The teams were able to form a partnership working across different cultures and in a remote environment. One example that symbolises the close relationship that developed between the workers is that during their time in the community Neami workers were given ‘skin’ names. These are part of the kinship system in Aboriginal societies—a way to divide society into named categories and a way for people to interact with each other, without which it is difficult to interact. Sunrise staff said that the Neami staff having skin names helped with community integration. Neami staff were also given Sunrise t-shirts to wear which helped to decrease suspicion and increase engagement within the community.

Another important strategy was ensuring that the team were connected to a key community person who assisted with engagement within the community, as well as with connection with community members and possible future consumers.

The day-to-day work for the project team varied greatly. Each visit by the Neami team to Ngukurr included different activities, so no two visits were alike. However relationship building between the staff and consumers was the main focus of the visits. Quite often the support visits included activities designed to create bonds between the workers and consumers that were culturally appropriate. These activities included going on fishing trips to the nearby river or going to find bush tucker or bush medicine. One aim of these activities was to support consumers to reconnect with parts of their culture as their culture would play a major role in their recovery.

Land (or country) holds a unique place for the Aboriginal community. The connection the community has with the land is so deep that for example, leaving the place means losing part of one’s self. As some of the Sunrise staff explained, there are four areas that support the person (or spirit) – country, law, dreaming and family. Breaking down of any one area results in the person ‘dying’.

The partnership between the two organisations combined the local knowledge of Sunrise with the service delivery experience of Neami. Both organisations entered the partnership holding mutual respect for each other. Even though Neami’s role in the project was to be coaches and mentors, the project was just as much a learning experience for Neami as it was for Sunrise. This mutual respect for each other was fundamental in building a trusting relationship. This local support service was able to garner a sense of community ownership and pride as it is staffed by locals.
I’m so excited to be here!” says a young woman who’s just arrived and is glancing nervously around the room. “It’s so hard to find spaces like this” she explains as she takes a seat. I see a couple of heads nod in agreement and feel the excitement in the room as people start to introduce themselves.

Women from a variety of backgrounds, Vietnamese, Sudanese, Filipino, Greek, Chinese and Brazilian to name a few, are seated around a large table having all responded to the call out for young same-sex attracted (SSA) women from culturally diverse migrant or refugee backgrounds. They are here to take part in the first part of the Our Voices, Changing Cultures Project being run at the Multicultural Centre for Women’s Health - a project seeking to give some insight into the specific cultural contexts through which these women experience their lives and sexualities.

The project, which commenced in February of this year, uses storytelling approaches and theatre techniques to explore topics including visibility, the idea of coming out, the role of culture and mental health and wellbeing. One of the main aims of the project is to assist the youth and mental health sectors to better address the needs of, and work with, SSA young women from culturally diverse migrant and refugee communities. As the project

*LGBT is an acronym for Lesbian, Gay Bisexual and Transgender

**This article uses ‘queer’ as an umbrella term to include a range of alternative sexual and gender identities including gay, lesbian, bisexual and transgender or gender questioning.
officer of this project, and a young same-sex attracted women from a migrant background myself, the project feels personal, but I’m acutely aware it’s also about transforming individual experiences into personal connections. As a participant points out in a discussion about support and mental health and wellbeing: “it’s about creating a space that we would want to be in and that we feel safe in”.

In the 2014 report *Nothing for Them: Understanding the support needs of Lesbian, Gay, Bisexual and Transgender young people from refugee and newly arrived backgrounds*, it is noted that LGBT people affiliated with particular cultural and religious groups are at an increased risk of both physical and mental ill-health. It is widely known that LGBT youth are one of the most vulnerable groups of young people in Australia, still subject to high rates of homophobia and heterosexist discrimination and abuse. If you add to this being from a culturally diverse immigrant or refugee background, you get “double trouble” with LGBT youth having to negotiate the homophobia and transphobia from within their cultures whilst also navigating racism and religious intolerance from within LGBT communities. At the 2004 Australian GLBTIQ Multicultural Council (AGMC) Conference, a number of delegates spoke of their experiences of living queer lives within their own ethnic communities and the importance of support from within these communities. While this is an important issue, what is also required is culturally appropriate support from the wider LGBT community and a better understanding of the ways that culture, race and sexuality intersect in young women’s lives.

Talking about mental health is not easy, and many participants discussed the stigma and shame involved in talking openly about their mental health. Almost all participants in the project agreed that “we need to talk about it more” but that the topic is “a big taboo generally, not just in refugee and migrant communities”. For those whose families
had experienced much trauma coming to Australia there was an added hesitation to open up about these issues. One participant stated that “being a refugee and knowing and remembering some of the intense things that my family experienced in order to come here for a better life… my family as a whole needed to put certain things aside in order to survive. Like cultural things and things that would benefit their mental health”. Survival is an important theme for women who feel that they are often unable to be understood both within their communities and from wider LGBT communities. Discussing the dilemma one woman asked “do I join the white people who don’t know what my story is or do I join the straight people who still don’t know what my story is?” She noted that if she had come out to her family before finding other queer women from her cultural background to support her, she risked being abandoned and she would have been “so lost”. “I would have had nobody to fall back on or to tell me no it’s OK, we are people and we do exist. And we will be here to help you out and support you.” For women who rarely see themselves represented on television or in the media, it has been clear that finding others like them is an empowering experience. As one women noted, up until very recently “I assumed being queer meant being white”.

When I asked the young women to tell me some things that have proved helpful to their mental health and wellbeing a participant was quick to yell out “I love QPoC [Queer People of Colour] groups!” Laughter ensued but this important response highlighted one of the most exciting aspects of the Our Voices project. As the initial excitement to a room full of faces showed, the project has been successful in its attempts to start building a small community through which young same-sex attracted women can link up and talk. Community has been very important to many of the women in the project, with one participant stating that “…when you come out or if you decide that you can’t come out to your family - then [in both cases] you’ve just lost most of your community”.

With the Our Voices performance coming up in late November I hope that this project will give the wider LGBT community a chance to see the complexity of women’s lives, helping to increase the visibility of young women's stories in society and create a greater understanding around the support needs of LGBT young women. As well as increasing understanding, the project has created autonomous spaces where young same-sex attracted women from culturally diverse immigrant and refugee backgrounds can connect and help to support and empower one another.

For more information about the Our Voices, Changing Cultures project, or a full list of references, please contact: Monique Hameed monique@mcwh.com.au
MENTAL HEALTH STIGMA – INFLUENCING HELP SEEKING BEHAVIOUR IN CALD COMMUNITIES

PENNY ANTONOPoulos

Penny Antonopoulos has worked in health and community care for over 15 years, as Health Education Officer with NSW Health; Project Officer with the Commonwealth Respite & Carelink Centre, and currently as Manager of Disability & Mental Health Programs at Advance Diversity Services, formerly St George Migrant Resource Centre (SGMRC). Penny has a wealth of experience in community development and has played a key role in the development of service partnerships, collaborative working relationships and service sector capacity building as manager of the St George and Sutherland Multicultural Access Project and CALD Community Care Program, at SGMRC. Penny has undertaken research into mental health services, disability in the context of hospital presentations, and the CALD carers’ experience. Penny is co-author of Love stories: understanding the caring journeys of aged Greek-Australian carers’, Health and Social Care in the Community (2015). Penny is an accredited Partners in Depression group facilitator, working in partnership with the Hunter Institute of Mental Health; member of the South Eastern Sydney Partners in Recovery Program Advisory Committee; member of South Eastern Sydney Recovery College Expert Advisory Group; and member of Diversional Therapy Australia.

