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Review of the Framework for Mental Health in Multicultural Australia

Final Report

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Contents

Executive summary

The *Mental Health in Multicultural Australia* (MHiMA) Project was funded by the Australian Government Department of Health to provide advice and support about mental health and suicide prevention for people from culturally and linguistically diverse (CALD) backgrounds. The aim of MHiMA was to strengthen the capacity of individuals, communities and health service providers to address the mental health needs of Australia's immigrant and refugee populations in a culturally inclusive and responsive manner.

MHiMA received three year funding covering the period July 2011 to June 2014 and was delivered through a consortium arrangement comprising four partners. Funding was held by the University of South Australia (project auspice) on behalf of the consortium and project management was undertaken by Queensland Health (Metro South). A twelve month funding extension was then provided to the consortium for the period July 2014 to June 2015.

MHiMA has been in flux since June 2014 and in September 2015 Mental Health Australia took over as MHiMA caretakers. The current arrangements are in place until June 2016 by which time Mental Health Australia is to provide advice on what should happen next.

This review has been commissioned by Mental Health Australia as part of its broader deliberations about the future of MHiMA. It is a review of one MHiMA critical deliverable, namely the *Framework for Mental Health in Multicultural Australia* (the 'Framework').

Key findings of the review are set out from page 5. This includes key findings with respect to governance and management (page 5), the Framework itself (page 8), the MHiMA website (page 12) and the findings from the MHiMA Framework implementation pilot sites (page 19).

The final section of this report sets out six key recommendations (see page 24). Without repeating these recommendations, the overall thrust of these recommendations is that:

- Future investments to build capacity in multicultural mental health should recognise the different needs of different sectors and stakeholders.
- Future investments should recognise that capacity in multicultural mental health needs to be focused on achieving improvements at levels ranging from community awareness and stigma reduction through to competent specialist diagnosis and treatment services.
- Achieving transformational improvements in multicultural mental health requires a multipronged strategy. The MHiMA project should not receive ongoing funding in its current form. A different approach is required.
- A single organisation should be engaged to maintain and further develop the MHiMA Framework as set out in the body of this report.
- The MHiMA website should be developed into a clearinghouse and knowledge exchange. The aim is that it becomes the definitive online resource for those needing information and resources about multicultural mental health.

Section 1. Introduction and background

The *Mental Health in Multicultural Australia* (MHiMA) project was funded by the Australian Government Department of Health to provide advice and support about mental health and suicide prevention for people from culturally and linguistically diverse (CALD) backgrounds. The role included representation and support for CALD communities' interests in the mental health sector and raising awareness of mental illness and suicide prevention in CALD communities.

MHiMA was charged with engaging and maintaining productive relationships with relevant stakeholders such as CALD communities, state and territory mental health specialists and mainstream services, relevant government agencies and the tertiary sector. Engagement was not to be an end in itself but, instead, to be a key strategy in improving access, responsiveness and quality of mental health services and suicide prevention programs for people from CALD backgrounds. A further goal was to facilitate access to information about mental health and relevant services.

The aim was to strengthen the capacity of individuals, communities and health service providers to address the mental health needs of Australia's immigrant and refugee populations in a culturally inclusive and responsive manner.

MHiMA was initially established as a three year funded project covering the period July 2011 to June 2014 that was delivered through a consortium arrangement comprising four members:

- Queensland Transcultural Mental Health Centre (QTMHC)
- Victorian Transcultural Mental Health (VTMH)
- Centre for International Mental Health, Melbourne University
- Mental Health Substance Abuse Research Group, Human Rights and Security Cluster, University of South Australia

Funding was held by the University of South Australia (project auspice) on behalf of the consortium and project management was undertaken by Queensland Health (Metro South).

It is this iteration of the MHiMA Project to which this report's recommendations apply.

The period since June 2014 has been characterised as a period of instability and flux. A twelve month funding extension was provided to the consortium for the period July 2014 to June 2015 and some relationship issues within the consortium came to a head during this period. In mid 2015 the Government funding agreement finished and the consortium dissolved. The Department of Health then asked Mental Health Australia to act as caretakers for MHiMA, while the Government considered next steps for the project. Mental Health Australia took responsibility for MHiMA for the period September 2015 until June 2016 and agreed to provide advice to the Department on what should happen next.

This review has been commissioned by Mental Health Australia as part of its broader deliberations about the future of MHiMA. Mental Health Australia sought a review of one MHiMA critical deliverable, namely the *Framework for Mental Health in Multicultural Australia* (the 'Framework') and requested us to make recommendations on its future implementation. Mental Health Australia indicated that the review should incorporate, but not be limited to, the following:

- An examination of the current on-line structure of the Framework, including the portals, tools, information, and resources.
- An examination of the mode of delivery and implementation in pilot sites including the work of Implementation Officers (including level of contact with other Implementation Officers), training delivery, monitoring of sites and services, report and information recording, and liaison with services.
- The sustainability of the current model of delivery and the expansion of the Framework to others services and sites.
- Recommendations for the future delivery and implementation of the Framework.

This report addresses each of these issues.

Section 2. Methodology

The review has been undertaken in a number of steps, summarised below.

Preliminary contact with key stakeholders

Initial telephone contact was made in December 2015 with the staff employed on the MHiMA project at that point and with the leads of the four consortium partners. The purpose of this contact was:

- To introduce the team and our proposed approach
- To ascertain any specific concerns key stakeholders might have and to identify whether those concerns can be addressed within the review
- To ascertain the availability of project documentation, utilisation data and administrator rights to the MHiMA website
- To organise further consultations in January-February 2016.

Documentation and data review

A documentation and data review was undertaken throughout the project including:

- Content analysis of the main components of the Framework
- Analysis of data entered into the website from participating services
- Analysis of MHiMA website data on hits and downloads over time

- Content analysis of the Framework and its component parts and how these mapped to the National Standards for Mental Health Services (2010) and the National Safety and Quality Health Service Standards (2011)

We also sought (and analysed where they existed) any reports provided by the project to the Framework pilot sites, any available information reported about face-to-face training by either implementation/project officers or pilot sites and any quantitative data collected by MHiMA staff, key stakeholders or pilot sites.

Consultations with key stakeholders

Consultations with key stakeholders occurred over January and February 2015 both by telephone and face to face. These consultations focused on stakeholder perceptions of the strengths and weaknesses of the Framework as it developed, the lessons that were learnt and stakeholder views on recommendations for the future. Some targeted consultations also explored issues of project accountability and reporting as well as related administrative matters. A list of key stakeholders consulted as part of the review is included as Attachment One.

Meetings with the National CALD Consumer and Carer Working Group and the MHiMA Project Advisory Group

Mental Health Australia convened meetings of these two groups on 17 and 18 February 2016 respectively. Both meetings were held at Mental Health Australia in Canberra. Professor Kathy Eagar presented to both groups, provided a preliminary assessment of findings and sought views from both groups about potential future recommendations. These two days also provided the opportunity for Professor Eagar to meet with MHiMA and other staff nominated by Mental Health Australia. A list of organisations represented at the two days is included as Attachment One.

Section 3. Key findings

MHiMA project management and governance

MHiMA was established as a consortium that comprised two state transcultural mental health services (Queensland and Victoria) and two university research groups (located in Melbourne and Adelaide). MHiMA staff were located with consortium partners and individual consortium members took responsibility for specific elements of the work program.

A full evaluation of MHiMA management and governance arrangements is beyond the scope of the current review. However, key stakeholders interviewed as part of the current review found it very difficult to separate the Framework from the MHiMA project overall. While there are differences in perspective about how well the project was managed and how much it achieved, it is clear that there were significant issues that adversely affected MHiMA as a whole and each of its component parts.

The net effect is that, while some elements of the MHiMA work program were completed, the majority were not. The following is a brief summary of what MHiMA delivered during the period 2011 to 2015. It is organised under the eight domains that comprised the MHiMA work program and which were included in the Department of Health funding agreement. More information about these domains is included in Attachment Two and Attachment Three.

Domain 1: ENGAGEMENT & PARTNERSHIPS

MHiMA established a variety of mechanisms to engage key stakeholders in the early phases of the project. However, internal relationship problems within MHiMA inevitably had flow-on effects to broader relationships with external stakeholders. While some key stakeholders have a good understanding of MHiMA and what it was aiming to achieve, MHiMA had no visibility in other quarters.

Engagement and partnerships are not ends in themselves. MHiMA needed effective engagement and partnerships in order to achieve its broader objectives. This review has found that MHiMA was only partially effective in meeting these broader objectives.

Domain 2: CONSUMER & CARER PARTICIPATION

MHiMA established and supported a National CALD Consumer and Carer Working Group (NCCCWG, established in January 2013). Members of the NCCCWG were selected through a national expression of interest process and were paid sitting fees to participate in various MHiMA activities. Members of the working group participated in their own right rather than as representatives of states or other organisations.

Members of the working group who attended the consultation in February 2016 are listed in Attachment One. These members indicated at that meeting that they felt that they had been able to make an important national contribution to MHiMA and to CALD mental health and suicide prevention more broadly. At the same time, they recognised that governance issues

beyond their control had impacted on MHiMA and what it had been able to achieve over the four years.

As with Domain 1 above, consumer and carer participation is not an end in itself. MHiMA rightfully engaged with consumers and carers in the design of the Framework and members of the working group were happy that they were fully consulted in the development process. The NCCCWG was not formally involved in the piloting of the Framework (as the pilots occurred at a local rather than a national level) although some members of the Working Group were involved in other capacities.

Members of the Working Group aspire to see MHiMA become an independent organisation with the NCCCWG developing into an independent peak organisation that represents CALD mental health consumers and carers at a national level. Their view is that MHiMA has achieved important progress but that there is much more to be done. Working Group members recognise that it is not realistic to expect MHiMA to become an independent organisation in the short term. They therefore accept that, if MHiMA and the NCCCWG are to continue in some format into the future, they will need to be under the auspice of another organisation at least in the short term.

