National Mental Health Commission

Engagement with Culturally and Linguistically Diverse communities to support the development of the National Stigma and Discrimination Reduction Strategy

Final Report

Prepared For:

National Stigma and Discrimination Reduction Strategy
National Mental Health Commission

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1. EXECUTIVE SUMMARY

This report has been prepared by Swagata Bapat, Principal Consultant, Swagata Bapat Consulting, for The National Mental Health Commission (the Commission) in relation to their work in developing a National Stigma and Discrimination Reduction Strategy (the Strategy).

The consultant was engaged to design and deliver a consultation process to highlight Culturally and Linguistically Diverse (CALD) perspectives on Stigma and Discrimination related to mental ill-health, trauma, and distress, and to identify specific actions and levers for change that could be considered for inclusion in the draft Strategy.

This report provides a summary of feedback sourced through review of relevant documents, consultation with peak bodies at a facilitated roundtable, and individual consultations with key stakeholders in the multicultural mental health space.

Whilst it is outside of the scope of this engagement to provide recommendations, the consultant has also included some brief suggestions about further actions to build on and refine the feedback to date and further guide the Commission's thinking in relation to the draft strategy.

It should be noted that consultations were conducted over a short 5-week time schedule (end Feb - end March 2022) due to the impending federal election and associated restrictions of Caretaker Mode.

Stakeholders provided feedback about **Stigma and Discrimination related to mental ill-health, trauma, and distress in CALD populations** including highlighting core considerations underpinning the strategy and its development, themes in relation to stigma and discrimination in CALD populations, and themes related to intersectionality. Specific issues highlighted included:

- Language barriers and differing cultural understandings of mental health
- The limitations of the term "CALD" and how this may add to stigmatising views, and experiences of discrimination
- The impact of trauma and the complex interrelationships between trauma and mental ill health and distress for many people from CALD communities
- The impact of shame and cultural stigma on self-stigma
- The importance of considering family, carers, and broader cultural community
- The stigmatising impact of media reporting of incidents involving CALD communities
- The lack of representational lived experience for CALD communities &
- Intersectional issues including the impact of race and racism, family violence, LGBTIQA+, and the specific needs of "carers", young people, and older people

Stakeholders suggested several **actions for reducing the experiences of stigma and discrimination based on mental ill-health for people from CALD backgrounds which included**:

- *Actions at a national level* such as development of national mental health strategies and action plans, building the data and evidence base in this space, considering funding mechanisms and other incentives to focus on CALD communities, development of media guidelines, and development of public campaigns

- *Workforce recommendations* included actions to address CALD workforce representation, the development of a multicultural mental health peer workforce and peer networks, a national roll out of bilingual and bicultural workers, and further development of the CALD specific lived experience space.

- *Training and Education actions* addressed national training in relation to engaging with issues of racism, cultural competency training for clinicians, interpreter training, community education, media training and guidelines, and undergraduate training for health professionals.

- A significant focus of actions was on the *mental health service system* - and included things such as partnership between specialist (trusted) services and mainstream services, reorienting service models and approaches, establishing mechanisms to bridge the divide between services and the communities, and the importance of codesign.

It should be noted that whilst these mental health service system focussed actions appear to address more general “service development” issues rather than stigma and discrimination – feedback suggests that the current service system is not culturally safe and results in experiences of stigma and discrimination for people from CALD backgrounds.

There is a strong argument that having a mental health system (and other systems) that respond in more culturally safe and appropriate ways is key to reducing the experience of Stigma and Discrimination based on mental ill-health for people from CALD backgrounds.

Finally, despite *intersectional issues and groups* being highlighted by stakeholders– only a limited number of actions were identified to specifically address the needs of these groups. It is recommended that this is explored further with stakeholders and communities given the importance of taking an intersectional lens on the work of stigma and discrimination.

Advice and Considerations Around Consultation and engagement with CALD Communities included feedback about previous experiences of over consultation and lack of action from a range of organisations and government bodies, considerations about who to consult given the diversity of people who fall under the “CALD” umbrella, and advice about how to consult including ensuring that consultation occurs at the “grassroots” and not just with peak bodies and organisations, and taking into consideration the significant issue of lack of trust in authority and government.

Suggested further Actions

This is a complex and multi-layered space that encompasses a very diverse group of people, experiences, and intersectionality. Whilst the consultation process to date has provided useful feedback, it has also highlighted several gaps which may benefit from further exploration. The limited time available for consultation has also meant that some key stakeholders were also not able to be part of this process.

It would be useful to consider further opportunities for facilitated conversations with stakeholders (including those that have not yet been able to contribute to the discussion) to:

- Sense check feedback to date
- Further explore gaps in knowledge including:
    - Successful programs, and strategies in this space that may be suitable for scaling
    - Actions and levers for change in relation to intersectional issues including racism, family violence, LGBTIQA+, young people and older people.
    - Actions and levers for change in relation to carers
- Further refine the approach to public consultation and explore models for consultation in the CALD space

The consultant would be happy to support the Commission in their thinking and planning in relation to this process should this be helpful.

2. INTRODUCTION

This report has been prepared by Swagata Bapat, Principal Consultant, Swagata Bapat Consulting, for The National Mental Health Commission (the Commission)

The report summarises feedback from stakeholders, in relation to the Commission's goal of highlighting Culturally and Linguistically Diverse (CALD) perspectives on Stigma and Discrimination related to mental ill-health, trauma and distress, and to identify specific actions and levers for change that could considered for inclusion in the draft Strategy.

This report presents feedback in the following areas:

- Feedback about Stigma and Discrimination related to mental ill-health, trauma, and distress in CALD populations
- Suggested actions for reducing the experiences of stigma and discrimination based on mental ill-health for people from CALD backgrounds
- Advice and considerations around consultation and engagement with CALD Communities

2.1. Project Background

Swagata Bapat Consulting was engaged by The National Mental Health Commission (the Commission) in relation to their work in developing a National Stigma and Discrimination Reduction Strategy (the Strategy), which is due for completion by December 2022.

