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Introduction

1 Please tick this box to indicate you have read and understood the above information.

Check box to indicate you have read and understood the above.:
Yes

2 Please select the statement that best applies to you.

I am responding to this survey on behalf of an organisation (representing the organisation's views)

Consent for Organisational Respondents

1 The National Mental Health Commission may want to quote from your responses to this survey in confidential reports to the Australian Government. Please choose the statement below which applies to your organisation.

My organisation's name may be associated with any direct quotes taken from this online survey response.

About Your Organisation

1 What is the name of the organisation submitting this response?

enter name of organisation:
Mental Health in Multicultural Australia (MHiMA)

2 What is your name?

your name:
Mr Hamza Vayani

3 What is your role in the organisation?

your role in the organisation:
Executive Officer

4 What is your email address (in case we have any questions about your response)?

enter your email address:
exec@mhima.org.au

5 Select the issue(s) with which your organisation is most engaged in relation to mental health.

education, online support, carer/family support, cultural issues

Other :

6 What state(s) and/or territory(ies) does your organisation operate in?

Tasmania, New South Wales, Victoria, South Australia, Western Australia, Queensland, Australian Capital Territory, Northern Territory

Other:

7 Select the best description for your organisation. [If more than one applies, please select the one which reflects the greatest proportion of the organisation's activity.]

Other type of representative organisation

Other:

Evidence of the mental health 'system' working well

1 Please provide an example from your own experience (or that of your organisation) of a service, programme, policy or initiative demonstrating value for money (cost-effectiveness):

Insert your example of cost-effective use of resources here.:
An example of cost effective service delivery is the existence of statewide Transcultural Mental Health Services in New South Wales, Queensland, Victoria and Western Australia. The statewide model for Transcultural Mental Health Services needs to be maintained as a specialist resource for Local Health & Hospital Services in each state mental health system to access training and development of mental health staff in culturally responsive practice; and to enable support in more complex case management.

In all of the Transcultural Mental Health Services that exist there are specialist state-wide transcultural mental health clinical consultation services for people from Culturally & Linguistically Diverse (CALD) backgrounds with the exception of Victoria. In addition all statewide services have CALD consumer and carer groups; and many of the CALD consumers and carers feed into the national Consumer & Carer Working Groups that MHiMA has established to enable national advocacy and joined up national thinking about mental health service planning and policy development in relation to CALD mental health across Australia.

These services have been evaluated to be efficient models to enable culturally tailored mental health care to be provided and are regarded internationally as best practice models in transcultural mental health.

2 An example of an innovative approach to funding, organising, or delivering mental health support:

Insert your example of innovative approaches here.:
The Framework for Mental Health in Multicultural Australia is an innovative online resource developed by MHiMA that is designed to support mental health services in delivering improved and culturally responsiveness focused mental health support at both organisational and worker level.

The Framework is an integrated online package consisting of an Organisational Cultural Responsiveness Assessment Scale (OCRAS), strategies and outcome indicators for organisations and workers backed up with resources and best practice examples referenced to the National Safety and Quality Health Service Standards (2012) and the National Standards for Mental Health Services (2010).

An Introductory Guide that explains how the Framework can be used to improve mental health support for people from CALD backgrounds. The Framework also includes 5 key concept sheets that provide supporting evidence and background information about the key theoretical underpinnings behind what constitutes a culturally responsive mental health service. The Framework uses an outcomes based approach to drive culturally responsive service improvement focused on four key outcomes area that align with national and state based mental health policies. The four key outcomes are:
1. Consumer, carer and family participation
2. Safety and quality
3. Promotion, prevention and early intervention
4. Workforce.

3 An example of good integration, joint working, or collaboration with other services, programmes or initiatives:

Insert your example of integration, joint working or collaboration here.:
MHiMA has been able to constructively and effectively raise key considerations around CALD mental health issues. To date MHiMA's approach has and continues to be focused on developing practical initiatives to address the lack of available data, meaningful reporting and highlighting existing limitations around the capacity, effectiveness and efficiency of mental health services being able to meet the needs of CALD populations in collaboration with a number of key stakeholders across Australia.

