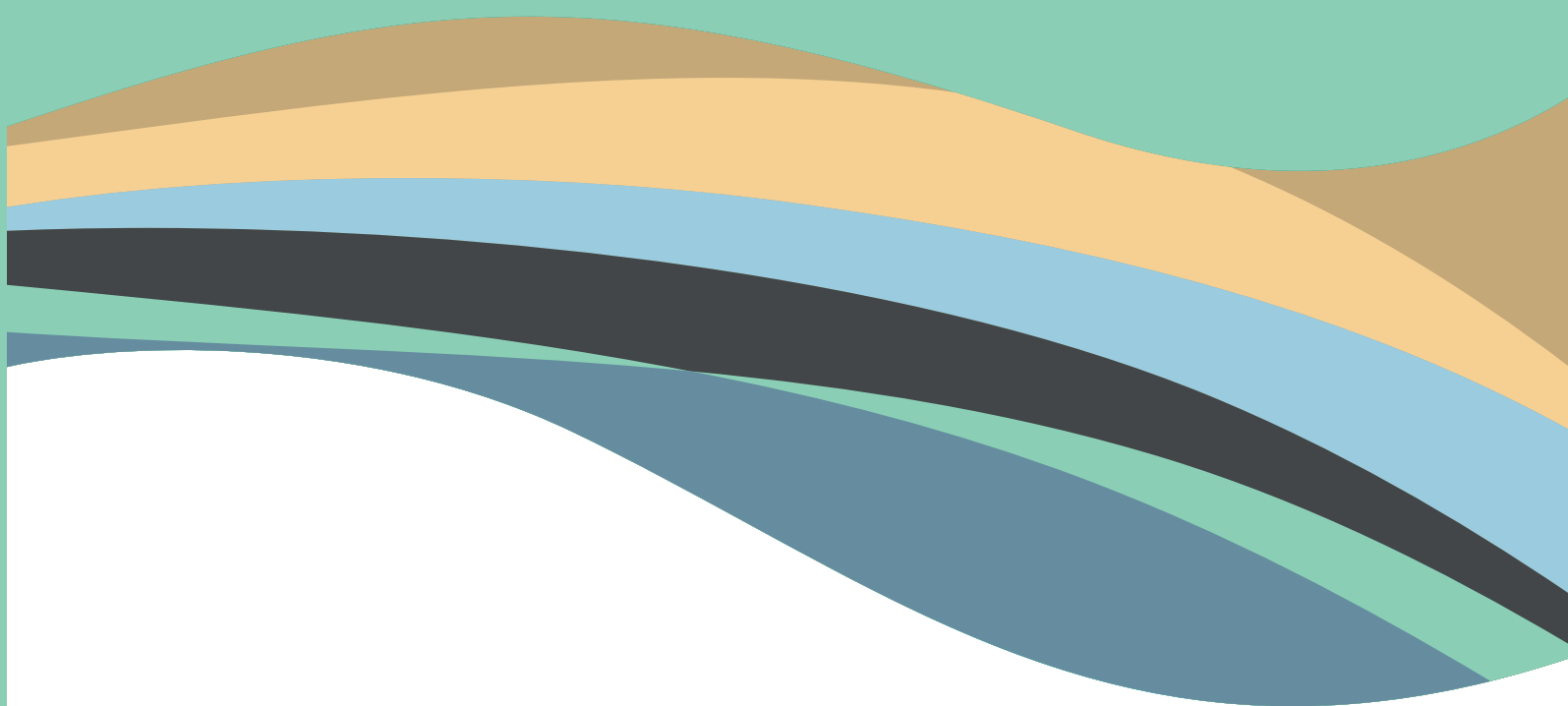
BREAKING BARRIERS BRINGING UNDERSTANDING (3BU) PROJECT

A study of CALD communities' perceptions, attitudes and awareness of mental health and service provision in Penrith, Hawkesbury, Blue Mountains and Lithgow LGAs

AUGUST 2015 - JULY 2016

NAJEEBA SYEDA



NMA

This project is an initiative of Nepean Migrant Access Inc. funded by Nepean Blue Mountains PIR under the Innovation Fund 2015

Table of contents

List of Acronyms

3BU	Breaking Barriers Bringing Understanding
CALD	Culturally and Linguistically Diverse
GP	General Practitioner
KPI	Key Performance Indicator
LGA	Local Government Area
NBM	Nepean Blue Mountains
NBMLHD	Nepean Blue Mountains Local Health District
NGO	Non-Government Organization
NMA	Nepean Migrant Access Inc.
NSW	New South Wales
PHN	Primary Health Network
PIR	Partners in Recovery
PR	Permanent Residency
PTSD	Post-Traumatic Stress Disorder
TMHC	Transcultural Mental Health Centre
TIS	Translating and Interpreting Services

List of Appendices

List of Tables

Acknowledgements

The successful completion of the 3BU Project is an outcome of valuable contributions from many community members, community workers, mental health service providers and professionals, project steering committee and the staff of Nepean Migrant Access Inc. I extend thanks to all of them and to NBM Partners In Recovery (PIR) for providing funding for this project.

My special thanks to Laura Sardo for her support, guidance and valuable suggestions throughout the project period and during the writing of this report.

I extend my special thanks to Sergio Gonzalez for his contributions to this project, for generously sharing his experience and knowledge on community mental health issues and for his insights in the data analysis. His support in the facilitation of focus group discussions, interview transcriptions, and the proof-reading of this report is acknowledged with gratitude. I also thank him for putting together information for mental health services resource.

I offer sincere thanks for the support, assistance and commitment of the following individuals and organisations for the project:

- 3BU Project Steering Committee: Julie Poultney (NBM PHN), Una Turalic (NBMLHD Multicultural Health Services), Nadia Garan (Transcultural Mental Health Centre), Paul Teki (Penrith Community Mental Health Service), Jelena Opacic (Penrith Community Mental Health Service), Jatinder Kaur (Mental Health Service, Nepean Blue Mountains Hospital), Froid Xavier (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, STARTTS), Laura Sardo (Nepean Migrant Access Inc.
- Members of the Maltese, Macedonian, Indian Punjabi, Iranian, Afghani, Japanese, Bhutanese and Filipino communities in the Hawkesbury and Penrith LGA
- Members of multicultural focus groups in the Blue Mountains and Lithgow
- Afagh Afaridan, SydWest Multicultural Services
- Aurelia Gallardo, (Member of Project Steering Committee until March 2016)
- Brian Maruziva (Member of Project Steering Committee until January 2016)
- Dr Om Dhungyel, Association of Bhutanese in Australia
- Harinder Kaur, Herman Foundation
- Helen Azzopardi, Maltese Community Member
- Jaswant Singh, Penrith Sikh Temple
- June Southern, Aftercare, Lithgow
- Kerri Simpson, Richmond Community Services Inc.
- Kim Scanlon, Lithgow Information and Neighbourhood Centre
- Lisa Koek, Japanese Play group
- Luke O'Connell, NBMLHD Multicultural Health NSW
- Mahnaz Niknam, Iranian Community Member
- Mary Clements, Blue Mountains Food Service Inc.
- NSW Transcultural Mental Health Centre
- Pruksachuen Attapron, Lithgow Information and Neighbourhood Centre
- Puspa Acharya, Coordinator - Bhutanese Seniors' Group
- TAFE, Lithgow

Executive Summary

The Breaking Barriers Bringing Understanding (3BU) Project is an initiative of Nepean Migrant Access Inc. (NMA) funded by Nepean Blue Mountains PIR under the Innovation Fund 2015. The project studied the mental health perspectives of Culturally and Linguistically Diverse (CALD) communities in the Penrith, Hawkesbury, Blue Mountains and Lithgow LGAs. The project's aims were to:

- Raise awareness of mental health issues and reduce associated stigma
- Provide information on mental health services available to CALD communities
- Identify any barriers to access to services
- Assist services in developing culturally appropriate work practices leading to increased CALD access to their services.

Qualitative research methods were used to explore the perceptions, barriers to access and gaps in services. Focus groups and semi-structured interviews were used to collect information from the participants. Key participants of the project were CALD communities, mental health service providers, NMA's clients and some community leaders. The main themes emerging from the focus groups were:

- the presence of mental health issues among the CALD communities,
- associated perceptions and stigma of mental health,
- help-seeking and service access behaviours.

The identified access barriers were:

- poor English language proficiency,
- lack of knowledge of services,
- systemic barriers.

The findings suggest that there was a significant presence of mental health issues in the participant CALD communities. Depression and anxiety were the most common mental health issues resulting from a host of reasons reported in relation to migration and the resettlement experience. Among participating CALD communities, there was a common tendency to keep mental health issues within the family mainly due to stigma and cultural considerations. There was a lack of information about mental health service providers, however, most participants considered their GP (General Practitioner) as the first point of contact to provide a referral to a psychologist or a mental health service. In addition to stigma and lack of knowledge of services, language barriers and cost of mental health services, were seen as barriers for CALD individuals to access to mental health services.

All service providers interviewed by this project had a very limited number of CALD clients, with the exception of one organisation with about 30-40% CALD clients, mainly due to its having a designated worker for CALD communities. Most organisations collected ethnicity information about their clients but there was no evidence that the data was used internally to help develop strategies to increase CALD access.

The level of cultural competency among the mental health service providers interviewed was identified as a systemic barrier for CALD individuals' access to services. The lack or poor use of interpreters, limited

skills in the use of interpreter services, seemingly insufficient use of existing translated materials, attitudes of workers and the absence of CALD focused performance indicators and accountability standards, were contributing factors for the seemingly inadequate level of cultural competency evident among service providers. The lack of outreach mental health services and a lack of coordination between the services was identified as another barrier at the service level.

Service providers from the Blue Mountains and Lithgow Local Government Areas (LGAs) reported a lack of locally based mental health services, adding pressure on mental health crisis services. Limited transport availability and geographic distances were also stated as barriers for effective service delivery, in addition to a lack of funded community development/education programs. Unemployment among the adult population in Lithgow was identified as a contributing factor to the incidence of mental health issues.

This report's findings have highlighted gaps in the health system. The system was considered confusing, complex and bureaucratic in nature, making it difficult for many CALD community members with limited knowledge of English to navigate it. Out of pocket costs for counselling were also identified as a barrier by both community members and service providers. Most psychologist participants considered the limited number of hours for counselling allocated by Medicare and the Transcultural Mental Health Centre (TMHC) insufficient to make an impact for CALD clients, especially for clients with complex needs and a history of torture and trauma.

According to some participants, a lack of appropriate accommodation and family support for people living with chronic mental health issues often resulted in homelessness, increasing the barriers to accessing mental health.

To address the barriers to access and gaps in service delivery, the following recommendations are proposed:

1. The delivery of community education programs providing information about common mental health issues, including signs and symptoms of mental illnesses, services available and information about counselling processes. These programs need to be designed and delivered in a culturally sensitive manner, in consultation with community leaders and specialised workers.

2. To overcome language barriers, mental health service providers need to introduce internal procedures, so that: an accredited interpreter is engaged when the need arises; all staff are trained in the use of the interpreter services, and; the practice of staff and relatives being used as interpreters is thoroughly discouraged.

3. Mental health service providers need to engage with communities through awareness raising activities and outreach of services.

4. A better service co-ordination is needed among mental health service providers for sharing information, resources and promoting the referral process.

5. Service providers need strategies in place to increase the cultural competency of their staff and service in general. This may involve cultural competency training, the appropriate use of interpreters,

accountability measures to ensure a culturally competent practice, the employment of bi-lingual staff, and building a knowledge base within the service on the migration and settlement experience.

6. At the initial intake or referral, a CALD specific service assessment needs to be made for CALD clients. This practice may effectively reduce the duration of treatment.

7. An increase in Government funding for CALD specific mental health services including the recruitment and appropriate training of bi-lingual staff, additional counselling hours and community engagement activities.

8. Addressing homelessness among people living with severe and chronic mental health issues by increasing housing packages.

9. Provision of transition housing options needs to be considered for clients with severe and chronic mental health issues leaving hospital care.