The Strategy is being designed through a collaborative process with those who have experienced stigma and/or discrimination associated with their mental ill-health.

Workshops held in 2021 highlighted that people from culturally and linguistically diverse backgrounds experience mental ill health and Stigma and Discrimination in a different way, and as a result the Commission engaged Swagata Bapat Consulting to undertake further targeted, collaborative and culturally appropriate engagements with people from culturally and linguistically diverse backgrounds to inform development of the Strategy.

The request for work included the design and delivery of a consultation process to highlight CALD perspectives on Stigma and Discrimination related to mental ill-health, trauma, and distress, and to identify specific actions and levers for change that could considered for inclusion in the draft Strategy.

It should be noted that the work was required to be conducted within a tight time schedule given the impending federal election and associated restrictions of Caretaker Mode.

2.2. A note about language throughout this report

The consultant acknowledges that the language used to describe elements of this work is limited in terms of how accurately it captures the experiences of people from CALD communities, the role of carers, families and the broader cultural community, and the concept of lived experience.

These language issues have been highlighted by stakeholders during the consultation process and are explored further in this report.

For the purposes of this report, the author will utilise the term "CALD" – to mean people, families/ carers, and communities from culturally and linguistically diverse and multicultural backgrounds; "lived experience" to denote anyone who has personal experience of mental ill-health, trauma, and distress, or who has a caring / support role for someone with personal experience of mental ill-health, trauma, and distress.

It is important to note that in CALD Communities the concept of "carer" stretches much broader than just immediate family members, and may also include the extended family, religious or cultural leaders, and the broader cultural community.

Unless otherwise specified, "Stigma and Discrimination" will refer to experiences of Stigma and Discrimination in relation to mental ill-health, trauma, and distress in culturally and linguistically diverse populations.

2.3. Approach

The approach to this work has evolved and been shaped in response to feedback as the project has developed. As a result, there have been two significant changes to the way the consultation process has been designed.

The consultant would like to acknowledge and commend the open and flexible approach the Commission has taken to the way the consultation process has been designed and delivered, and their willingness to adapt their approach in response to feedback from stakeholders.

The timeline of approaches is summarised below.

1. *Initial approach suggested by Commission* – one workshop with participants from peak bodies and relevant organisations, along with lived experience consumers and carers. Feedback identified some limitations with this approach given the challenges (particularly in CALD groups) about speaking up around authority and power.

2. As a result of this feedback, it was agreed that the preferred approach was to facilitate 3 separate conversations:

    - One with service providers/ peak bodies.
    - One with people with lived experience of mental ill health; and
    - One with people with lived experience in caring / supporting roles as family or community

However, initial conversations with peak bodies about engaging with people with lived experience within communities highlighted some challenges with this approach including

- Lack of time to develop trust and engage people
- Concern about how effective the consultation process might be without having the established relationships with the communities
- Concern about the experiences of over consultation and lack of action from a range of organisations and government bodies in the past

3. The final agreed approach, given the feedback and the time constraints was

a. The facilitation of a roundtable with CEOs (or delegates) from peak bodies in the multicultural / mental health space
b. A series of targeted conversations with people from these peak bodies to identify considerations for the roundtable discussions and more broadly for the strategy.
c. A small number of consultations with people in the consultant's own network. Including the Health Issues Centre, Multicultural Mental Health Advocates Collective and the SAARI collective.

3. STAKEHOLDER CONSULTATIONS

3.1. Initial conversations with Stakeholders

The consultant conducted consultations with stakeholders in relation to the strategy prior to the design and facilitation of the Roundtable. These stakeholders included individuals from the consultant's own network with lived experience; people with lived experience of caring for someone with mental ill health, and senior leaders of peaks, service providers and researchers working in this space.

These conversations and feedback from the roundtable discussion form the basis of the feedback within this report.

3.2. The Roundtable

The roundtable was held on Friday 25th March 2022 as a 3-hour virtual meeting. The goals for the roundtable were to:

- Identify actions that will help drive change to reduce the experience of Stigma and Discrimination based on mental ill-health, trauma, and distress for people from culturally and linguistically diverse backgrounds.
- Provide advice to help understand where the Strategy could make most impact, building on the substantial existing and ongoing work in the space of multicultural mental health.

The roundtable focussed on the following areas for discussion:

- Framing and setting of context - including a brief overview of the draft strategy, timelines for consultation, scope of the strategy and consultation, definitions, and guiding principles
- Overview of the themes from feedback to date – and identifying any gaps
- Identification of actions to reduce the experience of Stigma and Discrimination related to mental ill-health, trauma, and distress in CALD groups
- Advice about consultation with communities
- Advice about next steps

4. FEEDBACK ABOUT STIGMA AND DISCRIMINATION RELATED TO MENTAL ILL-HEALTH, TRAUMA AND DISTRESS IN CALD POPULATIONS

The following section summarises feedback from stakeholders in relation to stigma and discrimination related to mental ill-health, trauma, and distress in CALD populations.

Feedback has been arranged into themes for the sake of clarity of identification and reporting, however it should be noted that this is a complex and multilayered space and many of these themes are interrelated.

This section has been divided into the following areas –

1. Core Considerations underpinning the strategy and its development
2. Issues to consider in in relation to Stigma and Discrimination
3. Intersectional issues

4.1. Core Considerations underpinning the strategy and its development

Participants identified several important principles in relation to both the strategy content, and the process of consultation to build CALD perspectives and voices into the strategy. These include:

- Recognise and build on previous work and knowledge in the CALD / Mental Health / Stigma and Discrimination space – particularly work led by CALD communities and organisations.
- Work in collaboration with CALD communities and specialist CALD services where these exist and are resourced
- Be open, honest, and transparent about issues CALD communities experience and acknowledge where the system fails CALD communities.
- Ensure that the work captures nuances and detail and does not just "scrape the surface"
- Ensure that the Strategy maintains a balance between immediate and long-term priorities
- Ensure voices of lived experience, including carers, families and other cultural supporters are heard throughout the strategy
- Grassroots consultation should be applied where possible – this may be most useful in understanding strategy implementation issues in the local area both in terms of geography, and the needs of specific cultural groups.

