



**Operational Framework**  
**for the Implementation and Operation**  
**of the**  
**State-Wide Multicultural Mental Health Program**  
**a**  
**Partnership Between**  
**Queensland Transcultural Mental Health Centre**  
**&**  
**District Mental Health Services**

**September 2006**

**Guidelines for Managers and Supervisors**

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## Terms and abbreviations used

MMHC	Multicultural Mental Health Coordinator
SLPC	State-Wide Liaison & Policy Coordinator
CALD*	Culturally and linguistically diverse - 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.
NESB	Non-English speaking background
QTMHC	Queensland Transcultural Mental Health Centre
TCCS	Transcultural Clinical Consultation Service
MMHPP&EI	Multicultural Mental Health Promotion, Prevention & Early Intervention
HSD	Health Service District
EDTC	Education, Development & Training Coordinator
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 and culture.
Cultural competency*	The ability "to see beyond the boundaries of one's own cultural interpretations, to be able to maintain objectivity when faced with individuals from cultures different to one's own and be able to interpret and understand behaviours and intentions of people from other cultures non judgemental and without bias".
District MHS	District mental health services, integrated mental health services consisting of specialised mental health services within the general health system coordinated across inpatient and community settings, located within the catchment areas of health service districts.

Mental Health Networks	Outside the densely populated southeast corner of the State, a Network consists of groups of district health services within an extended geographic catchment area. Each has an identified principle service centre to support and supplement the services available within the smaller district satellite services.
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.

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

## QTMHC key contacts

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Greg Turner	State-wide Liaison and Policy Coordinator
Rita Prasad-Ildes	Manager
Penny D' Ath	Information, Resource and Senior Administration Officer
Polly Nip	Clinical Services Coordinator
Elvia Ramirez	Transcultural Mental Health Promotion, Prevention and Early Intervention Coordinator
Greg Turner	A/Education, Development and Training Coordinator

***All staff listed above can be contacted on Groupwise email.***

## Purpose of the framework

The purpose of this framework is to provide clear information on the role of the Multicultural Mental Health Coordinator (MMHC) positions and the relationship between this position, the District Mental Health Service, and the Queensland Transcultural Mental Health Centre. Specifically it will:

- Identify locations of the MMHC positions
- Clarify the role of the MMHC
- Clarify the funding of the MMHC positions
- Clarify the classification type and level of the MMHC positions
- Clarify the role of the QTMHC State-wide Liaison and Policy Coordinator
- Provide clarity on reporting relationships
- Identify relevant stakeholders
- Provide a rationale for the creation of the MMHC positions

## Location of positions

During 2006-07, nine 1.00 FTE MMHC positions and two 0.5 FTE MMHC positions will be rolled out across Queensland. The locations of the 1.00 FTE positions are:

- Cairns Network (the position will be based in the Innisfail HSD and will cover the Innisfail, Cairns and Tablelands HSDs).
- Townsville HSD
- The Prince Charles Hospital HSD
- Royal Brisbane & Women's Hospital HSD
- Royal Children's Hospital HSD
- Princess Alexandra Hospital HSD
- Mater Children's Hospital HSD
- Logan-Beenleigh HSD
- Gold Coast HSD

The locations of the 0.5 FTE positions are:

- West Moreton HSD
- Bayside HSD

In 2008-09 a further two 0.5 FTE positions will be funded to be based at:

- Sunshine Coast HSD
- Redcliffe-Caboolture HSD.

# Multicultural Mental Health Coordinator role description

## Purpose of the position

This position will be responsible for facilitating culturally responsive mental health care to consumers and their families from culturally and linguistically diverse (CALD) backgrounds within the framework of the *National Standards for Mental Health Services*, the *National Practice Standards for the Mental Health Workforce* and the *National Framework for the Implementation of the National Mental Health Plan in Multicultural Australia*.

The position will develop strategies to build the cultural competency of District Mental Health Services to respond to the clinical needs of people from CALD backgrounds presenting with mental disorders, to facilitate equitable access to available mental health services for people from CALD backgrounds within the catchment area, and develop and implement effective and appropriate mechanisms to ensure input from people from CALD backgrounds into the service's consultation, evaluation, planning and delivery processes.

Specifically the position will focus on:

- Clinically supporting the assessment, treatment and care of consumers from CALD backgrounds through a consultation and liaison role with clinicians within the service.
- Facilitating access to specialist services and resources through the Queensland Transcultural Mental Health Centre and local multicultural services and programs.
- Building the capacity of the service to enhance its cultural responsiveness through policies, procedures, education and development.
- Networking and liaison with local multicultural communities within the catchment area to monitor the profile of unmet mental health needs.
- Engagement with local multicultural groups and communities to facilitate mental health promotion and increase mental health literacy to facilitate equitable access to services.

## Organisational environment and key relationships

The position will be located at, and managed by, the district mental health service with strong links to the Queensland Transcultural Mental Health Centre. The Queensland Transcultural Mental Health Centre (QTMHC) is a state-wide service located at, and administered by, the Princess Alexandra Hospital and Health Service District. This Centre works in co-operation with the Mental Health Branch, Area Health Services, District Health services, other government departments, and community organisations.

The Centre has state-wide responsibility for policy implementation and provision of support to district mental health services; it is the focal point for mental health issues of people from culturally and linguistically diverse backgrounds in Queensland, and nationally links with *Multicultural Mental Health Australia*.

The Queensland Transcultural Mental Health Centre will provide state-wide coordination and support to multicultural mental health coordinators through training and development, regular meetings, provision of relevant resources and peer support to ensure consistency of practice and to maximise outcomes. This will also include the sharing of information amongst the multicultural mental health coordinators across the state to facilitate efficient use of resources, sharing of best practice and minimisation of isolation.