Advance Diversity Services (ADS), formerly the St George Migrant Resource Centre (SGMRC) is a community based not for profit organisation in Rockdale, Sydney, which has been providing services and supports to culturally and linguistically diverse (CALD) communities for over 30 years. SGMRC commenced operations in 1981 following recommendations from the Galbally Report (Migrant Services and Programs, 1978) which recommended establishing migrant resource centres to meet the needs of migrant communities. The Migrant Resource Centres were intended to support ethnic and community organisations and help them play a greater role in provision of migrant welfare, to serve as a base for ethnic groups and to encourage self-managed services at the local level. Since its establishment, SGMRC has worked with different waves of migrant and refugee settlers, assisting and advocating for culturally and linguistically diverse (CALD) communities to enable the effective use of their skills and capacities; and thereby maximise their access to the social and economic opportunities available in the Australian community. From these foundations the organisation has consolidated and expanded its services to include services for youth, families, older people, people with disabilities, people with mental illness and their carers’ and families, with a recent name change reflecting the diversity of its services.
In 2014 ADS was funded to deliver the Partners in Recovery (PIR) mental health program in the St George & Sutherland areas of Sydney, working in partnership with lead agency, Central and Eastern Sydney PHN and a consortium of local multi-sectoral service providers. Partners in Recovery is a nationwide program funded by the Australian Government Department of Health aiming to better support people experiencing severe and ongoing mental illness, their carers’ and families, by connecting them to services and supports to help them achieve optimal health and wellbeing. PIR organisations also work to drive collaboration between relevant sectors and service providers within the region to ensure that all relevant needs of people experiencing mental illness are met. ADS’s PIR Program is uniquely CALD-specific. ADS employ bilingual and bicultural Support Facilitators to provide culturally responsive care coordination to consumers from CALD backgrounds as they move through their recovery journey. Recovery from the perspective of the person with mental illness means gaining and retaining hope, understanding ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self (National Standards for Mental Health Services 2010). ADS has also delivered the ‘Partners in Depression’ psycho-educational program for carers in partnership with the Hunter Institute of Mental Health to local CALD communities, delivering the program in Greek, Chinese and Macedonian, and regular and ongoing workshops in partnership with St George & Sutherland Community Mental Health to carers of people with a mental illness from Chinese background. ADS are also a partner of the South Eastern Sydney Recovery College, a pioneering educational initiative in Australia, focused on learning and growth for better mental health. The College offers comprehensive education and training programs, developed and delivered by people with lived experience of mental health concerns and health professionals. A number of CALD-specific courses are included in the curriculum.

Through these partnerships and collaborative working relationships, as well as regular community consultation, ADS has been able to explore the help seeking behaviours of people with mental illness and their families and carers, and identify barriers to accessing mental health services and unmet needs. The feedback of bilingual case workers, group facilitators and support facilitators provides a wealth of qualitative data on these issues, and adds value to quantitative studies based on minimum data sets (MDS) collected by funding bodies, providing a cultural perspective that can be explored to assist with and strengthen the capacity of the mental health service sector to support CALD communities. MDS is a set of nationally agreed data items that are collected in relation to clients, the services they receive, and the outlets that provide these services to. The contextual background is also an important consideration. People from CALD backgrounds have significant lower level of access to mental health care and support in the wider community. This
results in much greater responsibility being placed on family members without adequate support and education (Department of Health). There is also evidence in mental health, disability and aged care services that people from CALD backgrounds seek support services when they reach crisis point, whether as a result of a hospitalisation or with the encouragement of second generation adult children who initiate contact with services. This highlights the importance of working with families and carers to build family resilience and grow the support network of the person living with mental illness.

Over the past 12 months ADS has worked with over 20 local community groups, pensioner groups, carer support groups and social groups delivering information on mental health services and community supports, and assisting CALD consumers and their families and carers to navigate the service system. The stigma attached to mental illness in CALD communities resonated strongly at the majority of these sessions with participants discussing the effect of stigma on help seeking behaviour. ADS works to break down that stigma and assist people with mental illness, their families and carers to access services that can help improve their situation and quality of life. ADS have supported 122 consumers under the PIR program during the 2015 financial year, with 33.3% of those from CALD backgrounds. The main language groups supported were Chinese, Greek, Arabic, Macedonian, Serbian and Croatian, reflective of local demographics.

All communities experience stigma, whether we look at the dominant culture in Australia or people from CALD background. Psychoeducation can assist to start the conversation about stigma and to provide information and education on diagnosis, symptoms and the management of mental illness. Psychoeducation can help empower people with a mental health condition and their families to deal with their condition in an optimal way. It is important, however, to deliver psychoeducation and health promotion campaigns in community languages, with inclusive communication tools. For example, the use of interpreters, translated material, bilingual/bicultural peer support. People from CALD backgrounds are limited in terms of their access to group therapies and individual counselling and psychological supports. In NSW CALD consumers benefit from access to Trans Cultural Mental Health psychological services, however, it is difficult to find diagnosis-specific support groups or therapeutic groups, such as an anxiety support group for anxiety or depression, or a group offering Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy or other therapies in community languages. People from a CALD background may be referred to mainstream groups, however, access to interpreter services can be limited, both in terms of availability and the challenges of participating in a group via a third party.

For many CALD communities stigma is embedded in cultural values, with varying meanings attached to disability and mental illness, ranging from sin, punishment, or for some cultures, caring for a child with a disability is considered a blessing, a role that is valued and respected. Similarly, stigma and self-stigma can be associated with feelings of shame, blame, guilt, sadness, or grief. Those delivering mental health and other services cannot make assumptions about culture and the meaning attached to a mental health diagnosis, hence the need for strengths based, person-centred approach to assessment and service delivery. A discussion about culture must be incorporated into assessment. It is important to be mindful that stigma is embedded in deep feelings relating to cultural values as well as knowledge and education, or lack thereof, related
to mental health diagnosis. Service providers need to explore the appropriateness of assessment processes and service delivery mechanisms to ensure they are culturally responsive to the needs of CALD communities. Service providers need to have a conversation with people experiencing mental illness about what the mental health system was like in their homeland. What experiences did they have in their homeland? Were they traumatized by previous experiences with the mental health system, here or abroad? Issues such as these, explored with cultural sensitivity, will prevent re-traumatization of the person with mental illness, and their carers’ and families.

Potential for disclosure also has a significant impact on help-seeking behaviour. Our CALD communities, particularly at a local level, are close-knit and connected. Disclosure of mental illness can raise concerns in families regarding relationships and marriage prospects, job prospects, status and respect in the community. There is fear that disclosure will not only impact the person experiencing mental illness, but also siblings and the extended family. This results in mental illness being ‘hidden’, and a reluctance to access support services. People from CALD backgrounds who have experienced torture and trauma in their countries of origin may also be suspicious of the ‘establishment’, ‘government’ or ‘bureaucracy’. Consequently, they may be reluctant to share information readily during intake or assessment processes, for example, or answer personal questions. Integrating trauma informed practice into the delivery of services to CALD communities will allow providers identify trauma-responses during interactions with the consumer. The South Eastern Sydney Partners in Recovery program has provided recovery orientated practice and trauma informed care training to all Support Facilitators engaged to deliver the program. The trauma training in particular is about trying to understand the way a person sees the world based on their experiences, and informs how best to work with the client and tailor service interactions to avoid further trauma.

ADS strongly value the importance of linkages, partnerships and collaboration across human service sectors and CALD communities, and recognise the discussion about stigma has to be had with individuals, families and communities, to influence help-seeking behaviour, address barriers, and increase access to mental health services by CALD communities. With the Australian Government unrolling the National Disability Insurance Scheme (NDIS) over the next few years, this climate of collaboration and the need to incorporate cultural perspectives and cultural competency into practice is crucial.
During the last decade, Australia settled approximately 130,000 people through its Refugee and Humanitarian Program. At the time of writing another 30,000 people live in the Australian community as asylum seekers and are awaiting the outcome of Refugee Determination processes. The literature estimates that world-wide up to 35% of refugees have been physically tortured or psychologically violated. It is further estimated that approximately 45,000 people who are refugee survivors of torture and trauma have settled in Australia in this period.

This essay describes the mental health work with refugee survivors of torture and trauma undertaken by the members of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). FASSTT is a network of eight not-for-profit agencies – one in each State and Territory - that respond to the needs of refugee survivors of torture and trauma. The essay also seeks to make the case for a specialist mental health services response for this cohort of the CALD population.
FASSTT Focus on the Legacy of Trauma and Building Recovery in a New Context

FASSTT member agencies seek to address the impact of torture on the individual, the family and the community through counselling and advocacy, health assessment and referral, information provision, training of other service providers, research and service innovation.

