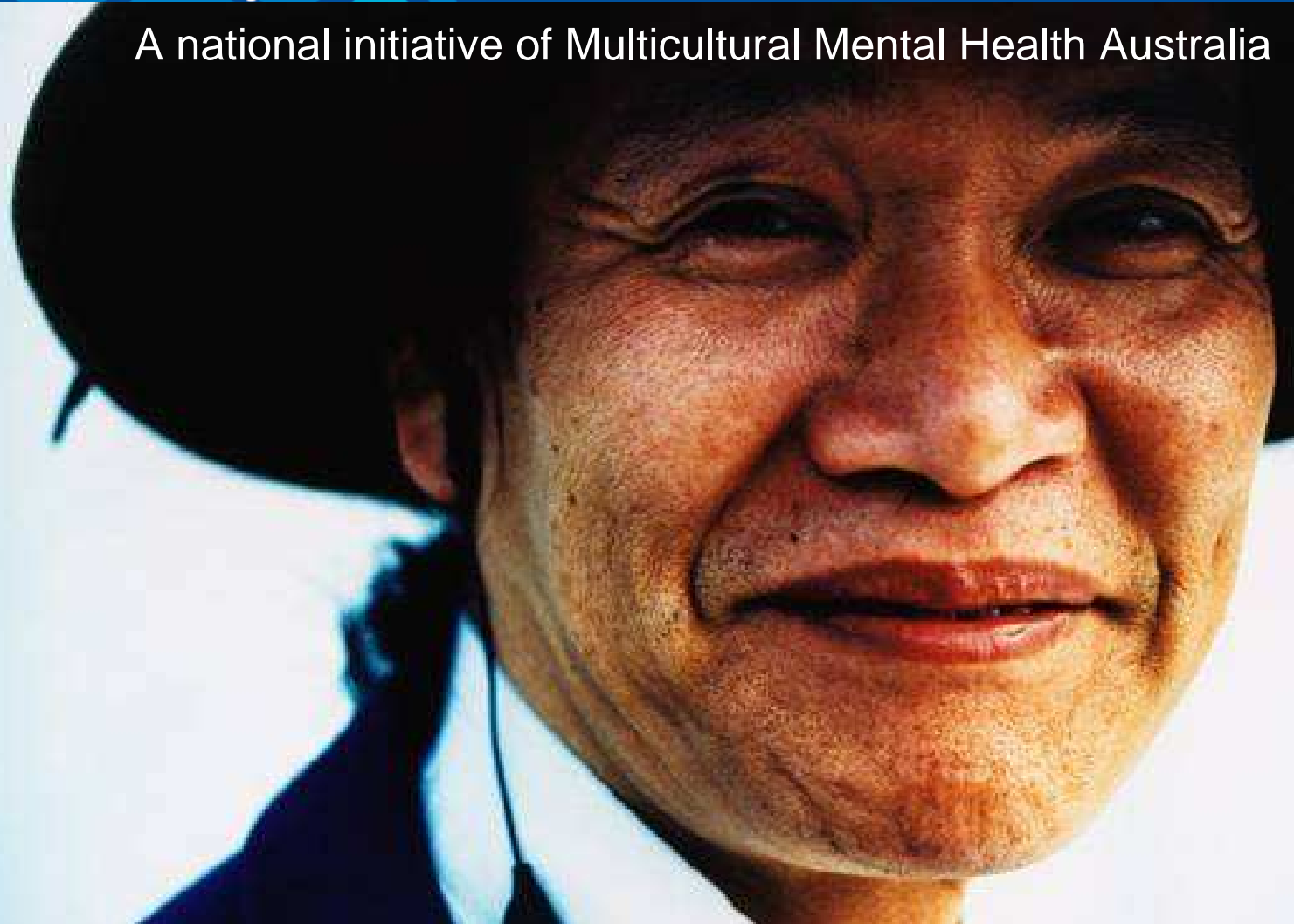# Stepping Out of the Shadows
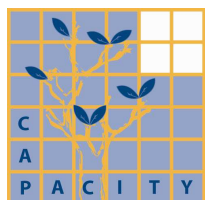
Reducing Stigma in Multicultural Communities

A national initiative of Multicultural Mental Health Australia

Project Report

June 2010

national mental health strategy

CAPACITY

multicultural MENTAL HEALTH AUSTRALIA

Multicultural Mental Health Australia

Multicultural Mental Health Australia (MMHA) actively promotes the mental health and well-being of Australia's diverse communities and seeks to improve access, responsiveness and quality of mental health services for these communities. It achieves this through partnerships with the Australian mental health sector, transcultural mental health and refugee services and networks, federal, state and territory governments as well as the community.

Multicultural Mental Health Australia is funded to provide national leadership in transcultural mental health under the National Mental Health Strategy and National Suicide Prevention Strategy of the Commonwealth Department of Health and Ageing.

Multicultural Mental Health Australia's Priority Areas	
Priority Area 1	Policy advice, development and implementation
Priority Area 2	Community capacity building and development
Priority Area 3	Communication, education & information dissemination
Priority Area 4	CALD carer & consumer support & representation
Priority Area 5	Workforce development

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CONTENTS

APPENDICES

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4/46

INTRODUCTION

Stigma creates barriers to seeking help, early detection and negatively affects upon recovery rates and prognosis. It also isolates individuals and their families and reduces their capacity to participate in their communities and the broader society in meaningful and satisfying ways.

Although stigma about mental health and illness exists in all cultures around the world, people from culturally and linguistically diverse (CALD) communities who experience mental health issues/illness face a double disadvantage. This means increased discrimination because someone has a mental illness *and* belongs to an ethnic community. This may result in those people having even less contact with and knowledge of the services and networks that are available for them.

Multicultural Mental Health Australia's *Stepping Out of the Shadows: Reducing Stigma in Multicultural Communities* is a national training package that has been especially designed to reduce stigma in communities from CALD backgrounds as:

- There is a lack of mental health promotion that is meaningful to people from CALD communities; and

- People from CALD backgrounds tend not to access mainstream mental health services as much as people from mainstream Australia do.

The national training package is supported by the state and territory departments of Health and Human Services, and the Australian Government's Department of Health and Ageing.

The package aims to reduce the negative impact of stigma on CALD communities by exploring how individuals and communities can deal with stigma and mental health issues in practical ways. It is highly relevant to CALD communities as it acknowledges and builds on the strengths, traditions, and ways of thinking that exist in their communities.

This report outlines the development and implementation of the project. It also presents the findings and recommendations from a national process evaluation of the project conducted by independent consultants, Cultural Perspectives.

ACKNOWLEDGEMENTS

The development and implementation of the Stepping Out of the Shadows Stigma Reduction Project has only been possible due to the contribution and commitment of many whose efforts are making a difference for individuals and their families from CALD backgrounds who are impacted by mental illness.

Multicultural Mental Health Australia would like to acknowledge and thank the following agencies, government departments and individuals for their contribution and commitment:

- The Australian Government Department of Health and Ageing - for providing funds for the development of the project and with guidance on project implementation via the MMHA Joint Officers Group.

- The following MMHA Joint Officers Group members for their support and guidance:

    a. Australian Capital Territory Department of Health – Mental Health Branch

    b. New South Wales Department of Health – Mental Health and Drug and Alcohol Office

    c. Northern Territory Department of Health and Families – Mental Health Branch

    d. Queensland Health – Mental Health Branch

    e. South Australian Department of Health – Mental Health Branch

    f. Tasmanian Department of Health and Human Services – Mental Health Branch

    g. Victorian Department of Health – Mental Health Branch

    h. Western Australian Mental Health Commission

    i. Federation of Ethnic Communities Councils of Australia

    j. Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs

    k. MMHA National Consumer and Carer Reference Groups representatives

- The Queensland Transcultural Mental Health Centre for partnering with MMHA to develop community education package

- The Consumer and Carer Lead Trainers

- Bernadette Wright (WA Transcultural Mental Health Services) and Rajiv Ramanathan (Multicultural Mental Health Australia) as Lead Trainers

- MMHA would also like to extend thanks to the following services who participated in the project:

ACT	Multicultural Youth Service Migrant and Refugee Settlement Services ACT Mental Health Community Coalition ACT Women's Centre for Health Matters Carers ACT Individual consumer volunteer
NSW	Fairfield Community Mental health (Sydney South West Area Health Service) Multicultural Health Unit (South West Area Health Service) Multicultural Health Unit – Western Zone (Sydney South West Area Health Service) Greater Southern Area Health Service Bondi Community Health (South East Illawarra Area Health Service) Multicultural Health Unit (Hunter New England Area Health Service) New South Wales Transcultural Mental Health Centre
NT	Top End Mental Health Service Headspace Top End
SA	Relationships Australia SA Migrant Resource Centre SA African Communities Council SA Country Health SA – Mental Health (Pt Augusta) Survivors of Torture and Trauma Assistance and Rehabilitation Service Child and Adolescent Mental Health Service (Port Adelaide) African Women's Federation/ Australian Refugee Association
TAS	Migrant Resource Centre (Southern Tasmania) Aspire mental health Service Phoenix Centre for survivors of torture and trauma
VIC	Mental Illness Fellowship VIC Diversitat The Victorian Foundation for Survivors of Torture ADEC Mercy Mental Health Goulburn Valley Area Mental Health Service Norwood Association Multicultural Centre for Women's Health North West Area Mental Health Service
WA	Fremantle Multicultural Centre Univ. of Western Australia – Community, Culture & Mental Health Unit RUAH Community Services MAITRI Mental Health - Multicultural Services Centre WA Association for Services to Torture and Trauma Survivors (ASETTS)

- MMHA would like to especially thank the numerous Community Trainers and Community Leaders, many of whom worked voluntarily, yet with tireless passion to make a difference in their communities.
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8/46

BACKGROUND

Introduction

Mental health problems can affect all Australians, regardless of one's cultural or linguistic background (Stolk, Minas, & Klimidis, 2008). Mental health problems do not discriminate who they impact on. Despite this, getting help for mental health problems is difficult for many Australians, particularly those from culturally and linguistically diverse (CALD) backgrounds.

Figure 1 shows that Australia's population is significantly diverse. The 2006 Census by the Australian Bureau of Statistics identified that almost 44% of Australia's population were born overseas or had at least one parent born overseas. Of those born overseas, 62.1% were born in a non-main English speaking country. The census also identified that 15.8% of the population speak a language other than English at home (ABS, 2006 & DIAC, 2008).

Despite this diversity, not all Australians have equal access to culturally appropriate mental health treatment and care when they need it.

Table 1 - Australia's Diversity	
44%	of Australians were born overseas or have at least one parent born overseas
62.1 %	of those born overseas were born in a Non-English speaking country
15.8%	of Australians speak a language other than English
13.8%	of Australians were born in a Non-English speaking country

CALD communities and mental health treatment

Research[1] has shown that Australians from CALD backgrounds, particularly those born in non-English speaking countries, and who are affected by mental health problems tend to:

- have lower rates of access to community and inpatient mental health services compared with Australian-born people;

- have higher rates of involuntary and lower rates of voluntary admission to mental health services;

- be hospitalised for longer;

- be more likely to present for treatment at the acute, crisis end of a mental illness episode.

Getting help at the acute stage of a mental illness can be very traumatic and can cost individuals and their families their health and wellbeing. It may also delay recovery rates and possibly worsen prognosis. Longer and involuntary hospital stays also increases the costs of care that may have been prevented through early intervention and preventative strategies.

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[1] For ease of reading, references are listed in this footnote: Minas, Lambert, Kostov, & Boranga, 1996; Klimidis et al, 1999; Stolk, Minas, & Klimidis, 2008; Minas, Silove, Kunst, 1993; Sozomenou, Mitchell, Fitzgerald, Malak & Silove, 2000; DOHA, 2004

Barriers to getting help when it is needed

There is a growing body of Australian and international research on the perceptions of CALD users of mental health services and their carers, CALD communities, and mental health staff[2] that tend to attribute the persistence of the previously outlined disparities to the following categories of factors:

- cultural perceptions, beliefs, stigma and knowledge of mental illness, its causes and treatment options (which can influence whether the person decides to seek help for their mental health problems in the first place); and

- cultural responsiveness of services and, more broadly, the mental health system (which can influence the experience people have with the mental health service and whether or not they will return or recommend it to others) .