For example MHiMA has been able to facilitate opportunities for knowledge exchange and partnership between CALD Mental Health initiatives across states and territories. Key and meaningful ways in which MHiMA has been able MHiMA to integrate and facilitate joint working and collaboration around CALD mental health considerations is through utilisation of a range of engagement and partnership mechanisms which include:

- MHiMA State & Territory Reference Group
- MHiMA Consumer & Carer Working Group
- Mental Health Drug & Alcohol Principal Committee
- Australian Bureau of Statistics
- Australian Commission on Safety & Quality in Healthcare
- Australian Institute of Health & Welfare
- Department of Health (Commonwealth)
- Health Workforce Australia
- Independent Health Pricing Authority
- National Mental Health Commission

4 An example of a service or initiative which supports the needs of the whole person (e.g. physical health, housing, education and training):

Insert your example of support for elements of a 'contributing life' here.:
Depression is a key issue in the CALD population, especially refugees and older migrants.

Mental Health Services adopting recovery frameworks are becoming more aware of the multi psycho-social needs of their consumers and are thinking about ways to improve comprehensive service delivery.

Partnerships with community mental health services have had some success in providing services not catered for by clinical mental health services.

For example the New South Wales Transcultural Mental Health Service CALD Carer Support program takes a holistic approach to facilitating:

o Access to support to respite services
o Building capacity through mental health literacy programs
o Improving community education of pathways to care and
o Education and training for the Bilingual Group Leaders who facilitate these support groups

The Queensland Transcultural Mental Health Centre has developed a 6 session multicultural depression and chronic diseases self management program which has been evaluated to be effective in reducing depression and increasing self management skills. The program has been run as a group program and has also been utilised as part of psycho-education for individuals.

Both of these initiatives have the potential to be scaled up to be delivered nationally.

5 Up to 2 examples of services, programmes, policies or initiatives which effectively target and meet the mental health needs of specific communities:

Insert up to 2 examples of effective targeting of specific communities :
Example 1:
Transcultural Mental Health Services in New South Wales, Queensland and Western Australia include delivery of direct clinical services to CALD consumers. Investment in these services enables the needs of CALD communities to be addressed in a way that is cognisant of the complexity of cultural considerations in the assessment, treatment planning and recovery journey involved following mental illness.

• Statewide Transcultural Mental Health Services (in all of the states where they exist) have repeatedly demonstrated their capabilities in either being able to directly deliver or facilitate the development of local mental health service capability in meeting the needs of CALD consumers and their families/carers.

• Continued investment in Statewide Transcultural Mental Health Services is critical to enabling linkage of CALD consumers and carers to clinically safe mental health services both in acute and community care settings.

Example 2:
The newly released Framework for Mental Health in Multicultural Australia effectively strengthens the approach of Statewide Transcultural Mental Health Services. In addition, it enables states and territories where such services do not exist to develop a clear understanding and action orientated outcomes focused on meeting the needs of CALD populations that require effective and efficient culturally responsive mental health services.

6 An example of effective and efficient use of reporting:

Insert an example of effective reporting:
The NSW Government has developed an annual reporting framework via its Multicultural Policies and Service Program. The annual reporting requirement by all public health services is based on the NSW Community Relations Commission and Principles of Multiculturalism Act 2000.

Annual reporting provides a framework for planning for CALD communities in NSW and ensures accountability across all levels of service provision.

A similar whole of government approach is also currently in development in Queensland.

The example is New South Wales is one that could may have merit in being adapted and adopted across all states and territories in Australia.

Such an approach could form the basis for effective and efficient allocation of resources/reporting to meet the needs of CALD populations requiring efficient service access and effective mental health service delivery outcomes.

Such an approach could be feasible given that development of the Framework for Mental Health in Multicultural Australia has involved extensive national consultation and concept testing.

Such an approach would also enable transparent, efficient and evidence based analysis around value for money and the capability of mental health services in meeting the needs of CALD populations which now form over 27% of the population with this trend expected to increase.

7 An example of a service, programme, policy or initiative which is not subject to unnecessary red tape (e.g. approvals processes, extensive forms, reporting etc.):

Insert examle of avoiding red tape here.:
An example of an initiative in WA is the development of resources to assist clinicians and other service providers to work effectively with CALD consumers and carers (eg. Directory of Bilingual/Bicultural Mental Health and General Practitioners. This is a compendium of translated tests and inventories; and the publication of Transcultural Dialogue which highlights pertinent issues in this sector across WA.

