CONSULTATION REPORT

PROJECT | **Responses to Alcohol and Other Drugs and Mental Health in Multicultural Communities**

CLIENT | Multicultural Futures WA

DATE | 17.05.20

VERSION | FINAL 4

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EXECUTIVE SUMMARY

Multicultural Futures WA has been contracted by the Mental Health Commission (MHC), to explore possible responses to alcohol and other drugs (AOD) and mental health (MH) in Culturally and Linguistically Diverse (CALD) communities. This project includes a series of consultations conducted by Aha! Consulting (this report) and the completion of a series of literature reviews from which a co-design process can be conducted.

This report collates the responses from four primary forms of engagement:

- **Sector Consultation Forum:** A two-hour forum was held on 21 January 2020 at Technology Park in Bentley for service providers and policy makers from both the AOD and MH sectors.
    - A follow up interview was also conducted with the WA Association of Mental Health (WAAMH) and with WA Primary Health Alliance (WAPHA).
- **The Multicultural Mental Health Sub Network Workshop:** A 1.5-hour workshop was held on 21 January 2020 at Technology Park in Bentley for members of the Multicultural Mental Health Sub Network Steering Committee.
- **Conversation Cafés**: A series of 18 'conversations' were hosted by community ambassadors from different multicultural communities. A total of 189 people from over 20 different cultural backgrounds, collated into six different geographic groupings, were engaged through this process.
- **Consumer Interviews**: A series of five x 1-1 phone interviews was conducted with consumers from different ethnic backgrounds. The method of phone interviews was chosen in respect of the COVID-19 social distancing requirements. Three of the consumers had lived experience with AOD and all five had lived experience of MH.

Please see **Appendix One** for the breakdown of the process participants.

Dominant Themes

It is clear that AOD and MH issues are a major concern for both the CALD community and service providers. Providers are seeing a comparatively greater prevalence of MH issues in the community and report this as growing faster than AOD.

Community members felt that alcohol was the most common substance used and that depression and anxiety were prevalent.

There was clear expression from the community that young people were the most vulnerable group due to peer pressure and cultural changes as communities settle into western society. Also, the greatest obstacles to supporting those with AOD and mental health issues were the shame and stigma attached to having issues with addiction and/or mental health, and therefore people were hesitant to seek support.

A number of consumers noted that some communities where there is post-traumatic stress from religious/racially motivated conflicts resulted in their ex-patriate communities being quite fragmented due to migrants coming from different sides of these conflicts. The result are limitations on people's ability/willingness to offer or seek community support.

Other consumers spoke of their appreciation for the support offered yet expressed a desire for more direct and practical help, i.e. finding work. The sense was that this would prevent the decline into depression and/or addiction in the first place. The concern expressed was that the support, whilst valued, left consumers feeling dependent on the providers rather than building their own independence.

The community described social and religious activities as most beneficial in supporting individuals with AOD and mental health issues, particularly in a friendly and non-judgmental environment. The hosts of the community forums reported the need to have professional services within their community to overcome potential language barriers. This view aligned with service providers who felt that on the ground, services were critical to building the relationships and understanding required that would make the support accessible.

Sector Forum

A total of 14 people attended the sector workshop which looked to explore the prevalence of AOD and MH issues in CALD communities, the causes of these issues, what supports existed and what supports are needed.

The sector workshop started by asking participants four questions:

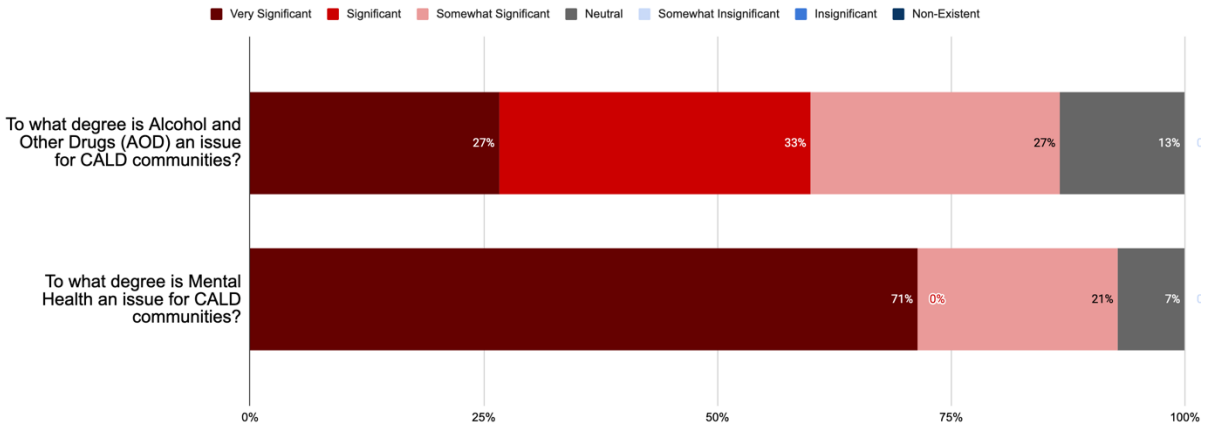
1. To what degree is AOD an issue for CALD communities?
2. How would you characterise the prevalence of AOD issues in CALD communities?
3. To what degree is MH an issue for CALD communities?
4. How would you characterise the prevalence of MH issues in CALD communities?

A follow up 1-1 interview was conducted with WAAMH and WAPHA that followed the same question format as the forum. Their views are included in this write up.

To What Degree Are AOD and MH an issue for CALD Communities?

As can be seen in **Figure 1** below, the providers' experience is that AOD and/or MH is a significant issue facing CALD communities. Of note, forum participants are suggesting that mental health is a very significant issue in these communities.

Figure 1: To what degree is Alcohol and Other Drugs and Mental Health an issue for CALD communities?



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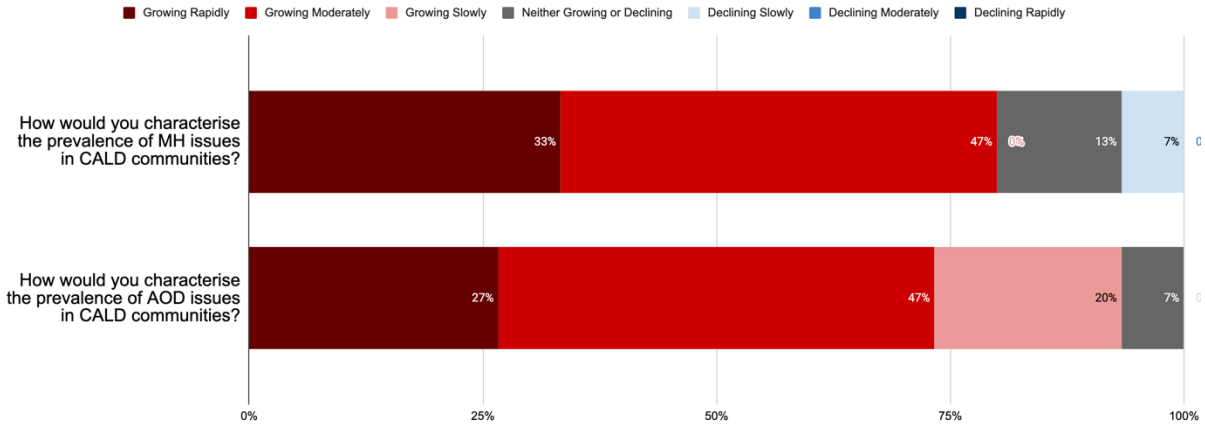
The Prevalence of AOD and MH Issues within CALD Communities

In terms of the prevalence of either AOD or MH issues in CALD communities and as shown in **Figure 2**, most providers see the issues as growing. Once again, forum participants are suggesting the prevalence of MH is growing more quickly than AOD.

Figure 2: How would you characterise the prevalence of AOD & MH issues in CALD communities?



