Government of **Western Australia**
Department of **Health**

Multicultural Mental Health Sub Network Establishment Report

Including outcomes of the Multicultural Mental Health Sub Network inaugural Open Meeting

20 June 2016

better health ▪ better care ▪ better value

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Executive Summary

Multicultural Mental Health Sub Network

The Mental Health Sub Networks were established to support the Mental Health Network (MHN) in engaging with and delivering outcomes for specific cohorts of mental health service users.

This report outlines the process of establishment of the Multicultural Mental Health Sub Network Steering Group, with a focus on the outcomes of the Open Meeting that will inform the Group's work.

Open Meeting

The MHN in conjunction with the Mental Health Commission (MHC) hosted the Multicultural Mental Health Sub Network Open Meeting on 20 June 2016.

The Open Meeting was attended by 68 people, including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The Open Meeting program is available in Appendix A.

The panel members spoke to a number of issues and possible solutions highlighting the following:

- Empowerment through knowledge.
- Challenges of dealing with adversity across different cultures.
- Impact of intergenerational trauma.
- Improvements to access and coordination of services.

The workshop session captured the common issues raised by participants, as identified by the Open Meeting facilitator:

- Limited provision of culturally and linguistically appropriate information, especially lack of funding and access to interpreters.
- A need for more effective involvement of culturally and linguistically diverse (CaLD) communities, consumers, carers and workers in the co-production and implementation of services (e.g. CaLD trainers).
- Establishment of a centralised coordinating function to address navigation challenges for CaLD clients and services, potentially a centralised Transcultural Unit or Centre of Excellence.
- Need for cultural competency education, upskilling and training to build awareness of issues faced by cultural groups, address cultural assumptions and reduce stigma.
- Inadequate funding commitments or models that don't deal with cultural complexity; uncertainty around ongoing sustainability of services.
- Impact of changes associated with new National Disability Insurance Scheme (NDIS) systems and arrangements.
- Need for an increased focus on the social determinants to mental health, particularly employment and housing factors.
- Geographical location and public transport issues for effectively accessing services
- Increased need for advocacy and community awareness raising for CaLD mental health needs.
- Better CaLD specific support networks and programs required.

- Need for increased research and data on CaLD specific mental health experiences, access issues and consumer outcomes.
- Culturally sensitive approaches and language required for addressing CaLD specific experiences of trauma, identity formation and cultural dilemmas.

The workshop included an opportunity for the participants to nominate which issues and gaps they considered to be highly important. The two most highly rated items were:

- Hub and Spoke model (of a centre of excellence providing a statewide service) to ensure access geographically for all.
- Information overload for consumer.

The themed outcomes from the workshop session are outlined under Workshop outcomes with the detailed participant input, including the rating, available in Appendix B.

Steering Group

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN Executive Advisory Group for final approval. A list of the Inaugural Steering Group for the Multicultural Mental Health Sub Network is available in Appendix C.

The information collected from the Open Meeting workshop will be used to guide the Multicultural Mental Health Sub Network Steering Group in the development of their work plan and to inform and support the MHC in the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Multicultural Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health on the planning of health services.

Introduction

Mental Health Network

The establishment of the Mental Health Network (MHN) was undertaken by the Department of Health with the support of Professor Bryant Stokes, Acting Director General, Department of Health in partnership with Mr Timothy Marney, Mental Health Commissioner, Mental Health Commission (MHC).

The MHN was launched during Mental Health Week in October 2014. The MHN is led by Co-Leads Dr Helen McGowan and Ms Alison Xamon.

The MHN Executive Advisory Group (EAG) membership includes consumer and carer representatives as well as representatives from the Department of Health, MHC, Office of Mental Health, Primary Care, Mental Health Clinician Reference Group, Office of the Chief Psychiatrist, Western Australian Primary Health Alliance (WAPHA) and the Western Australian Association of Mental Health.

The objective of the MHN EAG is to support and guide the MHN to undertake the following:

- Contribute to improving the mental health and wellbeing of Western Australians.
- Draw upon a community of practice approach to share information, engage with the sector and community, foster collaboration and develop partnerships.
- Engage with organisations and individuals to support innovation and change.
- Develop an agreed set of strategic priorities across the mental health sector.
- Promote system change including continued development of a person-centred and recovery orientated culture, with better integrated and connected services.
- Promote adoption of recognised best practice across the sector.

The Mental Health Sub Networks structure was created to support the MHN to meet these objectives.

Mental Health Sub Networks

The Sub Networks are intended to focus on the needs of a particular cohort, be task orientated and to deliver products by bringing together the right people, from the community sector, Health, consumers, carers and other interested parties. A structured approach was taken to engagement and the establishment of each of the Sub Networks.

A prerequisite to the establishment of each Sub Network included confirmed sponsorship from a health service, identified co-ordinators and support of key stakeholders within the sector prior to progressing the development of the Sub Networks.

The MHN Co-Leads took a leadership role in networking with individuals and organisations to identify and establish the Sub Networks.