Such an approach could be upscaled and shared nationally via MHiMA's online knowledge exchange mechanism. This mechanism is an easy way of sharing information nationally by sharing local expertise and knowledge and is not subject to unnecessary red tape as there are minimal approval processes/forms.

8 An example of effective monitoring of outcomes and experiences to drive service improvement:

Insert an example of monitoring and use of outcome and experience information:
In WA all monitoring outcomes are linked to the Department of Psychiatry's statistics collection mechanism.

In all states and territories consumer data is now recorded into a number of electronic patient information management systems. Currently there are examples of

small scale approaches to using data from electronic patient information management systems to drive service improvement.

MHiMA is currently in the process of negotiating a nationally consistent approach to enable effective monitoring of outcomes and experiences to drive service improvement on a systematic basis in every state and territory through utilisation of existing data collection in a number of targeted acute mental health inpatient units which will use the newly developed Framework for Mental Health in Multicultural Australia as a basis for driving service improvement that can be tracked against data that will rely on pre and post Framework implementation impact assessment focused on:

o CALD Consumer and carer experience of acute mental health inpatient units

o Acute inpatient mental health performance in areas such Length of Stay and re-admissions within 28 days

o Acute inpatient mental health performance in terms of Safety & Quality considerations e.g. misdiagnosis/treatment plans due to language/cultural barrier, utilisation of seclusion and restraint and medications management.

9 An example of meaningful involvement of people living with mental health problems and/or their families/supporters (for example, in the planning of services, decision-making, or feeding back views):

Insert example of meaningful involvement:
Involvement of CALD consumers with language and cultural barriers in providing feedback and/or service planning is vital.

For example CALD consumer facilitators has been utilised in Queensland. The CALD consumer facilitators are bilingual and trained to interview and/or conduct focus group discussions on agreed questions with consumers from their own cultural backgrounds.

Often work needs to be undertaken with bilingual consumers to ensure the questions are understood within their cultural contexts and beliefs about mental illness. This is an effective model in gaining input from CALD consumers who are usually excluded from mainstream processes due to language and cultural barriers.

In WA the Transcultural Mental Health Service has worked collaboratively with the WA Mental Health Commission and the WA Health Cultural Diversity Unit in organising a very popular seminar series called ‘Let’s Talk Culture’. This seminar is designed to meaningfully involve carers and consumers as presenters on topical issues in the sector. These seminars allow interactions with the broader community.

10 An example of clear public accountability for the outcomes of investment:

Insert example of clear accountability for outcomes:
All of the Transcultural Mental Health Services that currently exist have undergone numerous reviews for the purpose of establishing accountability for outcomes of investment. All of these reviews have not resulted in any criticism associated with poor investment outcome; and have repeatedly reinforced the value and need in investing in such service provision.

11 An example of regular and effective use of evaluation or research to inform evidence-based practice:

Insert example of use of evaluation or research :
‘Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion’ is a discussion paper produced by MHiMA as a spotlight report from the National Mental Health Commission. This discussion paper highlights significant data and research gaps around CALD focused mental health research which is also acknowledged by the Australian Bureau of Statistics and Australian Institute for Health & Welfare. There is evidence that this discussion paper is stimulating debate at national levels and is being at local service level to guide thinking around addressing data collection gaps and analysis of service delivery outcomes for CALD populations on a routine basis.

12 An example of effective workforce planning, development or training:

Insert example of effective workforce development or training:
In Queensland and New South Wales reviews of mental health service capacity based on demographic data has resulted in investment in workforce capacity to meet the needs of CALD populations requiring mental health services.

For example in Queensland this process resulted in recurrent investment in Multicultural Mental Health Coordinator positions in most area health services across that state. This capacity in terms of dedicated workforce has enabled effective local service planning, development and training resources to be developed.

13 An example of the use of technology to improve the experience or effectiveness of services:

Insert example of effective use of technology:
Tele-health and video conferencing facilities are regularly used in Queensland and Western Australia to facilitate state-wide access to the specialist services delivered centrally such as transcultural mental health workforce education initiatives or access to specialist clinical services delivered via bilingual workers. Mental health services across these states are able to make referrals to the state-wide transcultural consultation service and receive input from bilingual clinicians and/or cultural consultants in assessments and psycho-education with CALD consumers and their families and carers. This use of technology has been critical in enabling increased accessibility of effective interpreter services and culturally responsive clinical services to consumers in rural and remote areas.