10. Clear information on different mental health service pathways needs to be made available to CALD communities in order to reduce confusion and system navigation difficulty.

11. Improvements in the provision of psychological services is needed at the system level, with changes such as cultural competency training of GPs and psychologists, and the reduction of clients' out of pocket expenses for counselling.

12. An increase in the Medicare and TMHC funded counselling hours for CALD clients, especially for clients with complex needs.

13. Address the issue of bulk billing for psychiatric treatments.

Specific recommendations for Lithgow and Blue Mountains Local Health Districts:

- An increase in government funding for mental health services, community development and social services for the people of Lithgow.
- Establishing a fully funded drop-in centre in Lithgow for people with mental health issues.
- An increase in psychological services in both areas.
- An inquiry into the workings of the Lithgow Community Health Service with the purpose of maximizing its potential.
- Outreach of mental health services for different areas in the Lithgow LGA.
- Improving Drug and Alcohol Services for the Lithgow LGA.
- Systems to be put in place for the appointment and retention of psychiatrists in Blue Mountains Hospital.
- An increase in crisis mental health services on weekends in the Blue Mountains Hospital.

Introduction/Background

New South Wales (NSW) is the most culturally and linguistically diverse state in Australia, with 25.7% of its population born overseas in more than 250 countries. About 22% of the people speak a language other than English at home and 260 languages are spoken. Among people who speak a language other than English at home, 18.6% spoke English very well or well, 3.9% are unable to speak English well or not at all[1]. Most of the CALD population lives in the Sydney metropolitan area. The Nepean Blue Mountains area (Penrith, Hawkesbury, Blue Mountains and Lithgow LGAs) is among others areas in Sydney attracting considerably large numbers of migrants and refugees for settlement, particularly the Penrith LGA.

The CALD communities living Nepean Blue Mountain area come from a variety of cultural, linguistic and religious backgrounds. About 10% population speaks a language other than English at home and 17.6 % people are born overseas. The main CALD groups in the area are Filipino, Indian, Maltese, Italian, German and Macedonian. There has been a marked increase in the number of people born in Thailand, Bangladesh, Tonga, Nepal and Cambodia between 2006 and 2011. The most recent settlement from 2010 to 2015 is of humanitarian entrants (refugees) from Southern Sudan, Iran, Afghanistan and Sri Lanka[2].

The 2007 National Survey of Mental Health and Well Being indicated that about half of the Australian population between the ages of 16-85 had a mental disorder at some point in their life. One in five Australians had a mental health disorder in past 12 months[3]. Access to mental health services across the board is affected by the associated stigma. Among CALD communities the access rate is low in Australia[4]. The reasons for low access could be the communities' perception of mental health and associated stigma, limited knowledge of mental health issues and Australian mental health services, either due to personal circumstances such level of education, cultural values or to the limited resources to address metal health in their countries of origin[5]. The Penrith LGA, in particular, has a high representation of newly arrived refugees experiencing issues of mental health associated with the migration process and aggravated by the refugee experience which in many cases involves torture and trauma. This is often the result of war, physical and mental torture, a prolonged stay in refugee camps, displacement and family separation. The relative small numbers of CALD residents in the other targeted LGAs increases the social isolation and limits the service provision allocations, both factors exacerbating any mental health issues.

Cases of depression or anxiety are often seen as a "weakness" among the CALD communities. These cases are usually dealt with by family members, community and/or religious leaders with best intentions, but no professionally acquired skills to understand and address the complexities of mental health, the long term consequences for the sufferers and the associated risks. In some countries, the lack of resources reduces mental health services to institutionalization, increasing the fear and the stigma associated with mental health. In some locations, there are no mental health services or professionals to support people living with a mental health issue (e.g. refugee camps).

---

[1] Demographic Fact sheet NSW, Transcultural Mental Health 2016

[2] Demographic Fact sheet NSW, Transcultural Mental Health 2016

[3] National Survey of Mental Health and Well Being, ABS, 2007

[4] The State of Play: Key Mental Health Policy Implications for CALD Communities in Australia, n.d. Multicultural Mental health Australia.

[5] Howarth, N., Wakefield, A., (2014) Building the Case for Reform-The experience of people from refugee and CALD background negotiating the mental health system who are at the risk of developing or have severe and persistent mental Health conditions. Mater UQ for Primary Health Care Innovation, QPASTT and QTCMHC.

The diversity of CALD communities poses a great challenge for mental health services to deliver services that are culturally sensitive and address the complex needs of CALD communities. This diversity also requires a systemic approach, policy shift and a change in the delivery and management of the mental health programs[6].

The 3BU Project is an initiative of Nepean Migrant Access funded by PIR under their Innovation Fund to study the CALD communities' perspectives on mental health, to help overcome the associated stigmas, organise consultations and develop strategies to raise community awareness of mental well-being.

Project Aims and Objectives

The aims of the 3BU Project:

- Raise awareness of mental health issues and reduce associated stigma
- Provide information on mental health services available to CALD communities
- Identify any barriers to access
- Assist services in developing culturally appropriate work practices leading to increased CALD access to their services

The specific objectives of the 3BU Project:

- Conduct consultations to explore the perceptions, beliefs and attitudes of CALD communities towards mental health issues.
- Conduct consultations to identify the specific issues of the different CALD groups in relation to access to services.
- Provide information about mental services to CALD communities.
- Conduct interviews with service providers to identify issues and gaps in services for CALD communities.
- Suggest strategies for mental health service providers to deliver culturally sensitive services to CALD communities.

A steering committee was established to oversee the project's development. The main role of the steering committee was to ensure that the project objectives were achieved. Members of the 3BU Project Steering Committee are as follows:

- Laura Sardo, NMA.
- Julie Poultney (NBM PHN)
- Una Turalic (NBMLHD Multicultural Health Services)
- Nadia Garan (Transcultural Mental Health Centre)

[6] Transcultural Rural and Remote Outreach Project: Building Partnerships across the Great Divide, (2010), Transcultural Mental Health Centre.

- Paul Teki (Penrith Community Health Centre)
- Jelena Opacic (Penrith Community Health Centre)
- Jatinder Kaur (Mental Health Unit, Nepean Blue Mountains Hospital)
- Froid Xavier (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, STARTTS)

Methodology

Qualitative research methods were used to collect information from the participants of the project[7]. The focus group was the main methodology employed to collect information from CALD communities. Community members with personal experience of mental health issues and a number of community leaders were also interviewed individually. The focus group discussions and interviews were guided by a list of open-ended questions (Appendices 1&2). Some focus groups were attended by professional interpreters to ensure accuracy where necessary.

Individual interviews were conducted with mental health service providers, and some of the service providers were interviewed over the phone. A list of open ended questions was prepared for the interview[8] (Appendix 3). The focus group sessions and interviews were audio recorded with the participants' permission. A project statement outlining the purpose of the project, research procedures, confidentiality protocols and potential benefits to the CALD community was prepared and provided to the participants prior to the consultations and interviews (Appendix 4). Participant consent forms were signed by all participants (Appendix 5).

Purposive sampling was used for the selection of participants. Communities were identified with the help of the project's steering committee, NMA's data and the data from the targeted areas Councils' community profiles. Most communities consulted were in the Penrith LGA, being the most multicultural among the four project areas. Communities were selected on the basis of willingness to participate, their population and settlement period i.e. those who migrated 20-50 years ago and recently arrived communities (within 5 years). Representatives of prominent mental health service providers, private practice psychologists and TCMH clinicians in the project's LGAs were interviewed.

The focus group discussions and interviews were audio recorded and transcribed for analysis. Thematic data analysis techniques were used. The data was coded manually. The themes were identified and classified. Verbatim quotes have been used throughout the report to support the findings.

[7] Liamputtong, p. (2013), Research Methods in Health-Foundation for Evidence Based Practice, Second Edition, Oxford University Press Australia.
[8] The lists of questions were adapted from TRROP Report (2010) by Transcultural Mental Health Centre and Latrobe City CALD Communities' Access to Mental Health Service Mapping and Scoping Project Report.

Community Consultations Analysis of Findings

Community consultations were carried out to study the perceptions of mental health issues of CALD communities living in the areas targeted by the project. The aim of these consultations was to explore the attitudes and stigma associated with mental health and the role these play in access to services. Another important aspect of these consultations was to determine barriers that CALD communities experienced in accessing related services.

Table 1: Focus Groups and number of Participants by Project Area

Project Area	Penrith	Hawkesbury	Blue Mountains	Lithgow	Total
No. of Focus Groups	7	1	1	1	10
No. of Participants	69	6	8	4	87

The focus groups held in the Blue Mountains and Lithgow consisted of multicultural groups due to the small number of CALD individuals from the same background living in these areas. However, in the Penrith LGA, the focus groups were conducted with ethno-specific communities. In the following text, although the participants are referred to according to their ethnic background, most of them have been Australian citizens for many decades and some are permanent residents.

Table 2: CALD Communities and Geographical Areas Consulted by 3BU Project

Project Area	Penrith	Hawkesbury	Blue Mountains	Lithgow	Total
Communities	Afghan, Bhutanese, Filipino, Iranian, Japanese Maltese Indian Punjabi	Macedonian	Dutch Italian Japanese Filipino	Chinese Thai Cambodian Ethiopian	16

Mental health issues: The presence

A significant number of participants acknowledged the presence of mental health issues amongst their family, friends and members of their community. During focus group discussions, it was reported by some participants that they had experienced mental health issues themselves.

"I think it is pretty common. I have been here for ten years and I know a few people with mental health problems. We all know one, I won't say their name but everyone knows one".

Another participant stated,

"Depression is affecting every age group in our community. Even kids who were born and grown up in Australia have depression. Women in particular are suffering from depression".

The most common mental health issues reported were depression and anxiety, however, some participants reported knowing people with schizophrenia and post-traumatic stress disorder (PTSD). Most participants stated that some contributing causes for the occurrence of mental health issues were: low socio-economic status, migration, pre-migration (including traumatic events) and post-migration (financial stresses, unemployment, isolation, language barriers, family breakdown and acculturation). For example, one of the participants reported:

"Back in India we have a community life; there is family and friends, extended family. You are always surrounded by people. When you come here it is one family unit. If you do not live in the area where the Gurdwara (temple) is or close by, then you don't have the community support. I know that she actually got depressed because of that".

Another participant stated:

"Culturally, it is very hard for them to cope but people who have lived here for years are also prone to depression because they still cannot fit in".

Communities settled in the Penrith LGA for a longer time were more open to accept the presence of mental health issues, mainly because, in their opinion, there was a general acceptance of mental health issues in Australian society and many services were available for treatment. In comparison, emerging or more recently arrived communities such as the Bhutanese and the Afghani community had very limited knowledge of mental health issues and services available in Australia. Most participants agreed that a lack of understanding of mental health issues was attributed to lack of services available in the country of origin and also to the strong stigma associated with mental health issues. A Bhutanese community leader analysed the situation in these words:

"No, there are no services available [in Bhutan], only for extreme cases, when it is already too late. They are intervened but otherwise, no. Depression is most common and many people know about it but people deny having it. Denial is the first reaction. That's why mental health issues are never discussed in the community".

The Indian Punjabi, Filipino and Maltese were some of the longest settled CALD communities in the Penrith LGA. All of the above communities reported the presence of mental health issues in second and third

generations as well. The perceived reasons for younger generations facing mental health issues were different for each community. These reasons included the young people's inability to meet their parents' academic and cultural conformity expectations, financial pressure, lack of resilience and family breakdown. The Macedonian community members in the Hawkesbury and the Dutch community members in the Blue Mountains also reported similar trends in their communities.