4.2. Issues to consider in relation to Stigma and Discrimination

4.2.1. Language and Cultural Understandings

Feedback in relation to language and cultural understandings includes things such as:

- Mental health / illness is a term which may not translate well into many other cultures given their social and collectivist model of health and wellbeing.
- Language of "mental health issues" doesn't capture the traumatic experiences of many of these communities related to things such as migration, war, displacement, torture, loss of social and cultural connections, or the refugee and asylum-seeking process.

- Mental health and related terms are shortcuts for things that are multi-layered and complex experiences for people in CALD, refugee, and migrant populations.
- Idea of Stigma and Discrimination is a "white" concept

It will be important to factor these language and cultural issues into the content of the strategy as well as into considerations of how consultations are undertaken.

For example, the Commission may need to develop a culturally appropriate "form of words" that allow communities to be able to respond to and understand the consultation questions being asked in relation to the draft strategy and to give the actions in the Strategy itself meaning for CALD communities.

4.2.2. "CALD"

As highlighted at the beginning of this report, the use of the term "CALD" presents many challenges given that it is a catch all term utilised to describe anyone who isn't of white Anglo Celtic heritage. Approaching such a large and diverse group with the "one size fits all" label of "CALD" has many limitations - as approaches and strategies may not address the specific needs of each diverse community, and may add to stigmatising views, and experiences of discrimination.

Feedback from stakeholders stressed that

- All CALD communities are different
- There are differences within each community (e.g.: terms such as "Indian" may capture 100's of languages, different religious beliefs, different community groupings)
- There are multiple communities within communities
- Communities will often have distinct socioeconomic groups and differing levels of privilege within them

This complexity also poses some challenges in terms of who to consult with and how best to balance the consultation process within the time and resources available – and still get the best possible outcome.

4.2.3. Lack of trust in and fear of authority and the system

This issue was highlighted by all stakeholders across the consultations.

Issues identified included:

- Fear of disclosing mental health issues due to worry about potential discrimination in relation to visas, sponsorship of family members, work visas, citizenship, or residency applications etc.
- Asylum seekers – fear that authorities will access records and that this will impact on visa status
- People are more likely to seek support / information through local community leaders / religious leaders and other informal community leaders. (*it should be noted however that some people provided feedback that they were unlikely to seek support from these sources – particularly where there were additional issues such as stigma about sexual identity)

This feedback needs to be considered in terms of actions that are recommended in the draft Strategy as actions that are situated within large government bodies or other bodies seen as "authority" may not get good uptake and engagement from CALD groups.

It also suggests that any messaging / campaigns in relation to Stigma and Discrimination should come from trusted community sources to increase engagement.

4.2.4. The (Mental health) system

"Want to see people who look like me and feel like me"

"Our whole mental health system is very biased"

Stakeholders highlighted the fact that the mental health system, and broader service system is very "white" which impacts on how effectively it meets the needs of CALD communities, as well as how likely it is that people from CALD communities will seek help from mainstream (mental health) services.

Some of the issues highlighted included:

- The entire Mental Health System and workforce is very "white" – from funders, policymakers, decision makers and the broader workforce – to approaches to assessment, treatment, understanding of cultural views and models
- Often no opportunities to access services information in different languages

Several actions in relation to workforce and the service system are identified further in the report.

Again, the Commission may want to think about how any consultation processes around the draft strategy might address this issue of people feeling more comfortable to engage with people and processes that "look like me and feel like me".

4.2.5. Shame and stigma of acknowledging mental health issues / Cultural Stigma and its impact on self-stigma

"Culturally you don't admit to bad feelings – not allowed to talk about mental health issues within the cultural community"

Stakeholders highlighted feelings of **stigma and shame** connected to mental health issues**.** Examples of this include:

- Shame of acknowledging that you are struggling
- Stigma and shame for family members with relatives who experience mental ill health. Often families will not want their loved ones to access mental health services due to shame and stigma– e.g.: parents may feel shame and blame themselves for their child's problems
- People from CALD backgrounds are reluctant to use services that have the words "Mental Health" in them due to the stigma of mental health. (In addition, as highlighted earlier, the term "Mental Health" also does not adequately capture their experiences /cultural understandings).
- Many people from CALD backgrounds may be more focussed on material wellbeing – both in relation to ensuring basic material needs are met, as well as aspiring to "make good." As a result, mental and emotional wellbeing may not be acknowledged as a priority or relevant need.

4.2.6. Impact of Trauma

"Any work in this space must acknowledge the significant impact of trauma"

Participants highlighted the complex interrelationships between trauma and mental ill health and distress for many people from CALD communities and the impact of these issues on experiences of Stigma and Discrimination.

It was highlighted that trauma is present in the migration process, in the experiences of torture, war and violence, in the experiences of seeking asylum and more broadly in the disconnection from country of birth and the way of life, family and community connections.

Stakeholders highlighted the fact that traditional treatment approaches do not understand or address traumatic backgrounds and that in general the workforce providing services does not possess the cultural competency required to provide effective trauma informed treatment. (This issue is addressed by several recommended actions further in the report).

Examples were provided of the challenges experienced when this hasn't happened in mental health services for CALD populations.

- Example one - people found it difficult to implement the advice provided by practitioners (e.g., to focus on 'relaxation') when they were worried about the safety of their family who remained in the country of origin (e.g., worried about a sister who had nothing to eat and was in hiding).

- Example Two – person admitted to a public mental health facility and treated for an eating disorder. She refused to eat and was close to dying. However, it became evident that she did not have an eating disorder –she was a torture survivor and had been forced to eat terrible things as part of her torture in her country of origin.

Other stakeholders identified that one of the outcomes of trauma within communities was that future generations have been brought up not to raise mental health issues openly.

4.2.7. Family / community / carers

Family and broader cultural supports play a critical role in supporting people with lived experience of mental health issues, trauma, and distress in CALD communities – and may often be their only supports.

The cultural view of family, and the broader community has been highlighted as being different in most CALD communities to that of the traditional Western view of a nuclear family.