14 Any other example of a service, programme, policy or initiative which has proven to be efficient and effective and has resulted in good outcomes for people experiencing mental health problems and/or their families:

Insert any other example of efficient and effective service, programme, policy, initiative:
Stepping out of the Shadows, a multicultural stigma reduction program aimed at CALD communities to challenge stigma and promote acceptance of people with mental illness is an initiative that is cost effective and able to reach grass roots communities via a community trainer approach that has demonstrated to have a

wide spread level of acceptance in CALD communities. This program was implemented nationally via a model of training expert trainers in most states and territories who in turn recruited and trained CALD community trainers enabling the program to be delivered in a range of languages. The program includes a DVD in 16 languages. This program can be scaled up again as a national program.

Evidence of the mental health 'system' NOT working well

1 Please provide an example of services, programmes, policies or initiatives (from your own experience or that of your organisation) which demonstrate or encourage inefficiency in organisation or delivery of services:

Insert example of inefficiency:
It is vital that mental health services are aware of and plan service capacity to meet their local consumer population group by actively engaging with them. Services that do not do this fail to fully comprehend the complexities of working with CALD populations.

Failure by general mental health services to consult specialist multicultural mental health services in a timely fashion often leads to delayed diagnosis, poor consumer and family engagement with health care services and premature termination of treatment.

As a result this results in ineffective service delivery and inefficient use of resources and capacity. Unpublished state and territory data in a number of states and territories has demonstrated that people from Non English Speaking Backgrounds tend to experience increased risk of hospitalisation compared to Australian born and/or people from English speaking backgrounds and longer lengths of stay and severity of mental illness.

In addition, poor management and planning of mental health services being able to meet the needs of CALD population increases avoidable extra costs and risk of adverse events e.g. around issues such as cultural and language barriers, medication mismanagement and increased need for acute inpatient hospitalisation.

2 An example of an inappropriate balance or prioritisation of funding:

Insert example of inappropriate balance or prioritisation of funding:
Lack of funding/consideration during mental health campaigns and resources with translations not built into the original budget or as an afterthought resulting in haphazardly/missed opportunities to achieve meaningful. For example when cultural appropriateness and readability is considered from the conceptual stage the investment and outcome is better for the whole community and can be cost effective in the long run. In addition the lack of nationally consistent clinically safe quality standards around translation and interpretation of materials in other community language is problematic as services such as Health Direct Australia cannot reliably put such information online.

Investing in mental wellbeing and or stigma reduction communication campaigns targeted at CALD populations getting assistance and/or help seeking at an earlier stage will enable a more positive experience of Mental Health services and programs and also positively enable CALD consumers to achieve a contributing life.

3 An example of where different services, programmes, policies or initiatives are not well integrated or don't communicate with each other:

Insert example of poor integration or communication between services/programmes/initiatives/policies:
There is less flexibility in the way clinical services are able to work across the continuum of care. For example, in recognising the major role for GPs but the minimal opportunity for community partnerships this has meant that service responsiveness and innovation in many parts of the country in relation to CALD mental health needs has been slow. Similarly this barrier also exists for other multicultural support services such as ethno specific and settlement services. Medicare Locals and initiatives such as Partners in Recovery are key opportunities that have the potential to address these types of critical gaps around integration and communication between services.

4 An example of the needs of the whole person not being effectively addressed or met (e.g. physical health, housing, education and training):

Insert example of not meeting needs of whole person:
There are a significant number of examples across the country around lack of holistic focus on consumer healthcare. For example consumers with complex needs having only a single health need treated in isolation from other chronic health conditions such as diabetes. This approach is particularly problematic when clinical services are only intent on focusing on medication issues rather than the psychosocial support and the general mental health literacy capability of the consumer as whole.

