

CONSUMER PERSPECTIVE EDUCATION PROJECT

# HANDBOOK



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

Confucius

# 1. OVERVIEW OF STATE STEPPING OUT OF THE SHADOWS PROJECT

## **What is the aim of the state project?**

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

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

## **Why deliver a project specifically for CALD communities?**

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

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

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

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

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

### **Project resources:**

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

### **How does the project work?**

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

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

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

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

### **What has the project achieved so far?**

So far, the project has achieved the following things:

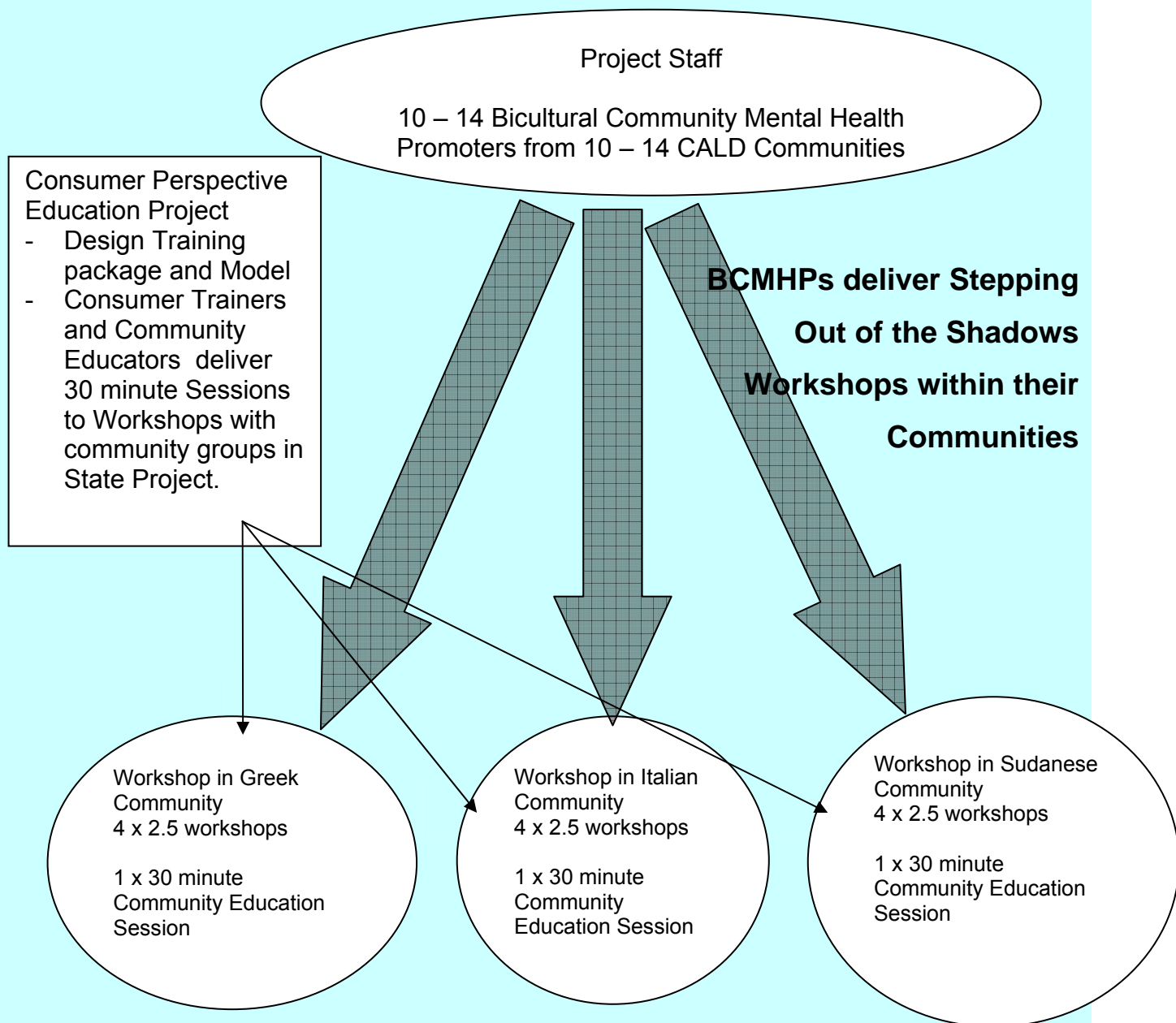
- 11 Training Programs have been delivered in the following communities:
  - Mandarin speaking
  - Sudanese
  - Spanish speaking
  - Italian
  - Croatian
  - Iranian
  - Serbian
  - Afghani
- One play has been developed and performed in the Burundi community
- Over 25 people have been referred to mental health services including GPs, QTMHC TCCS team, Child and Youth Mental Health Services (CYMHS) and psychologists.
- 3 Consumer Trainers have been employed to work with project staff to develop and implement Consumer Education into the project.