An Implementation Group of key stakeholders was then formed to assist in the organisation of an Open Meeting, including the selection of appropriate panellists to provide snapshots of key sector issues. The aim of the Open Meeting was to give the broad community the opportunity to actively participate in the formation of the Sub Network and provide critical input to shape its priorities moving forward.

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

Each Mental Health Sub Network Steering Group is required to have representation from:

- consumers
- carers or family members
- community managed organisations
- public community mental health services
- inpatient public mental health services
- inpatient and community private mental health services
- primary health services
- agencies delivering prevention and promotion programs and initiatives
- MHC
- mental health professionals from a range of disciplines including:
  - peer workers
  - allied health
  - nursing
  - medical
  - psychology
  - psychiatry
- individuals and agencies working in regions across the state including:
  - rural and remote and metropolitan districts/regions (particularly relevant for cross-sectoral working groups)
- individuals and agencies working with different age cohorts (relevant for cross-age cohort working groups), including:
  - infant children
  - adolescents
  - youth
  - adults
  - older adults
- the sponsoring organisation.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN EAG for final approval. In order to keep the Steering Groups at workable sizes, applicants were selected on the basis of their ability and willingness to represent the concerns of multiple cohorts.

A list of the Inaugural Steering Group for the Multicultural Mental Health Sub Network is available in Appendix C.

Multicultural Mental Health Sub Network Open Meeting

Stakeholders for multicultural mental health services in Western Australia met for the inaugural open meeting of the Multicultural Mental Health Sub Network at NIB Stadium, East Perth on 20 June 2016.

A total of 68 people attended the Open Meeting including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations.

- 91 people registered to attend the Open Meeting.
- 68 people attended the Open Meeting (75% of those that registered).
- 56 organisations were recorded as having representatives at the meeting.

Open meeting process

The energy and good will demonstrated throughout the establishment of the Multicultural Mental Health Sub Network continued to develop momentum throughout the Open Meeting.

The Open Meeting program is available in Appendix A.

Following the acknowledgement to country given by Mental Health Co-lead Ms Alison Xamon, the Open Meeting heard overviews from Dr Helen McGowan, regarding the MHN; Mr Timothy Marney presented Mental Health – The Big Picture, and Ms Beth Franca gave an overview of the Multicultural Mental Health Sub Network.

Panellists recommended by the Multicultural Mental Health Sub Network Implementation group then shared snapshots of key issues and perspectives in the multicultural mental health sector.

The outcomes of the panel discussion and workshop session as captured by the facilitator are themed and summarised below.

Panel discussion

The Panel consisted of representation from the following perspectives:

- Consumer — Mr Julio Neto
- Psychiatrist, ASeTTS — Dr Sue Lutton
- Clinical Psychologist — Dr Bernadette Wright
- Non-Government Organisation (Ruah) — Ms Siobhan Burka

The following points were captured by the facilitator during the panel session:

- We need to understand the system as consumers to coordinate our own recovery well, having the knowledge is important to recover faster ourselves and then educate other people in the same situation.
- It's critical that CaLD representatives are involved in informing care and service delivery:
  - the concept of dealing with adversity is different in different cultures; shame and stigma exists around having a family member with a mental health condition
  - trusting government health staff is also a different concept for different cultures.
- I hope the Sub Network can help to better educate services of cultural differences like language barriers, settlement issues and individual vs collective cultures.
- We must aim for culturally appropriate models, language support programs, cultural competency training, management support and CaLD consumer engagement.
- Working with trauma requires an environment of safety and good communication:
  - creating links with Centrelink and Housing is essential for safe environments
  - we need interpreters as the norm, not the exception, and not just phone interpreters
  - over-prescription issues exist, so working with pharmacies to ensure English language labels are properly translated or truly understood is really critical.
- Trauma is very complex and we need good quality culturally evaluated assessments:
  - we need to educate GPs, overseas trained doctors and mental health clinics
  - a holistic approach is required which needs to include trauma counselling and community based services.
- Children of refugees from traumatic experiences with culturally isolated parents are critical to support if we're to avoid intergenerational trauma:
  - we need to work with these groups and be aware of any parallel processes that we might be creating unconsciously through other agencies.

- We need better coordinated and more responsive services through a genuine holistic model of care, central coordinating unit to direct consumers and carers to appropriate services and guide clinicians:
  - look to build on what works well and reduce duplication.
- Better engagement of services through a community education and engagement initiative is critical.
- Better information and the need for evidence based planning as data continues to be lacking nationally in this space; shouldn't just be confined to language services data.
- Current systems are complex and difficult to navigate, even for carers and support workers; hope that the Network can improve access and timely delivery of services through sharing of best practice information:
  - reduce silos and further broaden inclusion through a transcultural central unit that can translate the Network's outcomes.

Following a networking break the meeting resumed with a workshop session facilitated by an external provider.

Workshop outcomes

Participants were asked to consider the panel presentations and take into account their own knowledge and experience of the sector to answer the following questions:

- What do you see as key issues, challenges and gaps in service delivery that are still to be resolved in the multicultural mental health space?
- For this issue, what potential solutions would you propose?

