framework for the implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia

national mental health strategy

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The development process included an extensive consultation period, including a National Consultation Forum in August 2003. Representatives of thirty-seven stakeholders in transcultural mental health, mainstream health and mental health and other service providers, consumer, carer and community groups with an interest in the mental health and well-being of multicultural Australia attended this Forum. Written comments were received from twenty-one organisations and eleven individuals. Local meetings were also conducted in Queensland (Brisbane and Cairns) and Tasmania (Devonport, Launceston and Hobart) to discuss the Consultation Paper. A further forty-eight organisations and individuals were represented at these meetings.

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Foreword

The *Mental Health Statement of Rights and Responsibilities* "recognises the aspirations of all Australian residents to a dignified and secure way of life, with equal access to health care, housing and education, and equal rights in civil, legal and industrial affairs". (Australian Health Ministers, 1991, p.ix)

This right of all Australians to good mental health, equal access to quality mental health services and the opportunity to participate in their health care is the starting point of the Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia.

In the years since the introduction of the National Mental Health Strategy, in 1992, there has been increased awareness of the specific issues that impact on the mental health and successful settlement in Australia of immigrants and refugees. Despite this, people from culturally and linguistically diverse (CALD) backgrounds remain a population group requiring special attention to their mental health status. The challenges of a diverse population – of developing culturally inclusive public policy, ensuring equity and access, planning and delivering culturally competent and appropriate services and developing and maintaining a culturally competent workforce – remain.

This Framework, endorsed by the Australian Health Ministers' Advisory Council National Mental Health Working Group after extensive consultation, responds to Australia's multicultural community: a community where one Australian in three has a culturally and linguistically diverse ancestry. It complements existing mainstream mental health policy, focusing specifically on mental health issues for people from culturally and linguistically diverse backgrounds and identifying specific areas for action for CALD communities in the future.

The Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia will build on the last decade of reform to improve the treatment and care for all Australians regardless of their cultural background.

Keith Wilson

Chair

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Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia

In 2003 the National Mental Health Plan 2003-2008[1] was launched, taking forward with restated and new directions the National Mental Health Strategy of 1992.[2] The National Mental Health Plan builds on the foundations of the last decade and continues to provide an ongoing agenda for service and community development to improve the mental health of all Australians.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia compliments the National Mental Health Plan[1] by focusing on the specific needs of Australia's multicultural community. In describing a broad national approach to the mental health and wellbeing of people from culturally and linguistically diverse (CALD) backgrounds, this Framework informs the implementation of the National Mental Health Plan in a diverse community.

In Australia in 2001 one person in three identified as having a culturally and linguistically diverse ancestry. This diversity, including diversity of language, culture and religion, contributes to the wealth and prosperity of Australia. It also presents challenges for the health sector: to ensure that the mental health needs of people from CALD backgrounds are met; to develop public policy to ensure equity and access for a diverse community; to plan and deliver culturally competent and appropriate services and develop and maintain a culturally competent workforce.

In line with the original aims of the National Mental Health Strategy 1992,[2] the Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia seeks to promote the mental health of all people in Australia from culturally and linguistically diverse communities, and where possible, to prevent the development of mental health problems and mental illness. It also aims to reduce the impact of mental illness on culturally and linguistically diverse individuals, families and communities, and assure the rights of CALD people with mental illness.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia promotes the support and inclusion of culturally and linguistically diverse communities, consumers and carers in the planning, delivery and evaluation of mental health care at all levels.

The Framework provides strategies for all government and non-government organisations, across the health and community sectors, to meet nationally accepted standards of service delivery and workforce practice in the provision of culturally competent and appropriate services.

The following principles underpin the Framework:

- A population health approach to mental health in CALD communities acknowledges the importance of culture and the migration experience in

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determining risk and protective factors that influence mental health.

- Consumers from culturally and linguistically diverse backgrounds, their families and carers, have the right to access mental health care provided in a manner which responds to their social, cultural, linguistic, spiritual, and gender diversity, and assures positive outcomes. They are key stakeholders in the design and delivery of culturally competent mental health services, with rights to participate in decision-making on all aspects of their mental health.
- The provision of culturally competent, responsive and efficient mental health services requires partnerships across the health and welfare system and with consumers and carers from CALD backgrounds.
- A culturally competent workforce is fundamental to the provision of culturally appropriate mental health services.
- A recovery focus, which respects consumers' personal, cultural and spiritual belief system, and that of their families, carers and community, should drive service delivery.
- Initiatives to ensure quality in mental health services must be appropriate for CALD consumers, their families and carers.
- Initiatives to develop innovative ways to provide services and research into new service models must be culturally competent and inclusive.
- Culturally appropriate service models, which are shown to be effective, must be sustainable in the long term and become part of mainstream mental health care.
- Achievement of better mental health outcomes for CALD consumers, their families and carers will require funding models and allocation of resources which consider the needs of CALD populations.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia sets out four priority areas for the next five years and identifies concrete tasks, expected outcomes and responsibilities for action.

The four Action Areas are:

- **A population health approach to mental health for people from CALD backgrounds** This Action Area aims to promote health and reduce illness by the development of culturally appropriate services that cover the spectrum of mental health care from the prevention of mental illness and the promotion of good mental health to treatment, rehabilitation, recovery and relapse prevention.
- **Improving service responsiveness to cultural diversity** This Action Area aims to improve the quality of mental health care and deliver improved mental health outcomes by developing services that are appropriate and accessible to the specific and diverse needs of CALD communities.
- **Strengthening quality** This Action Area aims to strengthen the quality and capacity of service delivery through increased consumer participation, adequate and appropriate funding of services and programs, culturally competent workforce development and the guarantee of consumer rights and legislation.
- **Fostering culturally inclusive research, innovation and sustainability** This Action Area aims to develop a mental health research agenda that is culturally competent and inclusive and considers the specific needs of CALD consumers, their families and carers.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia identifies stakeholder groups concerned with the wellbeing of CALD communities and calls for action across a range of sectors and at all levels of government, in partnership with individuals from CALD backgrounds, their families, communities and organisations. The Framework identifies the need for consistent reporting and monitoring of outcomes across the mental health system to measure the effectiveness of services and programs for people from CALD backgrounds.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia aims to promote and support the development of sound policy and good practice in multicultural mental health care in Australia and to develop high-quality mental health care for all Australians from diverse backgrounds.

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Australia is one of the most multicultural communities in the world. In 2001, 30 per cent of Australians identified as having a culturally and linguistically diverse ancestry. Two and a half million people in Australia were born in countries where English is not the primary language and 15 per cent of the population speak a language other than English at home.[3]

People in Australia from culturally and linguistically diverse backgrounds are not a homogeneous group – they speak over two hundred languages and practise most of the world's religions. Since the end of World War II Australia's population has increased in both size and diversity due to the resettlement of significant numbers of people from around the world, including areas of conflict. Initially, large numbers of people came to Australia from Italy, Greece, Holland and other parts of southern Europe, but recent decades have seen more arrivals from South-East Asia, eastern Europe and the Middle East.

No matter what their country of origin, new arrivals to Australia come from a range of social, educational and economic backgrounds and bring with them a range of protective and risk factors for mental health.

Cultural diversity and mental health

Australia's cultural diversity - including its diversity of language, culture and religion - greatly contributes to the dynamism and wealth of our society. However, it brings with it challenges to ensure that the complex health and mental health needs of a wide range of culturally and linguistically diverse groups are met.

Over a quarter of a million first-generation adult Australians from culturally and linguistically diverse backgrounds are estimated to experience some form of mental disorder in a 12-month period, based on the findings of the National Survey of Mental Health and Wellbeing.[4] This does not include second-generation Australians from multicultural backgrounds, many of whom face life stressors linked to their cultural identity or to traumatic events experienced by themselves or their parents. However, different cultures have different views of what constitutes mental health and mental illness, depending on what each particular culture regards as "normal" or "abnormal" behaviour, and the influence of other factors such as gender, class, education and religion.

The concept of mental health, as used in this document, is one that encompasses social, emotional and spiritual wellbeing across the lifespan. Mental health issues, such as depression, suicide and substance use are, in our society, all parts of the broader picture of health at the population level. Under the National Mental Health Strategy,[2]

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mental health has been progressively incorporated into the broader health sector.

The diversity of Australian society means the health sector must deal with the challenge of developing public policy which ensures equity and access to a diverse community; of planning and delivering culturally appropriate services; and of developing and maintaining a culturally competent workforce. An understanding of the role of culture is vital to the assessment, diagnosis and treatment of mental illness and is essential for everyone involved with the health and wellbeing of all people in Australia.

Purpose of the Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia

While mainstream national mental health policy addresses the needs of all Australians, including people from CALD backgrounds, the Framework for Implementation of the National Mental Health Plan 2003-2008[1] in Multicultural Australia builds upon that platform but focuses more strongly on stating the specific principles that will promote inclusion and prevent exclusion of CALD communities, consumers and carers in the promotion of good mental health and planning, delivery and evaluation of mental health care.

It describes a broad national approach to the mental health and wellbeing of people from culturally and linguistically diverse backgrounds, informs implementation of the National Mental Health Plan 2003-2008[1] and provides strategies for integration able to be implemented by all governments and non-government organisations, across the health and community sectors. It emphasises support for those people from CALD backgrounds who are consumers of mental health services, their families and carers, and the development of State, Territory and local working partnerships that are consistent with national policy and process. It sets out aims, principles and key policy areas requiring action.

Use of terminology

For the purpose of this document, the following key terms are defined as follows:

- "culture" is defined as a "set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment".[5]
- "cultural and linguistic diversity" refers to the wide range of cultural groups that make up the Australian population and Australian communities. It includes groups and individuals who differ according to religion, race, language or ethnicity. For ease of expression the abbreviation CALD is used interchangeably with "culturally and linguistically diverse".
- "cultural competency" means the ability "to see beyond the boundaries of (one's) own cultural interpretations, to be able to maintain objectivity when faced with individuals from cultures different from (one's) own and be able to interpret and understand behaviours and intentions of people from other cultures non-judgementally and without bias".[6]

This Framework covers both diagnosed mental illness and a range of broader emotional issues. However, while it refers to, and recognises close connections with related social health issues affecting the social health of people from culturally and linguistically diverse backgrounds, these issues are not the primary focus of the Framework.

A Glossary is located at the end of this document, and provides further definitions.

Structure

The first part of this document, Background, provides information on the need for the Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia and the overarching policy context in which the document exists. This is followed by details of the four Action Areas, and a discussion of implementation and evaluation.

Policy Context

The term "multiculturalism" was introduced by the Commonwealth Government in the 1970s and refers to the public policies that address the consequences of the cultural and linguistic diversity of Australian society. Multiculturalism recognises, accepts, respects and celebrates the cultural and linguistic diversity of our population and results in distinct benefits for the individual and Australian society as a whole.

The Australian Government appointed a National Multicultural Advisory Council in 1997 to develop a report that recommended a policy and an implementation framework for the next decade, aimed at ensuring that cultural diversity is a unifying force for Australia. This report, Australian Multiculturalism for a New Century: Towards Inclusiveness,[7] was launched by the Prime Minister in May 1999. It made recommendations about improving and refocusing multicultural policy. In response to this report, the Australian Government tabled A New Agenda for Multicultural Australia[8] in Parliament in December 1999.

The New Agenda highlights the need for Australian multiculturalism to be a unifying force for the nation and that it can only achieve this through inclusiveness and public policies that reflect the cultural and linguistic diversity of the Australian population.

The Government's current multicultural policy statement, Multicultural Australia: United in Diversity[9] was issued in May 2003. The statement gives particular emphasis to the Government's access and equity strategy, which aims to ensure government services and programs respond to the realities of Australia's diversity. Equity of access is enshrined in the 1998 Charter of Public Service in a Culturally Diverse Society[10] which aims to ensure that mainstream government services are planned and delivered with cultural diversity considerations in mind. The Charter integrates a set of service principles concerning cultural diversity into mainstream service planning, delivery, evaluation and outcomes reporting. The result is that services are better able to meet the needs of all Australians.

The Charter has been endorsed by the Commonwealth, State and Territory Governments and by the Australian Local Government Association and represents a nationally consistent approach to the delivery of culturally responsive government services.

Australian Mental Health Policy 1992-2003

In 1992, all Australian Health Ministers agreed to a National Mental Health Policy.[11] This policy initiative represented the first attempt to coordinate mental health care reform at a national level, and became known as the National Mental Health Strategy.[2] The Strategy brought about a major reform process in the way services are provided to people affected

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by mental illness and in the way mental health and mental illness are understood and approached at a national and state/territory level.

The policy directions of the National Mental Health Strategy are:

- to promote the mental health of the Australian community;
- to, where possible, prevent the development of mental illness;
- to reduce the impact of mental illnesses on individuals, families and the community; and
- to assure the rights of people with mental illness.

The Strategy identified twelve priority areas for reform, and defined specific policy directions and strategies for implementation in the areas of

- Consumer rights
- The relationship between mental health services and the general health sector
- Linking mental health services with other sectors
- Service mix
- Promotion and prevention
- Primary care services
- Carers and non-government organisations
- Mental health workforce
- Legislation
- Research and evaluation
- Standards
- Monitoring and accountability.