Torture has a specific definition and methods of torture are well documented. While some refugees may have experienced torture in the context of state-sanctioned terrorism, many more have experienced multiple human rights violations and traumas. Trauma is experienced not only in countries of origin where it may be the catalyst to leaving, but also during flight, in transit countries and in refugee camps.

FASSTT member agencies provide bio-psychosocial support to refugees and asylum seekers who are profoundly traumatised and whose recovery must develop essentially in a place of exile where systems, language, culture and identity all need to be renegotiated.

The majority of FASSTT clients have physical and mental health problems related directly to torture or trauma associated with their refugee experience. For example, FASSTT assessment data of adults in 2014/15 indicated the following psychological sequelae:

1. 73% of clients exhibited symptoms of anxiety to a significant degree;
2. 72% of clients exhibited symptoms of traumatic stress to a significant degree;
3. 68% of clients exhibited symptoms of depression to a significant degree.

The Case for Specialisation

Research suggests that the prevalence of trauma-related mental health issues is higher in populations of people of refugee backgrounds than in other migrant populations or indeed in the general population. FASSTT member agencies provide a specialist service response – that is – a service which not only recognises the prevalence of mental health concerns associated with the legacy of the refugee experience but also enduring vulnerabilities associated with resettlement and acculturation. These vulnerabilities manifest at the individual, family and community level. FASSTT services are united by a philosophy of developing a holistic response to trauma. FASSTT services are offered flexibly and allow for multiple entry and exit points to the service, such as referrals come from clients, families, communities as well as health and community services. Significantly, the refugee communities are engaged as partners in the recovery process and as agents for healing.

Refugee and humanitarian entrants, particularly survivors of torture and trauma, have particular needs and are accordingly appropriately treated as a special needs group within the mental health service context. These needs arise from the fact that their circumstances are commonly characterised by the following:

- extreme adverse life circumstances such as experience of war, persecution, torture, displacement and prolonged periods in refugee camps or countries of asylum prior to arrival;
- limited or disrupted schooling;
- family dislocation;
- limited health care before arrival in Australia;
- stressful nature of settlement demands;
• limited employment opportunities for new arrivals;
• limited social support and networks because of the small size of refugee communities and fragmentation within those communities;
• cultural and language barriers to accessing mainstream health services;
• (for asylum seekers and people on temporary and bridging visas), uncertainty about their future status and ability to remain in Australia.

Research reveals that contextual factors such as those listed above are important moderators of mental health. This is particularly the case for children and families who experience significant disruption to their sense of security and capacity to protect. However, in general, most people who arrive in Australia from refugee backgrounds are able to adapt and adjust to the changes required by their new situation when provided safety and some strategic support at particularly stressful times in the resettlement process. Recovery from trauma can then proceed.

FASSTT services increasingly deal with the mental health issues that manifest in context of the onshore refugee determination process. A long asylum seeking process is associated with a higher prevalence of mental health distress, precisely because of the impossibility of establishing the sense of safety required for recovery. Many people who arrived as asylum seekers are subjected to immigration detention, often for a prolonged period, and are denied the right to work and face uncertainty about their future in Australia – even those found to be owed protection as refugees are granted only temporary visas.

There is considerable research evidence that indicates that the mental health and well-being of refugees and those still in the asylum seeking process are affected not only by pre-flight experiences and individual resilience and vulnerabilities, but also the reception they receive in Australia from service providers and community alike.

**CONCLUSION**

The profile of the refugee and humanitarian population is constantly changing and will continue to do so. The profile reflects conflict situations around the world and decisions by government about regions from which refugees will be selected for resettlement. Changes can occur rapidly as borne out by the recent announcement of the Australian government that the Refugee and Humanitarian program will be expanded by 12,000 places in 2015/16 to settle refugees from the Syria conflict. In the year 2013/14, FASSTT agencies assisted close to 16,000 individual survivors of torture and trauma from 114 countries speaking 119 languages. The specialist focus of the FASSTT agencies allows us to swiftly develop new service approaches based on an understanding of the broad impacts of torture and trauma and the cultural fit of those approaches. The collective efforts of FASSTT have facilitated collaboration and innovation in service responses and research while simultaneously addressing public policy, systems advocacy and human rights concerns.

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1 Torture is the intentional infliction of severe mental or physical pain or suffering by or with the consent of the state authorities for a specific purpose. It is often used to punish, to obtain information or a confession, to take revenge on a person or persons or create terror and fear within a population. Some of the most common methods of physical torture include beating, electric shocks, stretching, submersion, suffocation, burns, rape and sexual assault. Psychological forms of torture and ill-treatment, which very often have the most long-lasting consequences for victims, commonly include: isolation, threats, humiliation, mock executions, mock amputations, and witnessing the torture of others including loved ones.
Decades afterward, I still recall the frequent waking, getting out of bed and moving around our Nairobi house in the dark. Sometimes I moved pots and pans, re-arranged furniture, but mostly I caused a disturbance. My parents decided to address my distressing behaviour by taking me to an older woman from our Goan community who chanted prayers and anointed me with chilli and garlic. Her incantations arrested the nocturnal disturbances, which never perturbed me again. The evil eye was diagnosed, the somnambulism caused by envy, inflicted on me with a look. I later learned that the evil eye is seen as the cause of many problems and illnesses globally with a multitude of rituals and remedies to either prevent or cure it.

My own experience of being a multiple migrant (Goa, Tanzania, Kenya, Aotearoa New Zealand, Australia) and then a clinician, has led me to consider many possible antecedents to mental illness. Mental health is a specialty in health where culture comes to the fore as it so strongly shapes how mental illness and is understood and treated. David Ingelby suggests that becoming a user of Western health care involves accepting its underlying philosophy and values and “acquiring health literacy”. Mental health care is grounded in biomedicine and evidence-based practice which assume universalism across cultural difference.
Yet, imposing culturally derived norms, values and labels from a specific location to another context, and assuming treatments, or management will work is problematic. For if clinicians focus on mental illness without understanding the cultural context or without realising that clients and their families might integrate both biomedical and more “traditional” beliefs, quality psychiatric assessment can be impaired, increasing the potential for inaccurate diagnosis and inappropriate treatment and care. Incorrectly identifying culturally appropriate behaviour or experiences as psychopathology is problematic, just as assuming that something is cultural rather than considering the issue of psychopathology. Hence a fundamental tension in mental health service delivery is the tension between universalism and cultural particularism.

The limits of universalism can be seen in different approaches to cultural competence in mental health. A technical perspective assumes mainstream frameworks and treatments can be universalised to all patients/clients and that more sensitivity and overcoming linguistic and cultural barriers will assist therapeutic efforts. With a technical approach to mental health, the goal of care is to deliver it efficiently and increase utilisation (efficacy). Strategies can include access to language matched information and professional interpreting services, or improving mental health literacy and awareness, supporting community resilience and coping strategies. However, technical approaches do not ask questions about power imbalances between groups. When care is given through a critical lens (equity), the questions become what is going on
when interventions developed for one population are applied to another? What are the underlying power relations? Whose interests are being served? Is there a covert attempt to impose the values and perspectives of the dominant group?

Contemporary neoliberal health discourses have co-opted patient rights movements and positioned patients as consumers; active partners in health who are responsible for their own health. Consumer engagement and health literacy form a suite of strategies for inducing medical citizenship, so that individuals can participate and become knowledgeable consumers. However, in order for medical citizenship to be a two way process, one’s own beliefs about the causes of illness and the corresponding treatments must also be considered. Health literate organisations need to be open to a multiplicity of illness explanations and to those locations from which such beliefs are derived. As Beijers and de Freitas note, “Health care is transforming social suffering into illnesses and diagnoses, while often denying the social and moral origins and implications of the suffering”.

One of the mechanisms for developing cultural competence in mental health service delivery is to widen the reductionist gaze of biomedicine. Often people from refugee and migrant backgrounds view the effectiveness of psychiatry and counseling as mechanisms for dealing with the challenges of living with skepticism. Many instead turn first to informal sources outside the health system including self-help, family, community, social networks, and various forms of spirituality, and religion.