A participant from the Indian Punjabi community said:

> *"The kids want to live their life Australian way but the families pressurize them to live a more traditional life, so they get depression and it is very hard for them to come out of it".*

Talking about the reason why younger generations experienced stress and mental health problems, a Maltese participant said:

> *"When we came here we came with nothing, what we have got we appreciate it a lot, but may be our children have got everything, they haven't done the hard work, so when they have a small problem, or miss something they feel it more than we feel it. They don't appreciate that it took us 50 years to get what we have, they want it quickly".*

Mental health issues: The perception

About half of the communities that participated in this project recognized some mental health issues. For example, they identified depression, which manifested itself with sadness, stress or pressures resulting from the low socio-economic conditions highlighted in the paragraphs above. Most of the participants of these community groups never used or heard the word, "depression" in their early lives, however, the word depression was commonly understood by the participants these days. Following are the comments from members of the Filipino and Maltese communities:

> *"In my country no one had heard of word depression". Everyone had problems and you tried to fix them in the best way you could".*

> *We don't say she's depressed we say she's just sad; during our time, we never had the words to describe it as depression. We just thought we were sad. It never occurred to us that something was wrong with us".*

According to other participants, mental health issues were not even acknowledged or recognized by their community members in general, implying that people might have had a mental illness without knowing it.

> *"I think people do not know if they have got a mental health issue. They go through all those circumstances and they go through these issues, they do have anxiety and they do have stress, but they do not even know".*

A Bhutanese community leader said:

> *"Most of the cases probably they do not know, even if they do, they do not like to express it. It is quite a taboo. It is sort of denial in the sense not by understanding, not knowing it, it is never discussed in the community".*

The reason for not knowing or recognizing mental health issues was a lack of awareness and knowledge, especially when they lived in their country of origin. According to the Iranian group for example, most people in Iran did not consider mental health problems as a health concern. Thus, according to this group they were considered normal. After further discussion with the participants, it emerged that if people did not recognize the symptoms of mental illnesses, they would not do anything about it. The Macedonian group, on the other hand, could identify a person with mental health issues if that person was not behaving in the normal way.

> *"They find out, friends and others nearby... you know when someone is not responding the way they are supposed to, you can tell something is wrong".*

According to members of the Macedonian group, it was hard to recognize that someone had mental health issues if people managed to act normally and hide the issue. Some participants reported that mental health issues were perceived by their community as a challenge, being something that they were expected to "man up to" or "just deal with it".

Mental health issues: Stigma

In every consultation, people acknowledged the presence of strong stigma attached to mental health issues in their community. Generally people preferred not to talk about mental health issues with friends or the larger community because it would impact negatively on their lives. Some cultures preferred not to talk about it because they wanted to keep family matters within the family. In some of the cultural groups consulted, the participants stated that generally people in their community were reluctant to talk about their mental health issues to anyone because they feared being labelled "crazy". Some of the comments from the participants illustrated this point:

> *"People look down upon people with mental health issues and discriminate against them, if he or she is sleeping, they would call them lazy and has nothing to do, there is positive and a negative aspect to it, people call him or her mad" (Thai participant).*

> *"I know the story of a man who had severe mental illness, he burned the house down once, so the family kept him chained in the house" (Bhutanese participant).*

> *"People hide the illness. They are thought to have gone crazy...They are called crazy. There is gender discrimination, if it is a boy who is sick they do not worry too much about it but if it is girl they hide it because if everyone knows then she will have no prospect for marriage. She will be labelled as crazy" (Afghani participants).*

"If you have a sister or a brother and you know they have mental illness, nobody will marry them. They think it is genetic. So they try not to tell anybody. They hide it within the family" (Dutch participant).

"If she is unmarried, they will worry about her prospects of marriage. There will be no match for her. The same problem is for the boy, and if they are married, they do not disclose it (illness) to the in-laws" (Afghani participant).

For all the participant communities except Maltese, experiencing mental health issues was a matter of shame and/or a sign of weakness, although discussed among family members, it was hidden from the rest of community. According to a Japanese community member, mental health issues were seen by the community as a sign of personal weakness.

"Basically, people think that if you've got a mental illness, you are not strong enough; your mind is not strong enough".

In the Bhutanese and Indian Punjabi community, having a mental health issue was considered to be that person's fault.

It seems like your fault that you have mental illness. People do not like to talk about it. And even [when] people go to the doctor [they still] cannot talk about it... saying that I have a mental health issue" (Bhutanese community member).

The existence of stigma among communities was considered generational by some participants. Communities that have been settled in the project areas for a long time, reported that strong stigma about mental health issues still existed among the older generation (the parents). Conversely, children who were born and brought up in Australia were more accepting and open about mental health issues and more likely to seek treatment. One participant said:

"It goes from generation to generation; we kept these things a secret. But our kids, they grew up here in Australia – different country, different traditions; they went to school, their eyes [are] more open... more freedom... more talk".

For recently arrived CALD communities, perceptions about mental health were largely based on beliefs and experiences from their country of origin and had an impact on their acceptance and treatment of mental health problems now they are living in Australia.

Mental health issues: Attitude change

Most of the participants believed that mental health issues were openly discussed in Australia, in mainstream community and in the media and that mental health services were available. The participants were asked if they noticed any change in the attitude of their community towards mental health issues after migrating to Australia. A change in attitude had occurred in some communities more than others. The more established communities such as the Maltese, Dutch and Filipino were more open to talk about mental

health issues among their family and relatives. The Maltese participants maintained that there was no stigma attached to mental health problems in their community; according to them, the changes had occurred over time and both the older and younger generations were more accepting of mental health issues and sought treatment.

Other established communities, such as the Macedonian and Indian Punjabi, reported to still have strong stigma attached to mental health issues. In the Macedonian community in the Hawkesbury LGA, people were still inclined to keep their affairs to themselves and their families - in terms of health and, in particular, mental health. However, the participants realized that by talking with friends, they would have had a better chance of getting help. During the conversation it was noticed that none of the members stated the names of available mental health services, referring to these as "places where they treat them"; possibly, this could be attributed to their lack of knowledge of mental health services or as an attempt to distance themselves from mental health issues, hinting at a possible fear of institutionalization, especially if services were perceived as that in the past.

Members of the Indian Punjabi community who participated in this study acknowledged that most of the people in their community had problems with integrating into mainstream culture. One participant, referring to Indian culture, said:

> *"The culture over here is the same or worse. Because we have come here many years ago and have retained our culture, but India has moved on".*

Another participant said:

> *"Here we live in the past. We live in Australia but our dreams, our way of life is still wandering in India that is why we do not settle here or adopt [the] Australian way of life".*

According to some participants, there was a slight change in the attitude towards mental health of people who lived in Australia for some time, and that it was likely that they would seek help if they experienced any mental health issues. Yet, newly arrived migrants and their parents seemed to have retained the same attitudes due to their limited exposure to Australian culture. Community life played an important role in India and people relied on their social networks for support, which decreased the likelihood of experiencing some types of mental health problems, but this community reported that in Australia such support was harder to find. According to the participants, if people did not live near the temple - which was a major social hub for the community - they might be more susceptible to mental health issues.

The younger generation (school-age children) were reported to have been experiencing mental health issues at an earlier age. The community identified two reasons also upheld by clinicians and mental health service providers interviewed for this project. Firstly, as most of the Indian Punjabi community members in this area were highly educated, they had high expectations for their children to perform well at schools. Secondly, they identified the pressure to conform to the culture and religion of the country of origin. The children, with exposure to a different way of life might desire to adopt some of the new ways, likely to

result in enormous resistance from families to accept those changes. The educational and social pressures, confusion and conflict resulting from the above reasons appeared to be a major cause of depression and anxiety among youth in this community.

Members of new and emerging communities in Penrith LGA - such as the Afghani and Iranian groups - reported an attitude change to mental health issues. One of the Afghani participants said:

> *"People at the start may not seek treatment because they do not know if there are services available here in Australia, but with more awareness they go and seek treatment for mental health issues. So there is a change in their attitude compared to people at home".*

There was a similar response from the Japanese community stating that Australian society was more open about mental health issues, therefore they could go to a GP and get a referral for a psychologist without being too self-conscious. However, within their community, mental health issues continue to be "hushed up" and the stigma that existed in the country of origin remains strong even now in Australia.

Mental health issues: Help seeking

The consultations explored the various communities' help-seeking behaviour. Most of the participants stated that people relied on family, religion and their GPs for help if experiencing mental health issues. When asked what they would think if they found out a family member or friend had mental health issues, most of the participants stated that they would be helpful and compassionate towards that person. Participants who experienced a mental health issue themselves said it has made them more empathetic towards that person. Usually, if a person was faced with a mental health issue, the family would be the first to know. However, there was some nervous reluctance from the Japanese participants to say that they would disclose the issue of mental health openly to the family. One of the participants said:

> *"Because it is mental health, I cannot show what is happening to me...you can describe what is happening to you but the other person may not take it seriously and then you might feel awkward".*

Most participants stated that their family and friends would seek help on their behalf. Some parents in the Indian Punjabi community would not seek help immediately because they were reluctant to recognize the symptoms and accept mental health problems. A participant summed this up in these words:

> *"It depends on family to family - it takes time to recognize the mental health issue. Initially you try and rationalize why it happened to my child, why my child is different from others? For many parents, accepting [that their child is having] mental health issues is itself a problem. It takes a long time [to accept it]. Once they accept it, they start looking for a remedy".*

According to the mental health clinicians from India and Nepal interviewed for this study, parents approached mental health services a little too late. Early diagnosis could help prevent more advanced mental health issues. One community member said:

> *"It is very rare that people would be diagnosed, not many at all. I haven't come across any who has actually been diagnosed. I think the focus needed here is making them aware of what their options are. If they do not know who they can talk to and about how they feel, there will be no diagnosis. If they cannot talk to the family, they can talk to the GP".*

With the exception of a few participants, most agreed that religion helped in healing. For some communities, religion itself and the community support available at the church, mosque or temple would help in dealing with stress and sadness, but not with major mental health issues. Some people preferred to rely on their faith and pray privately, instead of confiding in their religious leaders regarding mental health matters. One of the community leaders explained:

> *"They can rely on religious text and if they have problems they can pray. I think psychologically it helps, anything psychological, because it is a psychological problem. It might not solve the problem but it does help in healing".*

All participants stated that they were aware that if any family member had health problems they could consult a GP. Well established communities were more aware of the system; for example, going to the GP and being referred to see a mental health practitioner or a psychologist, if experiencing mental health issues.

Barriers in Accessing Mental Health Services

The various participant communities' perceptions, acceptance and stigma associated with mental health issues were identified as the major barriers in addressing these issues. The following were identified as additional barriers:

Communication using only English

The inability to speak and understand English was a barrier for recently settled communities in the Penrith LGA and CALD communities living in the Lithgow LGA. Some aged and newly arrived people from the Macedonian, Bhutanese, Iranian and Indian Punjabi communities experienced language barriers when accessing health (including mental health) professionals. The following statement by a Lithgow resident reveals the language difficulty that some CALD clients may face when dealing with a health service:

> *"I just walked in and went to the reception and told them what was wrong. I don't know if he understood me or not. When I had to go to Emergency in the hospital, my daughter came with me but she is only five years old. I understood some of what they said. But they said so much to me that I didn't understand.*

They wanted me to [fill] in a form with all the information and I thought blah blah blah and I thought I cannot understand any of this, so I just walked out".

Accessing a health service with no knowledge of how the system worked and very limited English was likely to be a daunting experience for a newly arrived CALD person. If a CALD client eventually managed to overcome language barriers and proceeded to access mental health services only to find themselves treated with cultural insensitivity, they were likely to feel discouraged from accessing that service in future. Many participants had similar experiences and one informed the researcher that a specialist refused to access the interpreter service because they had to pay for it. Many older participants saw a GP accompanied by their son or daughter to communicate with the GP on their behalf.

Some participants were offered an interpreter, but others did not even know that they could ask for an interpreter via the Australian national Translating and Interpreting Service (TIS). A few participants stated their discomfort with using an interpreter due to confidentiality issues, as well as the time it took to access the interpreter.

Lack of knowledge of services available

All communities consulted for this project revealed a lack of knowledge of the mental health services available in their local government area. As mentioned above, all participants knew about GPs and many knew about psychologists, but only a few participants were aware of CALD specific mental health services, mental health units at the local hospitals and mental health services provided by NGOs. Only two participants became aware of some mental health services through leaflets available at their doctor's surgery. The lack of information about mental health services seemed to have resulted in limited knowledge of different options available to them and the underutilisation of services by CALD communities.

