National Recovery-Oriented Mental Health Practice Framework
2nd Consultation Feedback

August 2012

Forward

Thank you for the opportunity to once again participate in the National Recovery-Oriented Mental Health Practice Framework consultation process. We have welcomed being a part of the initial consultation round, attending the forums and your willingness to invite more detailed advice. With the framework nearing completion, we welcome this opportunity to provide further comment.

We are particularly pleased that a detailed capability related to acknowledging Australia's culturally and linguistically diverse population has been integrated into a mainstream mental health framework. This will help to educate mental health service providers about cultural responsiveness. It will also reinforce arguments for regarding working effectively with immigrants and refugees in mental health settings as a core competency for all practitioners.

Our feedback will focus on how the framework addresses affects people from immigrant and refugee background experiencing mental illness or disorder and supports their recovery. It incorporates comments from three of MHiMA's consortium members:

- Queensland Transcultural Mental Health Centre,
- Victorian Transcultural Psychiatry Unit,
- University of South Australia Mental Health Nursing Group, Human Rights and Security Cluster

And also the following state-wide transcultural centres:

- Transcultural Mental Health Centre (NSW),
- West Australian Transcultural Mental Health Centre

General comments on the Framework

Be mindful of using jargon and metaphors throughout the document e.g. “aerosol term” (Framework p. 5). While they are useful, they are also open to misinterpretation. It may help to flag when a metaphor is being used. Similarly, some communities may not respond to describing recovery being as a “journey” (Framework, p 16). It may be misinterpreted as travelling. For readability, consider the inclusion of a glossary or defining terms as they arise such as “person - led recovery” (Framework, p.7); “recovery as self righting” (Framework p. 19), “clinical recovery vs personal recovery” (Framework p. 20).

In the recovery and relationships section (Framework, p 16), a reference could also be made to a person’s community/faith leader or organisation.

Consider that in some cultures LGBTI people (Framework, p.38) are vilified in their country of origin for their sexual identity and preference. They may be unaware of their rights in Australia and the support that is available.

Reference could be made to culturally appropriate and relevant parenting programs (Framework, p. 39). The need consider the culture of the parents and that their parenting style may be influenced by their migration history, past trauma, cultural values, religious beliefs or gender.

When working with adolescent and young people from refugee backgrounds (Framework, p. 40), different approaches such as sport and recreational programs can engage young people and build mental health and wellbeing.

Older adults from immigrant and refugee backgrounds (Framework, p. 41) may have higher rates of depression, be socially isolated and less likely to seek professional help for a mental health problem.

People from immigrant and refugee backgrounds in rural and remote communities (Framework, p. 42) may feel isolated due to a lack of ethno-specific community networks. This may be compounded if their families are still in their home country.

People with co morbid conditions from immigrant and refugee backgrounds (Framework, p.43) face cultural and linguistic barriers to accessing treatment. Co-morbid conditions can be highly stigmatised and compounded by isolation from a person’s ethnic community and family. These factors may negatively impact the person’s recovery process.

People from immigrant and refugee backgrounds are over represented in criminal justice and forensic settings (Framework, p. 44) and may stay in these facilities for longer periods due to inadequate cultural assessment and the lack of culturally appropriate treatment options.

In general, the role of general practitioners (GPs) needs to be acknowledged in this framework. GPs are often the first point of contact for people from immigrant and refugee backgrounds. Community perception of stigma and shame associated with experiencing mental health problems may lead individuals and families to accept help from a GP but not from a specialist mental health service

provider. GPs, therefore, need to be skilled in providing a culturally sensitive assessments and interventions and understand the concept of recovery and recovery action plans.

Similarly, the role of other community based organisations such as community health centres, migrant resource centres, ethno-specific welfare organisations, and providers of other social support services should also be acknowledged in the framework. We know that people from immigrant and refugee backgrounds commonly seek help for mental health and related issues from agencies and organisations outside the mainstream mental health system.

