

Appendices

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Appendix One

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.

- 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.

- BCMHP in consultation with Project Coordinator, tailor the Training Package to each of the target communities: 35 hours
- BCMHP organise and conduct the ten-hour training program with at least five different groups of at least six people each.
- 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

- 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)
- Record consumer perspectives of stigma (explore an evaluation tool)
- 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

- Identify opportunities for integration
 - 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	Development and dissemination of communication strategies using ethnic radio and print media.
September 08	
October 08	BCMHPs to carry out 3 Training Programs over the course of 9 months, other responsibilities include:
November 08	
December 08	- Continue recruitment and more general communication strategies
January 09	
February 09	- Support referral processes and access to mental health services
March 09	
April 09	- 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	QTMHC Project team finalise results, consolidate evaluation outcomes and write final reports.
June 09	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.

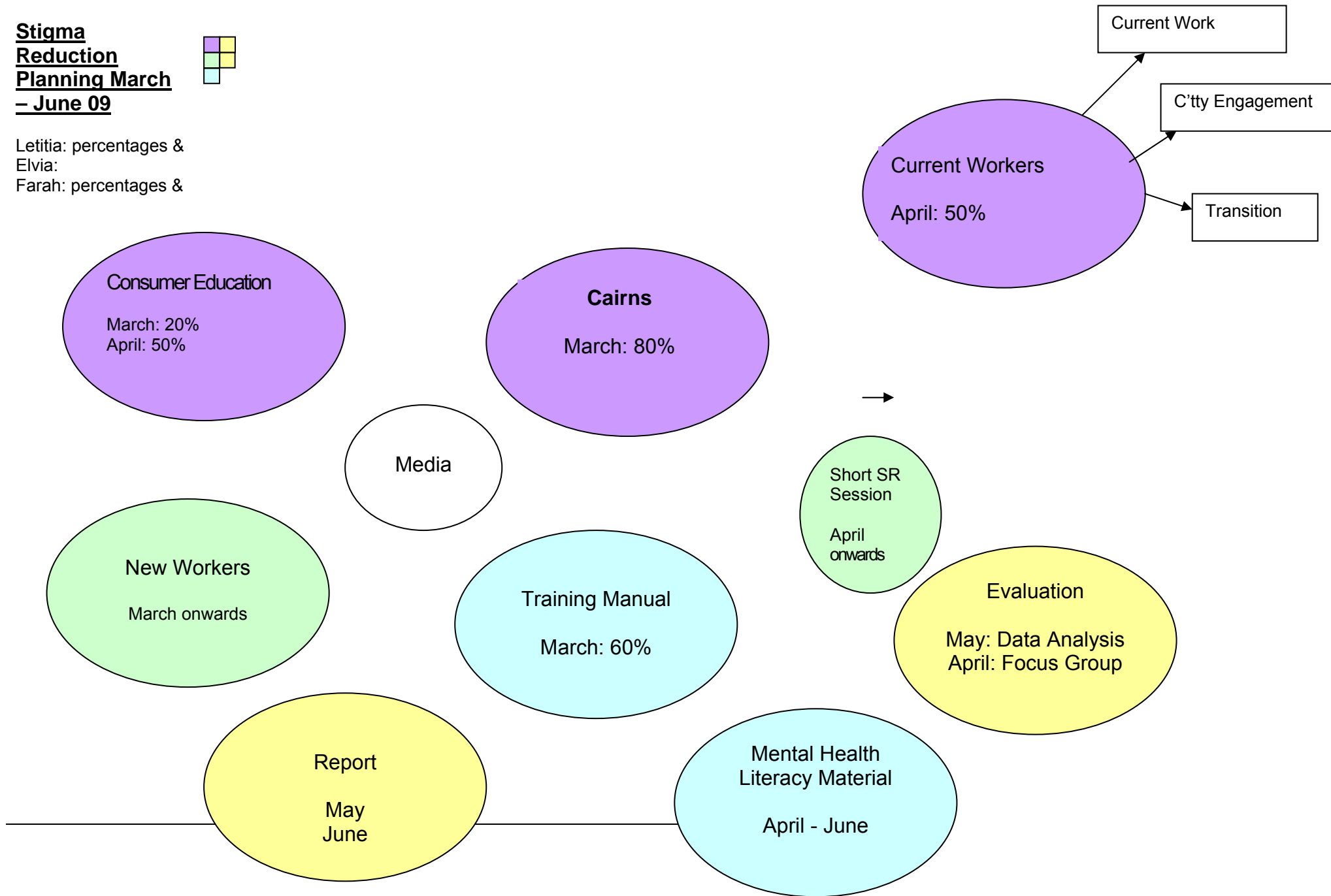
Allocated hours to be used until the end of June 09:

17 hours

**Stigma
Reduction
Planning March
– June 09**



Letitia: percentages &
Elvia:
Farah: percentages &



Appendix Two

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 community².