A further issue for the future is the process by which individuals are selected to participate on the NCCCWG or a future consumer and carer group. As noted above, the current members of the NCCCWG were selected through a national expression of interest process and participate as individuals in their own right. A key question for the future, which cannot be answered at this point, is whether future members should be appointed as representatives of jurisdictions or other organisations rather than as individuals. This question needs to be considered in the context of broader decisions that are made about the future of the Framework and MHiMA more generally.

Domain 3: COMMUNICATION

MHiMA developed a number of mechanisms to communicate with key stakeholders with its website being a key communication resource. Our review findings in relation to the MHiMA website are set out on page 13. As that section indicates, MHiMA established a list server and produced a series of newsletters among other resources. However, the sections of the website that had the capacity for interactive communication were not enabled during the life of the project and nor was the capacity for the sharing of resources. This is largely due to the relatively short timeframe between the website being completed and the windup of the consortium as well as broader project governance issues.

Domain 4: POLICY DEVELOPMENT & IMPLEMENTATION

The *Framework for Mental Health in Multicultural Australia* was the key deliverable under this domain and is the focus of this review. The Framework was successfully developed and remains the key practical deliverable of the MHiMA project. The following sections setting out the findings from this review focus on this Framework in more detail.

Domain 5: PROMOTION, PREVENTION & EARLY INTERVENTION

Several clear deliverables were specified under this domain, including a model to support implementation of the 'Stepping Out of the Shadows Program' and the development and dissemination of a 'CALD Suicide Prevention Plan & Resource Tool'. While some progress was made in this domain, there were no final products that were accepted or piloted for implementation.

Domain 6: WORKFORCE & LEADERSHIP DEVELOPMENT

The findings in this domain are similar to Domain 5. Some training resources were developed and work began on a multicultural mental health workforce strategy. However, little or no progress was made in relation to other planned strategies such as strengthening state and territory multicultural mental health networks, establishing a network of multicultural mental health educators or developing and making available online multicultural mental health training resources.

Domain 7: SERVICE ACCESS, CO-ORDINATION & CONTINUITY OF CARE

The main deliverables specified under this domain included key process measures (stakeholder engagement and communication) and the documentation and promotion of culturally responsive mental health service provision, guidelines and resources.

The MHiMA website has the capacity to contribute to this domain through the provision of case studies. However, this capacity is yet to be realised in any significant way.

Domain 8: RESEARCH, EVALUATION, KNOWLEDGE EXCHANGE & INNOVATION

This domain specified a number of goals relating to research and data analysis. As with other domains above, while some progress may have been made, there were no clear deliverables at the end of the contract period.

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As this brief review of the eight domains has indicated, MHiMA set itself an ambitious agenda and specified key deliverables in its initial three year work program. Very few of these deliverables were achieved. In part this is due to the relatively short duration of the MHiMA project funding (an initial three year contract and then a further one year extension). But the other significant factor was project management and governance issues that adversely impacted on the work program.

The Framework, which is the focus of this review, is demonstrably the key deliverable of the MHiMA project during this period. While the Framework was inevitably affected by broader issues within MHiMA, it remains as an important resource with a life that extends beyond the project period.

MHIMA Framework

As noted above, the *'Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*' (the MHiMA Framework) is the focus of this review and the key product delivered by the MHiMA project.

The Framework is in electronic format on the MHiMA website[1] and consists of three components:

The Organisational Cultural Responsiveness Assessment Scale (OCRAS). The OCRAS is a self-assessment scale that organisations complete to assess their cultural competency and the factors in the organisation that enable cultural competency.

Implementation guides. Having completed the OCRAS, organisations use the implementation guides to develop an action plan to improve cultural competency. The guides consist of four key outcome areas with associated indicators.

Resources and information. A range of resource materials have been developed to assist organisations and individuals to build knowledge and skills. This includes five key concept sheets, a knowledge exchange centre and links to useful policy documents and websites.

Each of these components is considered below.

[1] http://framework.mhima.org.au/framework/index.htm

Organisational Cultural Responsiveness Assessment Scale (OCRAS)

The OCRAS draws heavily on two tools developed in the years preceding MHiMA. The original tool ('*Cultural competency standards – the audit tool*') was developed in Western Australia in 2008. The WA audit tool defined eight cultural competency standards and these standards remain as the basis of the MHiMA tool.

The second generation version was the *National Cultural Competency Tool (NCCT) for Mental Health Services* (2010). This tool was developed by a national consortium called Multicultural Mental Health Australia (MMHA) in partnership with the Western Australian Mental Health Commission. The NCCT maintained the same eight cultural competency standards and built on these by setting out a key principle for each as well as associated performance measures.

Figure 1 An example of an OCRAS standard

CULTURAL COMPETENCY STANDARD 1
The service's Strategic Business Plan, or equivalent, recognises the relevance of transcultural mental health issues in service planning, implementation and evaluation.

Principle
Cultural and linguistic diversity must be acknowledged and reflected in all stages of service planning, implementation and evaluation.

Performance Measure 1.1
The service has a Strategic Business Plan, or equivalent, clearly stating its commitment to meeting the mental health needs of people from CALD backgrounds.

Performance Measure 1.2
The service has a policy for ensuring delivery of culturally appropriate services to all cultural groups in the service region.

Performance Measure 1.3
The service has incorporated a statement about cultural diversity considerations in its recruitment documentation/processes for all positions at the service.

The MHiMA OCRAS have incorporated the NCCT in full. The eight cultural competency standards have been maintained as have the principles and associated performance measures. An example of the structure is given in Figure 1.

The OCRAS are designed as an assessment system to guide organisations through the development of an action plan to improve their cultural responsiveness. This is the same approach that MMHA adopted in developing the NCCT. A service assessing itself against the OCRAS needs to rate itself against each of these 33 performance indicators and then use this information to develop its action plan.

The eight cultural competency standards are set out below. There are a total of 33 performance measures across these eight standards.

Cultural competency standard 1
The service's Strategic Business Plan, or equivalent, recognises the relevance of transcultural mental health issues in service planning, implementation and evaluation.

Cultural competency standard 2
The service collaborates with key mental health government and broader community stakeholders working with people from CALD backgrounds.

Cultural competency standard 3

The service engages in evaluation, research and development of culturally appropriate service delivery relevant to transcultural mental health.

Cultural competency standard 4

The service ensures equitable access for people from culturally and linguistically diverse backgrounds, and their carers and families.

Cultural competency standard 5

The service adheres to a Language Services Policy.

Cultural competency standard 6

The service makes available and encourages mental health cultural competency training for its staff, with independently and externally evaluated state-endorsed cultural competency training to be used where available, and the use of culturally appropriate assessment and planning tools.

Cultural competency standard 7

The service ensures CALD consumer and carer participation in service planning, implementation and evaluation.

Cultural competency standard 8

The service has proactive support from senior management for developing transcultural mental health initiatives.

The full OCRAS standards and associated performance measures are set out in Attachment Four.

The OCRAS differ from the NCCT in two ways:

Electronic OCRAS

The OCRAS can be completed electronically on the MHiMA website. The NCCT was only on paper. Being on-line, the electronic OCRAS allow for the assessment to be interactive and there is capacity to collect data about each service that registers and enters OCRAS data

OCRAS scoring system

The OCRAS incorporates a scoring system, allowing a service to potentially calculate a score against each of the 33 performance measures, each of the eight cultural competency standards and as a whole. These scores could potentially be analysed to yield data across all services completing the OCRAS.

The scoring system is straightforward. A service assesses itself against each of the 33 performance measures and records one of three options – no (score 0%), developing (score 50%) and yes (score 100%). The total score is an average across the 33 measures.

Implementation guide

The Framework incorporates an implementation guide. It consists of four key outcome areas:

Outcome Area 1

CALD consumers and carers effectively participate at all levels of mental health service planning, delivery and evaluation

Outcome Area 2

Improved outcomes in access, coordination across the continuum of care, quality and safety for CALD mental health consumers, carers and their families.

Outcome Area 3

Increased mental health awareness, knowledge and capacity in CALD communities via culturally inclusive promotion, prevention and early intervention initiatives.

Figure 2 An example of an implementation guide outcome indicator and how it is scored

Outcome Indicator 1.1: CALD consumers and carers are represented on Committees and mechanisms in relation to service development, planning, service delivery, implementation, evaluation and policy development

Entry - The organisation accepts and respects the importance of CALD consumer and carer participation and establishes contact with CALD consumers and carers and multicultural organisations.

Developing - The organisation works in collaboration with CALD consumers and carers and multicultural organisations to ensure their input in service development, planning, delivery, implementation etc.

Advanced - The organisation employs CALD consumers and carers to ensure culturally tailored mechanisms to facilitate their input in service development, planning, delivery, implementation, evaluation, policy development and committee representation

Outcome Area 4

A culturally responsive and diverse mental health workforce which is supported to deliver culturally and linguistically inclusive practice.

Each outcome area has associated outcomes indicators. There are 43 outcome indicators across the four outcome areas. These 43 outcome indicators are not the same as the 33 performance indicators in the OCRAS. The 43 outcome indicators are included in Attachment Five.

These 43 outcome indicators were developed with the intention that they could be applied at the level of both organisations and individual staff. Each is ranked at three levels of achievement as illustrated in Figure 2. The implementation guide also includes suggested strategies linked to each outcome indicator to help organisations identify what they can do to improve on each domain.

MHiMA mapped the 43 outcome indicators in the Implementation Guide (but not the 33 performance indicators in the OCRAS) to the national mental health and quality and safety standards. This enhancement is discussed further below.

Training and information resources

The third element in the MHiMA Framework consists of resources and information designed to assist organisations and individuals to develop knowledge and skills. These resources currently include a limited number of best practice examples, five key concept sheets and links to policy

documents and websites. There is also the capacity for what is described as a knowledge exchange centre. However, this was never activated in the life of the current project.

MHiMA in the broader accreditation and standards context

As described above, the OCRAS consist of a series of eight cultural competency standards with associated performance measures that are designed as an organisational self-assessment system.

