Stepping out of the shadows Promoting acceptance and inclusion in multicultural communities in Queensland

Final report

April 2008 – June 2009

Queensland
Government

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Introduction

Background

In 2007-08, the Queensland Transcultural Mental Health Centre (QTMHC) developed a national multicultural community stigma reduction resource on behalf of *Multicultural Mental Health Australia* called *"Stepping out of the shadows – Reducing stigma in multicultural communities"*. The resource consisted of an Expert Trainer Manual, a Community Trainer Manual and a training DVD in 17 languages. The research and development of these resources included focus groups with 11 different multicultural communities in Queensland, training of seven expert trainers nationally and piloting of the training program via 63 community trainers from over 20 different multicultural communities across Australia.

In 2008, the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention provided funding to the QTMHC via the Mental Health Directorate, Queensland Health, to implement the program *Stepping out of the shadows – Promoting acceptance and inclusion in multicultural communities* in Queensland. Project implementation included the development and dissemination of communication strategies, mainly using the ethnic media, and the recruitment and training of a pool of Bicultural Community Mental Health Promoters to conduct a language and cultural adaptation of the *"Stepping out of the shadows – Reducing stigma in multicultural communities"* Community Training material and then deliver and evaluate up to ten hours of workshops with their own cultural communities.

Training packages on stigma reduction developed by the Qld Transcultural Mental Health Centre for Multicultural Mental Health Australia, (left) – Package for Expert Trainers, and (right) – Package for Community Trainers. The latter includes a 10 minute teaching DVD, *Stepping out of the shadows: A family's story* narrated in 17 languages including English.

Rationale

Evidence shows that the stigma associated with mental ill health has a significant negative impact across all cultures and communities, with some studies stating that the impact of stigma on a person's life can be as harmful as the effects of the mental illness itself.[1] Stigma has been "*demonstrated to be an obstacle to increasing mental health literacy and help seeking, early detection and early intervention, promoting isolation, marginalisation and discrimination.*"[2]

As stigma is a socially constructed phenomenon, "*cultural factors are key determinants of the nature and amount of stigma across different culturally and linguistically diverse (CALD) communities*"[3]. As such, the causes and effects of stigma in CALD communities can be quite distinct from the mainstream, and individual cultures will each have specific elements that are conducive to increasing or reducing stigma.

Generally however, "*CALD communities generally have low levels of knowledge around mental health issues/illness, are more at risk of developing mental health issues, are less likely to receive needed care than the general population and have a lower rate of participation in health promotion, prevention and treatment programs.*"[4]

There is limited evidence about strategies that can be implemented to reduce stigma in CALD communities. However, some work undertaken in Western Australia[5] plus ongoing work and consultations implemented by the QTMHC,[6, 7, 8] which guided the development of the **Stepping out of the shadows** training package, have provided a platform to implement this project which is necessary to provide CALD communities with stigma reduction education in a culturally meaningful and relevant manner.

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[1] Francis, C. et al (2002).
[2] MMHA (2002).
[3] Ibid
[4] Ibid
[5] Bakshi, L., Rooney, R. & O'Neil, K. (1997)
[6] Prasad-Ildes, R. & Ramirez, E. (2006).
[7] Chand, M. (2005)
[8] Qld Transcultural Mental Health Centre & Multicultural Centre for Mental Health and Wellbeing Inc. (2003)

Queensland Stigma Reduction Project Launch in May 2008. Enrique (Topo) Rodriguez (left) one of the keynote speakers at the launch talking to leaders and elders of the Iranian community. Topo, a rugby legend born in Argentina, shared his experience living with undiagnosed bipolar and stigma.

Goals and objectives

As per the Queensland Stigma Reduction Project Plan (Appendix 1), the project goal was:

To reduce the stigma associated with mental ill health among culturally and linguistically diverse (CALD) communities in Queensland.

The objectives of the project were as follows:

- To increase knowledge and understanding amongst target community members and leaders about mental health, mental ill health, the stigma associated with mental illness and its impact on consumers, families and communities.
- To increase the capacity of target communities to accept, include and support members with mental ill health.
- To increase the capacity of target community members to access relevant mental health services.

Target groups

The key target CALD communities were:

1. Afghani (Brisbane and Gold Coast)
2. Burundian
3. Cantonese-speaking
4. Croatian-speaking
5. Greek
6. Italian (Brisbane and Cairns)
7. Iranian (Gold Coast)
8. Japanese (Cairns)
9. Korean
10. Mandarin-speaking
11. Maori
12. Samoan
13. Serbian-speaking
14. Spanish-speaking
15. Sudanese (predominantly South-Sudanese)
16. Turkish (Gold Coast)
17. Vietnamese

Human resources

- A team of 13 sessional Bicultural Community Mental Health Promoters (BCMHPs) were employed. Some Promoters worked across communities, ie. Iranian and Afghani, and some communities had two Promoters working in different geographical areas, ie. Italian. There were difficulties retaining Promoters during the duration of the project in some communities, ie. Cantonese-speaking and Korean. Promoters worked a total of 150 hours each during the duration of project.
- Stigma Reduction Project Co-ordinator (1 FTE).
- Two short term Project Officers were employed to design, implement and document a detailed community communications strategy and engage with the NGO sector and ethnic/multicultural associations in order to deliver the *Stepping out of the shadows* workshops to established groups from additional CALD communities.
- CALD Consumer Participation Co-ordinator who played an active, supportive role co-ordinating consumers involved in the project.
- Mental Health Promotion, Prevention and Early Intervention Co-ordinator provided project supervision.

The team of Bicultural Community Mental Health Promoters in June 2008 attending training to equip them to facilitate the *Stepping Out of the Shadows* in their own cultural communities.

Key considerations and principles

There were several key considerations that underpinned the development of the project. These considerations included cultural appropriateness and the different levels of readiness to engage in mental health among the participating cultural communities. The diversity was primarily in the following areas:

1. Cultural frameworks and explanatory models of mental health and mental ill health.
2. Levels of acculturation and levels of knowledge about, and engagement with, Australian mainstream mental health systems.
3. Community infrastructure and community leaders' attitudes towards, and understanding of, mental health and mental illness.

In response to these considerations, the following principles and models informed the development and implementation of project strategies:

1. Culturally appropriate mental health promotion principles (Refer to the *Stepping out of the Shadows* (SOS) Expert Trainer Manual Literature Review – Appendix 2)

Key principles outlined in the literature state that to be effective in CALD communities, mental health promotion must:

- o align with the target community's culture;
- o follow community development principles and incorporate the community's existing inherent mental health practices;
- o follow a community readiness model;
- o establish and develop appropriate and relevant communication including the cultural and linguistic adaptation of material and the use of appropriate communication channels (eg. through elders or community leaders, ethnic media, etc).

2. Community Readiness Model

The Community Readiness Model[9] identifies and outlines nine levels of 'readiness' to engage with particular health promotion initiatives that a community may fall within. The nine levels range from lack of awareness or complete denial that a particular health issue exists in the community, to mobilisation and autonomy in effectively addressing the issue as a community. Communities may align with more than one level at a time, and different groups within each community may also align with different levels.

Each level of readiness can serve as a guide to the types of initiatives that would best serve the community. For example, if a community is predominantly in denial about the existence of an issue, awareness promoting initiatives would be the most effective and relevant.

The Community Readiness Model was utilised to prioritise the CALD communities this project would be working with during the life of the project. The Community Readiness Questionnaire (Appendix 3) was applied to workers from communities that services had identified, and then to leaders from those communities in which workers and other key informants had further prioritised.

3. Evidence based stigma reduction principles (Refer to SOS Expert Trainer Manual Literature Review)

As outlined in the Literature Review, the evidence based principles governing the effective reduction of stigma associated with mental ill health in CALD communities include:

- o initiatives that must respond to the diversity between each targeted CALD community, there is not a 'one size fits all' approach;
- o the three levels of stigma (community, service and individual levels) which must all be addressed;
- o the strategic involvement of consumers of mental health services which is crucial. Evidence shows one of the most effective methods

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[9] Plested, B.A., Edwards, R.W. & Jumper-Thurman, P. (2005).

of reducing stigma is positive contact between consumers (recovered or in the journey of recovery) and general members of the communities ('contact theory');

o the support and empowerment of carers and consumers to remain safe and ensure they are not given the responsibility of reducing stigma;

o initiatives that inherently increase mental health literacy (as defined in the Literature Review).

Project implementation

Strategies

As per the Queensland Stigma Reduction Project Plan, seven key strategies were developed to achieve the objectives. For a further breakdown of key activities for each strategy, refer to the Project Plan (Appendix 1). The project strategies were as follows:

1. Up-skill, support and retain/enhance the pool of Bilingual Community Mental Health Promoters (BCMHPs).

2. Engage with CALD communities to gain their support in the implementation of project strategies aimed at their own community.

3. Develop and deliver effective stigma reduction messages using the most effective communication mechanisms in each community.

4. Deliver the *Stepping out of the shadows – Reducing stigma in multicultural communities* sessions to each target community.

5. Involve mental health consumers in the delivery of stigma reduction activities.

6. Support community initiatives aimed at decreasing stigma and increasing mental health literacy.

7. Integrate relevant components of the project with other QTMHC Programs for sustainability.

Model

In 2007, QTMHC developed the *Operational Framework: Bilingual Community Mental Health Promoter Positions* (Appendix 4), a model to engage with members of CALD communities around mental health and mental illness. The stigma reduction project built on this work and established its objectives, strategies, key considerations and principles. This Model consists of a pool of BCMHPs who engage with their own communities to deliver and evaluate communication strategies, training and other related initiatives related to reducing stigma and increasing levels of mental health literacy.

The BCMHP Model was considered as the most effective model to meet the project's criteria and requirements for several reasons:

o   Evidence shows[10] that BCMHPs have the most capacity to present as a trusted figure in the community and thus engage with community members and transmit messages.

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[10] Vogel, J. (2009)

o BCMHPs act as a bridge (culturally and linguistically) between their communities and the project material and methodology, QTMHC and other relevant mental health organisations. This allows messages, information and processes to be appropriately adapted to individual communities by the BCMHP and for community and cultural needs to be effectively and safely relayed back to organisations.

The Stigma Reduction project applied and enhanced the BCMHP Model as follows:

1. Recruitment of BCMHPs for each of the target communities

    o Positions advertised through relevant media outlets, community organisations and strategic word of mouth.

    o Applicants who met the selection criteria were selected for an interview.

    o Key community leaders were invited to sit on interview panels wherever possible.

2. BCMHPs were trained in key relevant areas

    o Qld Health and QTMHC orientation.
    o Orientation on mental health promotion, prevention and early intervention conceptual framework, program and the Stigma Reduction project.
    o Training on the Stigma Reduction package.

3. BCMHPs were allocated 150 hours to use over the course of 12 months to implement their role.

4. The Project Co-ordinator monitored the BCMHP's work and progress, provided ongoing additional training and professional development and supervised each worker providing debriefing and professional supervision.

Consumer participation was integrated into the Model through a Consumer Perspective Education (CPE) Model (see Consumer Perspective Education Handbook – Appendix 5). CALD consumers of mental health services who identified as having lived experience of mental illness and expressed interest in becoming a Consumer Perspective Educator were trained to deliver 30 minute sessions whereby they 'tell the story' of their experience with stigma and living with mental illness.

CPE Model development (See Appendix 5)

1. The Project Co-ordinator and CALD Consumer and Carer Participation Co-ordinator planned a best practice model and implementation plan.

2. Three Consumer Perspective Educators were recruited and trained. Their role involved:

- o running focus groups with other CALD consumers and providing direct feedback to inform the development of a Consumer Perspective Education Handbook;
- o contributing to the training of other CALD consumers to become Consumer Perspective Educators; and
- o delivering Consumer Perspective Education Sessions in co-ordination with BCMHPs who were delivering SOS community sessions.

Implementation methodology

Upskill and support the pool of BCMHPs

- Identify key training and professional development components for BCMHPs.
- Implement regular group supervision, professional development and team building activities for BCMHPs.
- Provide one-on-one supervision sessions to BCMHPs in an ongoing capacity and at least once after the delivery of an initiative to provide debriefing, project support and collect verbal feedback.
- Support BCMHPs in facilitating referrals by providing referral pathway information.
- Link BCMHPs in with other relevant QTMHC projects, services and initiatives.

Communication of key messages

- Organise a project launch to introduce the project and the BCMHPs to leaders of target communities.

  - o Liaise with BCMHPs to identify key community leaders and members to attend the launch.
  - o Develop and launch a project brochure translated into 16 languages.
  - o Prepare a launch program including the identification of key note speakers.
  - o Identify and organise a venue, culturally appropriate catering and entertainment.
  - o Implement launch.
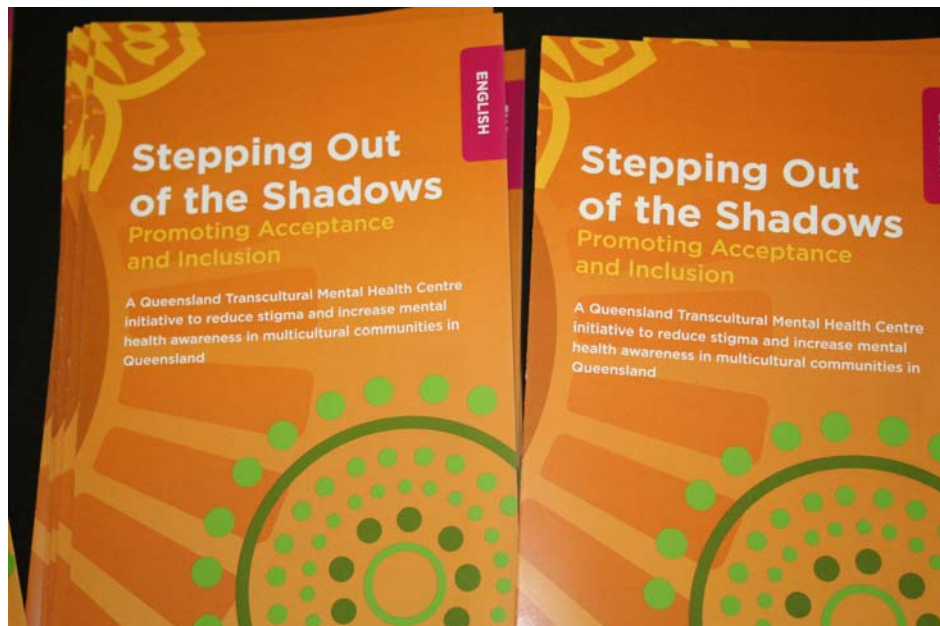
- Establish community readiness levels of target communities in order to design and format stigma reduction key messages.

  o Identify key informants from each target community, including BCMHPs.
  o Key informants to complete Community Readiness Survey. The diversity within and among CALD communities is also reflected in their different levels to engage in mental health and mental illness activities. To assess these levels the Community Readiness Model was used and the Community Readiness Questionnaire applied to key community informants.
  o Collate feedback and establish community readiness level. Data analysed is used to establish a baseline before project implementation and at project completion to assess any shift in readiness. The Model locates readiness in nine stages and each stage has corresponding activities and actions that encourage communities to progress and develop in readiness.
  o Design a narrative capturing stigma reduction messages: a family story.

- Widely disseminate stigma reduction key messages.

  o Liaise with BCMHPs to identify the most effective channels of communication for each target community.
  o Develop and translate communication strategy materials including written and audio material for print media and radio.
  o Commence dissemination of key messages using the media prior to BCMHPs initiating community engagement.
  o Support BCMHPs to continue disseminating stigma reduction key messages effectively.

Advertising stigma reduction skits to the Italian-Australian community in Dimbulah (Cairns and Hinterland Health Service District)

Cultural and language adaptation and delivery of the *Stepping out of the shadows: Reducing stigma in multicultural communities* training package

- Provide train-the-trainer training to BCMHPs.
- Support BCMHPs to adapt training material and key stigma reduction principles in order to implement community sessions in the most culturally appropriate and meaningful manner.
- Support BCMHPs to strategically identify which groups within their communities should be prioritised to receive training and attend initiatives (eg. community leaders, high need groups and groups that are best placed within the community to impact levels of community stigma).
- Support BCMHPs to effectively engage with their respective communities and recruit participants, ie. linking with agencies that provide direct service to members of target communities.
- Support BCMHPs so they are able to provide information about mental health services available and facilitate access to these when required.
- Support BCMHPs to effectively adapt evaluation mechanisms.
- Support BCMHPs to deliver and evaluate training sessions.

Support community initiatives aiming to decrease stigma

- Support BCMHPs in identifying and assisting with community initiatives aimed at reducing stigma, ie. find out those who are already considering or planning activities, discuss ways to enhance these, identify infrastructure

and other resources to support them, including identifying funding sources and linking the community with grant information workers.

Ethnic media groups interviewing QTMHC staff about the impact of stigma in CALD communities. Media outlets took the initiative to broadcast material via websites, television, radio and print media.

Integrate relevant components of the project with other MHPPEI Programs for sustainability

- Liaise with BCMHPs and use project evaluation results to establish mental health literacy needs within the targeted communities.
- Liaise with MHPPEI staff to establish how to best link in the Stigma Reduction Project to maximise outcomes and achieve sustainability.
- Liaise with the MHPPEI Co-ordinator and other QTMHC staff to respond to mental health literacy needs identified by communities.
- Implement activities as required.

Project achievements

Evaluation methodology

Conducting an evaluation of projects designed for CALD communities can present significant difficulties. In order to design effective and meaningful evaluation strategies and mechanisms, several factors were taken into consideration.

Considerations

1. *Lack of culturally appropriate evaluation tools suitable for use with CALD communities.* Most evaluation tools are designed from an individualistic framework and are based on bio-medical models of mental health and evaluation.

2. *The impact of translation on evaluation tools.* Translating evaluation tools from English into other languages can impact on the specific and overall meaning of the material's content and the overall efficacy of the evaluation. Cultural aspects of evaluation tools may also require translating which can further impact on meaning. Any change to meaning can alter or affect the type of feedback and evaluation data that is collected. This can present problems when working with validated tools, and can also present problems with maintaining consistency and interpreting data.

3. *Language and literacy levels (poor literacy and language levels of participants completing the evaluation).* Significant numbers of people in CALD communities are illiterate in English and/or their native language. As such, evaluation mechanisms must take the possibility of illiteracy into account.

4. *Evaluation as a foreign concept to certain cultures or cultural sub groups.* Conceptually, certain types of evaluation tools, especially ones seeking to establish personal opinions, frameworks or attitudes, are completely foreign to some cultural groups. Presenting such material to a group (even in their native language) can present and/or create significant challenges in eliciting data and serious barriers to participation and building trust within the group and community. Factors such as age, levels of acculturation and individual experiences and education also contribute to how evaluation tools are received and perceived.

Taking these factors into consideration, the project evaluation model was designed to try and capture data in ways that would be suitable for a diverse range of cultural and community needs.

Evaluation mechanisms

As outlined in the *Table of Achievement of Project Objectives* (below), a variety of evaluation mechanisms were implemented to capture data and outcomes. The written evaluation tools used with the participants (Appendix 6: *Training Program Evaluation Form* and Appendix 7: *Family Stigma Questionnaire*) were translated into relevant community languages. From the *Stepping out of the shadows* Community Training Package, the Family Stigma Questionnaire was selected over the Individual Stigma Questionnaire as it aligned more effectively with the predominantly collectivist cultural frameworks of the target communities.

Leaders from the Greek and Chinese communities attending the Stigma Reduction Project launch in May 2008.

The Maori Community Mental Health Promoter (left) engaging with a leader at the Project launch, May, 2008.

Table of achievement of project objectives (Outcomes Evaluation)

OBJECTIVES	EVALUATION MECHANISMS	INDICATORS OF SUCCESS
Increase knowledge and understanding amongst target community members and leaders about mental health, mental ill health, the stigma associated with mental illness and its impact on consumers, families and communities.	o Baseline Community Readiness Evaluation Questionnaire (Pre and Post). o Family Stigma Questionnaire (Pre and Post). o Non-Written Pre and Post Yes/No Question (participants stick coloured dots on a piece of paper to respond). o Training Program Report completed by BCMHPs after each workshop. o Verbal feedback provided by BCMHPs to Project Co-ordinator. o Facilitator Questionnaire.	o <u>Increased levels of community readiness to engage in mental health in target communities</u>. After 14 months, at post-project, three (3) communities have increased one level of readiness to engage in mental health, one (1) has increased two levels and four (4) have remained at the same level. It was difficult to determine shifts in other communities due to the lack of key informants. It is important to note that three (3) communities established their community readiness baseline at the time the other communities were conducting the post-assessment. These project achievements at the community level are significant, as moving from one level to the next involves an important shift in community attitude and means that a major number of people in these communities have been reached by the project multi-strategies. o <u>Participants' self-perceived increase in the understanding of stigma</u>. 66% of participants reported that because of attending the training they understood more about stigma in their community.

OBJECTIVES	EVALUATION MECHANISMS	INDICATORS OF SUCCESS
Increase capacity for members of target communities to accept, include and support members with mental ill health.	o Baseline Community Readiness Evaluation Questionnaire (Pre and Post). o Family Stigma Questionnaire. o Primary (supporting referral to a mental health service) and Secondary (providing information about services upon request) Access Records. o Verbal feedback provided by BCMHPs to Project Co-ordinator. o Project Co-ordinator recording the number of referrals as an indicator of support to someone with a mental illness.	o <u>Increased levels of community readiness in target communities</u>. As described above. o <u>Decrease in levels of stigma amongst participants</u>. 53% of participants reported that because of attending the training they thought differently about people with mental illness and their families, and 60% reported they believed they would behave differently towards people with mental illness and their families. o <u>Number of referrals made to QTMHC TCCS and other relevant mental health services</u>: 125. This includes self-referrals, family referrals, community referrals, BCMHPs referrals.
Increase capacity for target community members to access relevant mental health services.	o Primary (supporting referral to a mental health service) and Secondary (providing information about services upon request) Access Records. o Verbal feedback provided by BCMHPs to Project Co-ordinator. o Project Co-ordinator liaising with QTMHC staff to record numbers of participants attending other MHPPEI initiatives/training sessions. o Project Co-ordinator recording number of referrals made to QTMHC TCCS and other mental health services.	o <u>Increased levels of community readiness in target communities</u>. As described above. o <u>Number of community members who linked with other MHPPEI QTMHC initiatives</u>: 105 to the Depression and Chronic Disease Program, 18 children of participants became involved in the Building Resilience in Transcultural Australians (BRiTA Futures) Program. o <u>Number of referrals made to QTMHC TCCS and other relevant mental health services</u>: 125. This includes self-referrals, family referrals, community referrals, BCMHPs referrals.

Table of achievement of project strategies (Process Evaluation)

STRATEGIES	EVALUATION MECHANISMS	INDICATORS OF SUCCESS
Up-skill, support and retain/enhance the pool of Bilingual Community Mental Health Promoters (BCMHPs).	o Record training received by all BCMHPs (see BCMHPs Training Table). o Excel spreadsheet with project outcomes conducted by BCMHPs. o Record BCMHP retention rate. o Project training and support feedback form completed by BCMHPs at the end of project.	o All **22 BCMHPs** completed induction and ongoing training so they were able to conduct responsibilities in accordance with Qld Health criteria and project requirements. o **100% of BCMHPs** reported that they had been effectively trained and supported. o A satisfactory BCMHP **retention rate of 69%**
Engage with CALD communities to gain their support in the implementation of the project strategies aimed at the community.	o Outcomes of Community Readiness Questionnaire completed pre and post project by key informants from target communities. o Feedback from BCMHPs from each target community. o Records of project implementation.	o Number of key informants who completed the Community Readiness Questionnaire at pre-project: **33.** o Number of key informants who completed the Community Readiness Questionnaire at post-project: **13.** Three (3) communities established community readiness baseline at the time the rest of the communities were assessing community readiness post-project as they started later in the project. o Number of community leaders who attended the project launch: **97.** o Number of communication strategies implemented with the direct support of the community: **25.** o Number of two-hour community stigma reduction sessions delivered: **89.** o Estimated number of CALD people reached by the project's multi-strategies: **112,529.** o Number of agencies linked to the project: **28.**

STRATEGIES	EVALUATION MECHANISMS	INDICATORS OF SUCCESS
Develop and deliver effective stigma reduction messages using the most effective communication mechanisms in each community.	o Community Readiness Evaluation Questionnaire. o Record of communication strategies implemented. o Record of number of people reached by communication strategies. o Record of number of people who responded to communication strategies. o Record number of self referrals made to QTMHC TCCS as a result of the communication strategies. o Training Program Report completed by BCMHPs coupled with their verbal feedback provided to the Project Co-ordinator.	o Baseline of community readiness assisted in designing culturally appropriate stigma reduction messages and strategies and used communication mechanisms appropriate for each level of readiness: **the story of a family dealing with and overcoming stigma and discussions about stigma and the project were communicated via a play, a skit, radio ads and interviews, newspaper ads and articles, website articles and ads, project brochure distribution, BCMHPs personal contact, business card distribution and a TV documentary.** o Number of communication strategies implemented: **8.** o Estimated number of people reached via communication strategies: **111,679.** o 22 people contacted the QTMHC, 10 were accepted by the clinical services program
Deliver the *Stepping out of the shadows – Reducing stigma in multicultural Communities* Training Package in each target community.	o Training Program Report completed by BCMHPs. o Verbal feedback provided by BCMHPs to the Project Co-ordinator. o Program Evaluation Questionnaire. o Facilitator Questionnaire.	o Number of two-hour community stigma reduction sessions delivered: **89**. 64 delivered as part of the 4 workshop series, 6 as 2 workshop series and 19 as one-off workshops. o Number of CALD people attended community workshops: **341.** o Number of CALD people attending other stigma reduction group initiatives, ie. play, skit, seminars, project launch: **509.** o Participant levels of satisfaction with training programs/initiatives: **53% of participants believed the materials used were very useful, 42% believed the material was useful and no participants reported the material as not useful. 66% of participants believed the training program they attended respected their cultural values very much, and only 2% believed it had not really**

STRATEGIES	EVALUATION MECHANISMS	INDICATORS OF SUCCESS
		respected their cultural values.
Involve mental health consumers in the delivery of stigma reduction activities.	o Feedback from QTMHC CALD Consumer and Carer Participation Co-ordinator. o Record of mental health consumer participation.	o Model to upskill, resource and support mental health consumers as Consumer Perspective Educators developed with the active collaboration of the QTMHC CALD Consumer and Carer Participation Co-ordinator. o Number of mental health consumers trained as CALD Consumer Participation Educators: **5.**
Support community initiatives aimed at decreasing stigma and increasing mental health literacy.	o Record of community initiatives being supported by BCMHPs.	o Number of communication strategies implemented with the direct support of the community: **25.**
Integrate relevant components of the project with other QTMHC programs for sustainability.	o Integration processes recorded. o Record of people linked to other mental health promotion initiatives.	o MHPPEI Programs **co-ordinated** to link community members across projects and programs. o Number of community members participating in the stigma reduction activities who linked with other MHPPEI QTMHC initiatives: **123** (105 to the Depression and Chronic Disease Program, and 18 children of participants to the Building Resilience in Transcultural Australians (BRiTA Futures) Program).