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 seeking¹⁷.

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/illness²⁸.

Certain literature states that more effective than education is having contact with people with mental 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 managers 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 demographics 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 than 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 than 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 be 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 Islands⁴. “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.

REFERENCES

1. Agic, B. (2003) *Health Promotion Programs on Mental Health/Illness and addiction Issues in Ethnoracial/Cultural Communities; A Literature Review*. Student Practicum II, MHSc in Health promotion, Department of Public Health Sciences Faculty of Medicine University of Toronto: Toronto
2. Agic, B. (2004) *Culture Counts: Best Practices in Community Education in mental Health and Addiction with Ethnoracial/Ethnocultural Communities. Phase 1 Report*. Centre for Addiction and Mental Health: Toronto
3. ABC Radio (2004) *All in the Mind; Part 1 of 2 – Aotearoa Minds: Maoris Taking on Mental Health*. Radio Program on Radio National, 29 May
4. ABC Radio (2006) *All in the Mind; Aboriginal mental health Part 1 - Tiwi Islands*. Radio Program on Radio National, 10 June
5. Bakshi, L., Rooney, R. and O'Neil, K. (1997) *Working Transculturally to reduce Stigma to Mental Illness: A Guide*. Australian Transcultural Mental Health Network: Perth: 84
6. Bakshi, L., Rooney, R. and O'Neil, K. (1999) *Reducing Stigma About Mental Illness in Transcultural Settings: A Guide*. Australian Transcultural Mental Health Network: Melbourne: 77
7. Clarke, A. (1999) Changing Attitudes Through Persuasive Communication. In *Nursing Standard*. 13, (3) 45 – 47
8. Commonwealth of Australia (2004) *Framework for the implementation of the Mental Health Plan 2003 – 2008 in Multicultural Australia*. Department of Health and Aging, Health Priorities and Suicide Prevention Branch (www.mentalhealth.gov.au)
9. Constantine, M. and Sue, D. (eds.) (2005) *Strategies for Building Multicultural Competence in Mental Health and Educational Settings*. John Wiley and Sons Inc. Hoboken: New Jersey
10. Corrigan, P.W. and Penn, D.L. (1999) Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist* 54(9): 765 - 776
11. East, D. (1997) *I Want A Life!: Logan Mental Health Needs Assessment Report*. Logan Regional Resource Centre Inc.: Logan
12. Edwards, R., Jumper-Thurman, P., Plested, B., Oetting, E. and Swanson, L. (2000) The Community Readiness Model: Research to Practice. In *Journal of Community Psychology*. 28(3). 291 – 307
13. Fernando, S. (2006) Stigma, Racism and Power. In *Aotearoa Ethnic Network Journal* (1), June 2006
14. Francis, C., Pirkis, J., Dunt, D., Blood, R.W. and Davis, C. (2002) *Improving mental health literacy: A review of the literature*. Centre for Health Program Evaluation: Canberra: 110. (www.health.gov.au)
15. Garcia, A. (2006) Is Health Promotion Relevant Across Cultures and the Socioeconomic Spectrum? In *FAM Community Health* 29 (1S), pp. 20S – 27S
16. Institute of Medicine of the National Academies (2002) *Speaking of Health; Assessing Health Communication Strategies for Diverse Populations*. Washington: US
17. Jorm, A., Korten, A., Jacomb, P., Christensen, H., Rodgers, B. and Pollit, P. (1997) Mental Health Literacy: A survey of the public's ability to recognise mental disorders and

their beliefs about the effectiveness of treatment. In the *Medical Journal of Australia*; (166) 182 – 186