Strategies to improve access

A literature review (Procter, 2004) on initiatives to improve access, commissioned by the Multicultural Disability Advocacy Association of New South Wales, reviewed academic journals and government reports in the UK, US and Canada and found that approaches to improve access had the following in common:

- Anti-discrimination and equal opportunity legislation that provides rights to residents and citizens and overt public policy that acknowledges the issues of inequality, and establishes service obligations and equity targets for publicly funded services;

- Leadership and commitment from management and service staff;

- Targeted and integrated service models, i.e. a combination of targeted strategies to ethnic communities as well as mainstream integrated services. This includes having different strategies for new and emerging communities vis-à-vis more established communities;

- Cultural competence training; and

- Allocation of resources and time to community education and community development strategies that build relationships and networks with ethnic communities and leaders which, in turn, helps to strengthen community knowledge of the health issues, address stigma within those communities and build referral and advocacy pathways.

Multicultural Mental Health Australia's role

Multicultural Mental Health Australia (MMHA) works in partnership with government departments, mental health services, consumers and carers and the community to address the previously outlined disparities. Specifically, MMHA focuses on five priority areas to improve the capacity of mental health systems to address the mental health needs of a diverse Australia and to reduce stigma and build the capacity of consumers, carers and communities from CALD backgrounds to support each other to meaningfully participate and address mental health problems within their communities. These priority areas are discussed in Table 2 overleaf.

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[2] For ease of reading the references are listed in this footnote: Minas, Stuart & Klimidis, 1994; Rooney, O'Neil, Bakshi, & Tan-Quigley, 1997; Bower, 1998; Khalidi & Challenger, 1998; Fan 1999; Collins, Stolk, Saunders, Garlick, Stankovska, & Lynagh, 2002; Carers Victoria, 2003; MMHA 2004; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005; Kokanovic, Petersen, & Klimidis, 2006; and Rooney, Wright, & O'Neil, 2006; Alvidrez, 1999; The Sainsbury Centre for Mental Health, 2002; and Scheppers, Dongen, Dekker, Geertzen & Dekker, 2006

Table 2 - Multicultural Mental Health Australia's Priority Areas	
Changing systems, reducing stigma and building capacity	
Priority Area 1 Policy advice, development and implementation	▪ MMHA works in partnership with various state, territory and commonwealth government departments to address systemic issues within Australia's mental health system that affect the mental health outcomes of Australia's diverse population. This is done through convening forums for government mental health departments, consumer and carer representatives and peak multicultural agency representatives and through participation in various government and sector policy and planning forums. ▪ MMHA also holds policy consultations across the country, especially in those states and territories with limited transcultural mental health services and options. ▪ MMHA also assists with policy development through submissions to various government and departmental inquiries and reviews.
Priority Area 2 Community capacity building and development	▪ The *MMHA Stepping Out of the Shadows Stigma Reduction Project* is a key initiative of this priority area. This project focuses on developing the capacity of communities to address the stigma associated with mental illness through community education and development. It also assists participating agencies to build relationships with CALD communities within their catchment areas. ▪ MMHA is also working with partner agencies to identify strategies and resources to inform communities about suicide and suicide-prevention models for CALD communities.
Priority Area 3 Communication, education & information dissemination	▪ This priority area employs various promotional and educational strategies including engaging ethnic and mainstream media to highlight the issues faced by CALD consumers, carers and communities affected by mental illness with the aim of reducing stigma. ▪ It also builds the capacity of consumers and carers from CALD backgrounds to reduce stigma by training consumers and carers to present their stories to the public through the media other forums. ▪ Various multilingual resources and tools have been produced by MMHA, in partnership with government departments and non-government agencies, to increase the mental health literacy of communities from CALD backgrounds. These fact sheets are also used as a part of Priority Area 2's community capacity building initiatives.
Priority Area 4 CALD consumer & carer support & representation	▪ The consumer and carer priority area aims to build the capacity of consumers and cares from CALD backgrounds to meaningfully participate in national and state-based mental health policy forums through the development of national and state-based CALD consumer and carer reference and support groups. ▪ Another key activity of this area is to reduce stigma about mental illness in CALD communities by training and supporting CALD consumers and carers to participate and share their stories in the mainstream and ethnic media through the MMHA Speakers Bureau.
Priority Area 5 Workforce development	▪ This priority area is responsible for assisting the Australian mental health workforce to improve the quality of services to consumer and carers from CALD backgrounds. ▪ A major initiative of this priority area is the development of a National Cultural Competency Tool that is aligned with the newly revised National Standards for Mental Health Services. The tool assists mental health services to improve their capacity to work cross culturally.

Reducing Stigma

While MMHA is involved in a number of initiatives aimed at reducing mental health disparities for CALD communities, the focus of the MMHA Stepping Out of the Shadows project is to address mental health disparities by reducing stigma, building supportive communities and encouraging help-seeking behaviours.

The literature[3] on the impact of stigma in communities from CALD communities suggests that:

- Reducing stigma is an important part of improving mental health disparities as it can determine whether or not a person from a CALD backgrounds seeks help for mental health problems.

- Stigma can create barriers to seeking help, early detection and can negatively affect recovery rates and prognosis.

- Stigma isolates individuals and their families and reduces their capacity to participate in their communities and the broader society in meaningful and satisfying ways.

- There is a lack of mental health promotion initiatives that is meaningful to people from CALD backgrounds.

Thus the focus of MMHA Stepping Out of the Shadows stigma reduction initiative is to reduce stigma by harnessing the strengths and building the capacity of communities from CALD backgrounds to deal with stigma. This project falls under Priority Area 2 (*Community Capacity Building and development*) and is part of a suite of MMHA initiatives that aim to reduce stigma, such as those under Priority Area 3 (*Communication, Education & Information Dissemination*) and Priority Area 4 (*CALD Consumer & Carer Support & Representation*).

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[3] An extensive literature review on stigma and CALD populations was conducted as part of the development of the training package and is provided in the appendix.

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12/46

PROJECT DEVELOPMENT

Introduction

The development of the project began in 2008 when MMHA worked in partnership with the Queensland Transcultural Mental Health Centre to develop a Train-the-Trainer package that was piloted with community trainers and further refined. The pilot project process also included:

- A literature review, including a review of current academic theory and adult learning principles;

- Consultations with CALD communities; and

- Input from CALD consumer and carer representatives and key workers in the transcultural mental health sector.

Following the pilot project a Train-the-Trainer package was developed with Expert and Community Trainer manuals and a CD of fact sheets and a DVD in multiple languages.
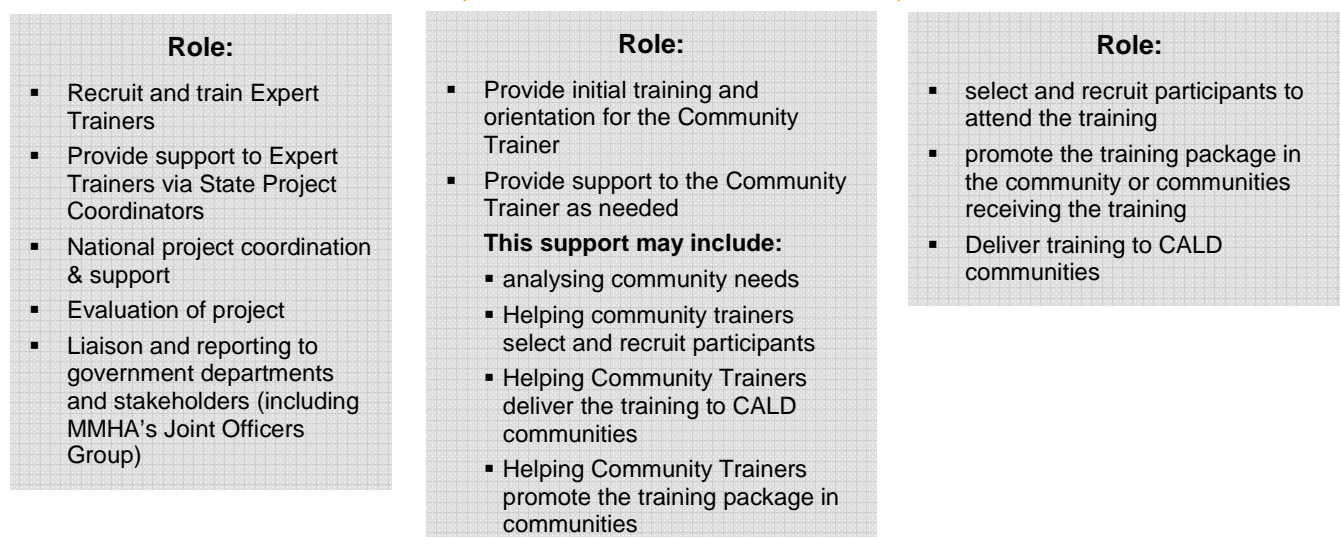
Training methodology

The training package is based on adult learning principles and is participant-centred. This allows participants' existing knowledge, explanatory models and cultural perspectives to create the foundation and framework of the sessions. This results in the training becoming aligned with, and relevant to, the different cultural frameworks of the individual groups.

The sessions and activities were designed to elicit the participants' knowledge and framework and to then respond to it by building on it through consolidating it or filling in gaps and challenging misunderstood concepts.

It is also based on community development principles that aim to build the capacity and empower communities to address the issue of stigma in meaningful and culturally appropriate ways. The model relies on MMHA training Expert Trainers who then go on to train and support bicultural/bilingual Community Trainers to deliver the education package to CALD communities (see figure 1 below for the Train-the-Trainer model used by this project).

Figure 1 – Train-the-Trainer model

MMHA (LEAD TRAINER) ● ● ● ➤ **EXPERT TRAINER** ● ● ● ➤ **COMMUNITY TRAINER**

Role:	Role:	Role:
- Recruit and train Expert Trainers - Provide support to Expert Trainers via State Project Coordinators - National project coordination & support - Evaluation of project - Liaison and reporting to government departments and stakeholders (including MMHA's Joint Officers Group)	- Provide initial training and orientation for the Community Trainer - Provide support to the Community Trainer as needed **This support may include:** - analysing community needs - Helping community trainers select and recruit participants - Helping Community Trainers deliver the training to CALD communities - Helping Community Trainers promote the training package in communities	- select and recruit participants to attend the training - promote the training package in the community or communities receiving the training - Deliver training to CALD communities

Content of the Training Package

(i) Trainer manuals and resources

The package consists of an Expert Trainer Manual, a Community Trainer Manual, an accompanying DVD (dubbed in 17 Languages) and a CD with fact sheets on mental health topics (available in 16 languages) (see figure 2 below). Other translated fact sheets were also available on the Multicultural Mental Health Australia website.

(ii) Community training content

The Community Trainer Manual includes 4 community sessions that:

1. **Explores how stigma is constructed and its impact** – This establishes the participants' understanding of stigma, including how it is constructed in their community and culture and how it impacts on individuals, families and communities;

2. **Examines the risk and protective factors** of mental health and mental illness and considers treatment options and preferences;

3. **Develops a rationale for reducing stigma** – this explores how stigma impacts on one's identity, help-seeking, treatment, recovery and maintenance and explores meaningful and practical strategies that can be used to cope with and reduce stigma;

4. **Develops individual goals aimed at reducing stigma** – this identifies strategies and an action plan that participants can use to reduce stigma within their circles of influence after completion of the course.

(iii) Session duration and adaptability

Each of the 4 sessions lasts for approximately 2 and ½ hours and has a range of interactive activities that aim to change attitudes. The sessions are flexible enough to be combined, reduced or extended depending on the participants' experiences, knowledge and training needs whilst still maintaining the core content. MMHA also developed guidelines on how to abbreviate the sessions to suit the communities' needs without losing the core messages of the package.