Mental health organisations completing the OCRAS are not working in isolation. In addition to the OCRAS, they are required to meet broader national standards of which multicultural mental health is just one element. It follows that the OCRAS need to be consistent with, and map to, these broader standards.

There are two sets of relevant standards. The first is the National Standards for Mental Health Services (NSMHS) that were endorsed by Health Ministers in 2010. The NSMHS present safety standards and best practice guidelines for service delivery to be applied across the broad range of mental health services. These standards have been endorsed for use but are not mandatory.

The other set of standards is the National Safety and Quality Health Service (NSQHS) Standards and an associated national accreditation scheme. These standards were mandated for national implementation in 2011. This system aims to create a nationally coordinated safety and quality accreditation scheme for all health service organisations including mental health services. Accreditation to the NSQHS Standards commenced on 1 January 2013.

In 2014 the Australian Commission on Safety and Quality in Health Care (ACQSHC) released its '*Accreditation Workbook for Mental Health Services*'.[2] This workbook is designed as a tool for health services implementing and being accredited to both the NSQHS Standards and the NSMHS.

This Workbook focuses on the process of accreditation and outlines the key steps in an accreditation process for the NSQHS Standards. It also provides information about how the two sets of national standards map to each other (areas where they match and items where there is no match) and provides examples.

Figure 3 An example of the mapping between an implementation guide outcome indicator and the national standards

Outcome Indicator 1.1: CALD consumers and carers are represented on Committees and mechanisms in relation to service development, planning, service delivery, implementation, evaluation and policy development

NSMHS standards: 3.1, 3.2, 5.3, 6.7, 7.2, 7.10, 7.11, 7.12, 7.14
NSQHSS standards: 1.1, 1.2, 2.1, 2.2, 2.3, 2.5, 2.6, 2.9, 6.5

The 43 outcome indicators in the Implementation Guide have been mapped by MHiMA to the two sets of national standards. An example is included in Figure 3. In this example, the one outcome indicator maps to 9 national

[2] http://www.safetyandquality.gov.au/publications/accreditation-workbook-mental-health-services/. Accessed 2/3/2016

mental health standards and 9 national safety and quality standards. Some indicators (such as this one) map to multiple standards, some map to only one standard and some map to none.

While the 33 performance indicators in the OCRAS have not been mapped to the national standards, an important finding from the pilot sites is that those undergoing accreditation at the time found the mappings to be very helpful and they reported that accreditation surveyors were appreciative of the MHiMA outcome indicator data made available to them.

MHiMA website

The MHiMA website was reviewed in the context of the the MHiMA Strategic Plan 2012-2014 to determine whether the website met the specified MHiMA goals.

The MHiMA Strategic Plan 2012-2014 contained a number of key actions relevant to the creation and function of the website, each discussed below. Futher analysis of the website, interactions with it and OCRAS survey completion is set out below.

Key actions contained in the MHiMA Strategic Plan

> *"1.1 Establish online engagement mediums to facilitate engagement with multiple and diverse stakeholder groups and individuals"*

The MHiMA website is rich in resources and the MHiMA website activity reports show some engagement with the website (discussed below). However, there is no mechanism for stakeholders to engage with *each other*, i.e. an online forum.

> *"1.3 Document and disseminate examples of practice innovation"* [3]

The Knowledge Exchange section of the website provides the capacity for a regularly updated and searchable collection of literature and policy, which potentially allows users to stay up to date with relevant research. The last update was June 2014. Prior to this date, this section of the website held monthly updates for a period of one year (starting April 2013).

It is possible to report on individual articles and resources using the website content reporting tool, but only in the period of 'Last Year'. Articles viewed and downloaded in the last year can be counted. However, the site does not track user data against this metric so it is unclear how or by whom the articles are being utilised.

> *"3.2 Develop a website that includes online mechanisms for interaction with and between stakeholders"*

[3] Note: this key action was repeated as key actions 2.3, 3.6, 4.4, 5.5 and 6.6

An online forum within the website[4] has been created and has been tested. However, it is not accessible from the MHiMA website and only contains test posts, demonstrating it was never used by the intended audience.

> *"3.4 Engage stakeholders via the website and targeted updates, campaigns and events."*

MHiMA disseminated regular information through the website and email campaigns. Stakeholder engagement in terms of the website can be evaluated by an analysis of the data on traffic, email campaigns and surveys captured in the website. These are reported below.

> *"6.3 Collaborate with e-learning providers to develop and integrate multicultural mental health e-learning programs"*

No e-learning is accessible from the website. However educational resouces are available through the education and training section of the site.

Site access and usage

The MHiMA website was designed and implemented by 'iformat', a company based in Melbourne. The 'iformat' portal provides site administrators with access to the site, including email campaigns, use of forms and site visits.

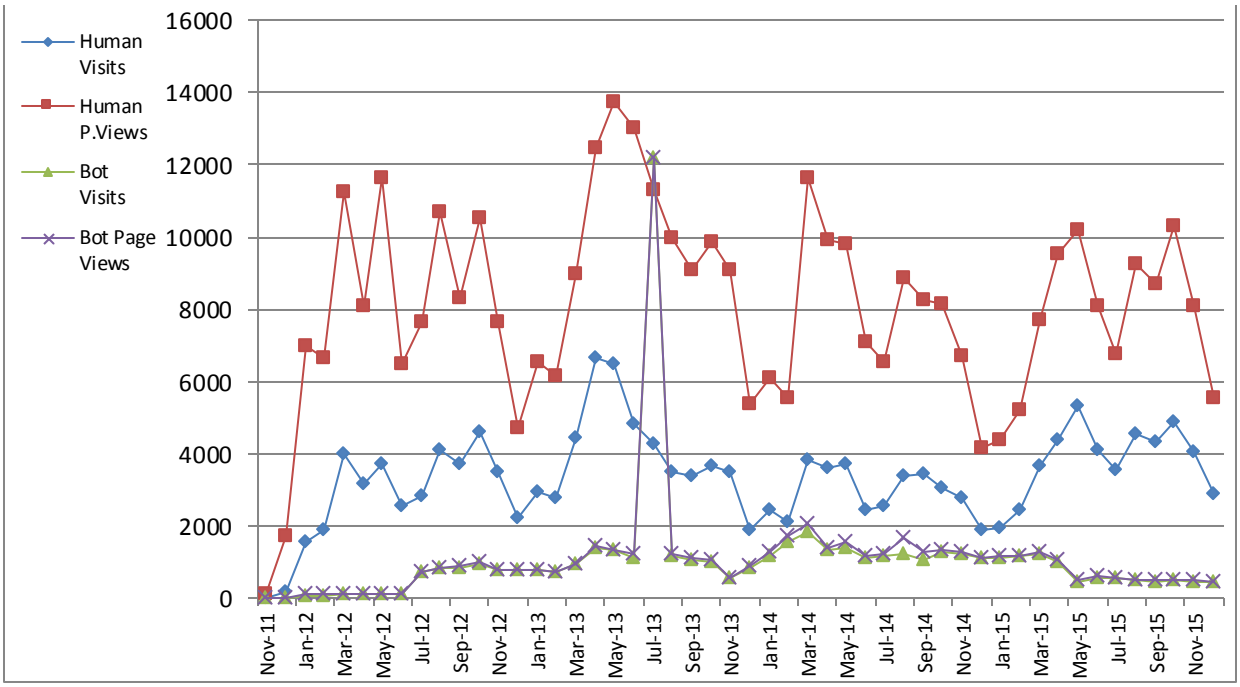
Visits and page views

The 'iformat' portal records 'visits', defined as access to the site from a particular IP address and 'page views' defined as access to various parts of the site. A 1:1 ratio of visits to page views indicates that only one page was viewed in a visit. One reason why this would occur is that many 'visits' are not actually purposeful visits to a particular website. Rather, they are non-human/automated hits by systems trawling the internet for other purposes.

The IP address of a visitor can reveal their geographic location and therefore it is possible to determine how many site visits originated in Australia. Page visits from outside Australia totalled 1,076,559 (80.8%) in the period November 2011 to 31 December 2015 and indicate a largely non-relevant audience. This is quite likely non-human/automated access.

[4] http://www.mhima.org.au/Admin/Forums.aspx

Figure 4 – MHiMA site monthly traffic, Australia only, 01/11/2011 - 31/12/2015



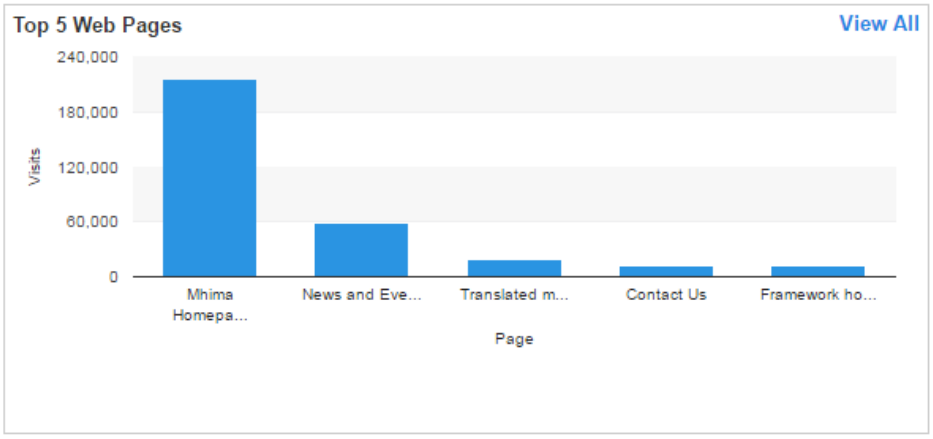
Source: http://www.mhima.org.au/Reports/Report_CustomizedReports.aspx

Only the views from Australia, 166,952 in total (12.5%), are relevant. At the country level it is possible to filter out non-human/automated sources (known as bots) and focus on human traffic. The average number of 'human' visits was 3,355 per month and human visits made up 76% of all visits. The average number of page views for these human visits was 2.21 pages.