Significant institutional barriers linked to Western liberal models of individualism prevent the acknowledgement of the value of these forms of support. These include the valuing of privacy, independence and the one-to-one relationship between consumer and professional. However, clinicians are increasingly appreciating the significance of these sources of support and facilitating better partnerships in care, particularly as they are guided by policy for example Standard 5 of the Victorian Cultural Responsiveness Framework which measures the ability of the health service to involve CALD consumers and their family in the planning and improvement of programs and services. In addition, The Cultural Diversity Plan for Victoria’s Specialist Mental Health Services advocates family-sensitive practice, viewing family and community resources as partners in recovery and encourages syncretism and innovation to take place.

Reconciling tensions between the universal and particular can be facilitated if collaborations between traditional healing mechanisms and western practice are made possible. People often utilize different health beliefs simultaneously in their search for optimal treatment and so clinicians must consider discourses beyond that of traditional healing as being primitive and unprofessional. Assimilation and acculturation into the dominant culture erode the healthy migrant advantage that migrants are initially blessed with. Migrant ill health and disparities increase as an outcome of racism and discrimination. Developing collaborative models that combine traditional and Western health knowledges and combining health literacy and consumer participation with better access and cultural competence can facilitate better health outcomes.
Much can be learned in the multicultural space from indigenous models of care, which consider the broader social and historical determinants of mental health. In Aotearoa New Zealand, where I have spent most of my life, Maori psychiatrist Mason Durie has conceptualised Maori health as encompassing mental (hinengaro), physical (tinana), family/social (whänau), and spiritual (wairua) dimensions. In Australia, the National Aboriginal Health Strategy (1989) views wellbeing through a communal lens, broadening the concept of well-being beyond the individual to the social, emotional and cultural well-being of the whole community. Situating Aboriginal and Torres Strait Islander mental health within a framework of social and emotional wellbeing emphasises wellness, harmony and balance rather than illness and symptom reduction (AIHW 2012). Connection to land, culture, spirituality, ancestry, family and community, interdependence between families, communities, land, sea and spirit are also seen as necessary for health. The Ways Forward National Aboriginal and Islander Mental Health Policy Report prioritises holism, self-determination, the need for cultural understanding, the impact of history in trauma and loss, human rights, acknowledges the impact of racism and stigma, kinship, cultural diversity and Aboriginal strengths.

As an educator, I am interested in how I can do my part to support medical pluralism, so that future generations of nurses can be effective and therapeutic. The Cultural Diversity Plan for Victoria’s Specialist Mental Health Services provides apt guidance, it emphasises being respectful and cultivating non-judgmental curiosity about other cultures. Rather than assuming that clinicians know everything, a spirit of openness and flexibility are advocated. Clinicians are encouraged to seek cultural knowledge in an appropriate way, tolerate ambiguity and develop the ability to handle the stress of ambiguous situations. I conclude with a whakatauki (proverb) from Aotearoa New Zealand. Naku te rourou nau te rourou ka ora ai te iwi (With your basket and my basket the people will live). What this means to me is that there is no, single way to do anything, there is no single person or discipline that has all the knowledge. We need each other’s experience and worldviews, we need collaboration and understanding and valuing in order for us to all be healthy and to make a better world for all of us.
Building Resilience in Transcultural Australians — The BRiTA Futures Program

Elvia E. Ramirez

Elvia E. Ramirez has been the Mental Health Promotion, Prevention and Early Intervention Coordinator at the Queensland Transcultural Mental Health Centre (QTMHC), Metro South Addiction and Mental Health Services (MSAMHS) since early 2001. She has a professional background in psychology and health promotion and has largely overseen the development and implementation of the BRiTA Futures group program. Elvia is also an accredited Standard Mental Health First Aid Instructor since 2007 and has delivered thirty 12-hour courses tailored to the perspectives of culturally and linguistically diverse (CALD) individuals, families and communities. Elvia and her family came to Australia from El Salvador over 25 years ago under the Special Humanitarian Program and she has since worked in the multicultural sector in women’s health, population health and transcultural mental health.

The BRiTA Futures program is a group program designed to build resilience in upper primary school aged children, adolescents, adults and parents from a CALD background so that they can more effectively deal with the acculturation process. The aim of healthy acculturation is to achieve a cultural identity that integrates practices and values of culture(s) of origin and of the culture of the receiving country and involves ongoing negotiation. Acculturation can be a lengthy and complex process impacted by life experiences, personal resilience and importantly attitudes of the receiving society with acculturation stress being a risk factor for mental health problems.

BRiTA Futures has been developed by the Queensland Transcultural Mental Health Centre (QTMHC), Metro South Addiction and Mental Health Services (MSAMHS). The program originated over ten years ago as a response to a national study about the mental health strengths and needs of adolescents with a CALD background, the Coping in a New World report. Issues of acculturation, or the emotional transition and adjustment to learn to live in a different culture, were identified as priority risk factors for the emotional wellbeing of this cohort. The BRiTA Futures for Adolescents program was designed and piloted with promising results that later were enhanced by incorporating program activities more appropriate for young people with a recent refugee experience and limited English language skills. In 2008, BRiTA Futures for Primary School Aged Children was released following a robust pilot phase. This program was aligned with key learning outcomes of upper primary school curriculum. In 2013, BRiTA Futures for Primary School Aged Children was listed as program guide of the Australian Primary Schools Mental Health Initiative, KidsMatter. On advice from KidsMatter, the resource manual of the primary school version is
available to be purchased and is easily incorporated into lesson plans. The resource manuals for the other two programs are available following attendance at a two day training program. Just recently, BRiTA Futures for Adolescents was added as a program guide of the Australian’s whole of school framework for positive mental health, MindMatters.

The BRiTA Futures for Adults and Parents program was launched late in 2012 following community and services consultation and a comprehensive literature review that provided the framework for the program. Bilingual and bicultural Program Facilitators and translated handouts are now available so groups in specific languages can be also run. This program has been particularly popular with settlement services and TAFE adult English classes with regular programs being conducted and evaluated in these settings.

To date in Queensland there are a total of 465 BRiTA Futures Program Facilitators. There has been strong national interest with two states in Australia developing strategies to sustain the BRiTA Futures for Adolescents program: a Youth Health Nurse from the Tasmanian Health Organisation – Primary Care who became a BRiTA Futures for Adolescents Train-the-Trainer has been training Program Facilitators in Tasmania since early 2014. The Intensive English Centre (IEC) at Cyril Jackson Senior Campus in Perth, WA, sourced funding for QTMHC to train Program Facilitators in 2013. Since then, other IECs have also incorporated the BRiTA Futures for Adolescents program into their curricula. Cyril Jackson IEC has also linked the program to the General Capabilities from the Australian Curriculum, the Australian Blueprint for Career Development and their own IEC curriculum. This ongoing engagement with the program has resulted in two BRiTA Futures for Adolescents Train-the-Trainers who will continue training staff of schools with an English as an Additional Language or Dialect (EAL/D) program in WA. These are truly inspirational outcomes.

Key content of the BRiTA Futures programs include:

(Upper) Primary School Aged Children (8 X 2-HOUR SESSIONS)

- Resilience in our multicultural classroom.
- Cultural identity and life experience: making me who I am.
- Building empowerment: self-talk and self-esteem, i.e. culturally appropriate strategies for building self-esteem and managing self-talk.
- Building social competencies: understanding cross cultural communication.
- Resolving conflict and coping with challenges i.e. understanding how cultural factors (culture of origin and receiving culture) contribute to conflict and explore ways to resolve these.
- Making life fun: beat stress and build optimism.
- Family and friends: staying strong with positive relationships.
- Family patterns of communication and family traditions.
- Bouncing back after hard knocks: how to stay resilient throughout life. Program review.
### Adolescents (10 X 2-HOUR SESSIONS)

- Trust and respect for building group cohesion and preparing for personal growth and for sharing who we are.
- Explore ways in which culture of origin, new traditions and life experience shape personal identity and affect our lives.
- Introduce the concept of stereotypes.
- Concept of habits and how these shape our thoughts, feelings and beliefs about ourselves.
- Habits and culture.
- Increasing our personal tool box for building self-esteem and having optimism for the future.
- Self-esteem and culture.
- Habits and culture.
- Introducing the concept of stereotypes.
- Concept of habits and how these shape our thoughts, feelings and beliefs about ourselves.
- Habits and culture.
- Increasing our personal tool box for building self-esteem and having optimism for the future.
- Self-esteem and culture.
- Habits and culture.
- Using humour for inner strength.
- Personal mentors.
- Gaining insight into the relationship between culture and spirituality.
- How culture shapes our personal values.
- Family, peer and community networks: how we are influenced by family.
- Cultural influences in solving problems and dealing with conflicts.
- Building strategies for establishing peer networks across cultures.
- Feeling okay about asking for help: where to find help for multicultural families in a complex world.
- Life goals and future planning: aspirations, goals and steps to achieve these.
- Program review.