## Duties and responsibilities

- Work in collaboration with team leaders and other key service staff in the development and implementation of plans, policies and procedures for the delivery of culturally responsive mental health care consistent with state and national policies and standards.
- Provide consultation to clinicians who are working with consumers from CALD backgrounds on issues relating to culturally appropriate service provision including information and resources, referral processes to relevant services or facilitation of access to appropriate cultural consultation.
- Provide or facilitate access to relevant training and development in relation to available resources, and cross-cultural practice issues in working with consumers from CALD backgrounds.

- Develop networks through outreach and liaison with local multicultural groups and organisations and develop strategies to facilitate equitable access to services.
- Provide appropriate consultation and education to local multicultural groups and organisations.
- Participate and contribute to mechanisms and initiatives supporting the application of quality standards and improvements within the service ensuring transcultural mental health input.
- Provide and/or facilitate provision of expert advice to the mental health executive on issues relating to developments in national and state policies affecting migrants and refugees and the implications for planning, evaluation and delivery of culturally sensitive and appropriate mental health services.

## Guidelines for the selection and recruitment of the MMHC

### Funding for the MMHC positions

The need to create a state-wide network of MMHC positions based in district mental health services was a key recommendation made by the Queensland Transcultural Mental Health Centre (QTMHC) in the *Review of Transcultural Mental Health Services in Queensland* (a copy can be downloaded from the QTMHC website – See QTMHC contact on Page 5). Following endorsement and approval of the review recommendations, \$1.69 million has been allocated to enhance transcultural mental health service funding, including an allocation of funding to establish MMHC positions in 13 district mental health services. These positions are currently positions funded at the PO3.2 levels.

Funding will be provided directly to the participating Districts by the Queensland Transcultural Mental health Centre via a Service Level Agreement. Offers of Funding, including conditions for the funding, will be made to Managers/Directors of the participating District MHS'. Upon acceptance of the Offer of Funding and signing of a Service Level Agreement, funds will be transferred to the participating District MHS.

Commencing 2006/07 recurrent funding will be provided to cover the following costs:

Items for 1.00 FTE	Amount provided
PO3-2 Salary, on costs and superannuation	73,500
Admin/operational costs	3,000
Staff training	1,500
Computer	1,745
Vehicle lease and operating	10,800
Mobile phone	400
TOTAL	90,945

Items for 0.5 FTE	Amount provided
PO3-2 Salary, on costs and superannuation	36,750
Admin/operational costs	1,500
Staff training	750
Computer	1,745
Vehicle lease and operating	5,400
Mobile phone	400
TOTAL	46,545

## **Classification type and level of the MMHC positions**

As part of the implementation of the recommendations of the Forster Review of Queensland Health Services, Queensland Health has made a commitment to increasing the number of clinical positions across the department. It is therefore a requirement that the MMHC positions are held by Professional Officers with appropriate clinical qualifications and experience. Funding has been allocated for the positions at the PO3.2 level.

The position is open to mental health professionals in the disciplines of psychology, occupational therapy, social work and mental health nursing. Qld Health Workforce Planning as well as HRM has advised that if a nurse is appointed to the position it should be as a PO, not as an NO. (Appointments of NO's require them to be employed specifically for nursing roles – the MMHC position is not a discipline specific role).

It is up to the District MHS to consider personal upgrades or promotions when they feel it is appropriate. However, for consistency across the state, it is recommended that all new positions start off at a PO3.2 level. If a District does decide to grant a personal upgrade or start a position at a level higher than PO3.2, or in a different classification type, the resulting disparity in funding will need to be met by the District.

## **Desirable background and experience**

As the MMHC position is mostly about building the capacity of the District MHS to respond to the mental health needs of people of CALD backgrounds, it is highly desirable for the person holding the position to have a good understanding of the various elements of the District MHS. QTMHC has found that credible and respected experience in, and understanding of, the mental health system is an important element for this position to be successful in achieving its goals.

An individual with clinical experience who is known and respected by their colleagues has been identified as a major contributor for success. As the position is involved in a diverse range of activities, e.g. training, community development, service development, clinical issues, it is important that the incumbent is someone who can work across all of these areas.

Experience and/or knowledge and skills in working with people from CALD backgrounds are also desirable. However if potential applicants do not currently have such experience or knowledge then the ability to rapidly acquire these is required. Potential applicants do not need to be from a migrant background themselves or be bilingual/bicultural, as working in a multicultural environment requires that all individuals have cross-cultural skills to be able to work with individuals and groups from other cultural and language backgrounds to their own.

As the QTMHC SLPC will be involved in the selection and recruitment of the MMHC, representatives from District MHS' are encouraged to discuss recruitment issues with the SLPC.

### **Job descriptions**

QTMHC can provide generic job descriptions to the District MHS which can then be modified to suit their own local HRM policies and procedures.

### **Selection panels**

It is suggested that selection panels be limited to three people, with four at the most. The selection panel should include a representative from the District MHS, the QTMHC SLPC, and a representative from the multicultural community sector.

## **Operational links with QTMHC**

### **Transcultural Clinical Consultation Service**

- Provide consultation and advice to clinicians on clinical matters and liaise with TCCS coordinator when required.
- Facilitate referrals to TCCS when required.
- Implement local arrangements regarding utilisation of the local bilingual/bicultural mental health workforce.
- Recruit and support local bilingual/bicultural mental health professionals who can provide clinical interventions (e.g. assessments, psycho-education, short term therapy, etc) to join the TCCS bilingual mental health consultants (clinical) sessional pool. Individuals within this pool can be utilised locally but may also be utilised across Districts via video-conferencing as arranged by the QTMHC TCCS coordinator and will be paid by TCCS.
- Recruit local bilingual/bicultural individuals who can provide cultural advice to join the TCCS bilingual mental health consultant (cultural) sessional pool. Individuals within this pool can be utilised locally but may also be utilised across Districts via video-conferencing as arranged by the QTMHC TCCS coordinator and will be paid by TCCS.
- Locate local accredited and recognised interpreters to be utilised by the local MH Service.