18. Jorm, A., Korten, A., Jacomb, P., Christensen, H. and Henderson, Scott. (1999) Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. In *Australian and New Zealand Journal of Psychiatry* (33) 77 – 83
19. Jumper-Thurman, P., Plested, B., Edwards, R., Helm, H. and Oetting, E. (2001) Using the Community Readiness Model in Native Communities. In Trimble, J.E. and Beauvais, F. (Ed.), *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence*. Department of Health and Human Services (DHHS Publication No. SMA 99 – 3440) : Washington, DC pp. 129 – 158
20. Kreps, G. and Kunimoto, E. (1994) *Effective Communication in Multicultural Health Care Settings*. Department of Speech Communication, California State University, Fullerton. Sage Publications.
21. Marie, D., Forsyth, D. and Miles, L. (2004) Categorical ethnicity and mental health literacy in New Zealand. In *Ethnicity & Health* 9(3). August. 225-252.
22. Matson, A. (2003) *Empowering the Community helper; Needs Analysis Report*. Kinectons and Multicultural Affairs Queensland: Brisbane
23. National Institute of Mental Health in England. (2004) *Celebrating our Cultures: Guidelines for Mental Health promotion with Black and Minority Ethnic Communities*. NIMHE: Leeds: UK
24. National Institute of Mental Health in England (2004) *From Here to Equality: 2004 – 2009 A strategic Plan to Tackle Stigma and Discrimination on Mental Health Grounds*. NIMHE: Leeds: UK
25. Northern Suburbs Migrant Resource Centre. (1997) *Investigation of Stigma and Mental Illness Amongst Non-English Speaking Background Communities and Development of Approaches to Its Reduction*. Commonwealth Department of Health & Family Services, ATMHN: Perth: 128.
26. Northern Suburbs Migrant Resource Centre. (1997) *Project 1: Investigation of Stigma and Mental Illness among NESB Communities and Development of Approaches to Its Reduction*. Northern Suburbs Migrant Resource Centre: Perth: 16.
27. Queensland Transcultural Mental Health and Multicultural Centre for Mental Health and Well-Being (2005) *A Model for CALD Consumer Participation in Mental Health, A Report on the Multicultural Consumer and Community Participation in mental Health Project*. Brisbane
28. Rosen, A. (2003) What developed countries can learn from developing countries in challenging psychiatric stigma. In *Australasian Psychiatry. Setting strategic directions in mental health policy and practice: the challenge of understanding and addressing the social determinants* 11(Supplement). s89-s88.
29. SANE Australia. (2002) *The SANE guide to fighting stigma*. SANE Australia: Melbourne: 45.
30. Spiteri, J. (Ed.) (2003) *Keeping Well, Mental Health Promotion, Prevention and Early Intervention for All: Report on the Third Transcultural Mental Health Promotion Forum*. Held on the 20th of September 2001.
31. World Health Organisation (2001) *Mental Health: Strengthening Mental Promotion*. Fact Sheet No. 220

32. World Health Organisation, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne (2004) *Promoting Mental Health, Concepts – Emerging Evidence – Practice*. Summary Report.

Appendix Three

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

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Operational Framework: Bilingual Community Mental Health Promoter Positions

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Abbreviations and terms¹²

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.

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' issues¹³. 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 reside¹⁴.

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 programs¹⁶. 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 environment¹⁷.

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 communities¹⁸. 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 provision¹⁹. 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 services²²;
- 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 functions²³;
- are less likely to voluntarily use mental health services for a mental disorder and are more likely to be hospitalised on an involuntary basis²⁴;
- 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 communities²⁵.

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 readiness³².
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 initiatives³³.

- 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 manner³⁴. 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 wellbeing³⁵. 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 resources³⁶. 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 America³⁷. 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 centuries³⁸. 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 Australia³⁹. 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 communities⁴⁰.

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:

- explore the suitability, adaptability and re-design of various group programs to priority communities;
- participate in community activities to assist with identifying community mental health priorities and suitable referral pathways to mainstream services; and
- 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

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 (Auseinet), 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	<ul style="list-style-type: none"> - Supervision with program coordinator - Focuses on issues of specific program(s) - Bi-monthly
Peer Supervision	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Co-ordinator OF BCMHP positions • key community member
Program reference group	*See description below	Within QTMHC	<ul style="list-style-type: none"> • 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

Appendix 1

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.