CALD Communities tend to identify more as collective rather than individualistic communities, and this impacts on many things such as the sense of responsibility for and care of family members, as well as the level of connectedness between family members and the broader community. The service system is often not equipped to understand or meet the needs of / adapt approaches to this collectivist thinking style. (One example is that of describing parents as being overprotective, enmeshed, not supporting the individuation of the child)

Feedback from stakeholders indicates that whilst the voice of carers / families /broader cultural supporters is critically important – it is often left out across many domains including service planning, policy development, decision making, service delivery and brooder consultation processes.

Other feedback highlighted that carer needs for information, support and services was also rarely considered.

4.2.8. Media reporting

The way that the media engages with and reports major incidents in relation to CALD populations was identified as an issue both in relation to people from CALD backgrounds with mental health issues, but also more broadly for CALD communities, resulting in stigmatising views in the broader community, and a heightened sense of protectiveness and fear within some communities about engaging with the broader community. For example, the media may inappropriately oversimplify acts of violence as religious extremism or a result of mental ill health.

One stakeholder commented that often behaviour which is a trauma/distress response can be reported inaccurately and negatively attributed to the characteristics of the cultural community.

These stigmatising responses can have a significant impact on whether and how CALD communities are willing to engage with and "be visible" in the broader community.

4.2.9. Lived Experience

"The people with lived experience in these processes often don't look like the people we see"

Many people commented on the fact that the people that they saw in lived experience roles, particularly in policy and decision-making spaces - did not look like the people that they saw in their work, highlighting that Lived Experience roles and definitions must consider the diversity of experiences.

The CALD Lived Experience space was described as a small but evolving space, with one stakeholder identifying that they were starting to see more requests for lived experience representatives from CALD backgrounds. Stakeholders highlighted that lived experience leadership in CALD communities may look very different and suggested that it was important to actively encourage CALD communities to develop its own style and ways of doing lived experience work.

Stakeholders also commented that it was important to consider how communities understand the concepts of lived experience leadership (and peer work).

The distinction between lived experience leadership and representation was also highlighted:

"Lived Experience leadership is important but shouldn't be confused with representation - they are different things"

4.3. Intersectional issues

"Anything to do with Stigma and Discrimination must take the complex layers associated with racism and trauma into account"

Feedback from stakeholders identified that there are multiple additional layers impacting on the thinking around Stigma and Discrimination in this group of people. These are identified below – and highlight the importance of taking an intersectional lens on the work around Stigma and Discrimination related to mental ill health, trauma, and distress, especially in CALD populations.

4.3.1. Racism

Many stakeholders identified the critical importance of considering the impact of race and racism in this work. This includes considering how racism may set the predisposing, and perpetuating factors for mental health issues, as well as the challenge of understanding and working with the multiple layers of Stigma and Discrimination in relation to race, and experiences of mental health issues, trauma, and distress.

Participants identified a range of experiences of Stigma and Discrimination in relation to race including:

- Stigma about race and cultural groups in the media,
- Stigma about race and cultural groups in the broader community
- Stigma about language
- Stigma about dress / appearance
- Stigma about religion

For some stakeholders, stigma and discrimination in relation to race was seen as being more significant than that of stigma and discrimination related to experiences of mental ill health, trauma, and distress. It may also be difficult for people to uncouple racism from mental ill-health-based stigma and discrimination.

4.3.2. Family Violence

Family Violence as a predisposing and perpetuating factor for mental ill health, trauma, and distress, adds an additional layer of complexity to the thinking in relation to Stigma and Discrimination.

Stakeholders identified several issues in relation to family violence including:

- Additional layers of stigma within some cultures about family violence
- Lack of knowledge in communities about laws
- Lack of knowledge about where to seek help
- Fear of reinforcing negative cultural stereotypes and likely discrimination against a community if brought to authorities
- Fear around contacting police due to the possible impact on family members (e.g.: will the sole income provider then be deported? Will it impact on visa status?)
- The impact of Isolation from the usual overseas support networks due to migration/displacement

4.3.3. LGBTIQA +

It was noted that there is still a high level of Stigma and Discrimination in relation to gender and sexual identity within many CALD communities, with alternative sexual identities and sexual preferences often not recognised as valid.

Feedback highlighted that many gender diverse and LGBTIQA + people from CALD groups are unable to openly be themselves in their community, due to the stigma - with one person describing how they had to leave the community to “be themselves”.

4.3.4. Across the lifespan and roles

Stakeholders noted gaps in terms of in relation to how well the voices and experiences of young people, older / aged people; and carers are captured and addressed. This is an identified area for further exploration.

5. ACTIONS IDENTIFIED FOR INCLUSION IN THE STRATEGY

The following section summarises feedback from stakeholders in relation to the possible actions for inclusion in the draft Strategy

This section has been divided into the following areas:

- Actions at a national level
- Actions related to the mental health service system
- Actions related to workforce
- Actions related to training and education

5.1. National Actions

5.1.1. Development of national strategies and action plans

Stakeholders identified the need for a *unified, consistent approach* to addressing the needs of CALD communities. The following actions at a national level were suggested:

- Development of a national communication plan and strategy to improve communication with CALD communities and assist with ensuring a targeted and streamlined approach to how communities are consulted. (This would include clearer communication on the broader ongoing mental health strategy conversations)
- The development of a national mental health strategy specifically for people from CALD backgrounds
- The development of a national a National Stigma and Discrimination Reduction Strategy specifically related to mental ill-health, trauma, and distress in CALD populations
- Establish mechanisms for better integration between commonwealth and state and territory jurisdictions (Stakeholders cited the different approaches and developments in different states – for example the work that is occurring with the Victorian reforms may not be replicated in other parts of Australia).

5.1.2. Build the evidence base in this space

Stakeholders highlighted the lack of good evidence and data in relation to the mental health of CALD populations – this does not appear to be part of routine data collection or embedded within service systems or broader settings - in the same way that it might be for Aboriginal and Torres Strait Islander people.

It was advocated that this may be an important action in building the evidence base and improving the quality of data captured to ultimately improve responses to and understanding of stigma and discrimination in CALD populations.