Figure 2 - Expert & Community Trainer Manuals, CD of multilingual factsheets, & multilingual DVD of family scenario
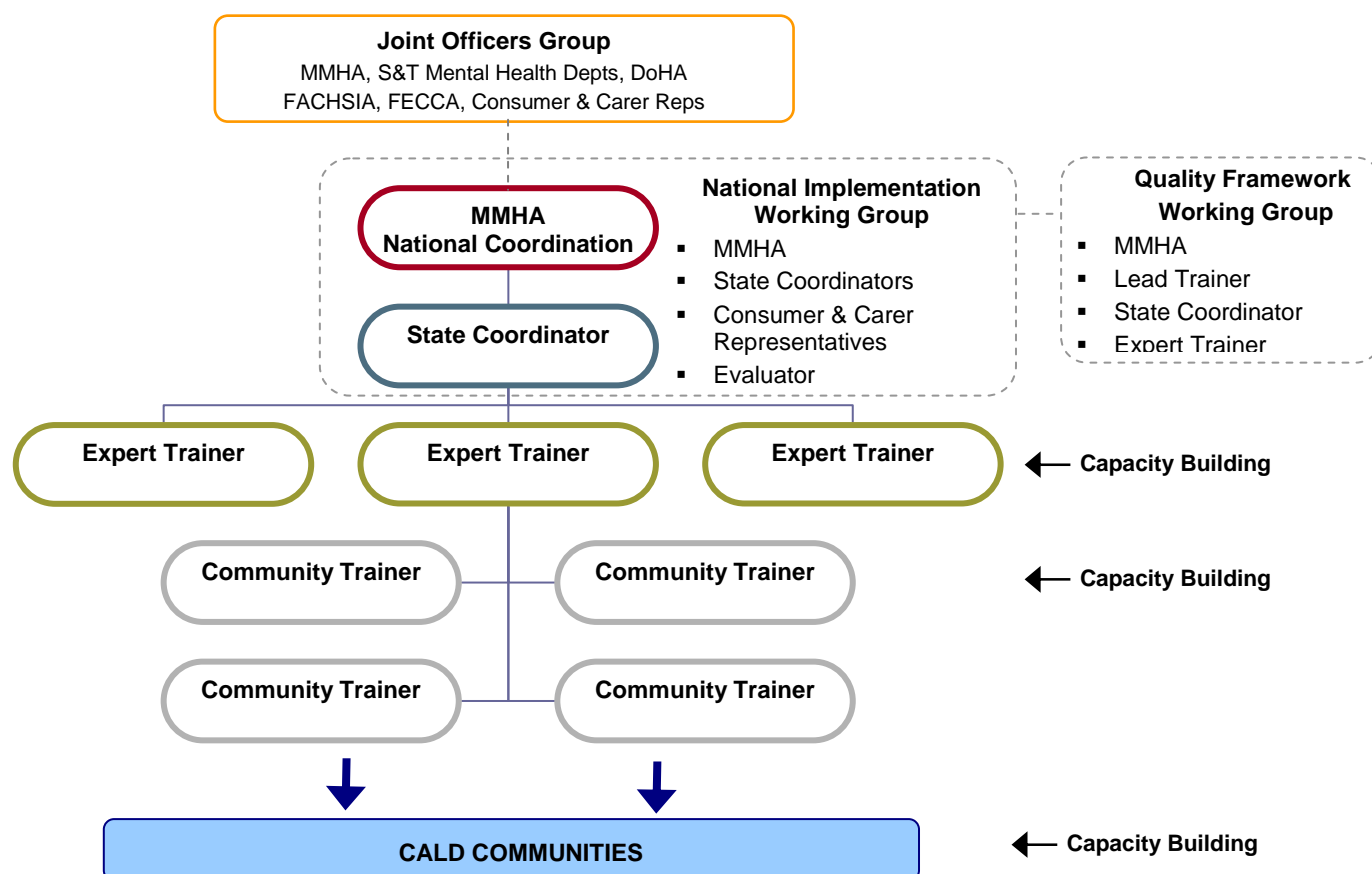
NATIONAL IMPLEMENTATION FRAMEWORK

Introduction

An important principle of the project was to build the capacity of agencies across the country to build relationships with CALD communities and to assist those communities to reduce stigma. To do this, MMHA, as a "Lead Trainer", recruited and trained agencies across the country to become Expert Trainers. As previously stated, Expert Trainers were then expected to recruit and train Community Trainers who would then implement the community education package directly with CALD communities. While implementation funding was not initially identified, the project success relied heavily on the goodwill of agencies to participate in the project voluntarily.

To support and guide the implementation of the project, MMHA developed new project infrastructures, such as a National Implementation Working Group and a Quality Framework Working Group.

MMHA also sought guidance and feedback from State and Territory Mental Health Departments,   the Commonwealth Department of Health and Ageing (DoHA), the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaCHSIA), the Federation of Ethnic Communities Councils of Australia (FECCA), and consumer and carer representatives. This was done through the MMHA's Joint Officers Group. The National Implementation Framework is visually represented in figure 3 below and is discussed in more detail later.

Figure 3 – National Implementation Framework

Joint Officers Group
MMHA, S&T Mental Health Depts, DoHA
FACHSIA, FECCA, Consumer & Carer Reps

MMHA National Coordination

State Coordinator

National Implementation Working Group
- MMHA
- State Coordinators
- Consumer & Carer Representatives
- Evaluator

Quality Framework Working Group
- MMHA
- Lead Trainer
- State Coordinator
- Expert Trainer

Expert Trainer

Expert Trainer

Expert Trainer

← **Capacity Building**

Community Trainer

Community Trainer

← **Capacity Building**

Community Trainer

Community Trainer

CALD COMMUNITIES

← **Capacity Building**

Agencies trained by MMHA

Between June and August 2009 MMHA trained 43 individuals from 38 agencies across the country to become Expert Trainers (see Table 3 below), with a focus on states and territories that had not received allocated funding for the project (ACT, NSW, NT, SA, TAS, VIC, and WA). The Queensland Transcultural Mental Health Centre had received funding for the implementation of the project in Queensland and therefore managed a separate implementation of a version of the project in Queensland. MMHA trained large numbers of Expert Trainers assuming that some Expert Trainers would be lost over the course of the project due to natural attrition.

Table 3 - Agencies trained by MMHA in the Stigma Reduction Package (Jun to Aug 2009)	
ACT	Multicultural Youth Service Migrant and Refugee Settlement Services ACT Women's Centre for Health Matters Carers ACT Individual consumer volunteer
NSW	Fairfield Community Mental health (Sydney South West Area Health Service) Multicultural Health Unit (South West Area Health Service) Multicultural Health Unit – Western Zone (Sydney South West Area Health Service) Greater Southern Area Health Service Bondi Community Health (South East Illawarra Area Health Service) Multicultural Health Unit (Hunter New England Area Health Service) New South Wales Transcultural Mental Health Centre
NT	Top End Mental Health Service Headspace Top End
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TAS	Migrant Resource Centre (Southern Tasmania) Aspire mental health Service Phoenix Centre for survivors of torture and trauma
VIC	Mental Illness Fellowship VIC Diversitat The Victorian Foundation for Survivors of Torture ADEC Mercy Mental Health Goulburn Valley Area Mental Health Service Norwood Association Multicultural Centre for Women's Health North West Area Mental Health Service
WA	Fremantle Multicultural Centre Univ. of Western Australia – Community, Culture & Mental Health Unit RUAH Community Services MAITRI Mental Health - Multicultural Services Centre WA Association for Services to Torture and Trauma Survivors (ASETTS)

State & Territory Project Coordinators

Maintaining and monitoring project quality was difficult because MMHA is not able to fund agencies to implementthe stigma reduction education project, making it dependent on voluntary participation. However, one way of monitoring the quality of program implementation was to have an agency take on a project coordination role at the state level. Consequently, MMHA worked with State and Territory Mental Health Departments to identify suitable state implementation frameworks, including potential State Coordination bodies. The various State & Territory Project Coordinators also provided the following practical support:

- Coordinating state project network meetings.

- Assistance with ideas on how to engage with the various communities in their catchments

- Assistance with preparing and providing training for the Community Trainers

- Community mapping to identify potential gaps

- Liaising with MMHA to provide practical on-the-ground support for the project. This includes facilitating communication between MMHA and the state's Expert Trainers and the various state and territory Departments of Health.

- Coordination of data collection and evaluation at the state level

- Coordinating distribution of resources for the project.

Most states have a state coordination role (see Table 4 below). In some instances these have been funded by the respective state or territory Department of Health. In others, agencies undertook the role on a voluntary capacity until suitable funding was identified or undertook the role as part of other funding arrangements.

Table 4 - State coordination roles in each state and territory	
ACT	2 day a week state coordination role funded by ACT health promotion for one year (not mental health) – taken up by MHCCACT
NSW	Incorporated within existing roles within the NSW TMHC - unfunded
NT	Not required as only two people had been trained as ETs
SA	Undertaken by the MRCSA on a voluntary capacity until suitable funding is identified.
TAS	Incorporated by Phoenix Centre into funding for CALD suicide prevention project
VIC	3 day a week position at ADEC, funded by mental health branch, Vic Dept of Health
WA	WA Mental Health Commission (Chair of State Coordination Group)

The development of support structures at the national and state and territory level has been an important enabler for the implementation of the project across various state and territory jurisdictions. State Coordinators usually convened project networks meetings every one to two months along with MMHA attending the meetings to provide

support and feedback. This also assisted with working towards maintaining quality in the implementation of the program. In some cases, prior to an identified State Coordinator, MMHA convened the network meeting.

Apart from attendance at the various network meetings, MMHA also provided ongoing telephone and email support to the various State Coordinators and Expert Trainers and their agencies as needed. This support included identifying relevant resources for the Expert and Community Trainers and providing advice and support with troubleshooting project implementation barriers.

National Implementation Working Group

MMHA created a National Implementation Working Group to guide the implementation and evaluation of the project. The National Implementation Working Group meets quarterly. Membership of the National Implementation Working Group consists of state and territory state coordinators or Expert Trainer representatives (where there is no state coordinator) and consumer and carer representatives. The National Implementation Working Group had the following functions:

1. Provide feedback on implementation progress and issues at the state and territory level.
2. Share successful implementation strategies between states and territories.
3. Achieve collaboration and input into program implementation and evaluation.
4. Identify key issues and recommend further action for MMHA, funding bodies, state and territory departments of health and human services and other implementation stakeholders.
5. Support and develop relationships and networks between states and territories.

Quality Framework Working Group

MMHA also set up a sub group from the National Implementation Working Group to help guide the quality improvement initiatives for the project. For example, this working group created a resource document on how to abbreviate the community education package to ensure that the key elements of the package were maintained.

Joint Officers Group

Apart from the National Implementation Working Group, another key strategy to ensure good governance of the project was the MMHA Joint Officers Group. The Group is convened by MMHA and consists of State and Territory Mental Health Departments, the Commonwealth Depart of Health and Ageing (DoHA), the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Federation of Ethnic Communities Councils of Australia (FECCA), and consumer and carer representatives. The Joint Officers Group is a forum to facilitate the implementation of MMHA's priority areas (including assisting with the implementation of projects with national applicability) and prioritise multicultural mental health policy issues. MMHA sought guidance and feedback from this group for the development, implementation and process evaluation of the project.

Consumer and Carer Involvement

Consumers and carers were involved as Lead Trainers to train the Expert Trainers and as members of the National Implementation Working Group to help guide the implementation of the project.

RESOURCE DEVELOPMENT

## Project resource development and clearinghouse function

In addition to the Expert and Community Trainer manuals, MMHA has also developed various resources that aimed to assist the Expert Trainers and their agencies with project implementation. MMHA also provided a clearinghouse function for the project by circulating resources that may have been developed by Expert Trainers or the State Coordinators. See Table 5 for a list of resources that MMHA has developed or circulated. Figure 4 is a sample of the additional resources developed.

Project website

MMHA is currently developing a website (as part of the new MMHA website) that will specifically be for the Expert Trainers and State Coordinators. The Expert Trainers and State Coordinators will have a password that they can use to access project specific resources.