## **2. OVERVIEW OF THE CONSUMER PERSPECTIVE EDUCATION PROJECT**

- The Consumer Perspective Education staff and Consumer Trainers will develop a Consumer Perspective Education Training Package and Model that fits into the state wide Stepping Out of the Shadows Project.
  
- The Consumer Trainers will be trained to:
  - Be able to train other CALD consumers to be Community Educators
  - Be able to deliver Community Education sessions to groups of participants attending workshops run by Bicultural Community Mental Health Promoters.
  
- Community Educators are CALD consumers who have been trained to deliver Community Education Sessions.
- Community Education Sessions are 30 minute sessions where Community Educators share their story and experience of stigma and mental illness to a group of participants.

**DIAGRAM 1.**

**STATE PROJECT: STEPPING OUT OF THE SHADOWS**



### 3. WHAT IS CONSUMER PERSPECTIVE EDUCATION?

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

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

Consumer Perspective Education achieves many positive outcomes:

- It gives people who do not have lived experience of mental illness credible and real insight, knowledge and information about what it is like to have a mental illness and go through the mental health services, and more generally about mental illness itself.
- It challenges stereo types that exist about mental illness and people living with mental illness in a positive way.
- Consumer Perspective Education personalises the experience of mental illness and creates human interaction between the Educator and the participants. This can have significant impact on people's levels of knowledge about mental illness, and importantly people's attitudes, feelings and behaviours towards mental illness and consumers of mental health services.
- Consumer Perspective Education is an opportunity for consumers to speak up with equal status and be empowered by sharing their experience, knowledge and expertises.

## **4. LITERATURE SUMMARY**

### **What is the literature summary?**

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

### **What do I do with the Literature Summary?**

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

For example:

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

## **5. CONSUMER FOCUS GROUPS**

### **How many focus groups do I have to run?**

Consumer Trainers should run 1 x 2 hour focus group each

### **How many participants should I have in my focus group?**

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

### **Who should the participants be?**

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

### **How long should the focus group be?**

Each focus group should last about 2 hours

### **Where do I run the focus group?**

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

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

The place should be:

- A safe environment for everybody
- Comfortable and private
- Easy to get to for participants and the Consumer Trainer

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

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

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

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

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

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

## Collecting/Recording Data

- All information that is recorded from the focus group should be private and confidential. Names of participants should be changed and things that could identify the participant should be excluded where ever possible.
- Explain how the information will remain private and confidential to the participants at the very beginning of the focus group. Take time to discuss any fears or questions the participants may have.
- Make sure all the participants know exactly what you are going to do with the information you record, and how you will record the information. Do not do anything without the participants' full knowledge and consent as this will be a breach of trust.
- Ways of recording the information include:
  - Using a tape recorder and writing the key points later in your own time.  
**If you use a tape recorder, participants must sign consent form. This is to make sure the participants fully understand what the tape recorder is used for and to show they have agreed.**
  - The facilitator taking notes as the focus group is run.
  - Writing the key points from the focus group together on butcher's paper.