Description of achievements

Objective 1: Up-skill and support the pool of BCMHPs

1.1 BCMHP Training Table

Training Received by BCMHPs April 2008 – July 2009	Received	Facilitator	Training Material
Queensland Health and PA Hospital Orientation, Code of Conduct, Workplace Harassment	April 2008	MHPPEI Co-ordinator	BCMHP Orientation Manual
Orientation to QTMHC, MHPPEI Program and HRM Administration processes.	April 2008	MHPPEI Co-ordinator	BCMHP Orientation Manual, project plan and materials
AUSEINET Introduction to Mental Health, Mental Health Promotion, Prevention of Mental Ill-Health and Early Intervention Module	July 2008	MHPPEI Co-ordinator (Registered Auseinet Module Trainer)	Auseinet Training Package
Stepping out of the shadows Project Orientation	May 2008 July 2009	MHPPEI Co-ordinator & Project Coordinator	*Stepping out of the shadows* Community Trainer Manual
Stepping out of the shadows Training Session 1 – 4 Included Consumer Perspective Education Session	July 2008	MHPPEI Co-ordinator & Project Co-ordinator CALD Consumer Carer Participation Co-ordinator Multicultural Mental Health Consumer and Carer Network President	*Stepping out of the shadows* Community Trainer Manual
Mental Health First Aid	June-July 2008	MHPPEI Co-ordinator (Registered MHFA Instructor)	Mental Health First Aid Instructor Kit
Orientation to the Mental Health System, Mental Health Act, Referral Pathways, QTMHC TCCS	July 2008 July 2009	TCCS Co-ordinator	Flow Chart (see BCMHP Orientation Manual)
Community Development and Engagement	February 2009	Project Co-ordinator & Chronic Disease Project Co-ordinator	Surviving Community Work Manual
Orientation to QTMHC Library and Multilingual Resources	July 2009	QTMHC Resource & Snr Administration Officer	Library Resource Pack

1.2 Support provided to BCMHPs

- BCMHPs received one hour one-on-one supervision sessions with the Project Co-ordinator after delivering each training program/initiative. During these supervision sessions, necessary debriefing was provided, processes and administrative work were monitored and support provided as necessary. Feedback on BCMHPs progress, professional achievements and recommendations for improvement were provided. Feedback from BCMHPs regarding the QTMHC, the project and the Project Co-ordinator's processes was collected. Opportunities for future professional development were identified.

- BCMHPs received ongoing one-on-one supervision sessions with the Project Co-ordinator as requested and required by BCMHPs. Relevant logistical and professional support was provided.

- Team building and development of group dynamics was conducted at all group supervision sessions, and additionally when new BCMHPs were employed.

- BCMHPs were informed of relevant voluntary professional development opportunities available within the sector.

- Additional information about referral support was made available by the Project Co-ordinator and TCCS Intake Officer. BCMHPs were encouraged to contact either of these workers whenever a referral was necessary to identify the best referral pathways and service provider information.

1.3 Staff retention and levels of satisfaction with support and communication

- Throughout the 15 months of the project, 22 BCMHPs were employed and 15 or 69% of BCMHPs were retained:

  o Three (from the Korean and two from the Maori communities) discontinued their employment due to personal reasons, ie. health and family problems. They reported feeling regret at having to discontinue with the project and expressed high levels of satisfaction with their time on the team.

  o Four BCMHPs' positions were discontinued from the project (from the Cantonese speaking, Croatian, Afghani (Brisbane) and Greek communities) as it was assessed that despite training and support they demonstrated an inability in being able to carry out their roles effectively.

  o 100% of retained staff reported that they felt extremely satisfied with the levels of support and training they had received and with the communication between themselves and the Co-ordinator. (As per verbal feedback and Appendix 8: *Project training and support feedback form*)

- Areas of high satisfaction included communication, one-on-one supervision sessions, responding to professional needs in a holistic way, logistical support with administrative components such as time sheets, etc. *"Everyone has been very helpful and responded to every need quite quickly. Thank you."*

- Areas identified as needing improvement or presenting challenges for the BCMHPs included Qld Health bureaucracy (high levels of paperwork, not being paid on time, receiving pay slips, sessional work time sheet processes) and limited number of working hours.

Objective 2: Engage with CALD communities to gain their support in the implementation of the project strategies aimed at the community

Engaging with members of CALD communities particularly with those who are in influential positions is essential to achieve outcomes in the mental health promotion field. Employing mental health promoters from target cultural communities and linking with agencies that are already delivering direct services to this population or want to invest in reaching out is also crucial in gaining trust of communities so they support the project. Project outcomes detailed in the *Table of achievement of project strategies* show that the level of engagement planned was achieved with the support of target communities. Services and initiatives cannot be implemented without this support.

Objective 3: Develop and deliver effective stigma reduction messages using the most effective communication mechanisms in each community

3.1 Number of communication strategies implemented

As per the Stigma Reduction Project *Evaluation Table* (Appendix 9), and the *Community Readiness Evaluation Outcomes* (Appendix 10)*,* desired numbers of communication strategies were delivered across all target communities in culturally relevant ways, reaching significant numbers of community members.

Members of the Burundi community performing a play on reducing of stigma in October 2008, attended by 79 people who reported at post-evaluation some shifting in their attitude towards mental illness.

3.2 Outcomes of communication strategies

- Communication strategies promoting mental health awareness and facilitating referrals to QTMHC TCCS service.

  As per the *Stigma Reduction Project Evaluation Table* (Appendix 9), there was an increase in self referrals to TCCS within some of the target communities as a result of the media material, suggesting an increase in these communities' mental health awareness and capacity to access services. This is further supported by the increase in community readiness levels demonstrated in the *Community Readiness Evaluation Outcomes* (Appendix 10).

- Communication strategies supporting BCMHP training and initiatives

  The launch of the project was identified as one of the most successful communication strategies in supporting the BCMHP community engagement and delivery of training and initiatives. BCMHPs reported that the launch supported them in presenting a clear role and status within their communities and with their community leaders and served as a good promotional tool for the project.

  It was difficult to gauge the impact of the media campaigns in terms of attracting participants to attend the stigma reduction community sessions. The Mandarin-speaking community was the exception with a significant number of participants in the training programs reported as being recruited through the media communication strategies. .

One of the four skits on stigma reduction performed in Mareeba and Innisfail in the Cairns and Hinterland Health Service District in 2009. Skits were written, performed and attended by over 200 people from the Italian-Australian community.

Objective 4: Delivery of the Stepping out of the shadows: Reducing stigma in multicultural communities workshops in target communities

4.1   Quality of training and initiatives delivered in target communities

As per the *Training Program Evaluation Table* (Appendix 11), 66% of participants believed the training program they attended respected their cultural values very much, and only 2% believed it had not really respected their cultural values. Ninety-one percent of participants believed the materials were very useful or useful. No participants reported the material as not useful.

4.2   Outcomes of training and initiatives delivered in target communities

- Increased capacity for target communities to accept, include and support members with mental ill health (decrease in levels of stigma, increased knowledge and understanding about mental ill health amongst target community members and leaders).

- Increased capacity for target community members to access relevant mental health services.

  As per the *Training Program Evaluation Table* (Appendix 11), 63% of participants reported that because of attending the training they understood more about stigma in their community, 51% reported they thought differently about people with mental illness and their families, 58% reported they believed they would behave differently towards people with mental illness and their families, and 62% of participants felt they had acquired more practical skills and knowledge in relation to reducing stigma in their communities.

  The *Family Stigma Questionnaire* (Appendix 7) outcomes also indicated a decrease in stigma towards people with mental illness amongst participants and an increase in mental health literacy.

  As per the *Community Readiness Evaluation Outcomes* (Appendix 10) the increase in levels of community readiness amongst most communities also supports a general pattern of stigma reduction and increased mental health literacy amongst community members and leaders.

  The numbers of participants and community members requesting referral support and information about how to access mental health services (as detailed in the *Stigma Reduction Project Evaluation Table* (Appendix 9) also indicates a decrease in stigma and increase in community members understanding how mental health services can support recovery from mental illness.

- BCMHPs as a mental health resource in communities.

  Eleven BCMHPs completed evaluation forms (Appendix 12) about their BCMHP role in their communities. They were asked to report on how their role was perceived and accessed by community members and leaders, and if this had changed from when they first began the project to the end of the project. Ten out of 11 BCMHPs reported that they were now regularly contacted by community members and nine BCMHPs reported that their community's perception and response to their role had changed and they reported a significant increase in the number of community members accessing them for mental health support and information, and perceiving their role as a valuable resource for the community.

- Upskilling of community leaders' capacity to support community mental health needs

  Community leaders from each community were strategically involved as the gateway to the communities as the initial starting point of the project. Key community leaders from each community were invited to the launch of the project, were consulted in how best to approach and engage with the community and were requested to complete the *Community Readiness Questionnaire* to establish a baseline of community readiness. It was established that most community leaders believed stigma was an issue in their communities to varying degrees, but engaging community leaders to actively participate in reducing stigma in collaboration with the project was not successful in every community, and in some communities, the leaders themselves posed barriers. Overall however, 17 identified community leaders attended training initiatives; initiatives such as plays and seminars were delivered in four communities in collaboration with community leaders; and one of the BCMHPs who was employed half way through the project was himself a community leader who decided to work on the project as he had identified that his community was in need of such initiatives.

Snapshots of leaders of CALD communities attending the Adult Mental Health First Aid Course as one strategy to increase their skills and knowledge to support people with mental health issues in their communities.

- Support community initiatives aimed at decreasing stigma and increasing mental health literacy

Several initiatives throughout the project were delivered in response to community requests and in collaboration with community leaders and organisations. A seminar was delivered to the Spanish- speaking community in collaboration with a key community organisation, in response to community members receiving information about stigma and mental health literacy through the Stigma Reduction Project and the Chronic Disease Project. Community members requested a seminar in Spanish to provide information about depression and recovery. As a result of this seminar, the community has requested further seminars on different topics including intergenerational conflict, relationship issues and other mental illnesses, such as Schizophrenia.

A group Mandarin-speaking training participants requested support in forming a carers' peer support group as a result of attending the training program. The project staff and BCMHP attempted to find sustainable support mechanisms within the NGO sector to achieve this but were unsuccessful.

As a result of the project, the Burundi Community Association has invited the BCMHP to attend their meetings to discuss and plan initiatives to decrease stigma and increase mental health literacy. Also, the Vietnamese Resource Network has planned a weekly information stall at a local shopping centre where Vietnamese men gather and have requested that the BCMHP provide mental health information. Finally, the Spanish-speaking, Chinese, Italian, Vietnamese and Sudanese communities have requested support to have relevant articles submitted to newsletters or websites, to have a guest speaker on radio programs in community languages and to have information stalls at community festivals.

4.3   BCMHP demonstrated capacity to complete tasks related to support and professional development provided

As per the *Training Program Evaluation Table,* the *Evaluation Table* and the *Community Readiness Evaluation Outcomes* (Appendix 10), BCMHPs overwhelmingly demonstrated the capacity to carry out key responsibilities related to training, professional development and support provided throughout the project. The outcomes of these responsibilities included:

- Responding to a high level of referral needs in their communities and effectively facilitating referral pathways.

- Presenting a high volume of information about stigma and mental health in respectful, appropriate and culturally meaningful ways.

- Effectively engaging with their communities to promote the program and recruit participants.

Objective 5: Involve mental health consumers in the delivery of stigma reduction activities

5.1 Project processes linking with QTMHC Consumer Representative to develop consumer participation model, material and infrastructure

- Working in collaboration with the QTMHC Consumer/Carer Participation Co-ordinator (CCPC).

   The Project Co-ordinator and CCPC collaborated to develop a best practice action plan for developing a model and training material based on the consumer facilitator model.

- Employing and working in collaboration with Consumer Perspective Education Representatives to run focus groups with CALD consumers to develop a model and material.

   Three CALD Consumer Representatives were employed to run focus groups with other CALD consumers to inform the development of the

model, best practice support mechanisms and training material. One of the CALD Consumer Representatives was forced to discontinue with the project due to family problems.

- Linking with Consumer Representatives from mainstream mental health services and key QTMHC staff to contribute to the final draft of the model and material.

- Development of the Stigma Reduction Project into the Mental Health Literacy Program in line with the QTMHC Operational Framework.

5.2 Outcomes

- Development of best practice Consumer Perspective Education Model

Eliciting CALD consumer input to inform model and training material

Eliciting CALD consumer input to inform the Model and training material proved to be the most challenging factor of this component. Both CALD Consumer Educator Representatives employed to run focus groups received comprehensive training around the project objectives and processes, and the Consumer Perspective Education component objectives and processes delivered by the Project Co-ordinator and CCPC. (See Consumer Perspective Education Project Handbook)

Bringing CALD consumers together to attend a focus group was extremely challenging for both workers. Both reported that CALD consumers from their own communities and the wider CALD community were extremely reticent to come together as a group in public due to the stigma and shame attached to such an event. Strategies such as ensuring privacy and confidentiality of all participants and the use of discrete and appropriate venues were employed with little success.

One worker was able to gather a group of four Vietnamese carers and consumers to attend the focus group at their local temple. Conceptually, the objective of the focus group proved to be another challenge for both the worker and the participants. This focus group did not result in obtaining input into the creation of a Consumer Perspective Education Model, but instead resulted in the delivery of a stigma reduction and mental health literacy session.

The conceptual objective of the focus groups was well understood by the other worker, however she was not able to recruit any participants to attend a focus group.

As a result, CALD consumer input was not elicited through focus groups. A Consumer Perspective Education Handbook containing a Model and training material was developed through collaboration and input from the Project Co-ordinator, the CCPC and the two consumer workers employed in the project. A group of key Qld Health staff (Metro South Early Psychosis

Consumer Consultant; QTMHC Manager, State Liaison and Policy Co-ordinator and MHPPEI Co-ordinator) were then consulted about the material and asked to provide feedback and make recommendations which were incorporated into the material.

It is recommended that the Consumer Perspective Education Model and training material be implemented and evaluated by consumer educators and participants in order to progressively gather and incorporate consumer input into how it can be improved.

- A pool of potential Consumer Perspective Educators has been identified and is ready to be trained.

- Consumer Perspective Education sessions were delivered by the CCPC and the Multicultural Consumer and Carer Network. Three of these sessions were delivered as a component of stigma reduction training programs, and participants gave verbal feedback that the sessions had been a powerful component of the training program for them. One other session was delivered as part of the seminar delivered to the Spanish-speaking community.

Objective 6: Integrate relevant components of the project with other QTMHC Programs for sustainability

6.1 Project link with QTMHC TCCS

- Collaboration in referral pathways between referrals originating from the project and TCCS.

  Communication mechanisms between the Project Co-ordinator and TCCS were established at the beginning of the project to ensure referral numbers were recorded and referral pathways and outcomes were monitored. The TCCS staff were regularly updated about initiatives being delivered by BCMHPs and the Project Co-ordinator attended TCCS case reviews for the first two months. This ensured that communication and referral pathways between the BCMHP, TCCS and the project were effective, and potential issues could be identified and resolved.

  Currently when BCMHPs support referrals to TCCS, the TCCS staff are able to communicate directly with the BCMHPs to support intake, gather collateral information and use the BCMHP to implement strategies where appropriate and necessary.

6.2 Project link with Chronic Disease and Self Management Project

- Integration of Stigma Reduction Project activities and processes into the Chronic Disease Project

   Stigma reduction concepts and strategies used for the Stigma Reduction Project have been integrated into the Chronic Disease Project processes. The Chronic Disease BCMHP for the Indian community identified that stigma presented a significant barrier in recruiting participants for the project. A meeting was held between the BCMHP and both Project Co-ordinators to discuss stigma reduction strategies that had been successfully implemented in the Stigma Reduction Project. As a result, communication strategies and re-framing of how the Chronic Disease Project was promoted in the Indian community was implemented.

- Collaboration between Stigma Reduction and Chronic Disease Projects

   The Chronic Disease Project and Stigma Reduction Project currently share two BCMHPs, (Vietnamese and Muslim communities).

   The Stigma Reduction Project delivered two initiatives in collaboration with the Chronic Disease Project. In both cases, the Stigma Reduction Project was used as an 'entry point' into the communities, to promote awareness of mental health issues, decrease stigma and increase the communities' capacity to access the Chronic Disease Project.

   Indian Muslim community

   A stigma reduction seminar was held for the women of the Indian Muslim community. The seminar was delivered by the BCMHP (who works on both projects) and a CALD consumer from the community. The seminar introduced the topic of stigma, decreased stigma and increased mental health literacy from an Islamic perspective, with 90 women attending. Participants were invited to register interest in attending future initiatives delivered by both projects. Over 50 women registered their interest. Individual one-off stigma reduction workshops were delivered to follow up concepts discussed during the seminar, answer resulting questions and increase the capacity of participants to successfully attend Chronic Disease programs. The workshops were successfully delivered with approximately 40 women attending, who were then referred on to the Chronic Disease program.

Spanish-Speaking community

As a result of the stigma reduction initiatives conducted in the Spanish-speaking community, and the relationship developed between the BCMHP and the Acacia Ridge Hispano-American Catholic Welfare Community Organisation, it was identified that community members were interested in receiving more information about depression and the Chronic Disease Project. At the request of the Hispano-American Organisation, the two projects collaborated to deliver a seminar titled *"Depression and Wellbeing"* which included a panel of three Spanish-speaking mental health practitioners (psychologist, GP, psychiatrist) and the parish Father. Over 50 people attended and a significant number of people requested more seminars on similar topics.

Challenges

1. Evaluation

There were several significant challenges in the development and implementation of effective evaluation tools.

Literacy and conceptual barriers

Although the evaluation tools were developed to be as simple and accessible as possible, and translated into relevant languages, BCMHPs reported significant challenges in implementing them effectively with their participants.

In certain groups, participants were illiterate in their native tongue, requiring the BCMHPs to provide verbal support to support participants in completing the forms, or delivered the questions verbally and recorded the information themselves.

Even when language was not a problem, the concept of filling out the Family Stigma Questionnaire was extremely challenging to participants and created a barrier to engaging with the participants. BCMHPs reported that the concept of filling out this type of questionnaire was in some cases completely alien or new to the participants, and as such produced reactions of anxiety, suspicion, anger, and unwillingness to complete the forms.

Participants' confusion and inability to accurately complete the questionnaires was evident. See Family Stigma Questionnaire Evaluation table.

Questionnaire nuances

The Training Program Evaluation Questionnaire did not appear to present any cultural misunderstanding when completed by participants. The *Family Stigma Questionnaire* however appeared to present some nuances that may have resulted in misunderstanding when translated into a non-English language and framework. An example of this is Statement #1 on the Questionnaire following a short story: *'Joan is the mother of Frank, a 30 year old man with schizophrenia. Frank lives with his family and works as a shop assistant at a nearby shop. Frank has been hospitalised several times because of his illness. This illness has disrupted his life significantly.'* The statement is 'Joan bears some responsibility for her son getting sick' which could be answered as 'Strongly Agree' to 'Strongly Disagree'. In the pre-training program evaluation, some Mandarin-speaking participants indicated they disagreed with this statement, however indicated that they agreed or strongly agreed with this statement in the post training program evaluation. This can be interpreted as an increase in levels of stigma and a decrease in mental health literacy. When analysed by the BCMHP however, it was reported that the

participants had interpreted the statement as meaning that Joan was responsible for her son getting ill by being unsupportive and stigmatising him. As such, their responses in the pre-evaluation indicated that they did not agree that Joan was responsible in other ways because they were unaware of the effects of stigma, but once they had completed the training, they were aware of the negative impact of stigma and therefore agreed that Joan was responsible although the story does not reflect any stigma perpetrated by the mother.

2. Sessional workers

Challenges of working with a pool of sessional workers included:

- Difficulty in building team cohesion and dynamics when workers operate primarily in an isolated capacity within their communities.
- Adapting administration processes for sessional workers based in the community.
- Difficulties in finding group meeting times to suit a wide range of workers.
- Finding workers with relevant skill sets who are available to work, or able to work small amounts and inconsistent working hours inherent to sessional work.
- Monitoring BCMHP administrative processes such as handing in timesheets, completing reports in English.

3. Stigma and community infrastructure

Consistent with community development and engagement work in general, political tensions, power dynamics and community leaders' individual agendas or own levels of stigma presented challenges in varying degrees in all communities. Issues included:

- Varying levels of stigma existed among some community leaders which presented a barrier to implementing the project.

- Religious leaders perceived all mental health work to belong to the spiritual realm and therefore were very reluctant to refer community members on to mental health services or promote the use of mental health services. Often this perception coincided with a fear of 'losing members' of the congregation to mental health services, and in this way perceived mental health services as 'competition' rather than allies. These leaders perceived the BCMHP as a threat, making it difficult to sustain the engagement of those leaders in the project.

- Political tension existed between different community factions, making it difficult for the promoter to remain neutral and conduct their job.

- Jealousy or mistrust of the BCMHP's role in the community, as community members sometimes felt suspicious of the BCMHP's motivation for doing the role.

4. Meeting cultural requirements when engaging with communities

Providing basic requirements such as child care or culturally appropriate catering was problematic under government processes and framework. Many BCMHPs ended up voluntarily preparing appropriate catering themselves when they ran groups, as it was culturally inappropriate to invite people from their communities to any kind of gathering without appropriate food.

Conclusion and future directions

The objectives of the *Stepping out of the shadows*: *Promoting acceptance and inclusion in multicultural communities in Queensland* have significantly been achieved and measured by key indicators such as increased levels of community readiness to engage in mental health and mental illness activities; communities initiating stigma reduction activities; and by an increased number of referrals to mental health services. These all contribute towards achieving the overall goal of the project which was reducing the stigma associated with mental ill health among CALD communities in Queensland. The literature supports the notion that CALD communities require a safe space and skilled facilitation to start discussing their own cultural beliefs, explanations and attitudes about mental health and mental illness and from there they can start paying attention to new information coming from the Western high income world.

This 15 month project has shown that by having sufficient resources to implement a number of co-ordinated strategies, desired stigma reduction outcomes can be achieved. However, reducing stigma is a long term intervention and as such, stigma reduction will be an intrinsic part of the Transcultural Mental Health Literacy Program (July 2009 – June 2011) with a broader scope and fewer resources. This holistic approach is consistent with the working definition of transcultural mental health literacy developed by QTMHC which is '*the knowledge, attitudes and abilities of CALD individuals, families and communities to use culturally inherent traditional practices and beliefs as well as those of the host culture to protect and enhance their social, emotional, spiritual and mental health and wellbeing regardless of their mental health status; to take action to prevent preventable mental health problems and disorders; to recognise alerting symptoms of mental health problems and disorders; to promptly seek appropriate help, articulate and negotiate cultural explanatory models with service providers and comply with prescribed treatments; to practice traditional and western self-help treatments; and to accept and include others and themselves in the community when experiencing mental health problems and disorders.*[11]

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[11] 'In Transcultural Mental Health Literacy Framework 2009 – 2017, Queensland Health, 2009.

The team of Bicultural Community Mental Health Promoters (three absent) from across the state attending training to implement a number of mental health literacy strategies in their communities.

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Appendices

1.   Qld Stigma Reduction Project Plan
2.   ***Stepping out of the Shadows*** (SOS) Expert Trainer Manual Literature Review
3.   Community Readiness Questionnaire
4.   Operational Framework: Bilingual Community Mental Health Promoter Positions
         Appendixes 1 to 15
5.   Consumer Perspective Education Handbook
6.   Training Program Evaluation Form
7.   Family Stigma Questionnaire
8.   Project training and support feedback form
9.   Stigma Reduction Project Evaluation Table (saved alongside this doc)
10. Community Readiness Evaluation Outcomes
11. Training Program Evaluation Table (saved alongside this doc)
12. BCMHP Feedback about Community Response to their Role

STEPPING OUT OF THE SHADOWS
**Reducing Stigma associated to Mental Illness
in Multicultural Communities in Qld Project Plan –
February 2008 – June 2009**

Goal
- Reduce stigma associated to mental ill-health among CALD communities in Qld

Objective
Engage with CALD communities and in partnership with them, plan, implement and evaluate three key culturally relevant strategies designed to decrease stigma;
a) communication of key messages,
b) the delivery of the *Stepping Out of the Shadows* Reducing Stigma in Multicultural Communities Training Package, in a format that is culturally meaningful, and
c) support community initiatives aiming to decrease stigma.

Primary Target Group
- Bilingual Bicultural Community Mental Health Promoters (BCMHP) – Stigma Reduction, QTMHC
- Contacts of communication infrastructures of target communities
- CALD Mental Health Consumers

Secondary Target Group
- Members of the following seventeen CALD communities in Qld:
    18. Afghani
    19. Burundian
    20. Cantonese-speaking
    21. Croatian-speaking
    22. Greek
    23. Italian (Brisbane and Cairns)
    24. Iranian
    25. Japanese (Cairns)
    26. Korean
    27. Mandarin-speaking
    28. Maori
    29. Samoan
    30. Serbian-speaking
    31. Spanish-speaking
    32. Sudanese (predominantly South-Sudanese)
    33. Turkish
    34. Vietnamese

- Other multicultural organisations and internal QTMHC Programs

QTMHC Staff
- Elvia Ramirez, MHPPEI Coordinator: overall management of project
- Janet Callinicos, Project Officer: design and document a detailed community communications strategy.
- Letitia Casagrande, Stigma Reduction Project Coordinator
- Thirteen sessional BCMHPs
- Dennis Gatbonton, CALD Consumer Participation Coordinator. Playing an active supportive role coordinating consumers involved in the project.