When exploring the possible reasons for the prevalence of AOD and MH in CALD communities, the group offered the following:

- That there are generational changes affecting communities
    - Young people feeling the peer pressure to fit into a wider society norm
    - For older people there are changes to the family dynamic that can leave them more isolated and at times depressed. The language barrier and loss of the elder roles were cited as key changes in these dynamics
    - There was evidence cited that showed culture was a protective factor for mental health, where increased integration into mainstream society led to increased cultural stress which leads to increases in MH/AOD issues.

- Cultural topics such as AOD and MH are still seen as taboo in several communities; as such these issues don't get discussed
    - Some are not wanting to seem like a burden or talk about these issues with people outside their community.

- There are a number of people who arrive in Australia with the residual trauma of getting to Australia or from the country they have left; this can mean that some people arrive in the country with mental health needs.

- It was also noted that anecdotally there is likely to be higher levels of MH issues than reported, as many people from CALD communities don't present at services.

- It was also less clear on what people from CALD communities identify as a mental health issue. It was noted that there will be different cultural views on what is a mental health issue, which would effect who migth identify themselves with a need. This makes it harder to get an accurate sense of what the prevalence actually is.
- For many of the above reasons, the access to accurate data was a key gap. The WAPHA community needs assessment is now done every three years and access to information on CALD communities is seen as limited to census data which identifies the number of people from CALD backgrounds in a particular region. However, it was noted that the understanding of the socio-economic of different geographical areas was well understood and there is often a correlation between these areas and migrant communities.

When exploring some of the reasons for the prevalence of AOD and MH, participants shared the following:

- Accessing services is an issue in CALD communities
    - Some felt that fear played a part, with concerns that visa applications would be denied if there are any issues disclosed and as such, they are left untreated
    - Some people feel isolated and not supported in non-culturally secure mainstream services
    - In some instances, the cost is an access issue
    - Others may not even know that services are available.
- Some participants noted that workers doing home visits face some cultural barriers that conflict with occupational health and safety standards (e.g. shoes off during home visits).
- It was suggested that the approach to prevention and treatment of MH is still very clinically driven and does not give enough credence to the systemic impacts on people and the role of social determinants on people's MH and well-being
    - E.g. Housing, employment etc. all have a role to play.
- For CALD communities this is exacerbated in climates where there is growing nationalism and fear of other cultures and communities. Increased xenophobia and discrimination were seen to lead to issues like MH.
- Another suggestion was that some of the increase in MH/AOD issues could be ascribed to an overall increase in the number of people migrating to Australia from different CALD backgrounds.
- It was also noted that alcohol and some drugs are more readily available in Australia.

Options for Alcohol and Other Drug and Mental Health Support Services

The forum participants engaged in discussion regarding options for AOD and MH services and the following questions were asked:

- What works?
- What are the barriers?
- What supports exist?
- What else is needed?

The following inputs in the tables below are the ideas generated/shared by the forum, which were then refined into possible approaches which are profiled later in this report.

It is recognised that the tables are a verbatim record of the information that was provided by the forum participants and therefore, further expansion and clarification around this information cannot be provided.

Options for alcohol and other drug services	
What works?	**What are the barriers?**

• Outreach programs
• Detox in the home
• Education of staff
  ○ Train the trainer
  ○ Peer learning
  ○ Reflective practice
• Needle syringe programs
• Peer workers
• Holistic approach
• Education in community
• De-stigmatising link to trauma
• Cultural:
  ○ Knowledge (practice informed evidence)
  ○ Relevance (evidence informed practice)
• Promoting services
• CALD staff
• Co-design with peers – self-determination and person centred
• In-reach services
• Dual diagnosis programs
• Mobile clinics (nicotine)
• Some AOD services have good family services, i.e. Palmerston
	• Language
	• Health literacy
	• Motivation
	• Isolation
	• Peer workers – no funding or access to training
	• Holistic approach – risks with some withdrawals and lack of understanding
	• Lack of support for family
	• Co-morbidity services
	• Not good at dealing with co-morbid clients
	• Lack of cultural competence
	• Lack of sustained funding
	• CALD is not one community
	• Community norms/pressures/politics
	• Mobile clinics (nicotine) – not enough of these and treatment is only for 12 weeks
	  ○ More data, research specific to CALD communities and access to it

What supports exist?	What else is needed?

• NSEP – outreach
• WHFS, Palmerston, S+C, MMRC, MF, Attach (UGW), DAWN
• Interpreter services
• Education – English
• Community events – sports, markets
• Mentor programs
• Cultural champions
• Cultural training:
  ○ Decreased stigma and discrimination
  ○ Increased awareness of barriers
  ○ Increased services
• Drug and Alcohol support unit
• CADS – access to medical specialists in AOD; no Medicare card = no service
• Rehab
• Family support network
  ○ Armadale/Cannington
  ○ Rockingham/Fremantle
• Peak body
  ○ Capacity building
  ○ Advocacy
• CALD services
  ○ Women's health
  ○ Assets
  ○ Multicultural Futures
  ○ Various project-based funding
	• Waitlist
	  ○ Process
	  ○ Pre-entry support/information so that people have an understanding
	• Priority
	  ○ Push in this area from services, funders, etc.
	  ○ Akin to cultural awareness/security, FIP (family inclusive practice) co-occurring
	• Consistent funding
	  ○ Covers increasing costs, i.e. wages
	  ○ Lack of continuity
	• Cultural competency training (positive)
	  ○ Available
	  ○ Cost effective
	  ○ More focussed approach
	• Increased media exposure – i.e. TV and community radio
	• Building partnerships
	• Developing trust
	• Outreach/planning/co-design/peers/defining target community

Options for mental health services

What works?

- Outreach
- Peer support groups
- Peers within services
- Specialised culturally appropriate services
- Trained and specialised staff that work within services
- Longer appointments
- Free or low-cost providers
- Translation services – free
- Interpreter phone services
- Community centres that provide free counselling services/including groups and meet-ups for interested people
- Free training for services of community members
- Support groups – free
- Co-designed programs
- Person centred
- Community – place-based approaches
- Self-determination
- Responsiveness
- Cultural beliefs informing organisational culture
- P+P that support organisational culture/cultural norms/values and beliefs

What are the barriers?

- No regional services
- Increased cost for effective services
- Waitlists
- Lack of knowledge of service providers about how to be culturally aware (cultural safety, source)
- Lack of services promoting what they provide to the consumers!
- Language/literacy – barriers to therapeutic work
    - Lack of rapport
    - Privacy
    - Communication
    - Culture
- Medicare cards required to access services
- FUNDING
- Procurement – needs to support capacity building
- Getting the information into the community and to the people who need it
- Not networking within each other's services
- Workers not comfortable to work within/ outside culture
- Project based funding – not recurring and no consistent staffing

What supports exist?

- Peak bodies
    - Capacity building
    - Advocacy
- DV programs for CALD women – MWAS, DVAS (advocacy services at Women's Health)
- Multicultural Futures
- Virtual legal aid
- Community based services – Communicare, Anglicare, Centre Care, Mercy Care
- Mainstream is not used as much as they should be
- Assets
- Brain Ambulance (Mental Health Education)
- ISHAR
    - Community Health Council WA
    - Richmond Wellbeing

What else is needed?