The Strategy was originally articulated in four major documents:

- The Mental Health Statement of Rights and Responsibilities[12] outlined the philosophical foundation of the Strategy. It was based on the principles of the United Nations Resolution 98B (Resolution of the Protection of Rights of People with Mental Illness) and was agreed to by Health Ministers in 1991. This document underpins the National Standards for Mental Health Services,[13] which were endorsed by the Australian Health Ministers' Advisory Council National Mental Health Working Group in 1996.
- The National Mental Health Policy[11] outlined the new approach to mental health care, promoting a move from an institutional to a community-based orientation. It defined the broad aims and Policy directions to guide the reform process for the twelve priority reform areas.
- The first National Mental Health Plan[2] charted an action plan for the first five years of the Strategy and described how Commonwealth and State and Territory governments would implement the aims and Policy directions of the Policy.
- Funding from Schedule F1 of the Medicare Agreements supported the First Plan, and Schedule B funds from the Australian Health Care Agreements assisted the implementation of the Second Plan.

Together, these documents are known as the National Mental Health Strategy.[2]

Progress through the first five years of the Strategy was summarised in 1997 in the document Evaluation of the National Mental Health Strategy, Final Report[14] which concluded that the mental health system in Australia at the commencement of the Strategy had been in a poor state and that considerable gains had been made. Despite the many positive developments, it also reported widespread dissatisfaction with many aspects of mental health services in Australia in 1997. Dissatisfaction was particularly prevalent among consumers and carers, primary health care practitioners and the community where the mental health system remained feared and unknown and continued to stigmatise and discriminate against those affected by mental illness. It was concluded that much work remained to implement the National Mental Health Policy.

In response, Australian Health Ministers endorsed a Second National Mental Health Plan in 1998.[15] The Second Plan was developed within the framework of the existing National Mental Health Policy[11] and provided a renewed commitment to the policy directions of the National Mental Health Strategy.[2] It built on the achievements of the first Plan and identified three additional areas for national

activity for the period 1998-2003: promotion and prevention; development of partnerships in service reform; and quality and effectiveness of service delivery.

Progress under the Second Plan was summarised in the Evaluation of the Second National Mental Health Plan (2002)[16] which concluded that, despite substantial additional reform, there is much still to be achieved, particularly in the areas of:

- meaningful consumer and carer participation;
- access to quality mental health care that is timely, respectful, individualised and holistic in its approach, coordinated within the mainstream health system and delivered in accordance with cultural and developmental needs; and
- funding, researching, planning, delivering and reporting on mental health care.

In response, Health Ministers agreed to the development of the *National Mental Health Plan 2003-2008,*[1] to set an ongoing agenda for service and community development in mental health in Australia over the next five years.

Mental health policy and cultural and linguistic diversity

The Mental Health Statement of Rights and Responsibilities *"recognises the aspirations of all Australian residents to a dignified and secure way of life, with equal access to health care, housing and education, and equal rights in civil, legal and industrial affairs"* and states that "*people with mental health problems or mental disorders should have access to services and opportunities available in Australian society for people of a similar age with equity and justice. Access to and availability of appropriate services requires consideration of specific needs and ideally is not limited by...cultural and ethnic barriers, communication capacity and skill, including language*".[12] The Mental Health Statement of Rights and Responsibilities outlines the philosophical foundation for consumer rights and includes the right to have their cultural background taken into consideration in the provision of mental health services as a key consumer right.

However, despite this and the priority accorded to people in Australia from culturally and linguistically diverse backgrounds in the first National Mental Health Plan, the evaluation of this plan recognised systemic inequalities in access to services and wide differences across States and Territories in the level of response to the needs of these population groups.[16]

Consequently, the Second National Mental Health Plan sought to "*improve treatment and care for a broader range of people with high level needs*", including people from culturally and linguistically diverse backgrounds.[15] Successive Australian and State and Territory governments have introduced a range of policy and legislative initiatives aimed at addressing social inequities experienced by culturally and linguistically diverse communities and individuals, particularly with regard to access to those services available to the general Australian community.

The Evaluation of the Second National Mental Health Plan identified a continuing need to improve outcomes for people from culturally and linguistically diverse backgrounds and, in identifying future directions, concluded that *"People from culturally and linguistically diverse backgrounds have a special need for culturally appropriate service delivery and recognition of the unique factors, such as refugee status, that impact on their social and emotional wellbeing".*[16]

The National Mental Health Plan 2003-2008

The National Mental Health Plan 2003-2008[1] consolidates the achievements of the First and Second Plans, addresses gaps identified in both, and takes the National Mental Health Strategy forward with restated and new directions. It can be viewed as an ongoing agenda for service and community development that sets priorities for 2003-2008. It represents a partnership between the key stakeholders in mental health.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia builds on the history of national policy development and program evaluation under the National Mental Health Strategy which is described above. It elaborates on issues contained in the National Mental Health Plan 2003-2008[1] in relation to the special needs of Australians from culturally and linguistically diverse backgrounds. Its development has been auspiced by the Australian Health Ministers' Advisory Council's National Mental Health Working Group.

Rationale for the Framework

The Mental Health Statement of Rights and Responsibilities[12] recognises the aspirations of all Australian residents to equal access to health care, housing and education, and equal rights in civil, legal and industrial affairs. The Statement of Rights states that people with mental health problems or mental disorders should have equal access to appropriate services that consider their specific needs and are not limited by cultural and ethnic barriers, or communication capacity and skill, including language.

CALD consumers, their families and carers

The National Standards for Mental Health Services,[17] Standard 1, Rights, outlines the actions required to ensure that all mental health consumers, their families and carers have their **rights** upheld. In relation to people from culturally and linguistically diverse backgrounds, it specifically includes the provision of information in appropriate languages and access to interpreters. Standard 3, Consumer, carer, community participation, further highlights the importance of consumer participation at all levels of service planning, delivery and evaluation.

CALD consumer and carer participation varies across jurisdictions, and, in the main, lags behind mainstream achievements in participation. Consumers, their families and carers from culturally and linguistically diverse backgrounds experience particular barriers to effective participation.

There have been numerous reports and studies highlighting the large range of inequalities faced by people of CALD backgrounds in gaining access to mental health services, and the quality of care they receive when using these services. It is well documented that language and cultural barriers present significant obstacles for CALD people in gaining access to mental health services. People of CALD backgrounds often miss out on generic and psychiatric support services or are unaware of the range of services and supports available and lack the necessary knowledge and understanding to access and use appropriate services. Family members and caregivers of CALD people may not have the opportunity to express their problems, frustrations and views about care-giving within a structured and appropriate environment.

Consumers need resources, support and training to participate at all levels of the mental health system. Development of appropriate strategies to enhance the capacity of culturally and linguistically diverse communities, as well as individuals to participate at all levels of the mental health system, are an essential element of compliance with this standard. It is also necessary for mental health services to create systems able to respond to CALD consumer and carer feedback.[18,19]

Carers from culturally and linguistically diverse backgrounds face similar issues to mainstream carers, however, specific issues facing CALD carers include: cultural attitudes towards mental illness and the acceptance of assistance from outside the family unit; perceptions of roles within the family and expectations of who should adopt the carer role; lack of translated information on illness, caring and carer support services; and issues of gender, including the traditional roles of women as caregivers.

Factors which can contribute to CALD carer wellbeing include: availability of information and practical support; availability of adequate respite care; accessible primary health care, particularly from general practitioners; and strategies to independently address needs of carers and assist them to develop their own strategies for coping.[20]

In CALD communities a **focus on recovery** is essential for promoting hope, wellbeing and a valued sense of self-determination for people with mental illness, their families and carers. Recovery has been defined as *"... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows*

beyond the catastrophic effects of psychiatric disability".[21] A recovery orientation emphasises the development of new meaning and purpose for consumers and the ability to pursue personal goals. The concept of recovery for CALD consumers, their families and carers may vary according to their explanatory models of their illness. It may be made more problematic by the stigma surrounding mental illness within communities that can be small and close-knit. For example, community perception, beliefs and judgements can reinforce social isolation and potentially override an individual's positive outlook about their recovery. Consideration of the perceptions of mental illness that can exist within CALD communities is essential to the provision of effective, recovery-focused rehabilitation and relapse prevention services.

Programs to promote **community awareness**, provide mental health information and education on mental health and mental illness and develop a range of advocacy services in partnership with community organisations, will increase mental health literacy, and promote early recognition of mental health problems and early help seeking. These programs must engage CALD community leaders in promoting acceptance of mental illness as a community issue and in reducing stigma.

Population health

A population health approach to mental health encompasses the continuum of mental health interventions from maintaining mental health to dealing with serious mental illness. The experience of decades of **population health** practice has shown us that a community's health is determined by more than the quality and availability of health services. National Health Priority Areas Report, Mental Health: A report focusing on depression argues that at a population level, mental health status includes a number of themes, including **culture and identity**. It also states "social-emotional ill health and mental disorders can result from oppression, racism, environmental circumstances, economic factors, stress, trauma, grief, loss, cultural genocide, psychological processes and poor physical health".[22]

The stresses associated with immigration and settlement in a new country may impact on individual health and wellbeing, and that of whole communities. These stresses may include coping with past experiences of flight, trauma, racism and discrimination; isolation and lack of social and family support networks and change of traditional roles within the family; loss of status, particularly vocational status; loss of self-esteem; feelings of powerlessness and communication difficulties. Some communities may be socio-economically disadvantaged while some smaller or emerging communities may lack established infrastructures to provide community members with social support. Individuals within each community may have their own genetic, social and environmental risks, as well as individual coping skills.

Groups at greatest risk

Risk factors and protective factors vary for particular **population groups** and at **particular times across the lifespan.** Culture-specific help-seeking behaviour, service utilisation, treatment patterns and patterns of morbidity may also vary. Specific groups within Australia's culturally and linguistically diverse population are at particular risk of developing mental health problems and may also be at risk of suicide.

Risk for mental illness may also occur across the lifespan, especially at points of transition, and the experiences of some groups may be such that individual resilience and hopes for recovery are significantly diminished. The pre- and post-arrival experiences of individuals, including, but not limited to, restrictions on freedom of movement, detention, loss of family, uncertainty of income, entitlements and legal status, may also make their needs more complex. For many immigrants, including long-term residents, past experience of war, trauma and upheaval may be frequently revived by recurring reports and images of conflicts in other parts of the world.

There is a great deal of evidence that trauma and loss may have profound and ongoing effects on many people who migrate to Australia as **refugees or who have experienced displacement, torture and trauma.** Refugees and survivors of torture and trauma face specific and complex stressors and are at very high risk of developing syndromes such as post-traumatic stress disorder, and the secondary morbidity which may occur with it, including major depression, substance use disorders, and a range of social dysfunctions. Children and young people who have either been victims of torture and trauma, or who have witnessed their parents as victims, can be at particular risk of future mental illness. For many young refugees, the lack of experience of hope and lack of stability may make effective recovery more difficult.[23,24,25,26,27]

Some newly arrived refugees may defer accessing support under a range of programs until other settlement issues, such as housing and employment, are resolved. While there is evidence to suggest that this delay may worsen the situation,[28] the right of the individual to choose whether they will accept health services remains fundamental. Achieving a balance between the individual's reluctance to accept support and the importance of early help seeking is fundamental to the provision of early assessment and intervention programs for newly arrived refugees. Despite the range of settlement support available, some refugees with very low English ability and limited basic knowledge and skills to adapt to Australian living conditions may never reach the primary health care stage, in which early intervention is possible. Further research is required to develop appropriate partnerships and service models to target those most isolated and at risk.

New and emerging communities generally lack completed family and social networks and often lack earlier generations of settlers or an Australian-born second

generation. These communities often lack knowledge of existing services, collective resources or effective organisations within a national network. Additionally they may not be part of the existing network of funding, be unfamiliar with submission-based government funding and have little influence on political processes. They may also have no effective community media or communication mechanisms. In these situations already restricted family networks are likely to form a substitute for formal organisations due to lack of information about, or access to, wider services. Despite their difficulty accessing government services they require highly targeted and specialised services and resources.

People from diverse backgrounds settling in rural and remote areas face the same barriers as mainstream populations including distance from urban centres; scattered and low-density populations; large administrative areas; poor infrastructure; and difficulties in attracting and keeping medical staff and practitioners, resulting in rural populations receiving overall lower standards of health care and lower overall health status than urban dwellers. In addition, they may face increased isolation due to language and communication barriers, remoteness from culturally appropriate services, lack of adequate social networks, alienation and discrimination, which can be exacerbated in culturally diverse communities in remote areas.

Women from culturally and linguistically diverse backgrounds have significant risk factors for post-natal distress and depression.[29,30] During the school years, **children** from culturally and linguistically diverse backgrounds may be confronted by perceived differences from the mainstream culture, by language problems and a range of issues related to cultural contexts of family life, education, and values about child behaviour. Conflicts may occur within the family due to pressures the child experiences from peers and dominant Australian cultural norms.

Adolescents and young adults from culturally and linguistically diverse backgrounds may experience heightened uncertainty related to cultural identity, discrimination, peer relations, cultural views on sexuality and sexual identity and work and family demands.[31] Expectations from family in terms of achievement, education, employment and fulfilling family goals can mean increased pressure and fear of failure. Life transitions that are part of young adult development can be more difficult to negotiate as a result of cultural views on sexuality and sexual identity, adult pair bonding, the establishment of work and career, potential for cross-cultural relationships, establishment of family, and birth of the first child. Particular difficulties may arise for young people from culturally and linguistically diverse backgrounds in education and work settings if language barriers exist, or prior learning or qualifications have not been transferable. Depending upon the resilience and resources of the young person, such life changes may increase vulnerability or, alternatively, provide a challenge that stimulates personal growth and maturation. These may result in increased risk of suicide, increased vulnerability to drug or alcohol problems, anxiety, depression, distress and poor self-esteem, which may be hidden by withdrawal, or alternatively, aggressive and acting out behaviours.