Appendix 2

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

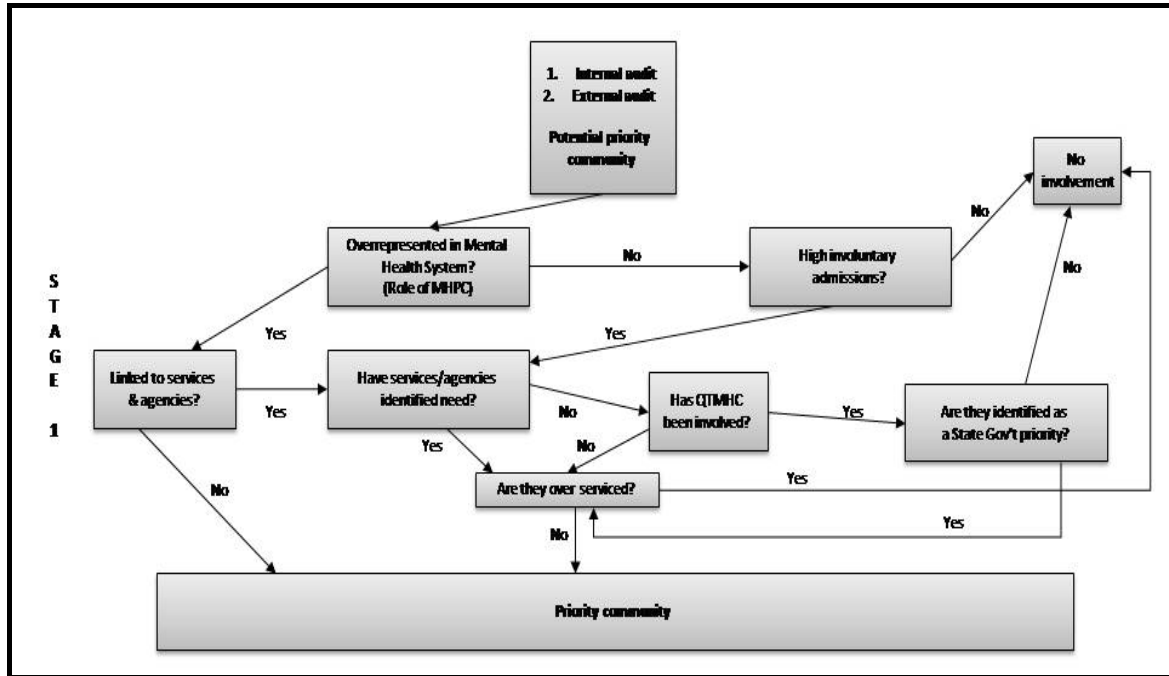
Please provide as many attachments as you need.