Cost of counselling

The out-of-pocket expenses of counselling and seeing a psychiatrist - or a specialist – was a barrier to many CALD participants, especially for CALD pensioners.

"It is not a good idea if it is going to cost a lot of money, if you are depressed or any other reason you have to go, [but] if you cannot afford it then you don't go because... where the money is going to come from? So either you get better or you [don't]".

"The psychologist that I went to see was the only one who bulk billed [in the Blue Mountains]. For everyone else, I would have to pay from my pocket and I was not prepared to do that. I wasn't in that position".

"I have to pay four hundred dollars every three months to see a specialist. I also have to buy medicine. I had to miss an appointment because I did not have money".

Reluctance to using medication

A reluctance to see a GP or a psychiatrist among some communities was reported because they were prescribed medication for their mental health issue straight away. The clinicians working in the Blue Mountains stated that there was a lot of resistance to the use of medication resulting in aggravated mental health problems for their clients.

System barriers

A shortage of psychiatrists in the Blue Mountains Hospital was reported. To receive treatment, many clients had no choice but to travel to Sydney to see a psychiatrist. The participants also stated that the system did not cater for people with mental health problems who were about to enter into a crisis situation. A woman, talking about her son, said:

> *"The problem with the system is that until he breaks down or harm himself or others, they cannot do anything about it; because he was not a minor. That was the most frustrating thing. We knew it was coming because he had stopped taking medication. We could not do anything until he broke down".*

Privacy laws were reported to be a barrier for some participants. They expressed their frustration at not being able to access the information about the illness of their son or daughter because they were not minors. One parent stated:

> *"He had a mental illness and yet as a parent they could not get...give us...detailed information because of the Privacy Act in the medical services. And to me it is wrong. Why should a mum and dad not be able to access the information of what is exactly wrong with him?"*

Table 3: Barriers in Access and Recommendations: Community Focus Groups Findings

Community	Access Barriers	Recommendations
Focus groups Penrith	Language Stigma Denial of mental health issues Confidentiality in counselling Lack of information about mental health services Cost of counselling System is confusing Reluctance to use medication Long waiting list at the specialists	More information and publicity of mental health and well-being to change attitudes towards mental health. Better use of interpreters. Bilingual workers. Mental health service providers to outreach their services. Community engagement. More information on mental health and the system services?? More funding for CALD community organizations Cultural Training for doctors and psychologists
Focus Group Hawkesbury	Stigma Lack of knowledge of services Language issue for older people The cost of mental health care Reluctance in using medication	More information on mental health services
Focus Group Blue Mountains	Stigma Lack of mental health services Shortage of psychiatrists System lets people "fall through the cracks" Privacy laws	Change in privacy laws. Change in criteria for hospital admission for people with severe mental health issues. Bi-lingual workers.
Focus Group Lithgow	Language Stigma Distance to mental health services. Transport issues and cost. No knowledge of mental health services. Waiting lists at the GP. Not familiar with the system Lack of mental health services	Interpreters should be offered. More information on services and system. More mental health services for the area.

Organisations providing mental health services and community development activities, clinicians and psychologists participated in this study.

Table 4: No. of Service Providers and Mental Health Professionals

LGAs	Penrith	Hawkesbury	Blue Mountains	Lithgow	Total
Number of Service Providers and professionals	15	5	7	4	30

CALD Specific Services: Data collection and performance evaluation

Most of the Penrith LGA services participating in this study reported that a very small number of CALD clients accessed their services with the exception of one organization which reported to have 30 to 40% of its clients from CALD background. About 14.6% of people living in the Penrith LGA spoke a language other than English at home[9]. The percentage of CALD clients accessing these services was as low as one percent in one case, and one third of the total participants were not aware of the percentage of CALD clients. One participant said:

> *"I think Penrith is not a particularly multicultural community. Penrith is quite Anglo. Our sister sites in Parramatta and Mt. Druitt have a much more multicultural clientele. Penrith is a bit different that way. I think there are CALD young people in the community who need mental health support. But they are not accessing us. We need to figure that out".*

The CALD clients accessing mental health services in the Blue Mountains corresponded with the demographic make-up of the area. According to the Blue Mountains Council's Community Profile Data (ABS, 2011) 5% of people speak a language other than English at home[10]. CALD communities were scattered throughout the LGA and it was observed during data collection that CALD populations did not organize themselves in ethnic community groups as was the case in Penrith. The services that participated in this study stated that sometimes they did not have any CALD clients because "there were not many around". A few CALD programs in the Blue Mountains area closed down due to low attendance numbers. It was almost impossible for services to apply for grants for CALD specific programs due to lack of CALD clients to justify the grant application. Only one organization reported to have up to 10% CALD clients.

[9] Penrith City Council, Community profile ABS Census data, 2011 at www.penrithcity.nsw.gov.au
[10] Blue Mountains City Council, Community profile ABS Census data, 2011 at www.bmcc.nsw.gov.au

The population make-up of Hawkesbury and Lithgow is not very different from the Blue Mountains; predominantly an Australian born population. The service providers reported having very few clients from CALD background. There were no CALD specific services available in these areas. The CALD population is scattered in Lithgow and in certain areas there might be a few families from the same ethnic background.

Less than half of the participant service providers offered a service specifically targeting CALD communities, but all services appeared keen to provide service to anyone who accessed the service regardless of their ethnic background. Most service providers could provide the necessary support to a CALD person because they practised a person-centred-approach. There was no intentional "leaving out" of CALD clients and most providers were keen to increase the number of their CALD clients. One participant said:

> ***"It is not that the willingness is not there, it is the whole process of doing it; it's how do we do it and how do we connect to the communities?"***

Some of the participants reported that their organization did not take any measure to attract more CALD clients. A couple of participants were at loss when in regard to strategies to engage effectively with CALD communities.

All service providers contacted for this study collected information from clients on their ethnic background and language spoken at home. Most of them maintained that data was collected as a funding requirement. There was no evidence that the information was used internally to compare the CALD service users to the CALD population living in the area, to monitor the use of interpreters for a particular language or develop strategies to improve services for CALD communities. Only one organization reported to have CALD clients as part of their Key Performance Indicators (KPIs). Most of the service providers did not have a target for CALD clients in a year.

Most of the service providers participants relied on online translated information materials for CALD clients. The information was printed out when required according to the needs of clients. Most participants expressed their satisfaction with the availability of online resources. Only three organizations reported to have important information about their services translated into relevant local community languages. Clinicians from the NSW Transcultural Mental Health Centre had access to a great deal of translated materials and had used them frequently. Other organizations either relied on translated on materials developed by other agencies or accessed the information online when needed.

Service Providers' Perspectives on CALD Communities' Perception of Mental Health Issues

Service providers contacted for this study confirmed the presence of stigma in communities. The majority of the practitioners believed that stigma for mental health issues existed across the board, in all communities in Australia that includes mainstream communities. One participant said:

> *"I think there is no difference between CALD and Anglo Australians, and there is strong stigma in the Anglo-Australian community about mental health issues. I ran a workshop in [state] and the lady said to me 'Good luck, try running it, no one will come' - the whole stigma thing".*

Another participant said:

> *"It seems to me that it is very similar across the board. Where for people born in Australia of white Anglo-Saxon background, for them there is a stigma to say they have depression and PTSD. I think it is general stigma so, sadly speaking, a lot of people are reluctant to come and so, put it off".*

The clinicians and psychologists working with CALD communities regarded stigma as a barrier in seeking help for mental health issues. The stigma for mental health - presenting itself as shame, a sign of weakness and something that should be hidden and dealt with privately delayed access to services, resulting in issues becoming more complex. One clinician analysed the situation in these words:

> *"Having a mental health issue, being diagnosed with one and seeking help is seen as being weak and obviously unproductive. People have used the words "crazy" and "mad" a lot of times. This type of attitude is quite prevalent in the CALD population. The CALD population is more linked with the family, and the family is one of the protective barriers we feel, because they do not allow plans for medication. The attitude towards it is that they should be ok, they would be fine, [meaning that] "we do not want your intervention". There is a lot of resistance".*

Resistance to medication by many of the CALD clients was reported by the practitioners. Some people preferred to try traditional and herbal medications first, or in combination with the medication prescribed by a mental health professional. Talking about Macedonian clients, a practitioner said:

> *"They take the person to the doctor and then they are unsure whether to take the medication, and the doctor would send them to a psychologist with an interpreter. They accept counselling better than medication".*

Practitioners working with young and adolescent people observed that stigma about mental health issues was generational, and that young people felt less stigma than their parents. One of the practitioners said:

> *"There is a lot more willingness to talk about personal experience, my friend, my sister, my cousin whatever it is - in comparison to people who are old and are "stuck" in their old ways, beliefs and culture".*

Not understanding the counselling process was identified as a barrier for some CALD clients by some clinicians and psychologists interviewed for this study. According to them, some clients did not have an understanding that the process of talking to a professional would help them change their way of thinking or looking at an issue.

> *"It makes me think of a young person from [country] I saw her not long ago. She just would not get why counselling would work. She was referred by a service, she had a history of abuse, and she said that talking about it would not help. She didn't get what counselling actually was. I think that is a big barrier".*

Service Provider Level Barriers

Underutilisation of interpreter services

More than half of the practitioners interviewed had never, or had only rarely, used interpreters. For some services the need to use an interpreter was never felt because of the small number of CALD clients or the practitioner spoke the language of the clients. The conversations with service providers revealed underuse of interpreter services. There was some reluctance to call an interpreter service because the time it took to organize an interpreter and the difficulty of having a three-way conversation. Some practitioners expressed their frustration over not being able to tell if the content of the conversation was interpreted correctly. One of the clinicians said:

> *"I think a lack of the clinician's initiative to tap into interpreter services is a big barrier. The service is under-used. Because of the unavailability of [live] interpreters, telephone interpreting is annoying and time consuming. Some interpreters are wonderful, they do a great job but others struggle a bit. So underutilization is a problem. That means the clients are not getting as much support as they should be".*

Another clinician said:

> *"I did not enjoy them. First of all it is very time consuming. I mainly used interpreters on the phone. I had to call them and put them on speaker. Another difficulty was the quality of the interpreting service. Some of them were very good; as opposed to some interpreters - they were a minority, but I would say they tend not to give the right account of what the client was saying".*

Concerns were expressed about the use of interpreters in counselling. The clients felt that confidentiality could be compromised because the interpreter could be someone from their community. One of the clinical psychologists who worked with interpreters all the time said:

> *"There are positives and negatives of using interpreters. Use of face to face interpreters isn't always great since clients do not want to be exposed to the interpreters. Almost 50% of the clients do not want interpreters. Some interpreters do their job professionally but others interpret giving their own meaning. It is not a good situation. It confuses the psychologist. It is not 100% communication".*

Having significant language barriers and not knowing how to navigate the health system could create a huge barrier for people from a CALD background accessing services. Although many services maintained that they would offer their CALD client an interpreter when they presented to the service with a language barrier, it was found that many organizations used their bi-lingual staff and relatives of the clients to interpret for the initial assessment. The community members who participated in this project also affirmed the use of their children as interpreters.

The difficulties at the service provider level included:

- no training for professional staff on how to use interpreter services effectively,
- at times reluctance by clients to use interpreters,
- the additional cost and time involved in organizing and engaging with interpreters.