## Writing the Final Report

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

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

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

## **6. FACILITATING A FOCUS GROUP**

### **What is a focus group?**

- The aim of a Focus Group is to find out what a certain group of people (target group) in the community think about a specific topic.
- A focus group brings a group of participants from the community and to ask them questions to find out what they think about the topic. The participants that are chosen represent the target group you want to know about.
- For this focus group, the target group is consumers from a multicultural background. We want to know what consumers of mental health services from culturally and linguistically diverse backgrounds think about Consumer Perspective Education.
- A focus group is NOT an education, information or training session. It is only to get participants' thoughts and ideas about a topic.

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

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

- As a facilitator of a focus group your role is to ask questions to allow participants in the group to talk and share their thoughts.
- Your role is NOT to teach, give information or educate the participants.

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

- make participants feel safe, comfortable to talk,
- make participants feel what they are saying is being heard and valued,
- keep participants focused on the questions and make sure the focus group time is used to discuss all of the points you need to cover,
- support the participants to respect other participants' views and experiences and to listen non judgmentally.

### **Tips on being a good focus group facilitator:**

- Be a good and active listener. This means listening in a non judgmental way and acknowledging that you have heard what is said. (Body language, paraphrasing, asking questions, giving time)
- Establish and maintain clear boundaries. (Time management, group rules, modelling behaviour that is expected from participants, transparency, clear objectives, taking control of group dynamics when necessary.)
- Be yourself and be welcoming and approachable.
- Create a comfortable environment for your participants. (Sit in a circle, have a quiet and private space, have snacks and drinks for them, tell them where the toilet is)
- Speak clearly and make sure everyone can hear you. Sometimes when we are nervous we speak faster or more quietly than usual, be aware of this and try and control it.

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

## **How to Handle Problems in the Group**

- Good group dynamics should include:
  - People in the group should allow others to talk and not interrupt.
  - People in the group should be respectful of others in the group and try and remain non-judgmental about what they hear.
  - People should generally stay “on topic” and not use the time to discuss other things that are not relevant to the focus group.
- A facilitator’s role is to try to create and maintain good group dynamics. Participants in the group are individuals and adults however and it is not possible (or appropriate) to control all aspects of their behaviour or try and control all of the group dynamics. Letting people be themselves and not taking their behaviour personally is very important for a facilitator.
- Some problems or issues in the group’s dynamics can occur, once again it is not the fault of the facilitator, but it is within the facilitator’s role to address it. On the next page there are some possible issues and some strategies you may use to address them.

**Problem 1:**

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

**Strategy:**

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

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

**Problem 2:**

One participant is very shy and not doing any talking.

**Strategy:**

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

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

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

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

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

**Problem 3:**

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

**Strategy:**

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

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

**Problem 4:**

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

**Strategy:**

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

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

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

## **Maintaining Personal Wellbeing**

- Be prepared in case any part of running the focus group causes you to feel overly anxious or distressed. Things that may trigger feelings of anxiety may include the expectations you place on yourself in the role of facilitator, stress about dealing with difficult group dynamics or participant behaviour, the content of what is discussed during the focus group.
- Have a clear idea of who your support network is in case you do need experience feelings of anxiety or distress as a result of working on the project and need to access support.
- Speak to either Dennis or Letitia if you are having any concerns or problems during the project, they are able to listen to you, provide debriefing, support you in resolving problems with the project and will provide referral support if you want.

## **Maintaining Participant Wellbeing**

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

- Be observant when running the focus group, try and recognise how participants are reacting to certain things being talked about. Try and recognise if or when participants seem overly anxious or distressed and address the situation.
- Address the situation. If a participant seems overly anxious or distressed, call for a break and talk privately to the participant to check how they are going.
- Do not judge a participant's reaction or force them to take action if they do not want to. Ask the participant what they need or would like to do and respond by giving them the appropriate referral numbers or information.
- DO take action if a participant is at risk of harming themselves or others.