### **Education, development and training**

- Complete QTMHC Train-the-Trainer modules.
- Deliver components of the training to MHS workforce and to associated NGO's, other government departments, etc.
- Deliver mental health literacy education to CALD community groups, associations, etc.
- Maintain records of training provided.
- Liaise with the QTMHC Education & Development Coordinator.

### **Mental health promotion, prevention and early intervention**

- Support the development of local multicultural mental health interest groups.
- Gather the MH issues from such interest groups and disseminate for the appropriate service response – this may be a local response or issues may be forwarded on to QTMHC or to other relevant agencies.
- Facilitate the involvement of such interest groups in the programs and processes of the local mental health services and vice-versa.
- Liaise with the QTMHC MMHPP&EI Coordinator.

### **Information and resources**

- Disseminate QTMHC information and resources throughout the District MHS.
- Ascertain the information and resource needs of the various settings within the District MHS, relevant NGO's and community groups.

- Liaise with the QTMHC Information, Resource and Senior Administration Officer.

### **Overall**

- Act as a conduit between the local mental health service, the local CALD communities and associated agencies, and QTMHC.
- Ensure a communication flow between stakeholders.

### **Planning and evaluation**

In the first year of operation QTMHC will develop a 12 month work plan for MMHCs in consultation with the local District MHS. A major component of this work plan will be the collection of baseline data against which annual evaluations can be based. In subsequent years, each MMHC will be responsible for developing and submitting a 12 month work plan with strategies that meet the objectives of the program. Assistance will be provided by the SLPC.

## Roles and responsibilities of participating districts and QTMHC

An overarching role of the state-wide MMHC strategy is to enable the QTMHC to have greater contact with District MHS' in order to improve mental health outcomes for CALD consumers and vice versa. In this way it can be seen as a 'Tidal Model' whereby information and resources flow in and out of the District MHS and QTMHC. The MMHC position is seen as a two-way conduit whereby the resources of QTMHC can be more effectively utilised at the District level while at the same time the local transcultural mental health issues can be brought to the attention of QTMHC. For such a model to work effectively there are roles and responsibilities for both the District MHS and the QTMHC.

The QTMHC has six key program areas:

- State-wide liaison and support
- Program and policy development, implementation and evaluation
- Transcultural Clinical Consultation Service (TCCS)
- Education, development and training programs
- Mental health promotion, prevention, early intervention program and stigma reduction programs and projects in multicultural communities
- Information and resource program, including library and website

**\*\* See Page 5 for contact details.**

Each of the six programs has a Coordinator who is responsible for their program area. The six program areas are integrated in many ways so that the QTMHC operates on a 'Whole-of-Centre' basis under the direction of the QTMHC Manager. It is important that the state-wide MMHC strategy is linked to all six program areas to ensure that all available resources are effectively utilised across the state.

### Roles and responsibilities of QTMHC

In regard to the state-wide MMHC strategy, the role for QTMHC is to provide support and coordination to the MMHCs and to the participating Districts. Overarching support, communication and coordination for the MMHC position and the District MHS will be through the QTMHC State-Wide Liaison & Policy Coordinator, however over time it is expected that the position will liaise with all six program coordinators.

QTMHC will provide the following support and coordination:

- Structured support to the MMHC and the District MHS will be provided by the QTMHC State-Wide Liaison and Policy Coordinator (SLPC). In the initial stages of the MMHC program this position will facilitate access to the Transcultural Clinical Consultation Service for clinicians within the district as well as access to training, QTMHC resources relating to education and

development; promotion, prevention and early intervention activities; and multilingual information and resources.

- The QTMHC SLPC will assist in the recruitment and selection of the MMHC through: the provision of generic job descriptions which the District MHS can adapt for their own use; involvement in short-listing applicants; participation in interview panels; and decision making processes regarding recruitment and selection.
- A state-wide induction program will be provided to all MMHCs in Brisbane. This will be organised and funded by QTMHC.
- QTMHC will organise and fund an annual training/liason program for all MMHCs which will include professional development and provide an opportunity for MMHCs to liaise face-to-face with each other.
- The development of defined communication pathways between the District MHS and QTMHC to ensure a two-way flow of information, particularly the dissemination of QTMHC resources to the District MHS.
- An exchange of information and data, including local data obtained by the District MHS on issues relating to people of CALD backgrounds being forwarded to QTMHC, and data obtained by QTMHC forwarded to the District MHS.
- QTMHC support to local multicultural mental health portfolio holders.
- QTMHC assistance in forming and developing Terms of Reference for local multicultural mental health interest/working groups.
- QTMHC assistance in developing specific policies and procedures related to multicultural mental health (e.g. interpreter procedures, etc).
- QTMHC assistance in supporting local CALD communities, organisations and networks to form consultative groups in order to provide the local District MHS with a direct link with CALD communities.

### **Role of the QTMHC State-wide Liaison and Policy Coordinator**

In order to provide support and coordination for the MMHC positions, the QTMHC has established a new position within its organisational structure. The State-wide Liaison and Policy Coordinator position will:

- Build and coordinate a state-wide model of team support for district multicultural mental health coordinator positions within the HRM frameworks and policies of district mental health services.
- Develop optimal working relationships and maintain strategic partnerships with all stakeholders including District Mental Health Services, Area Health Services, Mental Health Branch, key government and non-government organisations and multicultural groups that facilitates their participation and support for the operations and sustainability of the state-wide multicultural mental health coordinator positions model.
- Ensure that the state-wide multicultural mental health coordinator model has effective support mechanisms and build the framework for ongoing training and development of staff to meet these requirements.
- Provide input into program and policy development and review processes drawing on state-wide networks.

## **Roles and responsibilities of District Mental Health Services**

It is essential that the MMHC is supported by the management of the District Mental Health Service as the outcomes achieved by the MMHC will be measured by the establishment of systems, processes and protocols across the entire District Mental Health Service. Outcomes will be a sustainable response to the issues for people from culturally and linguistically diverse backgrounds at the local level.