Older people from diverse backgrounds may suffer stress in relation to loss, physical illness or disability or the onset of disorders such as dementia, which often results in a loss of competency in English. Biological, psychological and social factors, including social disadvantage, may all contribute to increased risk of depressive disorders and suicide, as may loss of function, and separation from family and culture. Nostalgia and loss of hope of returning to the homeland and increased inter-generational conflict are particular stressors in the later years of life. Older victims of torture and trauma may experience repressed or recurring memories.

Evidence base

In a study to identify gaps in Australia's mental health research and to identify mental health research priorities, an analysis of research publications and research grants indicates that research dealing with non-English speaking population groups made up only 2.2 per cent of published articles and attracted only 1.5 per cent of competitive research grant funding. A further examination of the goals of research found that "transcultural comparisons" figured in only 0.6 per cent of articles and 0.04 per cent of funding.[32] Existing **research** into the specific issues surrounding mental illness in people from CALD backgrounds is often scant or unconvincing and many issues require additional and rigorous research. Additionally, mainstream research into causes of mental illness, development of new treatments and models of care, and evaluation of the effectiveness of various interventions, frequently excludes consideration of people from CALD backgrounds because of the complexities (perceived or real) of their inclusion. These include logistics of data collection using interpreters, expense related to translation and problems of sample size. Additionally, consideration of varying explanatory models of illness and culturally driven understandings of wellbeing and mental illness can be seen to further complicate research. In some cases CALD populations, particularly those with low proficiency in English, are simply excluded from initiatives which establish incidence and prevalence of mental health problems within the Australian population due to methodological difficulties.

Suicide

Suicide by people born overseas represents 25 per cent of all suicides. Of these, 60 per cent are by people from non-English speaking backgrounds.[33,34] While suicide is not a mental illness (rather, it is a behaviour), it is strongly associated with mental illness, and the risk factors pertinent to both mental illness and suicide are overlapping and

interrelated. Thus, the issue of suicidal behaviour in CALD populations of Australia necessarily requires an integrated prevention response which acknowledges both the separateness of mental illness and suicide, and the association between the two.

Three major issues affect the mental health of people from CALD backgrounds in relation to suicidal behaviour. These are: difficulties concerning the accessibility and availability of suicide prevention health services, their under-utilisation and the lack of appropriately trained professionals with awareness of suicide risk assessment and intervention in CALD populations; the impact of sociocultural factors related to country of origin and factors which impact on this population post-immigration, including acculturation difficulties which increase suicide risk. These are exacerbated by a lack of attention to the needs of immigrant populations in the policies of a large proportion of service providers, the absence of education initiatives targeting cross-cultural suicide prevention skills amongst service providers and the perception among some community service providers that immigrant suicide is not an issue.

The evidence base regarding **suicide and its prevention** among people from culturally and linguistically diverse backgrounds is very limited. This lack of evidence on suicide and its prevention among people from CALD backgrounds is a major impediment to the development of culturally competent suicide prevention initiatives and impact on worker knowledge of epidemiological issues, risk and protective factors and efficacy of treatment interventions.

Primary health care

In the health sector, generalist providers who are not specialists in a particular area of health intervention provide "primary health care" services in the community. For example, general practitioners, pharmacists and community health workers provide primary health care. Accident and emergency services, hospital wards, youth health or mental health services may provide specialist care, or tertiary services.

Trends in the early help-seeking behaviour of people from diverse communities reveal their dependence on **primary health care**. Many people from culturally and linguistically diverse backgrounds with mental health problems seek assistance from general practitioners, often because of lack of understanding of how the mental health system works or fear that communication problems will be an issue for them in accessing mental health services. In most cases they prefer to see a GP who speaks their language and in whom they have confidence to manage their problems. Consultations conducted in the context of mental health shared care projects have found that poor communication between mental health services and GPs is a significant barrier to coordinated care and a major reason for the low levels of referrals to specialised treatment.

However, others may prefer to seek help outside their community, either because of fear of stigma and discrimination or because of distrust of the medical system due to past experiences.[35,36] Some people from CALD backgrounds may seek information about mental health and mental illness from non-health service providers like schools, housing authorities, councils, community agencies or 24-hour emergency services, and in some cases, the police and courts. This diversity of help-seeking behaviour reinforces the importance of adequate information on mental health service availability, the development of mental health awareness programs and cultural competency training, including the use of interpreters, for the range of traditional primary health care providers and non-traditional (and often non-health) service providers.

Service access and responsiveness

Historically, people from CALD backgrounds have been, and continue to be, under-represented in mental health **service access and utilisation** figures, for both outpatient and most inpatient services. People from CALD backgrounds typically present late to mental health services and are therefore generally more unwell than the mainstream population. A review of the literature also suggests that people of CALD backgrounds receive different treatment to the mainstream population. Specifically, practitioners are more likely to prescribe medication at the outset to people of CALD backgrounds than to patients from the mainstream.[37,38.39,40]

Factors **inhibiting access** to appropriate mental health services for people from culturally diverse backgrounds include: the **stigma** and community perception surrounding illness which may be experienced not only by the individual, but also by the caregivers and family; poor **mental health literacy;** lack of availability of or reluctance to use **bilingual practitioners and/or interpreter**s to overcome communication difficulties; **lack of translated information** in a variety of media on mental health and available services; and the lack of **culturally competent service providers** with an understanding of different cultural perceptions of mental health and illness.[41]

Culture influences how people understand, interpret and respond to themselves, to the world around them and to other people. **Cultural competency** requires a service provider to understand the concept of culture, its impact on human behaviour, and the interpretation and evaluation of behaviour. An understanding of the role of culture, and of the explanatory models of illness of other cultures, is integral to the accurate diagnosis and treatment of mental illness, and to the development of effective strategies for rehabilitation and recovery, and for mental health promotion and illness prevention. Cultural competency also implies recognition of other issues often associated with dealing with individuals from different cultures.[42] These include stigma, isolation, communication and language difficulties, and a sensitivity to the specific problems experienced by consumers and carers of diverse cultural backgrounds,

clinicians, and service providers when working with interpreters in the mental health setting.

Under any initiative for service reform, it is essential to ensure that the mental health workforce has the skills and knowledge to allow it to develop and enhance the way it provides services to people from CALD backgrounds.

The National Practice Standards for the Mental Health Workforce identify a need for awareness of diversity by individual professionals to provide care in a culturally sensitive and appropriate manner. In particular, the importance of family and community networks to the mental wellbeing of people from culturally and linguistically diverse backgrounds needs to be acknowledged. Specifically, they state *"Mental health professionals (will) practise in an appropriate manner through actively responding to the social, cultural, linguistic, spiritual and gender diversity of consumers and carers, incorporating those differences in their practice."(Standard 3).*[43]

To achieve enduring structural and systemic mental health reform that meets the needs of CALD mental health consumers, their families and carers, mainstream services must accept responsibility for the provision of effective mental health care for people from diverse backgrounds. This applies to all areas of care across the intervention spectrum including mental health promotion, illness prevention, early intervention, diagnosis and treatment, recovery and continuing care. This requires an **adequate level of resourcing** which must provide a balance across the entire spectrum of mental health interventions to meet the mental health needs of Australia's diverse population. Availability of specialist transcultural mental health services and centres varies across the state and territory jurisdictions. Where these services exist they provide essential support, education and clinical consultation as an adjunct to mainstream services. Mental health services require support in developing and implementing a systemic approach, adapting their service delivery to take account of cultural issues and to train staff in cultural competency.

The importance of partnerships

Non-government and community organisations also perform a key role in providing support services for CALD consumers, their families and carers with mental health problems and mental illness, by advocating for services to be more responsive and educating and supporting carers. While the demand on non-government mental health organisations has increased significantly over the past decade, their funding base remains limited. This limited funding base means that non-government and community services lack many of the essential tools to provide services to CALD consumers, their families and carers. These include easy and affordable access to interpreters or bilingual service providers, knowledge of and access to information in a range of media, capacity to develop in partnership with mental health services to translate resource into appropriate languages for their communities and communications with the mental health service sector. These services require an adequate funding base to provide culturally competent services to people from CALD backgrounds.

There is a need to consolidate traditional and proven partnerships between consumers, carers, community, transcultural mental health and multicultural health services and to develop ways to sustain and embed these partnerships as standard practice. Furthermore, there is a need to develop new partnerships with additional key stakeholders and service providers, to increase awareness of mental health issues in CALD communities, and promote proactive strategies to avoid potential mental health problems. Significant potential partners include CALD community leaders, the multilingual media, general practitioners, schools, police, the courts, the wider welfare system, the private sector, community and religious organisations.

Aims, Principles and Action Areas

The National Mental Health Plan 2003- 2008[1] is concerned with the mental health and wellbeing of all Australians and aims to provide a broader range of options for mental health care and address issues of access for people from CALD backgrounds. This Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia complements and informs national policy for all Australians by focusing on the particular issues in mental health for culturally and linguistically diverse populations and identifying specific areas for action to meet the needs of people from CALD backgrounds.

Aims

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia concentrates on furthering the original aims of the National Mental Health Policy 1992,[11] as they relate specifically to all people in Australia from culturally and linguistically diverse communities. In line with the aims of the National Mental Health Strategy, this Framework aims:

- to promote the mental health of all people in Australia from culturally and linguistically diverse communities;
- where possible, to prevent the development of mental health problems and mental illness for people from CALD backgrounds;
- to reduce the impact of mental illness on culturally and linguistically diverse individuals, families and communities; and
- to assure the rights of CALD people with mental illness.

Principles

The following principles underpin this National Framework and are fundamental to realising the aims of the National Mental Health Policy 1992,[11] for people from CALD backgrounds:

- A population health approach to mental health in CALD communities acknowledges the importance of culture and the migration experience in determining risk and protective factors that influence mental health.
- Consumers from culturally and linguistically diverse backgrounds, their families and carers, have the right to access mental health care provided in a manner which responds to their social, cultural, linguistic, spiritual, and gender diversity, and assures positive outcomes. They are key stakeholders in the design and delivery of culturally competent mental health services, with rights to participate in decision-making on all aspects of their mental health and recovery.
- Provision of culturally competent, responsive and efficient mental health services requires partnerships between and across the health and welfare system and with consumers and carers from CALD backgrounds.
- A culturally competent workforce is fundamental to the provision of culturally appropriate mental health services.
- A recovery focus, which respects consumers' personal, cultural and spiritual belief system, and that of their families, carers and community, should drive service delivery.

- Initiatives to ensure quality in mental health services must be appropriate for CALD consumers, their families and carers.
- Initiatives to develop innovative ways to provide services and research into new service models must be culturally competent and inclusive.
- Culturally appropriate service models, which are shown to be effective, must be sustainable in the long term and become part of mainstream mental health care.
- Achievement of better mental health outcomes for CALD consumers, their families and carers will require funding models and allocation of resources which consider the needs of CALD populations.

Action Areas

The four Action Areas encompass the spectrum of activities for ensuring good mental health in CALD communities:

- **A population health approach to mental health for people from CALD backgrounds**
- **Improving service responsiveness to cultural diversity**
- **Strengthening quality**
- **Fostering culturally inclusive research, innovation and sustainability.**

It is intended that this Framework act as a starting point for readers to help develop outcomes and strategies which are relevant to their local level needs. In this way the outcomes, strategies and performance indicators will be meaningful and match specific programs and activities.

Each of the Action Areas has the following sections

- **Background** – information setting the Action Area in the context of the National Mental Health Plan 2003-2008.[1]
- **Partnerships and participants** – describes the programs, organisations and groups whose work in general and multicultural mental health should contribute to the Action Area.
- **Priorities** – the major areas of activity within the broad Action Area.

Each Priority is divided into the following sections:

- **Rationale** - outlines the reason for choosing the priority.
- **Desired outcomes** - the anticipated benefits of undertaking strategies and initiatives as they relate to each Action Area.
- **Performance indicators** - the information that will be used to demonstrate progress towards achieving outcomes.
- **National Action** - examples of activities to be undertaken to achieve the outcomes.

Roles, responsibility and accountability

The health and mental health sectors alone cannot achieve all the goals of this Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia or implement all the recommended actions. The challenge of developing public policy and planning and delivering culturally appropriate services in a manner consistent with the aims of the National Mental Health Strategy[2] requires commitment at all levels of government and across jurisdictions. The needs and priorities of Australia's diverse communities are varied and dynamic. These needs, and the service systems and structures available to deal with them, vary across groups, communities and jurisdictions. Therefore, as a national document, this Framework sets out broad priorities and areas for action, and identifies stakeholder groups concerned with the wellbeing of CALD communities.

Roles and responsibility

In providing a broad direction, this document recognises that a number of areas within given Commonwealth and State and Territory health departments have responsibilities for mental health. It also touches on a range of issues that must be addressed in order for social and emotional wellbeing to be improved, including broad issues of discrimination, alienation, violence and racism, and the work of various sectors such as employment, education, housing, justice, immigration, and family and children's services. Agencies responsible for promoting human rights, such as the Human Rights and Equal Opportunity Commission and State and Territory anti-discrimination authorities, also have an important role to play, as do the private and non-government sectors and consumers and carers.

To achieve the change recommended in this document action will be required across a range of sectors and at all levels of government, in partnership with individuals from culturally and linguistically diverse backgrounds, their families, communities and organisations. The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia recognises the need for partnerships with communities, health service consumers, carers, health professionals, other government agencies, NGOs, service providers, and academics to identify and respond to the needs of a culturally and linguistically diverse client base to deliver culturally appropriate treatment and care.