The number of bi-lingual health professionals such as GPs and Clinicians in NBMLHD and the accessible bilingual resources were reported to be limited. It was difficult for some organizations to find a psychologist within the area who spoke their client's language. A service provider working with homeless people particularly faced difficulties in accessing an interpreter service because the interpreters were unwilling to go on the street with the workers. The worker said:

> *"Yes absolutely, particularly in the Mandarin Chinese Community, because they are quite elderly as well. So there is a big language barrier there. We use Google Translate, but it would be good to have [a real interpreter]. Because it is hard to find, we do their blood pressure, their blood sugar and that kind of stuff. But to find out exactly what their needs are... we haven't been able to do that because we cannot find an interpreter to come out with us".*

Attitudes of mental health professionals

Some of the participants believed that health professionals and allied staff in general (including mental health) demonstrated an authoritative attitude towards their clients. Coming from a position of power, it was easy for them to intimidate the clients from CALD background. A practitioner stated:

"It is not only the language barrier but it is the cultural understanding that the health professionals need to have of other cultures to understand that people have different mindsets. Because of this they feel that they are not being listened to, so they drop off. I have noticed that many professionals do not want to go through the process of booking an interpreter. I have [also] noticed that many CALD clients want to go to the professionals from their [own] community; doesn't matter if they do not have the expertise. It is a matter of trust. Trust is very important".

One of the CALD clinicians observed that Australian mainstream clinicians believed that if a client could speak sufficient English there was no need to make a referral to a culturally specific mental health service. According to this clinician they were inclined to overlook the cultural needs of the clients which reinforced the apprehensions that CALD clients might already have had about the system and clinicians. The clinician observed:

"The attitude of the mainstream clinicians needs to change. They need to incorporate a CALD component in their care plan at the time of the assessment. We can cut short of the duration of treatment time".

A manager of a mental health service provider emphasised the need for service providers to not only suspend their value judgement when they worked with CALD clients, but also to understand that all communities were not the same, and that there was diversity within communities. Therefore, there was a need to embrace a client-centred approach to service delivery.

"There are all kinds of beliefs around mental health that are common to some workers who are not too experienced; it might be confusing and they may find it difficult to "walk the walk" with that person along their own journey...a big challenge. Often, we are so "mental health positive" in the industry that we kind of forget to acknowledge that perhaps there are other ways of looking at it as well".

Lack of a coordinated approach by services

Mental health service providers contacted for this study worked closely, received referrals and networked with a broad range of community support organizations and government agencies. It was observed that despite resource sharing and partnership building among the organizations, there was a lack of coordination resulting in the overlap of services; it was attributed to the way the organizations were funded.

According to one participant, there was a gap in how the services linked with each other to identify people with mental health issues.

> *"Even though there may be people living in Housing NSW properties who have mental health issues and present at the office displaying a behaviour that Housing NSW might find challenging, a connection is not necessarily made for a mental health service referral and that is true in a number of community sector [services]".*

Reliance on information provision on the internet

Some participants observed that a growing number of services relied on the internet to provide information to their clients and that this could be a barrier for clients with no computer literacy or access to computer or internet. One participant stated:

> *"As I said before, a lot of things now rely on people looking up the internet. You know the kind of things you need for that, you need language, internet access, computer skills and computer availability".*

It was observed by some service provider participants that the information was not updated regularly on many websites. Some services might have moved, changed their names and addresses or had closed down, thus causing confusion and frustration for their clients and many agencies.

> *"There is actually more information available on the internet than there is actually available to people, and that can be quite overwhelming...when you are battling around and you are gotten to the point of willing to [ask for] help, but you cannot actually find it because the organization is no longer there so the information on the web is quite difficult for the people to navigate".*

The expectation of services for clients to access information on the web has a potential to increase isolation for people, because they would not need to visit the local organization, which might be the only social contact they had. One participant summed it up like this:

> *"I think there is a real loss if services are not available and visible in someone's community. It seems like some people would like a place to go to, but often there isn't a place to go. It is all very much "apply online" and I think that must make it tremendously difficult for people".*

Barriers to accessing mental health services in the Blue Mountains and Lithgow

Given the geographic and demographic nature of these two areas, the barriers to access for communities in general - and CALD communities in particular - were additional to the barriers experienced by clients in the Penrith and the Hawkesbury LGAs.

The service provider participants in Lithgow highlighted a number reasons for people to experience mental health issues; such as poverty, unemployment, isolation and lack of purposeful activities. Depression was common among the cohort of retrenched workers in the mining sector in Lithgow. The ability to retrain or and reskill could play a role in getting over some mental health issues, but it has been restricted by the lack of capital and choice of options.

Distance and transport issues

Access to mental health services was restricted by distance and transport issues for the residents of the Blue Mountains and Lithgow. The population is scattered in townships, especially around Lithgow, and some clients may live up to 50 kilometres from the town, where most services exist. Being an economically disadvantaged area, it was hard for people to own a car, they needed to rely on the local bus service. Similarly, in the Blue Mountains, people travelling by bus or train would need to walk long distances to reach these services. For most mental health services, people would have to travel to Penrith, Katoomba or Bathurst. The lack of mental health services, especially psychiatrists in Lithgow and the Blue Mountains forced people to travel, which meant setting aside a whole day for an appointment. The cost of transport was an additional concern.

Lack of mental health services

A general lack of mental health services was reported by service providers in Lithgow and Blue Mountains. There was no mental health unit at Lithgow Hospital, and Community Health Services was faced with a number of problems, often unable to cope with the number of clients. There were very few private psychologists and clinicians in the area, but with long waiting lists. Some comments by practitioners:

> ***"Overall, it is just that we do not have a unit at the hospital. There is only one mental health nurse at our hospital, and community mental health is quite short staffed".***

"My understanding is that the Community Mental Health system in Lithgow is pretty appalling, and it's very hard to keep workers down there. I still have to work out why that's the case. There is one very good worker that I know of, but they may be leaving shortly; I don't know...I'm just not hearing very good things about community mental health. I think somehow or other, something needs to be done to overhaul that service: I couldn't tell you what that is; we need public and private providers - so in a sense I'm trying to make up for that gap that is occurring at the Community Mental Health, whereas I shouldn't be. I get referrals from them they have some quite severe clients, but I do think that service needs to be sorted".

A need for a more effective drug and alcohol service was identified in Lithgow. The existing service based at Community Health was inadequately staffed, and also impacted by the general issues affecting the Community Health Service.

"Drug and Alcohol is another area which we lack support and we do not have any rehab nearby, and there are only one and a half workers, if you get my drift. One full-time and one part-time worker. So it is very minimal support for drug and alcohol also".

"Maybe [there's a need for] a new model to provide drug and alcohol service to people but maybe not coercive... but maybe a bit more encouraging for them to access the service".

In the Blue Mountains, the absence of psychiatrists, a high turnover of staff and limited mental health services especially on the weekend were some of the issues raised by the participants. A mental health practitioner maintained that due to a deficiency in Psychiatry, people with severe trauma and major mental health issues were forced to see a GP.

Discussing the gaps in mental health services in Blue Mountains one participant said:

"In the Blue Mountains we have a Mental Health Unit with only fifteen beds, and after-hours and on the weekend people have to be taken down to Penrith, and crisis mental health services are really under tremendous pressure".

System Level Barriers

Difficulty in navigating the system

The health system was perceived by service providers contributing to this study as confusing, complex and bureaucratic. It was considered a very difficult system to navigate even by people born in Australia who spoke English well. CALD communities faced a greater challenge in navigating the system considering that language difficulty and unfamiliarity with the system because the health system in their country of origin could be different or non-existing. A community worker who worked with young people and their families stated that there was a lot of fear among parents because they did not understand the system and they could not hand their child over to a system not knowing what was going to happen to them.

> *"There is a lot of confusion about the roles of different practitioners, I think there is a lot of confusions about what consumers' rights are. I think there is confusion about what sort of help is available, for whom and for how long and what is the cost going to be. I think there is confusion about where to go and if you don't get the response you were hoping for, makes people to stop, because they don't know where to go for a second opinion. I think that is especially difficult when you are not born here".*

Housing for people living with chronic mental health issues

Housing for people living with chronic mental illness was highlighted as a major concern by some participants. It was reported that many people got discharged from the hospital into homelessness. Many people stayed in the hospital for up to two years because they did not have any accommodation arrangements. There was a shortage of housing packages for people living with chronic mental health issues and the agencies were forced to prioritize the clients.

> *"One of the issues we have is that once people are released from Mental Health [hospital] they actually get released straight back into homelessness. So, there is no follow up, there is no casework, no wrapping-in services; these people are deemed to be well enough to go back in the society. And literally they go back on the street".*

The absence/shortage of transition housing arrangements was considered one of the major factors for homelessness after hospital discharge. Housing affordability was another issue especially for people living on a pension.

> *"People on the pension cannot afford ridiculous rents. It is not always viable to expect them to move away from where they live. Where they live might be closer to family or they are closer to everything they have known in their life. So it is rather isolating".*

Another participant said:

> *"We have clients that could do with supported living arrangements because their families had abandoned them. Which is really sad and doesn't happen to everyone but certainly happens to some. In my mind, people that are coming up are all Australians, Australian born. So that doesn't even matter if you are CALD, if it is CALD that means you have less family around so even more isolation".*

Lack of CALD mental health services and funding

A general shortage of mental health services in the public health system was reported by participants in all project areas. The following statements highlight the concerns of workers and practitioners.

> *"I think the barrier would be there are not enough services, not enough packages available in mental health services. So what we do is that we pick the hardest one or someone who needs it most, regardless of CALD or no CALD".*

> *"Hawkesbury Hospital on the weekends doesn't have security, doesn't have a mental health team".*

> *"Mental health teams are fairly stretched, so are our doctors, they aren't often in a position to make up for the system by holding people safely, protecting people from themselves or falling through cracks because the system is not working as well as it should".*

A shortage of beds and staff in the crisis team in the Blue Mountains was reported by participants.

> *"There aren't any resources for people who work on the crisis team to liaise with people like me who have community contacts. We often know a lot about community and risk level. I think we really need more beds and staff on the crisis team".*

> *"Mental health acute services are vastly understaffed for the work they do. I think it was on the news the other day - people falling through the cracks - I know that sort of thing happens and it is tragic".*

Talking about the lack of funding for mental health services, a manager said:

> *"I think any service in Australia would like to see more money made available because anyone who is involved in mental health knows there is need out there and that is something that we ourselves working with people try our best".*

Limited number of counselling sessions and the cost

A limited number of hours for counselling offered through mental health care plan were considered insufficient by many participants for CALD clients with language issues and especially for the ones with complex issues.

> *"The mental health system is built around a certain number of sessions, 6 or 10 so I think particularly for CALD women that speak very little English, being passed from person to person is not great when you have only 6 sessions. Or finally getting to someone and get cut off because you have limited sessions available. It is quite a big barrier for them. Particularly for some CALD women there is such a complex history behind them, they often have trauma history in their country of origin and then they have the story of migration. So there are varied amount of narratives of what is going on in their lives. That it takes just six sessions to learn about that. And all of a sudden they have to stop and wait for the next year".*

Even the number of counselling hours provided by TMHC were not enough to make an impact.