Responses were shared in real time via GroupMap - allowing cross pollination of ideas from all participants. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The following points were captured during the workshop session by the facilitator, summarised and themed:

Limited provision of culturally and linguistically appropriate information, especially lack of funding for, and access to, interpreters:

- Information overload for consumer - which is worsened for people who speak English as a second language (if at all).
- How is it ensured the consumer understands what is being said and what alternative methods are being used or could be used (including the use of appropriate interpreters)?
- Use of interpreters is essential and greater funding would be good; hard to keep up with new dialects and new and emerging communities.
- Quality of interpretation is important.
- Access to interpreters can be a challenge in terms of having an interpreter for a particular dialect available.
- General Practitioners (GP) not using interpreters; GPs should report on the number of times that they've organised interpreters.
- Funding for interpreters in all service models for mental health care, especially onsite.
- Inadequate access to onsite interpreters who are trained in mental health.
- Limited CaLD consumer and carer participation due to language difficulties and culturally inappropriate participation formats.
- Need specialised interpreters for mental health sessions and / or counselling.
- No, or limited, multiple language mental health information pamphlets.

- Small communities have difficulty with interpreters not being available for their language or available in a small cohort.
- Strong training of interpreters, including new interpreters is needed, specifically in the area of mental health literacy.
- Service directories must be available as audio and YouTube.
- Lack of information provided regarding current medical and clinical treatments.

A need for more effective involvement of CaLD communities, consumers, carers and workers in the co-production and implementation of services (e.g. CaLD trainers):

- Nothing about us, without us - decisions about CaLD mental health are principally being made by people of non-CaLD background.
- Tap into expertise of elders of the various CaLD communities, encouraging these leaders to have a voice, with methods or strategies put into place and linked to communities they are trying to help.
- Co-production seems to fall away quickly with multicultural clients; additional training and understanding is required.
- Mentoring support to promote the participation of consumers and carers from ethnic minority groups.
- Co-production of services to hear the consumers' voice, to acknowledge consumers as the expert in their care and support, and for people in the sector to learn.
- Community engagement is small and limited.
- For the mental health sector to employ multicultural workers and multilingual workers.
- Organisations to have culturally diverse representation in their workforce, including bi / multilingual.
- This forum, regrettably, does not reflect the cultural and linguistic diversity of the state, so all decisions that need to be made from today's forum should be referred to advocacy bodies such as the Ethnic Disability Advocacy Centre (EDAC) and the Ethnic Communities Council of WA (ECCWA) and service providers such as Association for Services to Torture and Trauma Survivors (ASeTTS), Fremantle Multicultural Centre (FMC) and Multicultural Services Centre of WA (MSCWA) before being implemented to ensure empowerment and ownership.
- Training is not usually conducted by CaLD people; training is conducted by Anglo-Australians (who may not know the cultural or linguistic aspect of that group of people), rather than trained CaLD workers.
- We appreciate partnership but CaLD people want to, and have the capacity to, take the lead.
- What is the capability for community leaders to navigate mental health issues within their community?

Establishment of a centralised coordinating function to address navigation challenges for CaLD clients and services, potentially a centralised Transcultural Unit or Centre of Excellence:

- Services unable to keep track of what services are available in their areas, especially with new and expanding services.
- Access of services and navigation of services that should not act in isolation. This leads to disjointed service delivery.
- Outreach, referral, directory or pathway through common steps of immigration and resettlement.
- Poor referral pathways.
- 'Hub and spoke' model to ensure access geographically for all; managed by a board to inform governance and strategic direction of the body.
- No wrong door approach.

- Service delivery will not be optimal without a centralised unit, which will lead inadequate care.
- Centralised units will be more holistic and effective.
- Need a centralised Transcultural Unit.
- Commitment to a state-wide mental health multicultural service including migrants, humanitarian entrants and intergenerational CaLD.
- One stop shop in government that is a holistic wellness centre (within government services) as a central resource service with evidence based practice.
- Central unit that delivers health and mental health service that is holistic and integrated covering the lifespan.
- Establishment of a centre of excellence that integrates research, interagency collaboration, prevention and intervention.
- Central database system for the broad range of stakeholders (e.g. forensics, police, mental health, medical etc.) to reduce people having to retell their story repeatedly (similar to the UK model).
- A state-wide transcultural mental health service must be governed by a representative, high-level body of key stakeholders, comprising Office of Multicultural Interests, Department of Health population and mental health, MHC and private sector in order to weather the storms of what's popular or the buzz words and focuses of funding bodies at that particular time.

Need for cultural competency education, upskilling and training to build awareness of issues faced by cultural groups, address cultural assumptions and reduce stigma.