When reporting on Australian visits, the total page visits were 220,724 over 4 years (an average of 55,000 per year or a bit over 4,500 per month). Curiously, there was a large peak of bot (non-human) traffic in July 2013, with 12,184 visits recorded, almost three times as much as the human visits for that month. There is no obvious reason.

Reporting on the pages accessed within the site, it was not possible to filter by location. The MHiMA homepage has by far the largest proportion of views as shown in Figure 5 even though this page lacks any detailed information that would be relevant to genuine enquiries. Genuine interaction with the MHiMA site and overall program is better assessed through analysis of referral links, email campaigns and the OCRAS survey completion.

Figure 5 - Web Content Overview, MHiMA portal, 01/11/2011 - 31/12/2015



Source: http://www.mhima.org.au/Reports/Report_Content_Graphical.aspx?reportId=3&reportName=Overview, Accessed 18/01/2016

Table 1 demonstrates the source of website traffic, whether from directly accessing the URL by typing into a browser, a search engine, referrals (a hyperlink from the MHiMA website or any other site), or a link from an email campaign.

The 'Visit to Views' ratio shows how many different pages were accessed for a visit from that source. While it is not possible to definitively determine how much traffic is genuine, the known genuine interactions (those from email campaign links) had a ratio of almost 4 pages per visit. However, there were only 313 visits sourced from email campaigns over the whole 4.5 years. For this analysis it was not possible to filter by country.

Table 1 – MHiMA Portal – Web Traffic Source 01/11/2011 - 31/12/2015

Source	Visits	Page Views	Ratio Visits:Views
Direct	774,333	896,752	1:1.16
Search Engine	384,885	629,211	1:1.63
Referral	172,447	306,393	1:1.78
Email Campaign	313	1,196	1:3.82

Source: http://www.mhima.org.au/Reports/Report_Content_Graphical.aspx?reportId=17& reportName=Traffic+Sources, Accessed 18/01/2016

Table 2 shows the source of referral links, defined earlier, with search engines highlighted as shaded rows. Search engines may appear in referrals when users are using a toolbar or the reporting tools cannot determine that a search engine has been used. The table demonstrates that most of the *referral* visits (113,916, 79.5%) were generated from within the site. Excluding the highlighted search engines, the remainder are from government organisations and mental health organisations. This referral traffic would appear to be genuine and is similar in magnitude to the human traffic from Australia reported earlier.

Table 2 - MHiMA Portal – Referral Links 01/11/2011 - 31/12/2015

Host	Visits	% Total Visits	Page Views	% Total Page Views
mhima.org.au	113,916	8.6%	178,338	9.7%
bing.com	4,597	0.3%	10,549	0.6%
beyondblue.org.au	2,732	0.2%	9,061	0.5%
framework.mhima.org.au	5,218	0.4%	8,978	0.5%
vtmh.org.au	2,600	0.2%	8,972	0.5%
health.gov.au	2,526	0.2%	7,241	0.4%
mmha.org.au	2,393	0.2%	4,847	0.3%
healthtranslations.vic.gov.au	1,153	0.1%	3,780	0.2%
health.qld.gov.au	696	0.1%	2,824	0.2%
vtpu.org.au	607	0.0%	2,130	0.1%
spiral.tufts.edu	1,134	0.1%	1,829	0.1%
baidu.com	1,677	0.1%	1,701	0.1%
kidshelp.com.au	733	0.1%	1,360	0.1%
mentalhealth.asn.au	352	0.0%	1,335	0.1%
search.conduit.com	729	0.1%	1,284	0.1%
refugeehealthnetwork.org.au	1,054	0.1%	1,163	0.1%
culturaldiversity.com.au	373	0.0%	1,013	0.1%
livingisforeveryone.com.au	255	0.0%	984	0.1%
mhpn.org.au	345	0.0%	936	0.1%
qpastt.org.au	181	0.0%	862	0.0%
TOTAL	143,271	10.8%	249,187	14%

Source:http://www.mhima.org.au/Reports/Report_Content_Graphical.aspx?reportId=19&report Name=Referrals, Accessed 18/01/2016

Email campaigns

Communication in the form of email newsletters and updates are managed from within the 'iformat' portal and offer useful metrics to determine the success of each campaign. For each campaign the number of emails opened is recorded against each user along with the number of users who took action (recorded against hyperlink clicks from within the email). Actions can be either subscribing to the newsletter, making a web form enquiry, posting to a forum or logging on to the website. Table 3 shows the newsletters sent using the 'iformat' portal until June 2015 and the actions arising from each.

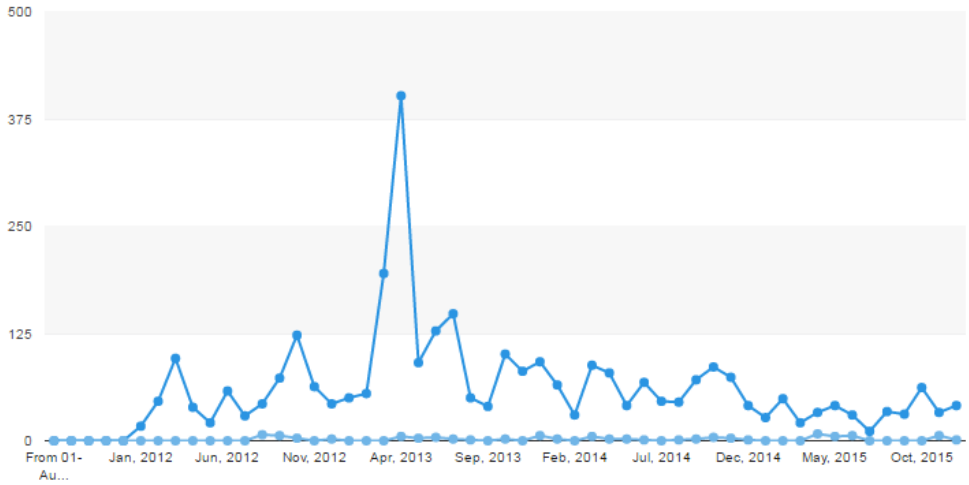
It can be seen in Table 3 that there were consistent email communications from MHiMA and that a percentage varying between 27% and 42% were opened. There were limited actions taken by users, except in the case of the 'Engaging CALD Communities Online Forum: Invitation to Participate' campaign. This campaign coincided with a large increase in subscribers, with 57 recipients registering for email updates, detailed in the 'actions taken' report (not shown). The additional subscribers shown in Figure 6 were added to mailing lists by administration users.

Table 3 – MHiMA Portal – Email campaign data, 01/11/2011 - 31/12/2015

Newsletter Name	Date	Recipients	Opened	Action	Unsubscribe	% opened
July Newsletter 2012	6/08/2012	899	286	1	4	32%
MHiMA e-bulletin	25/08/2012	940	303	3	3	32%
MHiMA e-bulletin	12/09/2012	966	317	2	9	33%
MHiMA e-bulletin	18/12/2012	968	324	2	2	33%
Engaging CALD Communities Online Forum	5/04/2013	1002	405	59	3	40%
MHiMA e-newsletter	23/04/2013	1040	329	6	3	32%
Online survey about a new national framework	20/05/2013	1046	318	1	1	30%
Framework Survey - One Week To Go	20/05/2013	1014	275	1	2	27%
MHiMA e-newsletter	24/06/2013	1020	328	2	3	32%
MHiMA e-newsletter	17/08/2013	1057	298	0	0	28%
MHiMA e-newsletter	26/08/2013	1063	375	5	1	35%
Mental health research and evaluation in multicultural Australia...	8/10/2013	1063	393	0	1	37%
MHiMA e-newsletter	10/12/2013	1096	357	2	4	33%
MHiMA e-newsletter - Issue 06	28/03/2014	1124	414	0	8	37%
MHiMA e-newsletter - Issue 07	20/05/2014	1162	451	2	3	39%
MHiMA has joined Facebook	30/05/2014	163	57	0	0	35%
Research Fellow Position	24/09/2014	1213	477	1	2	39%
RAISING OUR VOICES - Bridging the Divide to ...	29/10/2014	1198	340	0	4	28%
MHiMA e-newsletter - Issue 08	20/11/2014	1191	408	0	3	34%
Seasons Greetings	17/12/2014	1089	453	0	4	42%
Seasons Greetings	22/12/2014	1201	340	0	2	28%
Official Mental Health in Multicultural Australia response to	28/04/2015	1227	431	0	7	35%
MHiMA National CALD Consumer & Carer Working Group response ...	14/05/2015	1197	425	0	0	36%
MHiMA e-newsletter - Issue 09 - May 2015	29/05/2015	1197	322	1	10	27%

Source: http://www.mhima.org.au/Reports/Report_Content_Graphical.aspx?reportId=60&reportName=Campaigns, Accessed 18/01/2016

Figure 6 - MHiMA Portal Summary "Subscribers vs Unsubscribers' 01/11/2011 – 31/12/2015.



The proportion of web traffic generated by email campaigns was shown in Table 3 above. While a small proportion of views, it is can be safely assumed that this is genuine interaction with the website.

Online access to the OCRAS survey

The OCRAS survey was implemented by Strategic Data Pty Ltd of Melbourne using their 'web survey' tool. There is a link from the MHiMA framework subdomain (framework.mhima.org.au).

Feedback on the action plan during the consultations highlighted various issues (see page 20), one of which was that the action plan section of the website is onerous to complete. Making this component modular and scheduling sections to be completed periodically using an e-learning package or email campaigns could be investigated. This might help with both engagement and completion rates.

The security certificate in the survey tool needs to be reviewed by Strategic Data to upgrade it to SHA-2 encryption as SHA-1 will be blocked by most browser vendors (Microsoft, Google, Mozilla) starting in 2016.

Conclusions about the MHiMA website

The MHiMA site has a large amount of valuable content in an appealing site design. However, a major drawback of the site is its complex structure. Many users will find it difficult to navigate to the information they need without better guidance.

To improve the site structure, users should be presented with clear, limited options with instructions and directed into more linear workflows. Repeat visitors who understand the site could access more complex options from the existing menu.