Strategies
    8. Up-skill and support the pool of BCMHP-SR

9. Develop and deliver a series of culturally appropriate key messages using the most effective communication mechanisms of each community
10. Deliver the *Stepping Out of the Shadows – Reducing Stigma in Multicultural Communities* Training Package in each target community.
11. Increase participation of mental health consumers in stigma reduction and mental health literacy activities
12. Integrate relevant components of the project with other QTMHC Programs for sustainability
13. Implement relevant mental health literacy activities according to needs identified by QTMHC

Activities per each Strategy

Strategy One. Up-skill and support the pool of BCMHP-SR

1. Equip the pool of BCMHPs to effectively engage with own cultural communities re mental health promotion and reduction of stigma associated to mental ill-health.
   - Orientation about Qld Health, the PAH & HSD, the QTMHC, the MHPPEI Program and the Qld Stigma Reduction Project: 10 hours
   - Train BCMHPs in the delivery of the *Stepping Out of the Shadows – Reducing Stigma in Multicultural Communities* Training Package: 6.5 hours.

2. Increase levels of mental health literacy
   - Train promoters on the Mental Health First Aid course: 12 hours
   - Train promoters on the TCCS and the Qld Mental Health System: 3 hours

3. Provide individual and group supervision to promoters throughout the life of the project

4. Evaluate each of the activities and measure the increase of knowledge, attitudes and skills as a result of the above up-skilling activities.

Strategy Two. Deliver a series of key message using the most effective communication mechanisms of each target community.

1. Conduct a literature review of strategies implemented to effectively communicate with CALD communities in Australia and overseas and of key messages designed to decrease stigma.
2. Map out the communication infrastructures and contacts of each target community across the state.
   - Brief and request promoters to actively identify and document effective communication mechanisms and contacts: 5 hours
3. Plan how to best use the identified community communications mechanisms to deliver a series of key messages across the state, i.e. media and organised groups.
4. Design a series of key messages (community preparation to stigma reduction, stigma reduction – including attracting to attend the Stepping Out of the Shadows training – and mental health literacy) that are going to be communicated throughout the life of the project and across Qld.
5. Engage with contacts of community communication infrastructures re the delivery of key messages on/towards stigma reduction
6. Implement community communication activities.

7. Evaluate the process of the above activities and the recollection of the key messages by members of the target communities.

Strategy Three. Deliver the *Stepping Out of the Shadows* Training Package in each target community.

1. BCMHP in consultation with Project Coordinator, tailor the Training Package to each of the target communities: 35 hours
2. BCMHP organise and conduct the ten-hour training program with at least five different groups of at least six people each.
3. Evaluate the level of stigma around mental ill-health pre and post delivery of the Stepping Out of the Shadows Training Program

Strategy Four. Increase participation of mental health consumers in stigma reduction

1. Utilise existing networks to recruit consumers to participate in the delivery of key project strategies:
   - Dennis to design a consumer component in the delivery of ongoing communication strategies (delivery after June 08)
   - Dennis to design a consumer component in the Stepping Out of the Shadows Package (delivery after June 2008)

2. Record consumer perspectives of stigma (explore an evaluation tool)
3. Train, support and debrief consumers who are participating through the project

Strategy Five. Integrate relevant components of this project with other QTMHC Programs for sustainability

1. Identify opportunities for integration
   a. Develop join strategies with existing QTMHC Programs

Project time line:

July 08	BCMHPs adapt Training Manuals to be culturally meaningful QTMHC Project team establish base line evaluations in each community
August 08 **September 08**	Development and dissemination of communication strategies using ethnic radio and print media.
October 08 **November 08** **December 08** **January 09** **February 09** **March 09** **April 09**	BCMHPs to carry out 3 Training Programs over the course of 9 months, other responsibilities include: - Continue recruitment and more general communication strategies - Support referral processes and access to mental health services - Attend training, supervision and other meetings as required Please see Allocation of hours below for details of how to use the 150 hours.
May 09 **June 09**	QTMHC Project team finalise results, consolidate evaluation outcomes and write final reports. BCMHPs receive final debriefing and transition training if possible.

Allocation of the 150 hours for each BCMHP:

1. Delivering the Training Program

> The Training Program (4 x 2.5 hour sessions) should be delivered 3 times between August 08 to the end of April 09

> Allocation of hours for EACH TRAINING PROGRAM:

> 1. Delivering Sessions x 4 sessions (2.5 hours each)   10

> 2. Setting up and cleaning up x 4 sessions (1 hour per session)   4

> 3. Finding the venue, organising logistics (2 hours per Training Program)   2

> 4. Preparing the material for the Sessions (photocopies etc)
>   (2 hours per Training Program)   2

> 5. Following up attendance (3 hours including "Communications")   3

> 6. Consolidating the evaluation and report writing (3 hours per Training program)   3

> 7. Supervision after the Training Program (1 hour per Training Program)   1

> **TOTAL: 25 hours**

2. Recruitment of Participants

> This includes low level community marketing Training Programs
> in order to recruit participants as well as communicating to individuals
> and groups in order to recruit participants to attend a Training
> Program. These hours should be used for the recruitment of participants to
> all 3 of the Training Programs delivered, how to best allocate
> number of hours per Training Program will be up to each BCMHP. Allocation of
> hours to recruit for all 3 Training Programs: **8 hours**

3. General Communication Strategies

> This includes general high level Communication Strategies to
> promote the Project and Program and responding to requests
> for information sessions, radio appearances etc.

> Allocation of hours to be used until the end of April 09:   **15 hours**

4. Facilitating referrals of community members to mental health service providers

> This includes identifying people who want referral support or
> information about mental health service providers and pathways,
> as well as time to support people in appropriately accessing
> the pathways.

> Allocated hours to be used until the end of April 09:   **15 hours**

5. Attending supervision, meetings and further training

This includes supervision **other than the post Training Program** supervision, attending meetings and training as required by QTMHC.

Allocated hours to be used until the end of June 09: **20 hours**

6. Supporting community initiatives

This includes any support you have given to groups in the community who are starting or continuing initiatives to reduce stigma. This can include attending meetings to support the creation of an initiative, or spending time linking the group with relevant services who can support them in their initiative.

Allocated hours to be used until the end of June 09: **17 hours**

Letitia: percentages &
Elvia:
Farah: percentages &

Current Work

C'tty Engagement

Transition

Current Workers

April: 50%

Consumer Education

March: 20%
April: 50%

Cairns

March: 80%

Media

Short SR
Session

April
onwards

New Workers

March onwards

Training Manual

March: 60%

Evaluation

May: Data Analysis
April: Focus Group

Report

May
June

Mental Health
Literacy Material

April - June
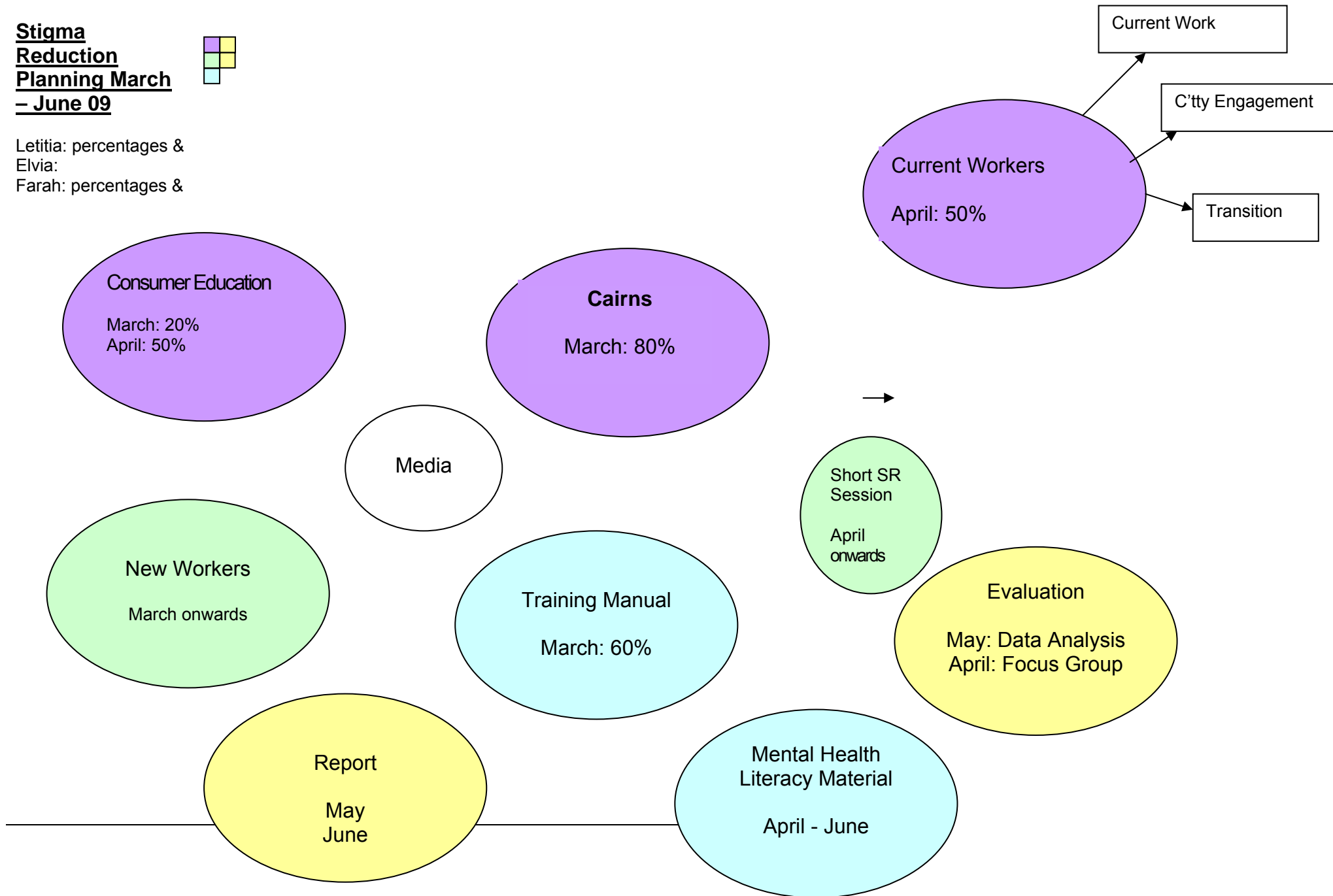
Literature Review

Executive Summary

The objective of this literature review is to provide an overview of research literature addressing:

- Stigma around mental health issues and mental illness in a cross-cultural context, including definitions, types, levels and sources of stigma;

- Impact of stigma in a cross cultural context;

- Culturally appropriate and competent approaches to addressing and reducing stigma, and

- Mental health literacy in a cross-cultural context and the relation between mental health literacy and stigma.

Key Findings:

- Cultural factors are key determinants of mental health and therefore key determinants of the nature and amount of stigma across different Culturally and Linguistically Diverse (CALD) communities

- Cultural factors can contribute to increased stigma and also be protective factors that decrease stigma

- Stigma manifests on three levels: individual, community and service level and is demonstrated to be:
  - an obstacle to increasing mental health literacy and help seeking;
  - an obstacle to early detection and early intervention, and
  - promoting isolation, marginalisation, discrimination

- Stigma affects individuals with mental health issues/mental illness and extends to all associated family, carers, friends and service providers

- CALD community members affected by mental health issues/illness experience a "double whammy" and can experience increased stigma leading to increased discrimination, marginalisation and isolation.

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

- To be effective, initiatives to reduce stigma must be culturally relevant and competent and must acknowledge and incorporate the diverse cultural range of explanatory models of mental health and illness

- Increased mental health literacy can contribute to stigma reduction in CALD communities if it is understood in a cross cultural context and in terms of attitude and knowledge levels

- Contact between people affected by mental health issues/mental illness and general public can contribute to stigma reduction if carried out in strategic and appropriate manner

> **"Stigma's impact on a person's life may be as harmful as the direct effects of the disease."**
> Corrigan PW and Penn DL (1999)

Defining Stigma in a Trans Cultural Context:

Western Framework Definition

Stigma can be defined within a western framework as "the application of a negative label or mark that distinguishes people in the community (and is) manifested in negative attitudes, behaviours and feelings towards the identified group"[5]. The literature supports that stigma results from and functions within social construct and is a "reflection of the way people relate to one another, or the way society relates to a person or group of people...Essentially the process of stigmatisation revolves around exclusion of particular individuals or group of people from certain types of social interactions (Kurzban and Leary (2001) in Fernando, S. (2006).

Stigma is not a phenomenon that is exclusive to the mental health arena but stigma specifically associated with the mental health has been denoted by Vatz as "an unjust and

involuntary labelling process that misconstrues the character and personalities of individuals affected by mental disorder."[16]   The literature supports a more comprehensive definition of stigma associated with mental health/illness. For the purposes of this review, stigma is understood as a phenomenon encompassing processes, dynamics and beliefs leading to negative labelling or construction of people associated with mental health, mental illness and suicide. This includes people with mental health issues/illness and extends to their carers, friends, families and service providers and people similarly associated with suicide [5, 11, 13, 18, 24, 25, 26, 28. 29].

Stigma in a cross-cultural context

As stigma is a socially constructed phenomenon, culture is a key determinant in all its aspects (causes, definition, application and impact). The literature recognises that stigma per se exists across all cultures worldwide however that it is not "fixed, indelible or universal... and is culturally applied" [28]. As such, it varies greatly in nature and amount across cultures [2, 5, 26, 28].

Impact of stigma

The literature demonstrates that the impact of stigma in culturally and linguistically diverse communities is serious and far reaching [1, 5, 6, 13, 14, 24, 25, 28, 29]. Some of the literature states that the impact of stigma on a person's life has been as harmful as the effects of mental illness itself [14, 28].

Belonging to a CALD demographic and being affected by mental health issues/illness can result in increased discrimination and marginalisation, or a "double whammy", resulting in less contact with and knowledge of services/networks available for assistance.
Stigma manifests at an individual level, a community level and at a service delivery level. This means its effects impact at those three levels. Stigma is demonstrated to be an obstacle to increasing mental health literacy and an obstacle to help seeking, especially seeking help in the early stages of the development of mental disorders, hindering early detection and early interventions. Stigma promotes isolation, marginalisation, discrimination, fear, unemployment and contributes to difficulties in finding accommodation. Stigma is an

obstacle to "consumers being welcomed as members of mainstream activities and being valued as members of the community" [26] All of this perpetuates misinformation, acts as a barrier to accessing and providing appropriate support, decreases hope and makes recovery and rebuilding self esteem harder. It also acts as an obstacle to people with mental illness being heard in the community or at a service delivery level (eg. grievance procedures being taken seriously etc).

"Symptoms (which may include suicide) may worsen in those with mental illness due to factors such as lack of treatment, belief that the mental illness is incurable, lack of support and possible ridicule in the community preventing early detection of mental illness and engaging in help seeking and preventable behaviours" [5].

At a service delivery level, stigma attached to services acts as an obstacle to access and equity of these services. Stigma towards mental illness has been shown to exist among health professional and service deliverers. At this level, stigma acts as an obstacle to these deliverers providing appropriate services (including appropriate assessments and referrals) [5, 13, 18, 24, 25, 26, 28].

Sources of stigma

Bakshi, Rooney and O'Neil (1997) listed the primary sources for stigma in Non English Speaking Background (NESB) communities as:

- culturally embedded attitudes

- lack of knowledge about mental illness

- lack of knowledge about how to help those with a mental illness

- fear

- community services

- cultural traditions

    ("i.e. culture of avoidance and marginalisation of the mentally ill which occurs

    regardless of the problem or reason. As part of the community's belief system, it is a

behaviour that is learned and passed on within the community, especially while these beliefs are not discussed or challenged.")

- lack of time, energy and cohesion in NESB communities

- stigma perpetuates stigma

- by association

- lack of role models

Explanatory models and culturally embedded attitudes

Cultural factors are among the key determinants of mental health; culture determines "whether and when people seek help, what types of help they seek and the level of stigma they attach to both mental illness and addiction"[2].

The literature states that culturally embedded attitudes (including mental health explanatory models) are key determinants of stigma in culturally and linguistically diverse (CALD) communities [2, 5, 26, 29]. "There is evidence that different groups regard psychiatric illness differently. For example Pietsch and Short (1996) reported NESB mental health clients' views on mental illness varied from complete rejection through to culturally specific understanding"[26].

Bakshi, Rooney and O'Neil (1997) site that different factors of culturally embedded attitudes "hold varying degrees of negative associations with those living with mental illness". They include culturally embedded beliefs that:

- mental illness occurs because of bad deeds or as the result of a previous life in one's ancestry;

- mental illness is a result of bad karma or caused by evil spirits;

- mental illness is contagious or talking about mental illness can cause mental illness.

These models differ substantially from the western bio-psycho-social model that attributes causation of mental health issues/mental illness to biological or psycho-social factors. The literature supports the need for education around the bio-psycho-social model of mental illness in CALD communities, which it states would "decrease the perception that mental illness is a punishment brought upon a person by their own actions or as a sign of weakness, and promote tolerance and understanding of why people can develop a mental health problem"[6].

In terms of working cross culturally to increase mental health knowledge and decrease stigma however, the literature also supports the fundamental need for a comprehensive approach that encompasses diverse perspectives and belief systems and recognises explanatory models from diverse cultural backgrounds.

The literature states that the failure to recognise the diverse causal factors or belief systems in mental health promotion initiatives can reduce the effectiveness of the promotion [2, 5, 26]. To "explain that 'mental illness is a biological illness like any other', often results in negative attitudes to mental illness becoming even more entrenched...and more positive attitudes can be elicited by public education offering a wider array of psycho-social causal factors"[28]. As culture and identity is accepted as forming an integral component of mental health status, [8] acknowledgement and recognition of explanatory models that people from diverse cultural backgrounds believe is necessary for mental health promotion to be effective [2, 5, 6]. "Meanings that people give to mental health/illness and substance use problems determine the effectiveness of health promotion programs designed to prevent or reduce those problems" [2].

Cultural infrastructures
The literature shows different cultural infrastructures (eg. collectivist Vs individualistic) can contribute both positively and negatively to the prognosis of people affected by mental health issues and stigma in different situations.

In comparing psychiatric stigma between developing and developed countries, Rosen (2001) highlights

that "since 1979 (developing countries) have demonstrated a far better long-term outcome for schizophrenia, particularly in rural regions".   He attributes this comparatively better prognosis to various factors including some typically collectivist social factors predominant in developing countries, including:

- "- greater social inclusion of people with mental illness;

- communal solidarity around the affliction;

- retention of a culturally valued work role;

- non-isolation of the family;

- a higher threshold for detecting madness or labelling the person as mad;

- the community seeing the cultural relevance or oracular value of psychotic content; and

- perceiving of persons with psychosis who are reasonably well functioning as 'shamans', thus of relatively high status".

Cultural infrastructures can also contribute to the nature and amount of stigma in a community.

Collectivist cultures' notions of shame and collective responsibility can lead to increased and compounded issues around stigma.

Individualistic and collectivist cultures will also have different responses to focus of stigma reduction campaigns, with the collectivist cultural communities responding less to messages promoting benefits for the individual and more to messages promoting the benefits for the family and community[2].

Relationship between mental health literacy and stigma

The term "mental health literacy" was coined by Jorm and colleagues, and refers to knowledge and beliefs about mental disorders which aid their recognition, management or

prevention including; the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; knowledge of self treatments and of professional help available; attitudes that promote recognition and appropriate help seeking[17].

The literature states that ethno cultural groups are more at risk of developing mental health issues are less likely to receive needed care than the general population and have lower rate of participation in health promotion, prevention and treatment programs [2, 5, 15, 26]. CALD specific risk factors contributing to high vulnerability include: pre-migration trauma, economic and social disadvantages, isolation, racism, discrimination, oppression, and cultural pressures (including acculturation processes and consequences). Systemic barriers to CALD demographics accessing treatment, prevention and promotion services include; language factors, discrimination, stigmatising attitudes, mistrust of mainstream service providers and incongruence of health promotion intervention deliverers and the target demographic [2, 5, 8, 15, 24, 25, 26].

CALD demographics generally have low levels of knowledge around mental health issues/illness.

"Although the level of knowledge about mental health and substance use and associated problems varies both within and across ethno cultural groups, field studies among these groups found generally inadequate knowledge of mental illness and the harmful effects of drugs"[2].   The key areas identified as requiring increased levels of literacy included:

- distinction between mental illness and physical or intellectual disability or impairment;
- causal attributions and attributions (eg. mental illness is contagious etc)
- distinction between mental illness and substance abuse, including causal attributions of mental illness related to substance use;
- symptoms of mental illness and mental health issues and issues that may be associated with or compound conditions and situations (eg. gambling, financial mismanagement, attitudes etc)

- relation of violence to mental illness;

- prognosis and/or recovery potential of mental illness and self care and maintenance;

- health system in Australia;

- ways of supporting someone with a mental illness.

Overall, the majority of the literature acknowledges that there is a link between the level of knowledge about mental health/illness and the level and nature of stigma [1, 6, 14, 28]. The literature varies however when defining the nature or strength of this link. On the whole, the literature that focuses specifically mental health literacy and mental health promotion in multicultural communities does not expand on what is understood by mental health literacy, beyond the generic definition as outlined by Jorm et al.

Some literature argues that poor mental health literacy is a key cause for stigma, and that education or campaigns improving mental health literacy result in the reduction of stigma [1, 6, 14, 28]. "The attitudes of the public towards mental health issues are recognised as an important factor in the perpetuation of stigma (and) research has indicated that those with a better understanding of mental illnesses are less likely to hold stigmatising attitudes"[14]. "Knowledge about risk and protective factors for mental health, symptoms of mental health problems and mental illness, and sources of help builds emotional resilience and begins to dispel the stigma of mental illness"[8].

Other literature does not support a direct link between increased knowledge around mental health/illness and decrease in stigma. Bakshi, Rooney and O'Neil (1997) state that stigma occurs "regardless of the level of understanding of mental illness" and that an increase in knowledge of mental health issues/illness does not necessarily lead to a greater tolerance or acceptance of mental illness. "People may know about the causes, treatment and theories of mental illness but still have very negative attitudes and behaviours towards those who are mentally ill. Those with (apparently) greater knowledge of mental illness can still have very negative attitudes (eg. bad or dangerous), feelings (eg. fear), and behaviours (eg. avoidance, denial, stigmatising)".

As previously discussed, Rosen also states that health promotion done in an inappropriate manner can actually lead to greater entrenchment of negative feelings towards mental health issues/illness[28].

Certain literature states that more effective than education is having contact with people with menta health issues/illness, [11, 14] "the best way of changing people's view points is through normal, everyday contact with consumers, in public, in the workplace and in schools"[11].

Some literature states that despite their medical and/or psychiatric training and high levels of contact with people with mental health issues/illness, stigma also exists amongst health professionals [18, 26].

Jorm et al (1999) demonstrate that compared with the general public, health professionals actually have more negative attitudes towards the long term outcomes for people with mental illness and their chances of being discriminated against. Jorm et al outline that although there may be basis in reality for the health professionals' negative attitudes, they need to be careful "about what expectations they convey to patients and their families (as there is) evidence that patients who perceive devaluation or rejection by society have a worse outcome". They also continue to state that health professionals' awareness of adverse prognosis might need to be "tempered lest it hamper their own clinical performance".

In relation to the public, Jorm et al demonstrate that there are more negative attitudes associated with the prognosis for people with schizophrenia than depression. They continue to state however, that for both disorders the public's attitudes may be overly optimistic and that "much remains to be done towards having the public appreciate the gravity of both depressive disorder and schizophrenia".

Jorm et al state that "attitudes are not only individual characteristics, but are also influenced by the culture within healthcare systems and that several findings indicate that greater exposure to people with mental disorders and greater public education may not necessarily lead to more positive attitudes".

To better understand the link between mental health literacy levels and stigma in CALD communities, it is necessary to unpack the original concept of mental health literacy with a cross-cultural framework.

The key topics of mental health literacy consist of: problem identification; causal attributions; knowledge of risk factors; treatment preferences and attitudes that promote recognition and appropriate help seeking. It is important to note two factors that underpin mental health literacy in CALD communities. Firstly, CALD communities have dynamic natures and health beliefs of individuals within these communities will evolve naturally according to interaction with the dominant culture's health system and their stage of acculturation (eg. the interplay between the adoption of dominant cultural norms and retention of traditional cultural beliefs). Secondly, "not all people identify with their cultural background. Socio-cultural environment influences people's health beliefs and values, so different individuals and generations within the same family may have different health beliefs and perceptions of health problems"[1].

In a transcultural context, each of these topics takes on additional aspects and requirements to be effectively applied.

To be authentic, problem identification must take place within a context of culturally diverse "manifestations of mental illness, (because) how people describe and interpret their symptoms vary with race, ethnicity and culture"[1]. This includes phenomena such as culture-bound syndromes and concepts that may be indicative of mental disorder in a western framework but acceptable and appropriate in another cultural framework. Literacy enabling the recognition of specific disorders would thus require knowledge of different cultural frameworks and mental health understandings, as well as the ability to effectively negotiate the different frameworks to accurately recognise disorders.

Literacy of causal attributions requires similar knowledge and processes as problem identification. Having knowledge of the Western bio-medical or bio-psycho-socio explanatory model of mental health does not necessarily mean literacy for members of CALD demographics. To be literate in causal attributions requires; knowledge of both host culture (Western); culture of origin explanatory model and the ability to negotiate both and come to an effective, accurate and applicable level of understanding.

Culture and identity are also important components of risk and protective factors. (Although Jorm et al do not specifically list protective factors or resilience factors in the list of topics included in mental health literacy, we have included them within the topic of risk factors to make it more comprehensive.)

Literacy requires knowledge of how culture and cultural infrastructures can impact on mental health: how they contribute to increasing vulnerability to mental health issues/illness or contribute to increasing resilience protective factors in relation to mental health issues/illness.

Treatment preferences for CALD demographics can span treatments available in the host (Western) system and culturally specific communities or cultural health system they belong to. Literacy in this topic requires knowledge of both systems and understanding of the scope or range of treatments available but most importantly, requires the ability to navigate options effectively to understand which treatment options will be the most appropriate and successful for particular situations. To gain a functional understanding of the host system, several barriers may have to be successfully overcome. These include language barriers, social distance factors, lack of appropriate sources of information of service delivery, discrimination, stigma, etc which fall under the topic of how to seek mental health information. A person from a CALD community may have to develop a specific set of skills if they are to have the capacity to find mental health information, knowledge of available sources of information may not be enough for them to be able to actually access the information.

Qualifying literacy as attitudinal as well as knowledgeable

The key underlying factor in all of these topics is that for there to be literacy, there must exist the attitudes that promote recognition and appropriate help-seeking; knowledge of information or facts is not enough in itself to qualify as literacy. Literacy demands the capacity for appropriate application and a propensity to act on it.