- The State Government Substantive Equality Policy, the Language Services Policy and the Multicultural Services Charter are clearly not being reflected in the service provision to ethnic minorities.
- Service that works with mainstream to upskill service providers working directly with clients.
- Limited GP knowledge of issues and what is available in the community.
- Community education on respect for diversity and making communities safe.
- Education is critical at all levels - family education, clinician education, school education.
- Educate on culture, beliefs, values and traditions.
- Increased health literacy, and speaking and understanding English for older multicultural people; provide access to English language lessons to try and reduce language barrier.
- Challenges in assumptions around the identification of culture, language and identity.
- Create a new language and memorandum of understanding on the centrality of notions of soul and spirit, and expansion of best practices to include concepts of aligned practices.
- Essential cultural competency training for all mental health service providers from clinicians to administrators and cleaners.
- Stigma reduction and mental health awareness needed.
- Better understanding of what people have left behind in their countries.
- Those in the public systems need to have better understanding of cultural differences.
- Relationships between clinicians and consumers, and problems regarding language and cultural barriers.
- Importance of introducing linguistics during early development in schools (Piarra Waters school as a model).

Inadequate funding commitments or models that don’t deal with cultural complexity; uncertainty around ongoing sustainability of services:

- More culturally appropriate action and funding.
- Been here before, lots of talk over the years with no action or funding.

- Activity based funding models do not align well with the complexity of issues that people with CaLD backgrounds may often present with, which potentially has a negative impact upon access to services moving forward.
- Individualised Community Living Strategy (ICLS) funding is not adequately accessed by CaLD consumers; this needs to be rectified.
- The MHC observation of the significant prevalence of mental health issues within ethnic communities is not matched by the levels of funding that are required to address them in a culturally and linguistically diverse way.
- Challenge around the competing demands of convenience and efficiency within busy health services and accessing appropriate resources to assist in the care and support of people from CaLD backgrounds.
- No long term funding means new guidelines each time funding is renewed.
- Increased sustainability of programs, services and funding should be the responsibility of the government.
- Woefully inadequate funding to address suicide prevention within ethnic communities.
- Less talk, more action.
- Need for senior management and executive level commitment to continuously develop and expand culturally diverse services beyond tokenism.
- The sustainability of sub-acute clinical service delivery remains uncertain.
- Inadequate funding for torture and trauma.
- Competitive environment limits partnerships and communication.
- Lower access to primary mental health and higher levels of involuntary admission reflects systemic discrimination in terms of funding.
- Perinatal depression either discontinued or inadequately funded.
- Mental health systems are already under stress, as are the people working within them.

Impact of changes associated with new NDIS systems and arrangements:

- NDIS does not provide funding for training and relationship development.
- NDIS new systems are just trying to understand mental health let alone cultural difference.
- Impact of the NDIS and navigating this; telling stories and accessing relevant, suitable and individual support.
- Gap in clinical services for co-morbid cognitive delay and mental health disorder / alcohol and drug abuse.
- Gaps in diagnostic processes for those with undiagnosed mental health conditions and disability.
- Gaps in supporting people with multiple diagnosis (disability and mental health) and comorbidity alcohol and other drugs (AOD).

Geographical location and public transport issues for effectively accessing services:

- Public transport routes currently don't generally assist people to access services in the community.
- The geographic location of hospitals and non-government organisations (NGO) is a barrier magnified by transport systems.
- Distribution of CaLD populations is diverse and varied in itself, in terms of geographical locations.

Increased need for advocacy and community awareness raising for CaLD mental health needs:

- Independent advocacy that is culturally responsive.
- Community is unaware of what's available.
- Lack of promotion for wellbeing and recovery language.

- Advocacy work is critical.
- A compassionate society.

Need for an increased focus on the social determinants to mental health, particularly employment and housing factors.

- Whole of government response is necessary.
- Employment access for CaLD people.
- Centrelink to use interpreters also and provide more information.
- Wellbeing is about connection to communities of choice, housing, relationships and employment.
- Bullying, prejudice and discrimination within employment and access to health within communities.

Better CaLD specific support networks and programs required:

- Whole of service system directory be funded by the State.
- Community support for families with mental health or trauma consumers.
- Cultural health workers are needed (similar to other states).
- Program - circle of security groups with interpreters and culturally safe delivery models.
- CaLD clients not feeling welcome at the service.
- Ongoing support and the client being constantly informed of the care plan and process.
- Support networks for new arrivals through provision of liaison teams to translate mental health awareness, communication and support pathways in Australian services.
- More support networks needed.
- Treatment, support and discharge needs to be provided in a culturally approach manner.
- Balance between accessing services generally for people from CaLD backgrounds vs the need for specialist CaLD services to address needs.
- Issues such as domestic violence not being considered in the relationship with mental health (e.g. services being very specific with criteria).
- Drug and alcohol / mental health to be the expectation and to be planned for.
- To better address mental health issues in prevention and early intervention.
- Lack of infant and early years work with mothers on attachment.
- Culturally appropriate accommodation for CaLD mental health consumers, with support workers onsite.

Need for increased research and data on CaLD specific mental health experiences, access issues and consumer outcomes:

- Need for increased data around issues of access and identification for people from CaLD backgrounds for the purposes of local evidence.
- Lack of mental health research dealing with CaLD population groups.
- Specific evaluation frameworks established for assessing services and measuring consumer outcomes for CaLD consumers.
- Examination of mental health disorders ensuring state of the art examinations, and valid and reliable measures (world standards).