The participating District MHS Manager/Director is ultimately responsible for the provision of support, direction and supervision of the MMHC to ensure that the key objectives outlined in the service agreement are met. Line management and supervision of the position may be delegated to an appropriate Team Leader. It is up to the District MHS to decide where the position would be physically located, however it is important that the position has ready access to all of the District MHS facilities and settings.

It is up to the District MHS to decide the supervisory relationships for the position, however the following guidelines may be useful. In regard to 'Professional' supervision it will depend on whether the successful applicant is a PO, an NO, or an AO. Clinical issues would appropriately be the responsibility of the Clinical Director or their delegate. Operationally the position would most appropriately report to the Manager of the District MHS or their delegate.

The District Mental Health Service will be responsible for:

- Meeting the objectives outlined in the service agreement.
- Providing the MMHC with a management structure, supervision, appropriate office space, computer, telephone and vehicle.
- Ensuring the MMHC is able to focus only on the duties outlined in the MMHC Position Description, and is not utilised for other duties related to the District MHS.
- Forwarding relevant local data obtained by the District MHS on issues relating to people of CALD backgrounds to QTMHC.
- Liaising with the QTMHC SLPC in regard to any issues related to the MMHC position and associated activities.

## **Reference group**

It is important to have input and involvement from local multicultural support agencies and ethnic associations to ensure that key local issues are identified and responded to. It is recommended that the District MHS establish a Multicultural Reference Group in order to have a mechanism that can provide input into the activities conducted by the MMHC. Such a group should comprise of representatives from the following stakeholder groups:

- One or two senior representatives from the District MHS. Ideally this person would be the manager, service development coordinator, or a team leader.
- Key representatives from relevant mental health NGO's.

- Key local multicultural workers eg., settlement support workers, refugee support workers, ethnic health workers.
- Representatives from key local ethnic associations.

It is recommended that the number of people on a Reference Group is kept to approximately six people. At times it may be appropriate for individuals from outside of the Reference Group to be invited to meetings where relevant.

# APPENDICES: Excerpts from the 2005 Review of Transcultural Mental Health Services in Queensland

## APPENDIX A: Background to the Statewide MMHC Program

Providing state-wide coverage has been challenging for the QTMHC. Since 1996 a network of transcultural district coordinators has been operating at various levels that have been important contacts for the QTMHC to engage with in order to disseminate transcultural mental health information at the local level. This network of transcultural district coordinators has worked with varying degrees of success, but overall it has been problematic due to difficulties in engaging busy people who take on this role over and above their regular duties, particularly for those district coordinators who are in clinical positions.

In 2002, QTMHC commenced discussions with the Cairns, Logan-Beaudesert and Gold Coast District Mental Health Services, being the three districts with the highest numbers of CALD population groups after PAH, to create a transcultural district partnership. In 2003, non recurrent funding was received by the QTMHC from the Mental Health Unit to formalise the partnerships through service agreements with these three districts which provided them with funding enabling them to take a staff member off-line part time for 12 months to focus on transcultural issues locally. In 2004, QTMHC used the same model to create a district partnership with PAH and Mater CYMHS focusing on refugee mental health issues within its catchment area.

This partnership model proved to be very successful in achieving a range of outcomes:

- Increased capacity for the District MHS to deliver culturally appropriate services to consumers and carers from CALD backgrounds (training was provided to all teams across Logan and Gold Coast, new procedures were introduced regarding the use of interpreters and when to access TCCS).
- Improvements in cultural responsiveness in relation to assessment, diagnosis and treatment through increased use of QTMHC bilingual mental health consultants (79% increase in Logan, 110% increase in Gold Coast).
- Improved working relationship and coordination between the District MHS and local multicultural support agencies to provide services to people from culturally and linguistically diverse backgrounds. (at each site the local mental health service pro-actively outreached to local multicultural groups, Logan conducted a community leader forum, Cairns participated in the local multicultural services network, Gold Coast has established ongoing and sustainable links with multicultural groups beyond the period of project funding, PAH has initiated an inpatient support program in partnership with local multicultural groups).
- Incorporation of multicultural mental health into the District MHS Service Strategic and Business Plans.

## District consultations

Following an analysis of district demographics it was decided to focus consultations on district mental health services with significant CALD demographics: Gold Coast, Logan-Beaudesert, Mater CYMHS, PAH, RBWH, RCH CYMHS, TPCH, and the Northern Network incorporating Cairns, Innisfail and Tablelands. A number of methods were used to collect information:

- Meetings with Executive managers, clinical directors, mental health Team Leaders (RBWH, RCH, Mater, TPCH, Gold Coast)
- Clinician focus groups (clinicians at Logan and PAH)
- Community sector/multicultural agencies focus groups (Toowoomba, Logan)
- Teleconference (Northern Network)
- Surveys (clinicians and community)

Meetings with mental health executive management in the above districts revealed strong support for district multicultural mental health positions:

- They welcomed district multicultural mental health positions along the lines of the forensic positions which add value to a clinical setting in terms of the expertise and resources it brings on issues working with a special needs population group such as CALD consumers.
- They endorsed the partnership model approach as a useful mechanism to facilitate linkages between the QTMHC and district mental health services to ensure access to QTMHC programs and services when required.
- All indicated a growing awareness of issues for consumers of CALD backgrounds and the complexities in providing culturally appropriate services.
- All acknowledged that their services were under utilised by CALD groups living in their catchment area and the need to network with local multicultural groups.
- All indicated a "readiness" to take on a multicultural mental health position.
- Some commented that positions such as these are most effective when they are well integrated within the district mental health service and not seen as an "add-on" position.
- Some concerns were expressed about the Indigenous mental health positions in terms of isolation of workers, lack of support and coordination and classification levels. There was agreement that a strong support and coordination structure offered through QTMHC would be essential in terms of ensuring consistency of practice amongst these positions and to maximise outcomes.
- Comments about the classification of the position were mixed, some districts expressing a strong preference for at least a PO3 level, while others prefer the option of AO classification.
- Most indicated the need for the positions to include laptops and vehicles due to the need to be mobile across the entire service.