Q1. What is your response to the section 'Recovery and Compulsion'? Would you like to suggest any changes? Additions?

Practitioners considering using coercive strategies and involuntary treatment with individuals from immigrant or refugee backgrounds need to be mindful of a number of issues.

Misinterpreting cultural idioms of distress can lead practitioners to overestimate or underestimate the degree to which an individual risks harming self or others. Cultural sensitivity training, supervision and support can increase practitioner confidence and competence around making these challenging clinical judgements.

An assessment of the person's level of English proficiency should be considered a core part of a comprehensive mental state assessment. An interpreter should not only be engaged when the person's English proficiency is very low, but also when the person capacity to communicate in English is limited to expressing their basic and immediate needs. If either the person or the practitioner is significantly simplifying their speech in order to communicate with each other, then the involvement of an interpreter is indicated. To not do so is a known significant risk for the person undergoing treatment and for others (Department of Health, 2009, p. 18). These considerations apply to working with individuals and their family members at all stages of recovery.

Transcultural or bilingual health practitioners also can also be engaged to work with the individual, family and treating team. They have an important role to play in facilitating communication and providing advice and support. CALD peer specialists are also important to consider, as they are able to speak to individuals in their first language, share experiences of contact with mental health services and facilitate family involvement.

In addition to the questions outlined on the upper part of p12 (Summary & Questions), practitioners should be encouraged to ask: How will this individual and his/her family members interpret the team's decision to be coercive or proceed with involuntary treatment? This is especially important in working with individuals from immigrant and refugee backgrounds for a number of reasons. The person and his or her family may:

- Have limited or no experience of government agencies or health services acting with benevolent intent. It may be their view, arising from experiences formed in their country of origin, that contact with emergency services, police and mental health services is likely to lead to violence, indiscriminate loss of liberty or negative repercussions for other family

members. For this reason, individuals or family members may be reluctant to share information that may help the practitioner make a more adequate risk assessment.

- Have limited understanding of their rights in relation to accessing an interpreter, being informed about the mental health care they receive, being given the information that they need to fulfil their caring role and the medico-legal processes that should accompany involuntary treatment. For this reason service providers have additional responsibilities to ensure that their right to information and safety are upheld.

- Interpret the mental health team's response as consistent with severe custodial practices e.g. shackling, used to manage acutely unwell individuals in some countries. For this reason, practitioners have a responsibility to carefully and thoroughly explain the limits and intent of the coercive practices that they use. They should also educate family members about how to manage challenging behaviours when they arise at home.

- Have a very different understanding to the one formed by the mental health service about the current situation. Their understanding may have a religious dimension. If this is the case, then services should consider how they can assist individuals to safely connect with their faith traditions. This includes facilitating contact with community and faith leaders. Providing culturally and spiritually appropriate support can assist the recovery process for the individual and the family.

- Lack understanding about the benefits and also the limits of the medical and therapeutic approaches to treating mental illness. They will need information, provided in culturally and linguistically sensitive ways, about the treatment and management options available. In particular the rationale for using seclusion or involuntary treatment needs to be carefully explained.

- Find the experience of seclusion, being forcibly removed from contact with other people and, in particular, family, frightening, disorientating and traumatising. They may see more contact with others rather than less as the key to healing.

We recommend an addition to the organisational features outlined over pages p 12 & 13 (Summary and Questions) consistent with Australian reports into safety in mental health settings (National Mental Health Working Group 2005, p. 6) and Canadian practice guidelines (Kirmayer et al, 2012 p. 3):

- Monitoring of the cultural and social characteristics of individuals who are subjected to the use of coercive strategies or involuntary treatment is required to ensure that services detect sources of bias and are reflective about the institutional dynamics of racism that can impact on mental health work.

Q2. What is your response to the schema of Domains and Capabilities? Would you suggest any changes? What further opportunities might be identified? What further resources might be helpful to mention?

We note the intention on p.8 of the Framework to use a consistent and respectful language and avoid certain terms throughout the document. With this in mind please review each of the capabilities as the terms "service user" and "consumer" and "carer" do feature in a number of the descriptions.