Table 5 - Additional project resources developed or circulated
▪ Community Trainer Flyer
▪ Checklist for training
▪ Community Readiness Model journal article
▪ Community Readiness Summary from LIFE
▪ Expert Trainer training plan
▪ Sample MOU
▪ Sample one day CT training plan
▪ Guidelines for abbreviating the community education package
▪ State Coordination flyer template
▪ Information kit for Community Trainers
▪ Information Kit for Expert Trainers
▪ Application Form for Community Trainers
▪ Powerpoint slides for Expert Trainers
▪ Contact list template
▪ Reporting template
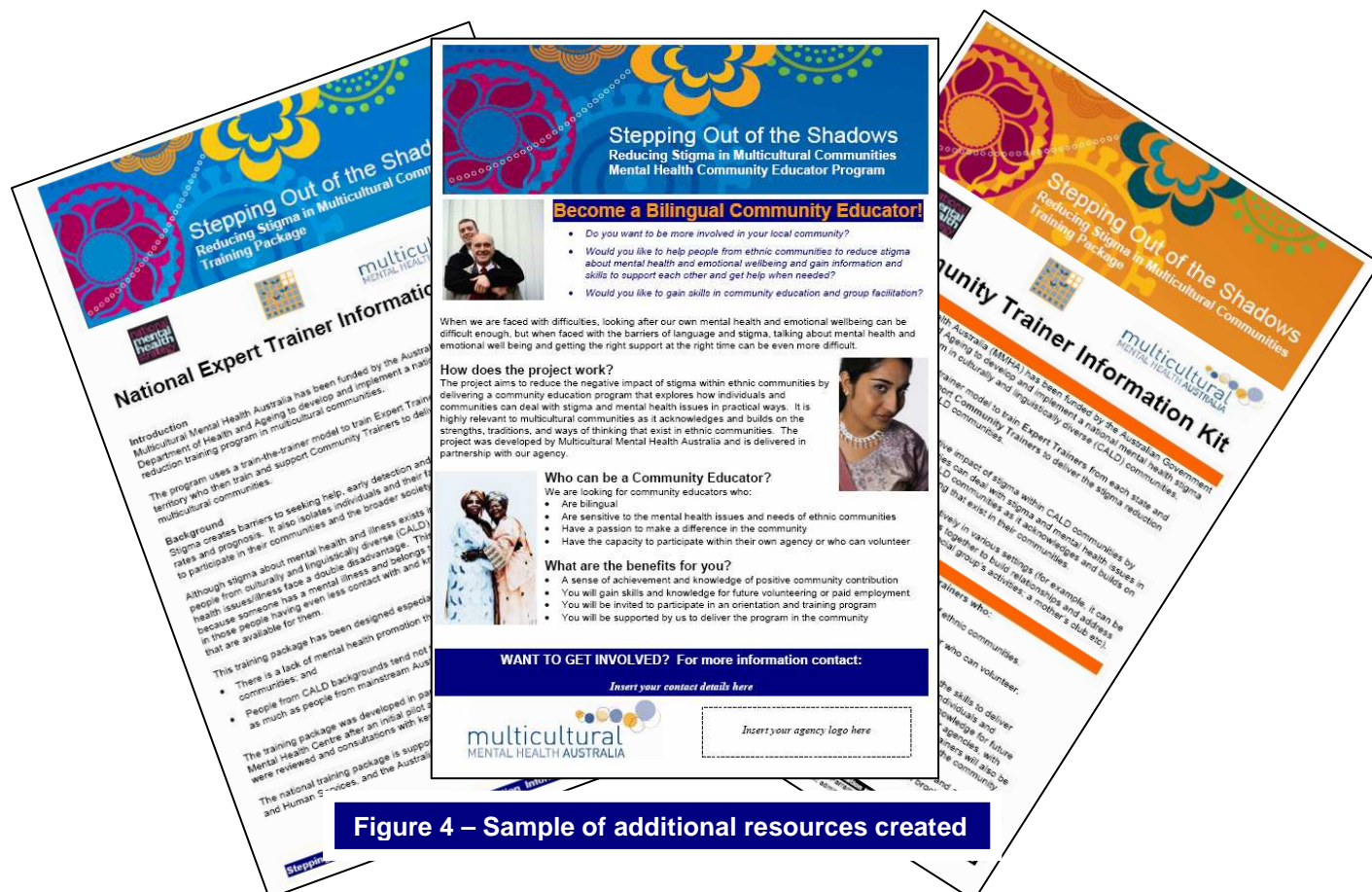
Figure 4 – Sample of additional resources created

PROJECT PROCESS EVALUATION

Introduction

As part of the quality improvement process of the project, MMHA sought to identify areas for further development, improvement and long term sustainability of the Stepping Out of the Shadows project. MMHA therefore engaged an external evaluator, Cultural Perspectives, to conduct a national evaluation of the project. The small number of community education sessions that were conducted during the data gathering period of the evaluation (November 2009 to April 2010) necessitated that the evaluation be process focussed, providing a qualitative assessment of project design and implementation. It sought to identify key issues with the implementation of the project and the content of the community education package. Where community education sessions had been completed, Cultural Perspectives sought to evaluate the outcomes of those community education sessions through secondary sources (the Community Trainers).

Cultural Perspectives reviewed key project documentation and processes and interviewed key project stakeholders including Community Trainers, Expert Trainers and their agency management, and the State Project Coordinators. Feedback was also received from State and Territory Mental Health Departments via the MMHA Joint Officers Group.

A detailed report by Cultural Perspectives of the evaluation methodology, findings and recommendations is provided in the appendix. This section of the report summarises the findings and key recommendations made in the attached evaluation report (p.45).
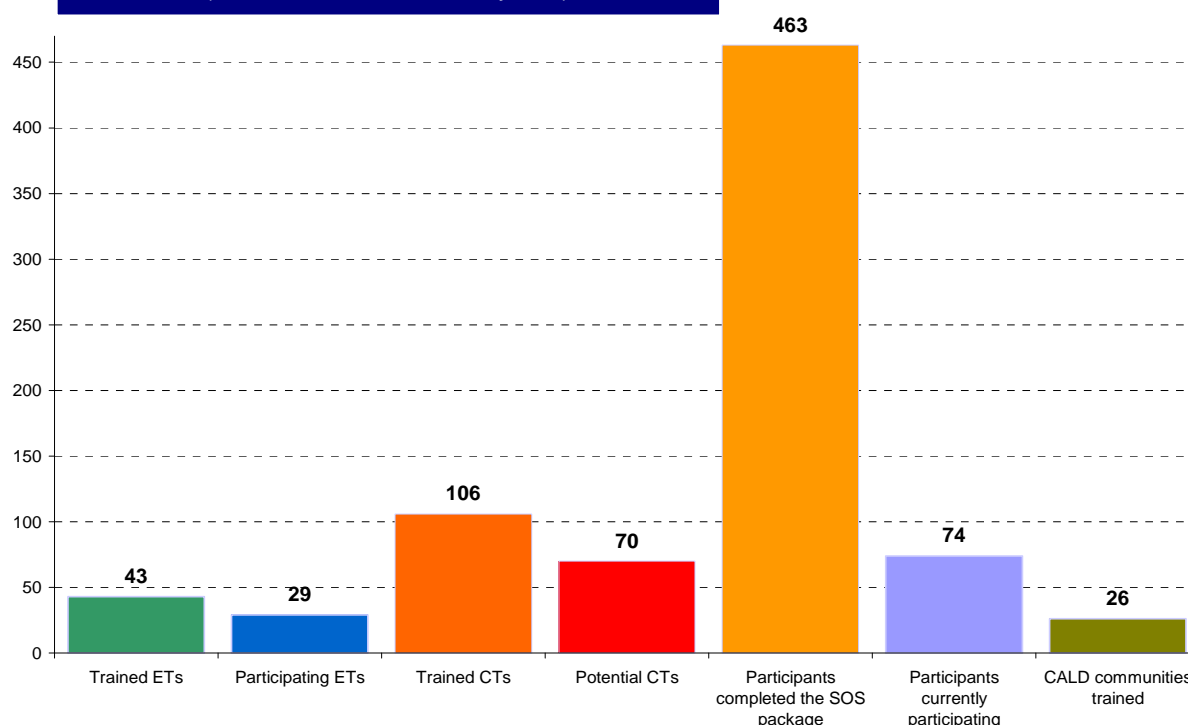
Initial outputs

Since the project began implementation in March 2009, the project engaged a number of stakeholders across Australia. In total 43 individuals from 38 different agencies were initially trained to become Expert Trainers for the project. As at June 2010, there were 29 remaining Expert Trainers with natural attrition being an expected outcome of the Expert Trainer component of the project. It is also important to note that some Expert Trainers withdrew participation due to a lack of capacity to implement the project. This was sometimes due to a lack of agency support which resulted from a lack of identified project implementation funding.

At the time of gathering data (May 2010), 106 Community Trainers had been trained by various Expert Trainers, and a further 70 individuals were either still completing the training program or were identified as potential Community Trainers. As at May 2010, 463 community members from 26 different CALD backgrounds had completed all four sessions of the community education package and a further 74 were still participating.

Again it is important to note that the bulk of the figures for the community participants were from agencies that had identified project implementation funding, in particular, funding for the payment of Community Trainer wages. This enabled those agencies to secure commitment from individuals who took on the Community Trainer role, to invest valuable time in building relationships with the various CALD communities and with following through with training those communities. This issue is highlighted as a priority recommendation within the evaluation as it affects the future sustainability of the project. Figure 5 overleaf presents a summary snapshot of the project outputs based on data collected in May 2010.

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20/46

Figure 5 – Project Statistics Snapshot
(Based on data collected in May 2010)

It should be noted that the statistics only provide concrete measurable data on those who have completed and/or participated in the project, including community participants. It therefore does not include those who may have been reached through flow-on effects from community participants communicating the stigma reduction messages to other family members and friends, nor does it include audiences that were reached through stigma reduction media promotions.

Summary of key findings

This next section summarises the key findings that are articulated in more detail in the attached evaluation report.

(i)   Program investment

The evaluation found that the program was implemented inconsistently across Australia due to varying funding models between states and territories with some not identifying any funding. While many agencies, including their Expert and Community Trainers, have already made significant investments (both in-kind and financially), it was found that the project would not be sustainable without adequate implementation funding.

Some agencies had identified implementation funding, in particular the payment of wages for the Community Trainers. This resulted in those agencies being able to secure commitment from the Community Trainers. This enabled those agencies to roll-out the full community education package. Initial findings indicate that completion of the community education package has resulted in reduced stigma and increased accessibility to mental health services with one service reporting increased referrals to the service from participants who had completed the education program.

(ii)   Training processes & materials

It was found that the communities that had completed the program were relatively newly arrived (within the last five to ten years). Many had low English proficiency and also had low literacy levels in their own language. This meant that some of the training resources – apart from the translated fact sheets – required significant translation while other resources, such as the DVD were identified as significant strengths.

The content of the community education sessions could also be further enhanced with the inclusion of more mental health literacy components such as through partnerships with Mental Health First Aid.

(iii)   Program development

The program could be further developed with greater consumer and carer involvement at all levels of the program, including capitalising on MMHA's Speaker's Bureau. A practical barrier to this however is the high levels of stigma that prevent consumers and carers from CALD backgrounds from speaking out about their personal stories.

A key capacity building principle also included the need to give communities more ownership over the project. This was balanced with the need to ensure that a consistent quality framework was maintained across training sessions. MMHA's guidelines on how to abbreviate the community education sessions helped towards this end, however MMHA needs to investigate improved project communication structures to increase the sense of community feedback and ownership of the project.

The project would also benefit from building on MMHA's existing partnerships with mainstream programs such as Mindframe, Beyonblue, SANE, LIFE and Lifeline and build new partnerships with Mental Health First Aid to increase the capacity of mainstream programs to reach CALD communities.

Another key project enabler is the need for greater support for Expert and Community Trainers from their own agency and from the State Coordinators for further training and development opportunities to enhance their ability to deliver the project objectives. Continuing "professional development" of the project also serves to maintain the quality of service delivery and enthusiasm and focus on the project.

(iv)   Monitoring, reporting and quality improvement

It was found that the evaluation tools provided in the manuals were being under-utilised due to the variety of tools that were available. This caused confusion for some Community Trainers and Expert Trainers in selecting the most appropriate tool. They were also considered too time consuming to undertake. MMHA's feedback from trainers was that this was not seen as priority, particularly when project implementation time is reliant on those volunteering their time to participate.