- Funding
    - Provider training and capacity building for specialised and general services
    - More CALD staff
    - Beyond finite projects
    - Specifically for CALD services
- More planning/co-design
- Way of promoting knowledge of services – APS, ACA, AASW – collaboration and increased GPs' awareness
- Outreach
- Education about MH to destigmatise
- Trauma education
- GPs – appointment times

• Reconnect, family well-being supportive service (Mercy Care), health and well-being talks – MH, stress – TAFE, AMEP (WHFS)	• Consistency, relationship building, trust – increased funding – flexible funding, longer contracts, worker well-being supports • Resource library of clinicians who have knowledge and understanding of CALD communities/languages for direct work and consultancy • Community directory to provide information on services • Graphic information • More collaboration/networking – need to address stigma within communities themselves so that issues can be acknowledged • Mental Health Commission as a focal point for CALD communities

Responding to the Needs

The next stage of the forum was to explore a range of possible responses to supporting people in CALD communities with AOD or MH issues. These possible responses included;

- Time is required to focus on relationship building with the communities and individuals. Trust and stigma are seen as key barriers and as such the responses and services need to be personal
    - It is hard, expensive and takes time for services to offer the consistency required to build relationships, but it works.
- Education and targeted support in schools
    - With the language barriers it is often more effective for the kids to provide information to parents.
- Separate services but a consistent strategy are needed
    - The 'no wrong door' approach was seen as important to balance people feeling overwhelmed about where to go and recognising the co-morbidity factors.
- Increased capacity building with mainstream and specialist services
    - Cultural awareness training was seen as essential, along with the support for services to understand what is needed to deliver cultural security.
- Procurement focussed on allowing time for relationships and service outcomes to be established.
- Use of community ambassadors (in-reach).
- Co-design with communities – not 'one' CALD group.
- Bring in family and community support
    - Don't know what community needs and wants
    - Don't know what will work for community.
- Taking services to people.
- Accessibility of mainstream
    - Ensuring their location, décor, signage and intake process is culturally secure and accessible.
- Engagement/community/family
    - Investing time in ground level community development and relationship building, so that service providers have relationships with families and communities.
    - Trust is a key issue in many of these communities and as such, relationships are a critical element of service accessibility.

In exploring these themes with WAAMH and WAPHA through an interview after the forums, the following insights were provided:

(1) What services/approaches are most effective when working with CALD communities in WA?

There needs to be a range of services offered from CALD specific and mainstream services that are culturally informed and secure.

The 'no wrong door' is an important principle to maintain – it has to be easy for people to get into the system. There also has to be an avoidance of a 'one size fits all' approach to working with CALD communities which are comprised of multiple, diverse communities, each of which will have unique and distinct needs, preferences and requirements.

"What is needed is a system that provides the right support at the right time to reduce acuity of MH issues".

As for all consumer cohorts, a capacity building and community development approach that considers specific cohort needs and nuances is required.

Mainstream services can learn other ways of delivering service (i.e. learn from speciality services). This requires resources and time to invest in building relationships across services and resources – e.g. time and staffing.

It was noted that, while traditionally there has been a desire to develop bespoke services for every cultural group, the sustainability of this approach was in question. WAPHA noted a blend of offerings was always going to be needed; however, focussing on better equipping mainstream services to work with CALD communities was an important element to ensure they could access these services.

(2) How would you characterise the availability of these types of services/approaches for these communities in WA?

There are some specific services and some service providers report getting push back from funders about how they use funding.

For example: Paying for catering for a community lunch, which is the culturally appropriate approach but sits outside of the 'funding contract'.

These restrictions, be they real or perceived, limit how providers can engage and support these communities in the way that they know works best.

Other sectors are seen to have a more bundled approach to service provision that enables services to integrate prevention and some community development work into core service delivery.

While accessibility is part of standard contracts, lack of dedicated resourcing means that it is challenging to embed this in a meaningful way. Without setting clear expectations and

the resources on which of the multiple issues the funder deems as important – organisations will prioritise different to what the funders are suggesting is required.

The list of requirements being placed on mainstream services is growing without the resourcing to deliver on this capability.

For example: CALD, MH, AOD, Trauma Informed, Aboriginal Culturally Secure, Disability, LGBTIQ etc.

Each has a genuine need for services but there are not the resources (leadership, funding, capacity building) provided to deliver what is expected.

There could be value in more exploration on:

- How to tailor contracts better to allow this kind?
- How to change reporting frameworks from outputs to outcomes?
- If these challenges are due to systemic constraints, relationship with funding managers or simply the interpretation of contracts?

"Services want to do this better – but desire/moral imperative and having the physical resources/capacity are two different things."

WAAMH

(3) What other services/approaches are needed when working with CALD communities in WA?

The range of services is needed across service and geographic types. To achieve this would require support to build the capacity of the broader sector and looking beyond dedicated MH providers.

There are many other types of services that are helpful for MH, but they may not be MH specific service, e.g. youth services, clubs etc.

This community development approach could enable the supports and strengths already inherent in the community. The model could deliver community work and outreach into these communities by people from that community.

The approach needs service providers willing and able (skills and time) to talk with the people in the communities and establish strong relationships in order to have the right people in that community vouching for the service – otherwise, consumers won't access that service.

Working in a more community development context can be challenging to the clinical mind set of services. A formal service is not always needed, and community development focussed programs could do more for these communities.

Finally, it is considered that a more comprehensively resourced whole of sector approach to workforce development would support improved mental health service delivery across the community mental health sector. This would enhance all services including those that support people from CALD communities.

"There is too much focus on individual services figuring out what they need to do and not enough systemic leadership and capacity building to raise the bar for the whole system."

The disconnect between state and federal programs and funding can make it harder to reach communities and optimise the allocation of resources.

Anecdotally, the use of telehealth during the coronavirus outbreak is showing an increase in the number of CALD community members accessing services. This suggests that the stigma of being seen to go to a GP and access services was still a key barrier. It was suggested that community ambassadors could become an important focal point to help reduce this stigma and support communities to better understand what could be considered 'normal' and what supports are available.

The Top Strategies Required to Support CALD Communities

The sector forum participants then reviewed the position response options and needs and focussed on prioritising these options to then exploring in more detail what would be required for each option.

1. Increase the education of multicultural communities

- Build accessible learning experiences and collateral
    - Production of graphics and tools, i.e. cards
    - Conversation-style learning
    - Meet around food
    - Prioritise cultural awareness/safety training for service providers.

- Build relationships
    - Focus on rapport building – be genuine
    - Peer support workers
    - Small groups to create a safe space.

- Focus on the needed content
    - Safety, i.e. alcohol and drugs (such as needle exchange)
    - Build awareness around consequences/effects of AOD and MH
    - Lift the taboo around MH
    - Teach how it works in Australia – MH and AOD.

- Provide resources for schools, TAFE (EAP) and community services.

2. Improve the accessibility of mainstream services

- Understand the needs of the CALD communities – peer based/co-design
    - Identify someone in the organisation specifically designated to focus on the area of CALD AOD/MH; this liaison officer to map the identified communities
    - Have a clear understanding of what some of the CALD group conflicts are or what is appropriate and what is not appropriate
    - Clear understanding of CALD group cultural norms, barriers, values, etc.

- Improve engagement
    - Translate service information into accessible formats and language
    - Taking the programs to people, rather than expecting them to come to you
    - Getting the leadership of CALD communities involved

    - Identify the specific needs and specific CALD groups, e.g. international students who don't have Medicare.

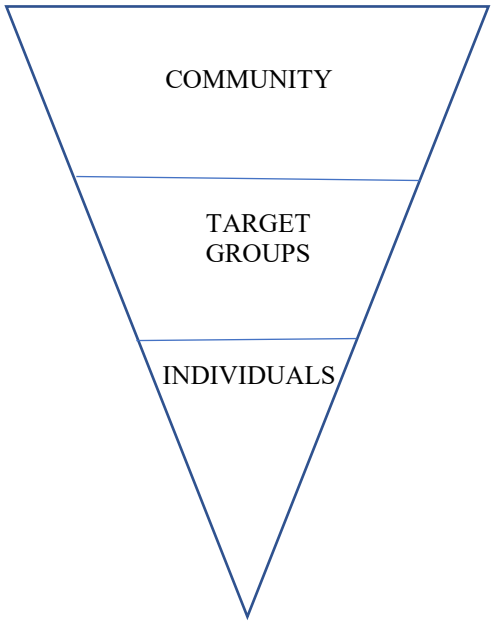
- Think about what we're talking about when we are referencing CALD
    - Language
    - Ethnicity
    - Cultural connection
    - Country of birth
    - Commonalities, etc.