We are pleased to see the inclusion of a capability "Working with people from immigrant and refugee backgrounds, their families and communities". It is appropriate to include this in the "person first and holistic domain" and we note, as you do, that there is considerable cross-over between the capabilities and the domains.

See below for some minor suggested changes/ additions to the "Working with people from immigrant and refugee backgrounds, their families and communities".

Skills

Please include

"Ability to work with CALD consumer and carer peer services to support the person with mental health issues"

Knowledge

"Awareness of relevant community organisations and resources"

Good practice

Follow "Respect and respond to people's cultural and religious beliefs" with another point "Connect with the person's faith tradition"

Include

"Engage community groups through mental health education and stigma reduction initiatives"

Good Leadership

Replace "Actively seek the participation of consumers and carers from CALD backgrounds" with "Advocate for the participation of consumers and carers from CALD backgrounds'

Follow "Provide staff with opportunities to acquire the core attitudes, knowledge and skills related to cultural responsiveness" with another point: "Provide staff with a reflective space, through supervision, to explore their own assumptions about mental health, illness and recovery"

Opportunities

Please include

"Develop a whole-of-organisation cultural responsiveness plan"

"Join local, state and national networks, form partnerships and work across sectors to improve access and equity and create culturally responsive services"

Resources

Please include

"The websites of Mental Health in Multicultural Australia (MHiMA) and state transcultural mental health networks provide a range of resources and links"

"The national e-learning initiative MHPOD (Mental Health Professional Online Development) includes a transcultural module"

You also asked, in your email, for comments and references in relation to the capability "Supporting participation and social inclusion and advocacy on social determinants"

We are very supportive of the inclusion of this capability and the content included in this draft is sound. Some general comments for your consideration:

- This capability is making the link between "private troubles" and "public issues". The capability focuses on individual intervention, but there is scope to consider service and system obligations to respond at the level of service design to the needs of disadvantaged groups. This capability could have two areas of focus – how to respectfully work with individuals who are materially disadvantaged– and – how to address the needs of a local populations who are materially disadvantaged
- Consistent with using the language of social inclusion, this capability should emphasise developing programs that support people to engage in education and employment in addition to providing social welfare support where and when they need it.
- The capability focuses on the markers of disadvantage or poverty (poor housing, low income, inability to afford health care etc). It could also discuss inequality. We know that it's not just one's actual income and level of education that impacts negatively on health, it is also how one is positioned relative to others in the community that matters, i.e. lacking control over one's living circumstances is a risk factor for developing a range of illness, including mental illnesses. People living with the effects of mental health problems are multiply disadvantaged in this respect. Again this has implications for how practitioners, services and systems respond at the level of individuals and groups (Wilkinson & Pickett 2009).
- We could include the importance of listening to this aspect of the person's lived experience as an important part of good recovery practice, i.e. the knowledge that comes from not only of living with mental health problems but also from living with extreme disadvantage.
- Finally there is space for considering how disadvantage and inequality affects individuals in the context of families and communities.

Request to provide brief anecdotes or quotes that illustrate points made in any part of the framework.

We would be happy to provide stories that reflect Australia's cultural diversity and that could help to illustrate any aspects of the recovery framework. Please get in touch to discuss how best to provide this input.

Thank you for the opportunity to provide this feedback. We look forward to having further discussions about how we may be able to be involved in the implementation of the framework.

References

Department of Health (2009) *Cultural responsiveness framework: guideline for Victorian health services*. Victorian Government, Melbourne.

Kirmayer, L, Kenneth Fung, K, Rousseau, C, Lo, HT, Menzies, P, Guzder, J, Ganesan, S, Andermann, L, McKenzie, K.(2012). Guidelines for training in cultural psychiatry, *The Canadian Journal of Psychiatry*, 57, (3).

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Wilkinson, R & Pickett, K (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better*. Allen Lane, London.