### Adults and Parents (8 X 2-HOUR SESSIONS)

- Healthier and brighter future in a new and different culture: strengthening our protective factors for wellbeing.
- A different and common journey: the migratory process.
- Emotions associated with every stage of migration.
- Understanding the concept of acculturation.
- The importance of culture in rebuilding cultural identity.
- Introducing negotiation as a skill to deal with acculturation stress.
- Resilience skills to cope with adverse situations related to the migratory and acculturation process.
- Weaving links: the importance of social connectedness for wellbeing – building meaningful relations with family, cultural community, other migrants, services and the receiving society.
- Help-seeking behaviours.
- Understanding the process of communication and how culture influences communication within families and communities.
- How migration impacts the roles of man, woman, mother and father and strategies to deal with these changes.
- Intergenerational challenges for all generations in the family – how acculturation exacerbates these.
- Negotiation skills to effectively deal with intergenerational challenges.
- Program review.
A purpose built database has been created to store and analyse program evaluation data in order to build evidence about the effectiveness of the **BRiTA Futures** program. Culturally appropriate quantitative and qualitative tools have been developed and continue to be refined and improved with feedback from program facilitators, i.e. the Multicultural Youth Resilience Questionnaire© and the Adult Acculturation Resilience Scale©. Tools are applied at pre, post and during the intervention and are completed by program participants and program facilitators. To date, three journal articles have been published and a research project in partnership with the Queensland University of Technology has received ethics approval to commence shortly to further analyse evaluation data. The **BRiTA Futures** program is in a unique position to continuously collect information about the mental health risk and protective factors of the program participants and program facilitators are encouraged to collect and share this information with the QTMHC in order to ensure the program remains an effective resilience building program for children, adolescents and adults from CALD backgrounds.
Minister for Health Sussan Ley has promised significant reform to Australia’s mental health system. Presumably she is basing this promise around her Government’s response to the 2014 Review of Mental Health Services carried out by the National Mental Health Commission.

The parlous state of Australia’s mental health ‘system’ makes such promises most welcome. But the Commission’s review focused on Commonwealth-funded mental health care – they contribute around $2.8bn while the states and territories $4.5bn to total mental health spending. Real reform will surely need to deal with the totality of mental health.

Whatever reforms are pursued, the role of Primary Healthcare Networks (PHNs) is likely to be prominent. What could this look like and what are the implications for Australia’s CALD communities?

Since its inception in 2006, the Better Access Program has continued to grow quickly. It now costs around $15m every week. While no doubt many people have benefited, there is also evidence that some key groups may be missing out on Better Access. CALD people who do not speak English are certainly one group that has not benefitted from the Better Access program, as services delivered under this program are not eligible for free interpreter services. According to people in the sector, the cost of the interpreter as well as the gap fee in many instances has been a key barrier to this program for CALD people.
The other critical context here is the failure of state and territory mental health services to lift the rate of access to mental health care. While expenditure on state mental health services has increased by 52% and direct care FTE staffing by 19% since 1992, the rate of community access to state services is unchanged nationally since 2006-07. Despite this, many people struggle to get access to acute care services, being admitted only if they can demonstrate a high risk of harm to themselves or others.

They are often merely stabilised, medicated and then discharged to little if any community support where they can quickly deteriorate and require further admission. This creates the so-called ‘revolving door’. It is poor and inefficient care.

The community mental health sector has failed to flourish. Many public community mental health services have withered and withdrawn to the hospital campus. Funding to the non-government sector has increased a little but it remains a peripheral element of the mental health budget, with key existing funded programs now slated to shift across to the NDIS.

More generally, while there have been recent increases in total mental health spending in Australia, mental health’s share of the overall health budget is in fact in decline – in 2012-13 it was about 5% of the total health budget. Yet mental illness accounts for 13% of the total burden of disease.

So where does this leave the PHNs? What is becoming clear is the lack of service options between Better Access and the emergency department of the local hospital. This void is called community mental health.

While some people may benefit from Better Access and some may qualify for acute hospital care, there is a large group of people missing out on care. These people typically have moderate or fluctuating mental illness often in combination with other complexities such as addiction problems or co-occurring physical health issues plus social or community problems like housing. This ‘missing middle’ may often be in receipt of general health or other government services, but rarely mental health care.

The scope of PHNs is really only now being defined. The Commission recommended they be renamed Primary and Mental Healthcare Networks to emphasise their new role. The Commission’s Review also recommended several actions specifically designed to foster better primary mental health care among CALD populations (see Recommendation 17), including; contributing to the reduction of stigma and discrimination; exploring partnerships with transcultural services; implementation of the excellent Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery and; the setting and monitoring of explicit equity-oriented targets for people from CALD backgrounds.

Clearly opportunities for the PHNs to engage in hospital avoidance and early intervention in mental health care are numerous, including in direct relation to the CALD community.

There is a need to ensure we are capitalising on the opportunity afforded by publicly-funded access to psychology services. Current fee-for-service models, like Better Access, may not be the best or only way to arrange this. At the very least there should be no barrier to the use of interpreter services. The mental health needs of the ‘missing middle’ are largely unaddressed. Some PHNs already have good links to community sector organisations providing a blend of psychosocial and clinical services to people. Good community mental health can often mean focusing as much on employment, housing and education as on health care. These links could be strengthened.

There is already evidence to support a significant boost to provide more mental health nurses in general practice, expanding the scope of primary services available in the community. Programs such as New Access are also demonstrating the positive impact of peers, mentors and coaches in providing low intensity mental health support in the community.
What do PHNs need in order to seize this opportunity? What structures need to be in place so that the PHNs can share their learnings about effective approaches to mental health care, including in relation to the CALD community? What are appropriate benchmarks by which to assess whether changes are working, both for the CALD and general communities, and how will these be assessed?

While the prospect of greater government attention around these questions is quite exciting, the challenges for CALD communities are profound. Vital questions about the mental health and welfare of Australia’s large CALD population remain unanswered due to enduring, fundamental flaws in existing data collection processes. This was well documented in the recent paper Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion, prepared by Mental Health in Multicultural Australia10. Simply put, this paper stated that national mental health data collections DO NOT support evidence-informed mental health policy and practice or mental health reform in multicultural Australia.

One job that is clear for PHNs is to deliver better population health planning, including mental health. The current failure to properly research, understand, plan, deliver and evaluate multicultural mental health care in Australia is completely unacceptable. Successive state and federal governments have abrogated their responsibilities to address key data and other deficiencies which impede reform.

PHNs could be the catalyst to finally spur overdue investment in the information infrastructure necessary to properly account for the mental health of their CALD populations. It will be vital the CALD community is ready to provide PHNs with expert advice about specifications and approaches.

7 The Framework can be found here: http://framework.mhima.org.au/framework/index.htm
8 Evaluation of the Mental Health Nurse Incentive Program can be found here: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-e-evalnurs
10 The paper prepared by MHiMA for the National Commission can be found here: http://www.mentalhealthcommission.gov.au/media/80646/2093%20MHiMA%20CALD%20REPORT_06.pdf
I recently attended the 16th International Mental Health Conference at the Gold Coast and heard the inspirational Monique Faleafa from Le Va Pasifika delivering the keynote address about “we can only travel at the speed of trust” and that “engaging across cultures is key for better health outcomes”. Le Va is New Zealand’s national hub for Pacific mental health and addiction workforce development, as well as providing national coordination for the disability support services sector. They play an important role in translating policy into practice for all three sectors at a national level, meeting local needs.