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

## **7. PRIVACY AND CONFIDENTIALITY**

### **Why is privacy and confidentiality important?**

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

- without privacy and confidentiality, participants will not feel safe discussing their thoughts and experiences
- privacy and confidentiality protects people from being gossiped about or their personal information being talked about without their knowledge or consent

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

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

- 1. What does privacy and confidentiality mean to you in this focus group?**
- 2. How would maintaining privacy and confidentiality help you in this focus group?**
- 3. What are some rules the group should follow to establish and maintain privacy and confidentiality?**

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

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

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

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

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

## **8. FOCUS GROUP DELIVERY PLAN**

### **Introductions:**

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

### **Housekeeping:**

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

### **Explain the following things to the participants:**

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

### **Privacy and Confidentiality:**

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

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

### **Ask the participants the Focus Group questions:**

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

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

## **Conclusion and Debrief:**

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

## **9. FOCUS GROUP QUESTIONS**

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

### **PROMPTS:**

- Some types of support include:**
  - Training in public speaking**
  - Training in how to talk about personal experiences in public**
  - Debriefing**
  - Training in how to handle problems that could happen when telling your story**
- What would make you feel comfortable to talk about your lived experience of mental illness in front of a group of people?**
- How could we make sure that there is “equal status” in the group between yourself as a CALD Consumer and the other participants in the group?**

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

**PROMPTS:**

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

## **10. CONSUMER TRAINER SUPPORT ACTIVITY**

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

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

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

# 11. CONSENT FORM

## Consent for Focus Group Participation to be Tape Recorded

### 1. Consent

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

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

Rita Prasad-Ildes  
QTMHC Manager  
[Rita\\_Prasad-Ildes@health.qld.gov.au](mailto:Rita_Prasad-Ildes@health.qld.gov.au)

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

### 2. Conditions/limitations

My consent is subject to the following limitations:

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

### 3. Undertakings

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

I understand that QTMHC:

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

### 4. Description of image or recording

Tape recording of discussion had during the Consumer perspective Education Focus Group:

Time:

Date:

Location:

## 5. Participant details

For the purposes of this consent form, the person whose image or recording is used is known as “the Participant”.

Full name of Participant:

\_\_\_\_\_

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

Address of guardian:

Signature of Participant or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

Full name:

Position:

Department:

Details of identification sighted – (e.g. driver’s licence, student card.)

Signature:

Date:

### **Important note:**

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

### **IMPORTANT PRIVACY INFORMATION:**

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

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

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

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

## EXPLANATORY NOTES

### **What is this consent for?**

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

### **What sort of publications could this material appear in?**

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

### **What is a recording?**

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

### **Who is a child?**

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

### **Who is a person with a decision-making disability?**

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

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

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

### **Modification or Withdrawal of consent**

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

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## 12. SUPPORT CONTACTS

- For support if you are having issues or problems related to anything with the project ring:

Dennis and/or Letitia

QTMHC (07) 3167 8333

They will provide:

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

- For participants who need clinical support as a result of participating in the focus group ring:

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

000

Ambulance or Police

24 hours a day 7 days a week

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

1300 858 998

PA Mental Health Emergency Number

24 hours a day, 7 days a week

**Mental Health Issue that is not an emergency ring:**

- **Dennis or Letitia**

**(07) 3167 8333**

**Monday – Friday**

**8.30 – 5.00**

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

**or**

**- QTMHC TCCS Intake Officer**

**(07) 3167 8333**

**Monday – Friday**

**8.30 – 5.00**

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

**For 24 hour phone counselling ring:**

13 11 14

Lifeline Phone Counselling

24 hours a day, 7 days a week

**Suicide Helpline Call Back Service**

Interpreters Available

1300 659 467

### Training Program Evaluation Questionnaire

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

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

**1. Because of attending this training program I now:**

*Please tick as many boxes as you want. It's ok if you don't tick any.*

- understand more about stigma in my community
- think differently about people with mental illness and their families
- will behave differently towards people with mental illness and their families
- feel I have more practical skill and knowledge to reduce stigma in my community