Accountability

Clear and transparent accountability regarding resource use was a major theme emerging from the Evaluation of the Second National Mental Health Plan,[16] particularly from consultations conducted by the Mental Health Council of Australia. Appropriate mechanisms are required to ensure accountability for the expenditure of mental health resources, for the processes of service development, and for the achievement of outcomes. Accountability also requires the consistent reporting and monitoring of outcomes across the diverse parts of the mental health care system.

National monitoring of progress towards implementation of the priorities identified in this Framework should occur through national reporting on service access to CALD communities, and through the evaluation and reporting of the National Mental Health Plan 2003-2008.[1] Reporting on and monitoring of performance indicators to measure outcomes and effectiveness of services and programs for people from CALD backgrounds is essential and must be an integral part of these processes.

At all levels of responsibility, monitoring systems using agreed specific and measurable indicators must collect data to inform progress in meeting the needs of CALD communities.

A population health approach to mental health for people from CALD backgrounds

Population health programs are those concerned with the health status of the whole population, or whole population sub-groups within the total population. A population health approach is based on the premise that health at the individual, local and global levels is the result of a complex interplay of biological, psychological, social, political, environmental, civil and economic factors. Population health programs are designed to promote health and reduce illness. They include monitoring and evaluating a population's health status.

Initiatives under the National Mental Health Strategy[2] recognise the importance of the whole spectrum of interventions for mental disorders - from prevention through to treatment and long-term care and use a modified version of the intervention spectrum of Mrazek and Haggerty,[44] which incorporates early intervention and recovery and reflects the Australian context. The National Mental Health Plan 2003-2008 (p. 9) states that *"interventions to promote mental health and reduce the impact of mental health problems and mental illness must be developed relevant to the needs of population groups. These interventions must be comprehensive, encompassing the entire spectrum of interventions from prevention to recovery and relapse prevention... Only a balance of interventions across the entire spectrum can meet the diverse needs of population groups and thus impact on incidence, prevalence, morbidity and mortality and other factors associated with mental health problems and mental illness."*[1]

Providing mental health services for people from diverse cultural and linguistic backgrounds across the spectrum involves the development of culturally appropriate interventions, from the prevention of mental illness and the promotion of good mental health to treatment, rehabilitation, recovery and relapse prevention. Interventions should be supported by an appropriate evidence base, and informed by ongoing monitoring and evaluation of their capacity to meet the needs of diverse groups within the population.

Partnerships and participants

- Initiatives under the National Mental Health Strategy, including
  - National Mental Health Plan 2003-2008[1]
  - National Action Plan for Promotion, Prevention and Early Intervention for Mental Health[45]
  - Mindframe Media and Mental Health Initiative
  - National Action Plan for Depression.[46]

Action Area 1

- Consumers, carers and community groups, including
  - CALD consumers, their families and carers
  - CALD communities and organisations
  - Peak multicultural community organisations including Australian Multicultural Foundation, Federation of Ethnic Communities Councils of Australia and State Ethnic Communities Councils
  - Mainstream consumer and carer organisations.
- Initiatives under National Suicide Prevention Strategy,[47] including State, Territory, regional and local suicide prevention networks and planning groups.
- Related portfolios in State and Territory governments, State and Territory Mental Health Services and Primary Care Services and State and Territory Transcultural Mental Health Centres and programs.
- Capacity building and mental health promotion initiatives, including
  - Auseinet—the national network for promotion, prevention and early intervention for mental health
  - beyondblue (National Depression Initiative)
  - Health Promoting Schools initiatives such as MindMatters and CommunityMatters and the National Families Strategy.
- Data collection initiatives, including
  - Information Strategy Committee
  - National Minimum Data Sets for Mental Health Care
  - National Public Health Partnership Group
  - ABS National Health Survey Program
  - monitoring activities of Australian Institute of Health and Welfare
  - hospitals, health information database providers, and the Australian Bureau of Statistics.
- Research and research funding organisations, including the National Health and Medical Research Council, Australian Institute of Family Studies, Australian Institute of Criminology, National Drug and Alcohol Research Centre, National Youth Affairs Research Scheme, National Centre in HIV Social Research, universities, and public health and population health units.

Priorities

Action Area 1 aims to promote health and reduce illness by the development of culturally appropriate services that cover the spectrum of mental health care from the prevention of mental illness and the promotion of good mental health to treatment, rehabilitation, recovery and relapse prevention.

This Action Area identifies the following priorities:

- **Identifying population need**
- **Promoting mental health and preventing mental illness in CALD communities**
- **The importance of a recovery focus**

Priority 1.1 Identifying population need

Rationale

Monitoring and surveillance of mental health within diverse populations, as well as consideration of social and environmental factors, such as changes in employment status, level of education and social capital, should inform the development of mental health interventions for people from CALD backgrounds.

Indicators relevant to monitoring mental health outcomes for people from CALD backgrounds need to focus on epidemiological data about the incidence and prevalence of risk and protective factors related to mental health and mental illness, as well as levels of morbidity and mortality within communities and specific population groups.

Desired outcomes

- Effective data collection systems consistently measure population need in CALD communities across jurisdictions, and identify changes in mental health and wellbeing, the incidence and prevalence of mental health problems and mental illness and mental health service usage.
- Changes in the risk and protective factors for mental health in CALD population groups within the Australian population are monitored by inclusion of CALD communities in national data sets.
- Epidemiological information from surveillance of mental health status in CALD communities informs policy, planning and program development, and resource allocation.

Performance indicators

- Information on ethnicity and language included in National Minimum Data Sets for Mental Health Care.
- Ethnicity and language and service usage data regularly collected by States and Territories, for analysis and reporting in the National Mental Health report.
- Components on CALD populations included in reporting on the National Mental Health Plan 2003-2008.[1]

National action

- Identify existing mental health data sets across Australia, the levels at which that data is collected and gaps in existing data sets specific to CALD populations.
- Develop a new uniform national minimum standard for the collection of data which incorporates data on ethnicity and language.
- Review, and if necessary modify and develop, existing data collection systems to collect data to underpin CALD service provision across the health and welfare system.
- Establish and support partnerships between health information systems and population and mental health surveillance systems, including mental health services, GPs, private psychiatrists, to include collection of appropriate data related to ethnicity and language.
- Promote development of indicators and measures of community wellbeing and connectedness in CALD communities.
- Support research to identify and explore protective factors in CALD individuals, particularly those at greatest risk.
- Widely disseminate results of monitoring and research on mental health and illness in CALD communities.

Priority 1.2 Promoting mental health and preventing mental health problems and mental illness in CALD communities

Rationale

The National Mental Health Plan 2003-2008 (p. 18) stresses the importance of mental health promotion in protecting, supporting and sustaining the emotional and social wellbeing of the population. It also acknowledges the importance of supportive social, economic, educational, cultural and physical environments, of the recognition and acceptance of diversity and of communities in which people feel involved, included and empowered. *"Endeavouring to prevent mental health problems, mental illness and suicide involves understanding the factors that heighten the risk of these occurring and the factors that are protective against them, identifying the groups and individuals who can potentially benefit from interventions, and developing, disseminating and implementing effective interventions across the lifespan... An understanding of risk and protective factors enables preventive interventions to be targeted."*[1]

Mental health promotion strategies for people from culturally and linguistically diverse backgrounds should aim primarily at increasing mental health literacy. Knowledge about risk and protective factors for mental health, symptoms of mental health problems and mental illness, and sources of help builds emotional resilience and begins to dispel the stigma of mental illness. The multilingual media have a major role to play in education regarding mental health in diverse communities, as do schools, workplaces, and primary health care and community organisations.

Many of the risk and protective factors for mental health problems, mental illness and suicide occur in the daily lives of individuals and communities. As such they are outside the influence of mental health services, which alone cannot make changes to risk and protective factors. Successful strategies to prevent mental illness and improve coping mechanisms for dealing with stress should be developed in partnership with other sectors and with diverse communities. This has the added advantage of increasing mental health awareness and reducing stigma. Prevention programs should

be targeted to groups at greatest risk. The development of culturally appropriate tools to monitor the effectiveness of these programs in diverse communities is also essential.

In some cultures, the interdependency of physical and mental health is significant. Some CALD communities may present to health services or practitioners with physical symptoms rather than those more frequently associated with Western models of mental illness. General practitioners, particularly those from CALD backgrounds, are well placed to detect and intervene early in an episode of illness as part of their concern for their patients' interwoven mental and physical health care needs.

Mental health services must also be aware of the increased risk to the mental health of the children, families and carers of CALD consumers. An understanding of the cultural implications of the role of family and carers will enhance the likelihood of services delivering effective and culturally appropriate interventions that reduce risk and increase protective factors.

Desired outcomes

- Mental health services and CALD communities have a shared understanding of mental health and mental illness and of ways to reduce risk of mental illness.
- People from culturally and linguistically diverse communities know about mental health, how to manage mental illness and to reduce the risk of getting ill.
- Stigma and discrimination associated with mental illness in CALD communities is reduced.
- Community capacity to enhance, within a primary prevention framework, the resilience of people from CALD backgrounds is strengthened.
- Changes in the risk and protective factors in CALD population groups within the Australian population are monitored.

Performance indicators

- Increased coverage of mental health issues in multilingual media.
- Increased availability of translated community information for CALD communities.
- Increased research on risk and protective factors in CALD communities.

National action

- Develop, with CALD communities, a shared understanding of mental health and mental illness and of effective and culturally acceptable ways to reduce risk, promote mental health and prevent mental illness.
- Identify ways to improve mental health literacy by reviewing programs for effectiveness in shifting attitudes, increasing mental health knowledge and reducing the stigma of mental health problems and disorders in CALD communities.
- Develop and disseminate throughout CALD communities translated information delivered in a variety of media about early signs and symptoms of mental health problems and mental disorders, where to get help, and how to provide support.
- Establish a multilingual media reference group to provide expert advice on media strategies and monitor multilingual media coverage of mental illness and suicide.
- Form a group of experts and spokespersons for mental health issues in CALD communities and facilitate their consultation across the media.
- Engage multilingual community media in mental health promotion through media community education campaigns on a range of issues.
- Consolidate the evidence base from Australia and overseas on risk and protective factors for suicidal behaviour in CALD communities, conduct research to address gaps, evaluate universal, selective and indicated interventions, and disseminate the findings in a nationally coordinated manner.
- Develop and build on existing programs that increase protective factors for mental illness in CALD communities by building supportive relationships, connectedness to family, community, work or school; interpersonal skills, support networks and social participation.
- Implement and evaluate evidence-based population approaches to improving mental health in CALD communities delivered in a range of settings and across the lifespan.
- Develop programs to enhance the capacity of CALD communities to provide support during adverse life events and to reduce risk factors and enhance protective factors for suicidal behaviours for at-risk groups.

Priority 1.3 A recovery focus

Rationale

A focus on the unique and individual process of recovery, and an emphasis on the provision of rehabilitation and relapse prevention services for people from CALD backgrounds, are key concepts that should guide the delivery of mental health services. While there can be no one model of recovery, service provision sensitive to the understandings and interpretations of mental illness in CALD communities can facilitate the recovery process and service delivery can become recovery oriented.

In some communities stigma surrounding mental illness can be more prevalent and enduring than in mainstream communities and may be experienced not only by the individual, but also by carers, friends and family. Therefore, it is important that rehabilitation and relapse prevention

processes include strategies to optimise individual recovery and acceptance of the individual and their family by the community. This can be facilitated by the developing links between mental health support services and people from CALD backgrounds, including key CALD community members and welfare organisations. Ongoing education of the family and community about mental health and mental illness is imperative in order to further address stigma attached to mental illness.

Desired outcomes

- Education and information about mental health and mental illness for CALD people includes a focus on recovery.
- Models of rehabilitation and relapse prevention focus on recovery, reduce stigma and optimise community acceptance of the individual and their family.

Performance indicators

- Inclusion of the issue of recovery in research into CALD communities' understanding of mental illness.
- Cultural differences for CALD consumers included in mainstream research into recovery and rehabilitation models.
- Inclusion of recovery focus in information about mental illness provided to CALD communities.
- Increased access to recovery and rehabilitation programs for CALD consumers.

National action

- Support the development of evidence-based recovery and rehabilitation program models for CALD consumers.
- Ensure that recovery and rehabilitation programs developed within mainstream services consider the needs of culturally diverse communities.
- Include consideration of CALD consumers' understanding of recovery in the development of community information and education programs.

Improving service responsiveness to cultural diversity

The increase in the cultural and linguistic diversity of the Australian population demands corresponding and appropriate mental health service responses positioned within the framework of national, state and local multicultural, mental health and health policies. For people from culturally and linguistically diverse backgrounds, mental health problems may be more prevalent at particular stages of the lifespan, and for some groups. The mental health system, and its range of interventions across the spectrum of care, should be responsive to these differing needs.

Services should reflect the cultural diversity of their communities and should be provided in a manner sensitive to the cultural mix of that community and its varying needs. Services must consider these issues in consultation with culturally and linguistically diverse communities and collaborate with people from CALD backgrounds in strategic planning to overcome identified barriers. Mental health services that are accessible, culturally appropriate and effective, and capable of meeting the needs of CALD communities, will have flexibility and experience to further respond to the needs of all members of society.[48]

The underutilisation of mental health services by people from CALD backgrounds highlights the need to review current models of service planning and service delivery to ensure the provision of culturally sensitive, quality care across the whole spectrum. This includes assessment, treatment planning and implementation, discharge planning, community-based care, rehabilitation and relapse prevention, reporting and evaluation.