5 An example of practices which result in people living with mental health problems and/or their supporters having a poor experience:

Insert example of poor experiences:
Often the lack of English proficiency means that people from CALD backgrounds are perceived as less cooperative. This perception tends to arise due to a lack of cross cultural competency and awareness in the mental health workforce. Such an experience is often made worse and compounded where carers are shunned from the overall care of the consumer and/or due to the lack of availability of bilingual or culturally responsive staff being employed by mental health services.

6 Up to 2 examples of services, programmes, policies or initiatives where the specific needs of particular communities are not effectively recognised or met:

Insert example of not meeting particular needs of specific communities:
Example 1:
The lack of translational CALD mental health research is in an inhibitor for services which are interested in addressing service gaps through utilisation of contemporary evidence-based research practice. Better coordination and governance around evaluation and research would assist in supporting creativity and

innovation in terms of CALD mental health service planning, allocation of resources and routine review of service delivery outcomes.

Currently many programs are tasked/funded to work with CALD communities but are not resourced or supported to undergo routine evaluation. Investing in resources in evaluation and impact on a routine basis would enable acknowledgement and improvements in their expertise in developing services that can effectively and efficiently demonstrate the value of their work with CALD communities.

Example 2:
The lack of a nationally agreed approach or concerted policy focus around improving cultural responsiveness in mental health services and workforce capability strategies to meet the needs of CALD consumers and carers noting the increased population diversity that Australia will be facing for the foreseeable future.

7 An example of excessive red tape (e.g. unnecessary and burdensome reporting requirements taking resources away from service delivery):

Insert example of excessive red tape:
Nil response.

8 An example of failure to use outcomes monitoring as a quality improvement tool:

Insert example of failure to use outcomes monitoring:
The lack of involvement of specialist multicultural mental health services in the development of some tools results in there not being relevant/appropriate outcome measures around mental health system performance for CALD communities. The inherent risk of this approach is that whilst overall mental health system performance maybe improving the gaps between those population groups that are most vulnerable or at risk of being underserviced are at risk of being left further behind. As such this further entrenches marginalisation, discrimination and diminishes the chance of CALD communities having the comparable opportunities of being able to lead a positive and contributing life.

9 An example of failure to meaningfully involve people who use services in their design or delivery (e.g. by incorporating their feedback):

Insert example of failure to meaningfully involve people:
CALD consumers and families are frequently excluded from formal consultative processes due to perceived logistical and cultural barriers. In addition there are no mentoring or development programs to develop the CALD peer consumer workforce or to develop cultural competency/responsiveness of the peer consumer workforce.

10 An example of unclear or opaque accountability for outcomes:

Insert example of unclear accountability for outcomes:
Generic feedback around mainstream mental health services often fails to identify service and outcome gaps if population data and future demographic trends are not considered. Often where there is an attempt to consider the needs of CALD populations the integrity of cultural and language demographic data is de-prioritised by ‘the system’ due to upfront cost considerations which in itself is a ‘false economy’ as subsequent outcomes around effectiveness and efficiency of mental health services meeting the needs of CALD populations become even more unclear and opaque.

In addition, whilst there are the National Mental Health Standards there is no requirement to prove mental health services are meeting these accountabilities.

11 An example of a locality/area where there is duplicated provision of services or programmes:

Insert example of a locality or area where there is duplicated provision:
Nil response.

12 An example of an area, state or territory where there are gaps in services or programmes:

Insert example of area where there are gaps in service provision:
Across rural and remote areas there is a lack of programs that can effectively service the mental health needs of CALD population groups.

13 An example of where research activity is poorly prioritised, funded or organised:

Insert example of poorly prioritised research activity or failure to translate research into practice:
There is an unacceptably low paucity of quarantined funding to research the needs of almost one third of Australia’s CALD population.

The Garrett et al. 2010 study which reviewed Australian health care research articles, found that out of a total of 4146 articles published during the period 1996-2008, only 2.2% were primarily concerned with multicultural issues. As such it appears that CALD populations and their needs are not a priority.

Research efforts around CALD Mental Health issues are currently not prioritised. One immediate area that could be addressed is investing research into existing CALD mental health initiatives in order to build a robust evidence base around approaches that work/that could be further improved and scaled up across Australia based on clear evidence.