Increasing mental health literacy must therefore be understood as more than increasing knowledge about mental health issues/illness in a Western framework. It must be qualified in terms of increased knowledge encompassing diverse cultural explanatory models and the development or adjustment of attitudes that promote accurate recognition and appropriate help seeking.

In these terms, it is possible to conclude that increased mental health literacy would have a significant impact on the amount and nature of stigma that may exist within a CALD community. It is also important to highlight that the methods used to increase mental health literacy and decrease stigma, will need to fulfil the key requirements of literacy and address attitudinal and knowledge components to be effective.

Reducing stigma in multicultural communities

For stigma reduction initiatives in multicultural demographics to be effective, they must therefore authentically address relevant community needs in the grain of the audience's culture. "Because of the cultural diversity inherent in stigmatisation of mental illness, it is necessary to develop new culturally sensitive ways of reducing stigma. Substantive data suggest that designing programs to meet the specific needs of ethno-racial/cultural groups will improve access and utilisation of health promotion programs and consequently, reduce stigma and disability burden from mental illness and addictions"[1]. The literature supports various methods and frameworks as fundamental to creating and initiating stigma reduction in CALD communities.

1. *Responding to cultural diversity*

   Cultural diversity within and across cultural demographics must be mapped, recognised and taken into account when creating stigma reduction initiatives. "What may be the most effective in one community may be different in another" [2].

2. *Addressing the three levels of stigma*

   For stigma to be reduced, strategies must be aimed at community, service and individual levels. All three levels are interconnected and function simultaneously [5, 28]. The literature states that public attitudes and service providers/health professional attitudes can impact directly on how consumers perceive themselves and their prognosis. It also tells us that the type and amount of contact that the community and service providers/health professionals have with consumers can impact on their levels of stigma 'Acceptance through changes in feelings, attitudes and behaviours towards those living with a mental illness can only take place through a multi-level community education process where members of the community provide positive examples for other members about ways to respond, and counter the negative beliefs within the community which stigmatise those with a mental illness. However for a community change to take place, the individual and service delivery levels must also be addressed as they reinforce the stigma at a community level"[5].

3. *Strategic involvement of consumers*

   The majority of the literature supports that strategic involvement of and contact with non-stereo-typical consumers is associated with the development of more positive attitudes [11, 14]. Crucial to this methodology is ensuring the consumers involved are empowered and authentically involved in, or driving the nature of their involvement and initiative, and that it is done in a way that is safe and productive for both consumers and target demographic. Components of effective types of contact include involvement of non-stereo typical consumers in public education programs, local activities ("consumer

activities"), relationship building, normal everyday contact, visibility and contact in schools, workplaces and the public.

4. *Increasing mental health literacy*

For increased mental health literacy to be effective in reducing stigma in multicultural communities, mental health literacy must be understood in terms of knowledge, attitude and ability to function transculturally. Initiatives must aim to be effective in changing attitudes to align and be compatible with increased or altered levels of knowledge.

5. *Individual strategies*

Bakshi, Rooney and O'Neil (1997) outline the important role in the whole process of understanding mental illness that carers and consumers play, and make recommendations of topics that consumers and carers could address and be supported in addressing by their counsellors, case mangers and health professionals. They emphasise that any individual education should be strategic and carried out in a way that ensures consumer and carer safety. "Individual strategies are recommended so as to empower people with a mental illness and their carers and not to place the responsibility of reducing the stigma to mental illness on this target group". The list of topics includes:

- Understanding the causes of mental illness. This can divert them away from self-blame, guilt and fear.
- Understanding the treatment, medication and where appropriate the side effects of the treatment so as to encourage compliance with medication.
- Acknowledging the stress related to migration.
- Acknowledge the trauma of being a refugee – at the time of leaving one's country, and in transit and on arriving to Australia.
- Providing information about the range of support systems and skills on how to negotiate access.
- Practical and emotional support for carers.

- Equipping carers with information and knowledge so that they do not isolate or hide their relative.

Bakshi, Rooney and O'Neil go on to suggest various examples of individual strategies, including counsellors and health professionals within the mental health system providing support and education as an integral part of the care they provide, the development of culturally and linguistically appropriate self-help material, stress assessment tests to move the illness away from being a "fault" to giving people permission to acknowledge the stress created by the process of migration and carer support groups. We would add peer support network and groups.

Effective Health Promotion Campaigns

Agic (2004) uses Kahan and Goodstadt's (2001) definition of best practice in health promotion as "those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation"[2]. Potential barriers to effective health promotion include; cultural mismatch between initiative and target audience culture; stigma; mistrust of source of information or authorities; language and knowledge of the health system [1].

Effective health promotion in CALD demographics must address the needs of the target audience and be **congruent with the audience's cultural, social and communication structures, systems and beliefs**. "Projects that reflect the dominant culture, are often not relevant to people from different cultural backgrounds (and) concepts that reflect the dominant culture are often not directly transferable to communities with different cultural backgrounds"[2]. Kreps and Kunimoto (1994) tell us to be aware that "no matter how 'rational' the goals of a health care campaign are, from family planning to organ donation, cultural roots run deep and will influence audience member interpretations of the campaign". They refer to family planners in developing countries that birth control campaigns introducing birth control techniques "to the female population, wife or mother, often did not work without

knowledge of the family power structure (as for example) in India, the grandmother was the person who had the authority to instruct women in such matters". They state that effective health promotion strategies need to be congruent with the messages of the targeted cultural groups, which incorporate the intrapersonal and relational levels of the cultures' communication systems".

The application of **community development principles** is fundamental to accurately defining community needs, mapping cultural demographics and interpersonal and social infrastructures and identifying and incorporating existing inherent mental health cultural practices. It will also promote community ownership of, involvement with and validation of any initiative [1, 2].

The application of the **community readiness model** ensures initiatives and messages align with the target demographic's level of readiness in terms of hearing and responding to messages provided. If a community is at the stage of denial of the existence of any mental health issues in their community for example, an initiative aimed at increasing knowledge around symptoms of psychosis will be at risk of not being heard at all, compared with an initiative aimed at promoting awareness of the existence of mental health issues and decreasing fear [1, 2].

The majority of the literature also states that **effective communication** is instrumental to successful health promotion and that the "capacity of health messages to reach out to diverse communities depends largely on the strategy used to convey the information to the intended audience"[2]. Effective communication is far more comprehensive that the act of interpreting a message from one language into another either verbally or in written form. Effective communication requires:

- Messages and information to be *culturally adapted* to target audience culture for it to be relevant, understood and meaningful. "Direct translation (or interpretation) which does not take cultural concepts into account, limits the usefulness of the health

information"[2]. It can also lead to misunderstanding or the production of unintelligible messages. An example of this are messages aimed at a collectivist culture; the ones that "pivot on individuals are less effective than messages that focus on affects on family members"[2]. A message designed within a purely western framework may focus on individuals and need to be adapted to focus on family instead if it is to be used in a CALD community.

- The *mode of delivery* is crucial to the health promotion initiative and often very culturally specific. In most cases the target audience is more receptive to the source of the information that the information itself. The source will determine how it is heard, how it is believed and whether or not the information will be acted on, as can seen once again with Kreps and Kunimoto's example of birth control education in developing countries. Trust is also implicit in the mode of delivery; there must be trust between the source of information and the target audience. The mode of delivery should also be determined by the culture's preferred method of communication. An example of how necessary and effective this is can be seen in the Aim Hi initiative for increasing indigenous mental health, diagnosis and recovery on the Tiwi Islands[4]. "The project involves the interweaving of physical, social and cultural approaches to mental health and the key to its success is combining the methods of western psychiatry and more traditional Aboriginal ways, particularly when it comes to assessment and diagnosis". The traditional communication method of story telling is at the heart of the communication that happens in this project.

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Stepping Out of the Shadows: Promoting Acceptance and Inclusion in Multicultural Communities in QLD

COMMUNITY READINESS SURVEY

Name and Community:

_____

1. On a scale of 1 to 10, please rate the general level of concern about mental health problems and mental illness in your community.
    (1 = not concerned at all and 10 = very great concern)

    1   2   3   4   5   6   7   8   9   10

2. On a scale of 1 to 10 how much of a concern are mental health problems and mental illness to the leaders of your community?
    (1 = not concerned at all and 10 = very great concern)

    1   2   3   4   5   6   7   8   9   10

3. Do you know of any community discussions or meetings about mental health problems or illness that have happened in your community?

    If yes, please note them below and describe the outcomes of those discussions/meetings.

    _____

    _____

    _____

    _____

    _____

4. What is the general attitude of members of your community towards mental illness?

    _____

    _____

    _____

5. On a scale of 1 to 10, please rate the level of general community support that would be given to an individual or family affected by mental illness? (1 = no support at all, 10 = very high level of support)

1   2   3   4   5   6   7   8   9   10

6. How knowledgeable are members of your community about mental health problems and mental illness?

_____

_____

_____

_____

_____

7. How would people obtain information about mental health problems and mental illness in your community?

_____

_____

_____

_____

_____

8. Are individuals or families affected by mental illness or mental health problems currently getting help? Who or where are they getting help from?

_____

_____

_____

_____

_____

_____

_____

9. What are the main barriers to people from your community accessing mental health services and other related services for help?

_____

_____

_____

_____

_____

10. Do you know of any activities or programs in your community that promote mental health and wellbeing? Please describe these activities.

Current Activities:

_____

_____

_____

_____

Past Activities:

_____

_____

_____

_____

11. On a scale of 1 to 10, please rate the level of awareness that people have of these activities or programs in your community?
(1 = no awareness at all and 10 = very aware)

1   2   3   4   5   6   7   8   9   10

12. What are the rates of participation from community members in the activities or programs that promote mental health and wellbeing?

_____

_____

_____

_____

13. How are these leaders involved in the activities or programs regarding mental health and wellbeing in your community?

_____

_____

_____

_____

14. What do you see are the main barriers for participation in programs and activities that promote mental health and wellbeing?

Barriers for community participation:

_____

_____

_____

_____

Barriers for leader participation:

_____

_____

_____

_____

15. Would the leadership support more efforts? If no, why not?

_____

_____

_____

_____

_____

Operational Framework:

Bilingual Community
Mental Health Promoter Positions

2009

Queensland Transcultural Mental Health Centre

QTMHC key contacts

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Operational Framework: Bilingual Community Mental Health Promoter Positions

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Contents

Abbreviations and terms[12]

Abbreviations

CALD	Culturally and linguistically diverse
NESB	Non-English speaking background
QTMHC	Queensland Transcultural Mental Health Centre
TCCS	Transcultural Clinical Consultation Service
MHPPEI	Mental Health, Promotion, Prevention & Early Intervention
BCMHP	Bilingual Community Mental Health Promoter

Terms

Cultural diversity	Refers to the wide range of cultural groups that make up the Australian population and Australian communities. It includes groups and individuals who differ according to religion, race, language or ethnicity. The term is used to reflect intergenerational and contextual issues, not just a migrant experience.
Mental health promotion	Action to maximise mental health and wellbeing among populations and individuals.
Mental health literacy	The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help seeking.
Multiculturalism	The term 'multiculturalism' summarises the way Australia addresses the challenges and opportunities of our cultural diversity. It is a term which recognises and celebrates Australia's cultural diversity. It accepts and respects the rights of all people in Australia to express and share their individual cultural heritage within an overriding commitment to Australia and the basic structures and values of Australian democracy. It also refers specifically to the strategies, policies and programs that are designed to make our administrative, social and economic infrastructure more responsive to the rights, obligations and needs of our culturally diverse population; promote social harmony among the different cultural groups in our society; and optimise the benefits of our cultural diversity for all people in Australia.
Transcultural mental health	Extends the definition of mental health to look at the interactions of individuals and groups within a culturally diverse environment, to identify specific risk and protective factors for those individuals and groups who may be marginalised within the dominant culture, and to address societal and structural issues within the environment in order to promote their mental health and wellbeing.

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[12] these definitions are taken from the glossary of *the Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*

Summary

The purpose of this framework is threefold: firstly, the framework provides a rationale for the creation of a network of Bilingual Community Mental Health Promoter (BCMHP) positions and an approach for the prioritisation of CALD communities offering some guidelines, issues and considerations for implementation. Secondly, the framework describes a process to identify, prioritise and engage with CALD communities regarding mental health promotion. Thirdly, the framework clearly outlines the role of the BCMHP positions; the relationship with the Queensland Transcultural Mental Health Centre (QTMHC), particularly with the Mental Health Promotion, Prevention and Early Intervention Program, under which these positions operate; and identifies the elements that support the BCMHP positions including the role of a positions co-ordinator.

The approach used by this framework is critical for successful mental health promotion within culturally diverse communities and includes the following elements:

- community engagement;
- community capacity building;
- consideration of community level of readiness for engagement;
- multimodal communication strategies; and
- approaches to group program implementation.

These elements mean that organisations such as QTMHC need to be flexible in the way that mental health promotion activities are developed and delivered and need to focus on the collaborative and reciprocal nature of engaging with CALD communities to implement these activities.

Understanding and acknowledging the ability of CALD communities to provide their own, culturally specific frameworks so the activities are meaningful is a central component of this framework. The assumption is that cultural communities already have an intrinsic knowledge, skills and ability to conduct activities that promote mental health and wellbeing within their communities, and that all what is required is to support them with resources to initiate or enhance implementation and be more ready to receive new information that builds on their existing capacity.

BACKGROUND AND RATIONALE

Background

The need to create a pool of Bilingual Community Mental Health Promoter (BCMHP) positions within the Qld Transcultural Mental Health Centre was a key recommendation made in the *Review of Transcultural Mental Health Services in Queensland*.

Following endorsement and approval of the review recommendations, $28,000 was allocated to QTMHC to employ Bilingual Community Mental Health Promoters to enhance the capacity of QTMHC to engage with cultural communities. The funding allocated was for wages only, with the positions funded at an AO3.1 level.

The QTMHC uses a variety of Bilingual Community Workers throughout its various programs. With the availability of funding for mental health promotion within CALD communities, QTMHC is now in a position to recruit and train bilingual community mental health promoters to develop and implement community based initiatives within their particular communities.

The use of Bilingual Community Mental Health Promoters in mental health promotion will:

- increase the capacity of the MHPPEI Program; and
- develop links between CALD communities and QTMHC and other mental health services.

The BCMP positions program will build on existing mental health promotion programs already in place to increase community mental health literacy. The BCMHP positions will be the link between these programs and the communities. For further information, please refer to the following reports: *Multicultural Community Development in Mental Health Project – Stage One*, Multicultural Centre for Mental Health and Wellbeing (Harmony Place) and QTMHC, 2003; and *A model for CALD consumer participation in mental health. A report on the Multicultural Consumer and Community Participation in Mental Health Project*, QTMHC and Harmony Place, 2005; *Stepping Out of the Shadows: Reducing Stigma in Multicultural Communities,* Multicultural Mental Health Australia, 2008, *Building Resilience in Transcultural Australians (BRiTA Futures) Program – Adolescents and Primary School Aged Children versions,* QTMHC, 2008; *Depression and Chronic Disease Self-management Program,* QTMHC, 2008.

Rationale

Mental health is an inseparable part of total wellbeing and is affected by a wide range of social and environmental factors that reside outside the health sector. The influence of race, gender, class and sexuality, as well as employment and social circumstances means that mental illness is not only affected by bio-chemical and genetic factors, but also external, 'whole of life' issues[13]. Given this, strategies to promote and prevent mental health are as important as the promotion of the economic, physical, spiritual, social and cultural health of people and the communities in which they reside[14].

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[13] Ministry of Health (2002). Building on Strengths: A new approach to promoting mental health in New Zealand/Aotearoa. Ministry of Health: Wellington, NZ

[14] Wiseman, J. (n.d.). Broadening and deepening mental health promotion: the importance of coalition building. VicHealth: Melb, Vic.

Mental health promotion is defined in this framework as *"…Any action that enhances the mental health and well being of individuals, families, organisations or communities"*[15].

There is an increasing awareness of the differences that exist between CALD communities and the broader population in relation to involvement within the mental health system and access to mental health services and programs[16]. For many CALD communities, the risk of mental health issues is increased, due in part to the reduction of protective factors (such as family support, community connectedness, cultural identity, isolation, etc) and the stresses of acclimatising to a new and different, cultural and physical environment[17].

There is substantial evidence that suggests that promotion activities have the capacity to reduce the risk, stigma and burden of mental illnesses, and to promote mental health and wellbeing, particularly within CALD communities[18]. Mental health promotion *can* increase the mental health awareness and literacy of CALD communities. It *can* reduce the stigma associated with mental illness; promote social inclusion; improve service delivery; reduce the risk of mental illness, and foster better relations.

At the same time there is a growing realisation that people from CALD backgrounds are disproportionately affected by mental health problems due in part, to the gap in service provision[19]. In order to ensure that this gap is not assimilated into mental health promotion activities, organisations need to engage with cultural communities in the spirit of mutuality and collaboration.

However, mental health promotion within CALD communities is not only about enhancing the ability of individuals and communities to better cope with external stresses and pressures, it is also about developing a range of strategies and activities that are consistent with a culture's framework of mental health and wellbeing.

CALD community mental health promotion

The literature indicates that many CALD communities[20,21]:

- have a limited knowledge of mental illness, mental health systems, and support services;
- engage in a range of pathways to care that are often very different to the mainstream;
- rely on existing community networks such as GPs, family and community based services for support and access;
- use hospital and community based mental health services significantly less than those in the general community;
- are often subject to a lack of cultural awareness and sensitivity when engaging services[22];
- have negative associations with mental health problems and mental illness;

[15] Dept. Health (2004). Celebrating our cultures: Guidelines for mental health promotion with the South Asian community. Dept. Health: London.
[16] QTMHC & Harmony Place (2002). Multicultural Community Development in mental health project: Stage one report. QTMHC: Brisbane, Qld
[17] Commonwealth of Australia (2000). National action plan for the promotion, prevention and early intervention for mental health 2000: A joint Commonwealth, State and Territory initiative under the second National mental health plan. COA: Canberra, ACT.
[18] COA (2004). Framework for the implementation of the National mental health plan 2003 – 2008 in multicultural Australia. COA: Canberra, ACT
[19] Dusevic, N (2001). The road less travelled: Mental health promotion among CALD communities. In John Spiteri (ed). Keeping well: Mental health promotion, prevention and early intervention for all: Report on the third Transcultural Mental health forum 2001, pp 22-24. Transcultural Mental Health Centre: NSW.
[20] QTMHC & Harmony Place (2002). Multicultural Community Development in mental health project: Stage one report.
[21] Petric, T. (n.d.). Mental health in a multicultural society. NSW Transcultural Mental Health Centre: NSW.
[22] Mills, D. (2005). Cultural development analysis: Penrith City Centre & St Mary's Town Centre. Penrith City Council: Penrith, NSW.

- are subject to barriers that impede access that include language and cultural factors, stigmatizing attitudes, mistrust and lack of knowledge of the health system and how it functions[23];
- are less likely to voluntarily use mental health services for a mental disorder and are more likely to be hospitalised on an involuntary basis[24];
- identify social isolation as a contributing factor to mental illness;
- are reluctant to seek help and disclose difficulties outside of the family.

In relation to mental health promotion, CALD communities are:

- less likely to engage in mainstream promotion activities; and
- a very small number of interventions tend to be effective in reaching CALD communities[25].

The literature describes a broad range of services that are successful at engaging with CALD individuals, and all of them indicate that effective service delivery requires the service to have an[26,27,28]:

- understanding of the level of community readiness;
- familiarity with population sub-demographics;
- recognition of the needs of the target population;
- awareness of existing resource and gaps in services;
- knowledge of preferred methods of communication.

Guiding principles for implementing mental health promotion in CALD communities

Three key issues emerge as critical determining factors to the successful implementation of mental health promotion and prevention within CALD communities[29,30, 31]:

1. **Level of readiness**: A community's level of readiness determines whether a program can be effectively implemented and supported by the community. The research shows that the higher the level of readiness, the greater the degree of program success. Level of readiness also encourages an engagement with communities to develop their own, culturally specific initiatives that utilise local resources to guide the community to higher levels of readiness[32].

2. **Community capacity building and development**: The implementation of any new mental health promotion program requires community support to ensure its successful

[23] Keleher, H. & Armstrong, R. (2005). Evidence-based mental health promotion resource: report for the Dept. Human Services and VicHealth. VicHealth: Melb, VIC.

[24] Agic, B. (2003). Health promotion programs and mental health/illness and addiction issues in ethno-racial/cultural communities: A literature review. Centre for Addiction and Mental Health: Toronto, Canada.

[25] VicHealth (2002). Promoting the mental health and wellbeing of newly arrived communities: Learning's and promising pathways: Victorian health promotion and Foundation mental health promotion plan 1999-2002. VicHealth: Melb, Vic.

[26] Mills, D. (2005). Cultural development analysis: Penrith City Centre & St Mary's Town centre.

[27] Keleher, H. & Armstrong, R. (2005). Evidence-based mental health promotion resource: report for the Dept. Human Services and VicHealth.

[28] VicHealth (2002). Promoting the mental health and wellbeing of Newly arrived communities: Learning's and promising pathways: Victorian health promotion and Foundation mental health promotion plan 1999-2002.

[29] Agic, B. (2003). Health promotion programs and mental health/illness and addiction issues in ethno-racial/cultural communities: A literature review. Centre for addiction and mental health: Toronto, Canada

[30] VicHealth (2002). Promoting the mental health and wellbeing of Newly arrived communities: Learning's and promising pathways: Victorian health promotion and Foundation mental health promotion plan 1999-2002.

[31] Jane-Liops, E. & Barry, M (2005). What makes mental health promotion effective. Promotion & education (supplemental). 2, pp 47-54.

[32] Rowling, L. (2003). School mental health promotion – theoretical, conceptual and practical issues. Australian Journal of Guidance & Counselling. 13(1), pp 11-21

implementation, operation and integration. Capacity building and development is the most promising method of engaging and working with CALD communities. Community development seeks maximum participation of community members in all phases of the planning and design of initiatives[33].

3. **Multi-modal communication approaches**: No single approach works for everyone in the community. However, information oriented programs tend to work best when they employ a variety of communication tools with content that is both culturally acceptable and appropriate, and has been generated from within the community.

The community readiness approach is built on community development, the process of encouraging and enabling disadvantaged communities to take action in improving their health. It is the 'bottom-up approach' that allows communities to identify their own needs and engage in the planning and development of health promotion initiatives in a culturally and linguistically appropriate manner[34]. Community development is a dynamic process during which communities gradually change power in their favour. Arriving to this point however, requires access to various resources, including professional staff, the creation of community space and program materials, all these particularly during the early stages of the community development process.

In Australian CALD communities the key factor of engagement used by mental health promotion programs has been the use of community cultural development processes to improve individual and community wellbeing[35]. These processes have been found to be an effective intervention for promoting health and enhancing the ability of participants to function on broader political, social and environmental levels.

Issues and considerations

Although mental health promotion and prevention can have many positive benefits, there are also some key influences and pressures that require consideration. Many CALD communities view wellbeing as existing within a paradigm of human wholeness that includes physical wellbeing, family relations, community connection, cultural identity, spirituality and access to resources[36]. Wellness in this context requires a connection between all the elements of the whole person.

The mental health system within Australia however operates within a wider health sector whose delivery relies on models and frameworks that have been developed in Britain and North America[37]. Within this system, culture is often constructed as a barrier to the effectiveness of preventing mental health issues. Culture however, can facilitate mental health promotion initiatives. Many CALD communities have pre-existing strategies for health and well being, strategies which have been used and enhanced over generations and centuries[38]. The important issue facing mental health promotion within CALD

[33] Westoby, P. (2004). The role of community within healing: A framework for community capacity building with Southern Sudanese refugee community of Brisbane. In Multicultural families: investing in the future: conference proceedings. Pp 91-119. Centre for Multicultural and Community Development: Sunshine Coast, Qld.

[34] Agic, B. (2003). Health promotion programs and mental health/illness and addiction issues in ethno-racial/cultural communities: A literature review. Centre for Addiction and Mental Health: Toronto, Canada.

[35] Keleher, H. & Armstrong, R. (2005). Evidence-based mental health promotion resource: report for the Dept. Human Services and VicHealth.

[36] Agic, B. (2003). Health promotion programs and mental health/illness and addiction issues in ethno-racial/cultural communities: A literature review.

[37] Ministry of Health (2002). Building on Strengths: A new approach to promoting mental health in New Zealand/Aotearoa.

[38] Westoby, P. (2004). The role of community within healing: A framework for community capacity building with Southern Sudanese refugee community of Brisbane.

communities in Australia is the relevancy and extent to which mental health promotion models from these areas are applicable within the CALD context.

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health provides encouragement for the inclusion of culturally appropriate activities in the promotion of mental health and wellbeing with CALD communities within Australia[39]. The focus however remains on issues of cultural sensitivity and appropriateness whilst integrating western models of mental health promotion, practices and service delivery into CALD communities[40].

The most common practice of mental health promotion within the transcultural health sector focuses on information provision strategies designed to inform and educate individuals and communities. Other strategies, designed to enhance risk and protective factors, tend to be derived from pre-existing packaged programs developed within mainstream western health frameworks. Such approaches focus on risk and protective factors without taking into account the ways in which culture can create wellbeing for individuals and the role culture plays as an important determinant of achieving mental wellbeing and preventing mental health problems.

Furthermore, engagement with CALD communities for mental health and promotion can have drastic effects, from raising levels of expectations or anxiety, to creating further community division. QTMHC has a history of engaging with many CALD communities for a range of community development and enhancement projects. As a result, QTMHC has accumulated substantial knowledge on key issues and considerations to be aware of when undertaking community engagement and development. These include:

- the suitability of communities in relation to their readiness and ability to engage in projects;
- awareness of issues (internal and external) that currently impact on the community, i.e. cohesiveness of communities;
- the impact of Government involvement on the stability of a community;
- involvement of Non Government and Government sector services with a community;
- the ability to raise expectations or fears by being involved;
- increasing core work due to direct involvement (more referrals etc)
- using a best practice strategy to engage with specific communities, namely, employing bilingual/bicultural community workers
- employing bilingual workers over mid to long term.
- providing appropriate support and resources to bilingual workers
- being aware of community protocols before engaging with a particular community.
- if appropriate, prioritising engagement with those members of a community who influence it the most.
- truly involving a community in the management of the mental health promotion initiative to the level they have the capacity to.
- ways in which CALD communities are disengaged, particularly following assessment of community's needs and suitability, readiness and capacity.