**2. When talking about or talking to people with mental illness, I thought the training facilitator:**

*Please tick as many boxes as you want. It's ok if you don't tick any.*

- was respectful
- was sensitive towards people with mental illness and their families
- used factual information

**3. During the training program, I most enjoyed:**

*Please tick as many boxes as you want*

- the topic
- the activities
- meeting or being with the other people in the group
- getting practical skills to help my community or myself
- Other: \_\_\_\_\_

**4. What would you change about the training program?**

*Please tick as many boxes as you want. It's ok if you don't tick any.*

- make it shorter
- make it longer
- have less information
- have more information
- less group work
- more group work
- change the style of the facilitator
- Other: \_\_\_\_\_

**5. I felt that the training program respected my cultural values and beliefs**

*Please tick one box*

- yes very much
- yes mostly
- yes
- no
- no not really
- no not at all

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

- yes very useful
- yes mostly useful
- yes
- no
- no not very useful
- no not useful at all

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

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

## Appendix Seven

# Family Stigma Questionnaire

## Participant Questionnaire

### FACILITATOR ONLY

Anonymous ID: \_\_\_\_\_

Please tick one:

- Before Training Program
- After Training Program

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

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

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

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

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

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

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

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

- 1. Strongly Agree
- 2. Agree
- 3. Somewhat Agree

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

4. Joan should feel ashamed about Frank's illness.

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

5. Joan was not a very good mother to Frank.

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

6. I would not want to socialise with Joan.

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

7. I would be likely to pity Joan.

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

## Appendix Eight

### BCMHP Support Feedback Questions

Do you feel that you had sufficient support from QTMHC?

What could have been done better by staff?

What could you have done better?

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

## APPENDIX 9

**Stigma Reduction Project Evaluation Table: May 2008 - July 2009**

Community	Training Workshops (341 people)					Other initiatives (509 people)					Contacts/Referrals (125 people)			
	Series of Four	Series of Two	One Off Session	# of Parts	Make Up of Participants	Project Launch	# of plays & skits	# attended play & skits	# of Seminars	# attended seminars	TCCS from training	TCCS from media	To other agencies, estimated by BCMHPs	QTMHC from media
Afghani	4			20	comm members									
Afg/Iran Mixed (G	1			5	comm members							10		
African (Tigrinya, Kirundi, Dinka)			1	6										
Muslim			7	88	Comm members, only women	5		1	92				2	
Burundi			1	6		7	1	80		2		20		
Cambodian			1	8										
Cantonese Sp														
Croatian										1				
Greek	2			20	comm members	1				1				
Iranian	4			24	4 comm leaders	6								
Italian		1	2	21	comm members, 2 key comm workers	1						25		
Italian Cairns							2	183				5		
Japanese Cairns			2	13		0								
Korean		1											1	
Mandarin Sp	2	1		40	comm members inc 4 comm leaders	20					9		6	
Maori										6				
Samoa														
Serbian			1	20	3 comm leaders, comm members	2						1		
Spanish Sp	2		1	28	5 comm leaders, comm members	7		1	50			20		
Sudanese	1			8	comm members, only women	4				8				
Turkish						1						1		
Vietnamese			1	12		3					1	3	1	
Multicultural			2	22		12	3						2	
NGO Staff						28								
Mental health workers								7						
<b>TOTAL</b>	<b>16</b>	<b>3</b>	<b>19</b>	<b>341</b>		<b>97</b>	<b>6</b>	<b>270</b>	<b>2</b>	<b>142</b>	<b>18</b>	<b>10</b>	<b>85</b>	<b>12</b>