14 An example of poor use or planning of workforce/human resources:

Insert example of poor planning or use of human resources:
1800 and similar contact numbers are poorly resourced to meet the need of CALD consumers. It is not just access to interpreters but low level of staff cultural knowledge and skills. Inconsistency in the planning and operationalising of these services results in access issues for CALD communities. These service access barriers are also further compounded by the continued ‘silo’ basis in which services operate. This approach makes it difficult to form partnerships that allow

seamless service delivery catering to a variety of psycho-social needs. This is a significant disadvantage to CALD consumers who have many such issues.

15 Any other example of a service, programme, policy or initiative which has proven to be inefficient or ineffective and has not resulted in good outcomes for people experiencing mental health problems:

Insert any other example of inefficient or ineffective service, programme, policy or service:
There are many examples where a holistic recovery and person-centred approach are not used to enable the consumer's recovery. There are also examples of the input of carers/family members in the recovery of a consumer not being heeded. As such this can result in a poor outcome or relapse of the CALD consumer. In addition not spending the time to explain to CALD family members/carers the diagnosis, treatment (and it's importance) and side effects of medication are also highly problematic.

Actions Needed for Change

1 One practical step to improve things in the mental health system would be:

Insert first practical step:
Utilisation of the Framework for Mental Health in Multicultural Australia by Local Health Networks (LHNs), Medicare Locals (ML's), Headspaces & Program of Assistance for Survivors of Torture and Trauma (PASTT) is vital in ensuring that all consumers and carers from a CALD background can access culturally responsive mental health services.

It is anticipated that there will be many positives benefits in uptake and utilisation of the Framework in terms of reduction in long term costs with mental health services becoming more responsive to CALD consumer, carer and community needs in a recovery and person-centred manner. The Framework also has the capacity to be a transparent and cost effective quality improvement mechanism that is integrated with existing metnal health service accreditation requirements. As such it is envisaged that the Framework will create the capacity to incrementally and sustainably address the gaps around effective and efficient delivery of mental health services for CALD consumers, family members and carers.

2 A second practical step to improve things in the mental health system would be:

Insert second practical step to improve things:
Strengthening the capacity and resources for CALD consumer and carer participation nationally. This is critical because it is still largely a social taboo for CALD consumers and carers to discuss mental illness. For far too long, CALD consumers and carers have been disenfranchised and marginalised through Government policies both at State and Federal levels. This has created a disempowered group who treat mental illness as a shameful and stigmatising topic.

MHiMA's CALD consumer and carer participation nationally aims to address the above. MHiMA has been doing so through their "Digital Storytelling Project" by using the members of Consumer and Carer Working Group members to respectfully tell their stories.

MHiMA also held a Symposium at the Gold Coast in November 2013 to highlight the value of CALD consumer and carer participation as well as the key challenges and opportunities that needs to be addressed in Australian in relation to multicultural mental health.
A commitment at State and Federal government levels is imperative to ensure the future of CALD consumer and carer participation which is inclusive across all levels of the mental health system in Australia.

3 A third practical step to improve things in the mental health system would be:

Insert third practical step to improve things:
Better data collection and measurement of service impact/outcomes for CALD communities is vital. This step can be practically achieved through prioritising key recommendations from the Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion discussion paper that MHiMA produced for the National Mental Health Commission (NMHC) as a Spotlight Report.

Your Views on Mental Health Programmes Funded by the Australian Government

1 Do you/your organisation have an interest in commenting on Commonwealth-funded mental health programmes?

Yes (please continue below)

2 IF YES:Please indicate the programme/s you wish to comment on.

Better Access to Psychiatrists, Psychologists and GPs under the Medicare Benefits Schedule, Access to Allied Psychological Services (ATAPS), headspace, Partners in Recovery, Personal Helpers and Mentors (PHaMs), National Suicide Prevention Programme

Other:

3 Please briefly explain your involvement with the programme/s (e.g. as a provider, stakholder, consumer, family member, carer, professional, administrator etc.)

Your involvement in the programme or programmes:
Comments made in relation to Better Access, ATAPS, headspace, Partners in Recovery, PHaMs and the National Suicide Prevention Program are made by MHiMA as a national stakeholder body. The views expressed have been informed by feedback from the MHiMA Consumer & Carer Working Groups and state based Transcultural Mental Health Services in New South Wales, Queensland, Victoria and Western Australia.