Feedback was also provided about current data requirements being very "western" and not necessarily sensitive to cultural understandings of mental ill health. A specific example given was the requirement for a Q10 to be completed for each individual as part of a funding agreement.

Actions in this area may include:

- Working with communities to identify culturally meaningful and acceptable data requirements

- Development of, and agreement on a national data set in relation to CALD populations
- Adding routine data collection requirement for CALD communities into funding expectations and KPIs

5.1.3. Funding and other Incentives

Stakeholders highlighted the *lack of funding mechanisms and incentives* to pick up best practice tools/ implement evidence-based strategies / develop targeted programs in relation to CALD communities.

Suggested actions included:

- Building requirements for working with CALD communities into tender specifications, targets, and funding
- Fund grants rounds to grassroots communities to develop their own targeted anti-stigma initiatives
- Exploring whether work in this space could be tied to the Australian Council of Healthcare Standards accreditation and KPI's
- Funding arrangements with built in requirements for all staff to have undertaken training in multicultural mental health
- Services to be provided with funding to undertake training in multicultural mental health
- Development of a similar accreditation to rainbow tick / RAP for working with CALD communities
- Ensure funding periods of 4 years rather than for small pilot projects - to allow the time and resources to effectively engage the community.

One example provided of a successful of funding arrangement is that of the funding for COVID vaccine information which involved large funds being made available in small parcels to communities. This approach could potentially be replicated for initiatives in this space.

5.1.4. Media guidelines

- Develop media guidelines about how to report on and discuss mental health in a way that is culturally appropriate and non-stigmatising, and in line with how CALD communities explain their experience of distress.

5.1.5. Public Campaigns

Some feedback was provided about the need for public campaigns that use the channels that CALD communities are more likely to tune into - and gave examples of things such as community radio, social media, and “whatever else works”! It may be helpful to explore this action in further detail.

5.2. The Mental Health Service System

"The response to stigma – is connection – localised and culturally safe"

Much of the feedback about actions to address stigma and discrimination in relation to mental ill health, trauma, and distress in CALD groups, focussed on the current mental health service system and how it could be improved.

Whilst these actions may seem to address more general "service development" issues rather than stigma and discrimination, feedback suggests that the current service system is not culturally safe and results in experiences of stigma and discrimination for people from CALD backgrounds.

There is a strong argument that having a mental health system (and other systems) that respond in more culturally safe and appropriate ways is key to reducing the experience of Stigma and Discrimination based on mental ill-health for people from CALD backgrounds.

Feedback in relation to the mental health service system is summarised below.

5.2.1. Utilise a Community Development approach with CALD communities

- Community development outreach approach is needed rather than tradition clinical approach where people only seek help when needed and health services are the experts. This would require services to provide outreach to the local area and community and build relationships - providing proactive rather than reactive support
- Provide strength-based help seeking support that understands the experience of CALD communities, and encourages that people will get better
- Encourage community centered support and community supporting each other
- Ensure opportunities for social connection

5.2.2. Place based service provision

"Get mental health professionals out of offices and into community"

Participants highlighted the need for mental health service provision to occur in the person's community or in their home, including locating mental health service providers in local community settings and local hubs. The benefits of this approach included:

- Two-way knowledge transfer
- Earlier support and prevention.
- Sector learning about being culturally responsive, appropriate, and relevant

One stakeholder highlighted that this is their approach with clients who are newly arrived, as part of early intervention work and ensuring access for women who may not be able to travel to receive care/treatment.

5.2.3. Language and Cultural Models

"Don't use words like mental health if they don't have meaning for communities - use language of the communities"

"Don't impose western models that may not be appropriate"

- Reorient services to use the language for mental health that meets the community's needs and matches their experience - rather than experiences needing to match a health definition
- Mental health professionals to use accessible and culturally appropriate language rather than diagnoses and relying on the interpreter to translate those
- Plain language is important in verbal communication not only fact sheets and publication
- Use Culturally acceptable interventions that use performance and other media tailored in culturally appropriate ways to engage different groups - not one size fits all
- Engage the community to understand the language they use to describe their experiences - and ensure that health services adapt to use this language to describe the service offerings

5.2.4. Trauma informed services

Stakeholders highlighted the critical need for services that were trauma informed. Actions in relation to this are highlighted in the "Training and Education" section.

5.2.5. Understanding the role of carers / cultural supports and community members

- Establish mechanisms for ensuring that family members and the broader cultural supports in the community are considered as part of service provision.

5.2.6. Partnership / Collaboration between specialist (trusted) services and mainstream services

- Fund and Support initiatives which promote collaboration between specialist CALD and Refugee / asylum seeker services and mainstream services. This may include mainstream services coming to the specialist service location. For example, collaboration between Foundation House and mental health providers has helped some clients to overcome stigma and receive treatment. That has been achieved by, for example, arranging for the client to attend mental health treatment sessions at Foundation House (along with their trusted Foundation House counsellor), to allow for service provision in a trusted and culturally safe environment.

- Use of broader local mainstream settings for engagement of CALD communities and provision of services – for example stakeholders described the benefit of holding psychoeducation classes for new arrivals in community health centres, TAFEs, and adult education centres – to help destigmatise mental health.

5.2.7. Mechanisms to bridge the divide between services and the communities

People drawn from CALD communities can effectively bridge the gap between the communities and the service providers – this would help to increase access by increasing knowledge of services, lessen stigma and build trust.

Stakeholders highlighted several strategies to achieve this:

- Establish Community liaison groups for services which represent the diversity in community which have the function of reaching into the community.
- Establish Liaison roles at key contact points in health services such as reception that can help people in community navigate the service.