### **Clinician surveys**

An electronic survey was distributed to clinicians via directors and managers which received 31 responses from 14 district mental health services. The majority of respondents stated that they needed to work differently with consumers from CALD backgrounds and cited a range of examples including the need to take ethnic specific factors into account in assessment, allowing more time for appointments, involving the family, making more home visits and accessing TCCS for cultural consultancy. They stated that from their experience the most common psychiatric disorders that CALD consumers presented with were psychosis (drug induced and schizophrenia), depression, PTSD, anxiety and bipolar disorder.

Over 70% of respondents thought that there were barriers in their workplace that prevented consumers from CALD backgrounds accessing their service due to clinics being too structured and threatening, lack of front line bilingual/bicultural staff, lack of knowledge about how to enter the service, lack of trust, language barriers and previous experiences and assumptions. Solutions that were offered in response to these barriers included outreach and education, availability of multilingual information and/or bilingual staff, liaison with community members, and educating referral agencies.

A range of workplace barriers to providing CALD consumers with the assistance that is required were cited such as lack of access to interpreters, unclear referral pathways, restrictions of service provision, lack of training, lack of expertise in working with specific ethnic groups, apathy, clinical and impersonal environment and lack of resources and staff. Suggested solutions included training, employing a staff member responsible for transcultural issues, consultation with local CALD communities, contact with QTMHC, strategies to employ more bilingual/bicultural staff and education about specific cultures.

Over 50% of respondents had concerns about working with interpreters and provided the following examples: lack of access in emergencies, breaches in confidentiality, costs, interpreters putting their own interpretation on what has been said, and clients not feeling comfortable to open up in front of the interpreter. The following resources and activities were suggested to help them work with CALD consumers more effectively: Translated fact sheets, resource book on different cultures, training on CALD communities in the local area, more information about emerging communities and contacts, local transcultural worker, forums for workers to discuss issues and signs in services that Queensland Health will access interpreter services free of charge.

### **Clinician focus groups**

Two focus group meetings were held with clinicians at Logan and PAH each attended by 7 clinicians. Discussions at the Logan group focused predominantly on the role of the multicultural mental health coordinator since Logan has had this position in operation for the past 18 months. Clinicians indicated the position has made a difference in the service in terms of facilitating good mental health outcomes for CALD consumers:-

*“she is a great resource person, always sending out emails about training opportunities and resources that we would never have known about...”*

There was also a discussion about how the service is now seeing more CALD consumers, staff from adult services stated that they are frequently working with people from CALD backgrounds whereas staff from CYMHS indicated that they only sometimes work with CALD consumers and their families, indicating that more work needs to be done in that area. Feedback indicates that CALD consumers have been happy with the services that they have received which is reported back to the communities, which in turn has affected the communities' help seeking behaviour in a positive way. Staff at Logan indicated they do allow more time to see CALD consumers and tend to involve the family more than with non CALD consumers. They also indicated that they are not always aware of what support services are available for CALD consumers for follow up support and it has been useful to engage the local multicultural mental health worker in this process for access to additional resources.

The meeting with transcultural portfolio holders indicated that the portfolio holders have focussed on building network with relevant multicultural services but feel frustrated due to lack of time and competing demands. They indicated that CALD consumers' needs are generally more complex to respond to and that more people usually need to be involved. They indicated that a permanent multicultural mental health position within the service would be of great assistance, especially if it were able to provide direct support with new cases involving CALD consumers during the critical stage of engagement. They felt that the issue is not only about assessing consumers in a culturally appropriate manner but more importantly it is about engaging with the consumer, as they felt they have the mental health skills but not necessarily the cross cultural practice skills.

Other issues raised related to interpreters, specifically difficulties working with interpreters and the need for interpreters to receive training on working in mental health settings, and the fact that many people from CALD backgrounds who experience depression, anxiety and adjustment disorders generally do not get accepted by the service and that there is a lack of alternative referral options for such people in terms of availability of relevant services.

### **Community surveys**

A survey was distributed to 89 multicultural community sector organisations across the state to obtain mental health information about the current multicultural groups that they are working with. The survey received a response rate of 21% with 19 responses. (see Appendix A for details). Responses were from multicultural organisations that provide direct services to people of CALD backgrounds and a number of local city and shire councils that work with multicultural communities through the multicultural worker program in local government from 15 locations around the state.

79% were aware of the QTMHC and the services it offers and 73% identified specific CALD groups within their communities with mental health problems that were not accessing services. Some of the groups identified included women, young people, older people from CALD backgrounds, and refugees, specifically African refugees.

89% indicated that people from CALD backgrounds did not access the local mental health services for a variety of reasons including lack of knowledge about local services, shame and cultural beliefs, misinterpretations of manifestations of mental health problems, fear of being labelled, language and social isolation. Many suggestions were offered to overcome some of these barriers including: mental health promotion in different languages, information sessions to local CALD groups, networking between mental health services and local multicultural agencies, provision of outreach services, greater focus on early intervention, simplifying referral processes and provision of training to agencies working with CALD groups.

Those respondents that had received feedback from CALD mental health consumers indicated that it was generally negative: system too complex to understand, felt overwhelmed and fearful, no support for family/carers, not sensitive to their needs, general atmosphere frightening and tense, and generally a lack of satisfaction.

58% of respondents indicated that there were refugee communities residing in their local area with some of the following issues: depression, PTSD, grief and loss, experiences of rape, family separation, death, impact of immigration detention, unresolved issue relating to war experiences, anxiety and acculturation stressors. In addition a large number (79%) indicated concerns about CALD older people in their communities with some of the following comments:

*"CALD elderly become isolated which often leads them to becoming depressed"*

*"healthy ageing and support programs are urgently needed"*

*"many lose English with the onset of Alzheimer's"*

*"CALD elder abuse is high"*

## **Community consultations**

Community consultations were held with representatives from agencies working with local multicultural groups in Toowoomba and Logan attended by representatives from 24 agencies and groups.