As an example of the complex structure, the MHiMA framework has its own sub-domain (http://framework.mhima.org.au). This area of the site (also managed by 'iformat') has a similar look and feel to the MHiMA homepage yet it functions as a stand-alone site, with its own navigation and menu structure. This could be confusing to users switching between the two sites. Either integration with the main site or a clearer demarcation by differentiating this section of the site would assist users in navigation.

The survey tool provided by Strategic Data and used to populate the OCRAS is integrated into this site and not the main MHiMA website (http://www.mhima.org.au/). This is an example of clear demarcation, with the user aware they are in a stand-alone setting once logging in.

In the current structure, learning about the framework is self-directed and requires the user to navigate through various links. While these resources are useful, if they were compiled linearly especially in an e-learning module (as proposed in the strategic plan), users could have a clear path to understanding the Framework.

The web platform provided by 'iformat' provides useful tools. Some have been successful. For example, a successful feature of the web platform is the ability to run email campaigns to communicate with specific audiences while also tracking their engagement.

Other potential features of the site have not been utilised despite being key elements in the MHiMA strategic plan. As previously mentioned, the platform has the capability to run a forum module. But it has not been deployed. To support the strategic plan to engage stakeholders with each other, this feature could be enabled. Resourcing to moderate and administer the forum must be considered if proceeding with this approach.

If the MHiMA strategic goals are to be realised, the website would need to be restructured and a strategy developed to further engage users through email campaigns, forums, the OCRAS survey and site resources. Relationships with 'iformat' and Strategic Data would need to be maintained to undertake these changes within the present website arrangements. Additionally, engaging partners such as e-learning providers might also help increase engagement, particularly with understanding the MHiMA framework and completing the OCRAS survey and action plans.

The MHiMA website has the potential to increase engagement of stakeholder groups due to the professional standard of the website platform design, the survey tool capacity, the valuable resources it contains and its appealing site design. However, the original key actions relating to the site would need to be progressed and additional recommended changes made before these goals could be achieved.

The Framework pilot and feedback from the pilot sites

The Framework was piloted in 10 acute mental health inpatient units and this review has included interviews with a representative from each of these wards. Four other wards entered into negotiations to also participate in the pilot but these were not completed before end June 2015. Representatives of these four sites were not interviewed as part of the current review.

There are varying accounts about why the decision was made that the pilot testing would only involve acute wards. There are also varying accounts about why the decision was made that the piloting would be at the level of a specific ward rather than a broader organisational unit such as a whole hospital or a whole district or regional health service. Be that as it may, it is important to note that the pilot testing occurred only in acute units and that the Framework was not tested in other types of mental health wards, in community mental health services or in the non-government sector. This raises issues about the degree to which the results of the pilot sites can be generalised more broadly.

The hospitals that had wards that participated in the pilot testing were:

- New South Wales, Concord Hospital, Sydney Local Health District
- Queensland, Pandanas Ward, Gold Coast Hospital
- Queensland, Ward 2B, Logan Hospital, Metro South Health Service Hospital

- South Australia, Boylan Ward, Women's and Children's Hospital
- South Australia, Eastern Acute Service, Glenside
- Victoria, Dandenong Hospital, Monash Health Service
- Victoria, St Vincent's Hospital, Melbourne
- Western Australia, Ward 2K, Royal Perth Hospital
- Western Australia, Ward 6, Bentley Health Service

The pilot implementation involved the MHiMA Project national project coordination unit working with MHiMA consortium members and with 3.4 full-time equivalent Implementation Officers who were employed to work across the 10 pilot sites. This indicates a significant resource investment in the pilot stage.

The work of the Implementation Officers was coordinated by the national project coordination unit in Brisbane. The Implementation Officers did not work to a standard position description. However, these positions involved:

- Engaging and liaising with the pilot sites, including regular teleconferences and some face-to-face meetings and state/territory mental health/health departments;
- Providing and facilitating training and information sessions at each site;
- Following up on-site training, for example working with interpreters;
- Attending meetings with staff involved in the pilot sites;
- Assisting in some cases in ensuring OCRAS information was entered
- Maintaining case reports and records on the sites; and
- Liaising with the national team and other Implementation Officers, including participating in teleconference meetings 1-2 hours every one to two weeks.

The Western Australian Department of Health and the Western Australian Transcultural Mental Health Centre supported the pilot in Western Australia as did the Transcultural Mental Health Centre in New South Wales.

The intention of the pilots was that each ward would walk through the steps of the Framework as outlined on page 8. Services would complete each of the domains in the OCRAS and enter that information in the MHiMA website. The date that each service commenced that process is listed in Table 4 below. These dates range from September 2014 until August 2015. All ten pilot sites completed this step.

Table 4 – The 10 MHiMA Framework pilot sites

Ward	Date OCRAS first entered	Date implementation plan entered	Score
B	23/09/2014		80.0
A	9/10/2014		80.7

Ward	Date OCRAS first entered	Date implementation plan entered	Score
F	10/10/2014		70.7
H	14/10/2014		55.7
G	2/12/2014	25/08/2015	62.1
J	22/12/2014		25.0
E	24/12/2014		73.6
I	29/01/2015	15/04/2015	45.7
C	30/05/2015		80.0
D	25/08/2015		80.0

Following the completion of the OCRAS, the plan was that each pilot site would then complete an implementation plan. In the event, and as can be seen in Table 4 above, only two sites (sites G and I) began recording their implementation plan on the website. Neither was completed. The other eight organisations recorded no implementation plans at all.

As noted above, key stakeholders from the pilot sites were interviewed about their experience and were invited to make recommendations about the future of the Framework. While there were inevitably differences across sites, there were many common themes and experiences. These can be summarised as follows:

- The overall experience of completing the OCRAS was extremely positive. Key stakeholders interviewed commented that the OCRAS provided them with a structured opportunity to assess themselves against each domain and to identify opportunities for improvement. This created important opportunities for teams to come together and to work on strategies for improvement.
- All pilot sites commented on how resource intensive the process was if it is to be effective. The MHiMA Implementation Officers were described as valuable resources who made a significant contribution to the process. Several sites commented that they would have found it extremely difficult to complete the OCRAS self-assessment process without the support of the Implementation Officer.
- Most of the pilot sites required and received internal enhancements in order to complete the process. This was in addition to the support provided by the MHiMA Implementation Officers. In general, this was by way of a time-limited project officer who was employed internally to lead or support the process. These sites commented that they would not have been able to complete the OCRAS self-assessment process within existing resources.
- Almost every pilot site was able to cite examples of changes or enhancements they made during or after the assessment process to improve the cultural responsiveness of their service. Examples included training programs, engaging guest speakers and creating specific opportunities for consumers and carers to talk about the cultural context for their mental health issues. One simple example of this is a ward that hung a large world map in a common area and invited staff, consumers and carers to indicate on that map where they had been born. The feedback was that this created an opportunity for both consumers and carers to engage in conversation with staff and with other consumers and carers and that it

worked to create a common bond that had not been previously present. This is but one of many examples provided to the review.

- Several sites commented that they would have found it very helpful to have access to information about what other services were planning to improve their cultural responsiveness. While the MHiMA website has the technical capacity for forums and for information sharing, these capacities have not been enabled to date.
- Some of the pilot sites were undergoing accreditation around the same time as the pilot. They commented that completion of the OCRAS assisted them in the accreditation process.
- Several pilot sites indicated that, while they did not use the implementation planning component of the Framework, they did complete implementation or action plans. These services indicated that their organisation already had standard templates and systems in place for quality improvement initiatives. They used these internal systems rather than the MHiMA Framework. Three of the pilot sites provided the review with examples of the action plans they completed internally having undertaken the OCRAS as evidence of this.
- The pilot sites proved to be quite fragile in terms of their capacity to achieve sustainable long-term change. Several pilot sites cited examples where the turnover in one position had resulted in the whole self-assessment process effectively coming to a standstill. Some sites indicated that they were not confident that quality improvement initiatives could be continued without additional resources.
- The engagement of local management was a critical factor. Services where the local manager was committed to the process were more likely to be resourced and structured to complete each of the OCRAS domains and were more likely to be able to identify strategies to improve the cultural competency of their service. They were also more likely to achieve sustainable change. The pilot sites that were most successful were those where the pilot was integrated into local clinical governance and quality improvement structures and systems.
- Local management was more likely to drive improvements if there was support at a higher organisational level. These higher levels include hospital, district, regional and state management. Sustainable long-term improvements require high level buy in and leadership.

There was also a high degree of consensus about recommendations for the future. The participating pilot sites would recommend to other services that they undertake an OCRAS self-assessment. However, the majority felt that the process was potentially too rigid and that a more flexible structure would better accommodate the capacity and needs of different services.

Rather than the linear approach adopted in the pilot sites (and underpinned by the design of the MHiMA Framework), a more flexible approach was supported, with the OCRAS developed into a more modular format. Under this more modular approach, services would not walk through the process from beginning to end as the system is currently designed. Instead, services would complete specific modules to meet their needs at a particular point in time.

Several services commented that community mental health services would find the OCRAS easier to complete than would an acute ward. If available in module format, the Framework would also be suitable for primary mental health and the non-government sector.

There were mixed views about the optimum organisational unit size for implementing the MHiMA Framework. The pilots were conducted on a ward by ward basis and some pilot sites believed that this was optimum.

Others believed that the Framework is best implemented across a whole mental health service rather than ward by ward. They made the point that many performance and outcome measures involve changes in policy and in practice that need to be led at a senior management level.

The ten pilot sites all achieved improvements in their cultural competency, albeit at various levels and in different ways. However, the model is extremely resource intensive with the ten pilot sites being resourced by both MHiMA Implementation Officers and their own project staff.

Implementation across a whole mental health service would have been difficult in the context of the pilot sites. This is partly because of time and resource limitations. But it is also because the goal of the pilot sites was to test the MHiMA Framework and how best to implement. The MHiMA consortium decided that the best way to test this was in a contained way.