Estimated number of CALD people reached: 112,529

**APPENDIX 9**

**Stigma Reduction Project Evaluation Table: May 2008 - July 2009**

Communication Strategies (111,679 people)									Workforce Training (27)			
Broch	Print Ads	Print articles	Radio ads	Radio Ints	TV	Internet ads	Internet articles	# QLD people reached by print media	# QLD people reached by radio	# QLD people reached by TV	BCMH Promoters	NGO Staff
	0	0	0		0			0	0	0	1	
	0	0	0		0			0	0	0	0	
228	13	1	8		0		2	6950	1,000	0	1	
20	0	0	2		0			200	200	0	1	
	8	0	8		0			800	1,700	0	1	
269	4		8	1	0			300	3,200	0	1	
20	4		8		0			5200	5,000	0	1	
3	0		8		0			0	1,600	0	1	
73		3	8	1	0			3200	3,000	0	1	
0	4	3	0		0			8900	0	0	1	
0	0	0	0		0	0	0	0.00	0	0	1	
20	16	1	8		0	1		1200	500	0	1	
100	32	2	8		1		1	30000	2,400	8,000	1	
0	0	0	0		0			0	0	0	3	
0	4	0	8		0			800	3,000	0	2	
128	12		8		0			1600	1,100	0	1	
150	12	1	8		0			5350	1,600	0	1	
50	0	0	4		0	1		0	400	0	1	
154	0	0	8		0			0	600	0	1	
150	4		12		0			4000	7,500	0	1	
614	0	0	2		0			0	400	0		5
		3										
<b>1979</b>	<b>113</b>	<b>14</b>	<b>116</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>68500</b>	<b>33200</b>	<b>8000</b>	<b>22</b>	<b>5</b>

## Appendix 10

### Stepping Out of the Shadows

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

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

*Level 1: No awareness*

*Level 2: Denial/resistance - Community generally recognises that mental health issues exist but not in their community*

*Level 3: Vague Awareness - recognition that mental health is an issue in the community but little motivation to do anything about it; rarely would seek help*

*Level 4: Preplanning – clear recognition that mental health is an issue in the community and the community has started planning things that they can do; some individuals will access services*

*Level 5: Preparation – the community has started planning and is focussed on practical ideas while seeking help if needed*

*Level 6: Initiation – the community has just started action (establishing groups, starting projects and advocacy); accessing services starts to be normalised*

*Level 7: Stabilisation – working towards keeping their long term initiatives sustainable; accessing services is normalised*

*Level 8: Confirmation and expansion - community members are participating in current actions, and are evaluating and developing them; accessing services is encouraged*

*Level 9: High Level of Community Ownership – high level of community involvement and satisfaction; mental health professionals from community are highly involved with community*

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

#### **BURUNDIAN COMMUNITY**

(1 respondent: BCMHP)

Leadership of the community meet to discuss how the community can help members affected by mental illness, they are focussed on practical ideas and would like help with more information – the BCMHP is now regarded as a community leader and the mental health resource in the community who is often accessed for assistance (*Level 5*). Community members range from low awareness due to lack of understanding of what the health system does but have increased awareness about stigma associated to mental illness (*Level 3*), There is still some denial believing that mental illness could not happen to them (*Level 2*) to vague awareness with little knowledge of what to do about it but to contact the BCMHP (*Level 3*). Overall, the level of level of readiness in the Burundian community to engage in mental health has increased from the maximum of Level 4 at pre-project to the maximum of Level 5 at post-project evaluation.

(No respondents)

### **FARSI-SPEAKING COMMUNITY (Iranian and Gold Coast Afghani)**

(3 respondents: BCMHP and 2 community leaders)

The general community suffers from high stigma resulting in denial of mental health problems as a community issue (*Level 2*). Educated Iranians and Afghani, including leaders may know more about mental health issues but there is little motivation to do anything about it other than obtaining treatment via GPs or NGOs (*Level 3*). Giving that the leadership in these communities remains fragmented, little progress has occurred re level of community readiness to engage in mental health. It remains at the maximum level of 3.