- Establish Advisory Groups which are community/ethnicity specific which allow opportunities for codesign and coproduction of services and resources.
- Use existing channels of communication - for example if groups are currently actively engaging in networks via social media – then use this channel.
- Pay people from the community to work with their own community – people with lived experience who speak the language
- Establishment of senior liaison roles in services that engage community in planning and review Including accreditation
- Ensure a "direct link" person in health services for community as a key contact and for accountability

5.2.8. Service development considerations -

"Services should be designed for and with the community"

"Codesign / co -development / coproduction is vital"

Stakeholders provided a range of recommendations in relation to development of services. These include:

- Codesign
  - Codesign and tailor services to the community needs rather than expecting community members to access a western model of service delivery
  - Ensure Co-design occurs with the broader community not just mental health and community leaders
  - Establish opportunities for co-design/ service development and resource production, with (not to) community. For example, Covid funding encouraged local community led approaches to education of communities about COVID 19 - where the community was in control of the approach they took.
  - Ensure that you are engaging more marginalized groups within the community in the codesign and conversations that shape service design - including, young people, LGBTIQA+, women, carers and other cultural supporters, and older people.

- Resourcing
  - Ensure appropriate resourcing for effective codesign
  - Ensure that services and initiatives are funded over long period of time, with appropriate resourcing and time to build community relationships

- Establish local mechanisms to support service model development, implementation, and governance.

5.3. Workforce

5.3.1. Workforce representation

"People need to see their community in the people that support them"

Stakeholders identified the need for workforces to be more representative of the communities they serve including:

- Representation in mainstream services and boards
- Representation in executive leadership positions

- Representation at all levels of mental health programs and service delivery
- Representation across government in policy, funding, and decision-making spaces

Whilst it is outside the scope of this report to comment on the feasibility / regulatory requirements that may need to be considered in relation to targeted recruitment and workforce, there are several actions which might be helpful to explore further, and seek technical advice on, to improve workforce representation of people from CALD backgrounds.

Actions for consideration include:

- Targeted recruitment strategies that lead to better workforce representation
- Creating a reporting mechanism such as that for the Workplace Gender Equality Agency (WGEA) reporting – in relation to CALD representation at senior leadership and boards level.
- Identification of best practice case examples in relation to CALD workforce recruitment and representation
- Development of a broader strategy around workforce representation – there may already be work happening in relation to this in the Diversity, Equity and Inclusion space and it would be helpful to explore this further.

5.3.2. Mental Health peer workforce

Stakeholders highlighted the need to develop a mental health peer workforce that has a multicultural youth background. This would include:

- Expanding the current mental health peer workforce to ensure that this workforce is representative of diverse populations (An example provided of a successful pilot program which is ready to rollout is the MYAN pilot which would be worth further exploration.)

5.3.3. Peer Networks

Building lived experience communities and peer networks may be an effective way to respond to self-stigma in CALD populations. Interestingly many such networks appear to be developing in this space, for example the Multicultural Mental Health Advocates Network which has lived experience members. These may provide some information about the approach to development and implementation of these sort of networks.

Stakeholder suggestions included:

- Development of group-based models where people with shared lived experience support each other in community
- Development of paid positions for peer-to-peer work including peer consultants, evaluators, and researchers
- Building lived experience communities for people to support and learn from each other and collective experiences

5.3.4. Bilingual and bicultural workers

Bicultural and bilingual workers have invaluable skills including cultural and cross-cultural skills, often speaking multiple languages, and existing relationships where they are trusted by people in their communities.

Some actions identified include:

- National roll out of Bicultural workers in all service settings
- Development and implementation of a skills-based training program to support bicultural workers in their roles
- Upskill workers from refugee and CALD communities and provide them with training and support so they can work to effectively bridge the gap between the communities and service providers. This would help to increase access by increasing knowledge of services, lessen stigma and build trust.

5.3.5. Interpreters and translators

Interpreters and translators were identified as a critically important for reducing experiences of stigma and discrimination in relation to mental ill health in CALD populations. Actions specifically focussed on this part of the workforce have been highlighted in section 5.4 – Training and Education.

5.3.6. Lived Experience

Several actions related to Lived Experience were identified by stakeholders. These include:

- That the mental health sector needs to further build capacity of lived experience leadership from CALD and multicultural communities
- Build communities of practice of people with lived experience from CALD communities, to learn from each other, to normalise experiences, and build strength in the collective
- Promote the role of lived experience leadership in CALD communities.
- Develop CALD specific lived experience roles in mental health services and ensure these are part of how services engage with communities and people accessing services.
- Ensure that CALD lived experience is embedded at all levels of the organisations working in the mental health space.

5.4. Training and Education

Stakeholders highlighted the benefit of a range of training and education activities both within the mental health service system and outside of the system. The actions are summarised below.

5.4.1. Across the board

- Establish national training which focusses on knowledge and skill development in how to engage with the complex issue of racism

5.4.2. Clinicians and service providers in (mental health) service settings

- Develop and implement national cultural competency training for all clinicians and service providers, including understanding how to work with different CALD communities, and what the mental health experience looks like in each community
- Develop and roll out national training on trauma informed service delivery, and how to develop and implement trauma sensitive service settings.

5.4.3. Interpreters and Translators

- Establish mandatory national training for (mental health) workers on using interpreters
- Establish processes that allow opportunities for interpreters to debrief
- Establish mental health literacy training specifically for interpreters. (This may enable Interpreters to take on support roles). This training might focus on:
    - Understanding mental health issues and language and what might be needed in different settings

  - How to translate in appropriate ways

(There is work currently being done in Victoria around training interpreters in mental health which may be suitable to be scaled up nationally)

It is worth noting that stakeholders expressed frustration that this issue has been talked about for many years, with no action taken.

5.4.4. Education of communities

- Develop localised and culturally appropriate education campaigns about mental ill health, trauma, and distress, the benefits of seeking help, and the types of assistance that is available. These campaigns would need to target the community leaders and influencers, as well as the broader community at large.
- Fund psychoeducation classes for new arrivals in mainstream settings such as community health centres, TAFEs, or adult education centres as a means of destigmatizing mental ill health.

5.4.5. Media Training and Guidelines

- Establish a process for working with the media to develop a set of national media guidelines for reporting of mental health issues in CALD populations. (These guidelines could be modelled on the work that has been done on suicide reporting in the media)
- Develop national guidelines on reporting for CALD communities more broadly – not just in relation to mental health issues.
- Establish a process for collaborating with the media to help them report incidents in CALD communities.