3. Build engagement with specific communities

- Ask communities and listen to what services they want and how they want them.
- Recognise that CALD is comprised of different communities.
- Co-design specific contexts to different cultures/each culture.
- Focus on relationships – build trust.
- Have diverse workers and use their skills – part of internal capacity building.
- Cultural champions - people who have standing and strong rapport in the specific community and are able to support services to bridge access into those communities.
- Recognise that engagement takes time and costs money but is crucial.
- Maintain awareness of barriers and seek to address them (keep asking the questions and listen to the answers).
- Look at the funding arrangements and KPIs to maximise cross agency collaboration and community-based engagement/initiatives. For Example:
    - If communities respond well to events, then allow this to be part of the funding
    - If communities need someone on the ground, assisting with broader matters as a mean of building trust and rapport, then allow this to be part of the funding.
- More co-responses (e.g. police/MH expand more to CALD – good example is Mirrabooka).

4. Develop a systemic approach

- Consult with community – BROADLY
  - Cultural leaders/groups
  - Other services – what else is out there?
  - Individuals, families
  - Understand who we are not seeing
  - Collaborative working relationships.
- Identify needs, gaps, barriers (actual and perceived)
  - Decide on service focus.
- Use targeted consultation co-design
  - Be person-centred
  - Outcomes and measures.
- Build networks
  - Family support networks
  - What partners can we refer (warm, supported referral) people to with needs that are outside our scope of service?



Multicultural Mental Health Sub-Network Meeting

In 2016 the Multicultural Mental Health Sub-Network was established in support of the Mental Health Network to understand and engage with specific cohorts of mental health service users. Members of the Steering Committee for this Sub Network were invited to a meeting as part of this consultation process to explore their insights.

A model of service was previously developed by the Steering Committee which was presented at the meeting.

Principles-Based Approach

The group explored a set of core principles that would be important to apply to any model that is developed. The group felt that there was a set of consistent strategies that could be applied across a range of different multicultural communities, such as:

- Improve access to and budget for the provision of interpreter services.
- Provide opportunities for cultural leadership on the ground.
- Become transcultural in the approach to service provision
    - The transcultural approach does not assume the clinician is from an Anglo-Saxon background and recognises the need to build cultural awareness both ways.
- Build cultural competence.
- Focus on building the number of service providers (on ground and clinical liaison).
- Build the political leadership to recognise the diverse needs of different people.
- Improve data collection/utilisation
    - Harnessing community for data collection.
- Build service coordination across different life stages.

The model developed by the Sub-Network is a hub and spoke approach to the provision of a range of support services by people who are trained in the nuances of a transcultural approach to service provision. This core team would be able to support providers in different locations to either better understand how to adapt current service provision and/or make the necessary referrals. The core team would also support community members. Appendix Two of this report provides a detailed breakdown of the key elements of the model developed by the Sub-Network[1].

[1] MENTAL HEALTH NETWORK; A model for an effective and sustainable state-wide Transcultural Mental Health Service for Western Australia; May 2018

The Levers for Implementation

The Steering Committee offered the following insights into how to strengthen the advocacy and case for a model of support:

- Multicultural Policy Framework.
- Audit of strategies/policy that cover CALD needs.
- Recommendations from the Sustainable Health Review.
- Link to community development outcomes (i.e. the benefit and approach are not just clinically focussed).
- Demonstrate the money saved in prevention and outcomes achieved.

Consumer Interviews

A series of five x 1-1 phone interviews were conducted with consumers with lived experience from different ethnic backgrounds. The method of phone interviews was chosen in respect of the COVID-19 social distancing requirements. Three of the consumers had lived experience with AOD and all five had lived experience of MH.

In this section quotes are provided to more accurately reflect the consumer voice. Given the language barriers in the interviewees, the interviewer would often paraphrase their understanding of what was said in a more succinct manner. This was captured and feedback to the consumer provided to check if it was accurate.

Is there enough support for people experiencing AOD or MH issues in your community?

For those interviewed, the supports received were limited to family, friends and professional services (e.g. hospital, Not for Profit Organisations, GP etc.). There was not a strong sense of 'community' led support.

When exploring this further, the reasons given were that often there can be migration resulting from religious and/or racial persecution. When the migrants are people who were on opposite sides of those conflicts, the community established in Australia is more fragmented in nature and there are fewer opportunities for open disclosure of concerns or issues an individual may be facing.

"In many communities where there is war, arriving under humanitarian need – means some people we arrived with were also war criminals. This could never be mentioned and is a cause of stress/distress."

Consumer participant
(paraphrased by translator)

It was also noted that people often arrive with limited broader family support and, due to the general stigma that is present in multicultural and the wider community about issues like addiction and mental health, the individual tended to isolate themselves.

"There is not a strong [XXX] community in WA and so I felt like I had to integrate into Australian society, but this can be hard because culture, language, food – everything is different."

Consumer participant
(paraphrased and confirmed by interviewer)

What support did you get that helped?

While consumers often noted that the MH system in Australia is very good compared to their country of origin, there were some struggles (covered in the next question).

Overall the consumers interviewed found the medical support very caring, accessible and professional. GPs were in an important resource point for consumers and psychologists and mental health hospital services were praised for their work.

Not-For-Profit providers that helped people feel connected to part of a wider community, having a 'place to go' and providing inroads into a sense of belonging were mentioned.

"[NFP provider] was a big support by having activities and a welcoming/homely feel, they provided a non-judgmental space and made me feel that it was okay to be me."

Consumer participant
(paraphrased and confirmed by interviewer)

"Having someone that understands the different cultural backgrounds was very positive. This prevents you from sliding any further behind."

Consumer participant
(paraphrased and confirmed by interviewer)

What support did you get that did not help?

For the consumers interviewed, it was noted that due to the experiences in their home countries, trust could be a big barrier and at times they experienced services that 'didn't understand' them or their needs.

When exploring this further, there were two main categories:

(1) Supports that support but did not meet the underlying need

"Some support with counselling, housing and helps solve the problem in the short term – it is well received but it is not enough – it doesn't solve the long term problem … keep me dependent on the system – if I have a job and they helped me find work – this would be a bigger long-term support."

Consumer participant
(paraphrased and confirmed by interviewer)

(2) Supports that did not support

Some consumers spoke of services that were too focussed on what they were funded to deliver, and the consumer felt forced to sign off on activities and services that were not provided or that the nature of the service did not meet their need.

"... they just talk and review the past ... which is not enough ... brings back long-time memories that cause more pain ... which does not help."

Consumer participant
(paraphrased and confirmed by interviewer)

"There were some counselling services that were not helpful. Even though she spoke the language she was not helpful in her approach – trying to minimise the situation and made me more stressed."

Consumer participant
(paraphrased and confirmed by interviewer)

"Being in a facility with people with different degrees of MH cannot be that helpful – it can make you feel worse – seeing them go through more extreme episodes."

Consumer participant
(paraphrased and confirmed by interviewer)

What would make the biggest difference for people experiencing AOD/MH in CALD communities?

Getting people linked into the community and programs run by NFP providers was seen as very important.

"The worst thing in life is loneliness/isolation."

Consumer participant
(paraphrased and confirmed by interviewer)

"Connecting people to the community – belonging is important."

Consumer participant
(paraphrased and confirmed by interviewer)

"There is not enough to do of activity that creates a sense of belonging and purpose."

Consumer participant
(paraphrased and confirmed by interviewer)

For others, the critical support is not just dealing with the trauma or addiction but to look at the deeper social determinant and triggers for their decline in well-being in the first place.

Finally, the need to make it easier to find their way through the system was raised by a number of consumers.

"The fact that people have to go through so many people to find the right forms of support (e.g. GP to specialist). When there are multiple issues – each time they deal with an issue they have to talk to a different person – when they've comes from an environment where trust is low – it's very hard to build this trust and so they don't feel comfortable to share what is going on and what they need."