### **ITALIAN COMMUNITY**

(1 respondent: BCMHP)

There has been an increased number of programs and seminars on the topic of mental health in the community with some community organisations and groups starting advocacy such as a popular seminar series facilitated by an Italian psychiatrist (*Level 6*) and others working to keep their long term initiatives sustainable (*Level 7*). The general community have increased their awareness as a result of these programs but little motivation to do anything about it for reasons and attitudes depending on their generation – older people fear being ostracised, while younger people may not be interested (*Level 3*). Overall, this community has shifted one level from a maximum of Level 6 at pre-project to a maximum of Level 7 at post-project evaluation.

### **MANDARIN-SPEAKING COMMUNITY**

(2 respondents: BCMHP and 1 community leader)

The general community and some leaders recognise that mental health is an issue in the community but they do not like to talk about it openly (*Level 3*). Some community groups and their leaders have initiated community education projects – one respondent suggested running seminars to increase their understanding (*Level 5 – 6*). As at pre-project, some elements of the community have high level of ownership such as the Taiwan Women's League Qld, are still committed to continue delivering social and emotional wellbeing initiatives for their large membership (*Level 7*). The Mandarin-speaking community has remained in the same level of readiness to engage in mental health, Level 7.

### **SERBIAN COMMUNITY**

(2 respondents: BCMHP and 1 community leader)

The general community is more aware of mental health issues having attended two community meetings and Stepping out of the Shadows training - the respondents comment respectively that this is a “positive change” and “big step forward and more open talking” there is not yet motivation to do anything about it (*Level 3*). Leaders are involved with the existing activities and programs but have not yet initiated any activities (*Level 3*). This community has remained at the same level of community readiness to engage in mental health despite one of the most powerful leaders reacting unsupportively to the level of engagement of community members to the activities of the project.

### **SPANISH-SPEAKING COMMUNITY**

(2 respondents: BCMHP and 1 community leader)

There has been “a lot of community education over many years” including recent Stepping Out of the Shadows training which has raised community awareness about

mental health issues, however high levels of stigma and trust issues prevent people in the community from taking action (*Level 3*). Leaders usually welcome community education sessions (*Level 3*), while some facilitate support groups (*Level 5*). One community group is at preparation level, focussing on practical ideas with assistance where needed (*Level 5*). This community reportedly has increased the level of readiness from a maximum of Level 3 at pre-project to a maximum of Level 5 at post-project.

### **SUDANESE COMMUNITY**

(1 respondent: BCMHP)

The general community has awareness of mental health issues as a result of their experience of war, and “cultural activities” are well attended however the response did not mention any planning of mental health-specific activities or programs by the community (*Level 3*). The Lost Boys have been meeting for some time planning to take some action (*Level 5*). Leaders are of great “cultural importance” but lack motivation and time to plan action on the issue (*Level 3*). This community has increased the level of community readiness from a maximum of Level 4 at pre-project to a maximum of Level 5 at post-project evaluation.

### **TURKISH COMMUNITY**

(1 respondent: BCMHP)

There has been little change since the project started since most of the community “are just not interested” (*Level 1*). Stigma is high, with people not wanting to get involved as they are concerned about what others will think of them (*Level 2*). Community leaders are concerned, with one requesting help, but there have been no meetings or discussions (*Level 3*). This community has remained the same since the initiation of the project, however, it is worth noting that the BCMHP was absent for over six months or half of the project, so these findings are not surprising.