Discussions in the Toowoomba consultation centred particularly on groups identified "at risk" within the CALD communities such as the Sudanese refugees, CALD elderly especially Italian and Taiwanese and the itinerant migrant population. The Sudanese community is a growing community with approximately 800 refugees settled in the area, of which over 75% are under 25 years old. They present with multiple and complex needs related to trauma, lack of literacy skills, acculturation stressors and education and employment issues. It was clear that most agencies present did not have current links with the mental health service and a number of strategies were suggested to improve linkages and liaison including participation in local multicultural networks, outreach and training.

In Logan multicultural service representatives indicated that they had contact with a broad range of CALD groups in the local community including newly arrived groups from African and Middle Eastern backgrounds as well as longer term settlers from Vietnamese and Cambodian backgrounds and older established groups such as German. Groups that were identified particularly at risk in the local community included young people, refugees and the elderly. The refugee community, in particular, is a fast growing community with 200 new refugee arrivals in the past 2 months alone. Many present indicated that links with the local mental health service could be improved and offered a number of suggestions including greater interagency collaboration, participation in awareness raising activities, involvement of CALD consumers in awareness raising in their own communities, and conducting well being workshops for CALD communities in community settings.

## **Summary of consultations**

Consultations and surveys involved participants from well over a hundred different agencies and sources and generally provided consistent information. From the services people generally indicated difficulties in working with CALD consumers in terms of complexity, time, skills and confidence. They generally acknowledged that they could be doing more and made many useful suggestions but indicated lack of capacity at the organisational level to address these issues.

From the community it is clear that those services that are in contact with CALD communities are raising concerns about groups at risk within their own areas: refugees (particularly African and Middle Eastern), young people and CALD aged people. Generally there is little contact between mental health services and multicultural sector agencies and many suggestions have been made for improvement. There is clearly a "readiness" in both mental health services and in many multicultural agencies to proactively work together to address mental health issues for people from CALD backgrounds.

## **APPENDIX B: Rationale for selection of districts**

The selection of District MHS' to participate in the Districts Partnership program with QTMHC was based on a range of cultural demographic factors (from 20001 census) including:

- Percentage of the HSD who were born overseas.
- Percentage of the HSD who were born overseas in a non-English speaking country (NESC).
- Percentage of the HSD who speak a language other than English (LOTE).
- Percentage of the HSD who speak English poorly or not at all.

QTMHC also examined open case data from District MHS' and ascertained the percentage of open cases from a NESC.

QTMHC audited the number of referrals to the TCCS from each District MHS.

QTMHC explored the presence of special needs groups within District MHS catchment areas, such as large numbers of refugees, at risk youth, high proportions of CALD older persons.

QTMHC then initiated discussions with management from the District MHS' which QTMHC had identified as being appropriate for selection for the District Partnership program and in need of a MMHC position. When District MHS management agreed to their involvement, QTMHC went ahead with formal funding applications and developing an implementation strategy.

Data for each selected District MHS and Mental Health Network is presented below.

### **PRINCESS ALEXANDRA HOSPITAL**

- 26.7% of local population born overseas
- 67.6% of overseas born population from NESC
- 18.1% speaks a LOTE at home
- 11.5% of local population born overseas speak English poorly or not at all
- 16.3% of all open cases involve a person born in NESC
- 34 % of TCCS referrals come from this District
- High number of newly arrived refugees from Africa being resettled within catchment area
- Groups of CALD youth 'at risk' (eg. Samoans, Vietnamese, Japanese and Sudanese)
- Older CALD population groups, predominantly Greek and Eastern European.

## MATER HOSPITAL CYMHS

- 26.7% of local population born overseas
- 67.6% of overseas born population from NESC
- 18.1% speaks a LOTE at home
- 11.5% of local population born overseas speak English poorly or not at all
- High number of newly arrived refugees from Africa being resettled within catchment area
- Milpera State High School, a reception school for students from a migrant and refugee background, located within catchment area
- Yeronga, Coorparoo and MacGregor state high schools, which are feeder schools after Milpera have very high numbers of recently arrived migrant and refugee background students.
- Groups of CALD youth 'at risk' (eg. Samoans, Vietnamese, Japanese and Sudanese)

## GOLD COAST

- 24.8% of local population born overseas
- 42.9% of overseas born population from NESC
- 8.6% speaks a LOTE at home
- 5.9% of all open cases involve a person born in NESC
- Inpatients from NESC have longer admissions than those born in Australia (24.9 days vs 21.4 days)✦
- Aging CALD population residing within HSD, a number of multicultural aged care programs are Gold Coast based which are increasingly making referrals to TCCS.

## LOGAN BEAUDESERT

- 22.6% of local population born overseas
- 40.3% of overseas born population from NESC
- 8.1% speaks a LOTE at home
- 7.1% of all open cases involve a person born in NESC
- An extensive multicultural services network is located in Logan City including refugee support agencies as newly arrived refugees are increasingly being settled along the Logan-Gold Coast corridor.
- Large Samoan community residing within the district.