Consumer participant
(paraphrased and confirmed by interviewer)

"If the person is not happy with the person they are referred to, they don't feel it is okay to say they are not happy."

Consumer participant
(paraphrased and confirmed by interviewer)

Conversation Café

To better expand the reach of the consultation and to ensure strong cultural security, multicultural community ambassadors from different communities were invited to 'host' a conversation in their community. A conversation kit (see Appendix Three) was provided outlining the key questions and providing a template for the conversation that each host could adapt to best suit the needs of their community. Hosts were then asked to complete an online form to standardise the information obtained (see Appendix Four).

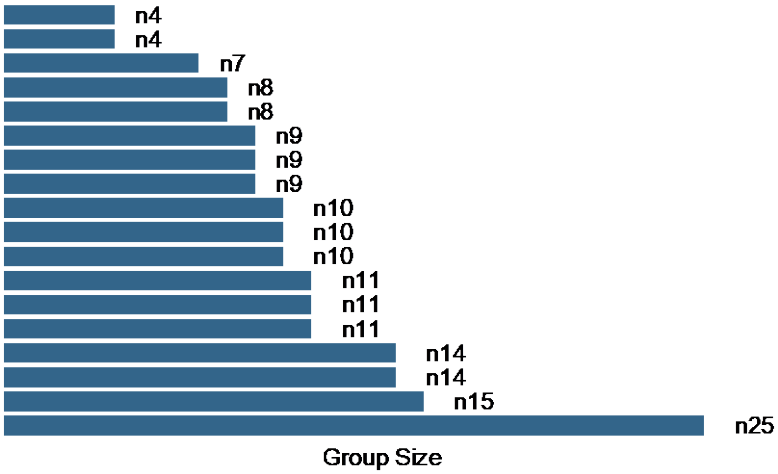
A total of 189 people from over 20 different CALD backgrounds were engaged through this process. The 20 CALD backgrounds were collated into six different geographic groupings.

Communities Engaged

Overall, 18 conversations were held. On average, a group included 6.4 females (range of 2 to 14) and 4.9 males (range of 0 to 18).

Figure 3: Number of people in each conversation

As shown in **Figure 3** the number of people in each of the 18 group conversations is shown on the right.



On average, the group size was 10.7 people (standard deviation = 4.9). Most groups had between 9 and 11 people. The lowest group size was four and the highest was 25.

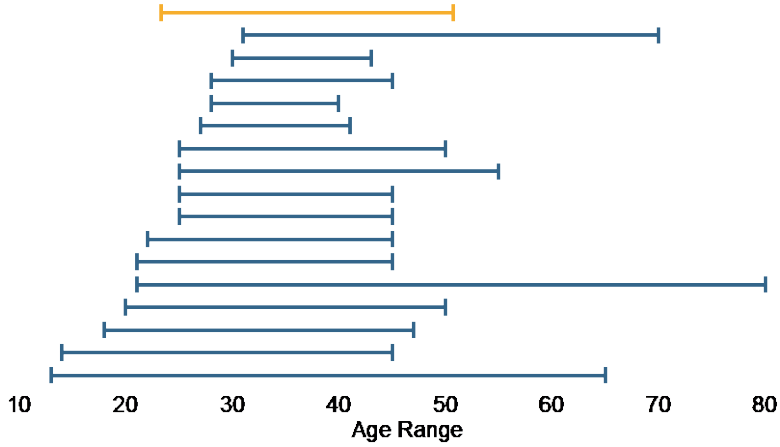
Six hosts commented on the engagement of the participants; three reported that group participation was high and three reported that group participation was low due to the sensitivity and stigma attached to the topics.

Figure 4: Age range for each group conversations

As shown in **Figure 4**, the age range for each of the 18 group conversations is shown on the right.

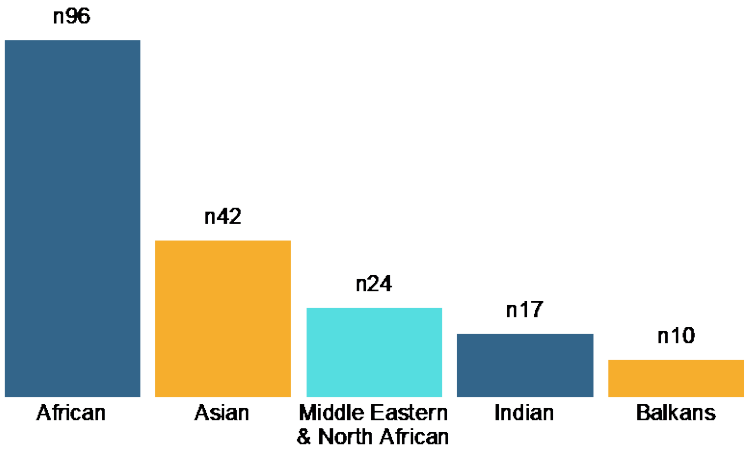
The average age range is shown in yellow and was between 23.9 and 37.5 years old.

The youngest age across all groups was 13 and the oldest was 80.



Facilitators were asked to report on the nationalities represented in the group. Each group was then coded into one of six broader CALD grouping. These grouping reflect key population groups in WA, the number of people interview do not reflective of the actual population size. **Figure 5** shows the total number of participants for each of the six cultural backgrounds is shown below. Participation from those with an African background was most common.

Figure 5: Number of participants from the six cultural grouping



Please see Appendix One for a more detailed breakdown of these groups.

Group Characteristics

The group facilitators were asked to comment on other details about the group which would help to contextualise their responses. From the 16 responses, ten provided responses; however, none of the responses gave details about mental health issues.

- Two facilitators reported that the groups included people with strong religious and conservative beliefs.
- Two facilitators reported that the group included mostly parents.
- Two facilitators reported language barriers, with one facilitator requiring an interpreter.
- One facilitator reported that the group had a deep understanding of the issues and causes of AOD problems in their community.
- One facilitator reported that the group all knew someone who personally knew someone who was affected by AOD.
- One facilitator reported that the group included migrants who had lived in Australia for less than six years.
- One facilitator reported that the majority of the group were low income earners or unemployed.

Exploring Alcohol and Other Drugs

AOD Preferences

The group facilitators were asked to comment on which types of AOD are more of a concern or more widespread in the community.

- 12 facilitators reported that alcohol is very popular in general
    - Three facilitators reported that beer and wine are most popular, particularly for youth due to their relatively low cost
    - One commented that the older population prefer drinking spirits
- Two facilitators reported that cigarettes are popular
- Three facilitators reported that marijuana is popular
- Other popular substances included ecstasy, hooka, amphetamines and khat[2] – though khat was described as being socially accepted.

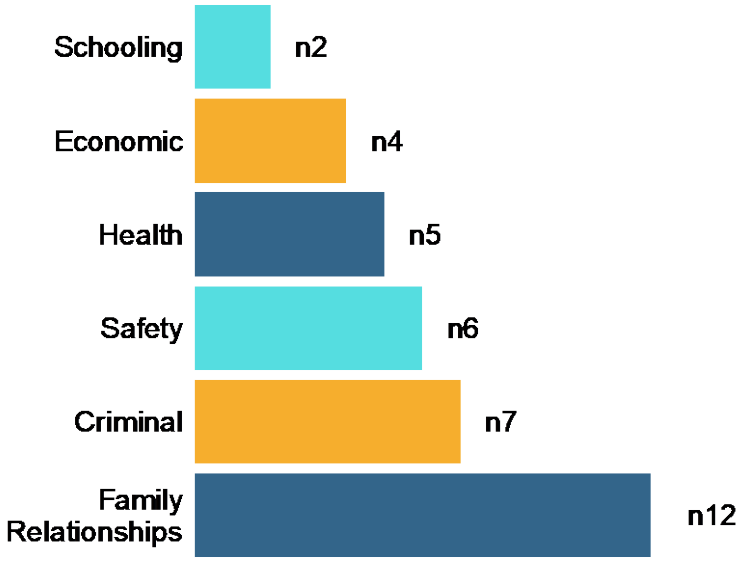
[2] Khat is a stimulant drug, which means it speeds up the messages going between the brain and the body. The drug is the leaves and buds of the khat plant (*Catha edulis Forsk*). Source: www.adf.org.au/drug-facts/khat/

AOD Concerns & Issues

Facilitators commented on the type of issues that AOD causes for their community. The frequencies of common themes are shown below.