Culturally sensitive approaches and language required for addressing CaLD specific experiences of trauma, identity formation and cultural dilemmas:

- ‘Retreat for spiritual cleansing' instead of ‘checking in’ to mental hospital.
- Navigating through potential identities and making choices to create self when there was no choice before and limited guidance of what it means to be an Australian.

- Families from diverse cultural backgrounds with their children born in Australia, have some children that face a divided process of developing an identity to this place and this time which may be in conflict with their parents' expectations.
- Ever changing multicultural community with new groups and issues coming in.
- More willingness to consider whole of person and living condition rather than just 'brain chemicals'.
- People should not need to lose their culture nor identity coming to Australia.
- Trauma informed practice is needed as a standard.
- Additional time required for consultations with CaLD clients.

The detailed participant responses are available in Appendix B.

Issues rated highly by participants

Participants were invited to identify the issues they believed were important by using the 'like' indicator in GroupMap. The points below are the issues and gaps identified by the wider group of participants as highly important.

- 'Hub and spoke' model needed to ensure access geographically for all; managed by a board to inform governance and strategic direction of the body.
- Information overload for consumer which is worsened for people who speak English as a second language (if at all):
  - How is it ensured the consumer understands what is being said? What alternative methods are being used or could be used (including the use of appropriate interpreters)?
- Impact of the NDIS and navigating this; telling stories and accessing relevant, suitable and individual support.
- Less talk, more action.
- Nothing about us, without us - decisions about CaLD mental health are principally being made by people of non-CaLD background.
- One stop shop in government that is a holistic wellness centre (within government services) as a central resource service with evidence based practice.
- Specific evaluation frameworks established for assessing services and measuring consumer outcomes for CaLD consumers.
- Tap into the expertise of elders of the various CaLD communities, encouraging these leaders to have a voice, with methods or strategies put into place and linked to the communities they are trying to help.

Next steps

The information collected from the Open Meeting workshop will be used to guide the Multicultural Mental Health Sub Network Steering Group in the development of their work plan and inform the MHC to support the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Multicultural Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health to advise on the planning of health services.

In addition to working on identified projects, the Steering Group will work to foster engagement and communication in the Multicultural mental health sector.

Developments, issues for broader discussion and achievements will be reported back to the broader Multicultural Mental Health Sub Network membership via the Health Networks.

Appendix A: Open Meeting program

Department of Health
Mental Health Commission
GOVERNMENT OF WESTERN AUSTRALIA

Multicultural Mental Health Sub Network Inaugural Open Meeting

Monday 20 June 2016

Gareth Naven Room, NIB Stadium, Pier Street, Perth

Registrants of this event will have the opportunity to find out how they can actively participate in the Multicultural Mental Health Sub Network and help shape its priorities.

Time	Program	
9.00am	Registration	All
9.30am	Introduction Acknowledgement to Country	Ms Alison Xamon
9.35am	Mental Health-The Big Picture	Mr Tim Marney
9.45am	Overview of Mental Health Network	Dr Helen McGowan
9.55am	Overview of Multicultural Mental Health Sub Network	Beth Franca
10.05am	Panel discussion – identifying issues and possible solutions in the multicultural mental health sector	Consumer – Mr Julio Neto Psychiatrist - Dr Sue Lutton Clinical Psychologist - Dr Bernadette Wright NGO - Siobhan Burka Primary Health - Dr Aesen Thambiran
10.25am	Networking break	
10.50am	Reflect and build on themes	Mr Will Bessen
11.45am	Joining the Multicultural Mental Health Sub Network and Steering Committee	Ms Alison Xamon
11.55am	Concluding remarks and acknowledgements	Ms Wendy Rose
12.00pm	**Close and Networking**	

Appendix B: Detailed participant input

The table below captures the individual issues and respective solutions raised by participants in the workshop session using the iPad technology.

The 'liked' indicator was used as a method to ensure the feedback component of the session was targeted to key areas within the available time frame and is also displayed.

Issue	Proposed Solutions	Liked
• Hub and Spoke model to ensure access geographically for all; managed by a board to inform governance and strategic direction of the body.	• So long as the hubs are based around existing infrastructure and services. • It will work provided an independent chair is appointed, with a track record of working with CaLD communities and people, with an understanding of mental illness.	7
• Information overload for consumer which is worsened for people who speak English as a second language (if at all). • How is it ensured the consumer understands what is being said and what alternative methods are being used or could be used (including the use of appropriate interpreters).	• Presence of a guide or an advocate to assist in navigating the system but who provides, owns, manages and funds this service? And does it move from service to service. • Do we look at increasing cultural competency training and education for existing and established advocacy services within the mental health system. • Committed funding for CaLD individual and systemic advocacy.	5
• Impact of the NDIS and navigating this; telling stories and accessing relevant, suitable and individual support.		4
• Less talk, more action.		4
• Nothing about us, without us - decisions about CaLD mental health are principally being made by people of non-CaLD background.		4
• One stop shop in Government that is a holistic wellness centre (within government services) as a central resource service with evidence based practice.		4
• Specific evaluation frameworks	• Including how to work with	4