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

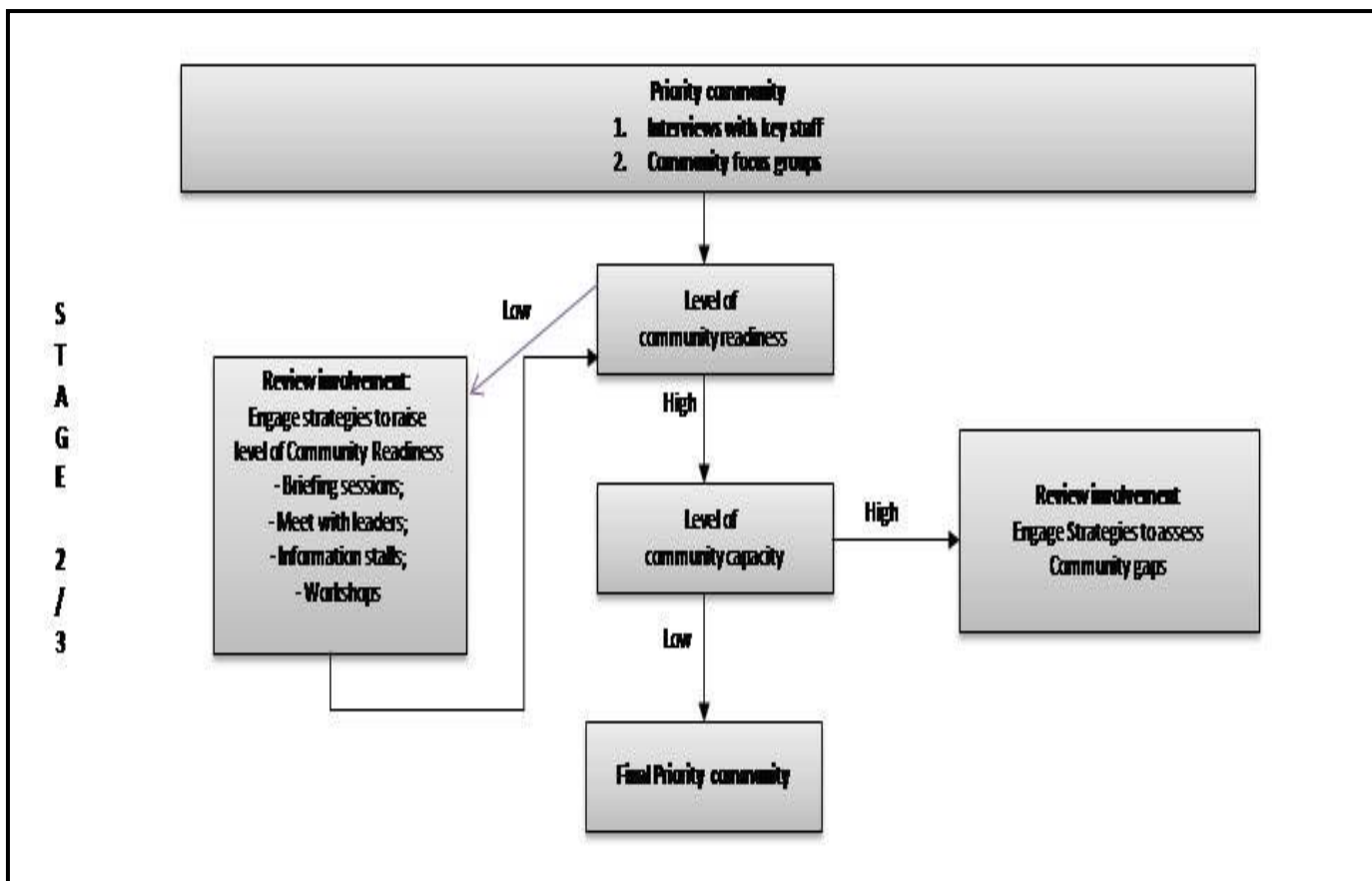


Checklist

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 Gov't priority?	Yes/No	
7	Is Community identified as "overserved"? - 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	

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 readiness⁴⁵:

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.

* Adapted from Plested, Edwards & Jumper-Thurman

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.

Appendix 6

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

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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
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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?

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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
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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
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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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Appendix 7

Community Readiness Rating Form

Six dimensions:

1	Community Efforts:	<ul style="list-style-type: none"> - 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:	<ul style="list-style-type: none"> - 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:	<ul style="list-style-type: none"> - 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:	<ul style="list-style-type: none"> - 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:	<ul style="list-style-type: none"> - 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

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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

Appendix 9

Community Mapping

Date of interview	Time	Community Group:	Participants Male: Female:	Language of session
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About your community group:

1	<p>What activities does your community group offer? Please describe them.</p> <ul style="list-style-type: none"> - 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.	<p>Does your community group have any plans for future activities?</p>	
3.	<p>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.</p> <ul style="list-style-type: none"> - How are they used? 	
4.	<p>What assistance do you think that your community group requires assisting with the activities that they do?</p>	
5.	<p>What strategies, methods or ways can be used to mobilise or encourage people to participate?</p> <ul style="list-style-type: none"> - How can people be encouraged to get involved in community activities that promote wellbeing? 	

About your community:

6.	<p>What are some of the different groups within the community?</p> <ul style="list-style-type: none">- 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.	<p>What issues are faced by the different groups within your community? Please give as much detail as possible.</p> <ul style="list-style-type: none">- 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.	<p>Who are the people in the community that people go to for help?</p> <ul style="list-style-type: none">- 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	

Appendix 10

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 6 th 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	<p>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.</p> <p>Split session: both groups will be looking at solutions</p> <ul style="list-style-type: none"> - 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 <p>Joint summary: Summary of activities from split session</p>
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.