## CAIRNS NETWORK

(data relates to Cairns HSD mental health service)

- 18.1% of local population born overseas
- 49% of overseas born population from NESC (62% Innisfail, 59% Tablelands)
- 8.6% speaks a LOTE at home
- 5.7% of all open cases involve person born in NESC

- Inpatients from NESC have longer admissions than those born in Australia (15.7 days vs 12 days)
- Aging CALD population residing within Network's catchment area
- Hmong, Serbian, German, Austrian, Swiss, Italian and Filipino communities residing within Innisfail District. Communities do not generally access local District mental health service, tend to "look after their own".
- Transient population of fruit pickers from CALD backgrounds in Innisfail District. Violence and alcohol abuse are high risk factors amongst this group.
- Large Samoan community residing in Cairns District

#### **ROYAL BRISBANE & WOMEN'S HOSPITAL**

- 18.5% of local population born overseas
- 52.3% of overseas born population from NESC
- 7.5% speaks a LOTE at home
- 8.7% of all open cases involve a person born in NESC
- 16.5% of QTMHC TCCS referrals come from this District
- Increasing number of newly arrived refugees from Africa being resettled within catchment area due to changes in immigration settlement policies where a shift is occurring from settling refugees on the north side of Brisbane instead of the southside.
- Aging CALD population residing within District, Italian and Eastern European

#### **ROYAL CHILDREN'S HOSPITAL CYMHS**

- 18.5% of local population born overseas
- 52.3% of overseas born population from NESC
- 7.5% speaks LOTE at home
- 0.8% of all open cases involve person born in NESC
- Increasing number of newly arrived refugees from Africa being resettled within catchment area including large families with young children.

#### **PRINCE CHARLES HOSPITAL**

- 18.5% of local population born overseas
- 52.3% of overseas born population from NESC
- 7.5% speaks a language other than English LOTE at home
- 8% of all open cases involve person born in NESC
- 5% of QTMHC TCCS referrals come from this District
- Increasing number of newly arrived refugees from Africa being resettled within catchment area
- Aging CALD population residing within District

#### **WEST MORETON**

- 14.3% of local population born overseas
- 41.7% of overseas born population from NESC

- 5.4% speaks LOTE at home
- 6.2% of QTMHC TCCS referrals come from this District
- Large Pacific Islander community residing within the district

## **TOWNSVILLE**

- 11.5% of local population born overseas
- 47.8% of overseas born population from NESC
- 5% speaks a LOTE

## **BAYSIDE**

- 19.2% of local population born overseas
- 36% of overseas born population from NESC
- 5.2% speaks LOTE at home
- 5% of QTMHC TCCS referrals come from this District
- Aging CALD population residing within District

## **SUNSHINE COAST NETWORK**

(data relates to Sunshine Coast HSD mental health service)

- 17.3% of local population born overseas
- 31.5% of overseas born population from NESC
- 3.3% speaks LOTE at home
- Aging CALD population residing within District
- 128 countries represented within this District, largest CALD communities are German, Italian and Dutch (older more established communities and aged population groups). Other communities are very small and almost "invisible".

## **REDCLIFFE-CABOOLTURE**

- 16.5% of local population born overseas
- 33% of overseas born population from NESC
- 3.7% speaks LOTE at home
- Large Samoan community residing within District

## APPENDIX C: Problems being addressed

- At the time of the 1996 census there were 542,989 overseas born people in Queensland from over 150 countries representing 17% of the total Queensland population. The National Survey of Mental Health and Wellbeing estimates the prevalence of mental illness in overseas born males to be 12.5% and 16.9% for females. Given that people who did not speak English were excluded from the survey, this figure is most likely an underestimation of the true rates of mental illness amongst Australia's immigrant communities. However, using these estimates it could be said that conservatively 77,104 overseas born people in Queensland may be suffering a mental illness.
- The available evidence in Australia, particularly from community based studies, supports the proposition of increased prevalence of mental illness amongst immigrant communities. So using the figure of 25%, which is closer to the estimate for the general Australian community meeting the criteria for experiencing a mental disorder in any year, this translates into 135,747 overseas born people in Queensland who currently may be potentially suffering a mental illness.
- Furthermore, these figures do not include second generation Queenslanders from overseas born parents, many who may have mental health issues arising from life stressors relating to cultural identity or to traumatic events experienced by their parents or themselves.
- There are 38 local government areas (LGAs) in Queensland where the proportion of overseas born exceeds 10% for the total population, with the three major concentrations being the south-east corner, the Wide-Bay Burnett region and LGAs between Whitsunday and Douglas in the north of the state. In addition there are relatively high proportions of overseas born people in Mt Isa and Stanthorpe.
- CALD communities in Queensland are also ageing with about a quarter of the Queensland population aged 60 and over born overseas, with about 44% of these coming from a NESB. About 47% of CALD older people 65 and over have settled outside Brisbane. Furthermore, a recent NSW study on immigrant suicide data found that the findings from age specific rates of immigrant suicide are alarmingly high with the rates for NESB males aged 75 and over, being 65.6% higher and for NESB females over 75 years, 177% higher than those for the general community.<sup>1</sup>
- While recognising the role of the transcultural mental health agencies in facilitating access to mainstream mental health programs, the diversity of the Queensland community means that mental health services in Queensland must develop service delivery strategies that ensure equity and access, including a

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<sup>1</sup> Dusevic N, Baume P, Malak AE (2001) The Development of a Framework for Suicide Prevention among culturally and linguistically diverse communities in NSW, NSW TMHC.

culturally competent workforce that is able to deliver quality clinical practice incorporating the understanding of the role of culture in the assessment and treatment of mental illness.

### **Pressure points for District Mental Health Services**

- People of CALD backgrounds continue to access mental health services late in the onset of mental illness, only when they are experiencing a major acute episode of mental illness.
- Research and local experience has demonstrated that late interventions with people of CALD backgrounds often result in police involvement, longer bed stays, resource intensive nursing care, and more complex care and discharge planning.
- Use of interpreters puts a financial strain on services, as well as the difficulty of accessing in emergencies, and increases the difficulty of clinical interaction with increased chance of clinical mistakes.
- People from CALD backgrounds are more likely to be misdiagnosed, or have a diagnosis that is missed, than are people from non-CALD backgrounds resulting in poor clinical practice and outcomes, and risks expensive litigation and diminished trust in mental health services.
- Capacity to be culturally responsive to the diverse community needs within District catchment areas as required by *National Standards for Mental Health Services*, *the National Practice Standards for the Mental Health Workforce* and the *National Framework for the Implementation of the National Mental Health Plan in Multicultural Australia*.