Reporting and communication could also be further enhanced through the use of web-based communication mechanisms to communicate and share learnings between project partners. As previously reported, MMHA is currently developing a web-portal for project partners to log on and download and/or share resources.

PRIORITY RECOMMENDATIONS

The Evaluation Report identified a series of recommendations to improve the implementation process of the project (see Section 8 of the attached evaluation report for a detailed list of recommendations). The evaluation also found that MMHA needed to address priority areas which were found to be critical to the sustainability and effective future development of the project. These priority recommendations are described below and are cross-referenced to the list of recommendations provided in Section 8 of the attached Evaluation Report:

1. Program Investment

(i) There is a need to develop a sustainable program funding model to facilitate the consistent implementation of the 'Stepping Out of the Shadows' program across Australia. The current reliance on voluntary participation, particularly of the Community Trainer participation, has hindered the consistent implementation of the project. Adequate program investment will help all states and territories to address Priority 1 of the 'Fourth National Mental Health Plan' for CALD communities. (Recommendations: 8, 11, 18)

2. Training Processes

(i) The project needs to increase consumer and carer involvement through: using the MMHA Speakers Bureau and consumer and carer reference groups to access consumers and carers to participate in the program; developing a consumer/carer "real life" stories DVD to use in training at all levels; improving integration of consumer and carer participation into training by targeting consumers and carers to become Expert Trainers and Community Trainers or to participate in training processes. (Recommendations 6, 29,30, 31, 32)

(ii) Develop MMHA-accredited training for Lead Trainers to be located in each state and territory to train future Expert Trainers and provide refresher training for Expert Trainers. (Recommendation 8)

(iii) Provide ongoing training and development opportunities for Community Trainers and Expert Trainers to enhance their skills and knowledge in delivering the program. (Recommendation 9)

3. Training Materials

(i) Revise the Community Training Manual so that it consists of core components and optional modules allowing greater flexibility while maintaining quality control. It is important to maintain and support community "ownership" of training materials as this is a key success factor for implementation. Therefore the project must simplify language in both the Expert and Community Training manuals and promote flexible use of training materials (within guidelines) to match community needs. (Recommendation 16)

(ii) Consider translating key components of the Community Trainer Manual into languages for which a high need has been identified. (Recommendation 19)

(iii) Develop a culturally competent mental health literacy training component in partnership with Mental Health First Aid. Make the Suicide Prevention Module developed in Tasmania widely available as an optional module. MMHA is working

on a national project with Tasmania and Western Australia to develop suicide prevention resources. (Recommendation 15)

(iv) Reduce per unit cost of future manuals by making them available online as PDFs and modifying existing design from a full colour manual to a two-colour manual, reducing any hard copy printing costs by approximately two thirds. (Recommendation 28)

4. Monitoring, Reporting, Quality Improvement

(i) Improve program monitoring and reporting systems to more comprehensively capture relevant program data and feedback and link these into a Continuous Improvement Framework to enhance the measurement and improvement of program implementation. (Recommendation 23, 24, 25, 27)

(ii) Further develop and maintain the password protected portal on the MMHA website for sharing of program information, good practice and resources within and between states and territories. (Recommendation 10)

(iii) Link 'Stepping Out of the Shadows' training to mainstream national training programs by building on existing partnerships with Mindframe, beyondblue, Lifeline and others so that mainstream services can better meet the needs of CALD communities, and address Priority 1 of the Fourth National Mental Health Plan. Link with other existing CALD-specific mental health education programs in order to support mutual capacity building and effectively meet the education needs of people from CALD communities. (Recommendation 33)

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24/46

NEXT STEPS

The MMHA Stepping Out of the Shadows Stigma Reduction project, by reducing stigma and encourage social inclusion and help-seeking behaviours, is an important, practical, step towards addressing mental health disparities for Australians from CALD backgrounds. It is aligned with Priority Area 1 under the Fourth National Mental Health Plan and its policy directive to change community attitudes and reduce stigma and improve the social inclusion of people experiencing mental illness (Commonwealth of Australia, 2009).

The evaluation of the project by Cultural Perspectives found that, where agencies were able to source sufficient funding, appropriate human resources and agency management support, it has demonstrated the ability to reduce stigma. And it has done so by building on and using the strengths that exist within the targeted CALD communities.

Initial outcomes also indicate that this has reduced stigma as a barrier to service access in those communities and has increased the capacity of those communities to initiate and implement community based stigma reduction activities. However, a key barrier to comprehensive national implementation is adequate resources for services and their Community Trainers to dedicate time to implement the project.

MMHA will use the findings of the process evaluation to improve the project's implementation processes including continuing to partner with the Commonwealth and State and Territory Mental Health departments to identify resources for consistent implementation across Australia. MMHA will also seek to conduct an outcomes evaluation of the project.

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27/46

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APPENDICES

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30/46

APPENDIX 1 - LITERATURE REVIEW

EXECUTIVE SUMMARY

The objective of this literature review is to provide an overview of research literature addressing:

- Stigma around mental health issues and mental illness in a cross-cultural context, including definitions, types, levels and sources of stigma.

- Impact of stigma in a cross-cultural context.

- Culturally appropriate and competent approaches to addressing and reducing stigma.

- Mental health literacy in a cross-cultural context and the relation between mental health literacy and stigma.

Key Findings

- Cultural factors are key determinants of mental health and therefore key determinants of the nature and amount of stigma across different culturally and linguistically diverse

- (CALD) communities.

- Cultural factors can contribute to increased stigma and also be protective factors that decrease stigma.

- Stigma manifests on three levels: individual, community and service level and is demonstrated to:

  o be an obstacle to increasing mental health literacy and help seeking

  o be an obstacle to early detection and early intervention

  o promote isolation, marginalisation, discrimination

- Stigma affects individuals with mental health issues/mental illness and extends to all associated family, carers, friends and service providers.

- CALD community members affected by mental health issues/illness experience a 'double disadvantage' and can experience increased stigma leading to increased discrimination, marginalisation and isolation.

- CALD communities generally have low levels of knowledge around mental health issues/illness, are more at risk of developing mental health issues, are less likely to receive needed care than the general population and have a lower rate of participation in health promotion, prevention and treatment programs.

- To be effective, initiatives to reduce stigma must be culturally relevant and competent and must acknowledge and incorporate the diverse cultural range of explanatory models of mental health and illness.

- Increased mental health literacy can contribute to stigma reduction in CALD communities if it is understood in a cross-cultural context and in terms of attitude and knowledge levels.

- Contact between people affected by mental health issues/ mental illness and the general public can contribute to stigma reduction if carried out in a strategic and appropriate manner.

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DEFINING STIGMA IN A TRANSCULTURAL CONTEXT

WESTERN FRAMEWORK DEFINITION

Stigma can be defined within a western framework as "the application of a negative label or mark that distinguishes people in the community (and is) manifested in negative attitudes, behaviours and feelings towards the identified group."[5] The literature supports that stigma results from, and functions within, social constructs and is a "reflection of the way people relate to one another, or the way society relates to a person or group of people." Essentially the process of stigmatisation revolves around exclusion of particular individuals or groups of people from certain types of social interactions (Kurzban and Leary (2001) in Fernando, S. (2006)).

Stigma is not a phenomenon that is exclusive to the mental health arena but stigma specifically associated with mental health has been denoted by Vatz as "an unjust and involuntary labelling process that misconstrues the character and personalities of individuals affected by mental disorder."[16] The literature supports a more comprehensive definition of stigma associated with mental health/illness. For the purposes of this review, stigma is understood as a phenomenon encompassing processes, dynamics and beliefs leading to negative labelling or construction of people associated with mental health, mental illness and suicide. This includes people with mental health issues/illness and extends to their carers, friends, families and service providers and people similarly associated with suicide.[5, 11, 13, 18, 24, 25, 26, 28. 29]

STIGMA IN A CROSS-CULTURAL CONTEXT

As stigma is a socially constructed phenomenon, culture is a key determinant in all its aspects (causes, definition, application and impact). The literature recognises that stigma per se exists across all cultures worldwide however that it is not "fixed, indelible or universal… and is culturally applied."[28] As such, it varies greatly in nature and amount across cultures.[2, 5, 26, 28]

IMPACT OF STIGMA

The literature demonstrates that the impact of stigma in culturally and linguistically diverse communities is serious and far reaching.[1, 5, 6, 13, 14, 24, 25, 28, 29] Some of the literature states that the impact of stigma on a person's life has been as harmful as the effects of mental illness itself.[14, 28] Belonging to a CALD demographic and being affected by mental health issues/illness can result in increased discrimination and marginalisation, or a 'double disadvantage', resulting in less contact with, and knowledge of, services/networks available for assistance.

Stigma manifests at an individual level, a community level and at a service delivery level. This means its effects impact at those three levels. Stigma is demonstrated to be an obstacle to increasing mental health literacy and an obstacle to help seeking, especially seeking help in the early stages of the development of mental disorders, hindering early detection and early interventions. Stigma promotes isolation, marginalisation, discrimination, fear, unemployment and contributes to difficulties in finding accommodation. Stigma is an obstacle to "consumers being welcomed as members of mainstream activities and being valued as members of the community."[26] All of this perpetuates misinformation, acts as a barrier to accessing and providing appropriate support, decreases hope and makes recovery and rebuilding self esteem harder. It also acts as an obstacle to people with mental illness being heard in the community or at a service delivery level (e.g. grievance procedures filed by someone with a mental illness may not be taken as seriously).

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"Symptoms (which may include suicide) may worsen in those with mental illness due to factors such as lack of treatment, belief that the mental illness is incurable, lack of support and possible ridicule in the community preventing early detection of mental illness and engaging in help seeking and preventable behaviours."[5]

At a service delivery level, stigma attached to services acts as an obstacle to access and equity of these services. Stigma towards mental illness has been shown to exist among health professionals and service deliverers. At this level, stigma acts as an obstacle to these deliverers providing appropriate services (including appropriate assessments and referrals).[5, 13, 18, 24, 25, 26, 28]

SOURCES OF STIGMA

Bakshi, Rooney and O'Neil (1997) listed the primary sources for stigma in non-English speaking background (NESB) communities as:

- culturally embedded attitudes

- lack of knowledge about mental illness

- lack of knowledge about how to help those with a mental illness

- fear

- community services

- cultural traditions (i.e. culture of avoidance and marginalisation of the mentally ill which occurs regardless of the problem or reason. As part of the community's belief system, it is a behaviour that is learned and passed on within the community, especially while these beliefs are not discussed or challenged.)

- lack of time, energy and cohesion in NESB communities

- stigma perpetuates stigma

- by association

- lack of role models

EXPLANATORY MODELS AND CULTURALLY EMBEDDED ATTITUDES

Cultural factors are among the key determinants of mental health and attitudes towards mental health. Culture determines "whether and when people seek help, what types of help they seek and the level of stigma they attach to both mental illness and addiction."[2]

The literature states that culturally embedded attitudes (including mental health explanatory models) are key determinants of stigma in culturally and linguistically diverse (CALD) communities.[2, 5, 26, 29] "There is evidence that different groups regard psychiatric illness differently. For example Pietsch and Short (1996) reported NESB mental health clients' views on mental illness varied from complete rejection through to culturally specific understanding."[26]

Bakshi, Rooney and O'Neil (1997) cite that different factors of culturally embedded attitudes "hold varying degrees of negative associations with those living with mental illness." They include culturally embedded beliefs that:

- mental illness occurs because of bad deeds or as the result of a previous life in one's ancestry

- mental illness is a result of bad karma or caused by evil spirits

- mental illness is contagious or talking about mental illness can cause mental illness

These models differ substantially from the western biopsychosocial model that attributes causation of mental health issues/mental illness to biological or psychosocial factors. The literature supports the need for education around the biopsychosocial model of mental illness in CALD communities, which it states would "decrease the perception that mental illness is a punishment brought upon a person by their own actions or as a sign of weakness, and promote tolerance and understanding of why people can develop a mental health problem."[6]

In terms of working cross-culturally to increase mental health knowledge and decrease stigma however, the literature also supports the fundamental need for a comprehensive approach that encompasses diverse perspectives and belief systems and recognises explanatory models from diverse cultural backgrounds.