Issue	Proposed Solutions	Liked
established for assessing services and measuring consumer outcomes for CaLD consumers.	consumers to develop evaluations. • Including CaLD consumers and carers are involved every step of the way in co-production and co-design principles.	
• Tap into expertise of elders of the various CaLD communities, encouraging these leaders to have a voice, with methods or strategies put into place and linked to communities they are trying to help.		4
• Balance between accessing services generally for people from CaLD backgrounds vs the need for specialist CaLD services to address needs.		3
• Central unit that delivers health and mental health service that is holistic and integrated covering the lifespan. • Service that works with mainstream to upskill service providers working directly with clients.		3
• Co-production seems to fall away quickly with multicultural clients; additional training and understanding is required.	• Timing of services for reaching consumers and clients. • Today's forum is an example of ratio of professionals to consumers.	3
• Employment access for CaLD people.		3
• Limited GP knowledge of issues and what is available in the community.	• Training available to GPs regarding holistic approach rather than simple medication prescription. • Provide training and information packs to GPs. • Multicultural workers available to GPs for consultation or for clients to liaise with for more options. • Good and clear referral pathways available to GPs. • Education for GPs regarding multiculturalism within University courses. • Make sure linked to WAPHA health pathways and networks.	3
		3

Issue	Proposed Solutions	Liked
• Mentoring support to promote the participation of consumers and carers from ethnic minority groups.		
• More culturally appropriate action and funding.		3
• Use of interpreters is essential and greater funding would be good; hard to keep up with new dialects and new and emerging communities. • Quality of interpretation is important.	• Use of professional interpreters, support for people to become accredited interpreters. • Understanding of medical terms needs a connected medical, NGO and consumer support triangle.	3
• Retreat for spiritual cleansing' instead of ‘checking in’ to mental hospital.		2
• Been here before, lots of talk over the years with no action or funding.		2
• Central database system for the broad range of stakeholders (e.g. forensics, police, mental health, medical etc.) to reduce people having to retell their story repeatedly (similar to the UK model).		2
• Centrelink to use interpreters also and provide more information.		2
• Community support for families with mental health or trauma consumers.		2
• Community is unaware of what's available.		2
• Need a centralised Transcultural Unit. • Service delivery will not be optimal without a centralised Unit, which will lead inadequate care. • Cultural health workers are needed (similar to other states). • Centralised units will be more holistic and effective.		2
• Independent advocacy that is culturally responsive.		2

Issue	Proposed Solutions	Liked
• Lack of infant and early years work with mothers on attachment. • Program - circle of security groups with interpreters and culturally safe delivery models.	• Funding for expansion of culturally appropriate multicultural circle of security groups allowing for early intervention (Women's Health and Family Services currently facilitates this).	2
• Mental health systems are already under stress, as are the people working within them. • How can this be minimised?	• Cross cultural competency training, Indigenous awareness, streamlined services and clear pathways, and support for those working in the sector. • Additional funding to establish more multiculturally appropriate and sensitive services to meet demand for support services, and to give consumers choice in services.	2
• NDIS new systems are just dying to understand mental health let alone cultural difference.	• NDIS is also struggling first of all to understand the functional impact of disability, let alone mental health and cultural issues.	2
• Lack of funding.	• Reverse the funding cuts to ASeTTS. • Reverse the perinatal mental health funding for CALD people. • Substantially increase funding. • Revive the transcultural mental health network, make it a statewide unit. • Training to be conducted by people from CaLD backgrounds. • Provide funding for carers and consumers to more effectively participate where it impacts on their health. • Funding for stigma reduction in ethnic communities to be delivered by CaLD people.	2
• Lack of promotion for wellbeing and recovery language.		2
• A statewide transcultural mental health service must be governed by a representative, high-level body of key stakeholders, comprising Office of Multicultural Interests, Department of		1

Issue	Proposed Solutions	Liked
Health population and mental health, MHC and private sector in order to weather the storms of what's popular or the buzz words and focuses of funding bodies at that particular time.		
• Access of services and navigation of services that should not act in isolation. This leads to disjointed service delivery.	• There is a fundamental need to develop integrated, culturally sensitive services where all providers work towards one common goal.	1
• Access to interpreters can be a challenge in terms of having an interpreter for a particular dialect available.		1
• Activity based funding models do not align well with the complexity of issues that people with CaLD backgrounds may often present with, which potentially has a negative impact upon access to services moving forward.	• Need more research moving forward (more evidence based research) around the issues that contribute to complexity. • Need evidence to prove that some clients need more time and interventions that will result in better outcomes. • So that services are not penalised under new funding models for spending more time, longer appointments, using more resources where it is clinically indicated to be needed.	1
• CaLD clients not feeling welcome at the service.		1
• Co-production of services to hear the consumers voice, to acknowledge consumers as the expert in their care and support, and for people in the sector to learn.		1
• Community education on respect for diversity and making communities safe.		1
• Community engagement is small and limited.		1
• Competitive environment limits	• A client centred approach is	1