Partnerships and participants

- Initiatives under the National Mental Health Strategy, including
  - National Mental Health Plan 2003-2008
  - National Action Plan for Promotion, Prevention and Early Intervention for Mental Health
  - National Action Plan for Depression
  - Better Outcomes in Mental Health Care Initiative
- Consumers, carers and community groups, including
  - CALD consumers, their families and carers
  - CALD communities and organisations
  - Mainstream consumer and carer organisations

Action Area 2

- Related portfolios in State and Territory governments
- State and Territory Mental Health Services and Primary Care Services
- State and Territory Transcultural Mental Health Centres and programs
- Private and public primary care providers including general practitioners, pharmacists, youth services, community services, schools, housing and residential care workers, income support services, telephone counselling services, internet providers, services for older people
- Program of Assistance for the Survivors of Torture and Trauma and other programs addressing the needs of at-risk groups
- Capacity building and mental health promotion initiatives
- COPMI Project
- Primary Mental Health Care Australian Resource Centre
- Initiatives under National Suicide Prevention Strategy, including State, Territory, regional and local suicide prevention networks and planning groups
- Data collection initiatives, including
  - Mental Health Outcomes and Casemix Collection
  - National Minimum Data Sets for Mental Health Care
  - Information Strategy Committee
  - hospitals, health information database providers, and the Australian Bureau of Statistics.

Priorities

Action Area 2 aims to improve the quality of mental health care and deliver improved mental health outcomes by developing services that are appropriate and accessible to the specific and diverse needs of CALD communities.

This Action Area identifies the following priorities:

- **Access to care**
- **Early intervention**
- **Access to community support services**
- **Continuity, coordination and integration of care**
- **Recognition and support for families and carers**

Priority 2.1 Access to care

Rationale

Equitable access to services is a cornerstone of all government policy stemming from a range of Commonwealth and State access, equity and social justice policies. The development of accessible services for people from culturally and linguistically diverse backgrounds means that those who require the service know of its existence, regard it as appropriate, can utilise it in a timely and easy manner and receive a range of services suitable to their needs. They can communicate adequately with service providers and are treated with respect and without prejudice.[37,41] Making services more responsive to the needs of a diverse range of consumers and carers improves the quality of mental health services and delivers improved mental health outcomes.

The mental health system should be responsive to those from CALD backgrounds with mental health needs in all population groups and across the lifespan. It is important for mental health services to be aware of the special needs of sub-groups within their geographical area and to have links with local primary health care providers, general practitioners, non-government organisations and multicultural support services to provide additional support when working with these consumers, their families and carers. For example, new arrivals under refugee and humanitarian programs may require a range of services including those provided by mental health workers and specialists in torture and trauma. CALD consumers with complex health needs, such as mental illness, in combination with physical and/or intellectual disabilities, or with substance misuse, may also require services from a range of providers.

Equitable access also depends upon an appropriate level, mix and distribution of services, attuned to the needs of total local populations, including people from culturally and linguistically diverse backgrounds. In some jurisdictions and localities, this poses challenges, especially given the demographic and geographical variations in CALD communities. In some areas although numbers may be low, the range of cultures represented may be broad and their needs high. To appropriately meet the needs of people from CALD backgrounds and to ensure system responsiveness, adequate data systems are required to accurately measure the prevalence of disorders in these communities and their utilisation of services.

Desired outcomes

- The mental health care needs of all people in Australia from CALD backgrounds, including those with special needs, are met.
- Mental health services and programs are accessible and culturally appropriate for a culturally and linguistically diverse population.
- Local system planning includes the needs of CALD populations based on population data, and available evidence on the incidence and prevalence of mental health problems and mental illness.
- People from culturally and linguistically diverse backgrounds are informed about the range of mental health services, their roles and availability.
- Mental health service usage by CALD communities is monitored.

Performance indicators

- Increased awareness by CALD communities of the availability of services.
- Increased use of mental health services by CALD communities.
- Increased cultural competency training for mental health staff.
- Regular collection and reporting of mental health service usage by CALD communities.
- Increased CALD consumer satisfaction with mental health service quality.

National action

- Develop, implement and review good practice (including guidelines) in a range of promotion, prevention and service delivery activities with CALD consumers, their families and communities, based on research evidence, consumer feedback and consultation with workers.
- Develop, implement and evaluate models for culturally competent service planning and delivery for CALD communities that meet local needs, are realistic and achievable, and can be adapted to a range of local contexts.
- Pilot, evaluate and disseminate service delivery models that address access for high-risk populations, such as refugees or new and emerging communities.
- Provide a broader range of options for mental health care for CALD communities, by improving links between mainstream mental health services and transcultural mental health services and community-specific services.
- Promote the development of intersectoral links with other services for CALD communities and sharing of knowledge and information about meeting the needs of local communities.
- Develop State and Territory plans to address issues of access for CALD communities and for groups who are additionally disadvantaged by geography, demographic factors, or clinical conditions.

Priority 2.2 Early intervention

Rationale

Early interventions target people displaying the early signs and symptoms of a mental health problem or mental disorder. Early intervention also encompasses the early identification of people suffering from a first episode of disorder.

CALD individuals, with early signs and symptoms, who are engaging in high-risk behaviour or experiencing a range of adverse life events, can be targeted using early intervention programs in a range of settings. These groups may be accessed prior to, or early in, the development of mental health problems, in schools or community groups, via programs targeting community participation and connectedness or dealing with the stress related to the migration experience. These programs should be developed and delivered in partnership with the non-mental health sector.

Detection, assessment and risk management strategies, validated for populations and population sub-groups from CALD backgrounds, are also essential to effective early intervention. There is a need for cross-cultural competency education for all primary health care providers, including general practitioners, to develop increased capacity to deliver culturally appropriate primary mental health care, including early recognition and intervention, accurate diagnosis, referral and follow-up. Also needed is improved communication and follow-up between primary health care providers, including GPs, and mental health services, and improved coordination of care across primary health care settings and specialist mental health services.

Desired outcomes

- Culturally appropriate early intervention models are valid for CALD populations, non-stigmatising and recognise the rights and needs of consumers, their families and carers.
- The mental health system has the capacity to recognise and respond in a timely and effective manner to the early signs and symptoms of first, or recurrent, episodes of mental illness in people from diverse backgrounds.
- People with early signs and symptoms of mental illness in CALD communities seek and receive help early.
- Primary care providers, including general practitioners, are supported in the provision of early intervention and continuing care for people from CALD backgrounds.

Performance indicators

- Earlier help-seeking by CALD consumers.
- Improved assessment by mainstream mental health service providers of the mental health status of CALD consumers.
- More appropriate referral of CALD consumers to specialist mental health services.

National action

- Consult CALD communities and community agencies on possible strategies to promote early help-seeking by people with early signs and symptoms of mental health problems and mental disorders.
- Review research into programs and initiatives associated with increasing help-seeking behaviour and its acceptability in CALD communities and develop, evaluate and implement evidence-based programs in education and community settings that increase early help-seeking by CALD consumers.
- Develop information systems for help-seeking, advice and referral, with a range of access points, including local services, internet providers, telephone counselling services and resource guides to raise awareness of the available services for relevant groups.
- Increase appropriate and timely access to mental health services and support for CALD people with mental disorders by developing, implementing and evaluating culturally sensitive, non-stigmatising early interventions within mainstream and specialised services.
- Review, develop and disseminate appropriate assessment protocols for CALD consumers to increase the capacity of primary care providers, including general practitioners, to detect and manage the early signs and symptoms of mental health problems and mental disorders.

Priority 2.3 Access to community support services

Rationale

Mental health consumers from culturally and linguistically diverse backgrounds, their families and carers, require systematic and coordinated intersectoral support from a range of services within and outside the health system. These include disability services, accommodation and domiciliary care, employment, education and training, and income support. Non-government organisations also provide significant support services to CALD consumers and carers. These services require an adequate funding base to allow utilisation of interpreters, provision of translated information, cultural awareness training and engagement of bilingual staff.

Negative attitudes toward people with mental illness and discriminatory practices experienced by mental health consumers generally can be exacerbated for CALD consumers, their families and carers. They might experience additional disadvantage when negotiating complex health and welfare systems because of discrimination based on race or ethnicity, religion, language

barriers, lack of familiarity with available services and lack of knowledge about their rights. It is essential that barriers to support services are removed, and all discriminatory practices, including racially based discrimination, abolished. Identification of stigmatising attitudes and practices, and cultural awareness education of intersectoral workforces, is essential for services to better understand and respond to the needs of CALD mental health consumers, their families and carers.

Desired outcomes

- CALD consumers experience equity of access to all services that impact on their recovery, including disability, accommodation, income support, education and training, employment, and domiciliary care.
- Models of funding increase the capacity of community organisations and NGOs to effectively meet the needs of CALD consumers, their families and carers.
- Providers of intersectoral services do not stigmatise or discriminate, either implicitly or explicitly, against CALD mental health consumers.

Performance indicators

- Increased provision of cultural competency training of community-based support services staff.
- Increased awareness by CALD consumers and communities of the availability of community-based support services.
- Increased referral to and utilisation of community support services by CALD consumers, their families and carers.
- Increased CALD consumer satisfaction with community-based support service quality.

National action

- Develop training programs and support materials for community support services to develop their understanding of mental health and mental illness in CALD communities and how to provide services to CALD mental health consumers in a culturally appropriate way.
- Develop effective mechanisms for disseminating information to mental health service providers on the range of community support service available to CALD consumers with a mental illness.

Priority 2.4 Continuity, coordination and integration of care

Rationale

Providing a fully integrated system of mental health care for CALD consumers, their carers and families requires coordination across and between sectors of the health system. The provision of culturally sensitive and appropriate mental health services requires a multifaceted approach by service providers across multiple sectors that acknowledges the potential cultural and communication barriers and engages CALD consumers, their families and carers in the development of innovative solutions.

Service provision should be responsive to the unique needs of CALD populations and provide coordinated and culturally competent treatment approaches that are suitable at different stages of the lifespan. As with mainstream populations, mental health problems and mental illnesses in CALD consumers have a developmental trajectory where vulnerability is followed by early signs and symptoms, which may develop into diagnosable disorder, which then may or may not recur. For some consumers, mental illness leads to chronic disability. The mental health system should be responsive to differing needs across the course of disorder, from early intervention to relapse prevention and rehabilitation. The response to different episodes of care should be coordinated and meet the individual and changing needs of CALD consumers, their families and carers.

Partnerships between and consultation with consumers, carers, community organisations, transcultural mental health and multicultural health services must be developed and accepted as standard practice. Key stakeholders in these partnerships and consultations include people from CALD backgrounds, general practitioners, schools, the wider welfare system, the private sector, and community organisations.

Development of funding and service delivery models, which include CALD communities and organisations, will increase understanding of cultural issues essential to the planning and delivery of culturally appropriate integrated care for CALD consumers, their families and carers.

Desired outcomes

- Mental health care and treatment is responsive to the culturally specific needs of CALD consumers, their families and carers across the lifespan, and are culturally and developmentally appropriate to the needs of different lifespan groups.
- Continuing care provided to CALD consumers, their families and carers across the course of their illness, through the provision of individual care pathways, is responsive to their culturally specific needs.
- Funding and service delivery models of integrated mental health care are culturally and linguistically appropriate to the needs of consumers from CALD backgrounds, their families and carers.
- Models of integrated service provision between mental health and other services provide effective mental health care for CALD consumers with complex needs.

Performance indicators

- Cultural needs of CALD communities are included in national initiatives to promote coordination of care and develop mainstream services.
- Effective use of specialist transcultural services by mainstream health and mental health services.

National actions

- Ensure that initiatives to develop standard assessment processes, shared assessment and outcome tools and evidence-based care pathways reflect the complexity of needs of CALD consumers, their families and carers.
- Ensure consideration of the needs of CALD consumers in the development of mainstream services and programs, including primary care, mental health services, drug and alcohol services, correctional services, etc.
- Enhance linkages and protocols between mainstream and specialist services and services working with CALD groups with mental illness, and increase service providers' awareness of these services and their referral criteria.
- Through cultural competency training, increase recognition of the impacts of culture on mental health and improve the capacity of the mental health sector and the general health sector to deal with this complex relationship.

Priority 2.5 Recognition and support for families and carers

Rationale

The needs of CALD families and carers should be acknowledged and services put in place to support their efforts and ensure that their own wellbeing is maintained. This is particularly important for children in families with a parent with mental illness, especially if the child is required to take on the role of carer.

Cultural competency in mental health service delivery includes the practitioner's ability to understand the emphasis many cultures place on the involvement of family in the patient's care. Initiatives in treatment planning that seek to engage CALD families and carers are essential. However, these initiatives must include an understanding of the role of family in CALD communities and its implications, particularly in relation to confidentiality and utilisation of respite care.

Desired outcomes

- Models of treatment planning engage CALD families and carers and value the role of family in CALD communities.
- The availability and range of culturally appropriate services for CALD carers support their efforts and ensure that their wellbeing is maintained.

Performance indicators

- National initiatives to develop guidelines for carer plans consider the need of CALD communities.
- Increased availability of multilingual information for CALD carers and families of people with a mental illness.

National actions

- Develop, in partnership with community organisations and NGOs, an understanding of the role of CALD carers of people with a mental illness.
- In conjunction with existing carer support organisations, review the availability, quality and cultural appropriateness of support and information for carers and families of CALD people with a mental illness, and pilot and evaluate innovative programs and resources to support them.
- Ensure that the development of guidelines for carer plans include the complex needs of CALD carers.