As shown in **Figure 6**, the most common issues were domestic, which included the breakup of families and aggression towards family members. Criminal activities were also commonly reported and included imprisonment and descriptions of crimes such as robberies and assaults. Safety captures issues surrounding injuries and driving under the influence of a substance. Others noted well-being impacts such as cognitive impairments, isolation and negative health consequences from long-term exposure to AOD. Economic issues surrounded (un)employment and providing for one's family. Schooling included a decrease in grades, ambition and one report of dropping out of school.

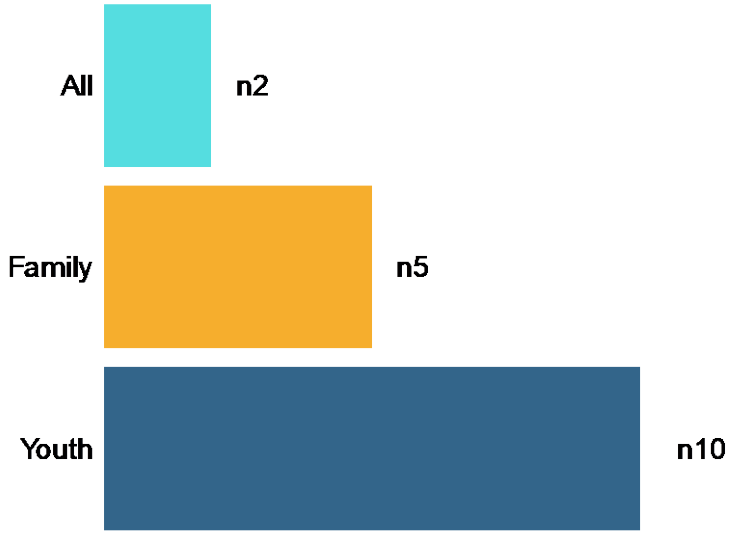
Figure 6: Most common concerns about AOD



Who Is Affected Most by AOD Issues?

Figure 7 shows the responses received by facilitators on whether AOD affected one part of the community more. The most common group was youth. The impact on youth was largely due to peer pressure and the use of AOD negatively impacted their education, safety and vocational opportunities. The mention of family members was also frequent and largely included comments about women and children being impacted by the father's AOD use. Two different facilitators suggested that the feedback from their group was that all community members were impacted equally. Lastly, one host expressed that individuals from low socioeconomic backgrounds are most affected. One host also commented that men are more affected because using alcohol is more acceptable for men than it is for women and because men receive less social support.

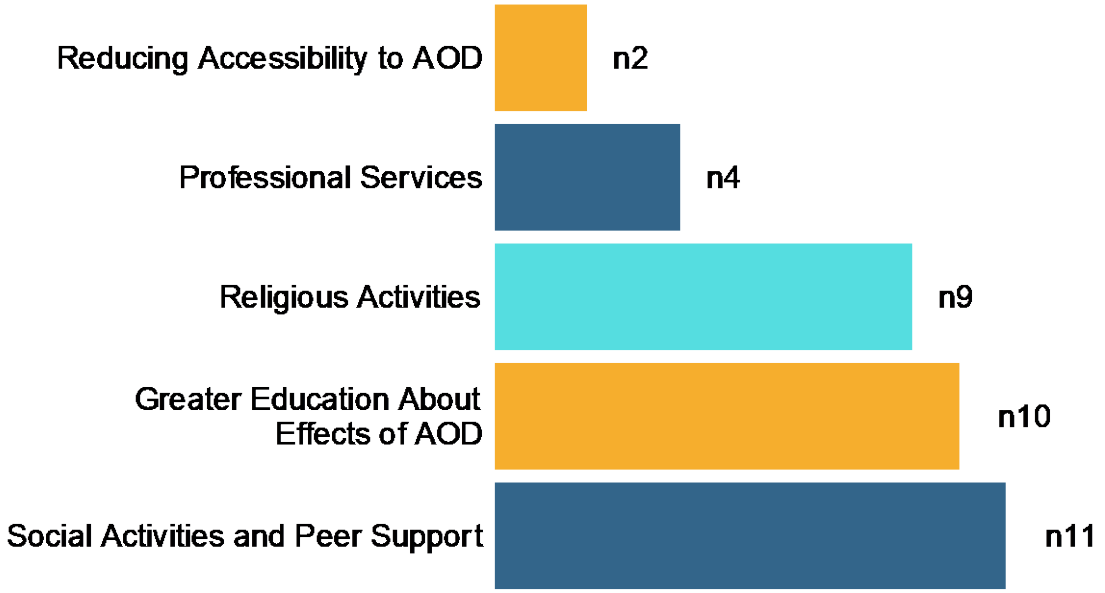
Figure 7: Most affected by AOD issues



Methods to Reduce AOD Impacts

Figure 8 shows the responses received by facilitators on methods that work in reducing the impact of AOD in their community. The most common theme was social activities, such as community and sporting events to offer greater social support from peers and a greater sense of social identity. Education included providing information to youth and parents about the negative effects of AOD. Religious activities were frequently suggested and included attending church services and a stronger connection with church leaders. Services included access to social workers, counsellors and other social services. Reducing accessibility to legal drugs by increasing prices was mentioned twice.

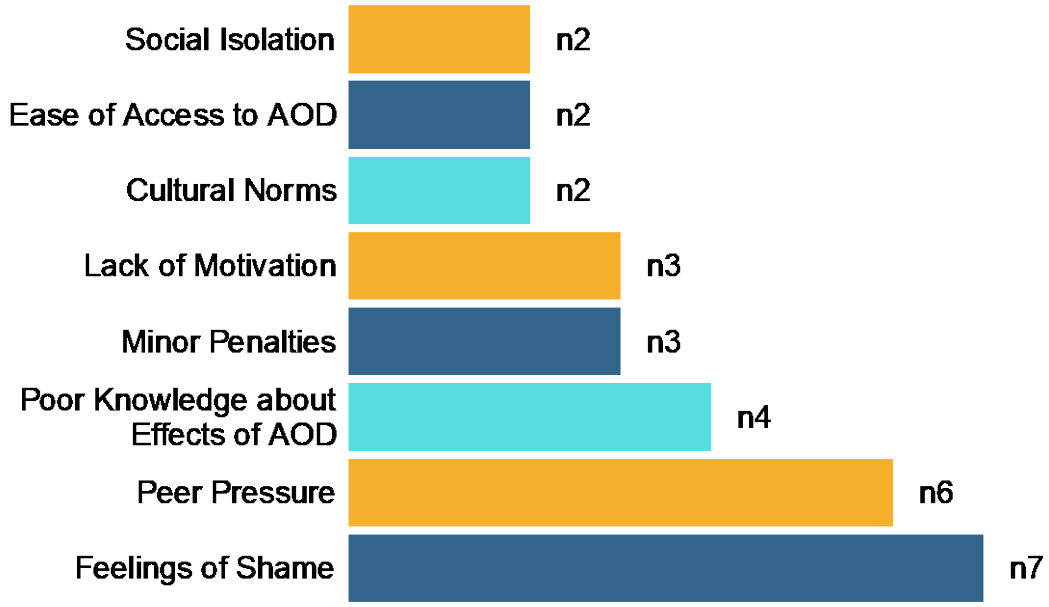
Figure 8: Methods to reduce the impact of AOD



Obstacles in Reducing AOD Impacts

Figure 9 shows the responses received by facilitators on what makes it harder to reduce the impact of AOD on their community. Social and peer pressure, as well as feelings of shame for help seekers, were the most common themes. A lack of education about the consequences of AOD was also common, as well as minor penalties or offences and a lack of motivation for those with AOD issues.

