MHIMA PROJECT CONSULTATION MEETING NOTES

Mental Health Australia

MHiMA
Mental Health in Multicultural Australia

National CALD Consumer and Carer Working Group (NCCCWG) and Project Advisory Group Meetings: 17 & 18 February 2016

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Introduction

Mental Health Australia is auspicing the Mental Health in Multicultural Australia (MHiMA) Project until June 2016. In September 2015, Mental Health Australia was asked by the Commonwealth Department of Health to develop a recommendation report on the future of the MHiMA project.

Mental Health Australia is using four engagement methods to build the recommendations report to the Department, including a public consultation process, two meeting days and an independent Framework review undertaken by Professor Kathy Eagar.

The purpose of the two meetings was to engage with the National CALD Consumer and Carer Working Group (NCCCWG – 17 February meeting) and the Project Advisory Group (Advisory Group – 18 February meeting) to assist Mental Health Australia to develop recommendations.

The previous iteration of the MHiMA Project established the NCCCWG in 2013. The NCCCWG's role has been to provide advice to the MHiMA Project as well as provide input to broader mental health reform as representation for multicultural consumers and carers.

Mental Health Australia brought together the Project Advisory Group in late 2015 to provide advice to Mental Health Australia about the future directions of the MHiMA Project. Members had previously been selected for their specific expertise in multicultural mental health. Some of the members on this group were involved in the previous iteration of MHiMA and two of the members are representatives of the NCCCWG (one consumer and one carer representative).

Mental Health Australia engaged Professor Eagar to undertake a review of The Framework for Mental Health in Multicultural Australia (The Framework) in late 2015. A trial of the Framework had been implemented in ten acute hospital wards across the country. The Framework review considered the development of the Framework, the tools within the Framework such as the Organisational Cultural Responsiveness Assessment Scale (OCRAS) and the implementation action plans developed as a result of engaging with the Framework.

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This paper presents the notes from the NCCCWG and Project Advisory Group meetings. There was a high degree of commonality in the issues raised across the two meetings. Where there was some divergence or material of specific interest raised, this is noted in this report. While these notes capture the issues raised at each meeting, it is important to note that not all participants agreed with all of the directions proposed – and were not asked to do so.

Overview of the meetings

Both meetings used the morning sessions to provide participants with more information about Mental Health Australia and discuss the workings of the respective groups. Professor Eagar also provided feedback on her findings from the Framework review and consulted the NCCCWG on their experiences with the Framework development and implementation. Mental Health Australia also gave an overview on the emerging themes from the very recent public consultation.

The second part of each day was used for brainstorming in smaller groups and reporting back on the project recommendations. This session considered the future of multicultural mental health from two perspectives; function and form. The first part of this session was devoted to consideration of what should be the key functions or activities in multicultural mental health in Australia over the next 1-2 years. The groups then considered the most appropriate structural response, or form, likely to facilitate achievement of these tasks.

Agreed Objective

At the 18 Feb meeting, the Project Advisory Group first gave consideration to the purpose of MHiMA. Some members stated that the project had suffered over the years from a lack of role clarity. The group decided a shared understanding of the role would help guide their conversations regarding the MHiMA Project function and form.

On this basis the Project Advisory Group suggested the following role definition for the project going forward:

> To be a strong, coordinated and representative voice for CALD mental health, influencing systemic change and quality improvement.

A guiding principle also enunciated was to avoid 'mainstreaming'. In other words, there was strong agreement by participants of the intrinsic value in ensuring a specific focus on the mental health needs of the multicultural community. This had been a guiding principle for MHiMA and its predecessors.

The overall role of MHiMA was not discussed in this way during the NCCCWG meeting on the 17 Feb. However, the above role definition can be seen to align with the NCCCWG's priority for MHiMA, which was to support the consumer and carer working group to influence government policy and advocate for CALD consumers and carers.

The Project Advisory Group also discussed the sustainability of national multicultural mental health activities. Members proposed that MHiMA needs to move away from being described as a project, and thought of more as an ongoing program. Recognising the importance of achieving long term changes in the services and resources available to CALD consumers and carers.

Key functions

As already stated, the first part of both meetings asked participants to describe key functions or tasks in CALD mental health, with a focus on those needing immediate action.