Strengthening quality

The National Mental Health Plan 2003-2008 notes that *"in general terms the notion of quality emphasises appropriate, evidence-based care that leads to measurable improvement and good results".*[1] The Plan continues to support the implementation of the National Standards for Mental Health Services,[3] the development of data collection and information systems and the development of outcome measures as the primary mechanisms for strengthening service quality.

The availability of reliable information about service outcomes and changes to health status of CALD consumers is vital for the ongoing development of high-quality mental health services for CALD communities. Culturally appropriate services determined by the needs of the community, jointly defined by consumers, carers, community and professionals, must use relevant outcome measures not substantially influenced by ethnicity or fluency in English to evaluate performance. Where these indicators do not exist or require modification, this should be agreed in consultation with cultural groups and individuals likely to be affected.

Partnerships and participants

- Initiatives under the National Mental Health Strategy, including
  - National Mental Health Plan 2003-2008
  - National Action Plan for Promotion, Prevention and Early Intervention for Mental Health
- Safety and quality initiatives, including
  - National Mental Health Working Group Safety and Quality in Mental Health Partnership Group
  - Australian Council for Safety and Quality in Healthcare
  - Better Outcomes in Mental Health Care Initiative
  - National Mental Health Information Priorities – Second Edition
- Workforce initiatives, including
  - AHMAC Australian Medical Workforce Advisory Committee
- Consumers, carers and community groups, including
  - CALD consumers, their families and carers
  - CALD communities and organisations

Action Area 3

- Peak multicultural community organisations including Australian Multicultural Foundation, Federation of Ethnic Communities Councils of Australia and State Ethnic Communities Councils
- Mainstream consumer and carer organisations

- Related portfolios in State and Territory governments, State and Territory Mental Health Services and Primary Care Services and State and Territory Transcultural Mental Health Centres and programs
- Professional associations such as the Royal Australian and New Zealand College of Psychiatrists, Australasian College of Emergency Medicine, Royal Australian College of General Practitioners, Australian Psychological Association and Royal Australasian College of Physicians
- Data collection initiatives, including
  - National Minimum Data Sets for Mental Health Care
  - National Public Health Partnership Group
  - ABS National Health Survey Program
  - Information Strategy Committee
  - Monitoring activities of Australian Institute of Health and Welfare
  - hospitals, health information database providers, and the Australian Bureau of Statistics
  - National Outcomes and Casemix Collection
- Academics, universities and other providers of professional, vocational and continuing education including TAFE colleges
- Research and research funding organisations.

Priorities

Action Area 3 aims to strengthen the quality and capacity of service delivery through increased consumer participation, adequate and appropriate funding of services and programs, culturally competent workforce development and the guarantee of consumer rights and legislation.

This Action Area identifies the following priorities:

- **Consumer rights and legislation**
- **Consumer and carer participation**
- **Safety**
- **Standards and monitoring**
- **Funding**
- **Workforce**

Priority 3.1 Consumer rights and legislation

Rationale

The National Mental Health Plan 2003-2008 (p. 24) states *"The rights of people with mental health problems and mental illness should be guaranteed and protected across the lifespan and at all times throughout the course of illness and recovery in accordance with the Mental Health Statement of Rights and Responsibilities and national and international conventions. Mental health services should be delivered in the least restrictive environment, with an emphasis on privacy, dignity, and respect. Consumers should have access to information on their rights, to advocacy services and to effective and appropriate mechanisms for complaint and redress."*[1]

CALD consumers, their families and carers must also have their rights communicated to them in an understandable manner appropriate to their culture and language. This may include the provision of translated information, either in written form, or as audio or videotape, the use of interpreters or employment of bilingual mental health staff.

Desired outcomes

- Commonwealth and all States and Territories have legislation and service provision that protect the rights of mental health consumers and the community, including those of CALD background.
- CALD consumers, their families and carers have access to information on their rights provided in an understandable manner appropriate to their culture and language.
- Advocacy services and mechanisms for complaint and appeal are culturally appropriate and accessible to CALD consumers, their families and carers.

Performance indicators

- National initiatives to review mental health and related legislation and complaints systems consider the need of CALD communities.

National actions

- Ensure that State and Territory legislation and service provision protect the rights of CALD consumers.
- Consider the particular needs of CALD consumers, their families and carers in the continuing review of mental health and related legislation and the adequacy of existing complaints systems.
- Ensure that information on National Standards of service provision and practice are available to CALD consumers, their carers and families in an understandable manner appropriate to their culture and language.
- Ensure that all State and Territory services provide CALD consumers, their carers and families with information on their rights in an understandable manner appropriate to their culture and language.

Priority 3.2 Consumer and carer participation

Rationale

Engaging CALD consumers and carers as partners in care builds their capacity to act as powerful agents for change. CALD consumers and carers need support and skills to participate in their own care, and in the design, planning and delivery of services. The provision of this support should be seen by services as an integral part of their meeting the National Standards for Mental Health Services.[13]

Participation by CALD consumers, their families and carers, needs to be supported at three levels: the individual care planning level, in service development at a local level, and in systemic change. This requires a holistic approach to participation and partnership that includes training and support for consumers and carers, and leadership and funding of responsive service models to develop the capacity of existing organisations and services to facilitate participation.

To enable full participation at the policy level, mainstream consumer and carer organisations need to be expanded and developed to include CALD consumers, their families and carers and to begin to effectively express issues affecting various cultural groups. At the same time these groups need to grapple with the issue of how to effectively represent the range of CALD consumer voices given the diversity of cultures, languages and religions that exist within the Australian community.

Desired outcomes

- Consumer and carer participation models meet the needs of CALD consumers, their families and carers.
- Mental health services develop the capacity to facilitate participation by CALD consumers and carers in individual care planing and in service planning, development and evaluation, at a local level.
- CALD consumers and carers have the skills and confidence to participate at national, State and Territory and local levels and across policy, planning and service delivery.
- Existing consumer and carer organisations develop the capacity to facilitate participation by CALD consumers and carers in systemic change.

Performance indicators

- Increased levels of full and meaningful CALD consumer, family and carer participation in policy and in service planning, delivery and evaluation.
- Consumer and carer representation mechanisms and structures include CALD representatives to reflect the ethnic mix of the target community.
- Positive results from NGOs, carers, consumers in satisfaction surveys measuring improvement in service quality.
- Increased input by CALD communities into service and program development and accreditation systems.

National action

In consultation with CALD consumers, their families and communities,

- develop a national framework for CALD consumer and carer participation and explore models of consumer and carer participation that meet the needs of CALD consumers, their families and carers
- develop, pilot and evaluate training and support mechanisms to increase the skills and confidence of CALD consumers and carers to participate at national, State and Territory and local levels and across policy, planning and service delivery, and
- review and improve current structures for ensuring meaningful CALD consumer, family and carer participation in policy and services planning, development and evaluation at national, State and Territory and local levels.

Priority 3.3 Safety

Rationale

The National Mental Health Plan 2003-2008 (p. 25), citing the National Health Performance Framework Report, states that *"Safety is a key component of quality and involves minimising the likelihood of potential harm from mental health care"*.[1] The development and implementation of safety protocols that protect consumers from abuse and make the activities and environment of mental health services safer for consumers, carers, families, staff and the community, should take into account the cultural beliefs of people from diverse backgrounds, and be culturally appropriate.

Of particular relevance to the safety of CALD consumers is the importance of an understanding of the differing effects of medication on particular ethnic groups and of the appropriate and safe use of prescription medication.

Desired outcomes

- CALD consumers, carers and families are prescribed and use medicines for mental illness appropriate to their ethnicity.

Performance indicators

- Reduced prescribing of inappropriate medication.
- National initiatives to develop and implement safety protocols consider the need of CALD communities.

National action

- Develop strategies to educate CALD consumers, carers, and families in the safe and quality use of medicines.
- Develop education materials for the mental health workforce on prescribing and dispensing of medications for people of CALD backgrounds.

Priority 3.4 Standards and monitoring

Rationale

Evaluation of performance, assessment of service impacts and outcomes, and accreditation against service and practice standards are essential for assessing service quality. These activities also act as a guide for the delivery of culturally appropriate services provided by culturally competent service staff. Measurement and monitoring of service quality for people from CALD backgrounds must be underpinned by skilled accreditation agencies appropriately accrediting standards of cultural awareness.

Also essential is the collection of standardised data about service utilisation and the incidence of mental illness in a multicultural community, including reliable data on mental health status, service usage and health outcomes. However, there is currently little consistency in quality, collection and availability of data on the use of mental health services by people from culturally and linguistically diverse backgrounds or their outcomes of care.

Nationally agreed measures of performance relating to the effectiveness of services and programs for people from CALD backgrounds need to be developed, by working with existing data collection systems to identify limitations and create new mechanisms for accurate and uniform data collection across jurisdictions.

To accurately diagnose the presence of a mental health problem or illness, and to assess the effectiveness of mental health interventions for CALD population groups, culturally appropriate assessment tools, and consumer and clinician rated measurement systems, must be specifically developed. It cannot be assumed, for example, that mental health outcome measures developed for the general

population will be effective in determining outcomes for people from CALD backgrounds.

Desired outcomes

- Implementation of National Standards for Mental Health Services[13] and National Practice Standards for the Mental Health Workforce[43] incorporate the cultural, social and spiritual values of consumers, their families and carers.
- Systems of assessing compliance with the National Standards for Mental Health Services[13] and National Practice Standards for the Mental Health Workforce[43] effectively measure cultural appropriateness and awareness of diversity.
- Outcome measures and measurement tools are appropriate for culturally and linguistically diverse communities.
- Outcomes of mental health care for people from CALD backgrounds are consistently monitored and reported in a timely manner.

Performance indicators

- National initiatives to develop outcome measures and performance indicators, and to establish continuous quality improvement cycles and public reporting based on the Mental Health Service Standards[13] and the National Practice Standards for the Mental Health Workforce,[43] consider the needs of CALD communities.
- Health professionals complete units in cultural competence at the undergraduate level.
- Assessment of cultural competency, based on tools developed nationally, included in accreditation of health services.
- Increased cultural competency skills of mental health workers.
- Increased access of CALD communities to mental health services.
- Increased CALD consumer satisfaction.

National actions

- Review national standards to ensure their relevance for CALD consumers.
- Review, modify and develop guidelines for culturally competent service delivery to complement the National Standards for Mental Health Services.[13]
- Review, modify and develop guidelines for culturally competent mental health practice to complement the National Practice Standards for the Mental Health Workforce.[43]
- Liaise with professional and industry associations, government and major community and private providers to disseminate and implement guidelines for the development of culturally competent services.
- Develop a nationally agreed set of complementary outcome measures and instruments and performance indicators appropriate to CALD consumers.
- Ensure that national initiatives to establish continuous quality improvement cycles and public reporting based on the Mental Health Service Standards[13] and the National Practice Standards for the Mental Health Workforce[43] include cultural competency.

Priority 3.5 Funding

Rationale

The provision of culturally appropriate services requires the commitment of resources. These resources include the time and funding required for service providers to gain cultural competency skills, the additional time and staffing demands of appropriate use of interpreters, and the resource allocation required for translations. Systems must be developed to ensure that the resources devoted to mental health care across the sector take into account the special requirements of CALD communities and are adequate to provide effective outcomes for people from CALD backgrounds. Both specialist transcultural services and mainstream mental health service providers have a role in the development of sustainable culturally appropriate service models for people from CALD backgrounds.

Desired outcomes

- Funding models and incentives take into account the provision of appropriate services for CALD consumers, carers and communities, and are adequate to meet community need and to ensure effective outcomes for people from CALD backgrounds.

Performance indicators

- National initiatives to develop funding formulae consider the needs of CALD communities.

National actions

- In the development of funding formulae based on population needs, consider the impact of ethnicity, language competency and CALD risk factors related to special needs groups, refugee status and other relevant variables.
- Develop funding formulae taking into account provision of programs which will lessen the adverse impacts of mental health problems and mental illness in CALD communities.

Priority 3.6 Workforce

Rationale

The supply, distribution and composition of the mental health workforce must match community need. It is also essential that the composition of the mental health workforce in all sectors of the system reflects the cultural and linguistic diversity of its community.

A culturally competent mental health workforce that does not stigmatise and is aware of the role of culture is fundamental. There is a need to develop the skills of the mental and general health workforce to work with people from culturally diverse backgrounds, and to provide training in culturally competent assessment, diagnosis and treatment, needs assessment, health promotion, service and organisational development and management.

Workforce strategies to develop cultural competency must encompass the spectrum of settings in which mental health staff are trained and employed. It is the responsibility of services, professional bodies, and providers of undergraduate and postgraduate training to develop in mental health professionals the attitudes, knowledge and skills required for cultural competency described in the National Practice Standards for the Mental Health Workforce.[43] It is also important to acknowledge the relationship between education and research to ensure that cultural competency training is in line with current best practice. Workforce development initiatives will also benefit from input by consumers and carers from culturally and linguistically diverse backgrounds.

The enhancement and use of the National Practice Standards for the Mental Health Workforce[43] to further develop a national core curriculum for cultural competency training programs, monitoring and accreditation procedures and the undergraduate and postgraduate curriculum is required to ensure standardisation, currency and relevancy. In recognising the multitude of training providers and packages available, it should be mandatory for all training offered to mental health service practitioners, to have been accredited or evaluated against these standards.