> *"You just get to know someone and the six hours are gone. Six hours and you have to write the assessment and all. So the poor person had got to know you and then you have to send them to someone else with an interpreter. It is just not right. That is a big barrier. Big barrier actually".*

The cost of counselling was an important issue for the participants of focus groups and was emphasized by some clinicians. One of them said,

> *"The bulk billing psychiatrists are hard to find so if the psychiatrist is not registered with community mental health so you have to pay privately and most people cannot afford that".*

A counsellor said:

> *"There are already so many issues they are dealing with on top of that they have to pay for it. It is difficult for them".*

Table 5: Barriers in Access, Gaps in Service and Recommendations: Services Providers Findings

Service providers	Access Barriers and Gaps in Service	Recommendations
TMHC Clinicians Mental Health Nurse and Occupational Therapist Mental Health Clinician Clinician and psychiatrist Psychologist	Stigma, Reluctance to use medication, Language, Isolation. TMHC hours not enough, Lack of understanding of mental health issues, Lack of information about services, Confidentiality issues in counselling,	Address the language issue, More psychological education and promotion, More bilingual Psychologists, Change the perception of clinicians, Clear Criteria for CALD assessment More bulk billing psychiatrists, System needs to stop people falling through the cracks
Psychologists Penrith, Hawkesbury, Blue Mountains, Lithgow	Stigma, Language, Lack of information about services, Lack of psychological education, Distance to mental health services, Transport availability and cost, Affordability (cost) of counselling, Non- attendance to counselling, Systemic problems in community health in Lithgow, Restrictive criteria by service providers, Lack of coordination between services, Lack community engagement, Issue of online services, Not enough funding for CALD programs, Crisis mental health under pressure	More drug and alcohol and mental health services for Lithgow, More community development activities in Lithgow, More employment opportunities, More psycho education, Free or cheaper counselling services, Coordination among services, Outreach services, Increased interaction with communities, More beds for Blue Mountains Hospital Mental Health Unit
Mental Health Service Providers Penrith, Hawkesbury, Blue Mountains, Lithgow	Stigma, Language, Traditional Thinking Lack of information about services, Not understanding the counselling process Confidentiality Lack of cultural understanding by clinicians Lack of coordination among services Services limited by criteria Lack of funding for CALD programs Lack of housing packages Difficulties in navigating the system, Community Health understaffed in Lithgow No mental health unit in Lithgow Hospital. Transport difficulties in Blue Mountains, Clients released into homelessness from hospitals Lack of bilingual staff Shortage of bilingual psychologists Limited number of counselling sessions under Medicare Acceptance/referral issues of people having a mental health issue and drug an alcohol addiction Lack of services on weekends in Hawkesbury and the Blue Mountains Hospitals Issue of online services and information Excessive turnover of staff in the Blue Mountains Hospital	More Funds for CALD specific services More funds for housing for people with severe and chronic mental health issues More Drug and Alcohol Services in Lithgow, Mental Health Drop-in centre for Lithgow More psychologists in Lithgow Extended number of hours for CALD clients More bilingual staff and psychologists More interaction with communities Training of awareness of mental health issues Cultural competency training for staff Work in partnerships Outreach services to communities

Post Consultations Project Activities

The following activities were undertaken to provide information and training to community members, community leaders and service providers.

Mental health Information sessions

One of the project's objectives was to provide information to CALD communities about mental health issues and services available in their LGA. The need for more information was also identified during focus group discussions by recently settled communities in the Penrith LGA, such as Iranian, Japanese and Afghani communities. The information sessions for these communities were held during the month of May in partnership with TMHC. TMHC clinicians who spoke the language of these communities were invited to provide information on most common mental health issues, signs and symptoms and relevant services available. The information sessions were evaluated. The participants found the information most useful and requested further information sessions. Please see Appendix 6 for photographs of the information sessions.

Cultural competency training

Cultural competency training workshops for community workers and community leaders were organized in early June at NMA's premises in collaboration with Nepean Blue Mountains PHN, PIR and TMHC. The need for this training was identified during consultations with mental health service providers and interviews with community leaders.

The community workers' training aimed to provide knowledge and skills to assist workers to work effectively with people from CALD backgrounds. The workshop included case studies and group discussion. The following topics were included in the training:

- An overview of the Transcultural Mental Health Centre
- What is culture and cultural differences
- Cultural Competency
- Perceptions of mental health in cultural contexts
- How to work effectively with CALD consumers/carers and communities

The training for community leaders included:

- An overview of the Transcultural Mental Health Centre
- Mental Health, mental illness and wellbeing; a basic introduction.
- Stigma; what it is, how it affects individuals and communities and strategies to reduce it: A case study
- Engaging with CALD consumers/career and communities.

For the flyer, program and photographs please see Appendices 7, 8, 9, 10.

Information resources

The following resources were developed:

- An information resource containing information on mental health service available in Nepean Blue Mountains region was developed by NMA. This resource provides information on the type of service, eligibility criteria,and contact details of the service.
- A comprehensive Multicultural Well Being and Community Support Care information card for CALD communities in the Nepean and Blue Mountains was developed and printed by Nepean Blue Mountains PHN. This card provides phone contacts for relevant services such as Interpreter services, crisis or emergency, mental health services and support, alcohol, drugs and gambling services, local hospitals among others. Please see Appendix 11 for images of the resource.

Lessons Learned

1. The duration of the 3BU project was one year from July 2015 to June 2016. July was dedicated to the development of the work plan and the Project Worker/Researcher recruitment. The project activities started mid-August 2015. Because of this, a one- month extension was negotiated to facilitate the writing of the final report and production of resources.

2. The project was successful in achieving its objectives of studying the perceptions of CALD communities, providing information to communities and in suggesting strategies for culturally competent services. The project provided opportunities for networking and creating partnerships. During the project period a large number of community members, community organisations and mental health services providers were contacted. Many helped by providing contacts of other potential participants for the project.

3. The project steering committee played a pivotal role as an advisory body in achieving the project outcomes. The committee made valuable contributions in terms of providing contacts for community consultations, monitoring the progress of the project and supporting the project's activities.

4. Reducing the stigma attached with mental health issues requires trust and rapport building with communities over a longer period of interaction. The one-year 3BU project duration however was considered insufficient to have a substantial impact on the change in attitudes of the communities towards mental health issues.

5. The 3BU project covered four LGAs of the Nepean Blue Mountains Local Health district. The scope of the project was too large and the time available to implement the project too short. A project of this scope could also benefit from more than one full-time staff. In the last 3 months of the project, a one day a week position was made available to assist the researcher in focus groups and transcriptions, however a full-time clerical position would have been more useful for the outcomes of the project. Provision of funds for out sourcing the transcription of the focus group discussions and interviews could also benefit the project.

6. In general, all communities contacted for this project in Penrith LGA were willing to talk about mental health issues with the researcher. Some communities were approached due to the apparent need for awareness raising but were unable to participate in the project. A more indirect approach is perhaps needed for mental health education for these communities.

7. An attempt to seek approval from the NBMLHD Ethics Committee for the 3BU Project was made but due to the timeframe, it did not materialize. Consequently, the project was denied access to clients, clinicians and staff of the NBMLHD hospitals.

Conclusions and Recommendations

The findings suggest that there was a substantial presence of mental health issues and stigma among participant CALD communities. The perception of mental health issues and help-seeking behaviour was influenced by culture and experiences in the country of origin for recently arrived communities. The attitude towards mental health issues of some communities settled in Australia long ago have changed over time, and the stigma around mental health issues is significantly less; representatives of service providers also confirmed these findings.

The barriers in access to mental health services were identified at three levels by the participants of this project. At community level, the inability to communicate in English, lack of knowledge of the services and the system and cost of mental health. At service level, the barriers were underutilization of interpreter services and attitudes of mental health professionals. At a system level, the difficulty in navigating the system and a lack of services for CALD communities were the major barriers.

Participants in the 3BU project have recommended the following measures to improve access of CALD communities to mental health services. The strategies are recommended at three levels: community, service and system level.

Recommendations: Community Level

Following are the recommendations to address the barriers at community level:

1) Community education programs

a. Deliver community education programs on mental health to reduce stigma among CALD communities. The need for such programs is greater for newly arrived communities because their decision to access mental health services is still guided by their experience and beliefs from their country of origin. The more established communities also required information about mental health services.

"We need education, information and advertisements. We should use TV and the media. We should use the media and let them [communities] know that there are services, especially let them know about interpreter services".

"Why [can't there be] video clips that show the actual situations acted out by people, showing the community what happens (symptoms) when someone has mental health issues...we need to know that when we see certain signs, then we know what is going on".

b. Community education programs need to be delivered with greater cultural sensitivity and a possible change of discourse about mental health that is non-stigmatising.

"Try and phrase things differently to get around the stigma of accessing these mental health services".

c. Education programs need to include information about the processes of counselling.

"I think there is a gap in the education somehow trying to help all the communities out there to understand what counselling is and how safe it is".

d. Community education programs need to address the reluctance of communities in the use of medication by breaking the myth that once on medication they will be on it for life.

e. Community leaders and representatives need to be consulted in the design and delivery of community education programs on mental health.

f. Provide training for community leaders, representatives and youth members on mental health-illness and well-being, how to reduce stigma and how to engage with communities.

Recommendations: Service Level

Following are the recommendations to address barriers at service level:

1) Use of interpreters/interpreter services

a. Services need to introduce internal measures/protocols to ensure that staff access an interpreter every time a need is identified for a CALD client.

b. Services need to provide training for staff on how to access interpreters, and on how to communicate effectively in three way conversations.

c. Services need to use professional interpreters to ensure the accuracy of interpreted conversation to ensure clients fully understand the information received and are able to express themselves correctly. Services need to discourage the use of family and bi-lingual workers as interpreters.

"I have noticed that once I have interpreter in the room with me it is a lot easier for the client to feel comfortable and build rapport and when they need the specialist service or counselling we book the same interpreter for them".

d. For clients who have concerns about confidentiality because the interpreter may be from their own community, services need to consider using telephone interpreters instead of onsite interpreters and clearly explain to the clients that professional interpreters are bound by confidentiality.

2) Community engagement

a. Mental health service providers need to outreach their services to communities in places known and frequented by those communities, building trust and providing information and service.

"I think services need to outreach. I think they expect people to come to them. We expect people to come to our building and find parking and do all the complicated stuff with reception staff which requires language".

b. Services need to engage more effectively with communities through consultations in order to find out their concerns and needs and then provide services tailored to their needs. The services need to have a welcoming environment, culturally competent staff and offer services that are suitable for a range of CALD clients.

c. Services need to engage with CALD communities in mental health awareness raising and provision of preventative mental health information to reduce stigma around mental health.

3) Better coordination among services

a. Mental health service providers need to improve interaction with other agencies which provide specialist services and community development activities. There is a need for services to share information more effectively with each other so that appropriate referrals can be made.

> *"We need to work in partnerships so that we can have an informed referral network so that we don't have to go through the bureaucracy... so that we can simply pick up the phone, have a chat about the client, with their permission, be able to easily refer the person, follow it up with an email. It is a good seamless way to ensuring that a client's needs are met in holistic manner not just mental health".*

b. Services need to develop protocols to follow when they come across dual diagnosis such as drug and alcohol and mental health issues to ensure an appropriate referral is made.

> *"There need to be places where people with dual diagnosis can go, instead of being shoved from one place to another because people do not want to take responsibility for them".*

c. The services also need to educate and train their staff to recognize the signs of mental health issues when dealing with clients.

4) Cultural competency

Mental health service providers need to have plans and strategies in place for cultural competency at all levels of their organization.

a. Services need to provide compulsory cultural competency training to their staff enabling them to provide culturally sensitive service to CALD clients. A refresher training may also be provided after a period of time after the initial training.

b. Staff need to be trained to access and use professional interpreter services.

c. Services need to develop strategies to ensure that staff practices include cultural competence skills after receiving the training. One strategy could be to include a check on the practice of cultural competency during staff supervision sessions. Services could also look into including staff cultural competent practice in performance appraisals.

d. Services need to employ more bi-lingual staff keeping in view the demographic changes in their LGA.

e. Services need to ensure that the CALD data collected at the time of initial assessment is used to improve the delivery of mental health programs for CALD communities.

5) Culturally appropriate assessment

a. Services and mainstream clinicians need to incorporate a CALD component/ strategies in the care plan of a client at the time of initial assessment.

b. A referral to TMHC needs to be made at the time of initial assessment so that the client can be integrated into the system with the help of a TMHC's clinician. This timely referral may help cut down the duration of treatment for the clients.

c. Clear criteria for services/clinicians to follow for referral to TMHC needs to be put in place.

> *"There should be some criteria, tick, tick, tick, yes the client needs TMHC service. So there is no clear definition or criteria for a client to be referred to TMHC. Probably there is but clinicians are not aware of it on the ground".*

Recommendations: System Level

The following recommendations are made to address the system level gaps and barriers identified by communities, service providers and mental health professionals.

1) Improve psychological services

The participants made the following suggestions to improve psychological services for CALD clients:

a. Psychological services such as counselling, need to be cost-free or set at a minimum of the clients' out of pocket expenses. Although Medicare provides a number of subsidized counselling sessions per year, not many counselling services are bulk billing their clients. People not able to afford out of pocket expenses simply put off going to counselling.