While the pilot sites provided valuable lessons, there is no doubt that implementation on a ward by ward basis will not achieve measurable improvements in the mental health care provided to CALD consumers and carers across Australia. Transforming the cultural competency of Australia's mental health services requires more systemic and strategic change.

Section 4. Recommendations

Recommendation One.

Future investments to build capacity in multicultural mental health should focus on, and recognise, the different needs of different sectors and stakeholders:

- Specialist mental health services managed and funded by states and territories
- National mental health and disability organisations that commission or deliver services such as, but not limited to, beyondblue, headspace and the National Disability Insurance Agency (NDIA)
- Primary mental health services, including those commissioned by primary health networks
- CALD consumers, carers and communities.

Recommendation Two.

Future investments should recognise that capacity in multicultural mental health needs to be focused on achieving improvements at three levels. All three levels are critical to improvements in multicultural mental health:

Level 1	Community awareness and stigma reduction
Level2	The provision of culturally sensitive and appropriate mental health services
Level 3	The provision of competent mental health diagnosis and treatment services for those CALD consumers with a mental health disorder.

Recommendation Three.

It is not realistic to expect a single organisation to meet the needs of all of these various stakeholder groups and to develop capacity at all three levels. A multipronged strategy is required. It follows that the MHiMA project should not receive ongoing funding in its current form. A different approach is required.

Note: The MHiMA initiative consisted of work across eight MHiMA domains (see Attachment Two) with 'success' defined by a mix of process and outcome measures (see Attachment Three). While each of these eight domains is important, there is no reason why responsibility for them cannot be distributed across more than one initiative or project. As one simple example, the future development of the Framework (Domain 4) could be pursued separate to initiatives to promote workforce development (Domain 6) and research (Domain 8).

Recommendation Four.

The Commonwealth engage a single organisation with the expertise and skills to maintain and further develop the MHiMA Framework and website as set out below.

The essential criterion is that this organisation needs to have specialist mental health knowledge. The ability to access expertise in multicultural issues is a secondary criterion. This organisation could be an existing Commonwealth entity (such as the National Mental Health Commission or the Australian Commission on Quality and Safety in Healthcare), an existing national mental health peak body (such as Mental Health Australia), a university or an appropriately skilled non-government organisation. Specialist multicultural organisations would not be suitable as the auspice organisation as they do not have the required expertise or credibility in specialist mental health.

Note: The organisation responsible for the MHiMA Framework and website may wish to enter into sub-contracting arrangements with other organisations and/or may wish to set up appropriate advisory structures. However, this is a matter of the responsible organisation. The Commonwealth should not require the organisation to deliver services through a consortium structure or require the establishment of specific advisory structures.

Recommendation Five.

The MHiMA Framework is a valuable resource that should be further developed. Specific recommendations in relation to this include:

1) Maintain the MHiMA Framework as an online resource but restructure it into a series of modules, each of which can be accessed and completed on a standalone basis.
2) Develop a mix of (a) generic modules and (b) specialist modules targeted to specific stakeholder groups and sectors and targeted to each of the three levels set out above.
3) Design each module so that it can be used for broader purposes than simply self-assessment and accreditation. These broader purposes include, but are not limited to, the setting of standards that can be used in mental health service commissioning and contracting and for use in performance agreements
4) Develop online flexible training modules and move away from the current approach which is highly dependent on face-to-face service support.

Recommendation Six.

Develop the MHiMA website into a clearinghouse and knowledge exchange. The aim is that it becomes the definitive online resource for those needing information and resources about multicultural mental health.

Some sections within the website need to be designed specifically for health professionals. Other sections need to designed for consumers, carers, families and friends. The whole website needs the capacity for the information in it to be read online or to be printed and read later.

The MHiMA website needs to be more than just a passive clearinghouse. It needs to be a knowledge network or exchange that actively evaluates material before it is published. All material in the website needs be evidence-based and quality assured by Australian mental health professionals. In addition, the pages designed for use by consumers and carers needs to be quality assured by multicultural consumers and carers with lived experience. This implies an ongoing role for the National CALD Consumer and Carer Working Group or another multicultural consumer and carer group.

There is no need for the website to develop all of its own resources. There are pockets of excellence in multicultural mental health across the country (including, but not limited to, the various state transcultural mental health centres) and there is important research evidence in the peer-reviewed literature that needs to be translated into practice. Contributions from these sources need to be welcomed and encouraged.

This recommendation has a number of specific technical elements:

1) The home page needs to direct users to pages and modules relevant to their needs. There needs to be a set of user options for consumers, carers and the community and another set of options for clinicians and researchers. An e-learning module on how to navigate the website needs to be developed for each group.
2) The existing three MHiMA website sub-domains need to be integrated into one.
3) Improve the site structure by presenting users with clear, limited options with instructions and directed into more linear workflows.
4) Give end-users the option of being able to browse the website without the need for registration or, alternately, to register on the website (as they are required to do now) and thus receive notifications, newsletters and other updates.
5) Develop an Intellectual Property (IP) Policy to guide the use of material that sits on the website. The overarching principles should be that (a) contributors own the IP they contribute (b) the MHiMA website administrator acknowledges ownership of IP throughout the website (c) end-users can use the IP sitting on the website as long as IP ownership is acknowledged and (d) end-users cannot change or further develop IP they do not own without the consent of the IP owner.
6) Features already in the MHiMA website that have not yet been deployed need to be enabled. This includes the capacity of the platform to run forum modules.
7) Engage partners such as e-learning providers to help increase engagement, particularly with understanding the MHiMA Framework and using it for multiple purposes.
8) Develop evidence-based e-learning modules that are relevant for each target group (see recommendation 1) and each level (see recommendation 2).
9) Ongoing engagement of end-users through email campaigns, forums, surveys and site resources is required.

Attachment One

Organisations consulted as part of the review

Organisations
MHiMA Pilot sites
Western Australia
Royal Perth Hospital
Bentley Health Service
South Australia
Eastern Acute Service Glenside
Women's and Children's Hospital
Victoria
Dandenong Hospital, Monash Health Service
St Vincent's Hospital, Melbourne
NSW
Concord Hospital, SLHD
Queensland
Gold Coast Hospital and Health Service
Metro South Health
Transcultural mental health centres
Queensland
Victoria
NSW
WA
Other
Office of Mental Health, Department of Health Western Australia
Individuals
Former consortium members and project staff
Queensland Transcultural Mental Health Centre (QTMHC)
Victorian Transcultural Mental Health (VTMH)
Centre for International Mental Health, University of Melbourne
Mental Health Substance Abuse Research Group, Human Rights and Security Cluster, University of South Australia
National Project Manager
National CALD Consumer and Carer Working Group (NCCCWG) Support Officer
Project consultant
MHiMA National CALD Consumer and Carer Working Group (NCCCWG) members: ACT carer, NSW consumer, NT carer, Queensland consumer and carer, SA consumer, Tasmania carer, Victoria consumer and carer, WA consumer
MHiMA Project Advisory Group members, representing:
Queensland Transcultural Mental Health Centre
Victorian Transcultural Mental Health
NSW Transcultural Mental Health Centre
WA Transcultural Mental Health Centre
Federation of Ethnic Communities Councils of Australia (FECCA)
National Ethnic Disability Alliance (NEDA)
Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)
NCCCWG (a consumer and a carer)
Phoenix Centre (TAS)
Multicultural Communities Council of SA
Multicultural Council of NT
ACT Multicultural Mental Health Network/MI Fellowship

Attachment Two

The eight MHiMA domains

This attachment sets out the eight domains specified in the MHiMA strategic plan 2012-2014. These domains defined the MHiMA work program, key actions and key indicators of success. These domains were streamlined into five work streams in the final year of the consortium's contract (2014-2015).

The ***MHiMA Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*** (the Framework) is the focus of this review. It was a key deliverable under Domain 4 (Policy development and implementation).

Domain 1: ENGAGEMENT & PARTNERSHIPS

This domain is about engaging multiple stakeholders from multicultural sector organisations, mental health service providers, government and non government, policy makers and others with an interest in multicultural mental health and suicide prevention. MHiMA is committed to fostering partnerships that are purposeful, collaborative, mutually respectful and sustainable.

MHiMA will:

- Develop and maintain partnerships with key organisations via a range of engagement mechanisms.
- Develop and maintain key partnerships with all states and territories.

Domain 2: CONSUMER & CARER PARTICIPATION

This domain is about meaningfully involving CALD consumers and carers. It is about ensuring that services and programs reflect CALD consumer and carer concerns and needs by being culturally appropriate and responsive with a focus on recovery-oriented programs. The emphasis in this domain area is about enhancing consumer a carer involvement across the different domains of MHiMA and facilitating contributions at a strategic level.

MHiMA will:

- Develop a CALD consumer and carer working group.
- Develop meaningful CALD consumer and carer participation mechanisms.
- Support CALD consumers and carers to participate in other relevant national and state based fora to ensure CALD consumer and carer contribution.
- Map, identify gaps and grow new networks of CALD consumer and carer representative groups.

Domain 3: COMMUNICATION

This domain is about communicating the activities and work of MHiMA and supporting actions and outcomes across all eight domain areas. This will involve engaging stakeholders including CALD consumers and carers, multicultural sector organisations, mental health service providers, policy makers and others with an interest in multicultural mental health and suicide prevention. It will also involve developing culturally and linguistically appropriate approaches to communicating with people from immigrant and refugee backgrounds. The work undertaken in this domain will have an implicit focus on supporting the reduction of stigma related to mental illness across the lifespan.

MHiMA will:

- Undertake a program of positioning and awareness raising strategies with CALD consumers and carers, multicultural sector organisations, mental health service providers, both government and non government, policy makers and others with an interest in multicultural mental health and suicide prevention.
- Develop communication strategies that show case knowledge, practice innovation, education and awareness in relation to multicultural mental health and suicide prevention.
- Explore and utilise innovative ways to communicate with appropriate community groups and organisations.
- Utilise effective communication mechanisms to facilitate multicultural mental health leadership and policy debate.
- Utilise communication strategies to facilitate networks, partnerships and collaboration.