Issue	Proposed Solutions	Liked
partnerships and communication.	needed.	
• Culturally appropriate accommodation for CaLD mental health consumers, with support workers onsite.		1
• Education is critical at all levels - family education, clinician education, school education. • Educate on culture, beliefs, values and traditions.		1
• Establishment of a centre of excellence that integrates research, interagency collaboration, prevention and intervention.	• Evidence substantiated claims.	1
• For the mental health sector to employ multicultural workers and multilingual workers.		1
• The geographic locations of hospitals and NGOs is a barrier magnified by transport systems.		1
• GPs not using interpreters; GPs should report on the number of times that they've organised interpreters.	• WAPHA may be able to provide information.	1
• Increased health literacy, and speaking and understanding English for older multicultural people; provide access to English language lessons to try and reduce language barrier.		1
• ICLS funding is not adequately accessed by CaLD consumers; this needs to be rectified.		1
• Navigating through potential identities and making choices to create self when there was no choice before and limited guidance of what it means to be an Australian.	• Develop programs which foster the creation of self and focus programs on self-identity concepts and recognition of personal values and the strength to be resolute in those personal values.	1
• NDIS does not provide funding for training and relationship development.	• More pre-employment training in the sector.	1

Issue	Proposed Solutions	Liked
• Need for senior management and executive level commitment to continuously develop and expand culturally diverse services beyond tokenism.		1
• Organisations to have culturally diverse representation in their workforce, including bi / multilingual.		1
• Poor referral pathways	• Link to WAPHA who are developing Health Pathways.	1
• Relationships between clinicians and consumers, and problems regarding language and cultural barriers.		1
• Service directories must be available as audio and YouTube.		1
• The sustainability of sub-acute clinical service delivery remains uncertain.		1
• The Mental Health Commissioner's observation of the significant prevalence of mental health issues within ethnic communities is not matched by the levels of funding that are required to address them in a culturally and linguistically diverse way.		1
• This forum, regrettably, does not reflect the cultural and linguistic diversity of the State, so all decisions that need to be made from today's forum should be referred to advocacy bodies such as EDAC and ECCWA and service providers such as ASeTTS, FMC and MSCWA before being implemented. To ensure empowerment and ownership.	• This is the point of having a Steering Group.	1
• Training is not usually conducted by CaLD people; training is conducted by Anglo-Australians (who may not know the cultural or linguistic aspect of that group of people), rather than trained	• This needs to change.	1

Issue	Proposed Solutions	Liked
CaLD workers.		
• We appreciate partnership but CaLD people want to, and have the capacity to, take the lead.		1
• Wellbeing is about connection to communities of choice, housing, relationships and employment.	• More hub models addressing holistic care.	1
• Families from diverse cultural backgrounds with their children born in Australia, have some children that face a divided process of developing an identity to this place and this time which may be in conflict with their parents expectations.		1
• No wrong door approach.		0
• A compassionate society.		0
• Additional time required for consultations with CaLD clients.		0
• Advocacy work is critical. • Without a centralised / integrative unit it is difficult navigating through the chaos.		0
• Bullying, prejudice and discrimination within employment and access to health within communities.		0
• Challenge around the competing demands of convenience and efficiency within busy health services and accessing appropriate resources to assist in the care and support of people from CaLD backgrounds. • e.g. the use of family to assist with interpreting, even though this may not be in the best interests of either the client or the family.		0
• Challenges in assumptions around the identification of culture, language and identity.		0

Issue	Proposed Solutions	Liked
• Commitment to a state-wide mental health multicultural service including migrants, humanitarian entrants and intergenerational CaLD.		0
• Create a new language and memorandum of understanding on the centrality of notions of soul and spirit, and expansion of best practices to include concepts of aligned practices.		0
• Distribution of CaLD populations is diverse and varied in itself, in terms of geographical locations.		0
• Drug and alcohol / mental health to be the expectation and to be planned for.		0
• Essential cultural competency training for all mental health service providers from clinicians to administrators and cleaners.		0
• Establishment of a Centre of Excellence which integrates research.		0
• Ever changing multicultural community with new groups and issues coming in.		0
• Examination of mental health disorders ensuring state of the art examinations, and valid and reliable measures (world standards).		0
• Funding for interpreters in all service models for mental health care, especially onsite.		0
• Funding for interpreters.		0
• Gap in clinical services for co-morbid cognitive delay and mental health disorder / alcohol and drug abuse.		0
• Gaps in diagnostic processes for those with undiagnosed mental health	• Community education and information in mental illness to	0