> *"Sadly, some psychologists have put up their fees way up so they get the Medicare rebate but still there is 40, 60 or 90 dollars gap between them; which I think is too much. So, a free service would be a better service or with a small fee".*

"CALD communities should have access to cheaper psychological services and rebate on medication. Because at the end of the day people have expectations from this country and hopes too, but when those hopes break, it is too hard".

b. The number of hours/sessions of counselling for CALD clients needs to be increased, especially for clients with English language difficulties, those with complex needs and/or those that have experienced torture and trauma.

c. Address the issue of non-bulk billing psychiatrists. There is a shortage of psychiatrists who bulk bill and many of the community members and service providers have raised the issue of inability to pay for a specialist's appointment.

"Bulk billing psychiatrists are hard to find so if the psychiatrist is not registered with community mental health...[clients]... have to pay privately. So most people cannot afford them".

d. Mandatory cultural competency training needs to be provided to the GPs and psychologists.

2) More funds for CALD mental health services

a. Ensure allocation of more funds for CALD specific services. There is a shortage of CALD specific service providers, and major non-government mental health service providers do not offer CALD specific services within their programs. There is a huge need for culturally sensitive services for CALD communities. Funding needs to be made available, for example, for the appointment of bi-lingual staff, additional counselling sessions and community engagement programs.

b. The allocation of increased funding for TMHC to improve and expand their services to CALD communities.

"More funds will allow organizations like the Transcultural Mental Health Centre to provide appropriate services to CALD clients; for example, after completing a number of sessions, if they can join a therapeutic session, that will be great".

3) Improve housing for people with chronic mental health issues

A shortage of housing for people with chronic mental health issues was identified as a gap in the project LGAs.

a. More housing and services packages need to be made available for people living with severe and chronic mental health issues.

b. Transition housing should be made available for people leaving the hospital. Many people are forced to stay in the hospital for a year or more because they do not have accommodation arrangements or are forced to leave the hospital into homelessness.

4) Improve mental health system

The mental health system in NSW was considered confusing and difficult to navigate for CALD clients with language barriers.

a. The existing CALD communities' confusion about mainstream mental health service providers, their role, and eligibility criteria need to be addressed by providing clear information and referral pathways across different mental health services.

b. Systems need to be put in place to reduce the number of people "falling through the cracks". There is a group of people with psychotic disorders that are not considered for hospital admission because their health risk is assessed to be not high.

> *"The hospital would not take them or they might see them for a few hours and they get discharged; the crisis teams and community health resources are limited. They tend to prioritize in terms of risk. There are people who fall through the cracks. They need help but they are not in a condition bad enough to be eligible for those services. They might not be well enough to go to the GP and get mental health plan happening, or to find a psychologist".*

c. Improve the system for greater family involvement in the care of clients with severe mental health issues. Some of the participants could not obtain information because of confidentially laws about the diagnosis of their adult children and as a result could not look after them in an effective manner. Some participants also criticized the system for not allowing them to bring their adult son or daughter for the hospital admission despite the fact that they were at near breaking point.

Recommendations for Lithgow and the Blue Mountains

Following are the recommendations for Lithgow and Blue Mountains LGAs:

a. The Government needs to provide increased funding to existing services for community development and social activities for people, especially for CALD people in the Lithgow area. A lack of employment opportunities and social activities were considered contributing reasons for mental health issues among the adult population. The need for more community development activities was identified by service providers and psychologists interviewed by this project in Lithgow.

b. Establish a mental health drop-in centre in Lithgow to assist people who are struggling with mental health issues but do not know where to go, how to seek help, or are unaware of their options. Mental health services are scarce in Lithgow and organizations that provide outreach services are not located at one place. A drop-in centre would help provide information and referrals to people about suitable services.

c. Systems need to be put in place to provide more psychological services through the Hospital in Lithgow.

d. More regular and less costly transport options need to be made available for people living in the Lithgow LGA.

e. Outreach of mental health services is recommended to address the distance and transport barriers for people in Lithgow and Blue Mountains.

f. An inquiry into the working of Community Health service in Lithgow is needed in order to maximize its potential for providing mental health services.

g. More drug and alcohol services are needed in Lithgow. The current service is a part of Community Health which is unable to meet the community needs.

h. Systems need to be put in place for the appointment and retention of psychiatrists in the Blue Mountains Hospital.

i. Systems need to be put in place to provide acute mental health services on weekends at the Blue Mountains Hospital.

Appendix 1

List of Questions for Community Consultations

Ice breakers.

What do you usually do when you or your family member are sick or have a medical emergency?

What will your community members do if they have a medical problem?

Let us talk about some of the feelings that people who have migrated to Australia may have experienced. I hope that most people feel happy about their life in Australia but some people may not feel very happy due to many factors such as: separation from family, unemployment, difficulties in understanding and speaking English, and other cultural problems. People may have experienced war or violence or natural disasters. There can be many things that can make people feel sad and angry. They might think that they are not coping with life in Australia.

1. Do you know anyone from your community who feels or might have felt this way?

2. Are there any particular mental health issues that people from your community have experienced as they tried to settle in Australia?

3. What is the attitude of people from your community towards mental health issues? Please give me examples of their perception or reaction towards a person who is experiencing these issues?

4. Is there a difference between the attitudes of people from your community here than the community back at home? Or what is the attitude of people back at home about mental health issues and how do they deal with these?

5. Do you think there is stigma associated with mental health in your community?

6. How do you feel when you hear that someone from your community has mental health issues? What sort of things come to mind?

7. Do people talk about mental health issues among their family or among community members?

8. How does the family deal with an issue once it has surfaced or has been talked about? What steps might they take to resolve the issue?

9. Does religion play a part in the healing or dealing with mental health issues for your community?

10. Would you, or members of your community, know where to go or seek help from when someone has mental health issues? Could you please name some service providers that you know of?

11. In your opinion, what are the possible factors that could prevent the family or persons with mental health issues from accessing a GP or mental health service providers? (Language barrier, gender of the health professional, confidentiality, cost, lack of information, family's approval etc.).

12. How do you think mental health service providers can improve their services for CALD communities (information material in community language, staff having more knowledge about culture and using telephone interpreters. Mental health worker from your community etc.).

13. What are your community's needs in regard to mental health information?

14. Is there anything else you would like to say before we conclude our discussion?

Appendix 2

List of Questions for Community Members

Let us talk about some of the feelings that people who have migrated to Australia may experience. I hope that most people feel happy about their life in Australia but some people may not feel very happy due to many factor such as separation from family, unemployment, difficulties in understanding English, and/or other cultural problems. People may people feel sad and angry. They might think that they are not coping with life in Australia.

1. Have you experienced any of those emotions yourself? Would you like to share your experience with me?

2. Do you know anyone from your community who feels or might have felt this way? Could you please give me some examples?

3. What are any particular mental health issues that people from your community have experienced while trying to settle in Australia?

4. What is the attitude of people from your community towards mental health issues? Please give me examples of their perceptions or reaction towards a person who is experiencing these issues?

5. Is there a difference between the attitudes of people from your community here than the community back at home? Or what is the attitude of people back at home about mental health issues and how do they deal with these?

6. Do people talk about mental health issues among their family or among community members?

7. How does the family deal with an issue once it is surfaced or talked about? What steps might they might take to resolve the issue?

8. Do you know or would members of your community know where to go or seek help from when someone has mental health issues?

9. Did you ever use any health services or mental health services yourself. Could you describe your experience? (If they had a negative experience then ask how things could be made better for you.)

10. Could you please name some mental health service providers if you can?

11. In your opinion what are the possible factors that could prevent the family or the persons with mental health issues from accessing a GP or mental health service providers? (Language barrier, gender of the health professional, confidentiality, cost, lack of information, family's approval etc.).

12. How do you think mental health service providers can improve their services for CALD communities (information material in community languages; staff having more knowledge about culture; using telephone interpreters; mental health workers from communities, etc.).

13. What information would you like to have or you think will be beneficial for the community? What are your community's needs with regard to mental health information?

14. Is there anything more you would like to say before we conclude our discussion?

Appendix 3

List of Questions for Mental Health Service Providers

Name of Organization: _____

Name of participant: _____

Position of participant: _____

1. Is your organization:

- ☐ Government?
- ☐ Non-Government?

2. What type of services does your organization provide?

3. What is /are your organization's main target group (s)?

4. Would you be able to tell approximately, what is the percentage of CALD clients that use your services?

5. Does your organization provide services specifically for CALD Communities? Does that include mental health services?

6. What sort of data (identification) do you collect from your clients? Do you collect information about their cultural background and language spoken at home? (If no, then how do you know the client's cultural background or language spoken by them?)

7. How does your organization measure its performance? Are there any performance standards that it follows?

8. What are the specific measures that your organization takes for CALD clients in order to provide services? (For example interpreters, bi-lingual staff, social workers etc.). Is not having bi-lingual workers a barrier?

9. Does your organization use interpreters? If yes, then how often are the interpreters used?

10. Can you describe your or your organizations experience of using interpreters? (Difficulties and advantages).

11. Are there any Translated materials available for CALD communities?

12. Do you work closely with other organizations? In terms of referral, sharing resources and information?

13. In your experience, what are the main mental health issues that your CALD clients experience?

14. Have you noticed any particular attitudes and beliefs about mental health issues among your CALD clients? Could you please describe those to me?

15. Keeping in mind the percentage of the CALD clients that your organization has, what in your opinion are the reasons or barriers that CALD communities may experience in accessing the services?

16. What sort of issues or problems arise in your organization while providing services to CALD communities?

17. In your opinion, what are the gaps in services over all in mental health provision to CALD Communities?

18. In your opinion, what measures on the part of mental health service providers can improve CALD communities' access to mental health services? Does your organization employ any of those measures?

19. What staff development activities does your organization provide its staff to be more culturally competent?

20. In your opinion, what would be an ideal mental health service provider to CALD communities?

Appendix 4

Project Statement

Before you agree to participate in this study, it is important for you to read and understand the following information on the purpose, benefits and risks of the study and how the study will be conducted.

Title of the Project: Breaking Barriers Bringing Understanding (3BU).

Purpose of the Project: This project will study the perspective of Culturally and Linguistically Diverse (CALD) communities on mental health in the Penrith, Blue Mountains, Hawkesbury and Lithgow LGAs. The project aims to raise awareness on mental health issues and reduce associated stigmas, provide information on mental health services available to CALD communities as well as to assist services to develop culturally appropriate work practices leading to increased CALD access to their services.

Research Procedures: You will be requested to answer questions in an interview and/or in focus group discussion. The interview will take about 30-45 minutes and a focus group may take an hour or more of your time. The interview and focus group discussion will be recorded and will be stored safely in Nepean Migrant Access Inc. for a period of five years.

Voluntary Participation: The participation in the project is voluntary, you can withdraw from the project at any time during the study without giving any reasons.

Foreseeable Risks: There are no foreseeable risks to you if you participate in this study. Your participation/contribution will help service providers adopt strategies that will contribute to better mental health services for CALD communities.

Project's Benefits: The project will increase the awareness of mental health issues and services among the CALD communities, thus increasing the support for individuals within their communities. The project will also link CALD individuals and communities to existing services, increasing the access of CALD communities to mental health services. It will establish a sustainable relationship between service providers and service users.

Confidentiality: The information that you will provide to the research will be confidential. The data will be stored in a locked cupboard with limited access. The information you will provide will be used anonymously and you will not be identified when your views are presented to other participants or any publication and reports. Your name will be changed when used in quotations.

Copy of the Findings: You will be provided with a summary of the findings of the research if you chose to receive it. Please contact NMA on 02 98332416 if you have questions and if you want to receive a copy of the summary of research findings.

Appendix 5

Informed Consent Form

Breaking Barriers Bringing Understanding (3BU) Project

Nepean Migrant Access Inc.
St. Mary's corner, Community and Cultural Precinct
29 Swanston Street, Building 5
St. Marys NSW 2760

Researcher: Najeeba Syeda
NMA, 02 98332416

Participant's Name: _____

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written statement to keep.

2. I understand that after I sign and return this consent form it will be retained by Nepean Migrant Access Inc.

3. I understand that my participation will involve an interview and/or focus group discussion and I agree that the researcher may use the results as described in the statement.