An action matrix

In the course of this discussion, and so as to focus on potential areas for immediate action, Professor Eagar suggested there were three key umbrella areas for the MHiMA project in the future; addressing stigma and promoting mental health in CALD communities; promoting patient safety; and building professional competency. There was then a question regarding to whom these activities were targeted. The following initial 'action matrix' was drawn:

Target Audience	Key Function		
	Stigma Reduction	Cultural Sensitivity/ Safety	Professional Competency
State and Territory Governments			
NGOs ie Lifeline, *beyondblue*			
Primary Health Networks (PHNs)			
Non-health agencies and services			
Federal Government			
National Disability Service (NDS)			
Communities			

The challenge posed by this matrix was to more clearly define the future functions of MHiMA and the intended audience. While the meetings did not attempt to complete the matrix, it was seen as a useful lens through which to consider future functions and design effective governance and representative structures.

Professor Eagar challenged the meeting participants to consider whether this range of actions was practical and achievable, and what the implications might be for necessary organisational structures (discussed more below).

Functions

The meetings discussed the following functions for the next iteration of MHiMA:

1. Supporting the CALD Consumer and Carer Working Group was seen as the top priority by the NCCCWG. They wanted to broaden and strengthen consumer and carer representation, increase networks and continue the CALD consumer and carer contribution to national reform through systemic advocacy and policy development at a national level. The Advisory Group echoed the importance of having the voice of CALD consumers and carers as an essential part of the MHiMA Project.
2. Bringing together CALD mental health expertise was seen as the top priority for the Project Advisory Group. A critical function is to make the most of the rare and precious CALD mental health expertise available in Australia. Much of this resides in the transcultural mental health services, in programs and services in those other jurisdictions without a centre, and in other organisations, particularly those dealing with people recently arrived in Australia. It was proposed that the next version of MHiMA

must be an effective place for this expertise to meet, grow and really impact on the shape and nature of Australian mental health care.

3. It was proposed MHiMA should provide Government with insight into CALD mental health issues. These issues remain a critical element of ongoing mental health reform. The next version of MHiMA should ensure government(s) are accurately appraised of the issues and challenges facing CALD mental health, right across the spectrum of government policy, including health, education, employment, welfare and so on. Government cannot afford to be blind to the mental health of the CALD community. Most Australian jurisdictions also now have their own mental health commission, typically keen to assist in refining local approaches to CALD mental health.
4. Both the NCCCWG and the Project Advisory Group demonstrated broad support for the continuation of the Framework for Mental Health in Multicultural Australia, and appeared to agree with Professor Eagar's proposal to develop the Framework into a Knowledge Network. The evaluation conducted by Professor Eagar indicated the Framework was a well-regarded and useful product. The evaluation also pointed out several key steps to capitalising on this platform, away from just a process of accreditation and towards a more flexible and useful role. These steps focus around the further development of the Framework to create a set of tools more tailored to suit different service areas – not a "one size fits all." This would see the Framework become the basis of a Knowledge Network, and a set of tools designed to encourage and train better responses to CALD mental health across a variety of service settings (see 5, 6 and 7 below).
5. Drawing on the Knowledge Network above, it was proposed to work with PHNs (Primary Health Networks) to provide them with the tools, skills and competencies to commission services to support their CALD populations. In November 2015, the Government announced in its response to the National Mental Health Commission's Review that mental health services will be commissioned through local PHNs. Work here is aimed at influencing the PHNs 'commissioning framework' so as to better address the needs of CALD communities. The meetings also referenced data indicating that CALD populations are too low a proportion of primary mental health care and too highly represented among acute admissions. There is work to be done in relation to early intervention in CALD mental health, working in partnerships between PHNs and local health districts.
6. As with 5 above but with specific reference to the NDIS. CALD take-up rates of NDIS packages are significantly lower than they should be according to demographics. There is an urgent need to ensure the NDIS properly caters to the needs of the CALD mental health population.
7. As with 5 above, it was proposed at the Project Advisory Group to have specific reference to the current aged care reforms affecting CALD people who experience mental illness. It should be noted that items 5, 6 and 7 listed here were all seen as having some limited potential for fee-for-service activities, with client organisations potentially willing to pay for CALD expertise to increase the quality of the service they can offer their CALD clients. The recent mental health reforms are clearly placing new emphasis on the establishment of effective partnerships between government and non-government organisations. MHiMA's future efforts need to reflect this, including in relation to ongoing financial sustainability.
8. Developing tailored approaches to address the issue of suicide in CALD communities. Responsibility for national suicide prevention has recently shifted to PHNs. While there is an emerging framework around suicide prevention based on deployment of

evidence-based approaches, this evidence is particularly thin when applied to the CALD community. There is an urgent need to assist PHNs and to further develop the CALD suicide prevention toolkit and evidence base.