4 Please indicate in which state(s)/territor(ies)/town(s)/area(s) your involvement is or has been (or if national, state 'national').

indicate geographical area(s) of involvement:
Involvement in programs is informed by state and territory experiences and demonstrate the variability in outcomes and effectiveness in meeting the needs of CALD populations across Australia.

5 Please describe what, in your/your organisation's experience, has worked well with this/these programme/s. Please include brief concrete example/s of good practice. You may wish to comment on issues such as programme design, funding, local implementation, accountability, reporting, outcomes monitoring, evaluation, red tape (over-regulation), gaps in provision, or communication between services or programmes.

what has worked well with these programmes:
There has been variable experience nationally in terms of the effectiveness of PHAMS. An example of where PHAMS works well is in WA where the WA Transcultural Mental Health Service refers many consumers to this program. It is a program that is heavily used by CALD consumers as it provides a personalised support service enabling relationships to be built and time is afforded for this. PHaMS should ideally be well utilised in the rural and remote regions.

6 Please describe what, in your/your organisation's experience, has NOT worked well with this programme/ these programmes. Please include brief concrete examples. You may wish to comment on issues such as programme design, funding, local implementation, accountability, reporting, duplication, red tape (over-regulation), gaps in provision, or communication between services or programmes.

aspects of programme or programmes not working well:
Better Access – while an excellent initiative, continues to have significant access barriers for CALD people with language barriers exist as allied health in private practice do not have access to interpreting services via the commonwealth translating and interpreting service (TIS). As such this restriction excludes those with a language barrier from this service.

While ATAPS was in part established to facilitate access to psychological services for hard to reach population groups such as immigrants and refugees, in reality this has not happened as decisions on whether interpreters are funded as part of ATAPS is a local level Medicare Local decision. Some Medicare Locals do not fund interpreters citing the limited funding available in ATAPS to meet community needs.

Both Better Access and ATAPS have the potential to be effective programs for hard to reach groups such as CALD people as they are primary care based programs. However, due to a variety of issues including language and cultural barriers, stigma, and somatization, GPs often do not identify mental health issues in their CALD patients. Some GPs have been quite upfront about their reluctance to “lift the lid” on mental health issues for CALD consumers as they know there are limited referral pathways for their CALD patients.

Partners in Recovery has to date not delivered improved access to mental health support for CALD consumers as it appears to be another linkage or “facilitated referral” type of program to existing services rather than providing new services that fill existing services gaps for CALD consumers. There appears to be duplication between the case manager role of a public mental health service and that of the PIR program facilitators.

Headspace has similar barriers to mainstream mental health services in that there are limitations in its model that do not facilitate effective engagement with CALD young people such as lack of outreach and inability to access interpreting services. While there are some examples of good cross cultural practice around the country, these are isolated examples, and in the main Headspace has yet to effectively engage in the issues of multicultural mental health for CALD young people.

The National Suicide Prevention Program to date has had little impact on the CALD population. Funding dedicated for this in the past has been minimal and only resulting in ‘training’ from which outcomes have yet to be measured.

7 Please describe what specific actions, in your/your organisation's view, would improve the design, delivery, or operation of this programme/ these programmes in future.

specific actions to improve this programme or these programmes:
It is recommended that negotiations occur with TIS to enable access for allied health to deliver services under Better Access.

It is the experience of many Transcultural Mental Health Services that when they when advocate to GPs for a referral for their patient to ATAPS and request that an interpreter be provided that many GPs refuse to make referrals to ATAPS. The excessive red tape and paperwork and a reluctance to be involved in any Medicare Local program due to being constantly being asked to complete paperwork once referrals are made are cited as regular examples for why GPs are reluctant to facilitate referrals to ATAPS. Similar complaints have been made by practitioners who are ATAPS providers who have complained about the paper work impost on their time. Reductions around red tape to enable improved CALD service access to ATAPS would be extremely helpful.

In addition, it is recommended that consideration be given to increasing the number of eligible sessions for particular at risk groups such as refugees to 15 sessions. The current cap of 10 sessions is inadequate when dealing with a population group that has low levels of mental health literacy, compounded by issues that require additional time such as engagement, psycho-education and language support. Such changes will have significant impact on being able to engage CALD consumers in their care. The possibility of this being outcome being achieved would be further enhanced if bicultural health workers receive the same status as Aboriginal health workers under the MBS.