4. I acknowledge that:

   - ☐ Possible effects of participating in an interview and/or focus group discussion and consultation have been explained to my satisfaction;
   - ☐ I understand that participation in the project is voluntary. I have been informed that I am free to withdraw from the project at any time without explanation;
   - ☐ I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
   - ☐ I have been informed that with my consent the interview/focus group discussion will be recorded electronically and data will be stored at Nepean Migrant Access Inc. and will be destroyed after five years;
   - ☐ My name will not be referred to in any publications from the research;
   - ☐ I have been informed that a summary of the research findings will be forwarded to me, should I agree to this.

I consent to this **interview/focus group being** electronically recorded.

☐ **No** ☐ **Yes** (Please Tick)

I wish to receive a copy of the summary of research findings

☐ **No** ☐ **Yes** (Please Tick)

Participant signature: **Date:**

Appendix 6

Photographs of Mental Health Information Sessions

Appendix 7

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

CALD Mental Health Awareness

For Community Leaders

This workshop is a collaboration between the Transcultural Mental Health Centre, Nepean Migrant Access and the Nepean Blue Mountains Primary Health Network. The workshop provides community leaders with an introduction into the area of mental health, mental illness and wellbeing. Community leaders will learn about stigma, what it is and how it effects individuals and communities along with strategies for reducing it.

Community workers will learn how to engage with CALD consumers, carers and communities in the area of mental health. The workshop will include case studies.

- Overview of Transcultural Mental Health Centre services;
- What is culture and cultural differences;
- Cultural competency
- Perceptions of mental illness from a cultural perspective
- How to work effectively with CALD consumers/carers/communities

Presenter
Michele Sapucci, Transcultural Mental Health Centre

Mr Sapucci earned his Bachelor in Clinical Psychology at the University of Padua, Italy, and a Master in Human Resources and Industrial Relations at the University of Sydney.

He has 16 years of experience in mental health settings, particularly with migrants and refugees both in Italy and Australia. Michele is currently the Program Leader of the Mental Health Promotion, Prevention & Early Intervention Team at the Transcultural Mental Health Centre.

For Event enquiries, contact Najeeba on 9833 2416.

FREE

FACE TO FACE

Session
9.30 am Registration & morning tea
10 am to 12 pm Workshop

ST MARYS

Friday, 3 June 2016

Nepean Migrant Access Inc. Building 5

St Marys Community & Cultural Precinct

29 Swanston Street
ST MARYS NSW 2760

RSVP: 27th May 2016

NMA

partners in recovery
Blue Mountains • Hawkesbury • Lithgow • Penrith

Wentworth Healthcare provider of the Nepean Blue Mountains PHN

phn NEPEAN BLUE MOUNTAINS

Yes, I would like to register for this free workshop

Please clearly complete the fields below to register by phone call Najeeba on **9833 2416** or email: **najeeba@nma.org.au**

Attendance Session: ☐ **St Marys, 3rd June**

First Name **Last Name**

Organisation **Job Title** **Mobile**

Email ☐ Yes I would like to receive information from NBMPHN by email

Special Dietary Requirements (please give details)

How did you hear about this event? ☐ **Fax** ☐ **Email** ☐ **NBMPHN Website** ☐ **Word of Mouth** ☐ **Other**

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

CALD Mental Health Awareness

For Community Workers

This workshop offers community workers the knowledge and skills for working effectively with people from CALD backgrounds in the area of mental health. Participants will learn about the role of culture and cultural differences within the CALD community, and what it means to be culturally competent.

Perceptions of mental illness will be explored from a cultural perspective, including the causes, explanations and approaches to mental illness. Community workers will learn how to work effectively with CALD consumers, carers and communities in the area of mental health.

The workshop will include case studies and group discussions.

- Overview of Transcultural Mental Health Centre services
- What is culture and cultural differences
- Cultural competency
- Perceptions of mental illness from a cultural perspective
- How to work effectively with CALD consumers/carers/communities

Presenter
Michele Sapucci, Transcultural Mental Health Centre

Mr Sapucci earned his Bachelor in Clinical Psychology at the University of Padua, Italy, and a Master in Human Resources and Industrial Relations at the University of Sydney.

He has 16 years of experience in mental health settings, particularly with migrants and refugees both in Italy and Australia. Michele is currently the Program Leader of the Mental Health Promotion, Prevention & Early Intervention Team at the Transcultural Mental Health Centre.

For Event enquiries, contact NBMPHN on 4708 8100.

FREE

FACE TO FACE

Session
9.30 am Registration & morning tea
10 am to 12 pm Workshop

ST MARYS

Thursday, 2 June 2016

Nepean Migrant Access Inc. Building 5

St Marys Community & Cultural Precinct

29 Swanston Street
ST MARYS NSW 2760

RSVP: 26th May 2016

NMA

partners in recovery
Blue Mountains • Hawkesbury • Lithgow • Penrith

Wentworth Healthcare provider of the Nepean Blue Mountains PHN

phn NEPEAN BLUE MOUNTAINS

Yes, I would like to register for this free workshop

Please clearly complete the fields below to register by fax **(02) 9673 6116** or register online at **www.nbmphn.com.au/events**

Attendance Session: ☐ **St Marys, 2rd June**

First Name _____ **Last Name** _____

Organisation _____ **Job Title** _____ **Mobile** _____

Email _____ ☐ Yes I would like to receive information from NBMPHN by email

Special Dietary Requirements (please give details) _____

How did you hear about this event? ☐ **Fax** ☐ **Email** ☐ **NBMPHN Website** ☐ **Word of Mouth** ☐ **Other**

Appendix 8

CALD Mental Health Awareness Training by the Transcultural Mental Health Centre

IN PARTNERSHIP WITH THE NEPEAN-BLUE MOUNTAINS PRIMARY HEALTH NETWORK & NEPEAN MIGRANT ACCESS

2 June 2016 - 10am to 2.30pm

Registration & morning tea	9.30 – 10.00am
Overview of Transcultural Mental Health Services	10.00 – 10.10am
What is culture (cultural identity) and cultural differences + group discussion	10.10 – 10.35am
Cultural competency + case studies	10.35 – 11.05am
Perceptions of mental illness from a cultural perspective, causes, explanations and approaches to mental illness	11.05 – 12.05pm
Lunch break	12.05 – 12.35pm
How to work with CALD consumer/carer and communities + case study	12.35 – 1.15pm
Workshop close	2.30pm

Appendix 9

CALD Mental Health Awareness for Community Leaders by the Transcultural Mental Health Centre

IN PARTNERSHIP WITH THE NEPEAN-BLUE MOUNTAINS PRIMARY HEALTH NETWORK & NEPEAN MIGRANT ACCESS

3 June 2016 - 10am to 12pm

Registration & morning tea	9.30 – 10.00am
Overview of Transcultural Mental Health Services	10.00 – 10.05am
Mental health, mental illness and wellbeing; a basic introduction + case example	10.05 – 10.50am
Stigma; what is it, how it affects individuals and communities, and strategies to reduce it + case study	10.50 – 11.35am
Engaging with CALD consumers, carers and communities	11.35 – 12.00pm
Workshop close	12.00pm

Appendix 10

Photographs of Cultural Competency Training

Appendix 11

Multicultural Card

Multicultural Wellbeing & Community Support

Blue Mountains | Hawkesbury | Lithgow | Penrith

INTERPRETER SERVICES

TIS is an interpreting service for people who do not speak English

Translating and Interpreting Service (TIS) 24 Hour Service 13 14 50

The TTY service provides support to people who are hearing impaired

National Relay Service (TTY) 24 Hour Service 13 36 77

CRISIS or EMERGENCY NUMBERS (24/7)

Police, Fire & Ambulance	000
Mental Health Access Team	1800 011 511
After Hours Health Advice & Information	1800 022 222
Alcohol & Drug Information Service	1800 422 599
Domestic Violence Assistance Line	1800 656 463
Lifeline	13 11 14
NSW Rape Crisis Centre	1800 424 017
Link2home	1800 152 152
Kids Helpline	1800 551 800
Child Protection Helpline	13 21 11

MENTAL HEALTH SERVICES & SUPPORTS

A range of health services including information & support, assessment, counselling and treatment for people with a mental health concern

NSW Transcultural Mental Health Centre	1800 648 911
NSW Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS)	9794 1900
Nepean Blue Mountains Local Health District (NBMLHD) Community Health (Central Intake)	1800 222 608
NBMLHD Multicultural Health Service	4734 1600
Bridging the Gap, St Marys	9673 1211
eHeadspace	1800 650 890
Uniting Recovery (includes Headspace & Likemind)	1300 364 097
Salvos Counselling Freedom & Hope, Penrith	4731 1554

ALCOHOL, DRUGS & GAMBLING SERVICES

These services provide treatment for drug use or gambling addiction

Drug and Alcohol Multicultural Education Centre	9699 3552
NBMLHD Drug & Alcohol Service	1300 661 050
Multicultural Problem Gambling Service for NSW (MPGS)	1800 856 800
Dianella Cottage (women only)	4782 9265
ONE80TC - Residential Rehabilitation	1800 679 657

LOCAL HOSPITALS

Nepean Hospital, Kingswood	4734 2000
Blue Mountains Hospital, Katoomba	4784 6500
Lithgow Hospital, Lithgow	6350 2300
Hawkesbury District Health Service, Windsor	4560 5555
St John of God Hospital, North Richmond (Private Mental Health)	4570 6100

INFORMATION, ASSISTANCE & REFERRAL

My Aged Care	1800 200 422
Multicultural Disability Advocacy Association	9891 6400
National Disability Insurance Scheme (NDIS)	1800 800 110

ACCOMMODATION & SUPPORT

The Right Door	1800 760 071
Christ Mission Possible (CMP)	1300 435 728
Platform	4760 0800
Mission Australia	4724 3000
Wentworth Community Housing	4777 8000

REFUGEE SUPPORT

These services provide information, support and treatment

Nepean Migrant Access Inc., St Marys	9833 2416
NSW Refugee Health Service (Central Intake)	8778 0770
Settlement Services International (SSI)	8799 6700
SydWest Multicultural Services	9621 6633
Westmead Children's Hospital HARK Clinic Health & Assessment for Refugee Kids	9845 3315

WOMEN'S HEALTH SERVICES

These services provide women's health services, counselling & support

Blue Mountains Women's Health and Resource Centre, Katoomba	4782 5133
Penrith Women's Health Centre	4721 8749
The Women's Cottage, Richmond	4578 4190
Family Planning Association NSW Penrith	4749 0500

COMMUNITY SUPPORT SERVICES

Lower Mountains Neighbourhood Centre, Blaxland	4739 1164
Springwood Neighbourhood Centre	4751 3033
Mid Mountains Neighbourhood Centre, Lawson	4759 2592
Katoomba Neighbourhood Centre	4782 1117
Lithgow Information & Neighbourhood Centre (counselling available)	6352 2077
Richmond Community Services Inc.	4588 3555
Blue Mountains Food Services Multicultural Social Support Group	4759 2811
Nepean Community & Neighbourhood Services (various locations)	4721 8520
Mamre House, St Marys	9670 5321
Nepean Migrant Access Inc., St Marys	9833 2416
St Marys Area Community Development Incorporated	9673 2169
Richmond PRA (includes Westclub)	9393 9000

HOME SUPPORT & RESPITE FOR CARERS

GP2home (After Hours)	1800 472 4663
Baptist Community Services Nepean CALD Domestic Assistance	4702 1100
Blue Mountains Volunteer Home Visitors	4782 1777
Nepean CALD Community Care Support Service	4732 6366
SydWest Multicultural Services, Penrith	9621 6633

073_0616

phn NEPEAN BLUE MOUNTAINS

Wentworth Healthcare

Multicultural Health & Community Support Services

Wentworth Healthcare Limited (ABN 88 155 904 975) as Nepean Blue Mountains PHN.
See www.nbmphn.com.au/disclaimer for more information
Produced in collaboration with Partners In Recovery (PIR), a Commonwealth Funded Initiative 2016, with support from Nepean Migrant Access

www.mentalhealthhelp.com.au