9. Contributing to national approaches to improve CALD data collection. It is generally acknowledged that this area of mental health information remains poor. Making real improvements to access to regular, quality information on CALD mental health will be a critical area for activity in the future, driving understanding, research, monitoring and reporting. Links to key government agencies and processes (e.g. the Mental Health Drug and Alcohol Principal Committee (MHDAPC)) will drive these improvements and are reflected in the suggested organisational structures discussed below. The NCCCWG specifically felt that it is important to build on and implement the recommendations made in the recent paper produced by MHiMA *Mental health research and evaluation in multicultural Australia: developing a culture of inclusion*, (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852843/).
10. Developing approaches which permit national reporting on the health and welfare of the CALD mental health community – evaluation and monitoring role. One aim here is to highlight inequities in practice, a situation which, for example, sees medication used far more often in CALD communities than talking therapies. This has significant risks to individuals and their families, and costs to the community.
11. Contributing to CALD workforce development – both professionals and peers. One aspect of this is in relation to the service workforce, in mental health and other related areas of service provision. However, another aspect would involve nurturing the next generation of skilled CALD mental health champions and leaders, in transcultural organisations, other bodies and vitally, among CALD consumers and carers. The NCCCWG also highlighted the importance of promoting CALD education for the mainstream mental health workforce and other relevant professionals, to ensure appropriate standards of CALD knowledge are required in accreditation and other key processes.
12. Developing tailored approaches to mental health promotion, awareness and stigma reduction in CALD communities. Audit of existing tools, effective communication of issues and concepts, strategic use of the media and community leaders to share information.

The NCCCWG made several suggestions in addition to those listed above:

13. Exploring the CALD recovery framework and translating the concepts in the National Recovery Framework into CALD contexts to increase relevance to CALD consumers and carers. The NCCCWG mentioned that the lived experiences of recovery are different for CALD consumers and a better understanding of recovery needs to be developed.
14. Developing best practice approaches to the utilisation of translators and interpreters. Too often, the need for interpreter services is ignored due to cost or inconvenience, relying on family members to interpret instead.
15. Evaluating of e-mental health services and resources for CALD communities. Recent Commonwealth reforms in mental health indicate a strong new push for online mental health services to be the first step for most people with a lived experience of mental illness in Australia, only moving to face-to-face professional care if needed. Data about the effectiveness of e-mental health services is already strong and growing but its utility in CALD settings is less clear. There is an urgent need to ensure CALD communities do not miss out on access to these exciting new mental health care pathways.

One key principle identified across the two meetings was that any future iteration of MHiMA should not lose the array of precious skills and resources built up over past years by MHiMA and its predecessors. Past years have seen significant strides in better understanding CALD mental health. Australia is constantly receiving people from new communities who have different perceptions about mental health and different needs. The challenge of meeting CALD mental health needs remains largely unaddressed, with community awareness often still poor.

There is a lot to be done. These existing CALD mental health resources must be used and built upon, not discarded.

Optional structures for the MHiMA Project

At both meetings, participants acknowledged a consortium arrangement was unlikely to be successful, based on the collapse of the recent project and the challenges faced by previous consortia working in this space. This is supported by the evaluations of those previous projects.

Many in the CALD mental health sector would welcome the establishment of a new independent national body to lead the work in this area. However, given current financial and other constraints, funding to enable the establishment of a new and fully independent national entity seems unlikely.

Another option discussed was an auspicing arrangement, possibly the most likely model to progress CALD mental health. Different suggestions were proposed for host organisations, including Mental Health Australia, the National Mental Health Commission, FECCA and NEDA. While a number of participants in the Project Advisory Group said that they would prefer for the project to stay with a mental health focused organisation, no clear consensus was reached on the best organisation to host the future of a multicultural mental health program. The NCCCWG indicated a preference for Mental Health Australia to auspice the program and not other organisations such as FECCA or NEDA. There was also strong support from the NCCCWG to eventually establish an independent organisation, noting that there may need to be a transition phase. The transition phase would require the NCCCWG to be hosted and supported by another organisation whilst processing and establishing an independent stand-alone organisation. The NCCCWG proposed Mental Health Australia would be best organisation to do this.

Given the project history, both groups recognised the key issue under any auspicing arrangement would be clarity of responsibility and governance. The meetings were of the view that the Commonwealth's ongoing willingness to fund CALD mental health activities will largely rest on its confidence in improved accountability and oversight by the auspicing body.

They also thought the Commonwealth will need to see clear 'line of sight' accountability under any auspicing arrangement, to grow confidence that any funding provided is directed towards agreed goals and can be fully acquitted against these outcomes.

Possible MHiMA governance and auspicing arrangement

The meetings were able to articulate some key principles of how any auspicing arrangement could look. Although a specific governance and management model was not discussed in detail, it is hoped that the principles discussed in both meetings are captured below.