[39] COA (2004). Framework for the implementation of the National mental health plan 2003 – 2008 in multicultural Australia. COA: Canberra, ACT.
[40] Spiteria J. (2001). Advancing transcultural models of mental health promotion. . In John Spiteri (ed). Keeping well: Mental health promotion, prevention and early intervention for all: Report on the third Transcultural Mental health Forum 2001, pp 16-18. Transcultural Mental Health Centre: NSW.

Successful program implementation requires a number of key considerations, foremost of which is an organisations commitment to engage community development principles and to work collaboratively with CALD communities.

The approach

The mental health promotion program operates in four phases that begin with identifying each of the CALD communities that will be a part of the program and progresses to strategies to engage, recruit and train BCMHP's as well as implementing activities within each community.

Phase One: Community identification, prioritisation and engagement.
Specific CALD communities are identified as appropriate or suitable for the program and engagement is made with key community members.

Phase Two: Recruitment & training of BCMHPs.
Specific strategies are implemented for recruitment within the priority communities; BCMHP's are recruited and trained.

Phase Three: Program planning.
Specific program activities are organised as negotiated by the program and community groups including all the supporting elements that are required.

Phase Four: Program implementation and evaluation.
All elements of the program are operational including program reference groups and evaluation strategies are in place.

The current program of recruiting bilingual community workers takes the approach that the most effective way in which to address mental health and wellbeing from within a community is to actively engage with that community. The goal of the current program is to:

- enhance and develop the inherent strategies and activities for mental health and wellbeing that exists in all cultures. This includes exploring the capacity of traditional practises as valid approaches to mental health and wellbeing; and

- reducing stigma and other negative responses associated with mental illness;

Strategies to be accomplished are:

- engaging with cultural communities to assess needs, skills and cultural strategies and activities for mental health and wellbeing;

- recruiting committed and skilled individuals within any particular cultural community;
- supporting those individuals in the development of health and wellbeing strategies and activities that are consistent with their particular cultural community;
- supporting and assisting those individuals in the development of strategies and activities which aim to reduce the negative responses associated with mental illness and mental problems;

- supporting the development of cultural activities that encourage resilience and coping and to achieve cultural validity and acceptance of these activities within the predominant Australian cultural context.

Resource allocation issues do not enable the QTMHC to provide services to all CALD communities and provision must be allocated on need and suitability. Based on the information provided, distinguishing criteria for resource allocation to CALD communities includes:

- those with a high involvement in the mental health system;
- communities with high needs;
- communities that are not currently serviced by other agencies or have a low level of service provision;
- communities that demonstrate a level of readiness and capacity.

This framework describes a process of working in partnership with CALD communities to develop mental health promotion activities within each respective community. It is imperative that the CALD communities who participate in this program are given every opportunity to determine the skills, background, tasks and type of person/s to do these activities and that the role descriptions and supporting elements reflect this.

Mental health promotion and prevention activities within CALD communities have the capacity to increase mental health literacy, reduce stigma and enhance the health and wellbeing of people and communities. If not handled correctly, it also has the capacity to create social and emotional health problems such as anxiety, unrealistic expectations and divisions within communities.

To ensure that mental health promotion and prevention programs have a positive impact on communities, organisations need to understand that engaging in development with cultural communities is a time consuming process that progresses in small steps. Furthermore, organisations that seek to promote programs with cultural communities need to be open to input and direction in the implementation and application of these programs.

There is no simple answer or approach that works in every community or even in the same way. Community development and engagement requires actual engagement to negotiate the best and most suitable approach for any given community.

The following guidelines document strategies that *can* be used in the implementation of mental health promotion approaches within cultural communities. However, they are not prescribed strategies that *must* be used,: they are simply suggestions for ways in which cultural communities can be given the opportunity to provide input into mainstream programs and to ensure mainstream services are flexible and authentically meet the needs of cultural communities.

GUIDELINES FOR COMMUNITY IDENTIFICATION, PRIORITISATION AND ENGAGEMENT

This section of the framework describes the process for differentiating between communities and prioritising those to be included in the mental health promotion program, from all other cultural communities at any given time. The process uses two different approaches to assess a community's suitability for involvement:

- A **deficit approach.** Identifies communities with very high social, emotional and mental health needs. Assessment is based on their involvement within the mental health system, including the different programs at the QTMHC, and on the services and supports that are being offered to that community from Government and Non-Government Organisations.

- A **strengths approach.** Focuses on the existing capacity and readiness of a community by identifying its inherent strengths and key community leaders in this area. A strengths approach identifies the key, interested community leaders, strategies to engage community leaders and existing capacity and resources of the community.

STAGE 1: IDENTIFYING POTENTIAL PRIORITY COMMUNITIES

Identifying potential communities to participate within the mental health promotion program adopts a **deficit approach**. That is, communities are prioritised according to high levels of contact with the mental health system and/or QTMHC; gaps in service provision; identified needs from external services and agencies, etc.

The following selection process has been developed as a means to distinguish between the vast numbers of CALD communities in order to determine appropriate communities to participate in the MHPPEI program. It operates as a three step process, with each step refining the selection of communities.

Step 1:
Based on an internal audit of QTMHC contacts with CALD communities by ethnicity, country of birth and the collective experiences of QTMHC with CALD communities.

Using the *Audit to Identify Potential Priority Communities* (Appendix 1), collate information according to the following three scales:

Scale 1: Internal audit of Transcultural Clinical Consultation Service (TCCS) contacts with CALD populations by ethnicity and identify the top five (highest).

Scale 2: Internal audit of Transcultural Clinical Consultation Service (TCCS) contacts with CALD populations by country and identify the top five (highest).

Scale 3: Internal audit of the QTMHC based on collective experiences of QTMHC staff.

NOTE: Communities that rate on two or more scales progress to Step 2.

Step 2:

An external audit of multicultural sector agencies involvement with CALD populations. Selection can be based on multicultural sector agencies identifying populations of need via interview and completion of a community network survey. This step establishes those CALD communities which multicultural sector agencies identify they are working with and who require further assistance and support (Appendix 2)

Step 3:

Compare and contrast data collected in Step 2 with community involvement within the mental health system, State government priorities and engagements with QTMHC (Appendix 3).

Following this comparison, a small list of communities is now available. Progress to Stage Two.

STAGE 2: SELECTING PRIORITY COMMUNITIES

Stage 2 is a strength-based approach to prioritising communities and requires moderate community engagement with targeted members of potential communities from Stage 1. The objective of this stage is to gain some insight into the makeup, condition and character of the community from members of that community to gain a measure of community readiness and capacity (Appendix 4). Communities have, at this point, not been selected as priority communities to be involved in the mental health promotion program.

Stage 2 uses the *Community Readiness Model* (Appendix 5) as the framework to conduct the first assessment with the identified community. The model suggests an early engagement with bicultural members of the community who currently work in the relevant field of focus for the program, in this case, mental health. This approach is not to raise expectations that QTMHC will include this community within the program if it is not yet ready.

In a respectful manner, the QTMHC will contact mental health professionals who are linked with the relevant community or professionals from a similar field. This requires the QTMHC to develop or use existing links across Queensland mental health services to determine individuals that are from the cultural communities in question in order to be aware or updated on the community's local situation and identify particular pathways to link with the community.

Suitable key informants are those 'professionals' who are actively involved within the community. Ideally they will be mental health professionals employed within Qld Health, but can be from any profession if none are available from the mental health sector. This should be a one-on-one personal interview that involves the application of a survey using the *Community Readiness Questions – Individual Survey* (Appendix 6).

> **IMPORTANT NOTE:**
>
> This process is to determine the best strategy with which to approach and engage *key* community members and groups/agencies in a focus group.
>
> It is therefore important that Qld Health employees are approached as key informants in the first instance, as approaching the community too early may result in raising a level of expectation or anxiety.

The outcome of this process is that after consultation with key informants, you will be able to produce a list of:

- individuals, organisations and agencies to contact;
- appropriate ways to engage with these contacts;
- appropriate methods of engagement; and
- a measure of community readiness and capacity in relation to mental health promotion.

Using the *Community Readiness Rating Sheet* (Appendix 7), score responses from the *Community Readiness Survey* to determine those communities that will be the final communities which will participate in the mental health promotion program.

Collate the information collected from the *Community Readiness Survey* of the most appropriate individuals and organisations to contact within the community for a community engagement/focus group, including information on cultural protocols, meeting places, etc.

STAGE 3: ENGAGING WITH PRIORITY COMMUNITIES

Stage three describes the process of engaging with *key* community members and groups/agencies in a focus/consultation group that have been identified as a result of the readiness surveys (see Appendix 8 for an overview of these stages).

Key community members are those members of the community that are potentially interested in this program, are actively involved in the community and are recognisable within their own community.

Key community agencies/groups are those agencies/groups that are currently active in community activities that are potential wellbeing activities.

> **IMPORTANT NOTE:**
>
> It is not appropriate for external services or agencies to attend this meeting unless expressly identified in the surveys.

1. Contact identified key community members, groups/agencies to attend a community focus/consultation.

2. Generate presentation pieces.

3. Organise meeting (catering, venue, etc).

4. Conduct focus/consultation meeting.

The purpose of the focus/consultation groups is to:

- create an open forum for discussion;
- discuss the QTMHC MHPPEI program and get feedback on the program from the community focus group;
- discuss community willingness to participate in the program;
- decide on the feasibility of employing a Bilingual Mental Health Promoter within the community;
- discuss best pathway for the recruitment and employment of a Bilingual Mental Health Promoter;
- develop possible work strategies for the Bilingual Mental Health Promoter;
- be a platform/base from which future and ongoing community engagement/contact is established. This can include developing, or transforming into, a community (specific) reference group who advise the Bilingual Community Mental Health Promoter.

The long term goal of the focus/consultative group is to develop an operational plan for the planning, implementation and evaluation of the MHPPEI program within their cultural community in collaboration with key community leaders,. This requires ongoing engagement and relations with key community leaders to participate in providing direction to the program. The process is as follows:

Planning:
In collaboration with key community leaders, develop an operational plan for the implementation of the MHPPEI program within their cultural community.

The initial task for the Bilingual Community Mental Health Promoter will be to provide a 'map' of their respective community in relation to existing cultural activities that promote social and emotional wellbeing. Developing a map could include interviewing key members of the community to explore areas of assistance, surveying community needs, exploring existing activities that promote wellbeing, etc. Assistance in the development of this map will be provided by the QTMHC.

An example of a mapping exercise is attached in Appendix 9.

Developing work plans

Work plans should be developed with the BCMHP as a result of the mapping exercise and the issues identified by the focus and community reference groups. These work plans can determine the engagement activity that a BCMHP does each month, the allocation of hours and resources and the timeframe for activities.

An example of a work plan tool is attached (Appendix 10). A planning tool is also attached (Appendix 11).

Another strategy is to develop the work plan of activities in collaboration with key community leaders for the implementation of the MHPPEI Program within their cultural community. This is also an opportunity to re-engage with community focus groups, to get feedback and input on any mapping exercise, and develop these groups into community specific reference groups.

Evaluation:

Given the nature of the program, a single evaluation approach is not recommended, however a number of suggestions are made to measure the use of different elements of the program.

Participatory Action:

Organise a post program community consultation with key community leaders and agencies, with the aim of conducting a participatory action group evaluation discussion of the program implementation and operation.

Community Readiness:

Conduct a post program survey of community readiness with key informants. Compare and contrast the community readiness surveys conducted prior to the program implementation and post program implementation. This will measure if the community has progressed through the dimensions of readiness.

Outcomes:

Measures the level of community involvement and participation in various elements of the program including:

- number of community leaders participating in focus/consultation groups;
- number of community leaders participating in training;
- an increase in demand for QTMHC services across respective communities;
- an increase in participation of the community in targeted, planned activities;
- increased demand for education or information sessions from the community, particularly in relation to mental health education and stigma reduction;
- strengthening of the community;
- an increase in the capacity of the community;
- increased dialogue across the community; and
- increased participation across the community.

BILINGUAL COMMUNITY MENTAL HEALTH PROMOTER ROLE DESCRIPTION

PURPOSE OF THE POSITIONS

The purpose of the BCMHP position is to enhance the capacity of the QTMHC to engage with CALD Australians of all ages on prevention, with a major focus on universal prevention, and community early recognition of mental health problems, as per the graphic of the *Mental Health Promotion Spectrum* (Mrazek & Haggerty 1994) (Appendix 12). However, BCMHPs will have the option to expand their role to selective prevention interventions provided they have the required qualifications and attend relevant training.

The positions aim to:

- enhance and develop the inherent strategies and activities for mental health and wellbeing that exist in all cultures. This includes exploring the capacity of traditional practices as valid approaches to mental health and wellbeing;

- increase the levels of capacity for mental health of targeted CALD communities;

- reduce stigma and other negative responses associated with mental illness; and

- increase levels of mental health literacy of CALD communities;

In order to achieve these goals, Bilingual Community Mental Health Promoters will be engaged to undertake a number of duties, namely:

- to develop, support and enhance traditional cultural practices and activities that support mental health and wellbeing within each priority community;

- provide a link between their respective community and the QTMHC;

- promote the mental health promotion programs and services offered by QTMHC; and

- deliver and evaluate the impact of universal prevention group programs, such as the stigma reduction and mental health literacy community workshops.

PRIMARY DUTIES AND RESPONSIBILITIES

Where considered appropriate and required, the Bilingual Community Mental Health Promoter will undertake to:

- participate in training, professional development and supervision provided by QTMHC;
- complete the Community Survey providing own perspective about levels of community readiness to engage in mental health;
- adapt community training material to own cultural community prior delivery;
- inform the QTMHC of appropriate traditional practices that are suitable as mental health promotion and prevention activities and are currently or potentially occurring within their respective communities;
- support and enhance these traditional practices for inclusion within mental health promotion and prevention activities with the community;

- engage with the community. The range of engagement starts with the acknowledgement of the community resources to maintain and enhance their social and emotional wellbeing, to being open to discuss of concern to the planning of taking community action to address those concerns with actions including taking advantage of the mental health promotion programs and other services offered by QTMHC.
- link community members to these activities as mental health and wellbeing initiatives;
- implement activities that aim to reduce stigma and increase mental health literacy in their own cultural communities that could include: facilitating group discussions; organising group programs which could be run by a BCMHP from that cultural community; conducting community education sessions using the resource materials provided; supporting community leaders with mental health initiatives initiated by the community; organise or support creative and engaging activities;
- become a resource for referrals and if required, a support for referrals; and
- participate in appropriate community activities, forums and meetings as a representative of the QTMHC.

Where considered appropriate, and in consultation with the MHPPPEI Co-ordinator:

o explore the suitability, adaptability and re-design of various group programs to priority communities;
o participate in community activities to assist with identifying community mental health priorities and suitable referral pathways to mainstream services; and
o work in co-operation and collaboration with other program areas within the QTMHC.

KEY QUALITIES OF BILINGUAL COMMUNITY MENTAL HEALTH PROMOTERS
As the Bilingual Mental Health Promoters are focused on enhancing the capacity of the QTMHC to engage with cultural communities, it is highly desirable for the person holding the position to have a commitment to work for the betterment of the community; to have strong networks and a good understanding of the relevant cultural community at a local level; to be recognised across the community and to be able to engage locally with various elements of the community (youth, seniors, etc).

As the position is also focused on building the capacity of the community for mental health, the person would need to have experience at developing activities and programs within the local cultural community linking with local resources for sustainability.

Other qualities include:

• a high level of communication skills in English and in a language from the priority community;
• the ability to understand and to function in the mainstream system and in the cultural community infrastructure;
• understanding mental health and being sensitive towards consumers with mental health problems/disorders;
• the ability to initiate creatively around community priorities and using their cultural explanatory models so that initiatives are meaningful;
• the ability to work independently and as part of a team and within project goals and timeframes; and
• actively contribute to project outcomes through input and participation.

It will also be necessary to include any elements that the community identify as relevant and appropriate to the position.

SUPPORTING ELEMENTS OF THE BCMHP POSITIONS

The BCMHPs are supported by a number of elements including direct support from staff at QTMHC, with particular responsibility on the Co-ordinator of the MHPPEI Program who plays the role of co-ordinator of the team of BCMHP positions. Support is provided in the form of how BCMHPs are recruited, training, supervision and a community reference group.

GUIDELINES FOR SELECTION AND RECRUITMENT

The literature suggests recruitment and selection with cultural communities needs to consider alternative pathways to engage with CALD individuals. This includes the manner in which information about the position is distributed, the processes that are used in interviews and panels, and the communication styles used to provide information.

Position advertising considerations

Suggestions for alternative advertising processes to encourage diverse applications include:

- utilising community focus/consultation groups as a method of distributing expressions of interest;
- distributing application kits through appropriate, established networks;
- holding an information/briefing session;
- advertising through ethnic media such as Radio 4EB and ethnic newspapers;
- distribution through community newsletters;
- advertising through mainstream media and local community newspapers (such as Quest); and
- preparation of a press release.

A number of sample expressions of interests for the position of Bilingual Community Mental Health Promoter have been developed (Appendix 13). These expressions of interest take into account the different position specifications as a result of the community consultation groups.

Culturally engaging selection and interviewing processes

Suggestions for alternative selection and interviewing processes include:

- **Selection panels.** It is suggested that selection panels be limited to two people, with three at the most. The selection panel should include a representative from the QTMHC and from the community.

- **Interview questions.** Questions should be culturally sensitive and appropriate and reflect the expressed concerns as outlined by the community focus/consultation groups.

- **Culturally sensitive interviewing processes.** Include a significant support person/s in the interview (such as an elder, leader or support person) or hold the interview in a culturally relevant space such as a community centre.

WORKING CONDITIONS

The Mental Health Promotion, Prevention and Early Intervention Program at QTMHC has a number of programs that employ individuals on a casual/sessional basis. The experiences of this employment type have been difficult as there are insufficient hours to maintain the worker in regular, satisfactory employment. Consequently, it is recommended that either the number of communities that are prioritised for involvement within the MHPPEI program be limited to a small number of communities at any given time or that the BCMHP working in one program with one community also works in another program with the same community in order to provide the promoter with more working hours. It is also recommended that a set period of a minimum of two years is allocated for a community's involvement within the MHPPEI program or until the community is at the level of readiness to take control of their own affairs.

TRAINING

BCMHP positions are offered an intensive orientation training and more specific training on the mental health promotion program they will be focusing on. The *MHPPEI (Mental Health Promotion Prevention and Early Intervention) Sessional Bilingual Community Mental Health Promoters Orientation Training Manual*[41] offers detailed information and resources about the following:

- Queensland Health, including mandatory training;
- the mental health system in Queensland;
- Queensland Transcultural Mental Health Centre,
- the role of the BCMHP,
- the human resource management procedures,
- community capacity building;
- mental health promotion, prevention and early intervention; and
- project planning, implementation and evaluation

The training is delivered over the period of time required for each BCMHP with a minimum of three full days. In addition, all BCMHP positions undertake the 12-hour course *Adult Mental Health First Aid*[42] and the six-hour training on *Understanding Mental Health and Wellbeing: An Introduction to Mental Health, Mental Health Promotion, Prevention of Mental Ill-Health and Early Intervention*[43]. The most important outcome of the training program is to equip the BCMHP to engage with the cultural community around mental health and mental illness according to the level of community readiness of that community and to respond to the mental health needs.

The specific training on the mental health literacy program they will be delivering is the responsibility of the program coordinator and the amount of time required for the BCMHP to familiarise with the resource material and adapt it to their own cultural group prior delivering will vary from program to program.

The elements of the training programs are re-visited during the ongoing training provided to the BCMHP positions once they have had the opportunity to start applying these

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[41] Queensland Health (2009) *MHPPEI (Mental Health Promotion, Prevention and Early Intervention) Bilingual Community Mental Health Promoters Orientation Training Manual*, Queensland Transcultural Mental Health Centre, Brisbane.

[42] Kitchener BA & Jorm AF. (2002) *Mental Health First Aid Manual*. ORYGEN Research Centre, Melbourne.

[43] Parham, J. & Patterson, A. (2008). *Understanding Mental Health and Wellbeing: An introduction to mental health, mental health promotion, prevention of mental ill-health and early intervention: Participant Booklet*. Australian Network for Promotion, Prevention and Early Intervention for Mental Health IAuseinet), Adelaide.

elements while working in the community. A sample of a training program delivered in 2007 to the team of BCMHPs is attached as Appendix 14.

ROLE OF THE COORDINATOR OF THE BCMHP POSITIONS

The role of the program co-ordinator includes:

- providing ongoing support to the BCMHP positions;
- identifying, preparing and delivering a training program for Bilingual Community Mental Health Promoters;
- co-ordinating the preparation of support materials for the Bilingual Community Mental Health Promoters, including the acquisition or translation of educational resources;
- Supporting the BCMHP positions in the adaptation of training material to their cultural communities and the delivery of information sessions or workshops to community groups;
- be on-call every time a BCMHP position is delivering a session to community groups;
- facilitating bimonthly peer supervision to the pool of Bilingual Community Mental Health Promoters and individual supervision when required;
- linking Bilingual Community Mental Health Promoters to appropriate training and resources within the QTMHC;
- co-ordination across the different communities; and
- exploring opportunities for work within other program areas of the QTMHC and other services.

REFERRAL PROCESSES

As one of the key roles of the BCMHP positions is to recognise mental health problems in members of their own cultural community and respond by referring them to appropriate services, BCMHPs are provided regularly with the most updated information about existing services in the private, NGO and public mental health system (see Appendix 15). BCMHPs however have the responsibility to research the currency of the information prior handing it over to members of the community. They are reminded that one source to assess currency is the Transcultural Clinical Consultation Service (TCCS).

BCMHP positions are encouraged to contact the Transcultural Clinical Consultation Service for non-urgent matters. For urgent matters during business hours they are directed to contact emergency services or TCCS, if the emergency situation occurs during business hours and there has been not a positive response to the presenting situation.

It is well documented that members of CALD communities tend to experience cultural and language barriers accessing mental health services even when given contact details of a service. The implications are that BCMHP positions often are required to support the initial contact between the person and family experiencing the mental health issue and the mental health service. BCMHP positions are strongly encouraged to support an empowering process so the person and family feel comfortable and confident in accessing the service. This would often mean that the service is also meeting the cultural and linguistic needs of its clients.

A referral flow chart is being developed.

SUPERVISION

Due to the casual nature of these positions, supervision will need to be flexible and as frequent as feasible. Supervision models will need to be adaptable to the circumstances of Bilingual Community Mental Health Promoters and can include the following suggested formats:

Element	Content
Professional Supervision	- Supervision with program coordinator - Focuses on issues of specific program(s) - Bi-monthly
Peer Supervision	- Team supervision between Bilingual Mental Health Promoters as a group process - Focuses on professional and work related issues of the broader role - Monthly - Facilitated by Co-ordinator, MHPPEI or delegated officer
Mentoring	- **Community mentoring** from within focus group with the Bilingual Mental Health Promoter selecting a mentor within their community to guide community cultural processes and issues. The focus is on personal and professional issues from within a cultural context - **Professional mentoring** from an employee of Qld Health (possible link to District Multicultural Mental Health Coordinator positions) - Occurs on a needs basis and is focussed on personal, professional and organisational issues.

OTHER COMMUNITY AND ORGANISATIONAL SUPPORTS

Other supports include the development of community specific reference groups to provide cultural support and knowledge to the BCMHPs as well as the development of a mentoring relationship between BCMHP's and a key member of each community

Type	Description	Location	Responsible person
Community reference group	Provide cultural and community knowledge and support *See description below	Could emerge from community focus group	• Co-ordinator of BCMHP positions • key community members with an interest in mental health promotion
Mentor	Provide cultural supports and an elder/Senior relationship to support BCMHPs	Emerge from community reference group	• Co-ordinator OF BCMHP positions • key community member
Program reference group	*See description below	Within QTMHC	• Co-ordinator of BCMHP positions • Key stakeholders, i.e. representatives from NGOs and community reference groups, mental health services. • BCMHPs

Each prioritised CALD community must endeavour to establish a Community Reference Group to provide guidance and mentoring to the BCMHP of that community and provide direction and support to the work in that community. This could be an existing group that adds to their current agenda or the original reference group established during the prioritisation phase.

A representative from the Community Reference Group will also be involved in a Program Reference Group which will provide support and direction to the QTMHC on the BCMHP positions and will be resourced by the QTMHC. The Program Reference Group will include representatives of all the CALD communities participating at any given time and workers from key Non-Government Organisations (NGOs) and mental health services. The group will meet four times per year and the QTMHC will provide the payment of sitting fees of $50.00 per meeting to community representatives involved.

The establishment of a Program Reference Group of other non-community specific stakeholders (such as NGO's and other government agencies) may negatively influence the planning of community specific activities for the BCMHP's. Consequently, establishing the Program Reference Group after the communities have determined their approach, allows for each community to have some independent control over the way that the program unfolds within their specific communities.

The QTMHC has a range of program areas that can offer support to the BCMHP. These include:

- **Education, Training and Development** Program - can offer training support.
- **Multicultural Mental Health Coordinators - based** in Health Service Districts with the most significant CALD populations can provide local links and supports.
- **Transcultural Clinical Consultation Services (TCCS)** - offer assistance regarding any concern about the mental health of members of the community.
- **Information and Resource Library -** Resources and materials related to transcultural mental health issues and translated materials are available.
- **Mental Health Promotion, Prevention and Early Intervention** Program. Given that the team of BCMHPs sits under this program, they get the most support from it including linking them to NGO multicultural organisations, supporting their engagement with leaders and structures of own cultural communities, supervision, debriefing, material resources, work stability, ongoing professional development and risk management mechanisms.

Appendices

Scale 1: Audit to Identify Potential Priority Communities

Scale 1:

Internal audit of Transcultural Clinical Consultation Service (TCCS) contacts with CALD populations by ethnicity and identify top 5 (highest) contacts.

- What populations have had the highest number of referrals or contacts to TCCS?

» **List the top 5 populations by country and ethnicity.**

This information can be provided as an intake print out from TCCS.

Scale 2:

Internal audit of Transcultural Clinical Consultation Service (TCCS) contacts with CALD populations by country and identify top 5 (highest) contacts.

- What populations have had the highest number of referrals or contacts to TCCS?

» **List of the top 5 populations by country and ethnicity.**

This information can be provided as an intake print out from TCCS.

Scale 3:

Internal audit of QTMHC based on collected experiences of QTMHC staff.

- Who has QTMHC identified as populations to watch?
- Who has QTMHC identified as populations requiring assistance?

» **List of populations identified by QTMHC.**

This information can be obtained as a result of discussions with program areas within QTMHC.