The literature states that the failure to recognise the diverse causal factors or belief systems in mental health promotion initiatives can reduce the effectiveness of the promotion.[2, 5, 26] To "explain that 'mental illness is a biological illness like any other', often results in negative attitudes to mental illness becoming even more entrenched… and more positive attitudes can be elicited by public education offering a wider array of psychosocial causal factors."[28] As culture and identity is accepted as forming an integral component of mental health status,[8] acknowledgement and recognition of the diversity of explanatory models is necessary for mental health promotion to be effective.[2, 5, 6] "Meanings that people give to mental health/ illness and substance use problems determine the effectiveness of health promotion programs designed to prevent or reduce those problems."[2]

CULTURAL INFRASTRUCTURES

The literature shows different cultural infrastructures (e.g. collectivist vs individualistic) can contribute both positively and negatively to the prognosis of people affected by mental health issues and stigma in different situations.
In comparing psychiatric stigma between developing and developed countries, Rosen (2001) highlights that "since 1979 (developing countries) have demonstrated a far better long-term outcome for schizophrenia, particularly in rural regions." He attributes this comparatively better prognosis to various factors including some typically collectivist social factors predominant in developing countries, including:

- greater social inclusion of people with mental illness

- communal solidarity around the affliction

- retention of a culturally valued work role

- non-isolation of the family

- a higher threshold for detecting madness or labelling the person as mad

- the community seeing the cultural relevance or oracular value of psychotic content

- perceiving persons with psychosis who are reasonably well functioning as 'shamans', thus of relatively high status

Cultural infrastructures can also contribute to the nature and amount of stigma in a community. Collectivist cultures' notions of shame and collective responsibility can increase and compound issues around stigma.

Individualistic and collectivist cultures will also have different responses to the focus of stigma reduction campaigns, with the collectivist cultural communities responding less to messages promoting benefits for the individual and more to messages promoting the benefits for the family and community.[2]

RELATIONSHIP BETWEEN MENTAL HEALTH LITERACY AND STIGMA

The term 'mental health literacy' was coined by Jorm and colleagues (1997), and refers to knowledge and beliefs about mental disorders which aid their recognition, management or prevention including: the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; knowledge of self treatments and of professional help available; attitudes that promote recognition and appropriate help seeking.[17]

The literature states that ethno-cultural groups that are more at risk of developing mental health issues are less likely to receive needed care than the general population and have lower rate of participation in health promotion, prevention and treatment programs.[2, 5, 15, 26] CALD specific risk factors contributing to high vulnerability include: pre-migration trauma, economic and social disadvantages, isolation, racism, discrimination, oppression, and cultural pressures (including acculturation processes and consequences). Systemic barriers to CALD demographics accessing treatment, prevention and promotion services include: language factors, discrimination, stigmatising attitudes, mistrust of mainstream service providers and incongruence of health promotion intervention deliverers and the target demographic.[2, 5, 8, 15, 24, 25, 26]

CALD communities generally have low levels of knowledge around mental health issues/illness. "Although the level of knowledge about mental health and substance use and associated problems varies both within and across ethno-cultural groups, field studies among these groups found generally inadequate knowledge of mental illness and the harmful effects of drugs."[2] The key areas identified as requiring increased levels of literacy included:

- distinction between mental illness and physical or intellectual disability or impairment
- causal attributions and attributions (e.g. mental illness is contagious etc.)
- distinction between mental illness and substance abuse, including causal attributions of mental illness related to substance use
- symptoms of mental illness and mental health issues, and issues that may be associated with, or compound conditions and situations (e.g. gambling, financial mismanagement, attitudes, etc.)
- relation of violence to mental illness
- prognosis and/or recovery potential of mental illness and self care and maintenance
- health system in Australia
- ways of supporting someone with a mental illness

Overall, the majority of the literature acknowledges that there is a link between the level of knowledge about mental health/ illness and the level and nature of stigma.[1, 6, 14, 28] The literature varies however when defining the nature or strength of this link. On the whole, the literature that focuses specifically on mental health literacy and mental

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health promotion in multicultural communities does not expand on what is understood by mental health literacy, beyond the generic definition as outlined by Jorm et al.

Some literature argues that poor mental health literacy is a key cause for stigma, and that education or campaigns improving mental health literacy result in the reduction of stigma.[1, 6, 14, 28] "The attitudes of the public towards mental health issues are recognised as an important factor in the perpetuation of stigma (and) research has indicated that those with a better understanding of mental illnesses are less likely to hold stigmatising attitudes."[14] "Knowledge about risk and protective factors for mental health, symptoms of mental health problems and mental illness, and sources of help builds emotional resilience and begins to dispel the stigma of mental illness."[8]

Other literature does not support a direct link between increased knowledge around mental health/illness and decrease in stigma. Bakshi, Rooney and O'Neil (1997) state that stigma occurs "regardless of the level of understanding of mental illness" and that an increase in knowledge of mental health issues/illness does not necessarily lead to a greater tolerance or acceptance of mental illness. "People may know about the causes, treatment and theories of mental illness but still have very negative attitudes and behaviours towards those who are mentally ill. Those with (apparently) greater knowledge of mental illness can still have very negative attitudes (e.g. bad or dangerous), feelings (e.g. fear), and behaviours (e.g. avoidance, denial, stigmatising)."

As previously discussed, Rosen also states that health promotion done in an inappropriate manner can actually lead to greater entrenchment of negative feelings towards mental health issues/illness.[28]

Certain literature states that having contact with people with mental health issues/illness is more effective than education.[11, 14] "The best way of changing people's view points is through normal, everyday contact with consumers, in public, in the workplace and in schools."[11]

Some literature states that despite their medical and/or psychiatric training and high levels of contact with people with mental health issues/illness, stigma also exists amongst health professionals.[18, 26]

Jorm et al (1999) demonstrate that compared with the general public, health professionals actually have more negative attitudes towards the long term outcomes for people with mental illness and their chances of being discriminated against. Jorm et al outline that although there may be basis in reality for the health professionals' negative attitudes, they need to be careful "about what expectations they convey to patients and their families (as there is) evidence that patients who perceive devaluation or rejection by society have a worse outcome." They also continue to state that health professionals' awareness of adverse prognosis might need to be "tempered lest it hamper their own clinical performance."

In relation to the public, Jorm et al demonstrate that there are more negative attitudes associated with the prognosis for people with schizophrenia than depression. They continue to state however, that for both disorders the public's attitudes may be overly optimistic and that "much remains to be done towards having the public appreciate the gravity of both depressive disorder and schizophrenia."

Jorm et al state that "attitudes are not only individual characteristics, but are also influenced by the culture within healthcare systems and that several findings indicate

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that greater exposure to people with mental disorders and greater public education may not necessarily lead to more positive attitudes."

To better understand the link between mental health literacy levels and stigma in CALD communities, it is necessary to unpack the original concept of mental health literacy with a cross-cultural framework.

The key topics of mental health literacy consist of: problem identification; causal attributions; knowledge of risk factors; treatment preferences, and attitudes that promote recognition and appropriate help seeking. These topics need to be seen in the context of two factors that underpin mental health literacy in CALD communities. Firstly, CALD communities have dynamic natures and the health beliefs of individuals within these communities will evolve naturally according to interaction with the dominant culture's health system and their stage of acculturation (i.e. the interplay between the adoption of dominant cultural norms and retention of traditional cultural beliefs). Secondly, "not all people identify with their cultural background. Socio-cultural environment influences people's health beliefs and values, so different individuals and generations within the same family may have different health beliefs and perceptions of health problems."[1]

In a transcultural context, each of the topics outlined above takes on additional aspects and requirements to be effectively applied. To be authentic, problem identification must take place within a context of culturally diverse "manifestations of mental illness, (because) how people describe and interpret their symptoms vary with race, ethnicity and culture."[1] This includes phenomena such as culture-bound syndromes and concepts that may be indicative of mental disorder in a western framework but acceptable and appropriate in another cultural framework. Literacy enabling the recognition of specific disorders would thus require knowledge of different cultural frameworks and mental health understandings, as well as the ability to effectively negotiate the different frameworks to accurately recognise disorders.

Literacy of causal attributions requires similar knowledge and processes as problem identification. Having knowledge of the Western bio-medical or bio-psychosocio explanatory model of mental health does not necessarily mean literacy for members of CALD demographics. To be literate in causal attributions requires; knowledge of both host culture (Western); culture of origin explanatory model and the ability to negotiate both and come to an effective, accurate and applicable level of understanding.

Culture and identity are also important components of risk and protective factors. (Although Jorm et al do not specifically list protective factors or resilience factors in the list of topics included in mental health literacy, we have included them within the topic of risk factors to make it more comprehensive.) Literacy requires knowledge of how culture and cultural infrastructures can impact on mental health, i.e. how they contribute to increasing vulnerability to mental health issues/ illness or contribute to increasing resilience protective factors in relation to mental health issues/illness.

Treatment preferences for CALD demographics can span treatments available in the host (Western) system and culturally specific communities or cultural health system they belong to. Literacy in this topic requires knowledge of both systems and an understanding of the scope or range of treatments available, but most importantly requires the ability to navigate options effectively to understand which treatment options will be the most appropriate and successful for particular situations. To gain a functional understanding of the host system, several barriers may have to be

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37/46

successfully overcome. These include language barriers, social distance factors, lack of appropriate sources of information of service delivery, discrimination, stigma, etc. which fall under the topic of how to seek mental health information. A person from a CALD community may have to develop a specific set of skills if they are to have the capacity to find mental health information. Knowledge of available sources of information may not be enough for them to be able to actually access the information.

QUALIFYING LITERACY AS ATTITUDINAL AS WELL AS KNOWLEDGEABLE

The key underlying factor in all of these topics is that for there to be literacy, the attitudes that promote recognition and appropriate help-seeking must exist. Knowledge of information or facts is not enough in itself to qualify as literacy. Literacy demands the capacity for appropriate application and a propensity to act on it.

Increasing mental health literacy must therefore be understood as more than increasing knowledge about mental health issues/illness in a Western framework. It must be qualified in terms of increased knowledge encompassing diverse cultural explanatory models and the development or adjustment of attitudes that promote accurate recognition and appropriate help seeking.

In these terms, it is possible to conclude that increased mental health literacy would have a significant impact on the amount and nature of stigma that may exist within a CALD community. It is also important to highlight that the methods used to increase mental health literacy and decrease stigma, will need to fulfil the key requirements of literacy and address attitudinal and knowledge components to be effective.

REDUCING STIGMA IN CALD COMMUNITIES

For stigma reduction initiatives in culturally and linguistically diverse communities to be effective, they must therefore authentically address relevant community needs in the grain of the audience's culture. "Because of the cultural diversity inherent in stigmatisation of mental illness, it is necessary to develop new culturally sensitive ways of reducing stigma. Substantive data suggest that designing programs to meet the specific needs of ethno-racial/cultural groups will improve access and utilisation of health promotion programs and consequently, reduce stigma and disability burden from mental illness and addictions."[1] The literature supports various methods and frameworks as fundamental to creating and initiating stigma reduction in CALD communities. Some of these are:

RESPONDING TO CULTURAL DIVERSITY

Cultural diversity within and across cultural demographics must be mapped, recognised and taken into account when creating stigma reduction initiatives. "What may be the most effective in one community may be different in another."[2]

ADDRESSING THE THREE LEVELS OF STIGMA

For stigma to be reduced, strategies must be aimed at community, service and individual levels. All three levels are interconnected and function simultaneously.[5, 28] The literature states that public attitudes and service providers/health professional attitudes can impact directly on how consumers perceive themselves and their prognosis. It also tells us that the type and amount of contact that the community and service providers/health professionals have with consumers can impact on their levels of stigma. "Acceptance through changes in feelings, attitudes and behaviours towards

those living with a mental illness can only take place through a multi-level community education process where members of the community provide positive examples for other members about ways to respond, and counter the negative beliefs within the community which stigmatise those with a mental illness. However for a community change to take place, the individual and service delivery levels must also be addressed as they reinforce the stigma at a community level."[5]

STRATEGIC INVOLVEMENT OF CONSUMERS

The majority of the literature supports that strategic involvement of, and contact with, non-stereotypical consumers is associated with the development of more positive attitudes.[11, 14] Crucial to this methodology is ensuring the consumers involved are empowered and authentically involved in, or driving the nature of their involvement and initiative, and that it is done in a way that is safe and productive for both consumers and the target demographic. Components of effective types of contact include involvement of non-stereotypical consumers in public education programs, local activities 'consumer activities', relationship building, normal everyday contact, visibility and contact in schools, workplaces and the public.