It is the reality that the Commonwealth will need to sign an agreement to manage the project going forward with one organisation, it is a critical factor in delivering clarity around the accountability of the program.

But even under such an arrangement, there was agreement that the project would require a group of organisations to commit expertise to guide the program. The suggestion was that this body, which this report has called an alliance, would be responsible for providing advice and guidance to a new national multicultural mental health program.[1]

This alliance would be the key engine established to drive the national response to multicultural mental health. The alliance would need national buy-in from the two sectors that the project would seek to influence and communicate with: the CALD sector and the mental health sector. It was proposed by the Project Advisory Group that national peak groups such as the Mental Health Australia and FECCA need to be represented here as well as other national CALD organisations, such as FASSTT (The Forum of Australian Survivors of Torture and Trauma), NEDA (National Ethnic Disability Alliance) etc.

It is generally accepted that effective CALD mental health strategies require strong links to the ethnic communities at the local level. The alliance will need its membership to build and nurture these links for actions to be effective, to build trust and a sense of ownership for the National Multicultural Mental Health Program among its constituency. It will need to become accountable to these communities, ensure Program relevance and demonstrate how it is making a difference to CALD mental health.

The Project Advisory Group meeting agreed that Mental Health Australia, FECCA and NEDA should meet separately to discuss possible arrangements.

It would also need to bring together and seek advice from the state and territory transcultural mental health centres which represent a large part of the repository of existing skills and resources. It would also need to cater for those jurisdictions without such centres.

For this process to generate authentic and meaningful change, as pointed out by the National Mental Health Commission, it needs to be person-centred. Structures to support the voice of mental health consumers and carers nationally have struggled to emerge. Over recent years there has been some investment in the development of a National CALD Consumer and Carer Working Group. This group, having survived changes in governance and organisational arrangements, has developed particular skills and insight into CALD mental health policy and programs. Consumer and carer engagement and capacity must be nurtured and strengthened in any future project. The alliance would need these skills to ensure the National Multicultural Mental Health Program operates with fidelity to consumer and carer views.

If the National Program is to have any chance of influencing services and behaviour 'at the coalface' it will need strong links into public mental health services. On this basis, there was a proposal for the alliance to have government representation from jurisdictions, trying to tie national CALD mental health strategies more effectively to local service change. The Project Advisory Group discussed how the "Joint Officers Group" (JOG) function had delivered these kinds of connections in the past and proven to be worthwhile. The JOG program was part of the Multicultural Mental Health Australia project run from 2005 – 2009. It is anticipated that links to MHDAPC would be important to future success. Connections to government processes are also critical to influence the future of mental health informatics, through

[1] 'national multicultural mental health program' is used in this report as a general term, and was not specifically nominated as the program name during either meeting.

groups such as Mental Health Information Strategic Standing Committee (MHISSC), to improve the quality of CALD mental health data collections.

The alliance would be responsible for the determination of priorities across the Program and would guide project staff (through an Executive Officer or similar) in the conduct of identified projects. It may be that some functions are conducted under the advisory body itself while others are outsourced to partner organisations. Where alliance members might undertake activity, advisory body member business rules would enforce strict and complete separation between the governance and service provision roles, to ensure probity and due process.

The alliance would therefore be the key guiding body under the Program, advising on directions and priorities. This would be critical in ensuring the Program avoids 'mainstreaming' as described earlier, instead retaining its unique and invaluable specific focus on designing responses in relation to CALD mental health.

Conclusion and next steps

The meetings acknowledged the difficult situation the MHiMA project was in. There was a clear desire to acknowledge and respect the considerable achievements of past years. This was enunciated by both consumers, carers and the organisations represented. In this context, the spirit of the two meetings and the willingness of participants to contribute positively was testament to a strong, shared motivation to find common ground for the future of CALD mental health.

The meetings succeeded in articulating a clear role for a national CALD mental health program going forward. They also outlined a set of unique functions designed to build on existing skills and experience so as to improve Australia's response to mental health among CALD communities. Finally, the meetings also discussed options of a structure that can be suitable for implementing the functions.

The meetings did not reach any final resolution about preferred structures or auspicing, and were not asked to. As agreed by the Project Advisory Group, Mental Health Australia, FECCA and NEDA have subsequently met to discuss the details of future possible auspicing arrangements, taking into account the characteristics and principles enunciated here.

Mental Health Australia undertook to ensure the notes of the two meetings were distributed to participants for their comment and feedback. Any feedback received will be taken into account as Mental Health Australia fulfils its obligations to provide recommendations to the Commonwealth about the future of the MHiMA project.