When I presented in the afternoon, I quoted Faleafa pertinent take away messages because they applied to connecting culture and care and creating trust through language – the only way to reach the vulnerable members of our multicultural Australian society.

One in four Australians were born overseas, and there are more than 22 million people in our country who all contribute different ideas, religions, languages and customs. The diversity of these people makes Australia a unique place to live but also creates challenges how to reach all Australians especially more fragile target audiences.

Nelson Mandela said: “If you speak to a man in a language he understands – it goes to his head. If you speak to him in his own language – it goes to his heart.”

The same applies for our multicultural Australian audience. Although the majority do speak English, it is imperative to reach them in their own language.

Whether you are a private or public institution – the aim is to get the right message across to your key audience. It is our duty of care to ensure those in need and those who care them get the information they require.
Let’s have a look at basic facts about Australia’s diversity: since 1945, more than seven million migrants have made Australia their home. Around 45 percent of Australians were born overseas or have at least one parent who was born overseas. People from more than 200 countries make up the Australian community. The top ten countries of birth in Australia are: Australia, the U.K., New Zealand, China, India, Italy, Vietnam, Philippines, South Africa and Malaysia. Australians practice more than 100 religions including Christianity, Buddhism, Hinduism, Islam and Judaism. More than 300 languages are spoken in Australian homes; the most common apart from English are Mandarin, Italian, Arabic, Cantonese, Greek, Vietnamese, Tagalog/Filipino, Spanish and Hindi.

The changing mix of origins of Australians is a topic of interest in every Census. We often quote the above statistic that a quarter of the population was born overseas. That figure has not changed much over the years; however what has changed is how that quarter is made up. The largest increase has come from India and China.

When you are translating for multicultural Australia, you are reaching out to culturally and linguistically diverse (CALD) communities. Before you begin, it is imperative to identify your readership: a Health Department with a brochure for people with mental illness will have different requirements to a City Council speaking to their multicultural citizens and you will have to frame your messaging and your tone in different ways.

You also need to ask yourself how long an individual or community has been in Australia. For example, Italians who have lived in Australia for 50 years have very different terminology and key word usage to Italians in their native country. Their home is Australia, and they are Australian – so, your messaging cannot be compared to what it would be if you were addressing their compatriots in their birth country. A competent translator in the origin country might do an outstanding job translating the text, but will still not give the right message to the Australian multicultural reader, because it is not using their language. Locally known keywords, names or government programs will often stay in English, because that is how they are known.

Another important deliberation is the age group: closely related to the previous point, the individual’s age group will determine the type of language to be used. Tone of language has to be adjusted. This applies to translation in general and is particularly important, as the language of older migrants may not have evolved naturally due to their distance from their birth country.
The key audience’s education level must also be considered. The tone of the translation should be dependent on your target audience, whether it is plain and simple, sophisticated or somewhere in between. The demography and geography of your target audience should also be noted. Convoluted sentences that are often found in lengthy government documents may be a challenge. Essential messages should be portrayed in the right terms for the audience, so that they completely understand.

CALD communities are an important target audience for health departments in government levels as well as for health device manufacturers. The language to be used will differ considerably here as well, depending on the target group. For example, is your health brochure for people with mental illness, or directed at people prone to sports injuries, or at the wide variety of CALD public groups?

Most of us know that not everything has to be translated. What should be left in English? Often, the question of where and when to use English in key phrases, is a matter of personal preference. For this reason, it is important to establish a style guide from the beginning to determine which terms are left in English and which are to be translated or explained. This can differ from language to language. In German for example, English terms are frequently used and accepted without an explanation. This is contrary to Arabic, where often everything will be translated, numbering included.

However, it is important to note that it is logical to leave the English words in for many instances. This is so the LOTE speaker knows which words to use when they come across that situation in their Australian daily life. It applies in everything from health programs to transport options.

Last but not least think about language specific differences. There can also be many subtle differences within a language group. Just to name one example: Serbian can be written in Latin (Roman) or Cyrillic script. Which one should you use? You need to check your target audience closely and avoid making assumptions.

There are many differentiators when translating for CALD communities, and this also includes the design aspect (i.e. which images and symbols to use). It is important to remember that Australian society has a very large multicultural audience that needs to be communicated with in the right way.

In return, we can harness this vital part of our community to share knowledge and ensure very important information to those affected by mental health problems and those who care for them is getting across.

Coming back to “Trust” – the vital ingredient in reaching out to our vulnerable communities – trust is created in many ways - language is one of them and enables us to travel with those who need it at the right speed… the speed of trust.
Vicki Katsifis has worked in mental health for twenty years. She has worked as a peer support worker in the community and also acute services. Vicki has been a pioneer in the area of consumer advocacy training. She was employed at the NSW Institute of Psychiatry and designed, facilitated and evaluated consumer advocacy courses from 1995 – 2001. Vicki worked in multicultural mental health, at both the national and state level coordinating a culturally and linguistically diverse consumer and carer reference group and a Speakers Bureau. Vicki won the Consumer of the Year award from the Consumer Activities Network (CAN) in 2008 for “Contributions to the promotion and acceptance of people living with mental illness within the Australian Community”. She currently works at the South East Sydney Recovery College and as a trainer and assessor for the Mental Health Coordinating Council of NSW.

JOURNEY TO RECOVERY

VICKI KATSIFIS

The South Eastern Sydney Recovery College is the first Recovery College to be established by a Local Health District and one of the first in Australia. It provides an educational opportunity for consumers, carers and staff that is different, innovative and inspiring.

My journey with the Recovery College has allowed me to view its trajectory from diverse perspectives. I am a Peer Educator with the College, I have also been a student and I am a Senior Peer Learning Advisor. All of these roles have provided a transformative and challenging experience for me.

The Recovery College model has emerged as a new approach for providing mental health education. Co-production is central to the model, where educational courses are co-developed and co-delivered by Peer Educators and Clinical Educators and where consumers, carers and professionals participate together as students.

The concept started in the United States in the 1990s with the development of Recovery Education Centres, based on principles of adult education. This has been adapted in the United Kingdom and is known as the Recovery College Model.

The Recovery College provides a broad curriculum of recovery based courses, which are courses that incorporate recovery principles such as hope, connectedness, identity, meaning, purpose and empowerment. These courses are designed to increase the student’s own personal resources and wellbeing and focus on their strengths.
A range of courses are delivered in four streams:

- **Stream 1:** Understanding Mental Health Conditions and Treatment Options.
- **Stream 2:** Rebuilding your Life – Developing Knowledge and Skills.
- **Stream 3:** Getting involved in Mental Health and Making a Difference.
- **Stream 4:** Recovery Supporting Practices for Mental Health Workers.

The South Eastern Sydney Recovery College is the first college in the world to offer courses in languages other than English, which is an amazing achievement.

The ‘Navigating the Mental Health System’ course has been co-facilitated in Cantonese, Mandarin, Greek, Arabic, Spanish, Russian, Nepali and will be run in Macedonian in 2016. ‘Mindfulness’ has been co-facilitated in Greek and Arabic and ‘Making Mindfulness Your Own’ (Advanced Mindfulness) in Arabic. For some communities, particularly those with high levels of stigma and smaller communities, we were unable to recruit Peer Educators. Instead, we recruited community members to co-facilitate the courses and a Peer Educator attended the sessions and shared their lived experience story.

Courses are held in venues across South Eastern Sydney, including at community colleges which are Recovery College partners. Courses are free-of-charge for people with a lived experience who reside in South Eastern Sydney, their carers and friends. Staff and volunteers of the District can also access the courses, as well as staff from community college partners.

My first experience writing a course for the Recovery College as a Peer Educator was very empowering. I worked on the ‘Introduction to Recovery’ course and came together with the Clinical Educator with many ideas. I thought it was important to have a discussion on whether the students believed recovery was possible, and used a laminated card scale from one to ten for people to stand on and generate a discussion. Then we revisited the activity at the end to see if students had changed their views. We also had an activity on what recovery meant to each student, incorporating recovery pioneer Helen Glover’s work. Use of a recovery door with laminated keys and locks on what helps and hinders recovery was another activity.