Domain 4: POLICY DEVELOPMENT & IMPLEMENTATION

This domain is about leading policy development processes and reforms that will benefit the health and well-being of immigrants, refugees and their families. MHiMA will seek to advance developments and the implementation of policy by building on the mental health policy architecture in place at Commonwealth, State and Territory government levels and advocate for culturally inclusive policy implementation.

MHiMA will:

- Partner with government organisations, non-government provider networks and consumer and carer representative groups to build capacity in multicultural Mental Health policy and implementation nationally.
- Identify, utilise, build upon and leverage off existing structures, resources and networks to guide culturally inclusive policy development implementation.
- Support and partner major policy development and implementation initiatives that address mental health issues for asylum seekers and bridging visa entrants.
- Develop strategies for monitoring, evaluation and make recommendations in relation to mental health policies most relevant to immigrant and refugee communities.

Domain 5: PROMOTION, PREVENTION & EARLY INTERVENTION

This domain is about leading multi-faceted partnerships to integrate culturally responsive approaches in the areas of stigma reduction, mental health literacy and suicide prevention.

MHiMA will:

- Develop high level strategic relationships with key individuals and groups to create a national focus on mental health and suicide prevention related issues for immigrants, refugees and their families.
- Engage and partner with national and state-based mental health stigma reduction and suicide prevention initiatives in order to develop strategies that facilitate the inclusion of immigrants, refugees and their families, particularly those most at risk.

Domain 6: WORKFORCE & LEADERSHIP DEVELOPMENT

This domain is about strengthening leadership for multicultural mental health and building a mental health workforce that is able to provide effective and culturally responsive mental health services.

MHiMA will:

- Strengthen leadership for multicultural mental health.
- Engage with national, state and territory mental health workforce initiatives to build in culturally responsive practice and mental health system development.
- Collaborate with states and territories to establish a multicultural mental health workforce capacity building strategy.
- Assist states with less developed multicultural mental health networks to convene and support relevant networks to improve local level coordination.
- Explore further development and delivery of online 'Multicultural Mental Health' training.

Domain 7: SERVICE ACCESS, CO-ORDINATION & CONTINUITY OF CARE

This domain is about improving mental health care and treatment for people from immigrant and refugee backgrounds. This includes primary health services, social service sectors, and specialist clinical and psychosocial services. Service gaps and the factors that impact negatively on pathways to care, service access and utilisation will be identified. This domain will also support the development of relevant guidelines and resources that will improve the cultural responsiveness of service providers and practitioners.

MHiMA will:

- Work with the relevant stakeholders across the states and territories, to identify areas of concern regarding service gaps and pathways to improve the cultural responsiveness of mental health service delivery.

- Develop plans in partnership with service providers and other stakeholders to address agreed priority areas.
- Support and build capacity at system and organisation levels to address these areas.

Domain 8: RESEARCH, EVALUATION, KNOWLEDGE EXCHANGE & INNOVATION

This domain is about developing a multicultural mental health research strategy and engaging research partners to assist in developing an evidence base that is informed by culturally appropriate research and evaluation approaches.

MHiMA will:

- Strengthen capacity for multicultural mental health research.
- Identify funding opportunities for multicultural mental health research and development and evaluation of multicultural mental health programs.
- Seek to influence research bodies to strengthen national multicultural mental health research capacity and multicultural mental health systems research.
- Improve access to published multicultural mental health research.
- Promote the use of multicultural mental health research by policy and decision-makers in policy development and service design and delivery.

Attachment Three

Key indicators of success by MHiMA domain

This attachment summarises the key indicators of success that the MHiMA initiative set for itself and that were documented in the MHiMA 2012-2014 strategic plan. There is widespread recognition among MHiMA key stakeholders that, for various reasons, very few of these indicators have been achieved. The specific reasons why specific key indicators have not been achieved are outside the terms of reference of the current review.

Domain 1: ENGAGEMENT & PARTNERSHIPS

- Online stakeholder engagement mediums established.
- Mechanisms are in place to facilitate effective engagement with key stakeholder groups.

Domain 2: CONSUMER & CARER PARTICIPATION

- Consumer and carer organisations and networks are identified and partnerships established.
- Mechanisms are in place for MHiMA to facilitate direct engagement with CALD consumers and carers.
- Increased participation by CALD consumers and carers at relevant national and state-based fora in relation to mental health and suicide prevention.

Domain 3: COMMUNICATION

- Increased awareness about MHiMA amongst key stakeholder groups.
- Analysis reports on visits and usage of website and online resources downloaded.
- Analysis of effectiveness of communication strategies in achieving delivery of MHiMA key actions.

Domain 4: POLICY DEVELOPMENT & IMPLEMENTATION

- Development and dissemination of the 'Framework for Mental Health in Multicultural Australia'.
- Acceptance and implementation of the 'Framework for Mental Health in Multicultural Australia' in states and territories.
- Number and nature of multicultural mental health contributions into policy and planning processes.

Domain 5: PROMOTION, PREVENTION & EARLY INTERVENTION

- Sustainable model developed to support implementation of the 'Stepping Out of the Shadows Program'.

- Development and dissemination of the 'CALD Suicide Prevention Plan & Resource Tool'.
- Acceptance and implementation of a 'CALD Suicide Prevention Plan & Resource Tool'.

Domain 6: WORKFORCE & LEADERSHIP DEVELOPMENT

- A 'Multicultural Mental Health' training program is developed and delivered.
- Key workforce initiatives include CALD specific strategies.
- A draft 'Multicultural Mental Health Workforce Strategy' is developed and discussed with governments.
- Strengthened state and territory multicultural mental health networks.
- Network of multicultural mental health educators established.
- Existing online multicultural mental health training resources are identified and, where possible, new resources are developed.

Domain 7: SERVICE ACCESS, CO-ORDINATION & CONTINUITY OF CARE

- Effective engagement of stakeholders at a system level and organisation level responses to improve service responses to people for people from immigrant and refugee backgrounds.
- Effective communication about CALD population mental health service access and utilisation.
- Documentation and promotion of culturally responsive mental health service provision, guidelines and resources.

Domain 8: RESEARCH, EVALUATION, KNOWLEDGE EXCHANGE & INNOVATION

- Improved capacity to carry out multicultural mental health research.
- Relevant databases identified and discussions entered into with data custodians for appropriate and ethically sound access to such databases for secondary analysis.
- Increased numbers of research students carrying out multicultural mental health research projects.
- Improved access to published multicultural mental health research.
- A multicultural mental health research strategy is developed and appropriately disseminated.
- A MHiMA monitoring and evaluation strategy developed and implemented.

Attachment Four

The eight cultural competency standards and 33 associated performance measures

CULTURAL COMPETENCY STANDARD 1

The service's Strategic Business Plan, or equivalent, recognises the relevance of transcultural mental health issues in service planning, implementation and evaluation.

Principle

Cultural and linguistic diversity must be acknowledged and reflected in all stages of service planning, implementation and evaluation.

Performance Measure 1.1

The service has a Strategic Business Plan, or equivalent, clearly stating its commitment to meeting the mental health needs of people from CALD backgrounds.

Performance Measure 1.2

The service has a policy for ensuring delivery of culturally appropriate services to all cultural groups in the service region.

Performance Measure 1.3

The service has incorporated a statement about cultural diversity considerations in its recruitment documentation/processes for all positions at the service.

CULTURAL COMPETENCY STANDARD 2

The service collaborates with key mental health government and broader community stakeholders working with people from CALD backgrounds.

Principle

To promote a coordinated approach to providing services, intersectoral links must be established with ethnic community organisations, non-government sectors and government agencies relevant to the specified communities.

Performance Measure 2.1

The service has ensured there is a position, or positions, allocated the responsibility for implementing the Framework across the service. Such a position/s could be existing Full Time Equivalents (FTEs).

Performance Measure 2.2

The service has liaised, consulted and fostered links with relevant multicultural or ethno-specific agencies, organisations or community-relevant resources in the course of client or case management. Linkages and consultations may be with, but are not limited to:

- Mental illness prevention
- Transcultural mental health centres/services and/or relevant networks in respective state or territory
- Migrant resource centres

- Places of worship
- Ethnic community organisations
- CALD consumer and carer advisory group

Performance Measure 2.3

The service has representation of CALD communities on its internal committees across all levels of service development and delivery

Performance Measure 2.4

The service has representation, where possible, on various CALD community associations in its service region.

Performance Measure 2.5

The service has disseminated information in English and in key CALD languages, via one or more modalities, including print, audio-visual or community information sessions and forums on:

- Mental illness prevention
- Suicide prevention
- Recovery
- Mental health promotion
- Mental health information
- Stigma reduction
- Benefits and rights of mental health consumers and their carers

To different cultural groups at community venues, including but not limited to:

- Community centres
- Places of worship
- Schools
- Ethnic community organisations
- Refugee services and services for survivors of torture and trauma
- CALD Consumer Advisory Groups (CAGs)
- Children's, youth and women's centres
- Other meeting places deemed important for the specified communities.

Performance Measure 2.6

The service has ensured that its staff and/or clinicians delivering a mental health program are aware and respectful of:

- existing alternative or complementary health and/or mental health service providers (e.g. traditional healers)
- key individuals in the specified community who may be consulted on religious and spiritual beliefs influencing assessment, treatment and management.

CULTURAL COMPETENCY STANDARD 3

The service engages in evaluation, research and development of culturally appropriate service delivery relevant to transcultural mental health.

Principle

Strategies to enhance service delivery for people from culturally and linguistically diverse backgrounds must be evidence-based.

Performance Measure 3.1

The service has an organisational culture which promotes research and development relevant to transcultural mental health in consultation with relevant stakeholders, including CALD carers, consumers and their families.

Performance Measure 3.2

The service has linked with external agencies that have had wide research experience with CALD communities.

Performance Measure 3.3

The service has protocols for collecting patient or client demographic data that are useful and relevant to the demographic profile of CALD communities in the given catchment or service area.