Figure 9: Obstacles to reducing AOD impacts



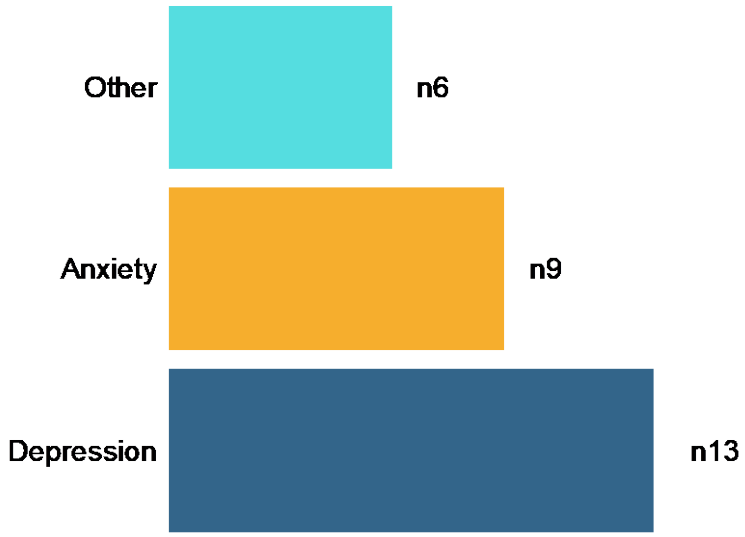
Exploring Mental Health

Common Mental Health Issues

Figure 10 shows the responses received by facilitators on what mental health issues are more common in their community. Depression and anxiety were frequent. Other mental health issues included PTSD (Post Traumatic Stress Disorder) – particularly for those from war-torn countries – eating disorders, bipolar disorder and schizophrenia. These other mental health issues were not attributed to a particular cohort.

One facilitator commented that, due to the stigma around mental health issues, it is difficult to get a sense of their prevalence.

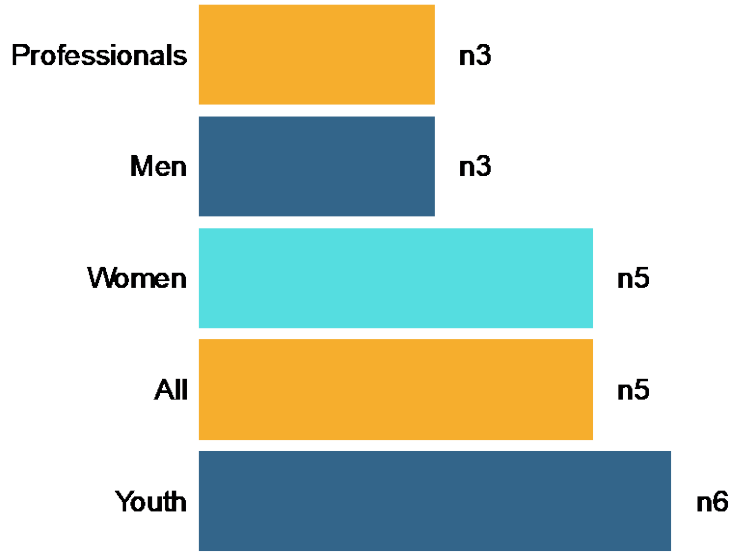
Figure 10: Most common mental health issues



Who Is Most Affected by Mental Health?

Figure 11 shows the responses received by facilitators on whether mental health issues were more common for a particular part of the community. Five facilitators said that all parts of the community have issues surrounding mental health. Youth and women were commonly reported to have mental health issues due to relying on others for support, being socially isolated and more vulnerable to incidents of violence. Individuals who were professionals in their home country were also reported to have higher cases of mental health issues as they struggled to find professional work. One facilitator commented that those who were exposed to war in their home country or stayed at refugee camps had more issues with their mental health.

Figure 11: Groups most affected by Mental Health issues



Supporting People with Mental Health Issues

Figure 12: what works when trying to support people with mental health issues

As shown by **Figure 12,** when asked what works when trying to support people with mental health issues in their community, social support was mentioned 16 times and professional services were mentioned 12 times. Social support included social activities in a friendly and accepting social environment to help the individual to have a greater sense of social identity within the wider community. Social services included access to psycho-educational material about mental health issues, counselling and other mental health professionals. One facilitator mentioned religious activities.

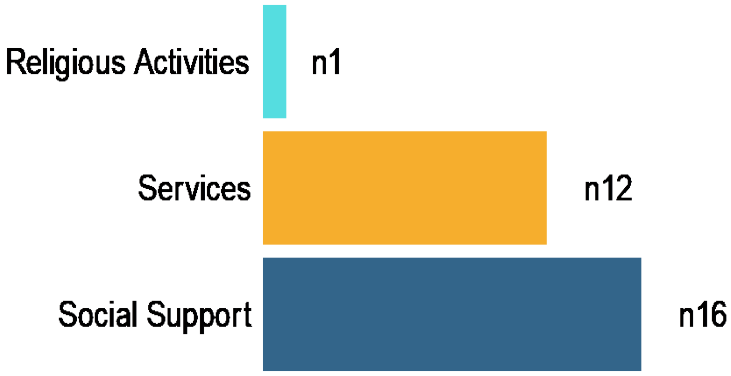
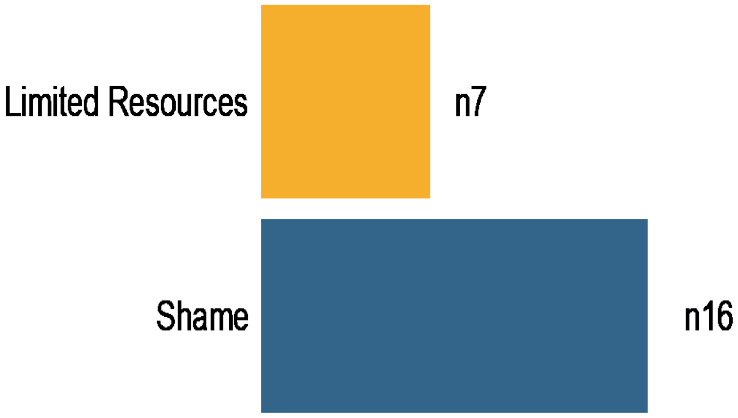


Figure 13: What makes it harder to support people with mental health issues

As shown by **Figure 13,** when asked what makes it harder to support people with mental health issues within their community, shame was mentioned 16 times. Facilitators expressed that individuals are hesitant to seek health support due to feelings of shame, embarrassment and isolation because of the stigma attached to mental health. Limited resources were mentioned seven times and included limited access to information about mental health issues and limited access to mental health services, particularly due to poor cultural considerations and language barriers. It was however unclear whether the limited access to services was due to the individual's unwillingness to access these services.



CONCLUSION

The consultation process reached a diverse cross section of the CALD community with 189 people engaged from six different CALD backgrounds and five lived experience members. The forums with providers and the Sub-network Steering Committee confirm the emerging themes from this consultation.

- AOD and MH are seen as issues of concern in these CALD communities.
- Providers are seeing a faster increase in MH in these CALD communities.
- The causation for these issues is complex and multi-faceted, bringing in issues of settlement in Australian culture, peer pressure and trauma.
- The community are seeing alcohol as the most prominent substance used due to cheap costs while the domestic issues were the biggest concern surrounding AOD abuse.
- Youth were the most impacted part of the community due to peer pressure and AOD impact on their education, safety and future job opportunities. Consistent with this, the greater obstacles in reducing the impact of AOD were peer pressure and the shame attached to seeking help.
- The most common mental health issues were depression and anxiety, and this was prevalent across the community, with some reporting that the issues were more common for women and youth.