5.4.6. Undergraduate Education systems

"not just western models, not just one small module on cultural responsiveness"

- Review current undergraduate health professional training curriculums and establish more holistic training curriculums that incorporate CALD perspectives.
- Establish support mechanisms for people with lived experience who are studying mental health undergraduate courses – to be able to safely bring and use their lived experience expertise to the learning and the work
- Add cultural competence training as a standard within all health professional training

5.5. Actions addressing intersectional issues.

Despite intersectional issues and groups being highlighted – very few of the actions identified specifically address the needs of these groups. This is an identified gap that needs further targeted exploration and consideration.

6. ADVICE AND CONSIDERATIONS AROUND CONSULTATION AND ENGAGEMENT WITH CALD COMMUNITIES.

The following section summarises feedback from stakeholders in relation to consultation and public engagement with CALD communities.

Whilst this section of the report provides detailed information about considerations for consulting with CALD communities, the consultant acknowledges that the Commission must balance the need for an effective consultation process with the realities of the available resources for consultation. The Commission will also need to be clear about the purpose of the consultation at this stage of the draft strategy development process.

It will be important for the Commission to identify a strategy that best builds on the information that has been sourced from the consultation processes to date as well as ensuring that any consultation with grassroots community groups is a meaningful use of their time and input – to avoid perpetuating the sense of “being over consulted with little outcomes”

The issues highlighted below not only provide useful advice in terms of consultation and engagement – but also provide some insight into experiences of stigma and discrimination in CALD populations. (For example, the sense of being “put under the microscope with limited outcomes / action may add to the perception of being discriminated against).

This section covers the following issues:

- Over consultation and lack of action
- Who do you consult with? Whose voices are you hearing?
- How do you consult?

6.1. Over consultation and lack of action

“People are sick of “being put under the microscope” with no actions or change”

“We have been talking about this for over 40 years”

“Not the first time these conversations are happening - important to pay respect to that and how much that takes from an individual/community “

Participants identified experiences of over consultation and lack of action from a range of organisations and government bodies - often being approached as a one off to meet the needs of a report / needs of a provider, with little interest in understanding what the needs of the community might be, and a sense of anger and frustration about how little action has come out of these consultation processes to date.

Additionally, it was suggested that mental health may not a priority for some communities and that consultation should be led by the needs and priorities of the community, not driven by the agenda of the people consulting.

“Reciprocal dialogue is essential so that it is not just about getting answers that we want”

The Commission will need to consider how it can engage stakeholders in a meaningful way and keep them informed throughout the process of strategy development and implementation, to avoid repeating the experiences of consultations to date.

6.2. Who do you consult with? Whose voices are you hearing?

As highlighted at the beginning of this report, the "CALD" community encapsulates a diverse and multilayered group of people. There are multiple communities within communities, as well as multiple voices within the CALD and Lived Experience space.

These complexities need to be acknowledged and taken into consideration in planning any consultation/ engagement process.

Issues to consider in planning a consultation process include:

1. *People with mental ill-health are often the least vocal in the community* - The consultation process will need to address how the views of this group of people are added into the thinking and consultation for the draft strategy. It is possible that this may be best done through trusted community brokers or processes which are already established in the community.

2. *Danger that organisations are seen as the representatives of the community – they are not!* Stakeholders advised that whilst it may be important to go through existing organisations - it is important to connect with the actual people, and that consultation shouldn't end with the peak bodies.

3. *There is often a disconnect between the **formal** leaders and the people in the community* -It is important to consult with broader community - not just community leaders given that formal leaders may not always adequately understand or reflect the needs and voices of the community.

4. *Different levels of privilege within communities.* There is Stigma and Discrimination within the community itself and often it is the more privileged members of the community whose voices are heard in consultation processes.

5. *Males are often the official representatives of the community / community leaders.* This results in much of the feedback being heavily gendered, with a lack of representation of female voices. This is further compounded by the point below – as carer voices are often female.

6. *Consultation needs to be inclusive of carers / families /broader cultural supporters within the community* - Feedback from stakeholders indicates that the voice of carers / families /broader cultural supporters is critically important – and is often left out of the conversation and the consultation process. Family and broader cultural supports play a critical role in supporting people with lived experience of mental health issues, trauma, and distress in CALD communities – and may often be the only supports available.

7. *Don't use the approach of the "top 10 languages"* Consultation processes often use the approach of the "top 10 languages" to identify who to consult with from CALD communities. Stakeholders report that communities with greater needs may often miss out when this approach is utilised (may be smaller communities with higher levels of trauma, challenges, more isolated, less support etc.)

8. *Hard to reach / marginalised groups within the community often go unheard in consultation processes.* Stakeholders identified a few groups whose voices are often not centred in the consultation process and resulting outcomes/strategies. These include young people, older people and older carers, people who don't speak English/don't have good literacy skills, people with disabilities, and people from the LGBTIQA+ community.

9. *Don't limit consultation to only get English speaking people.* Stakeholders highlighted the limitations of only consulting with English speaking people and suggested that this approach

would result in significant gaps in understanding. It was also highlighted that people who can speak English are often the gatekeepers of the community and may present information that:

- represents a personal agenda
- protects against anything that might lead to stereotyping or discrimination against their community

6.3. How do you consult?

The following section summarises feedback in relation to successful approaches to consultation and engagement.

6.3.1. Engaging communities for public consultation

Stakeholders highlighted that engagement with CALD communities is a slower process and that people are unlikely to be honest to people who are total strangers. The lack of trust in services and the government, which has been highlighted earlier in the report, is also important to consider in terms of how consultation is carried out.

Some of the advice from stakeholders included:

- ***Finding trusted local community representatives*** as an "in" to the community and to (co)facilitate consultations– this may include elders, bicultural workers, enablers and influencers in the community, leadership in the community and community brokers
- ***Consideration of communication and language*** including use of existing channels of communication in communities, using the language of the community to describe concepts such as stigma and discrimination instead of trying to explain mainstream and medical concepts that may not work for them
- ***Take a community development approach*** including considering what else is happening within communities, ensuring the actions meet the needs of community and relate to their experience, focussing on what the community itself wants and needs.
- ***Consider how to dovetail/piggy-back*** your consultation onto what else is happening in the community such as other initiatives, events, education sessions etc.