We tried to make the course fun, interactive and transformational. I felt respected for my lived experience knowledge and for what I brought to the table. Co-production was a new experience for me but it changed both of us in the process. The Clinical Educator now believes all mental health education should use co-production and I feel my lived experience is valuable and I am an equal partner in the education process.

Being a student of the Recovery College afforded me a chance to see what the experience was really like for the students and whether it did have the capacity to transform lives. I attended ‘Introduction to Mindfulness’ and ‘Understanding Anxiety’.

In the mindfulness course, I found it to be a very beautiful and inspiring experience ... introducing mindfulness exercises each week in a safe and respectful way. I found myself practising at home mindfulness of sight, sound, touch and taste. The ‘Understanding Anxiety’ course allowed people to share their strategies and experiences in an equal space and I took home so many new strategies to try.

Each student of the Recovery College meets with a Peer Learning Advisor and gets to set life and educational goals for their future and discuss their learning support needs through an individual learning plan. This process is a way of orienting the students to the Recovery College and was adapted from the UK model. As a Peer Educator and Senior Peer Learning Advisor, I found it gives...
the advisor a chance to get to know each student quite personally as hopes, goals and dreams are discussed and strengths are identified in the plan. Courses are also recommended to the students that align with their goals and dreams for the future. Having a peer conduct the learning plan is quite integral to the process, as the learning advisor can share their lived experience and hopes and goals and also what it is like to attend some of the Recovery College courses. This serves to demystify the Recovery College, as it can be daunting to some students to enrol.

The Recovery College has a research and evaluation strategy attached to it through the University of Technology Sydney. The College has a lived experience researcher working on the project. There has been a range of quantitative and qualitative research methods used. Each course is evaluated and these evaluations indicate that 100% of students had their expectations met, would recommend the course to others and gained valuable knowledge. Focus group outcomes reveal life changing outcomes: “The Recovery College made me pinch myself…helped me to grow, and it gave me the push that I had been resisting for a long time”.

From the feedback of focus groups, themes emerged that the College provided connectedness, moving beyond mental illness and mental health services, and demonstrated the value of the co-production model.

Learning plans also form part of the research. Students are asked to rate their health before and after the Recovery College experience. Social inclusion is also measured, as well as attainment of goals. This helps to determine whether the College has had a positive impact on students’ lives.

The Recovery College has received awards for its innovative work. These include the South Eastern Sydney Local Health District Improvement and Innovation Award in the ‘Patients as Partners’ category and the ‘Consumer Choice’ Award. The Recovery College was recently announced as the Partner of the Year by St George and Sutherland Community College.

I hope to see Recovery Colleges all around Australia. I think every consumer, carer and staff member should have the opportunity to attend courses and transform their lives and the way mental health services are delivered. The College encourages people on their recovery journey, challenges the status quo and is inspirational.
Lily Wu migrated to Australia from China 25 years ago. At 18 years old she was diagnosed with a mental illness. With the support of her family, friends, psychiatrists and GP, as well as the benefit of the medications, Lily has been able to successfully recover, leading an active, meaningful, productive and ‘contributing life’. Lily achieved a Bachelor of Arts, majoring in English in China; qualifications which are recognised in Australia. Lily is a mental health consumer representative on many national, New South Wales, and local area committees where she strongly advocates for the views of people with mental illness from multicultural, refugee and immigrant backgrounds. In the past 12 years Lily has worked in a number of government and non-government mental health services. She is passionate about employment and educational programs for people living with mental illness. Lily’s valued contributions have been highly respected by her colleagues.

I am a Peer Support Worker in the South Western Sydney Local Health District’s Mental Health Unit, a peer worker for CAN Mental Health Inc and a contract peer educator for the South Eastern Sydney Recovery College. This sees me use my expertise in mental illness and bilingual language skills to provide adequate peer support through educational programs for consumers in the inpatient units and an external community setting.

The challenges I face have included peer support interventions with mental health consumers and especially culturally and linguistically diverse consumers in units in the Fairfield, Liverpool and Campbelltown Areas.

I have provided peer support and advocacy for a young, pregnant migrant lady and followed her journey through the community in my capacity as a Peer Worker in the Hospital to Home Program of CAN Mental Health Inc. I have a lot of empathy towards patients like this, as she is also facing a custody battle with her baby. I personally believe that people with mental illness who have the ability to care for their child or children should be encouraged and provided with support for them to be good parents. There are many good examples and I am one of them.

Although this is a matter for the courts to decide, my personal opinion hinges off a report from Victoria’s Public Advocate, Colleen Pearce, which said: “There is considerable evidence that people with disabilities are generally able to successfully parent their children if they are provided with education,” the report says. (Found here: http://www.theage.com.au/victoria/parents-with-a-disability-face-greater-chance-of-losing-children-report-20150921-gjri4e.html)

Families facing this situation can be referred to a long term mental health service such as PIR – Partners in Recovery. I also operate in another capacity in a Peer Educator role with the South Eastern Sydney Recovery College, I have also co-written ‘Navigating the Mental Health System’ in Mandarin, along with two other Chinese Bilingual Counsellors and have Co-Facilitated the course in Mandarin for a group of Chinese consumers and carers at the St. George Migrants Recourse Centre. The feedback I’ve received from them is really encouraging and rewarding. I have also presented my personal recovery journey to Nepali speaking ‘Navigating the Mental Health System’ course.

In my main Peer Support Worker role in Mental Health SWSLHD, I have provided, participated and contributed my expertise in system advocacy and system changes. I have presented my personal recovery journey to our SWSLHD Board and Senior Management. The feedback from the people I’ve met has been spiritually uplifting and rewarding. I was also heavily involved with developing the 2015 – 2024 Mental Health Strategic Plan and Accreditation process and met the Surveyors. This feedback has given me great hope that mental health services have improved, meet the national standards and meet the needs of consumers and carers.

Improving mental health care in our multicultural society is ‘Everyone’s Business’. We all need to do something in order to live in a peaceful and healthy world.
‘HAVE A LEMON, MAKE LEMONADE’: IN SUPPORTING MENTAL HEALTH RECOVERY

NEVENA SIMIC

Nevena Simic holds a Bachelor’s degree in Social Work from the University of South Australia and a Master’s degree in Counselling attained from the University of Adelaide. Beyond the education Nevena’s expertise extends to encompass counselling, social work, lecturing, education and research working with varied cultural groups, communities and age groups. Outside of providing counselling, psychotherapy and cultural consultancy services, Nevena most recently lectured within the social sciences stream in a subject focused on ‘Working with Aboriginal Australians and Diaspora Communities’ at Tabor College in Adelaide. Currently, Nevena is a representative for South Australia at a national level as part of the Mental Health in Multicultural Australia (MHiMA) National Culturally and Linguistically Diverse (CALD) Consumer and Carer Working Group (NCCCWG). As part of the Australian Association of Social Work, Nevena is also a member of the South Australian Branch Management Committee (BMC) and Private Practice Subcommittee (PPS).

My own lived experience of despair, anxiety, depression, trauma and recovery through a number of years, has made me a much more sympathetic social worker and culturally sensitive psychotherapist and able to recognise the issues in others and respond to them appropriately. By speaking out sharing my own knowledge and skills I hope to help others with mental health experiences lead interesting and fulfilling lives.

It wasn’t too long ago, that I was homeless, and broke not only financially, but in body and mind also. At the time of writing, it was 17 years ago, but it feels like yesterday. In fact, it would feel like yesterday to you too, if you had the experience of becoming a refugee.

There I was, living in Sarajevo, the capital of Bosnia & Herzegovina, the region of the mountain ravine that slopes down and spreads from east to the west running into the Sarajevo plain. Life was giving in abundance of health and wealth. Then, April 1992, the war came in Sarajevo and I was forced to leave my home.

All of a sudden, I was pulled out. Out from my home where comfort existed and thrown into the middle of nowhere. There was a huge void, but in the middle of it, I was not alone. Three children aged from four to ten years old were there with me and I was their mother. Shivering in angst, mostly we were confused. Our naked existence pushed my level of adrenalin on a high, and I embraced any prospect to move from where we were at that time. So we were moving from one place into another, and again another. However, it seemed that all our intentions and efforts were taking us into the same nowhere, the space of emptiness. Eventually, instinct forced me to stop panicking, learn to be alert and observant. I believe those instincts helped me enter a world where real understanding and acceptance of change exists.