Improvement in the Suicide Prevention Program should be possible through adoption and support for the Suicide First Aid guidelines for helping a person from an immigrant or refugee background that are currently being developed by MHIMA. Resources for ‘train the trainer’ gatekeepers education will be created. It is envisaged that delivery of this resource will enable development of culturally-sensitive suicide education and resources and useful resources for use by different stakeholders (e.g. health, education, non profit and community sectors).

Your Views on Special Issues

1 Do you (or your organisation) have an interest in commenting on any of the following issues?

Mental health in rural and remote Australia (please answer question 3 below), Mental health research (please answer question 4 below), Mental health workforce development and training (please answer question 5 below)

2 What is your/your organisation's view about the current provision of support for Aboriginal and Torres Strait Islander people's mental health?

Views about Aboriginal and Torres Strait Islander mental health:
Nil response.

What specific action or strategy do you think has the potential to improve this?:
Nil response.

3 What is your/your organisation's view about the current provision of mental health support in remote and rural Australia?

Views on rural and remote mental health support:
The needs of CALD population groups in rural and remote areas are not at all prioritised or considered.

What specific action or strategy do you think has the potential to improve this?:
Determining the needs is a starting point where a scoping study or needs analysis can be conducted.

4 What is your/your organisation's view about the current funding, organisation and prioritisation of mental health research?

views on mental health research:
Investment in mental health research is limited and there is no national research agenda in place in relation to CALD Mental Health.

In addition, MHiMA has received several examples where research proposals have been rejected by research funding bodies due to costs with associated translation and interpreting.

What specific action or strategy do you think has the potential to improve this?:
Development of CALD Mental Health research capacity building initiatives involving the ARC and NMHRC would be a critical first step in addressing the inadequacies around CALD Mental Health research in Australia.

There needs to be a clear commitment to investing funding in research that enables the inclusion of CALD communities in a practical and meaningful. It is essential that investment in research is translational and enables improvements in mental health system performance meeting the needs of CALD communities.

5 What is your/your organisation's view about the current way mental health workforce development and training is carried out in Australia?

views on workforce development and training:
Currently there is little emphasis on employment policies promoting diversity reflective of the local demographic hence this cost neutral strategy works against more effective diversity responsiveness.

As such Australia requires a mental health workforce that is able to respond to the diversity of the Australian population. The principles of cultural and linguistic diversity are espoused by numerous national and state and territory level policy, form part of service accreditation standards as well as the curricula of many mental health education courses and programs.

However, the current operationalisation of these principles in the mental health sector are at best ad hoc and focus little beyond the entry level standards outlined by the National Standards for Mental Health Services 2010. Cultural and linguistic diversity is viewed by many in the sector as an additional burden in what is already a highly stressful and heavy workload for services and individual workers alike, rather than a part of integrated care delivery and generally the benefits of integrating cultural competency training in mental health within current curricula is not well understood.

What specific action or strategy do you think has the potential to improve this?:
• Adoption nationally of MHiMA Framework for Mental Health in Multicultural Australia by mental health services and individual workers as an ongoing quality improvement process to guide culturally responsive service delivery.

• The support of MHIMA's work in the development of a draft national multicultural mental health workforce strategy to facilitate and embed cultural competencies as a required skill set of the mental health workforce through education and ongoing training opportunities.

Upload Extra Documentation

1 If you have any further comments, please briefly state them in the box below or use the link to upload further documentation relevant to the review.Please note that although we will attempt to include this documentation in our anlaysis, we will place most importance on the responses you have provided in this online survey.

Further comments:
MHiMA Strategic Plan:
http://www.mhima.org.au/about-us/strategic-directions

MHiMA Discussion Paper 'Spotlight Report' for National Mental Health Commission:
http://www.mentalhealthcommission.gov.au/our-work/spotlight-reports.aspx

MHiMA Framework
www.mhima.org.au/framework
Note that the MHiMA Introductory Guide is attached to this submission.

Please use the link to upload further documentation:
https://consultations.health.gov.au/national-mental-health-commission/2014_mh_review/consultation/download_file?squid=question.2014-03-20.2259658684-filesubquestio