Performance Measure 3.4

The service has generated, through a mapping and needs exercise, or other appropriate information gathering or research, a profile of the CALD communities within its service region, which includes information, such as:

- population size of each community
- demographic and religious characteristics
- socio-economic status
- language requirements
- relevant community organisations
- how best to access the specified communities
- cultural sensitivities
- and that this profile is reviewed annually.

Performance Measure 3.5

The service has conducted research or projects in collaboration, or independently, to measure the needs of the CALD population in its region. Examples of projects could be:

- looking at the referral patterns or pathways typically taken by CALD consumers who access mental health services in the service catchment area
- determining what kind of programs the CALD communities would like to attend that may be congruent with their explanatory model of psycho-social remediation
- looking at the proportion of people from CALD backgrounds accessing service.

CULTURAL COMPETENCY STANDARD 4

The service ensures equitable access for people from culturally and linguistically diverse backgrounds, and their carers and families.

Principle

The rights of people from CALD backgrounds, and their carers and families, as set out in the Mental Health statement of rights and responsibilities (2012) and other legislated rights, must be ensured when delivering mental health services.

Performance Measure 4.1

The service has informed people from CALD backgrounds and their carers of their rights and responsibilities, using the client's preferred language and modality, where necessary, when accessing and using the service.

Performance Measure 4.2

The service has promoted awareness of its programs by disseminating information in English and in appropriate languages, via one or more modalities including print, audio-visual, or community information sessions and forums, to different cultural groups in places including, but not limited to:

- local doctors' surgeries
- hospitals
- community centres
- places of worship
- schools
- libraries
- other meeting places deemed important for the specified communities (e.g. sporting and cultural clubs, etc)
- chemists
- family courts
- ethnic radio and TV
- the service website, if available.

Performance Measure 4.3

The service has developed policies and procedures to facilitate the accommodation of specific culture-based needs of its CALD consumers, their carers and families, such as:

- childcare needs
- family roles and obligations
- dietary needs
- religious needs.

Performance Measure 4.4

The service has processes in place to access, where available, accredited or suitably competent interpreters who have been trained in mental health interpreting.

Performance Measure 4.5

The service has conducted assessment, diagnoses and treatment by formally qualified and culturally competent mental health clinicians, and/or provided services by appropriately qualified and culturally competent staff.

CULTURAL COMPETENCY STANDARD 5

The service adheres to a Language Services Policy.

Principle

People from CALD backgrounds have a right to receive the same best practice standard of mental health service as other Australians.

Performance Measure 5.1

The service has a Language Services Policy which provides guidelines for booking and effective use of interpreters in accordance with the Language Services Policy for their State or Territory. Where no such policy exits, a service needs to adhere to its own existing best practice guidelines in relation to language services.

Performance Measure 5.2

The service has negotiated with interpreter service agencies to ensure that, where available, accredited or suitably competent interpreters trained in mental health interpreting are booked to the service.

Performance Measure 5.3

The service has where available, used accredited or suitably competent interpreters, trained in mental health interpreting.

Performance Measure 5.4

The service has provided staff training on the effective use of interpreters and principles outlined within the Language Services Policy of the state/territory, or, where no policy is available, on the best practice language services guidelines upheld by the service.

Performance Measure 5.5

The service has sought to develop a staff profile which reflects the cultural diversity of the wider community; this could include services working together with bilingual workers sourced through relevant networks.

CULTURAL COMPETENCY STANDARD 6

The service makes available and encourages mental health cultural competency training for its staff, with independently and externally evaluated state-endorsed cultural competency training to be used where available, and the use of culturally appropriate assessment and planning tools.

Principle

Understanding of cultural differences must be incorporated in the development of all mental health programs and services.

Performance Measure 6.1

The service has ensured that all staff undergo a mental health cultural competency training program within the first 12 months of employment at the mental health service and ongoing annual professional development thereafter. State-endorsed training, that has been independently and externally evaluated, is to be delivered where available.

Performance Measure 6.2

The service has ensured that policy documents specify that assessment instruments or inventories administered on CALD clients are culturally appropriate, and where feasible, are culturally validated.

Performance Measure 6.3

The service has conducted development and implementation of more culturally appropriate assessment, review and treatment and or rehabilitation/recovery plans.

Performance Measure 6.4

The service has incorporated cultural competency into staff orientation and performance review requirements.

CULTURAL COMPETENCY STANDARD 7

The service ensures CALD consumer and carer participation in service planning, implementation and evaluation.

Principle

CALD consumers and carers are involved in the planning, implementation and evaluation of the mental health service.

Performance Measure 7.1

The service has consulted with CALD consumers and carers in the planning, implementation and evaluation of policies and programs for the service, so that issues of cultural diversity are incorporated.

Performance Measure 7.2

The service has engaged suitably trained CALD consumers and carers to deliver services where appropriate (e.g. peer support service).

Performance Measure 7.3

The service has taken satisfaction surveys of CALD clients, translated or interpreted, where needed, in preferred languages to:

- inform continuous improvement
- determine cultural appropriateness of various programs delivered by the service
- determine cultural competence of staff.

CULTURAL COMPETENCY STANDARD 8

The service has proactive support from senior management for developing transcultural mental health initiatives.

Principle

A formal commitment to dedicating resources is essential to achieve cultural competency.

Performance Measure 8.1

The service has budgetary policies and practices that allocate resources and fiscal support to facilitate delivery of evidence based programs for CALD communities and to assist the service in achieving cultural competency.

Performance Measure 8.2

The service has genuine and active support for FTEs who are designated the responsibility for monitoring the progress of the service in attaining cultural competency through the implementation of the Framework.

Attachment Five

The four key outcome areas and 43 associated outcome measures

Key Outcome Area 1: CALD consumers and carers effectively participate at all levels of mental health service planning, delivery and evaluation

Outcome Indicator 1.1: CALD consumers and carers are represented on Committees and mechanisms in relation to service development, planning, service delivery, implementation, evaluation and policy development
Outcome Indicator 1.2: Training and support for CALD consumers and carers is provided, including mentoring and supervision
Outcome Indicator 1.3: Culturally responsive approaches are incorporated into person-centred and recovery oriented care
Outcome Indicator 1.4: Working relationships with CALD community leaders and multicultural organisations are developed and maintained
Outcome Indicator 1.5: CALD specific approaches are incorporated in peer support models
Outcome Indicator 1.6: CALD consumers are provided with information, including their rights, in an appropriate language and format
Outcome Indicator 1.7: CALD carers are provided with information, including their rights, in an appropriate language and format
Outcome Indicator 1.8: CALD consumers are provided with culturally appropriate mental health care

Key Outcome Area 2: Improved outcomes in access, coordination across the continuum of care, quality and safety for CALD mental health consumers, carers and their families.

Outcome Indicator 2.1: Improved access to culturally appropriate mental health services
Outcome Indicator 2.2: Improved access to professional interpreters
Outcome Indicator 2.3: Improved access to multilingual mental health rights and responsibilities information
Outcome Indicator 2.4: Improved CALD data collection
Outcome Indicator 2.5: Improved CALD relevant research development
Outcome Indicator 2.6: Improved CALD consumer safety
Outcome Indicator 2.7: Improved culturally appropriate mental health assessments
Outcome Indicator 2.8: Culturally appropriate discharge planning
Outcome Indicator 2.9: Improved access to professional interpreters for CALD mental health consumers and carers
Outcome Indicator 2.10: Increased development and access to multilingual resources for CALD mental health consumers and carers
Outcome Indicator 2.11: Enhanced culturally inclusive strategic planning
Outcome Indicator 2.12: Enhanced culturally inclusive mental health education and training
Outcome Indicator 2.13: Increased use of culturally appropriate assessment
Outcome Indicator 2.14: Ensuring non-discriminatory practices
Outcome Indicator 2.15: Integration and coordination of services with multicultural sector support services
Outcome Indicator 2.16: Enhanced resourcing of CALD quality and safety strategies

Outcome Indicator 2.17: Improved use of information and communication technology in CALD specific initiatives
Outcome Indicator 2.18: Improved person-centred care
Outcome Indicator 2.19: Enhanced cultural approaches to recovery-oriented mental health care

Key Outcome Area 3: Increased mental health awareness, knowledge and capacity in CALD communities via culturally inclusive promotion, prevention and early intervention initiatives.

Outcome Indicator 3.1: Improved access to culturally appropriate suicide prevention support, care, services, resources and information for CALD consumers and carers
Outcome Indicator 3.2: Improved suicide prevention approaches for at risk CALD groups, including CALD older people, refugees, women carers, children and young people
Outcome Indicator 3.3: Strengthened evidence base about CALD suicide prevention initiatives
Outcome Indicator 3.4: Improved community outreach with CALD priority groups: older people; women; refugees; carers; children and young people
Outcome Indicator 3.5: Increased number of CALD specific stigma reduction, mental health literacy programs and Mental Health First Aid delivered
Outcome Indicator 3.6: Increased integration of CALD perspectives into mainstream stigma reduction initiatives
Outcome Indicator 3.7: Improved CALD community capacity building and engagement
Outcome Indicator 3.8: Improved social participation of CALD people with mental illness
Outcome Indicator 3.9: Improved economic participation of CALD mental health consumers

Key Outcome Area 4: A culturally responsive and diverse mental health workforce which is supported to deliver culturally and linguistically inclusive practice.

Outcome Indicator 4.1: Improved knowledge and skills in cultural responsiveness in the mental health workforce
Outcome Indicator 4.2: Improved knowledge and skills about seeking specialist cultural assistance and input when required
Outcome Indicator 4.3: Improved skills in working with interpreters and adherence to language services policies in mental health
Outcome indicator 4.4: Improved skills in working with translators and multicultural services in mental health
Outcome Indicator 4.5: Increased diversity of the professional mental health workforce which is representative of the ethnic and cultural groups in the community
Outcome Indicator 4.6: Improved retention of a culturally and linguistically diverse mental health workforce
Outcome Indicator 4.7: Increased training of the multicultural sector workforce in mental health and suicide prevention