Appendix 11

Meet with BCMHP to develop workplan

1. Identify key areas of work

- including clear activities & strategies for BCMHP

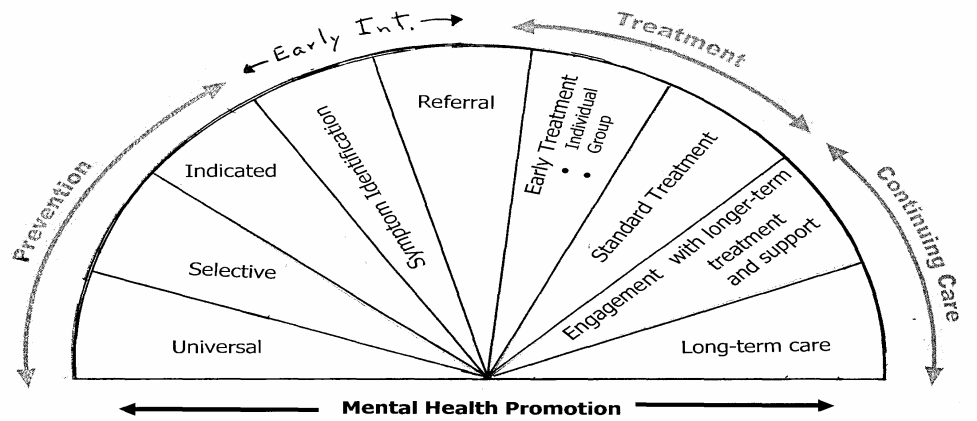
No	Goal	Task	Who	When
1				
2				
3				

2. Discuss potential for “satellite” activities

- any mental health week activities
- BRITA, etc

Appendix 12

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 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.

APPENDIX 14

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:

<i>Didactic:</i>	Information presented via lectures or presentations.
<i>Experiential:</i>	Information presented via appropriate guest speakers.
<i>Reciprocal:</i>	Learning is developed by students processing information into their particular community, via group discussions and presentations.
<i>Resource Development:</i>	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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ▪ QTMHC folders ▪ PowerPoint ▪ Brochures of Harmony Place and QPASTT
Working Conditions	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Operational Framework doc • PowerPoint • Peer Supervision doc & worksheet
Tasks assignation	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Introductions & welcoming • Trainers, trainees & Program for the day; Housecleaning 	Elvia Ramirez Moroni Pugh	9 – 9:15
Qld Mental Health system	<ul style="list-style-type: none"> • 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	<p><i>Elvia to introduce and provide context of District positions:</i></p> <ul style="list-style-type: none"> • Overview of Logan District & Logan District Position 	Elvia Karen Grimley	10:45 – 11:15
Mental Health & wellbeing & Stigma	<ul style="list-style-type: none"> • Part 1: Mental illness, mental health & wellbeing • Part 2: Barriers & stigma 	Moroni	11:15 – 12:00
LUNCH: 12:00 – 12:30			
CCC Forum	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Overview of QTMHC 	Rita Prasad-Ildes	2:30 – 3:00
Overview of TCCS	<ul style="list-style-type: none"> • General overview • Services of TCCS 	QTMHC – TCCS Simone Bell	3:00 – 3:45
Discussion	<ul style="list-style-type: none"> • Facilitated discussion of mental health issues within cultural communities 	Moroni to lead	3:45 – 4:15
Closing	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Introductions & welcoming • Trainers, trainees & Program for the day • Housekeeping 	QTMHC – promotions Moroni Pugh	MP to develop 9 – 9:15
Community Cultural Development A	<ul style="list-style-type: none"> • CCD principles & practise 	QTMHC – promotions Moroni Pugh	9:15 – 9:45
Community cultural development B	<ul style="list-style-type: none"> • Community development in the context of culture 	Moroni Pugh	9:45 – 10:30
MORNING TEA: 10:30 – 10:45			
Capacity Building	<ul style="list-style-type: none"> • How to build capacity within your cultural community 	Moroni Pugh	10:45 – 11:30
Capacity resource games	<ul style="list-style-type: none"> • Development of Capacity and resources in community 	Moroni Pugh	11:30 – 12:30
LUNCH: 12:30 – 1:15			
Critical examination of Community Development	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Introductions & welcoming • Housekeeping 	Elvia Ramirez, TMHPPCEI, QTMHC	9 – 9:15
Mental Health Promotion A	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Strategy development of MH promotion activities within each cultural community • How, what and why? 	Elvia Ramirez, TMHPPCEI, QTMHC	MP to develop 1 – 2
	<ul style="list-style-type: none"> • 	QTMHC – MHP	2 – 2:45
AFTERNOON TEA: 2:45 – 3:00			
Closing	<ul style="list-style-type: none"> • 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

For psychological issues such as emotional distress, grief and loss, relationship problems addictions and other normal reactions to stressors.

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.

Services

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, Kinnections, ZigZag and other counselling services listed in the *Lifeline Resource Directory*.

Public Services

Public health services such as community health centres.

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.