** Communities that rate on two or more scales progress to Step 2.

Template for agencies to map out existing community initiatives that promote mental health and prevent mental health problems

Please provide as many attachments as you need.
Thank you very much for your contribution.

Name of organisation:	
Person supplying information:	
Contact details:	
Date:	
Mental health promotion/prevention of mental health problems activities/programs your organisation is currently or has been recently running	
Target CALD communities by language, ethnicity, religion, gender, age	
Target geographical areas	
Contact person of programs and activities in your organisation	
Bilingual community workers employed by your organisation	
Materials that support bilingual workers and program/activities developed/adapted or used by your organisation	
Reports or any other documentation produced from implementing the above	
Communities identified as requiring assistance	
Comments:	

Phase two Selection process:
Identification tool

Flowchart
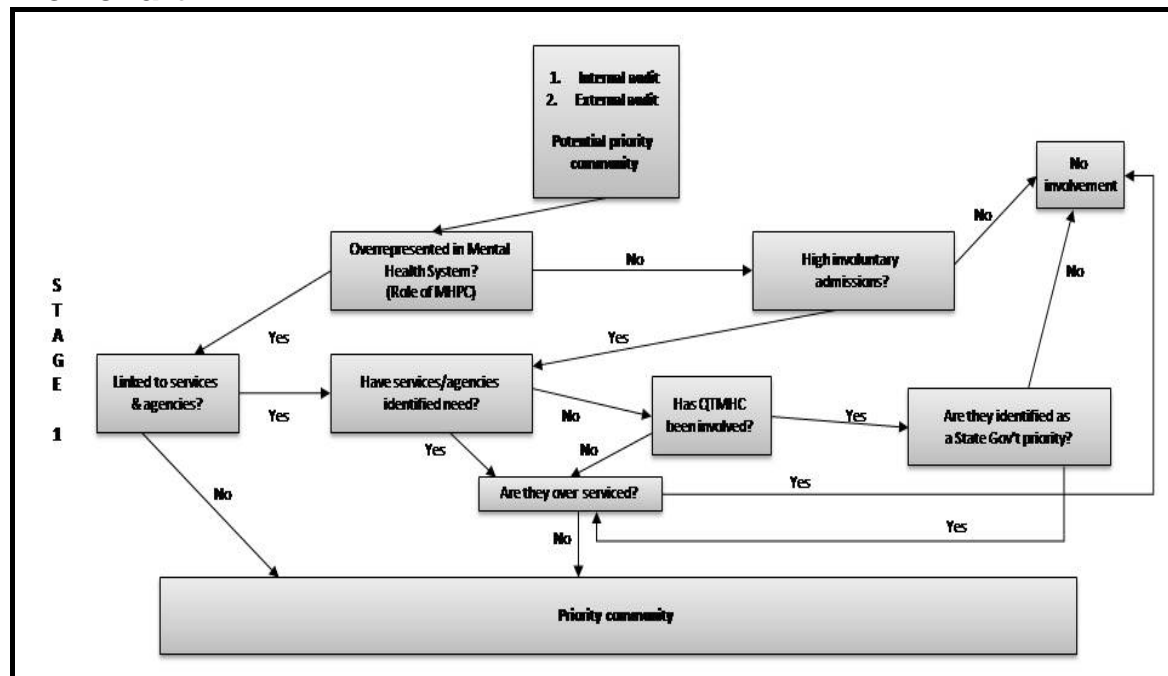
Checklist

Name of population:

No	QUESTION	RATE	COMMENTS
1	Involvement in Mental Health System	High/low	
2	Involuntary admissions	High/low	
3	Linked to Community agencies and services? - Names of Agencies - Type of contact with Agencies - Identification of potential pathways into community - Identification of programs and services within communities	Yes/No	
4	Have Agencies/Services identified need? - What specific areas of need?	Yes/No	
5	Has QTMHC been previously involved? - Type of involvement? - Feedback from involvement	Yes/No	
6	Is Population an identified State Govt priority?	Yes/No	
7	Is Community identified as "overserviced"? - do a lot of agencies already provide services; - Is community active within these agencies; - Have communities developed extensive links with these agencies		
8	Has population been selected as a suitable candidate as Target community? - If no, why not?	Yes/No	

Appendix 4

Stage two overview of community readiness
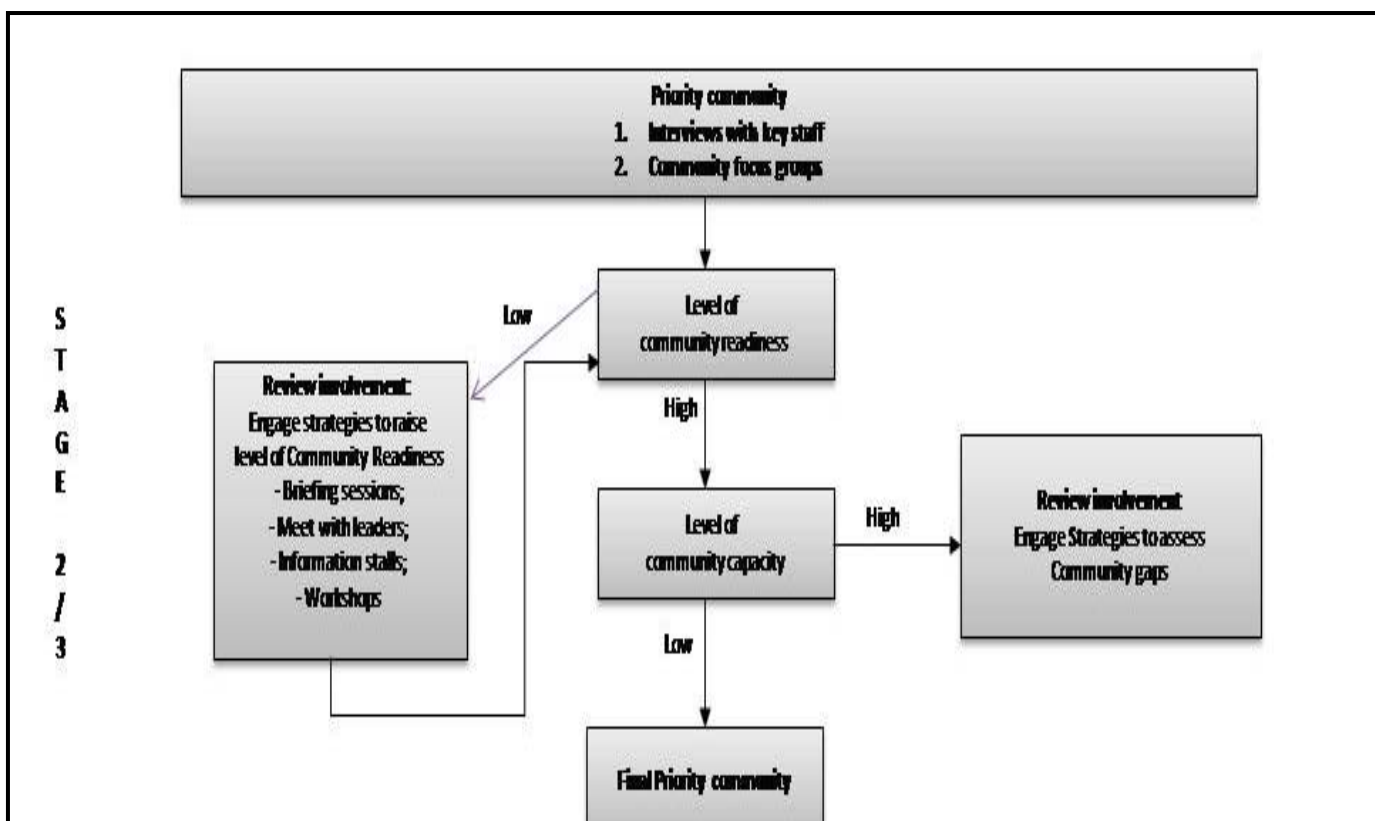
Community Readiness Model

The *Community Readiness Model* was developed to assess the preparedness of a community to address various social issues. It originally came from social researchers of Native American Studies and prevention research as an amalgam of psychological readiness theory and community development. It is used extensively in health promotion and prevention in the US, UK and Australia as a tool to justify program implementation and as a guide for that implementation. It has also been used with indigenous and ethnic communities in drug and alcohol abuse and mental health, promotion and prevention.

The *Community Readiness Model* assesses a community's ability to take action along six key dimensions. These are:[44]

    A. Community Efforts: What existing efforts are in place within the community;
    B. Community knowledge of efforts: Do community members know of these efforts;
    C. Leadership: Are community leaders supportive of the issue;
    D. Community Climate: What is the attitude of the community towards the issue;
    E. Community knowledge of the issue: How much do community members know about the issue and it's local implications;
    F. Community Resources: What resources are available to support efforts.

In assessing these dimensions the Community Readiness Model locates community readiness in nine stages, and each stage has corresponding activities and actions that encourage communities to progress and develop in readiness[45]:

STAGES OF COMMUNITY READINESS

	STAGE	DESCRIPTION
1	No Awareness	Issue not generally recognised by the community or leaders as a problem (or it may truly not be an issue)
2	Denial/Resistance	Recognition of issues as a problem by some community members, however there is no acknowledgement that it is a local problem
3	Vague Awareness	There is some recognition that the issue is a local problem but there is little enthusiasm to do anything. No identifiable leadership around issue or it lacks energy or motivation.
4	Preplanning	There is a clear recognition that the issue is a local problem and that something needs to be done. The community has initiated some discussion of the issue however there is no idea of planning or how to progress.
5	Preparation	The community has begun planning and is focussed on practical details such as sourcing funding and resources.
6	Initiation	Community has just commenced programs and has involved staff in training
7	Stabilisation	Programs are viewed as stable with trained and experienced staff. However there is little program development, planning and evaluation.
8	Confirmation/Expansion	Community members are participating in current programs and

[44] Jumper-Thurman, P., Plested, B., Edwards, R., Helm, H., & Oetting, E. (2000). Community readiness: A promising model for community healing. In D. Bigfoot-Subia (Ed). Native American topic-specific monograph Series. Oklahoma City: OK.

[45] Plested, B, Edwards, R. & Jumper-Thurman, P. (2000) Community readiness: a handbook for successful change. Tri-Ethnic Center for Prevention Research. Sage Hall: CO.

		activities. Programs are being evaluated and further developed.
9	High level of Community ownership	High level of community involvement. A range of programs, services and activities and the community has detailed, sophisticated knowledge of risk and protective factors.

<p align="right">* Adapted from Plested, Edwards & Jumper-Thurman</p>

There are some points to consider when using the Community Readiness Model. First it reflects strong American cultural values, particularly the way in which 'community', community work and community development are defined. For example, the highest level of development on the community readiness scale is a community that is well resourced, financially stable with well developed infrastructure and professionals who engage within the community. For many CALD and indigenous communities, this is not the case as resources and professional drain is a common occurrence that does not necessarily affect the readiness of a community to institute change. Furthermore there would seem to be no encouragement in this model to enhance existing activities and strategies or to develop culturally valid traditions to institute change. All programs that are implemented seem to be developed from outside of the community, and applied within.

However the Community Readiness Model does provide a useful tool for CALD mental health promotion particularly as it highlights the capacity and ability of a community to implement and sustain program activities. It does though require modification and simplification to make it suitable for the needs of CALD communities that are being assessed for involvement with mental health promotion and prevention programs.

These modifications include:
- ➢ Removing culturally loaded aspects of the survey;
- ➢ Allowing for group processes in the delivery of the survey
- ➢ Interpreting the survey qualitatively.

Community Readiness Questions: Individual Survey

Existing Community efforts

1. **On a scale of 1 to 10 (1 being not at all and 10 being very great concern) rate the level of concern about mental health and wellbeing in your community.**

1	2	3	4	5	6	7	8	9	10

2. **Do you know of any activities or programs in your community that promote mental health and wellbeing? Please describe these activities.**

    ....
    ....
    ....
    ....

Community knowledge of efforts

3. **On a scale of 1 to 10 (1 being not at all and 10 being great awareness) rate the level awareness that people have of these activities or programs in your community?**

1	2	3	4	5	6	7	8	9	10

4. **How long have these activities or programs been going on in your community?**

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    ....
    ....

5. **What are the strengths and weaknesses of these activities or programs?**

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6. **Are you aware of any planned activities around mental health and well being going on in your community?**

    ....
    ....
    ....
    ....
    ....

Leadership

7. **On a scale of 1 to 10 (1 being not at all and 10 being very great concern) how much of a concern is mental health and wellbeing to the leaders of your community?**

1	2	3	4	5	6	7	8	9	10

8. **How are these leaders involved in the activities or programs regarding mental health and well being in your community?**
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9. **Would the leadership support more efforts?**
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Community Climate

10. What is the attitude to mental health and well being of members of your community?

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11. What do you see are the main obstacles for programs and activities that promote mental health and well being within your community?

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Knowledge of the issue

12. How knowledgeable are members of your community about mental health and wellbeing? Please explain.

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13. What type of information is available in your community regarding mental health and well being?

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14. How would people obtain information about this mental health and well being in your community?

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Community Resources

15. Whom would an individual affected by this issue turn to first for help and why?

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16. What is the level of expertise and training of mental health specialists in your community?

1	2	3	4	5	6	7	8	9	10

17. What is the community's and/or local business' attitude about supporting efforts with people volunteering time, making financial donations, and/or providing space?

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18. How are the current activities or programs funded? Please explain.

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Community Engagement

19. Who do you feel are the best people to contact within your community who may be interested in mental health and wellbeing issues? Can you provide their contact details.

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20. What is the best way to contact these people? (for example phone, letter, email, etc)

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21. What is the best method for engaging with these people? (for example one to one; forum; group process, etc)

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22. If we were to have a community meeting with these people, what processes, protocols, should we be aware of?

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23. Can you think of any other, better words to use instead of the words "mental health and wellbeing? (for example emotional wellbeing)

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Community Readiness Rating Form

Six dimensions:

1	Community Efforts:	- what is the level of concern in the community - Are there current programs or activities in the community - Do individuals in the community know of these activities - Are these activities ongoing	1 None at all 2 Extreme low 3 Low 4 Emerging 5 Moderate 6 Active 7 High 8 Very High 9 Extreme High
2	Community knowledge of efforts:		1 None at all 2 Extreme low 3 Low 4 Emerging 5 Active 6 Moderate 7 High 8 Very High 9 Extreme High
3	Leadership:	- are leaders concerned - are leaders involved in activities - do leaders support more activities	1 None at all 2 Extreme low 3 Low 4 Emerging 5 Active 6 Moderate 7 High 8 Very High 9 Extreme High
4	Community Climate:	- attitude of community members to mental health and wellbeing - what is the level of acceptance of activities	1 None at all 2 Extreme low 3 Low 4 Emerging 5 Active 6 Moderate 7 High 8 Very High 9 Extreme High
5	Community knowledge of the issue:	- what level of knowledge do - community members have of mental health and well being - Is there information available about MH&W -	1 None at all 2 Extreme low 3 Low 4 Emerging 5 Active 6 Moderate 7 High 8 Very High 9 Extreme High
6	Community Resources:	- level of expertise and training in the community - what level of SUPPORT is there - what level of funding is there for MH & W	1 None at all 2 Extreme low 3 Low 4 Emerging 5 Active 6 Moderate 7 High 8 Very High 9 Extreme High

1	No Awareness
2	Denial/Resistance
3	Vague Awareness
4	Preplanning
5	Preparation
6	Initiation
7	Stabilisation
8	Confirmation/Expansion
9	High level of Community ownership

1 None at all
2 Extreme low
3 Low
4 Emerging
5 Active
6 Moderate
7 High
8 Very High
9 Extreme High

Overview of prioritisation process
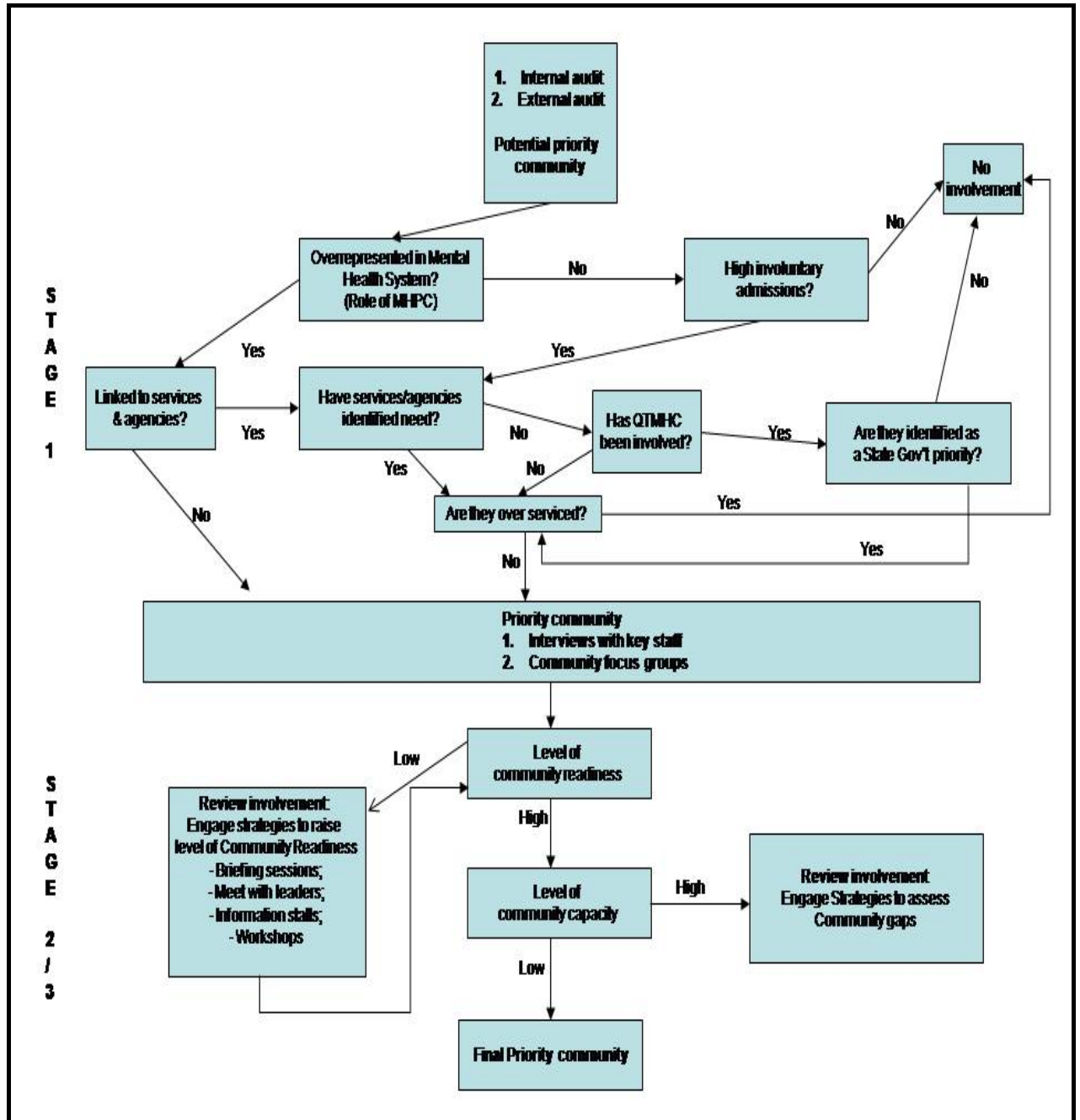
Community Mapping

Date of interview	Time	Community Group:	Participants Male: Female:	Language of session

About your community group:

1	What **activities** does your community group offer? Please describe them. - Who organises these activities? - Who goes to these activities? Who do the activities target - What is the purpose of these activities? - When, where and how often are these activities?	
2.	Does your community group have any plans for future activities?	
3.	What resources does your community currently have? Provide examples and describe in detail. Radio program, newsletter, a meeting place, religious leaders, skilled and knowledgeable people, links with local services. - How are they used?	
4.	What assistance do you think that your community group requires assisting with the activities that they do?	
5.	**What strategies, methods or ways can be used to mobilise or encourage people to participate?** - How can people be encouraged to get involved in community activities that promote wellbeing?	

About your community:

6.	What are some of the different groups within the community?
	
	    - women, men, age groups, ethnic background, country they migrated from, etc
	    - Are there any groups that you think need extra help? If so, list the top three.
	    - What sort of help do these groups need? Please give a list.	

7.	What issues are faced by the different groups within your community? Please give as much detail as possible.
	
	    - what are some of their problems that are unique to them?
	    - How have you seen them over come these problems?
	    - For example An issue for women may be one of 'access' to other appropriate women to talk with about issues.	

8.	Who are the people in the community that people go to for help?
	
	    - Can you identify other people that are helpful?
	    - How are they helpful?
	- Who are the people who are always helping others in the community?
	- Who are the people who influence a big sector within the community?
	- How do they influence the community?	

9.	Comments	

Vietnamese Community

Task: Organise three community events with a focus on "Social and emotional wellbeing". Events will occur every four months and organised by a working party consisting of Dan Nguyen (Vietnamese Social Welfare Network); Elvia Ramirez and Moroni Pugh (QTMHC) and Lorraine Cutler and Ofelia Rivera (Harmony Place) and potential inclusion of Mai Nguyen (Vietnamese Women's Association). Each event will have a different focus: Women and families with young children

First community wellbeing event:

Date	Saturday the 6th of October 2007
Timeframe	3-4hrs from 9:00 AM to 1:00 PM
Target Area:	Inala
Target Group:	Some 150 people (parents/carers and their teen-aged children). Intends to actively target those YPs not already linked to the VYNetwork
Venue:	Community space at the Vietnamese Catholic Association, Inala
Focus	Parents and Teenagers
Overall idea	Bring parents and teenagers together in one forum to discuss issues and look for solutions
Overall structure	Joint session →Split session→Joint summary→ lunch . Also QTMHC and Harmony Place will set an information displays.
Specific idea	**Joint session:** Information session with speakers talking about relevant topics. The facilitators are Hahn and Dan. At this session QTMHC is to be acknowledged and would be an opportunity to talk about services provided by QTMHC. **Split session: both groups will be looking at solutions** - Parents panel: key speakers provide more depth/facilitate discussion amongst parents of topics: Hahn. - Young people: facilitators from the Vietnamese Student's Association and the Vietnamese Youth Club/Vietnamese Youth Network **Joint summary:** Summary of activities from split session
Other support:	Childminding and lunch will be provided relying largely on volunteers.
Resources:	QTMHC has already provided a copy of a PowerPoint presentation focusing on the acculturation process, a DVD on intergenerational issues specifically developed by and for the Vietnamese community in Australia, 40 hours for the organisers of the event plus 10 more hours to further support this particular event.
Tasks	Dan – develop a detail plan of the event and implement it in partnership with the other members of the Vietnamese Social Welfare Network.
Evaluation:	Evaluation will be conducted orally

Other developments: Dan has now been appointed as the Vice-President of the Vietnamese Community Association (Qld Chapter). He'll held the social welfare portfolio and is interested in issues such as DV, addictions and mental health. Dan plans to work with the leaders/members of the executive of the association to educate them. HP expressed interest in becoming involved with leaders. Also expressed interest in being part of the Vietnamese Community Reference Group for the BCMHP.

Meet with BCMHP to develop workplan

1. Identify key areas of work
   - including clear activities & strategies for BCMHP

No	Goal	Task	Who	When
1				
2				
3				

### 2. Discuss potential for "satellite" activities
   - any mental health week activities
   - BRITA, etc

A mental health promotion model as it applies to working with
people from culturally and linguistically diverse backgrounds
Adapted from the Mrazek & Haggerty 1994 Mental Health Intervention Spectrum for Mental Disorders
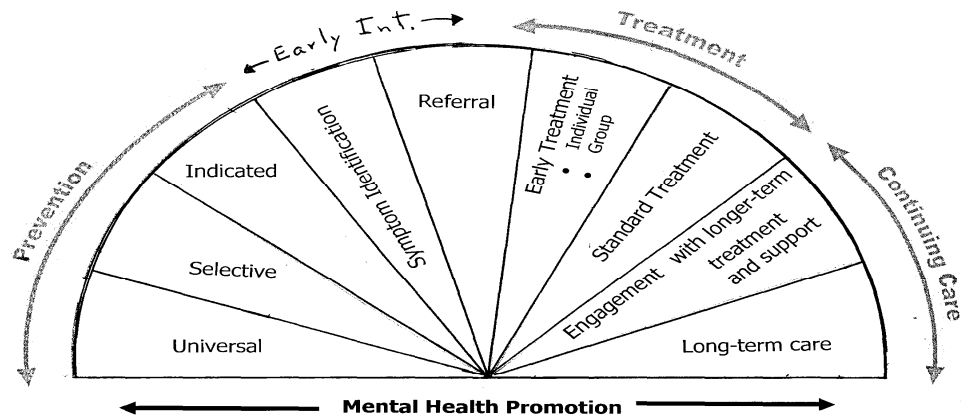
Qld Transcultural Mental Health Centre, 2007

Queensland
Government
Queensland **Health**
Qld Transcultural Mental Health Centre

QUEENSLAND TRANSCULTURAL MENTAL HEALTH CENTRE
QUEENSLAND HEALTH

Bilingual Community Mental Health Promoters (Sessional)
Afghani, Maori, Samoan and Vietnamese
April 2007 – 30 June 2009
AO3 casual hourly rate $27.20

The Qld Transcultural Mental Health Centre (QTMHC) is currently seeking applications from suitably experienced people from the Afghani, Maori, Samoan and Vietnamese communities, to work as **Bilingual Community Mental Health Promoters**. The QTMHC is starting a new long term approach, the *Community Mental Health Promotion Strategy*, which will work with a range of culturally and linguistically diverse (CALD) communities. Initially this strategy will be piloted with the four communities listed above.

The purpose of the strategy is to work with communities to strengthen their inherent cultural approaches to keeping socially and emotionally healthy and improve their wellbeing. QTMHC aims to achieve this by engaging with families, leaders and other members from these communities and by involving them in the planning and implementation of activities that these communities identify as important cultural approaches to enhancing wellbeing.

The QTMHC is a state-wide service and operates from within the Division of Mental Health, Princess Alexandra Hospital and Health Services District. QTMHC implements a range of programs and services addressing mental health issues in multicultural communities. The Bilingual Community Mental Health Promoters will enhance the capacity of its Mental Health Promotion, Prevention and Early Intervention Program to work with a number of multicultural communities in a culturally appropriate manner.