At the beginning, I have to admit, these for me were completely new concepts; feelings and behaviours that were another burden that was draining my energy. Despite the vigilant mind being supportive, feelings of hopelessness and despair were destroying the whole of my actual being. The amount of stress was becoming only bigger and bigger. The bucket of tolerance wanted to explode.

In August 1998 my children, already teenagers and I arrived to Australia. Adelaide was the City of our choice. We believed the boys might be able to pursue a good education while I might retire. Australia for us was the open door. We embraced the opportunity. We learned the language and engaged within the life of the society. Feelings of belonging emerged. Australia became our homeland. For the peace given to us, I give back.

Nowadays, when millions of people around the world have no choice but to flee their homeland to escape war, genocide, torture and persecution, I, who once was recognised as a genuine refugee and had experience of ‘a fair go’, am proudly in a position to follow principles of social justice, human rights, collective responsibility and respect for diversity.

My experience of recovery from my own lived experience has led me to become a member of the MHiMA National CALD Consumer and Carer Working Group (NCCCWG). My voice has merged into this meaningful engagement of others from multicultural backgrounds with lived experience. Our expert efforts made the Framework for Mental Health in Multicultural Australia - Towards culturally inclusive services alive. And, we hope that in creating national mental health reform, this tool can help people from CALD communities in Australia experiencing mental health issues recover their well-being and be returned to strength in health and mind.
Angela Rao has been involved as a carer representative in the mental health sector for the last 6 years. She first became involved in mental health advocacy work with respect to the inadequacy of mental health services for CALD carers as a result of personal experience caring for a family member. CALD carers are a group who are often vulnerable and disenfranchised. Angela has network connections within the community, with community-based organisations and represents carers at the “grass roots” on different committees. She is WA’s carer representative on the Mental Health in Multicultural Australia (MHIMA) National CALD Consumer and Carer Working Groups (NCCCWG). Angela is also a member of the Lived Experience Advisory Group contributing to the implementation of WA’s Mental Health Bill 2013 and volunteer at Health and Disability Services Complaints Office (HadSCO). Angela’s valuable contributions ensure that issues for ethnically diverse groups are not forgotten.

I and my family migrated to Australia from Myanmar in 1994 and settled in Western Australia. A family member of mine, who I care for, fell ill with a mental illness. There were many challenges in dealing with services from the perspective of a carer from a culturally and linguistically diverse (CALD) background. These experiences gave me the passion and desire to try to advocate for carers of multicultural backgrounds.

In November 2013, I was appointed to the Mental Health in Multicultural Australia (MHIMA) National CALD Consumer and Carer Working Groups as Western Australia’s Carer representative. Prior to this I had minimal contact with other mental health carers nationally. My appointment as WA’s Carer representative to MHIMA has increased my knowledge, skills and confidence and extended my networks in WA and across Australia. I have shared the knowledge and skills gained through working with MHIMA with other carers from multicultural and refugee backgrounds in WA. My work has a strong emphasis on empowering other carers and increasing their knowledge around mental illness and recovery. Being a National CALD carer advocate for MHIMA also played a part in my being selected to participate in work to implement WA’s Mental Health Act 2014. This is all due to my appointment to the MHIMA NCCCWG.

My positions are varied and I am always on the lookout to ensure that carers of CALD background are not overlooked. I’ve learned through my discussions and information sharing with other MHIMA carers that the issues which CALD carers face in WA are no different from those from other states in Australia.

In November 2014 I was invited to speak about my lived experience as a national CALD Carer Advocate and as a representative for the MHIMA at the Raising our Voices Multicultural Mental health and Well-being Conference which was held in Canberra. At the conference I met other carers like me from different parts of Australia. I shared the knowledge I gained with other MHIMA carer members and in feedback on policies affecting carers of CALD backgrounds.

It’s important that CALD carers know their rights and are treated with respect and dignity and have their views and needs taken into account along with the views and needs of their loved ones receiving care when decisions are made that impact them. My work with MHIMA allowed me to become more involved in contributing the CALD carer voice in activities such as; lobbying, advocacy, media campaigns, surveys, policy development and committee representation.

With the support of MHIMA NCCCWG members, I have achieved all of the above. I enjoy the work I do on behalf of MHIMA. I hope to continue to expand my skills, knowledge and networks to benefit all carers of CALD backgrounds in WA and Australia.
The importance of advocacy for people with mental health issues from CALD backgrounds

Sonia Di Mezza

Sonia Di Mezza is the Deputy Chief Executive Officer of the Aged, Carer and Advocacy Service (ADACAS), a not-for-profit organisation based in the ACT. She holds a Masters of International Law. She has worked as a human rights lawyer in Pakistan, Lebanon, Sudan, India and Australia and speaks French, Italian, Spanish and Arabic. The focus of her current work is on advocating for the human rights of older people in the ACT with a special interest in those from a culturally and linguistically diverse (CALD) background.

For a person with mental health issues it can be problematic asserting one's voice and having one's rights realised. The situation can become even more complex when a person not only has a mental health issue, but is of a culturally and linguistically diverse (CALD) background.

I am the Deputy CEO of the ACT Disability, Aged and Carers’ Advocacy Service (ADACAS). My work includes advocating on behalf of older people, people with disability and people with mental health issues. I first became involved in the Mental Health in Multicultural Australia (MHiMA) National CALD Consumer and Carer Working Group (NCCWG) in 2013. My involvement in the group came from caring for my mother who was beginning to show the first signs of developing Alzheimer's disease. So I have personal lived experience of caring and advocating for my Mother's needs.

When a person has a mental health issue it can be difficult to articulate what they might want or need. The mental health issue can in itself, be difficult to deal with, so being able to communicate and access the support and services that might be needed can be challenging.

Other factors that may compound the situation further are a person’s ability to communicate effectively in English, or when they face barriers which are drawn from either their cultural background, or from adjusting to life in a new country. These may compound the situation even further. It may make it difficult for them and perhaps their family to understand what is happening and how they can access the help they need.

Having an advocate in the life of a person with a mental health issue and from a CALD background can make the world of difference. The advocate works on the express wish of the client, finds out what help they would like and what difficulties they are facing and then works closely with the client to ensure that they are able to access their rights.

Sometimes the advocate is able to speak the language of the client, making it easier to communicate and understand what is needed. The obvious advantages of having a bilingual worker who is also an advocate are manifold. The advocate is able to properly understand both the language of the client as well as the cultural context within which they function. Where the language is not spoken the advocate can access interpreters or other bilingual workers who can help bridge the communication gap.

The relief that our clients experience when accessing advocacy in such a way can often be significant. I can provide many examples of how advocates have helped and ultimately improved outcomes and the life of people living with mental illness. One example of this was a client we assisted who had depression due to domestic violence. She had been subjected to and been kept in social isolation by her husband for more than two decades due to her not being able to understand English. With the support of her advocate, she was able to break away from her destructive marriage and access legal assistance, counselling to deal with her depression, medical assistance to help improve her health, and public housing. In many instances the impact of advocacy on CALD clients is life-changing. Without advocacy support many people simply would not be able to access the mental health services they desperately need. If you should find yourself in such a situation, do not hesitate to locate an advocate in your state or territory that may be able to support you.

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Mohammad Al-Khafaji
Youth Chair

ABOUT FECCA

FECCA is the national peak body representing Australians from culturally and linguistically diverse (CALD) backgrounds. We provide advocacy, develop policy and promote issues on behalf of our constituency to government and the broader community. FECCA supports multiculturalism, community harmony, social justice and the rejection of all forms of discrimination and racism.

FECCA’s membership comprises state, territory and regional multicultural and ethnic councils. FECCA has an elected executive committee and a professional national secretariat implementing policies and work programs on behalf of its membership and stakeholders.

For more information and to read more about FECCA’s policies and program, please visit our website: www.fecca.org.au. Alternatively, please contact the FECCA office on (02) 6282 5755, or email: admin@fecca.org.au.
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