Desired outcomes

- Specialist and mainstream health and mental health service providers have increased skills to meet the needs of people from culturally and linguistically diverse backgrounds.
- Guidelines for culturally competent mental health practice complement the National Practice Standards for the Mental Health Workforce.[43]
- A national standard for cultural competency training supports the National Practice Standards for the Mental Health Workforce.[43]
- The proportion of mental health workers from diverse backgrounds within the mental health workforce is increased and has appropriate support and career structures.

Performance indicators

- Increased cultural competency of the mental health workforce.
- National initiatives to enhance the mental health workforce include initiatives to increase the number of CALD mental health workers.
- National initiatives to develop the National Practice Standards for the Mental Health Workforce,[43] consider the need of CALD communities.

National actions

- Ensure that initiatives to implement the National Practice Standards for the Mental Health Workforce[43] include activities to promote culturally competent practice.
- Promote awareness and acceptance of cultural diversity in the mental health workforce by developing and distributing cultural awareness packages.
- In conjunction with local service providers, develop and conduct programs to enhance the knowledge and skills of health and mental health professionals, about the importance of culture in the prevention, diagnosis, assessment and treatment of mental illness and the promotion of good mental health.
- Review, modify and develop a set of national guidelines for culturally competent practice to complement the National Practice Standards for the Mental Health Workforce.[43]
- Promote the development and delivery of undergraduate, postgraduate and ongoing training in cultural competency for the mental health workforce.
- Provide easy access to the latest evidence, guidelines and model programs related to mental health service provision for CALD individuals and communities.
- Promote the involvement of professional bodies and education and training institutions in initiatives to increase the proportion of people from culturally and linguistically diverse backgrounds in the mental health workforce, and provide appropriate support and career structures to enhance their retention.

Fostering culturally inclusive research, innovation and sustainability

To underpin mental health policy and practice and to promote research into mental health and mental illness, the National Mental Health Plan 2003-2008[1] commits to the future development of a strategic mental health research agenda and a national framework for prioritised, coordinated, innovative research and development.

Within the context of research initiatives under the National Mental Health Plan 2003-2008,[1] it is essential to ensure that research initiatives consider the needs of all Australians and that research is culturally competent and inclusive. Research into the burden of mental illness, effective and efficacious strategies to promote mental health and prevent mental health problems, early intervention initiatives, innovative and cost-effective treatments and service models must consider the specific role of culture and the needs of culturally diverse communities.

Partnerships and participants

- Research initiatives under the National Mental Health Plan 2003-2008.
- Consumers, carers and community groups, including
  - CALD consumers, their families and carers
  - CALD communities and organisations
  - Peak multicultural community organisations including Australian Multicultural Foundation, Federation of Ethnic Communities Councils of Australia and State Ethnic Communities Councils
  - Mainstream consumer and carer organisations.
- Related portfolios in State and Territory governments, State and Territory Mental Health Services and Primary Care Services and State and Territory Transcultural Mental Health Centres and programs.
- National data collection initiatives
  - Information Strategy Committee
- Academics, universities and other providers of professional, vocational and continuing education including TAFE colleges.
- Research and research funding organisations, including the National Health and Medical Research Council, Australian Institute of Family Studies, Australian Institute of Criminology, National Drug and Alcohol Research Centre, National Youth Affairs Research Scheme, Australian Rotary Health Research Fund, universities, and public health and population health units.

Action Area 4

Priorities

Action Area 4 aims to develop a mental health research agenda that is culturally competent and inclusive and considers the specific needs of CALD consumers, their families and carers.

It identifies the following priorities:

- **Research**
- **Ensuring sustainability**

Priority 4.1 Research

Rationale

Service-based research to improve responsiveness, strengthen quality, develop consumer- and carer-administered mental health outcome measures and develop innovative approaches to quality improvement must be undertaken with a focus on the totality of the population and in partnership with culturally diverse consumers, their families, carers and communities. Research into the cultural competency of the mental health workforce and cultural competency training needs is also important.

Research is also required in the area of suicide prevention. Specifically research should focus on developing suicide prevention initiatives that are suitable and tailored for effective outcomes in CALD populations, community education regarding the stigma around suicide, the effect of social and political factors on suicidal behaviour, training of bilingual general practitioners and religious leaders to facilitate early intervention for suicide prevention and improved family support for families caring for those at risk.

The collection of data relating to the use of mental health services by people from culturally and linguistically diverse backgrounds from all jurisdictions and the standardised use of minimum data sets on ethnicity, and population samples that reflect the cultural diversity of Australia's population, will contribute to the quality of research and to the planning and management of quality health services within a multicultural society.

Desired outcomes

- Research into the causes of mental health problems and mental illness, the risk and protective factors for mental health, and models of recovery is culturally competent and inclusive.
- Evaluations of the effectiveness and efficiency of mental health interventions, and the development and sustainability of new models and systems of mental health care are culturally competent and inclusive.

Performance indicators

- National initiatives in quality improvement based on the National Mental Health Service Standards[13] and the National Practice Standards for the Mental Health Workforce[43] consider the needs of CALD consumers, their families and carers.
- Services routinely collected ethnicity data as part of the data collection for the National Mental Health Report.
- Evaluation of National Mental Health Plan 2003-2008[1] includes indicators of CALD access to services, outcomes for CALD consumers and effectiveness of targeted interventions.
- National framework for coordinated, innovative research and development established under the National Mental Health Plan 2003-2008[1] considers the needs of CALD communities and identifies key issues in CALD mental health for future investigation.
- Increase in the proportion of research grants targeting CALD mental health issues.

National actions

- Review existing data on service utilisation, and data collection systems, across jurisdictions to establish baseline data, identify gaps and make recommendations for improvements.
- Conduct holistic and recovery- and outcome-oriented research to identify clinical and service level interventions that have the greatest potential to increase mental health and reduce suffering across the lifespan in CALD communities and in groups at greatest risk.
- Support evaluation of best practice models of service delivery to CALD communities through publication and dissemination of evaluation resources.
- Disseminate research and evaluation findings on mental health and illness in CALD communities.

Priority 4.2 Ensuring sustainability

Rationale

For specialist and mainstream services to build their capacity to target CALD populations, funding of innovative programs should include criteria which ensure that these programs also target consumers, carers and communities from CALD backgrounds. There is concern, however, that pilot projects and developmental research initiatives do not attract ongoing, sustainable funding despite demonstrated effectiveness, and are often not sustainable within the general health system. Innovation targeting evidence-based, best practice for culturally and linguistically diverse consumers, their families and carers must be effectively disseminated and adequately resourced to enable ongoing implementation and translation into the mainstream service system.

Desired outcomes

- Mainstream innovations and pilot programs include interventions targeting consumers, carers and communities from CALD backgrounds.
- Innovative ideas and pilot programs shown to be effective for people from CALD backgrounds are disseminated and

are sustained in the longer term and become part of mainstream mental health care.

Performance indicators

- Increased inclusion of CALD populations in mainstream mental health pilot programs.
- Increase sustainability in mainstream and specialist mental health care of successful mental health innovations targeting CALD populations.

National actions

- Ensure that pilot projects targeting CALD populations are adequate to enable ongoing implementation and translation into mainstream, evidence-based best practice.
- Collect, collate and disseminate information about good practice in CALD service delivery through education, peer-reviewed and other publications, professional associations, networks, conferences, the internet and clearing-house services.

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia promotes the support and inclusion of culturally and linguistically diverse communities, consumers and carers in the promotion of good mental health and the planning, delivery and evaluation of mental health care at all levels. It provides a national approach to the mental health and wellbeing of Australians from culturally and linguistically diverse backgrounds within the context of the National Mental Health Plan 2003-2008.[1]

Evaluation

The Framework also identifies stakeholder groups concerned with the wellbeing of CALD communities and calls for action across a range of sectors and at all levels of government, in partnership with individuals from CALD backgrounds, their families, communities and organisations. The Framework identifies the need for consistent reporting and monitoring of outcomes across the mental health system to measure the effectiveness of services and programs for people from CALD backgrounds.

National monitoring of progress towards implementation of the priorities identified in this Framework should occur through enhanced national reporting on service access to CALD communities, and through inclusion of indicators of CALD access in the evaluation and reporting of the National Mental Health Plan 2003-2008.[1] Specific and measurable indicators of achievement in each of the principal Action Areas identified in this Framework should be agreed as part of the development of the evaluation framework for the National Mental Health Plan 2003-2008. Methods should also be established whereby national and State and Territory data can be collected to inform progress against these criteria, focusing on the broad outcomes identified.

States and Territories should also develop their own monitoring systems, relevant to their responsibilities for the mental health of people from culturally and linguistically diverse backgrounds, as part of local implementation plans.

Conclusion

The Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia sets out priority areas for action that will promote and support the development of sound policy and good practice in multicultural mental health care in Australia over the next decade. It informs policy and service development and sets an agenda

Implementation

to provide high-quality mental health care for Australians from culturally and linguistically diverse backgrounds with mental health problems and mental illness.

Attending to the issues addressed in the Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia will not only begin to meet the obligations of all service providers and stakeholders to meet the needs of all Australians, but also improve the health and wellbeing of the whole Australian community.

& Evaluation

ACCESS

The ability "to reasonably and equitably provide services based on need irrespective of geography, social standing, ethnicity, age, race, level of income or sex" [49]

ACCULTURATION*

Adaptation to a different culture.

ADVOCACY#

Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support to enable them to represent themselves.

ANXIETY*

An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal.

ANXIETY DISORDER*

An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal defined according to clinically derived standard psychiatric diagnostic criteria.

ASSESSMENT*

Ongoing process beginning with first client contact and continuing throughout the intervention and maintenance phases to termination of contact. The major goals of assessment are (a) identification of vulnerable or likely cases; (b) diagnosis; (c) choice of optimal treatment; and (d) evaluation of the effectiveness of the treatment.

CALD

Culturally and linguistically diverse.

CARER#

A person whose life is affected by virtue of a close relationship and a caring role with a consumer.

CHRONIC*

Of lengthy duration or recurring frequently, often with progression seriousness.

COMORBIDITY*

"The co-occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia."[50]

COMMUNITY CAPACITY BUILDING#

Developing investment in mental health on multiple levels in government and non-government sectors, and utilising the knowledge and expertise of consumers, carers and others in the general population.

COMMUNITY DEVELOPMENT*

Refers to the process of facilitating the community's awareness of the factors and forces that affect its health and quality of life, and ultimately helping to empower the community with the skills needed to take control over and improve those conditions. It involves helping communities to identify issues of concern and facilitating their efforts to bring about change in these areas.[51]

COMMUNITY EDUCATION*

An organised campaign designed to increase awareness of an issue.

COMPLEX CONDITIONS#

Conditions in which a person experiences mental illness as well as other multiple and complex social, emotional and/or physical health problems. Complex conditions include mental illness with problematic substance abuse, histories of abuse, intellectual disability, and challenging, at-risk, suicidal and criminal behaviours. People with complex conditions often have needs that require a coordinated response from multiple service sectors.

CONNECTEDNESS*

A person's sense of belonging with others. A sense of connectedness can be with family, school or community.

CONSUMER#

A person utilising, or who has utilised, a mental health service.

CONTINUITY OF CARE#

Linkage of components of individualised treatment and care across health service agencies according to individual needs.

CULTURE

Can be defined as a "set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment" (Helman 1990).

CULTURAL COMPETENCY

The ability "to see beyond the boundaries of (one's) own cultural interpretations, to be able to maintain objectivity when faced with individuals from cultures different from (one's) own and be able to interpret and understand behaviours and intentions of people from other cultures non-judgemental and without bias".[6]

CULTURAL DIVERSITY

Refers to the wide range of cultural groups that make up the Australian population and Australian communities. It includes groups and individuals who differ according to religion, race, or ethnicity.

DEPRESSED MOOD*

A sad or unhappy mood state.

DEPRESSION

The word "depression" is often used to describe the feelings of sadness which all of us experience at some stage of our lives. It is also a term used to describe a form of mental illness called clinical depression, which describes not just one illness but a group of illnesses characterised by excessive or long-term depressed mood which affects the person's life. Clinical depression is often accompanied by feelings of anxiety.

Glossary[1]

DEPRESSIVE DISORDER*

A constellation of emotional, cognitive and somatic signs and symptoms including sustained sad mood or lack of pleasure and defined according to standard diagnostic criteria.

DIAGNOSIS*

A decision based on the recognition of clinically relevant symptomatology, the consideration of causes that may exclude a diagnosis of another condition, and the application of clinical judgement.

EARLY INTERVENTIONS#

Timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of patients suffering from a first episode of disorder.

EFFECTIVENESS*

Effectiveness studies test the "real world" impact of interventions that have been shown to be efficacious under controlled conditions. These studies are imperative to determine the generalisability of controlled studies in the real world, because interventions conducted under highly controlled conditions may not translate well into the uncontrolled environment that is the real world.

EFFICACY*

Efficacy studies, usually randomised controlled trials, are undertaken under experimental or "controlled" conditions to develop and refine strategies. They provide important, but limited, information regarding the outcomes of interventions under ideal circumstances. They do not, however, yield information related to all the outcomes of interest .[53]

EPIDEMIOLOGY#

The study of the distribution and determinants of mental health and illness as applied to a whole community.

EVALUATION*

The process used to describe the process of measuring the value or worth of a program or service.