The bilingual community mental health promoters will work up to 14 hours per week between April to June 2007 and then will continue under a new arrangement after June 2007. It is anticipated each promoter will work at least a total of 170 hours per year until June 2009.

How to apply

You are invited to attend **a briefing session** to provide you with more information. This session will be on *Tuesday the 17th of April* at the Large Conference Room of the QTMHC between 4:00 PM to 5:30 PM. The address is 175 Melbourne Street corner with Edmondstone Street, South Brisbane.

Alternatively, you can complete the following application form and post it – along with your resume – to the Queensland Transcultural Mental Health Centre, PO Box 5767 West End Qld 4101, fax to (07) 3240 2282 or email to Elvia_Ramirez@health.qld.gov.au.

For further information please contact Elvia Ramirez, Mental Health Promotion, Prevention and Early Intervention Coordinator on 3240 2833.

Closing Date: **COB Monday 23rd of April 2007.**

Application for the position of
Bilingual Community Mental Health Promoter

Name:
Address:
Phone and Fax:
Email:
Ability to **speak** and **write** (please tick one box): Farsi ☐   Hazaragi dialect ☐   Dari ☐   Māori ☐   Samoan ☐   Vietnamese ☐ Spoken language: Very well ☐   Well ☐   Not Well ☐ Written language: Very well ☐   Well ☐   Not Well ☐
Current Qld Driving Licence: ☐ Yes   ☐ No
Days and times of the week you are available to work: Mondays ☐ Times available: Tuesdays ☐ Times available: Wednesdays ☐ Times available: Thursdays ☐ Times available: Fridays ☐ Times available: Saturdays ☐ Times available: Sundays ☐ Times available:

1. Please tell us why you are interested in the position of **Bilingual Community Mental Health Promoter** and what skills and experience you will bring to this position.

2. Please describe what strategies you think will be useful to get members of your community involved in activities around social, emotional and mental wellbeing.

3. Please describe your work experience – including voluntary work - in linking with services or any other support system in order to address needs identified by members of your community.

4. What are the cultural beliefs that members of your community have about keeping mentally well and mental illness that you think will influence the work that a bilingual community mental health promoter might do in your community?

Please return completed application form by 4:30 PM on Monday 23rd of April 2007.

TRAINING PROGRAM

Training is provided in several broad areas to introduce Bilingual Mental Health Promoters to working within a statutory organisation, as well as the field.

Each module shares several common teaching and learning elements, namely:

Didactic:	Information presented via lectures or presentations.
Experiential:	Information presented via appropriate guest speakers.
Reciprocal:	Learning is developed by students processing information into their particular community, via group discussions and presentations.
Resource Development:	Learning is encouraged via networking where students are linked to community based resources.

The outline of each training module is as follows:

Module 1   Presents a broad introduction to working within Qld Health and in particular, with QTMHC.

Module 2   Introduces the mental health system within Qld.

Module 3   Provides an overview to community cultural development principles and the impact of culture and mental health.

Module 4   Presents an overview of mental health promotion principles and practices.

TRAINING PROVIDERS:
 – **QTMHC Staff**
 – **MMHC District positions**

PARTICIPANTS:
 – **Bilingual Community workers (employed by QTMHC)**
 – **Community leaders and members from priority communities**
 – **Collaborative Community Sector employees**
 – **CALD Consumer facilitators**

ELEMENTS:
 – **Program Orientation**

- **Qld Mental Health System**
- **Community Development & Capacity Building**
- **Mental health promotion**
- **Community promoters presentation**

COMMON FEATURES:
- **Didactic information**
- **Reciprocity in education**
- **Practise application**
- **Guest Speaker**

VENUES:
- **MT GRAVATT**

DAYS AND DATES:
- **COMMENCING FRIDAY 16th MAY 2007 – TUESDAY 21st MAY 2007**

MODULE#1: PROGRAM ORIENTATION
DAY: WEDNESDAY
DATE: 16TH MAY 2007
TIME: 9AM TO 12:30PM
VENUE: QTMHC SMALL CONFERENCE ROOM

SESSION	CONTENT	PROVIDER	RESOURCE LOCATION / TIME
Introduction	• Introductions to training, trainers, training schedule & participants • Housekeeping	QTMHC - Moroni	9 – 9:30
The Community Mental Health Promotion Program within the context of the Mental Health Promotion, Prevention and Early Intervention Program in the QTMHC	• About the organisation – QTMHC • About the TMHPPCEI Program • About the Community Mental Health Promotion Program • Role descriptions: Community Consultants (Afghani), Bilingual Community Mental Health Promoters (Maori, Samoan) • Program support	QTMHC – Elvia and Moroni	9:30 – 10:15 ▪ QTMHC folders ▪ PowerPoint ▪ Brochures of Harmony Place and QPASTT
Working Conditions	• Timesheets; payments, employment conditions • Completion of Commencement Forms by BCMHP	QTMHC - Elvia	10:15 – 10:30 Forms
MORNING TEA 10:30 – 10:45			
Operational Framework: Handy things to know	• An overview of document • How the communities were selected Community Readiness model • Program evaluation model • Supervision models, including peer supervision	QTMHC – Moroni and Elvia	10:45 – 12:00 • Operational Framework doc • PowerPoint • Peer Supervision doc & worksheet
Tasks assignation	• Presentation and discussion of guidelines for a task to be completed by the BCMHPs only.	QTMHC – Moroni and Elvia	12:00 – 12:30 Guidelines doc
LUNCH 12:30 PM			

MODULE#2: **MENTAL HEALTH SYSTEM**
DAY: **FRIDAY**
DATE: **18TH MAY 2007**
TIME: **9AM TO 4:30PM**

SESSION	CONTENT	PROVIDER	RESOURCE LOCATION / TIME
Welcoming	• Introductions & welcoming • Trainers, trainees & Program for the day; Housecleaning	Elvia Ramirez Moroni Pugh	9 – 9:15
Qld Mental Health system	• Symptomology & Treatment • Issues • Act & MH system • Explanatory models • Stigma, culture & family	Lara Denman	9:15 – 10:30
MORNING TEA: 10:30 – 10:45			
Introduction to a District	*Elvia to introduce and provide context of District positions:* • Overview of Logan District & Logan District Position	Elvia Karen Grimley	10:45 – 11:15
Mental Health & wellbeing & Stigma	• Part 1: Mental illness, mental health & wellbeing • Part 2: Barriers & stigma	Moroni	11:15 – 12:00
LUNCH: 12:00 – 12:30			
CCC Forum	• Short film presentation "Matthews story" • 10 min presentation with a Consumer (x 2), clinician & carer. Followed by 45 min open forum	Dil, Dennis, Maria-Teresa, Hana,	12:30 – 2:00
AFTERNOON TEA: 2:00 – 2:30			
Overview of QTMHC	• Overview of QTMHC	Rita Prasad-Ildes	2:30 – 3:00
Overview of TCCS	• General overview • Services of TCCS	QTMHC – TCCS Simone Bell	3:00 – 3:45
Discussion	• Facilitated discussion of mental health issues within cultural communities	Moroni to lead	3:45 – 4:15
Closing	• Wrap up of module • Daily evaluations	Moroni	4:15 – 4:30

MODULE#3: COMMUNITY DEVELOPMENT & CAPACITY BUILDING
DAY: MONDAY
DATE: 21 MAY 2007
TIME: 9AM TO 4:30PM

CONTENTS:

SESSION	CONTENT	PROVIDER	RESOURCE LOCATION / TIME
Welcoming	• Introductions & welcoming • Trainers, trainees & Program for the day • Housekeeping	QTMHC – promotions Moroni Pugh	MP to develop 9 – 9:15
Community Cultural Development A	• CCD principles & practise	QTMHC – promotions Moroni Pugh	9:15 – 9:45
Community cultural development B	• Community development in the context of culture	Moroni Pugh	9:45 – 10:30
MORNING TEA: 10:30 – 10:45			
Capacity Building	• How to build capacity within your cultural community	Moroni Pugh	10:45 – 11:30
Capacity resource games	• Development of Capacity and resources in community	Moroni Pugh	11:30 – 12:30
LUNCH: 12:30 – 1:15			
Critical examination of Community Development	• Critically exploring western methods and contrasting with non western methods of CD • Government approaches to CD – who are we doing it for?	Moroni Pugh	11:15 – 2:45
AFTERNOON TEA: 2:45 - 3			
Community Development in cultural Communities	Community reps focus on insights into community development within their communities	Moroni Pugh	3:00 – 4:15
Closing	• Wrap up of module • Daily evaluations	Moroni Pugh	4:15 – 4:30

MODULE #4: MENTAL HEALTH PROMOTION
DAY: TUESDAY
DATE: 22 MAY 2007
TIME: 9AM TO 4:30PM

SESSION	CONTENT	PROVIDER	RESOURCE LOCATION / TIME
Welcoming	• Introductions & welcoming • Housekeeping	Elvia Ramirez, TMHPPCEI, QTMHC	9 – 9:15
Mental Health Promotion A	• What is it? • Mental health influences • Strategies for maintaining mental health • Mental health & emotional wellbeing	Elvia Ramirez, TMHPPCEI, QTMHC	9:15 – 10:15
MORNING TEA: 10:15 – 10:30			
Mental Health Promotion B	• Concepts of mental health education and mental health promotion • Identify elements that promote mental health • Discuss ways to implement this process • Explore resources for promoting mental health in community	Elvia Ramirez, TMHPPEI, QTMHC	10:30 – 11:30
Movie & discussion	• Mental health promotion movie • Discussion of promotion	Elvia Ramirez, TMHPPEI, QTMHC	MP to develop 11:30 – 12:30
LUNCH: 12:30 – 1:00			
MHP in cultural community	• Strategy development of MH promotion activities within each cultural community • How, what and why?	Elvia Ramirez, TMHPPCEI, QTMHC	MP to develop 1 – 2
	•	QTMHC – MHP	2 – 2:45
AFTERNOON TEA: 2:45 – 3:00			
Closing	• Wrap up of module • Evaluation Form	Elvia Ramirez, TMHPPCEI, QTMHC	MP to develop 3:00 – 3:30

Emergency and Not Urgent Mental Health Services

For psychiatric emergencies dial 000 or find the contact details of your local Mental Health Assessment Team in the Phone Book.

For less urgent mental health support contact LIFELINE 24 hour counselling services on 13 11 14.

The following table provides you with more information about mental health services available. This table is discussed with all the BCMHP positions during training provided by the Coordinator of the Transcultural Clinical Consultation Services, QTMHC.

| **Issues**	**Services**
For psychological issues such as emotional distress, grief and loss, relationship problems addictions and other normal reactions to stressors.	Private Sector Private psychologists, counsellors, social workers, general practitioners. Non-Government Organisations NGO services such as Lifeline, Relationships Australia, Gambling Help Services, Youth and Family Services, Harmony Place, Queensland Program of Assistance to Survivors of Torture and Trauma, Kinections, ZigZag and other counselling services listed in the *Lifeline Resource Directory.* Public Services Public health services such as community health centres.
Mental illness as described by the mental illness classification index books DSM-IV or ICD-10. These mental issues are biologically or genetically driven and might be triggered by stressors.	Private Sector Private psychiatrists, psychologists, mental health psychologists, mental health nurses, social workers and general practitioners. Non-Government Organisations NGO agencies such as Schizophrenia Fellowship, ARAFMI and other organisations listed in the *Lifeline Resource Directory.* Public Services Public services such as mental health

inpatient units or hospitals and
community mental health services.

CONSUMER PERSPECTIVE EDUCATION PROJECT

HANDBOOK

INDEX

Tell me, and I will forget.
Show me, and I may remember.
Involve me, and I will understand.

Confucius

1. OVERVIEW OF STATE STEPPING OUT OF THE SHADOWS PROJECT

What is the aim of the state project?

The Stepping Out of the Shadows; Promoting Acceptance and Inclusion in Multicultural Communities in Qld project began in June 2008, and will finish in June 2009.

It is a project designed to reduce stigma and increase mental health awareness in multicultural communities. Currently the project is working with 12 different CALD communities.

Why deliver a project specifically for CALD communities?

Although stigma exists in all cultures around the world this project has been designed especially for culturally and linguistically diverse (CALD) communities.

It is important to deliver a project specifically for CALD communities for several reasons, including:

- Lack of mental health promotion that is meaningful to people from CALD communities.
  Most mental health promotion programs are designed for mainstream English speaking
  Australian communities and these programs may not be meaningful for people from
  CALD backgrounds. This means people from CALD backgrounds miss out on a lot of
  mental health promotion.

- People from CALD backgrounds do not access mainstream mental health services as much as people from mainstream Australia do. There are many reasons for this including language and communication problems, different expectations of how mental health should be treated, not knowing enough information about what is available and how to use it, and shame about going to these kind of services.

  This project will support people from CALD communities to build on their strengths and work together to reduce any stigma that may exist and increase their wellbeing and quality of life.

Project resources:

- Stepping Out of the Shadows Training Program Package including a DVD teaching tool
- 12 Bicultural Mental Health Promoters
- Project brochures in 12 different languages

How does the project work?

In June 2008, at the start of the project, there was a media campaign using ethnic radio and print media. Promotional material about the project and the topic of stigma around mental illness were distributed through 4EB radio programs, ethnic newspapers and newsletters in over 13 communities.

Since June 2008 there have been 12 Bicultural Mental Health Promoters (BCMHPs) from 12 different communities employed on the project. The BCMHPs work with their communities to:

- Deliver the Stepping Out of the Shadows Training Program or deliver other types of initiatives to reduce stigma (e.g. producing plays)
- Support referrals of community members to appropriate mental health services

- Support and other initiatives that reduce stigma that have been started by their community

What has the project achieved so far?

So far, the project has achieved the following things:

- 11 Training Programs have been delivered in the following communities:

  Mandarin speaking

  Sudanese   Iranian

  Spanish speaking   Serbian

  Italian   Afghani

  Croatian

- One play has been developed and performed in the Burundi community

- Over 25 people have been referred to mental health services including GPs, QTMHC TCCS team, Child and Youth Mental Health Services (CYMHS) and psychologists.

- 3 Consumer Trainers have been employed to work with project staff to develop and implement Consumer Education into the project.

2. OVERVIEW OF THE CONSUMER PERSPECTIVE EDUCATION PROJECT

- The Consumer Perspective Education staff and Consumer Trainers will develop a Consumer Perspective Education Training Package and Model that fits into the state wide Stepping Out of the Shadows Project.

- The Consumer Trainers will be trained to:
    - Be able to train other CALD consumers to be Community Educators
    - Be able to deliver Community Education sessions to groups of participants attending workshops run by Bicultural Community Mental Health Promoters.

➢ Community Educators are CALD consumers who have been trained to deliver Community Education Sessions.

➢ Community Education Sessions are 30 minute sessions where Community Educators share their story and experience of stigma and mental illness to a group of participants.

DIAGRAM 1.

STATE PROJECT: STEPPING OUT OF THE SHADOWS

Project Staff

10 – 14 Bicultural Community Mental Health
Promoters from 10 – 14 CALD Communities

Consumer Perspective
Education Project
- Design Training
  package and Model
- Consumer Trainers
  and Community
  Educators deliver
  30 minute Sessions
  to Workshops with
  community groups in
  State Project.

BCMHPs deliver Stepping

Out of the Shadows

Workshops within their

Communities

Workshop in Greek
Community
4 x 2.5 workshops

1 x 30 minute
Community Education
Session

Workshop in Italian
Community
4 x 2.5 workshops

1 x 30 minute
Community
Education Session

Workshop in Sudanese
Community
4 x 2.5 workshops

1 x 30 minute
Community Education
Session

3. WHAT IS CONSUMER PERSPECTIVE EDUCATION?

Evidence shows that equal status and positive contact with people with lived experience of mental illness is one of the most effective strategies in reducing stigma.

Consumer Perspective Education is when people with lived experience of mental illness, or consumers of mental health services share their stories, knowledge and perspectives with people from the general community. For this project we call it *Community Education*.

Consumer Perspective Education achieves many positive outcomes:

- It gives people who do not have lived experience of mental illness credible and real insight, knowledge and information about what it is like to have a mental illness and go through the mental health services, and more generally about mental illness itself.

- It challenges stereo types that exist about mental illness and people living with mental illness in a positive way.

- Consumer Perspective Education personalises the experience of mental illness and creates human interaction between the Educator and the participants. This can have significant impact on people's levels of knowledge about mental illness, and importantly people's attitudes, feelings and behaviours towards mental illness and consumers of mental health services.

- Consumer Perspective Education is an opportunity for consumers to speak up with equal status and be empowered by sharing their experience, knowledge and expertises.

4. LITERATURE SUMMARY

What is the literature summary?

The Literature Summary is a summary of written information and evidence relevant to Consumer Perspective Education.

What do I do with the Literature Summary?

Read the Literature Summary and write a paragraph about what you thought.

For example:

- What were the most important points in the summary for you? Why?
- Did you disagree with anything in the summary? What did you
   disagree with and why?

5. CONSUMER FOCUS GROUPS

How many focus groups do I have to run?

Consumer Trainers should run 1 x 2 hour focus group each

How many participants should I have in my focus group?

Each focus group should have between 3 – 4 participants. Having a focus group with more than 4 people can make it difficult for people to have the time and space to really talk and express themselves. A small group makes it easier to create a comfortable environment where people can feel safe and relaxed talking about sensitive issues and experiences.

Who should the participants be?

Participants must be consumers of mental health services and come from culturally and linguistically diverse (CALD) backgrounds. Participants can all come from the same CALD backgrounds or can come from different CALD backgrounds.

How long should the focus group be?

Each focus group should last about 2 hours

Where do I run the focus group?

Focus groups can be run anywhere that is the most suitable for the group and the Consumer Trainer. This could be here at the QTMHC building or a room in another organisation or community building. If the

place you would like to run your focus group charges money to use their rooms, please talk to Letitia.

The place should be:
- A safe environment for everybody
- Comfortable and private
- Easy to get to for participants and the Consumer Trainer

Can I run my focus group together with another Consumer Trainer?

Because there cannot be more than 4 participants in each focus group, Consumer Trainers cannot combine groups to run a focus group together.

Having another consumer Trainer with you when running a focus group can be an important support for you however, and a great way to learn from each other.

For this reason, Consumer Trainers can attend another Consumer Trainer's focus group and support them or observe their focus group if they wish. You cannot however get paid to attend or observe another Consumer Trainer's focus group. If you do attend another Consumer Trainer's focus group, this would have to be in your own time.

Can I provide food and drinks for participants in my focus group?

Yes, providing snacks and drinks is an important part of making people feel welcome and relaxed. QTMHC can provide you with biscuits, tea, coffee, juice, milk, sugar, cups and plastic spoons for your focus group.

Collecting/Recording Data

- All information that is recorded from the focus group should be private and confidential. Names of participants should be changed and things that could identify the participant should be excluded where ever possible.

- Explain how the information will remain private and confidential to the participants at the very beginning of the focus group. Take time to discuss any fears or questions the participants may have.

- Make sure all the participants know exactly what you are going to do with the information you record, and how you will record the information. Do not do anything without the participants' full knowledge and consent as this will be a breach of trust.

- Ways of recording the information include:

- Using a tape recorder and writing the key points later in your own time.

    If you use a tape recorder, participants must sign consent form. This is to make sure the participants fully understand what the tape recorder is used for and to show they have agreed.

- The facilitator taking notes as the focus group is run.

- Writing the key points from the focus group together on butcher's paper.

Writing the Final Report

- The Final Report will be a collation of all the Consumer Trainers' Focus Group reports. The group should decide how the Consumer

Trainers will write the final report during the Consultation Workshop. Here are a few possible ways the report could be written:

- Each Consumer Trainer records the key points and the information they got from their focus groups. The Consumer Trainers and project staff then have a meeting together and verbally discuss the Consumer Trainers' findings and reports. As a group they write a list of the key points on a piece of butcher's paper. The project staff then write this list into a report.

- Each Consumer Trainer records the information they got from their focus groups. The Consumer Trainers then have a meeting together to discuss their reports and together write a final report.

6. FACILITATING A FOCUS GROUP

What is a focus group?

- The aim of a Focus Group is to find out what a certain group of people   (target group) in the community think about a specific topic.

- A focus group brings a group of participants from the community and to ask them questions to find out what they think about the topic. The participants that are chosen represent the target group you want to know about.

- For this focus group, the target group is consumers from a multicultural background. We want to know what consumers of mental health services from culturally and linguistically diverse backgrounds think about Consumer Perspective Education.

- A focus group is NOT an education, information or training session. It is only to get participants' thoughts and ideas about a topic.

What is my role as a facilitator of a focus group?

Your role as the facilitator of the focus group is to make people in the group feel safe and comfortable to share their ideas and experiences with the group.

- As a facilitator of a focus group your role is to ask questions to allow participants in the group to talk and share their thoughts.

- Your role is NOT to teach, give information or educate the participants.

As a facilitator of the focus group, the most important skills you will need are skills to:

- make participants feel safe, comfortable to talk,

- make participants feel what they are saying is being heard and valued,

- keep participants focused on the questions and make sure the focus group time is used to discuss all of the points you need to cover,

- support the participants to respect other participants' views and experiences and to listen non judgmentally.

Tips on being a good focus group facilitator:

- Be a good and active listener. This means listening in a non judgmental way and acknowledging that you have heard what is said. (Body language, paraphrasing, asking questions, giving time)

- Establish and maintain clear boundaries. (Time management, group rules, modelling behaviour that is expected from participants, transparency, clear objectives, taking control of group dynamics when necessary.)

- Be yourself and be welcoming and approachable.

- Create a comfortable environment for your participants. (Sit in a circle, have a quiet and private space, have snacks and drinks for them, tell them where the toilet is)

- Speak clearly and make sure everyone can hear you. Sometimes when we are nervous we speak faster or more quietly than usual, be aware of this and try and control it.

- Do not impose your opinions or perspectives on the participants. As a facilitator you may have to listen to opinions and ideas that are very different to your own, and this can be quite challenging. Remember, this focus group is to hear what other people think, so unless the participant is saying things that are offensive or hurtful to people in the group, allow the participant to talk without imposing your opinion, contradicting them or entering into a debate with them. This does not mean you have to agree with them, but maintain your role of facilitator, not teacher.

How to Handle Problems in the Group

- Good group dynamics should include:
- People in the group should allow others to talk and not interrupt.
- People in the group should be respectful of others in the group and try and remain non-judgmental about what they hear.
- People should generally stay "on topic" and not use the time to discuss other things that are not relevant to the focus group.

- A facilitator's role is to try to create and maintain good group dynamics. Participants in the group are individuals and adults however and it is not possible (or appropriate) to control all aspects of their behaviour or try and control all of the group dynamics. Letting people be themselves and not taking their behaviour personally is very important for a facilitator.

- Some problems or issues in the group's dynamics can occur, once again it is not the fault of the facilitator, but it is within the facilitator's role to address it. On the next page there are some possible issues and some strategies you may use to address them.

Problem 1:

One participant is talking much more than other participants, is not letting others talk and is not listening or interrupting them.

Strategy:

Thank the participant for their contribution and acknowledge something positive that has come out of it. Then remind the group of the short amount of time you have to run the focus group. Remind the group that you would like everyone to have the same amount of time to express themselves. Ask the participants to think about how much time they are talking and then tell them you will now monitor their talking time to make sure everyone has the same chances. You can even say, "If you have done a lot of talking up to now, please monitor yourself and do more listening and less talking from now on, and if you have not done a lot of talking until now, please monitor yourself and do more talking if you want to."

From then on, do not be afraid to interrupt the participant every time they talk for too long. You could say something like: "Ok, thank you for that, let's remember the time and let's now let others in the group have some time to express themselves."

Problem 2:

One participant is very shy and not doing any talking.

Strategy:

You can try and encourage the person to talk by making sure they are comfortable in the group and there is enough time for them speak.

When they do say something, be empathetic and encouraging, acknowledge and validate their contribution.

You can try asking them direct questions, such as "What do you think about that?" Make sure if you ask a direct question that the participant feels comfortable to not answer it if they don't want to. Do

not make people feel they are under pressure to talk and contribute, the direct question should be an encouraging and supportive experience not a scary and forceful one.

Try putting the group into pairs and getting the pairs to talk to each other about a topic before they talk to the whole group.

Problem 3:

One participant is quite agitated and angry. They want to talk about their own problems that are not relevant to the focus group.

Strategy:

Acknowledge the problems that the participant has talked about and validate their importance to that participant. You can say something like: "I understand that this sounds like a serious issue for you, I can understand why you are feeling upset."

Then remind the group what the topic of the focus group is, and what you are here to achieve **as a group**. Remind the group that it is important to remain on topic to respect every one else's time and effort at being there. If the participant still has problem staying on topic, feel free to interrupt them when they do it and say something like "Yes, once again, that does sound like a serious issue but it is not the topic that the other participants in the group and I are here to discuss today."

Problem 4:

One participant is aggressive and either behaves aggressively and inappropriately towards the group or another participant.

Strategy:

You can let the participant know that aggressive behaviour is not appropriate in this group as soon as it happens, and ask them to stop. It is important not to take the participant's behaviour personally, and to stay calm and neutral, speaking in a calm voice. Do not raise

your voice or try and enter into a debate with the participant about what they are saying.

Remind the participant of the group rules; remind them that this is a safe space for every one in the group and that any aggressive or disrespectful behaviour will not be accepted.

Maintaining Personal Wellbeing

- Be prepared in case any part of running the focus group causes you to feel overly anxious or distressed. Things that may trigger feelings of anxiety may include the expectations you place on yourself in the role of facilitator, stress about dealing with difficult group dynamics or participant behaviour, the content of what is discussed during the focus group.

- Have a clear idea of who your support network is in case you do need experience feelings of anxiety or distress as a result of working on the project and need to access support.

- Speak to either Dennis or Letitia if you are having any concerns or problems during the project, they are able to listen to you, provide debriefing, support you in resolving problems with the project and will provide referral support if you want.

Maintaining Participant Wellbeing

- Be prepared to provide support if a participant needs it, take referral numbers with you and be clear about who to contact if the situation happens.

- Be observant when running the focus group, try and recognise how participants are reacting to certain things being talked about. Try and recognise if or when participants seem overly anxious or distressed and address the situation.

- Address the situation. If a participant seems overly anxious or distressed, call for a break and talk privately to the participant to check how they are going.

- Do not judge a participant's reaction or force them to take action if they do not want to. Ask the participant what they need or would like to do and respond by giving them the appropriate referral numbers or information.

- DO take action if a participant is at risk of harming themselves or others.