**After 14 months, at post-project, three (3) of a total of 16 communities have increased one level of readiness to engage in mental health, one (1) has increased two levels and four (4) have remained at the same level. The other eight (8) communities have not been assessed at post-project due to the lack of key informants willing to participate in this evaluation. It is important to note that three (3) communities established their community readiness baseline at the time the other communities were conducting the post-assessment. The project achievements at community level are significant as moving from one level to the next involves an important shift in community attitude and means that a major number of people in these communities have been reached out with the project multi-strategies. There are other individual measures of the project outlined in the table *Stigma Reduction Project May 2008 – July 2009*.**

## APPENDIX 11

### STIGMA REDUCTION PROJECT - TRAINING PROGRAM EVALUATION TABLE JULY 2008 - JULY 2009

Community	# Parts	# Evaluation Completed	Because of attending the training the participants:				When referring to people with mental illness the facilitator:		
			Understood more about stigma in their community	Thought differently about people with mental illness and their families	Would behave differently towards people with mental illness and their families	Felt they had more practical skill and knowledge to reduce stigma in their community	was respectful	was sensitive towards people with mental illness and their families	used factual information
Afghani	9	8	4	3	4	5	7	3	7
Iranian/Afghani	13	11	7	9	11	9	8	8	9
Iranian	22	20	12	9	9	15	13	7	15
Italian (Brisbane)	21	19	15	9	9	11	17	13	16
Japanese	6	6	5	5	6	6	5	6	5
Mandarin Speaking	30	22	12	13	14	10	18	18	12
Spanish Speaking	15	11	9	4	5	8	10	8	8
Sudanese	8	7	2	1	2	0	4	4	0
<b>TOTAL</b>	<b>124</b>	<b>104</b>	<b>66</b>	<b>53</b>	<b>60</b>	<b>64</b>	<b>82</b>	<b>67</b>	<b>72</b>
Percentage		<b>100</b>	63	51	58	62	79	64	69

## APPENDIX 11

**STIGMA REDUCTION PROJECT - TRAINING PROGRAM EVALUATION TABLE JULY 2008 - JULY 2009**

Participants most enjoyed:				Changes the participants would make to the training program:							The training program respected participants' cultural values						The materials used in the training were useful					
the topic	the activities	meeting or being with other people in the group	getting practical skills to help themselves or their community	make it shorter	make it longer	have less info	have more info	less group work	more group work	change the style of the facilitator	yes very much	yes mostly	yes	no	no not really	no not at all	yes very useful	yes mostly useful	yes	no	no very useful	no not useful at all
7	4	4	5	1	5	0	5	0	5	2	3	0	5	0	0	0	3	4	0	0	0	0
8	6	6	11	1	3	0	7	0	6	0	5	0	5	0	1	0	5	4	2	0	0	0
15	14	8	17	1	13	0	10	0	9	2	10	2	7	0	1	0	12	3	5	0	0	0
15	13	15	14	6	5	6	1	6	0	0	13	5	1	0	0	0	12	3	0	0	0	0
5	6	6	3	0	0	0	4	0	2	0	2	1	3	0	0	0	2	1	3	0	0	0
12	3	11	18	1	7	0	15	0	9	1	18	2	1	0	0	0	8	6	7	0	0	0
8	7	6	8	1	0	0	3	0	4	0	10	0	0	0	0	0	9	1	1	0	0	0
1	0	0	6	0	6	0	0	0	0	0	5	1	0	0	0	0	2	1	1	0	0	0
71	53	56	82	11	39	6	45	6	35	5	66	11	22	0	2	0	53	23	19	0	0	0
68	51	54	79	11	38	6	43	6	34	5	63	11	21	0	2	0	51	22	18	0	0	0

## Appendix 12

### BCMHP Feedback about Community Response to their Role

NAME: ..... COMMUNITY: .....

Have the community been contacting you in your role on the project?

Do they know what you do, ask for your help, avoid you, greet you?

Has this changed since you first started on the project?

How have they been contacting you ? (At events, by phone, etc)

Did anyone contact you as a result of having done the training (or the play or an information session)?

Did anyone contact you having seen an advert in a newspaper or heard the story on the radio?

**Estimate numbers of referrals, times you've responded to requests for help, information, any contact from the community**

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