EVIDENCE-BASED PRACTICE*

A process through which professionals use the best available evidence integrated with professional expertise to make decisions regarding the care of an individual. It is a concept which is now widely promoted in the medical and allied health fields and requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

GOOD PRACTICE GUIDELINES*

Good practice is the benchmark against which programs can be evaluated. Good practice guidelines are statements based on the careful identification and synthesis of the best available evidence in a particular field. They are intended to help people in that field, including both practitioners and consumers, make the best use of available evidence.

[1] *Definitions marked*

 # are taken from the National Mental Health Plan 2003-2008.

Those marked

** are taken from National Commonwealth Department of Health and Aged Care. (2000b)* National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000. *Commonwealth of Australia, Canberra.*

INCIDENCE*

In community studies of a particular disorder, the rate at which new cases occur in a given place at a given time.

INTEGRATED MENTAL HEALTH SERVICES#

A network of specialised mental health service components within the general health system, coordinated across inpatient and community settings, to ensure continuity of care for consumers. The components can encompass assessment, crisis intervention, acute care, extended care, treatment, rehabilitation, specialised residential and housing support services and domiciliary care services. The network can be coordinated through area/regional management and uses a case management system across service components.

INTEGRATION#

The process whereby inpatient and community components of a mental health service become coordinated as a single, specialist network and include mechanisms which link intake, assessment crisis intervention, and acute, extended and ongoing treatment using a case management approach to ensure continuity of care.

INTERSECTORAL LINKAGES#

Collaboration between mental health policies/programs/services and other relevant policies/programs/services at Commonwealth, State and Territory and local government levels, as well as in the private and non-government sectors, designed to ensure the overall needs of people with mental illness are addressed effectively.

INTERSECTORAL SERVICES#

The process whereby inpatient and community components of a mental health service become coordinated as a single, specialist network and include mechanisms which link intake, assessment crisis intervention, and acute, extended and ongoing treatment using a case management approach to ensure continuity of care.

MAINSTREAM HEALTH SERVICES#

Services provided by health professionals in a wide range of agencies including general hospitals, general practice and community health centres. Mental health services will be delivered and managed as an integral part of mainstream health services so they can be accessed in the same way as other services.

MEDIA*

"Channel for mass communication of information to general and/or specific audiences (electronic media—radio, television, film; print media—newspapers, magazines)."[54]

MENTAL DISORDER*

A diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities.

MENTAL HEALTH#

A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential.[32] It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities.[19] Mental health is not simply the absence of mental illness. Its measurement is complex and there is no widely accepted measurement approach to date. The strong historical association between the terms "mental health" and "mental illness" has led some to prefer the term emotional and social wellbeing, which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders and some other cultural groups,[20] or alternatively, the term mental health and wellbeing.

MENTAL HEALTH LITERACY*

"The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking."[55]

MENTAL HEALTH PROBLEMS#

A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.

MENTAL HEALTH PROFESSIONALS*

"Professionally trained people working specifically in mental health, such as social workers, occupational therapists, psychiatrists, psychologists and psychiatric nurses."[54]

MENTAL HEALTH PROMOTION*

"Action to maximise mental health and wellbeing among populations and individuals."[15]

MENTAL HEALTH SECTOR#

Includes the specialist mental health sector (both public and private) and elements of the primary care sector providing mental health care.

MENTAL HEALTH SERVICE PROVIDER

A person who manages and delivers mental health services in a paid or voluntary capacity. Some providers may work with NGOs but usually they have professional qualifications and receive payment for providing services. They include nurses (mental health & general), general practitioners, psychiatrists, occupational therapists, social workers and psychologists.

MENTAL ILLNESS#

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IVR)[33] or the International Classification of Diseases, Tenth Edition (ICD-10).[34] These classification systems apply to a wide range of mental disorders for the DSM-IV and mental and physical disorders for the ICD-10. Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan (2003-2008).[1] In Australia, drug and alcohol problems are the primary responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their comorbidity with mental illness.

MULTICULTURALISM

The term multiculturalism summarises the way Australia addresses the challenges and opportunities of our cultural diversity. It is a term which recognises and celebrates Australia's cultural diversity. It accepts and respects the right of all people in Australia to express and share their individual cultural heritage within an overriding commitment to Australia and the basic structures and values of Australian democracy. It also refers specifically to the strategies, policies and programs that are designed to make our administrative, social and economic infrastructure more responsive to the rights, obligations and needs of our culturally diverse population; promote social harmony among the different cultural groups in our society; and optimise the benefits of our cultural diversity for all people in Australia.

MULTIDISCIPLINARY CLINICAL TEAM#

The identifiable group of mental health personnel comprising a mix of professionals responsible for the treatment and care of people with mental illness.

MONITORING*

The ongoing evaluation of a control or management process.[56] The continuous measurement and observation of the performance of a service or program to see that it is proceeding according to the proposed plans and objectives.[57]

MORBIDITY#

The incidence of disease within a population.

MORTALITY#

Death attributable to mental illness.

NEW AND EMERGING COMMUNITIES

Communities:

- Lacking institutional resources and being unable to draw on the collective experience;
- Needing to attract members who are settling in and have growing family commitments;
- Which are not part of the existing network of funding;
- Where the numbers they call on are small and newly arrived;
- Which have not created a media and lack communications interstate and within a metropolis;
- Where family networks are likely to form a substitute for formal organisations due to lack of information about, or access to, wider services;
- Which lack completed family networks, numbers and collective resources, knowledge of existing services, or effective organisations within a national network; and
- Which are unfamiliar with submission-based government funding and have little influence on political processes, while also having ineffective links with others in a similar situation.[58]

NON-GOVERNMENT ORGANISATIONS#

Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental illness. Non-government organisations may promote self-help and provide support and advocacy services for consumers and carers or have a psychosocial rehabilitation role.

OUTCOME#

A measurable change in the health of an individual, or group of people or population, which is attributable to interventions or services.

PARTNERSHIP*

An association intended to achieve a common aim.

PERFORMANCE INDICATORS#

Measures of change in the health status of populations and in service delivery and clinical practice, collected in order to monitor and improve clinical, social, vocational, and economic outcomes.

POPULATION-BASED APPROACH#

An understanding that the influences on mental health are complex and occur in the events and settings of everyday life. A population health approach encourages a holistic approach to improving mental health and wellbeing and develops evidence-based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention across the lifespan.

POPULATION HEALTH

Programs which attend to the health status of the whole population, or whole population sub-groups within the totality of a population. Population health programs are designed to promote health, reduce morbidity, and include monitoring and evaluating populations' health status. A population health approach is based on the premise that health at the individual, local and global levels is the result of a complex interplay of biological, psychological, social, environmental, civil and economic factors.

POSTNATAL DEPRESSION*

An episode of major depressive disorder occurring in the first 12 months after childbirth.

PREVALENCE*

The percentage of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).

PREVENTION*

"Interventions that occur before the initial onset of a disorder."[44]

Universal intervention*: A preventive intervention "targeted to the general public or a whole population group that has not been identified on the basis of individual risk."[44]

Selective intervention*: A preventive intervention "targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average."[44]

Indicated intervention*: A preventive intervention "targeted to high-risk individuals who are identified as having minimal but detectable signs and symptoms foreshadowing mental disorder ... but who do not meet DSM-IV diagnostic levels at the current time."[44]

PRIMARY CARE SECTOR#

The primary care sector includes GPs, and many other primary care providers such as emergency departments and community health centres, as well as others who are integrally involved in the detection, diagnosis and treatment of mental illness, and/or have much to offer in terms of promoting mental health.

PRIVATE SECTOR MENTAL HEALTH SERVICES#

Specialised health services that are specifically designed for the people with a mental health problem or mental disorder seeking treatment in the private sector. In Australia, private sector mental health services include the range of mental health care and services provided by psychiatrists in private practice, and those inpatient and day-only services provided by private hospitals, for which private health insurance funds pay benefits. Private sector services may also include services provided in general hospital settings and services provided by general practitioners and by other allied health professionals.

PROTECTIVE FACTORS*

Those factors that "produce a resilience to the development of psychological difficulties in the face of adverse risk factors."[59]

PSYCHOSOCIAL REHABILITATION#

Services with a primary focus on interventions to reduce functional impairments that limit the independence of people whose independence and physical/psychological functioning has been negatively impacted upon as a result of a mental illness. Psychosocial rehabilitation focuses on disability and the promotion of personal recovery giving people the opportunity to work, live and enjoy a social life in the community. They are also characterised by an expectation of substantial improvement over the short to mid-term. This term is sometimes used interchangeably with the term rehabilitation.

QUALITY OF LIFE#

This term embraces a spectrum of uses and meanings. Within this document "quality of life" is a multidimensional concept that includes subjectively and objectively ascertained levels of physical, social and emotional functioning. [60]

RECOVERY#

A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose as the person grows beyond the effects of psychiatric disability.[21]

REHABILITATION#

Intervention to reduce functional impairments that limit the independence of consumers. Rehabilitation services are focused on disability and the promotion of personal recovery. Consumers who access rehabilitation services usually have a relatively stable pattern of clinical symptoms and there is an emphasis on relapse prevention. This term is sometimes used interchangeably with the term psychosocial rehabilitation.

RELIABILITY*

The extent to which a test, measurement or classification system produces the same scientific observation each time it is applied.

RELAPSE PREVENTION#

Reducing recurrence of illness and strengthening functioning capacity.

RESILIENCE*

Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking, and help-seeking.

RISK FACTORS*

"Those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder."[44]

RURAL AND REMOTE COMMUNITIES*

The rural, remote and metropolitan areas (RRMA) classification was developed in 1994 by the then Commonwealth Department of Primary Industries and Energy and Commonwealth Department of Human Services and Health, based primarily on population numbers and an index of remoteness.[62] The RRMA categories show a natural hierarchy, providing a model for incremental health disadvantage with rurality and remoteness as risk factors. Based on population density, the following three zones and seven area categories are recognised:

Zone	*Category*
Metropolitan	Capital cities
	Other metropolitan centres (urban centres population >=100,000)
Rural	Large rural centres (urban centres population 25,000–99,000)
	Small rural centres (urban centres population 10,000–24,999)
	Other rural areas (urban centres population < 10,000)
Remote	Remote centres (urban centres population >=5,000)
	Other remote areas (urban centres population < 5,000)

SCHIZOPHRENIA*

A constellation of signs and symptoms which may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions and a restriction in thought, speech and goal-directed behaviour.[63]

SELF-HARM*

This includes the various methods by which young people may harm themselves, such as self-laceration, self-battering, taking overdoses, or deliberate recklessness. Recent research suggests that self-harm is more common than attempted suicide and is itself a serious youth health problem.

SHARED CARE#

Care provided collaboratively by GPs and specialist mental health care providers or by public sector mental health services and private psychiatrists.

SOCIAL AND CULTURAL DIVERSITY*

Refers to the wide range of social and cultural groups that make up the Australian population and Australian communities. It includes groups and individuals who differ according to gender, age, disability and illness, social status, level of education, religion, race, ethnicity, and sexual orientation.

SOCIOECONOMIC STATUS*

A relative position in the community as determined by occupation, income and amount of education.

SPECIALIST MENTAL HEALTH SECTOR#

Comprises both public and private mental health services and providers, including some specialist non-government organisations.. The primary function of these services is to provide treatment, rehabilitation or community support targeted towards people affected by mental illness. Such activities are delivered by providers, services or facilities that are readily identifiable as both specialised and serving a mental health function.

STAKEHOLDERS*

"The different groups that are affected by decisions, consultations and policies."[56]

STANDARDS

Clinical practice standards are defined and agreed clinical procedures and practices for the optimal treatment and care of people with mental illness. Service standards define what is required for a quality mental health service.

STRESSOR*

An event that occasions a stress response in a person.

SUBSTANCE DEPENDENCE*

The misuse of a drug accompanied by a physiological dependence, made evident by tolerance and withdrawal symptoms.

SUBSTANCE MISUSE*

"A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances."[65] Use may be to such an extent that the person is often intoxicated throughout the day and fails in important obligations and in attempts to abstain, but where there is not necessarily physical dependence.

SUBSTANCE USE DISORDERS*

Disorders in which drugs are used to such an extent that behaviour becomes maladaptive; social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological, as in substance misuse, or physiological, as in substance dependence.

SUICIDE*

Suicide is a conscious act to end one's life. By conscious act, it is meant that the act undertaken was done in order to end the person's life.

SUICIDAL BEHAVIOUR*

Suicidal behaviour includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

SYMPTOM*

An observable physiological or psychological manifestation of a disorder or disease, often occurring in a pattern group to constitute a syndrome.

SURVEILLANCE*

Close monitoring of selected health conditions in the population. The term has been expanded to include not only information on diseases, injuries and other conditions, but also information such as the prevalence of risk factors, both personal and environmental. Surveillance means continuous watchfulness over the distribution and trends of incidence through the systematic collection, consolidation, and evaluation of morbidity and mortality reports and other relevant data, together with timely and regular dissemination to those who need to know (Berkelman, Stroup and Buehler, 1997).

TRANSCULTURAL MENTAL HEALTH

Extends the definition of mental health to look at the interactions of individuals and groups within a culturally diverse environment, to identify specific risk and protective factors for those individuals and groups who may be marginalised within the dominant culture, and to address societal and structural issues within the environment in order to promote their mental health and wellbeing.

TRANSCULTURAL SERVICES#

Transcultural services promote access to mental health services for people from culturally and linguistically diverse populations. Transcultural services work with consumers, carers, health professionals and the community to promote positive attitudes to mental health and to ensure that the needs of people from culturally and linguistically diverse populations (including access, equity and cultural safety and appropriateness) are addressed at policy, planning and service delivery level.

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