SEE PAGE 27 AND 28 OF THIS HANDBOOK FOR SUPPORT CONTACT DETAILS

7. PRIVACY AND CONFIDENTIALITY

Why is privacy and confidentiality important?

Privacy and confidentiality is one of the most important parts of running a focus group for many reasons:

- without privacy and confidentiality, participants will not feel safe discussing their thoughts and experiences

- privacy and confidentiality protects people from being gossiped about or their personal information being talked about without their knowledge or consent

How do we make sure the focus groups maintain the privacy and confidentiality of participants and the Consumer Trainer?

- Consumer Trainer should explain what privacy and confidentiality mean for the focus group at the beginning of the session.

- If possible the Consumer Trainer and the participants should develop and write a list of rules together. This will encourage participants to own and respect the rules if they have been responsible for developing them. The Consumer Trainer can ask all or some of the following questions to get participants to create a list of rules that are meaningful for them and make them feel safe and comfortable:

1. **What does privacy and confidentiality mean to you in this focus group?**

2. **How would maintaining privacy and confidentiality help you in this focus group?**

3. **What are some rules the group should follow to establish and maintain privacy and confidentiality?**

- The Consumer Trainer should monitor that these rules are being followed by everyone in the focus group while the group is being run. Other participants should also support the Consumer Trainer in monitoring the rules are being followed.

- The Consumer Trainer should model the appropriate behaviour.

What are some privacy and confidentiality rules the group should follow?

- Participants should not talk about what was discussed in the focus groups to any one outside the focus groups (e.g. their friends or family). If participants need to talk to people outside the focus group about what happened during the focus group, they should try and only discuss things to do with them and not discuss personal information that others talked about. They should also talk in a way that does not identify anybody's identity.

- If participants want to talk about an experience that involves other people, they should keep the identity of the people involved

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confidential and either not use any names or use different names. They should also not talk about features that could identify the people in the story.

- When talking in the focus group, when participants talk about their own personal experiences and things that have happened to them, they may choose to say that the story is about them, or not tell people that the story is about them and say it happened to a friend or someone they know instead.

8. FOCUS GROUP DELIVERY PLAN

Introductions:

Introduce yourself to the participants and get the participants to introduce themselves and get to know each other a little before starting. You may do an activity where participants share something about themselves to the rest of the group, for example what their favourite food or holiday is.

Housekeeping:

Tell participants where the exits, toilets and drinks and food are. Make sure every one is comfortable.

Explain the following things to the participants:

- What 'Consumer Perspective Education' means
- What this project is about
- What will happen in the focus group

Privacy and Confidentiality:

Explain how the focus group will remain confidential. Work together as a group to develop a short list of rules about how the group will make sure there is confidentiality, and how the group will behave towards each other to make sure people feel safe and comfortable talking about their experiences and ideas. You can also ask them to think of a few rules about how to have good group dynamics. (Being respectful, letting others talk without interrupting, active listening)

You may wish to write the list on a piece of butcher's paper and stick it up on the wall where everyone can see them.

Ask the participants the Focus Group questions:

Ask the participants the questions without prompting any answers from them. Give them time and support to try and answer the questions themselves.

After they have given their answers, use the prompts to get more information from them or to guide them to answering more accurately or more fully.

Conclusion and Debrief:

As a group, talk about how the Focus group went and check the participants are feeling ok. Briefly talk about some of the positive points of the focus group to end in a positive way.

9. FOCUS GROUP QUESTIONS

1. **Have you ever had any experience of telling your story about mental illness before?**

2. **If you were going to tell your story (give Consumer Perspective Education) and share your experience of mental illness with a group of people from the community, what would you need to support you?**

PROMPTS:

-   **Some types of support include:**
    -   **Training in public speaking**
    -   **Training in how to talk about personal experiences in public Debriefing**
    -   **Training in how to handle problems that could happen when telling your story**

-   **What would make you feel comfortable to talk about your lived experience of mental illness in front of a group of people?**

-   **How could we make sure that there is "equal status" in the group between yourself as a CALD Consumer and the other participants in the group?**

3. **If you gave Consumer Perspective Education to a group of people, what do you think is the worst thing that could happen?**

4. **What do you think Consumer Perspective Education would achieve?**

      PROMPTS:

- **What would Consumer Perspective Education achieve for the general community?**
- **What could Consumer Perspective Education bring the consumer who is telling their story?**

10. CONSUMER TRAINER SUPPORT ACTIVITY

- What are some possible issues for Consumer Trainers on this project?

Make a list of any issues or problems that you think may come up during the project.

Together, as a group, discuss some solutions or strategies to handle these issues if they happen.

11. CONSENT FORM

Consent for Focus Group Participation to be Tape Recorded

1.   Consent

I _____give consent to the Queensland Transcultural Mental Health Centre (QTMHC) to make, use and/or retain a recording as detailed below that may identify me.

I understand that I can withdraw or modify my consent at any time in writing to:

Rita Prasad-Ildes
QTMHC Manager
Rita_Prasad-Ildes@health.qld.gov.au

Ph: (07) 3167 8333
Fax: (07) 3167 8322

2.   Conditions/limitations
My consent is subject to the following limitations:
- ☐ cultural considerations, *please specify*:
- ✓ use restricted to QTMHC
- ✓ usage restrictions, one type of publication etc, *please specify*: tape recording for development of training material only.
- ✓ expiry of consent, *please specify*: tape recording to be erased after the material is collated into a report.
- ✓ Other restrictions/conditions, *please specify.* Participant identities are to be kept anonymous, private and confidential.

3.   Undertakings
Subject to any conditions/limitations in Clause 2, I understand that by giving consent, QTMHC will use the recording for nothing other than purposes of the focus group: to gather information and record it in a way that maintains participants' anonymity and is only used to create the Consumer Perspective Education Training Package and Model.

I understand that QTMHC:
- will not pay me for giving this consent or for the use of the recording;
- will not infringe the rights of any third party by exercising its rights given in this consent.

4.   Description of image or recording
Tape recording of discussion had during the Consumer perspective Education Focus Group:
Time:
Date:
Location:

5.   Participant details
For the purposes of this consent form, the person whose image or recording is used is known as "the Participant".

Full name of Participant:
_____

Full name of guardian (if consenting for a minor or a person with a decision-making disability):

Address of guardian:

Signature of Participant or Guardian: _____

Date:_____

Note: QTMHC will use its best endeavours to identify the person signing this consent form and takes no responsibility for circumstances in which it is misled as to the identity or authority of a person to provide consent.

Witness (must be a Queensland Government employee) I have verbally explained this information to (name of participant) in relation to (description of image or recording) and witnessed the signing of this consent form.

Full name:
Position:
Department:
Details of identification sighted – (e.g. driver's licence, student card.)
Signature:
Date:

Important note:
Important information explaining this consent is located on the reverse side of this consent form. You may request a copy of this information at any time.

IMPORTANT PRIVACY INFORMATION:
QTMHC is collecting the information contained in this form to verify your consent for use of your image or recording for the purposes contained in the consent form. Your consent to the use of your personal information is required in accordance with the Queensland Government's Information Privacy Standard 42. The information privacy principles contained within this Standard govern the collection, use, storage, security, and disclosure of personal information.

Only authorised Departmental officers have access to this information. From time to time QTMHC may provide some or all of this material to other government departments and agencies, or to recognised media outlets for their use to promote QTMHC programs, services and initiatives as outlined above. Your personal information contained in this form will not be disclosed to any other third party without your consent, unless authorised or required by law.

If you have any queries about any privacy issues that relate to this consent form then please contact QTMHC.

The Participant must be given a copy of the signed consent form and explanatory notes.

EXPLANATORY NOTES

What is this consent for?

This consent form authorises QTMHC to use the specified recording of the participant to develop a Consumer Perspective Education Training Package and Model.

What sort of publications could this material appear in?

The material will only be used to inform the development of the above mentioned material.

What is a recording?

The recording referred to in this consent form includes the sound recordings of the Participant.

Who is a child?

A child is defined as any person who has not yet turned 18 years of age.

Who is a person with a decision-making disability?

For the purposes of this consent form, a person with a decision making disability is a person who cannot give consent because they lack capacity or have an intellectual or other impairment that affects their capacity to consent. If a person is an adult and unable to give consent, an authorised decision-maker must give consent on the person's behalf (see for example *Powers of Attorney Act 1998* and/or the *Guardianship and Administration Act 2000*).

What happens to the consent form once it is filled out?

The consent form is retained by QTMHC and will be placed on file. A copy will be provided to the Participant.

Modification or Withdrawal of consent

Consent can be modified or withdrawn in writing at any time however, any changes will only apply from the date of receipt by QTMHC. Any existing material in which the image or recording is used will not be withdrawn from use.

Queensland Government
Queensland **Health**

12. SUPPORT CONTACTS

- **For support if <u>you</u> are having issues or problems related to anything with the project ring:**

Dennis and/or Letitia

QTMHC (07) 3167 8333

They will provide:

- Debriefing for you
- Referral information for you or your participants
- Project support

- **For <u>participants</u> who need clinical support as a result of participating in the focus group ring:**

Mental Health Emergency that is potentially dangerous for the person or others ring:

> 000
>
> Ambulance or Police
>
> 24 hours a day 7 days a week

Mental Health Emergency that is not potentially dangerous to the person or others ring:

> 1300 858 998
> PA Mental Health Emergency Number
>
> 24 hours a day, 7 days a week

Mental Health Issue that is not an emergency ring:

- **Dennis or Letitia**

   > **(07) 3167 8333**
   >
   > **Monday – Friday**
   >
   > **8.30 – 5.00**

They can give you some referral options and advice about how to support the participant.

or

- **QTMHC TCCS Intake Officer**

     (07) 3167 8333

     Monday – Friday

     8.30 – 5.00

They can provide the participant a one-off clinical debriefing session. If the participant requires ongoing or further help after that, the TCCS consultant will refer them on to where they can get it.

For 24 hour phone counselling ring:

13 11 14

Lifeline Phone Counselling

24 hours a day, 7 days a week

Suicide Helpline Call Back Service
Interpreters Available

1300 659 467

Training Program Evaluation Questionnaire

Dear participant,
Please tell us what you thought about the *Stepping Out of the Shadows*
Training Program.

Your responses will help us understand if the program is achieving its aims
and how we can improve it.

1. **Because of attending this training program I now:**
   Please tick as many boxes as you want. It's ok if you don't tick any.

   ☐ understand more about stigma in my community

   ☐ think differently about people with mental illness and their families

   ☐ will behave differently towards people with mental illness and their
      families

   ☐ feel I have more practical skill and knowledge to reduce stigma in my
      community

2. **When talking about or talking to people with mental illness, I thought
   the training facilitator:**
   Please tick as many boxes as you want. It's ok if you don't tick any.

   ☐ was respectful

   ☐ was sensitive towards people with mental illness and their families

   ☐ used factual information

3. **During the training program, I most enjoyed:**
   Please tick as many boxes as you want

   ☐ the topic

   ☐ the activities

   ☐ meeting or being with the other people in the group

   ☐ getting practical skills to help my community or myself

   ☐ Other: _____

4. What would you change about the training program?
Please tick as many boxes as you want. It's ok if you don't tick any.

☐ make it shorter

☐ make it longer

☐ have less information

☐ have more information

☐ less group work

☐ more group work

☐ change the style of the facilitator

☐ Other:_____

5. I felt that the training program respected my cultural values and beliefs
Please tick one box

☐ yes very much

☐ yes mostly

☐ yes

☐ no

☐ no not really

☐ no not at all

6. Did you think the materials used in the training (DVD, Handouts, Fact Sheets etc) were useful?

☐ yes very useful

☐ yes mostly useful

☐ yes

☐ no

☐ no not very useful

☐ no not useful at all

7. Do you have any other comments? Please write them below:

_____

_____

_____

Thank you very much for your time in completing this questionnaire!

Family Stigma Questionnaire

Participant Questionnaire

Below is a short description of two people. Please read about these people and take some time to form an impression of them. Once you have done so, answer the questions about them that follow.

Joan is the mother of Frank, a 30 year old man with schizophrenia. Frank lives with his family and works as a shop assistant at a nearby shop. Frank has been hospitalised several times because of his illness. This illness has disrupted his life significantly.

Now, answer the following questions about Frank's mother, Joan. Circle the answer that is the closest to what you think.

1. Joan bears some responsibility for her son originally getting ill.

    1. Strongly Agree
    2. Agree
    3. Somewhat Agree
    4. Neither Disagree nor Disagree
    5. Somewhat Disagree
    6. Disagree
    7. Strongly Disagree

2. Frank's illness could rub off on Joan.

    1. Strongly Agree
    2. Agree
    3. Somewhat Agree
    4. Neither Disagree nor Disagree
    5. Somewhat Disagree
    6. Disagree
    7. Strongly Disagree

3. When Frank relapses, it may be Joan's fault.

    1. Strongly Agree
    2. Agree
    3. Somewhat Agree

4. Neither Disagree nor Disagree
5. Somewhat Disagree
6. Disagree
7. Strongly Disagree

4. Joan should feel ashamed about Frank's illness.
    1. Strongly Agree
    2. Agree
    3. Somewhat Agree
    4. Neither Disagree nor Disagree
    5. Somewhat Disagree
    6. Disagree
    7. Strongly Disagree

5. Joan was not a very good mother to Frank.
    1. Strongly Agree
    2. Agree
    3. Somewhat Agree
    4. Neither Disagree nor Disagree
    5. Somewhat Disagree
    6. Disagree
    7. Strongly Disagree

6. I would not want to socialise with Joan.
    1. Strongly Agree
    2. Agree
    3. Somewhat Agree
    4. Neither Disagree nor Disagree
    5. Somewhat Disagree
    6. Disagree
    7. Strongly Disagree

7. I would be likely to pity Joan.
    1. Strongly Agree
    2. Agree
    3. Somewhat Agree
    4. Neither Disagree nor Disagree
    5. Somewhat Disagree
    6. Disagree
    7. Strongly Disagree

BCMHP Support Feedback Questions

Do you feel that you had sufficient support from QTMHC?

What could have been done better by staff?

What could you have done better?

How was the communication between you and the coordinator or other QTMHC staff?

Stigma Reduction Project May 2008 - July 2009

Community	Training Workshops (341 people)					Other Initiatives (509 people)					Contacts/Referrals (125 people)				Communication Strategies (111,679 people)										
	Series of Four	Series of Two	One Off Session	# of Parts	Make Up of Participants	Project Launch	# of plays & skits	# attended play & skits	# of Seminars	# attended seminars	TCCS from training	TCCS from media	To other agencies, estimated by BCMHPs	QTMHC from media	Broch	Print Ads	Print articles	Radio ads	Radio Ints	TV	Internet ads	Internet articles	# QLD people reached by print media	# QLD people reached by radio	# QLD people reached by TV
Afghani	4			20	comm members										0	0	0	0		0			0	0	0
Afg/Iran Mixed (G	1			5	comm members								10		0	0	0	0		0			0	0	0
African (Tigrinya, Kirundi, Dinka)			1	6																					
Muslim			7	88	Comm members, only women	5			1	92				2	228	13	1	8		0		2	6950	1,000	0
Burundi			1	6		7	1	80			2		20		20	0	0	2		0			200	200	0
Cambodian			1	8																					
Cantonese Sp																8	0	8		0			800	1,700	0
Croatian											1				269	4		8	1	0			300	3,200	0
Greek	2			20	comm members	1					1				20	4		8		0			5200	5,000	0
Iranian	4			24	4 comm leaders	6									3	0		8		0			0	1,600	0
Italian		1	2	21	comm members, 2 key comm workers	1							25		73		3	8	1	0			3200	3,000	0
Italian Cairns							2	183						5	0	4	3	0		0			8900	0	0
Japanese Cairns			2	13		0									0	0	0	0		0	0	0	0.00	0	0
Korean		1												1	20	16	1	8		0		1	1200	500	0
Mandarin Sp	2	1		40	comm members inc 4 comm leaders	20						9		6	100	32	2	8		0		1	30000	2,400	8,000
Maori											6				0	0	0	0		0			0	0	0
Samoan															0	4	0	8		0			800	3,000	0
Serbian			1	20	3 comm leaders, comm members	2								1	128	12		8		0			1600	1,100	0
Spanish Sp	2		1	28	5 comm leaders, comm members	7			1	50			20		150	12	1	8		0			5350	1,600	0
Sudanese	1			8	comm members, only women	4					8				50	0	0	4		0	1		0	400	0
Turkish						1								1	154	0		8		0			0	600	0
Vietnamese			1	12		3						1	3	1	150	4		12		0			4000	7,500	0
Multicultural		2		22		12	3							2	614	0	3	2		0			0	400	0
NGO Staff						28											3								
Mental health workers										7															
TOTAL	16	3	19	341		97	6	270	2	142	18	10	85	12	1979	113	14	116	2	1	2	3	68500	33200	8000

Estimated number of CALD people reached: 112,529

Stepping Out of the Shadows

**EVALUATION OF POST-PROJECT LEVELS OF COMMUNITY READINESS
FROM 13 KEY INFORMANTS IN A TWELVE MONTH PERIOD
*(May 2008 – June 2009)***

Explanatory note: Level numbers in italics refer to the community's level of readiness to engage in initiatives related to mental health, mental health problems and mental illness, described briefly below.

Level 1: No awareness
Level 2: Denial/resistance - Community generally recognises that mental health issues exist but not in their community
Level 3: Vague Awareness - recognition that mental health is an issue in the community but little motivation to do anything about it; rarely would seek help
Level 4: Preplanning – clear recognition that mental health is an issue in the community and the community has started planning things that they can do; some individuals will access services
Level 5: Preparation – the community has started planning and is focussed on practical ideas while seeking help if needed
Level 6: Initiation – the community has just started action (establishing groups, starting projects and advocacy); accessing services starts to be normalised
Level 7: Stabilisation – working towards keeping their long term initiatives sustainable; accessing services is normalised
Level 8: Confirmation and expansion - community members are participating in current actions, and are evaluating and developing them; accessing services is encouraged
Level 9: High Level of Community Ownership – high level of community involvement and satisfaction; mental health professionals from community are highly involved with community

Based on the work of Jumper-Thurman, P., Plested, B., Edwards, R., Helm, H., & Oetting, E. (2000) *Community readiness: A promising model for community healing.* In D. Bigfoot-Subia (Ed). Native American topic-specific monograph Series. Oklahoma City: OK, and

Plested, B, Edwards, R. & Jumper-Thurman, P. Community readiness: a handbook for successful change. Tri-Ethnic Center for Prevention Research. Sage Hall: CO

BURUNDIAN COMMUNITY
(1 respondent: BCMHP)
Leadership of the community meet to discuss how the community can help members affected by mental illness, they are focussed on practical ideas and would like help with more information – the BCMHP is now regarded as a community leader and the mental health resource in the community who is often accessed for assistance *(Level 5)*. Community members range from low awareness due to lack of understanding of what the health system does but have increased awareness about stigma associated to mental illness *(Level 3)*, There is still some denial believing that mental illness could not happen to them *(Level 2)* to vague awareness with little knowledge of what to do about it but to contact the BCMHP *(Level 3)*. Overall, the level of level of readiness in the Burundian community to engage in mental health has increased from the maximum of Level 4 at pre-project to the maximum of Level 5 at post-project evaluation.

(No respondents)

FARSI-SPEAKING COMMUNITY (Iranian and Gold Coast Afghani)

(3 respondents: BCMHP and 2 community leaders)

The general community suffers from high stigma resulting in denial of mental health problems as a community issue *(Level 2)*. Educated Iranians and Afghanis, including leaders may know more about mental health issues but there is little motivation to do anything about it other than obtaining treatment via GPs or NGOs *(Level 3)*. Giving that the leadership in these communities remains fragmented, little progress has occurred re level of community readiness to engage in mental health. It remains at the maximum level of 3.

ITALIAN COMMUNITY

(1 respondent: BCMHP)

There has been an increased number of programs and seminars on the topic of mental health in the community with some community organisations and groups starting advocacy such as a popular seminar series facilitated by an Italian psychiatrist *(Level 6)* and others working to keep their long term initiatives sustainable *(Level 7)*. The general community have increased their awareness as a result of these programs but little motivation to do anything about it for reasons and attitudes depending on their generation – older people fear being ostracised, while younger people may not be interested *(Level 3)*. Overall, this community has shifted one level from a maximum of Level 6 at pre-project to a maximum of Level 7 at post-project evaluation.

MANDARIN-SPEAKING COMMUNITY

(2 respondents: BCMHP and 1 community leader)

The general community and some leaders recognise that mental health is an issue in the community but they do not like to talk about it openly *(Level 3)*. Some community groups and their leaders have initiated community education projects – one respondent suggested running seminars to increase their understanding *(Level 5 – 6)*. As at pre-project, some elements of the community have high level of ownership such as the Taiwan Women's League Qld, are still committed to continue delivering social and emotional wellbeing initiatives for their large membership *(Level 7)*. The Mandarin-speaking community has remained in the same level of readiness to engage in mental health, Level 7.

SERBIAN COMMUNITY

(2 respondents: BCMHP and 1 community leader)

The general community is more aware of mental health issues having attended two community meetings and Stepping out of the Shadows training - the respondents comment respectively that this is a "positive change" and "big step forward and more open talking" there is not yet motivation to do anything about it *(Level 3)*. Leaders are involved with the existing activities and programs but have not yet initiated any activities *(Level 3)*. This community has remained at the same level of community readiness to engage in mental health despite one of the most powerful leaders reacting unsupportively to the level of engagement of community members to the activities of the project.

SPANISH-SPEAKING COMMUNITY

(2 respondents: BCMHP and 1 community leader)

There has been "a lot of community education over many years" including recent Stepping Out of the Shadows training which has raised community awareness about

mental health issues, however high levels of stigma and trust issues prevent people in the community from taking action *(Level 3)*. Leaders usually welcome community education sessions *(Level 3)*, while some facilitate support groups *(Level 5)*. One community group is at preparation level, focussing on practical ideas with assistance where needed *(Level 5)*. This community reportedly has increased the level of readiness from a maximum of Level 3 at pre-project to a maximum of Level 5 at post-project.

SUDANESE COMMUNITY
(1 respondent: BCMHP)
The general community has awareness of mental health issues as a result of their experience of war, and "cultural activities" are well attended however the response did not mention any planning of mental health-specific activities or programs by the community *(Level 3)*. The Lost Boys have been meeting for some time planning to take some action *(Level 5)*. Leaders are of great "cultural importance" but lack motivation and time to plan action on the issue (Level 3). This community has increased the level of community readiness from a maximum of Level 4 at pre-project to a maximum of Level 5 at post-project evaluation.

TURKISH COMMUNITY
(1 respondent: BCMHP)
There has been little change since the project started since most of the community "are just not interested" *(Level 1)*. Stigma is high, with people not wanting to get involved as they are concerned about what others will think of them *(Level 2)*. Community leaders are concerned, with one requesting help, but there have been no meetings or discussions *(Level 3)*. This community has remained the same since the initiation of the project, however, it is worth noting that the BCMHP was absent for over six months or half of the project, so these findings are not surprising.

After 14 months, at post-project, three (3) of a total of 16 communities have increased one level of readiness to engage in mental health, one (1) has increased two levels and four (4) have remained at the same level. The other eight (8) communities have not been assessed at post-project due to the lack of key informants willing to participate in this evaluation. It is important to note that three (3) communities established their community readiness baseline at the time the other communities were conducting the post-assessment. The project achievements at community level are significant as moving from one level to the next involves an important shift in community attitude and means that a major number of people in these communities have been reached out with the project multi-strategies. There are other individual measures of the project outlined in the table *Stigma Reduction Project May 2008 – July 2009*.

STIGMA REDUCTION PROJECT   **TRAINING PROGRAM EVALUATION TABLE JULY 2008 - JULY 2009**

Community	# Parts	# Evaluation Completed	Because of attending the training the participants: Understood more about stigma in their community	Thought differently about people with mental illness and their families	Would behave differently towards people with mental illness and their families	Felt they had more practical skill and knowledge to reduce stigma in their community	When referring to people with mental illness the facilitator: was respectful	was sensitive towards people with mental illness and their families	used factual information	Participants most enjoyed: the topic	the activities	meeting or being with other people in the group	getting practical skills to help themselves or their community	Changes the participants would make to the training program: make it shorter	make it longer	have less info	have more info	less group work	more group work	change the style of the facilitator	The training program respected participants' cultural values: yes very much	yes mostly	yes	no	no not really	no not at all	The materials were useful: yes very useful	yes mostly useful
Afghani	9	8	4	3	4	5	7	3	7	7	4	4	5	1	5	0	5	0	5	2	3	0	5	0	0	0	3	4
Iranian/Afghani	13	11	7	9	11	9	8	8	9	8	6	6	11	1	3	0	7	0	6	0	5	0	5	0	1	0	5	4
Iranian	22	20	12	9	9	15	13	7	15	15	14	8	17	1	13	0	10	0	9	2	10	2	7	1	0		12	3
Italian (Brisbane)	21	19	15	9	9	11	17	13	16	15	13	15	14	6	5	6	1	6	0	0	13	5	1	0	0	0	12	3
Japanese	6	6	5	5	6	6	5	6	5	5	6	6	3	0	0	0	4	0	2	0	2	1	3	0	0	0	2	1
Mandarin Speaking	30	22	12	13	14	10	18	18	12	12	3	11	18	1	7	0	15	0	9	1	18	2	1	0	0	0	8	6
Spanish Speaking	15	11	9	4	5	8	10	8	8	8	7	6	8	1	0	0	3	0	4	0	10	0	0	0	0	0	9	1
Sudanese	8	7	2	1	2	0	4	4	0	1	0	0	6	0	6	0	0	0	0	0	5	1	0	0	0	0	2	1
TOTAL	124	104	66	53	60	64	82	67	72	71	53	56	82	11	39	6	45	6	35	5	66	11	22	0	2	0	53	23
Percentage		100	63	51	58	62	79	64	69	68	51	54	79	11	38	6	43	6	34	5	63	11	21	0	2	0	51	22

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Appendix 12

BCMHP Feedback about Community Response to their Role

NAME: …………………………   COMMUNITY: …………………………

Have the community been contacting you in your role on the project?

Do they know what you do, ask for your help, avoid you, greet you?

Has this changed since you first started on the project?

How have they been contacting you ? (At events, by phone, etc)

Did anyone contact you as a result of having done the training (or the play or an information session)?

Did anyone contact you having seen an advert in a newspaper or heard the story on the radio?

Estimate numbers of referrals, times you've responded to requests for help, information, <u>any</u> contact from the community