6.3.2. Utilising an approach that incorporates Online and Face to face consultation

Whilst stakeholders highlighted the importance of going to the community and conducting face to face consultations and targeted face to face meetings, they also suggested that online approaches would be a useful way to supplement the face-to-face consultations, especially as this might engage rural and regional communities more effectively and allow more opportunities to participate by making the process more accessible. (Note that one stakeholder expressed strong views that online engagement of people in this space does not work and advised against online consultation).

Another identified advantage of online approaches is that due to their anonymous nature, they may offer an opportunity for feedback which may not be provided as easily in a public forum due to concerns about how it may be viewed by the community members present.

It should be noted that unless translated into multiple languages / conducted with interpreters, online surveys and consultations will centre the voices of people from CALD communities who speak English, therefore skewing the feedback.

It was agreed that a combination of methods was required - online forums, surveys, as well as face to face engagement were all seen as important, with some stakeholders expressing the view that it was best to target face to face consultation and resources to grassroots levels.

6.3.3. Stages of consultation

"Don't just speak to them and end the conversation once you have information for the strategy"

Stakeholders highlighted the importance of consultation being part of a considered, staged, and ongoing process.

Advice in relation to the stages of consultation includes:

Pre-Consultation – Provide appropriate information to communities prior to the consultation. This includes considering what information is going out to support people to understand consultation concepts such as stigma; understanding privacy and consent and understanding how the information is going to be used and managed. Stakeholders also identified the need to break down the information so its accessible - plain English, broken down so easily understood.

Post consultation – It is Important that there is a clear process for feedback going back to communities post the consultation. This may include feedback about the next steps, sharing early thinking, and providing access to final reports and recommendations.

6.3.4. Other Practical Resourcing considerations

Stakeholders stressed that:

- People must be compensated for their time and input
- Consultation processes must invest in more opportunities with interpreting / use of bicultural workers to allow broader groups to access the consultation and feedback process
- Providing resources such as travel costs to get to places where consultation is held. If this is not adequate - this can limit engagement with consultation.

6.3.5. Models for consultation

The Settlement Council of Australia has identified a successful model of consultation that they have used to engage communities from CALD backgrounds. Whilst it was not possible to obtain details of this model during the stakeholder consultation timeline, this may be a helpful model to explore further.

6.3.6. Pathways to assist with the draft strategy consultation process.

Stakeholders were asked to identify the best pathways for engaging people, communities, and service providers for consultation on the draft strategy. The following table summarises feedback from the Roundtable about the organisations that have lead roles within the sector and the pathways they have into CALD communities.

It is anticipated that these identified pathways will require further exploration to understand the best approach to meet the purpose and required outcomes of the draft consultation process

Organisation	Potential Pathways
Embrace Multicultural Mental Health Project	***FECCA, NEDA, MHA*** ***Lived experience group(federated)*** ***Stakeholder group*** ***Embrace Governance Structure***
Settlement Council of Australia (SCOA)	***Access to lots of different groups - will require further consideration***
STARTTS	***Will require further consideration***
Wellways	***Will require further consideration***
Centre for Multicultural Youth	***Young people*** ***Paid - Peer-to-peer, peer consultants, evaluators, researchers***
Lead organisation within the sector	***Tender out the consultation to an organisation who is well trusted in this space - and can garner grass roots participation, demonstrate nuanced understanding, and cross-sectional reach***

Identified Target groups for consultation include:

- Carers, including young carers
- Bicultural workers
- geographical areas where (youth) suicide rates are high
- Consultation with the collective- community carers and supports
- Community leaders
- Grass roots community members
- Social influencers
- Rural/regional areas
- Leadership within communities - e.g. Both secular and religious leadership in the Jewish community

6.3.7. How this consultation informs other pieces of work

Stakeholders highlighted the need to ensure that any information and feedback gained from this consultation process is used to inform the approach to other pieces of consultation by the Commission in relation to CALD communities, and that it must also link to other pieces of work currently happening such as the National Anti-Racism Strategy.

7. SUGGESTED FURTHER ACTIONS

Whilst the consultation process to date has provided useful feedback, it has also highlighted several gaps which may benefit from further exploration. The limited time available for consultation has also meant that some key stakeholders were also not able to be part of this process.

This is a complex and multi-layered space that encompasses a very diverse group of people, experiences, and intersectionality.

It would be useful to consider further opportunities for facilitated conversations with stakeholders (including those that have not yet been able to contribute to the discussion) to:

- Sense check feedback to date
- Further explore gaps in knowledge including:
    - Successful programs, actions, and strategies in this space that may be suitable for scaling up
    - Actions and levers for change in relation to intersectional issues including racism, family violence, LGBTIQA+, young people and older people.
    - Actions and levers for change in relation to carers
- Further refine the approach to public consultation and explore models for consultation in the CALD space

8. APPENDICES

8.1. Appendix 1 - Areas of Good Practice that may require further exploration

These are pieces of work, models and reviews which were mentioned during the consultation process which may be useful to explore further as potential case studies for the Strategy:

- Let's Talk About Mental Health **–** Foundation House – CHIN community advisors and workers – development of a panel in haka chin – good engagement due to the people who are respected within the community being included
- our culture our health – bilingual health education officers – 4 sessions mental health literacy – mandarin speaking Chinese women – aim to build mental health literacy in the Chinese community
- Reverb Project – CMY – evaluated through ACIL ALLEN
- Settlement Council of Australia – models for consultation
- Embrace Project, Mental Health Australia - Focus on service delivery, and the service delivery workforce
- MYAN pilot project.

The following reviews were also mentioned during stakeholder consultations and may assist in informing the Strategy:

- The Interpreter Services review
- The National Anti-racism strategy
- The Royal Commission into Victoria's Mental Health System.