INCREASING MENTAL HEALTH LITERACY

For increased mental health literacy to be effective in reducing stigma in multicultural communities, mental health literacy must be understood in terms of knowledge, attitude and ability to function transculturally. Initiatives must aim to be effective in changing attitudes to align and be compatible with increased or altered levels of knowledge.

INDIVIDUAL STRATEGIES

Bakshi, Rooney and O'Neil (1997) outline the important role in the whole process of understanding mental illness that carers and consumers play, and make recommendations of topics that consumers and carers could address and be supported in addressing by their counsellors, case mangers and health professionals. They emphasise that any individual education should be strategic and carried out in a way that ensures consumer and carer safety. "Individual strategies are recommended so as to empower people with a mental illness and their carers and not to place the responsibility of reducing the stigma to mental illness on this target group." The list of topics includes:

- Understanding the causes of mental illness. This can divert them away from self-blame, guilt and fear.

- Understanding the treatment, medication and where appropriate the side effects of the treatment so as to encourage compliance with medication.

- Acknowledging the stress related to migration.

- Acknowledge the trauma of being a refugee – at the time of leaving one's country, in transit and on arriving to Australia.

- Providing information about the range of support systems and skills on how to negotiate access.

- Practical and emotional support for carers.

- Equipping carers with information and knowledge so that they do not isolate or hide their relative.

Bakshi, Rooney and O'Neil go on to suggest various examples of individual strategies, including counsellors and health professionals within the mental health system

providing support and education as an integral part of the care they provide, the development of culturally and linguistically appropriate self-help material, stress assessment tests to move the illness away from being a 'fault', to giving people permission to acknowledge the stress created by the process of migration and carer support groups.

EFFECTIVE HEALTH PROMOTION CAMPAIGNS

Agic (2004) uses Kahan and Goodstadt's (2001) definition of best practice in health promotion as "those sets of processes and activities that are consistent with health promotion values/ goals/ethics, theories/beliefs, evidence and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation."[2] Potential barriers to effective health promotion include; cultural mismatch between initiative and target audience culture; stigma; mistrust of source of information or authorities; language and knowledge of the health system.[1]

ALIGNING WITH TARGET GROUP'S CULTURE

Effective health promotion in CALD demographics must address the needs of the target audience and be **congruent with the audience's cultural, social and communication structures, systems and beliefs.** "Projects that reflect the dominant culture, are often not relevant to people from different cultural backgrounds (and) concepts that reflect the dominant culture are often not directly transferable to communities with different cultural backgrounds."[2] Kreps and Kunimoto (1994) tell us to be aware that "no matter how 'rational' the goals of a health care campaign are, from family planning to organ donation, cultural roots run deep and will influence audience member interpretations of the campaign." They give the example of family planners in developing countries and birth control campaigns introducing birth control techniques "to the female population, wife or mother, often did not work without knowledge of the family power structure (as for example) in India, the grandmother was the person who had the authority to instruct women in such matters." They state that "effective health promotion strategies need to be congruent with the messages of the targeted cultural groups, which incorporate the intrapersonal and relational levels of the cultures' communication systems."

COMMUNITY DEVELOPMENT PRINCIPLES

The application of community development principles is fundamental in accurately defining community needs, mapping cultural demographics and interpersonal and social infrastructures and identifying and incorporating existing inherent mental health cultural practices. It will also promote community ownership of, involvement with and validation of any initiative.[1, 2]

COMMUNITY READINESS MODEL

The application of the **community readiness model** ensures initiatives and messages align with the target demographics' level of readiness in terms of hearing and responding to messages provided. If a community is at the stage of denial of the existence of any mental health issues in their community for example, an initiative aimed at increasing knowledge around symptoms of psychosis will be at risk of not being heard at all, compared with an initiative aimed at promoting awareness of the existence of mental health issues and decreasing fear.[1, 2]

EFFECTIVE COMMUNICATION

The majority of the literature also states that **effective communication** is instrumental to successful health promotion and that the "capacity of health messages to reach out to diverse communities depends largely on the strategy used to convey the information to the intended audience."[2] Effective communication is far more comprehensive than the act of interpreting a message from one language into another, either verbally or in written form. Effective communication requires:

- Messages and information to be culturally adapted to the culture of the target audience for it to be relevant, understood and meaningful. "Direct translation (or interpretation) which does not take cultural concepts into account, limits the usefulness of the health information."[2] It can also lead to misunderstanding or the production of unintelligible messages. An example of this are messages aimed at reaching a collectivist culture; the ones that "pivot on individuals are less effective than messages that focus on affects on family members."[2] A message designed within a purely western framework may focus on individuals and needs to be adapted to focus on family instead if it is to be used with a collectivist culture.

- The mode of delivery is crucial to the health promotion initiative and often very culturally specific. In most cases the target audience is more receptive to the source of the information than the information itself. The source will determine how it is heard, how it is believed and whether or not the information will be acted on, as can seen once again with Kreps and Kunimoto's example of birth control education in developing countries. Trust is also implicit in the mode of delivery; there must be trust between the source of information and the target audience. The mode of delivery should also be determined by the culture's preferred method of communication. An example of how necessary and effective this is can be is seen in the Aim Hi initiative for increasing indigenous mental health, diagnosis and recovery on the Tiwi Islands. "The project involves the interweaving of physical, social and cultural approaches to mental health and the key to its success is combining the methods of western psychiatry and more traditional Aboriginal ways, particularly when it comes to assessment and diagnosis."[4] The traditional communication method of story telling is at the heart of the communication that happened in this project.

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APPENDIX 2 – PROCESS EVALUATION REPORT

BY CULTURAL PERSPECTIVES

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45/46

MULTICULTURAL MENTAL HEALTH AUSTRALIA (MMHA)

'STEPPING OUT OF THE SHADOWS': REDUCING STIGMA IN MULTICULTURAL COMMUNITIES TRAINING PACKAGE

PROCESS EVALUATION REPORT

Cultural Perspectives Pty Ltd

JUNE 2010

TABLE OF CONTENTS

1.   EXECUTIVE SUMMARY

1.1   BACKGROUND

Multicultural Mental Health Australia (MMHA) was funded by the Australian Government Department of Health and Ageing (DoHA) to develop 'Stepping Out of the Shadows: Stigma Reduction in Multicultural Communities', a national mental health stigma reduction education program for culturally and linguistically diverse (CALD) communities. The program objectives are to:

- reduce stigma;

- build on and use the strengths that exist in CALD communities to improve how they can deal with stigma and mental health issues; and

- identify and use different traditions and ways of thinking in CALD communities that can help people deal with stigma and mental health issues.

The program uses a train-the-trainer model to deliver the stigma reduction training package directly to CALD communities and forms part of MMHA's overall strategy to build the capacity of both CALD communities and the multicultural and mental health sectors to promote the mental health and well-being of Australia's diverse communities.

The 'Stepping Out of the Shadows' program national implementation commenced in March 2009. In November 2009, MMHA engaged the consultancy Cultural Perspectives to conduct an independent evaluation of the 'Stepping Out of the Shadows' implementation process. The aim of the evaluation was to identify key strengths, opportunities, and areas for improvement to inform the future development and improvement of the 'Stepping Out of the Shadows' program. The evaluation took place between 25 November 2009 and 29 April 2010.

1.2   METHODOLOGY

Due to the small number of community training sessions completed in the evaluation period, the evaluation is process focussed, providing a qualitative assessment of project design and implementation. The main methods used were:

- Structured in-depth interviews and focus groups with key informants including State Coordinators, Expert Trainers, Community Trainers, consumer and carer representatives, participating agency management staff, representatives of key working and advisory groups, and MMHA staff;

- Analysis of program training materials including Community and Expert Training Manuals, evaluation tools and training support documents provided to trainers;

- Analysis of program documentation including program reports, minutes of meetings, publicity and promotion materials; and

- Review of other mental health-related education and training programs targeted at mainstream or CALD communities and publications related to these, including evaluations, reports and journal articles.

The data were analysed thematically to identify strengths, opportunities and areas for development in key program areas. The key findings are described below, followed by key recommendations, which respond to these findings and synthesise the detailed process recommendations provided in the full report.

1.3   KEY FINDINGS

1.3.1   *Program Investment*

i.   **The 'Stepping Out of the Shadows' program has been implemented inconsistently across Australia** due to varying funding models, levels of commitment and integration into planning at the state and local agency level. **There has been significant community and participating agency investment in the project (both financially and in kind)** but the program is not sustainable without the allocation of adequate ongoing program funding and support at the national, state and local service level.

ii.   **Although this evaluation focused on program process, early indications of positive outcomes have been identified**. Where the program has been implemented with sufficient program funding and integrated into core business of the participating agency, community and organisational capacity has increased and the project had shown early indications of success in reaching program objectives. Where the program is being implemented without sufficient funding and organisational support, the community capacity building intent of the program is compromised as it depends on the "goodwill" of generally under-resourced CALD communities and participating agencies to deliver the program.

1.3.2   *Training Processes*

i.   **The program is clearly aligned with Priority Area 1 of the 'Fourth National Mental Health Plan**: an agenda for collaborative government action in mental health 2009-2014'. Priority 1 is 'Social inclusion and recovery' which aims to improve community understanding of the importance and role of mental health and wellbeing, and recognise the impact of mental illness through a sustained and comprehensive national stigma reduction strategy.

ii.   **So far the program has been delivered mainly to communities who have arrived in Australia within the last five to ten years,** predominantly from: Afghanistan, Iraq, Burma, Sudan, Liberia, Congo, Burundi, Sierra Leone and Eritrea. Many of these communities typically have low literacy levels both in English and in their own languages due to limited education opportunities. This has required significant adaptation of training materials, which are in English (with the exception of the mental health facts sheets and the training DVD), and often rely on participants having literacy skills. This has contributed to the visual and translated materials in the training package being identified as significant strengths.

iii. **Participating communities report that stigma reduction and mental health training is a pressing need in their communities** due to factors such as the experience of organised violence, war, abuse of human rights, separation from family, spending time in refugee camps, torture and trauma issues, and stresses related to migration and settlement.

iv.   **Openness to communities adapting and "owning" the training so that it could meet their needs was considered a key success factor in program implementation**.

v.   **The 'Stepping Out of the Shadows' program has achieved the following outputs**