The forum highlighted gaps in the ability for many mainstream service providers to offer services that are accessible to CALD communities. Comments from all participants (professional and community) reflected the need or desire for MH and AOD mainstream services to strengthen their cultural competence.

Professionals in the sector focussed their contributions more on improving accessibility to MH/AOD services, whilst communities prioritised prevention and early intervention.

Professionals noted that, whilst there are CALD specialist services available in WA, their resources are limited. The Sub-Network has suggested a model to build the requisite skills and referral pathways for a transcultural approach to service delivery. However, the validity and appropriateness of the suggested model was not tested with other stakeholders through this consultation process.

The community responses also noted the importance and value of protective factors, i.e. culture, community supports and the role of spirituality. Community comments suggest that the biggest obstacle in MH/AOD is the stigma towards such issues. Those consulted strongly suggested that the best way to support CALD people and to overcome this stigma is to invest in services that work alongside communities, building trust over time in a friendly and non-judgmental environment.

The participation of community members in this process also demonstrates an appetite and capacity to work together with services to improve MH/AOD outcomes in their communities.

The consumer experience highlighted the importance of new immigrants feeling that there is a community they can belong to and the need for support to establish income and a new life as key prophylactics to addiction and/or a decline in mental health.

Consumers also added the recognition that some CALD communities are not viable avenues for support, due to the historical context of the different sub-cultures/religious affiliation within that community.

Appendix One: Consultation Participants

- **Sector consultation forum:**

Agency

1. WAAMH
2. MENTAL HEALTH COMMISSION
3. MH CARER REPRESENTATIVE
4. WANADA
5. UNITING CARE WEST
6. UNITING CARE WEST
7. WOMEN'S HEALTH and FAMILY SERVICES
8. WOMEN'S HEALTH and FAMILY SERVICES
9. WOMEN'S HEALTH and FAMILY SERVICES
10. ZONTA
11. HEPATITIS WA
12. HEPATITIS WA
13. ST JOHN OF GOD
14. MERCYCARE

The Multicultural Mental Health Sub Network Steering Committee

- **Conversation Cafés:** This is the breakdown of cultural groups consulted

African backgrounds included
- African (not specified)
- Somali
- Nigerian
- Congolese

Asian backgrounds included
- Asian (not specified)
- Filipino
- Vietnamese
- Indonesian
- Thai

Middle Eastern background included
- Lebanese
- Egyptian
- Iranian
- Persian

Indian background
- Indian (not specified)

Balkans background included
- Serbian
- Croatian
- Bosnian
- Montenegrins

- **Consumer interviews:** Consumers were recruited from current Multicultural Futures clients and invited to participate in a phone interview. Their names are not provided here to maintain confidentiality. Consumers were remunerated for their participation in the process (a fee of $100 was paid to each participant).

Appendix Two: Multicultural Sub-Network Model

The following pages provide a detailed breakdown of the key elements of the model developed by the Sub-Network[3].

(a) State-wide Co-ordination

a. Coordinate transcultural mental health activities with key agencies and services in the sector at a local (metropolitan and rural) and, where necessary, at a national level. Effective coordination will serve to prevent duplication of services and ensure that mental health needs are met where they are needed.
b. Be a major point of reference for provision of key information on state-wide transcultural mental health issues for service providers and policy makers.

(b) Capacity Building

a. Build capacity and increase mental health literacy levels of ethnoculturally diverse communities through relationship building and engagement.
b. Assist the mental health sector in the development of policies to achieve and, if possible, exceed the standards regarding provision of culturally appropriate mental health care and treatment.

(c) Culturally Sensitive Consumer and Carer Engagement

a. Facilitate the endeavours of other agencies in developing a culturally responsive support program for carers and families from ethnoculturally diverse groups.
b. Partner with relevant peak agencies in building the capacity of consumers and carers from ethnoculturally diverse groups to develop the necessary skills and a stronger voice to effectively inform and participate in policy development and program design.

(d) Education and Training

a. Develop and deliver an education and training programme for the workforce in public mental health services and community agencies (including primary care practitioners) focusing on best-practice transcultural mental health care and management.
b. Create placement opportunities in its consultation-liaison program for undergraduate and postgraduate medical, nursing and allied health practitioners.
c. Provide cultural clinical supervision in person or via video conference to practitioners in mental health programs and services that are engaging with ethnoculturally diverse clientele.

(e) Resource Development

a. Develop transcultural mental health resources (e.g. translated information packages, directory of resources) and tools for clinicians to implement best practice.
b. Actively promote the implementation of the WA version of the National Cultural Competency Tool (NCCT) – a resource that will allow mental health programs and services to measure their cultural competency levels and to continuously improve through self-initiated prompts. Driven strategically by the Hub, the widespread utility of the NCCT by all MHC-funded programs will ensure all consumers from ethnoculturally diverse backgrounds will receive equitable services.

(f) Clinical Consultation-Liaison

a. Provide a sessional transcultural consultation-liaison service to mental health services in the community (refer 3.1.2 – The Spokes).

[3] MENTAL HEALTH NETWORK; A model for an effective and sustainable state-wide Transcultural Mental Health Service for Western Australia; May 2018

b. Provide secondary opinion on appropriate transcultural mental health care via VC/telephone to practitioners, particularly in country areas and including primary health care.

(g) Research

a. Identify and address gaps in relevant data sets collected currently across mental health programmes and services.
b. Coordinate partnerships with relevant educational institutions to develop a clear transcultural mental health research and evaluation agenda to inform service development and planning.
c. Collate information about research on transcultural mental health issues and other developments and dissemination of this information in a systematic manner to the sector.

Appendix Three: Conversation Café Kit

Community ambassadors were asked to coordinate participants and venues for a meeting in their communities. Ambassadors were given a support package that outlined:

- The overall meeting sequence and questions. With the recognition that questions may be translated, adapted to different languages and cultural contexts (see below)
- A guide on running meetings of this kind
- A link to an online form that provides a tool for consistent data entry of their meeting demographics and participant responses

Meeting sequence and questions

Part One – Introductions and context setting

Part Two - AOD

- In (y)our community, are some types of alcohol or other drugs more of a concern or more popular for some people?
- What are the kinds of concerns or issues that alcohol or other drugs cause for your community?
- Does it impact one part of the community more than another? Who, what is the impact and why?
- When trying to reduce the impact of AOD in your community, what works?
- What makes it harder to reduce the impact of AOD in your community?

Part Three – Mental health

- In (y)our community, are some types of mental health issue more common?
- What are the kinds of impact that mental health has on your community?
- Does one part of the community experience mental health issues more than another? Who, what is the impact and why?
- When trying to support people with mental health issues in your community, what works?
- What makes it harder to support people with mental health issues in your community?

Part Four – Closing

Appendix Four: Conversation Café – Online Form

These are the questions used to collate the information gathered by the community ambassadors.

Please tell us about the group you meet with:

- What date was the group held?
- Where was the group held?
- What was/were their cultural background/s?
- How many people attended?
- What was the gender balance?
- Describe the age range
- Is there anything else about the group that would help us understand their responses?

Please provide responses to the following:

- In (y)our community, are some types of alcohol or other drugs more of a concern or more popular for some people?
- What are the kinds of concerns or issues that alcohol or other drugs causes for your community?
- Does it impact one part of the community more than another? Who, what is the impact and why?
- When trying to reduce the impact of AOD in your community, what works?
- What makes it harder to reduce the impact of AOD in your community?
- In (y)our community, are some types of mental health issue more common?
- What are the kinds of impacts that mental health has on your community?
- Does one part of the community experience mental health issues more than another? Who, what is the impact and why?
- When trying to support people with mental health issues in your community what works?
- What makes it harder to support people with mental health issues in your community?
- Do you have any other comments/observations about this session?

End of document.