Issue	Proposed Solutions	Liked
conditions and disability.	reduce the stigma and shame. • Routine screening by GPs and other clinicians.	
• Gaps in supporting people with multiple diagnosis (disability and mental health) and comorbidity (AOD).	• How are people with hearing difficulties supported? Someone who has areas of needs in mental health, they have another language and are deaf.	0
• Inadequate access to onsite interpreters who are trained in mental health.		0
• Lack of interpreter.		0
• Importance of introducing linguistics during early development in schools (Piarra Waters school as a model).		0
• Issues such as domestic violence not being considered in the relationship with mental health (e.g. services being very specific with criteria).		0
• Lack of information provided regarding current medical and clinical treatments.	• Patient's rights (including new Mental Health Act) to be provided in patient's language.	0
• Lack of mental health research dealing with CaLD population groups.		0
• Limited CaLD consumer and carer participation due to language difficulties and culturally inappropriate participation formats.	• Funding for interpreters at consultation forums.	0
• Lower access to primary mental health and higher levels of involuntary admission reflects systemic discrimination in terms of funding.		0
• More willingness to consider whole of person and living condition rather than just 'brain chemicals.		0
• Need for increased data around issues of access and identification for		0

Issue	Proposed Solutions	Liked
people from CaLD backgrounds for the purposes of local evidence.		
• Need specialised interpreters for mental health sessions and / or counselling.		0
• No long term funding means new guidelines each time funding is renewed.		0
• No, or limited, multiple language mental health information pamphlets.		0
• Ongoing support and the client being constantly informed of the care plan and process.	• Access to interpreters • Flexibility in models of care to allow for culturally specific intervention (e.g. clients can be seen for more than a set number of sessions). • More of a dialogue with clients i.e. worker communicating their role but also client sharing their understanding and their goals. • Early intervention.	0
• People should not need to lose their culture nor identity coming to Australia.		0
• Perinatal depression either discontinued or inadequately funded.		0
• Public transport routes currently don't generally assist people to access services in the community.	• Factors such as infrastructure, public transport and existing services be used to design the boundaries for funding of services or catchment areas by service providers.	0
• Services unable to keep track of what services are available in their areas, especially with new and expanding services.		0
• Small communities have difficulty with interpreters not being available for their language or available in a small cohort.		0

Issue	Proposed Solutions	Liked
• Stigma of mental health.		0
• Stigma reduction and mental health awareness needed.		0
• Strong training of interpreters, including new interpreters is needed, specifically in the area of mental health literacy.		0
• Support networks for new arrivals through provision of liaison teams to translate mental health awareness, communication and support pathways in Australian services. • Outreach, referral, directory or pathway through common steps of immigration and resettlement.		0
• More support networks needed.		0
• Increased sustainability of programs, services and funding should be the responsibility of the Government.		0
• The State Government substantive equality policy, the language services policy and the multicultural services charter are clearly not being reflected in the service provision to ethnic minorities.		0
• Those in the public systems need to have better understanding of cultural differences.		0
• To better address mental health issues in prevention and early intervention.	• Holistic and person centred approach which is culturally sensitive to the individual be implemented.	0
• Inadequate funding for torture and trauma.		0
• Trauma informed practice is needed as a standard.		0

Issue	Proposed Solutions	Liked
• Treatment, support and discharge needs to be provided in a culturally approach manner.	• *WA Chief Psychiatrist Standards and Guidelines* as a measure. • *National Standards for MH Services* as a measure.	0
• Better understanding of what people have left behind in their countries.		0
• What is the capability for community leaders to navigate mental health issues within their community?	• More training or information for community leaders.	0
• Whole of Government response is necessary.		0
• Whole of service system directory be funded by the State.		0
• Woefully inadequate funding to address suicide prevention within ethnic communities.		0

Appendix C: Inaugural Multicultural Mental Health Sub Network Steering Group

At the conclusion of the Multicultural Mental Health Sub Network Open Meeting, expressions of interest in joining the Steering Group of the Sub Network were called for. The Sub Network Implementation Group selected the following representatives to form the inaugural Multicultural Mental Health Sub Network Steering Group:

- Christine Foo
- Katarina Barjakterevic
- Caroline Gumede
- Manjit Kaur
- Dr Ruth Lopez
- Dr Sue Lutton
- Leanne Mirrabella
- Julio Neto
- Wendy Rose
- Lydia Sung
- Dr Aesen Thambiran (co-chair)
- Dr Bernadette Wright (co-chair)
- Elizabeth Franca (deputy co-chair)
- Sioban Burka

Appendix D: Acronyms

Acronym	Definition
AOD	Alcohol and Other Drugs
ASeTTS	Association for Services to Torture and Trauma Survivors
CaLD	Culturally and Linguistically Diverse
EAG	Executive Advisory Group
ECCWA	Ethnic Communities Council of WA
EDAC	Ethnic Disability Advocacy Centre
FMC	Fremantle Multicultural Centre
ICLS	Individualised Community Living Strategy
MHC	Mental Health Commission
MHN	Mental Health Network
MSCWA	Multicultural Services Centre of WA
NDIS	National Disability Insurance Scheme
WAPHA	Western Australian Primary Health Alliance

This document can be made available in alternative formats on request for a person with a disability.