### **QTMHC response to the problems**

Given the above figures and the dispersed geographical distribution of CALD communities throughout the state, the QTMHC, a state-wide service with a staff team of 10 FTEs is clearly not resourced to respond to the level of need in the community and the level of need within mainstream mental health services to develop and maintain a culturally competent workforce.

In the 2004/05 financial year, 61% of referrals for clinical consultation services have come from health service districts within the Greater Brisbane and Logan/Beaudesert regions with the remaining 39% coming from other services around the state. There is clearly a need to do more work outside the South East Queensland region, particularly in regard to CALD older people outside Brisbane.

In order to try to provide as much coverage across Queensland, QTMHC as a resource and support unit working with mainstream mental health services, has in the past employed the following strategies:

- The use of tele-medicine and video conferencing to facilitate access to its clinical services.
- A train the trainer approach in its training program "Managing Cultural Diversity in Mental Health" where participants are trained to provide training at the local level.

- A network of district coordinators who have the transcultural portfolio across their district. This network consists of both clinical and non clinical personnel in 16 Health Service Districts who are key contact people for QTMHC to liaise with in regard to transcultural issues at their local services level.

Despite the strategies outlined above, QTMHC has found it difficult in some districts to have an ongoing and sustainable response to transcultural mental health issues. The response across districts has been varied, often depending on the interest and commitment of the district coordinator rather than any systematic response. The role of the transcultural district coordinator is a role that is taken on over and above regular duties and the amount of time that district coordinators can spend on local transcultural issues varies greatly.

This District Partnership program will enable the mental health services to develop and implement strategies to address culturally appropriate service provision issues such as: protocols and training for staff in working with interpreters; training on transcultural mental health issues; upskilling in available resources to deliver culturally appropriate services; contact and coordination with local multicultural groups; and opportunities to participate in mental health promotion and prevention activities for local multicultural groups. The focus of the program will be on the implementation of sustainable systems and procedures integrated within current practice.

## APPENDIX D: Queensland's cultural diversity and implications for mental health service provision

### Queensland's Diversity

As at the 2001 Census, 18.8% of Australia's population and 14.7% of the overseas born population lived in Queensland. This represents 601,693 people from over 180 countries or 17.1% of the total Queensland population<sup>2</sup>. In 2002-03 Queensland recorded a growth rate of 2.4% and gained 23,738 residents through natural increase, 39,207 through interstate migration and 27,122 people through net overseas migration.<sup>3</sup>

The top 10 source countries for persons who arrived in Queensland between 1991 and 2001 were South Africa, Philippines, Taiwan, Japan, China, USA, Hong Kong, Fiji, Viet Nam and India. In 2003-04 most settler arrivals to Queensland came from New Zealand, UK, South Africa, the Philippines and Sudan.

Queensland continues to settle around 10% of the approximately 13,000 refugee and humanitarian arrivals annually who are resettled in Australia which comprise mainly of refugees from Middle Eastern and African countries.

### Population diversity and implications for mental health service planning

The National Survey of Mental Health and Wellbeing estimates the prevalence of mental illness in overseas born males to be 12.5% and 16.9% for females. Given that people who did not speak English were excluded from the survey, this figure is most likely an underestimation of the true rates of mental illness amongst Australia's immigrant communities. However, using these estimates it could be said that conservatively **89,652** overseas born people in Queensland may be suffering a mental illness.

The available evidence in Australia, particularly from community or mental disorder specific studies, supports the proposition of increased prevalence of mental illness amongst immigrant communities. For example, a recent review of studies on the prevalence of schizophrenia<sup>4</sup> found that the prevalence of schizophrenia is higher in migrants than in "native born populations". This study also found that the prognosis for schizophrenia was better in developing rather than developed nations, possibly due to greater social connectedness and access to work. However, there are also other studies which offer an alternative explanation that the high rates of psychoses, and especially schizophrenia, in immigrant groups is due to misdiagnosis where cultural mores that are not easily understood are pathologised.<sup>5</sup>

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<sup>2</sup> 2001 ABS Census

<sup>3</sup> *Population Flows: Immigration Aspects*, Department of Immigration and Multicultural and Indigenous Affairs, 2005

<sup>4</sup> Saha S, Chant D, Welham J, McGrath J (2005) *A systematic review of the prevalence of schizophrenia*, PLoS Med 2(5):e141

<sup>5</sup> Bhugra, D, Migration and Mental Health, in *Acta Psychiatr Scand* 2004:109:243-258

So using the figure of 25%, which is closer to the estimate for the general Australian community meeting the criteria for experiencing a mental disorder in any year, this translates into **150,423** overseas born people in Queensland who currently may be potentially suffering a mental illness.

Given the impact of mental illness on families and the close knit nature of many immigrant families, a conservative estimate would be that well over a **quarter of a million** Queenslanders of immigrant background are affected by mental illness.

Such diversity poses particular challenges to ensure that the mental health needs of people from culturally and linguistically diverse (CALD) backgrounds are met and for Queensland Health it means that its mental health policies must ensure equity and access for a diverse Queensland community.

### **Social disadvantage and mental health**

Immigration itself is not associated with either an increased or decreased risk of mental illness, but factors related to the migration and settlement process are. It is well recognised that migrants and refugees experience socio-economic disadvantages in the Australian community related to their settlement experiences, particularly in the areas of unemployment, language, access to health and social services, racism and discrimination. It is also well established that mental disorders, as with most other health conditions, arise from an interplay of biological, psychological and social factors and a number of studies have demonstrated the relationship between mental health and social structure, social isolation, poverty, life events and psychological stress<sup>6</sup>.

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<sup>6</sup> Cullen M and Whiteford H, *The interrelations of social capital with health and mental health*, discussion paper, National Mental Health Strategy, Commonwealth Department of Health and Aged Care, 2001