SOS Project Statistics Snapshot

(Based on data collected in May 2010)
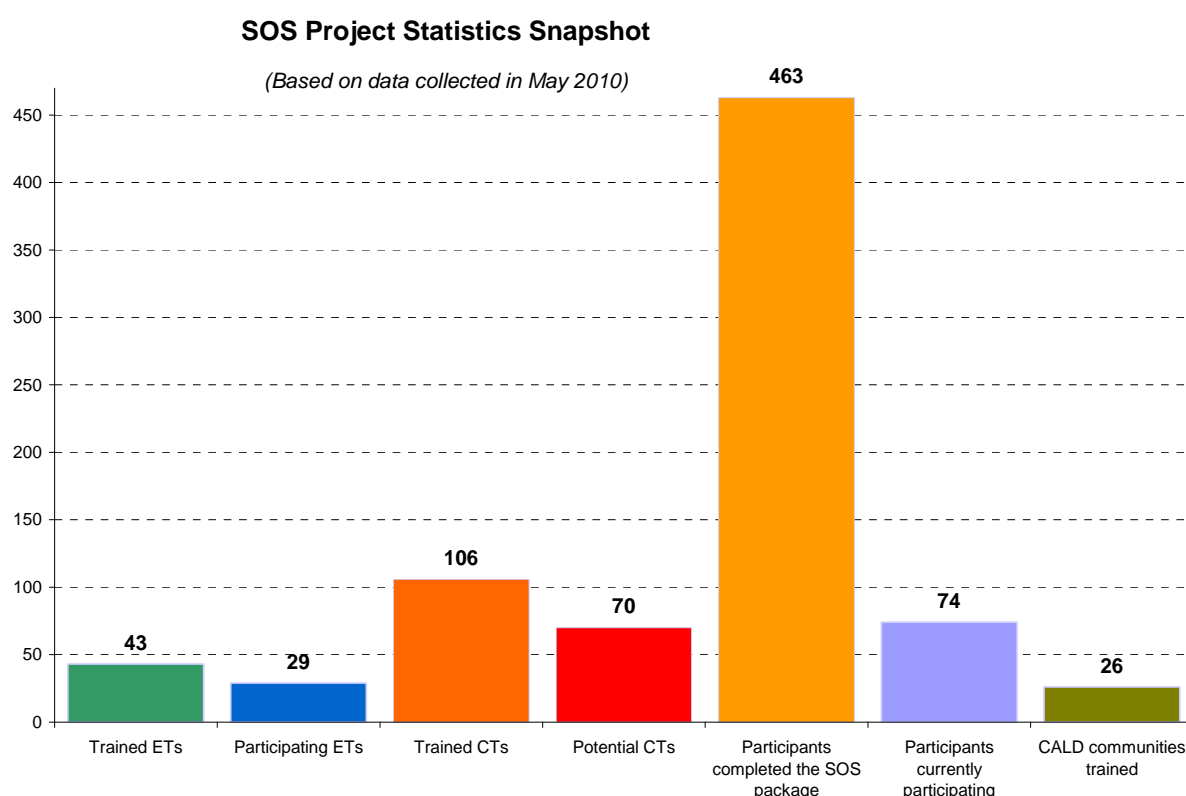
1.3.3 Training Materials

i. Although the training manuals are generally considered to be of high quality and are evidence based, the **Expert Training and Community Training manuals structure and language requires simplification to make translation easier and make it more appropriate to the target communities' needs.** This has been addressed by MMHA to some extent through the 'Stepping Out of the Shadows Guidelines for Abbreviating Community Education Sessions'.

ii. **Mental health literacy is a key building block in reducing stigma.** The program would benefit from the addition of an optional Mental Health Literacy module for communities that are "ready" for such information. This could strengthen the stigma reduction potential of the program.

1.3.4 Program Development

i. **CALD Communities need to provide ongoing input into program implementation** through the consultative mechanisms established by MMHA and that input needs to be shared within and between states and territories to enhance the sense of community "ownership" (a key program success factor) and ensure that program developments are informed by community needs.

ii. **Greater CALD consumer and carer participation is required in all aspects of the program** so that consumer and carer knowledge, expertise and capabilities are better integrated into program development and delivery.

iii. **The program would benefit from building on existing partnerships/relationships with national mainstream programs** including Mindframe, beyondblue, SANE, LIFE and Lifeline, and from building new partnerships with Mental Health First Aid and other mainstream programs **to increase the capacity of the mainstream to reach CALD communities**.

iv. **Community Trainers and Expert Trainers require greater participating agency and State Coordinator support** to implement the program as well as further training and development opportunities to enhance their ability to deliver the program objectives.

1.3.5 *Monitoring, Reporting, Quality Improvement*

i. **The program evaluation tools in the Expert and Community Trainer Manuals are being under-utilised** because the large number of tools causes confusion and they are a time consuming component in a program which already makes high demands on trainer and participant time.

ii. **The program currently seeks to apply emerging learnings from the project** through the MMHA Project Coordinator, National Implementation Working Group (NIWG), State Coordinator roles and the Community and Expert Trainer networks within each state. However, the sharing of good practice, resources and innovative ideas could be improved at the inter- and intra-state level by using web-based and other communication mechanisms to facilitate information flow and support program development.

1.4 PRIORITY RECOMMENDATIONS

Priority recommendations are described below and are cross-referenced to the recommendations in Section 8 of the evaluation report. These recommendations have been identified as priorities as they are critical to the sustainability and effective development of the program.

1.4.1 *Program Investment*

i. **Develop a sustainable program funding model to facilitate the consistent implementation** of the 'Stepping Out of the Shadows' program across Australia. The national health reforms announced in April 2010 provide an opportunity for program investment to be provided by the Department of Health and Ageing (DoHA) with contributions from the State and Territory Departments of Health and participating agencies at the local level. This will help all states and territories to address Priority 1 of the 'Fourth National Mental Health Plan' for CALD communities. (Recommendations: 8, 11, 18)

1.4.2 *Training Processes*

ii. **Increase consumer and carer program involvement through: using the MMHA Speakers Bureau and consumer and carer reference groups** to access consumers and carers to participate in the program; developing a consumer/carer "real life" stories DVD to use in training at all levels; improving integration of consumer and carer participation into training by targeting consumers and carers to become ETs and CTs or to participate in training processes. (Recommendations 6, 29,30, 31, 32)

iii. **Develop MMHA-accredited training for Lead Trainers** to be located in each state and territory to train future ETs and provide refresher training for ETs. (Recommendation 8)

iv. **Provide ongoing training and development opportunities for CTs and ETs** to enhance their skills and knowledge in delivering the program. (Recommendation 9)

1.4.3 *Training Materials*

i. **Revise the Community Training Manual** so that it consists of core components and optional modules allowing greater flexibility while maintaining quality control. It is important to maintain and support community "ownership" of training materials as this is a key success factor for implementation. Simplify language in both the Expert and Community Training manuals and promote flexible use of training materials (within guidelines) to match community needs. (Recommendation 16)

ii.   **Consider translating key components of the CT Manual** into languages for which a high need has been identified. (Recommendation 19)

iii. **Develop a culturally competent mental health literacy training component in partnership with Mental Health First Aid.** Make the Suicide Prevention Module developed in Tasmania widely available as an optional module. MMHA is working on a national project with Tasmania and Western Australia to develop suicide prevention resources. (Recommendation 15)

iv.   **Reduce per unit cost of future manuals** by making them available online as PDFs and modifying existing design from a full colour manual to a two-colour manual, reducing any hard copy printing costs by approximately two thirds. (Recommendation 28)

1.4.4 *Monitoring, Reporting, Quality Improvement*

i.   Improve program monitoring and reporting systems **to more comprehensively capture relevant program data and feedback and link these into a Continuous Improvement Framework to enhance the measurement and improvement of program implementation.** (Recommendation 23, 24, 25, 27)

ii.   Further develop and maintain the password protected portal on the MMHA website for sharing of program information, good practice and resources within and between states and territories. (Recommendation 10)

iii. Link 'Stepping Out of the Shadows' training to mainstream national training programs by building on existing partnerships with Mindframe, beyondblue, Lifeline and others so that mainstream services can better meet the needs of CALD communities, and address Priority 1 of the Fourth National Mental Health Plan. Link with other existing CALD-specific mental health education programs in order to support mutual capacity building and effectively meet the education needs of people from CALD communities. (Recommendation 33)

1.5 CONCLUSION

There are some significant process challenges for the 'Stepping Out of the Shadows' program, which have been identified above. Many of these could be addressed through the recommended program modifications, building on existing program strengths and the significant investment made by participating communities and agencies.

Where the program has been implemented with sufficient funding, appropriate human resources and agency management support, it has demonstrated the ability to reach the intended aims of the program to: reduce stigma; build on and use the strengths that exist in CALD communities to improve how they can deal with stigma and mental health issues; and identify and use different traditions and ways of thinking in CALD communities that can help people deal with stigma and mental health issues. The achievement of these aims has led to the reduction of stigma as a barrier to service access in CALD communities and increased CALD community capacity to initiate and implement community based stigma reduction activities.

The program is clearly aligned with national mental health Priority 1 as outlined in the 'Fourth National Mental Health Plan 2009-2014', which aims to improve community understanding of the importance and role of mental health and wellbeing, and recognise the impact of mental illness through a sustained and comprehensive national stigma reduction strategy. The 'Stepping Out of the Shadows: Reducing Stigma in Multicultural Communities' training package is comprehensive; however, it is not sustainable without the allocation of implementation funding to continue the program.

2. INTRODUCTION

Multicultural Mental Health Australia (MMHA) has been funded by the Australian Government Department of Health and Ageing (DoHA) to develop 'Stepping Out of the Shadows: Stigma Reduction in Multicultural Communities', a national mental health stigma reduction education program for culturally and linguistically diverse (CALD) communities. The program uses a train-the-trainer model to deliver the stigma reduction training package directly to CALD communities.

Multicultural Mental Health Australia identified the need to evaluate the implementation processes of the 'Stepping Out of the Shadows' program to identify key strengths, opportunities and areas for improvement to inform the future development and improvement of the program.

2.1 BACKGROUND

2.1.1 *Why focus on stigma reduction?*

Stigma creates barriers to seeking help, early detection and negatively affects upon recovery rates and prognosis. It also isolates individuals and their families and reduces their capacity to participate in their communities and the broader society in meaningful and satisfying ways. Although stigma about mental health and illness exists in all cultures around the world, people from culturally and linguistically diverse (CALD) communities who experience mental health issues/illness face a double disadvantage. This means increased discrimination because someone has a mental illness *and* belongs to an ethnic community. This may result in those people having even less contact with and knowledge of the services and networks that are available for them.

The literature demonstrates that the impact of stigma in CALD communities is serious and far-reaching (Bakshi et. al. as cited in 'Stepping Out' Literature Review). Some of the literature states that the impact of stigma on a person's life has been as harmful as the effects of mental illness itself (Francis, C., Rosen, A. as cited in 'Stepping Out' Literature Review). In terms of working cross culturally to increase mental health knowledge and decrease stigma, the literature also supports the fundamental need for an approach that encompasses diverse perspectives and belief systems and recognises explanatory models from diverse cultural backgrounds. These findings have informed the development of the 'Stepping Out of the Shadows' training package which has been developed especially for CALD communities.

2.1.2 Program Aims

The aims of the 'Stepping Out of the Shadows' project are to:

- reduce stigma;
- build on and use the strengths that exist in CALD communities to improve how they can deal with stigma and mental health issues; and
- identify and use different traditions and ways of thinking in CALD communities that can help people deal with stigma and mental health issues.

2.1.3 Program Development

The 'Stepping Out of the Shadows' training package was developed in partnership with the Queensland Transcultural Mental Health Centre (QTMHC) in June 2008. The package consists of an Expert Trainer Manual and a Community Trainer Manual. To complement the manuals, the package includes a CD-ROM with fact sheets on a range of mental health topics, which have been translated into 15 languages. The package also contains a DVD teaching tool dubbed into 17 languages including English.

The training package was developed based on the evidence around stigma and reducing stigma in CALD communities. The evidence was gathered through discussions with focus groups from 11 different CALD communities, key findings of a literature review, analysis of other training programs, and input from CALD consumer and carer representatives and key workers in the transcultural mental health sector. The draft materials were piloted with seven (7) Expert Trainers and 63 Community Trainers from more than 20 different CALD communities across Australia. Feedback from this pilot stage was incorporated into the final package.

The package has been designed to be as meaningful as possible to CALD communities around Australia. The diversity of cultural frameworks and explanatory models of mental health that exist in CALD communities has been used as the foundation for the development of the package and training methodology.

2.1.4 Program Structure

'Stepping Out of the Shadows' uses a train-the-trainer model to train **Expert Trainers** from each state and territory who recruit, train and support **Community Trainers** to deliver the training program. The training is provided at no cost to community participants. It is the responsibility of the Expert Trainers (or their organisation) to advertise, recruit, and conduct the training with Community Trainers, and then support the Community Trainers to organise and deliver education sessions within their community. (See Program Model: Diagram 1)

Diagram 1. – Program Model

Stage 1	**Expert Trainers**	Recruited and trained by MMHA and located within participating agencies
Stage 2	**Community Trainers**	Recruited, trained and supported by Expert Trainers
Stage 3	**Community Training**	Community Trainers recruit participants, promote and conduct training with selected communities
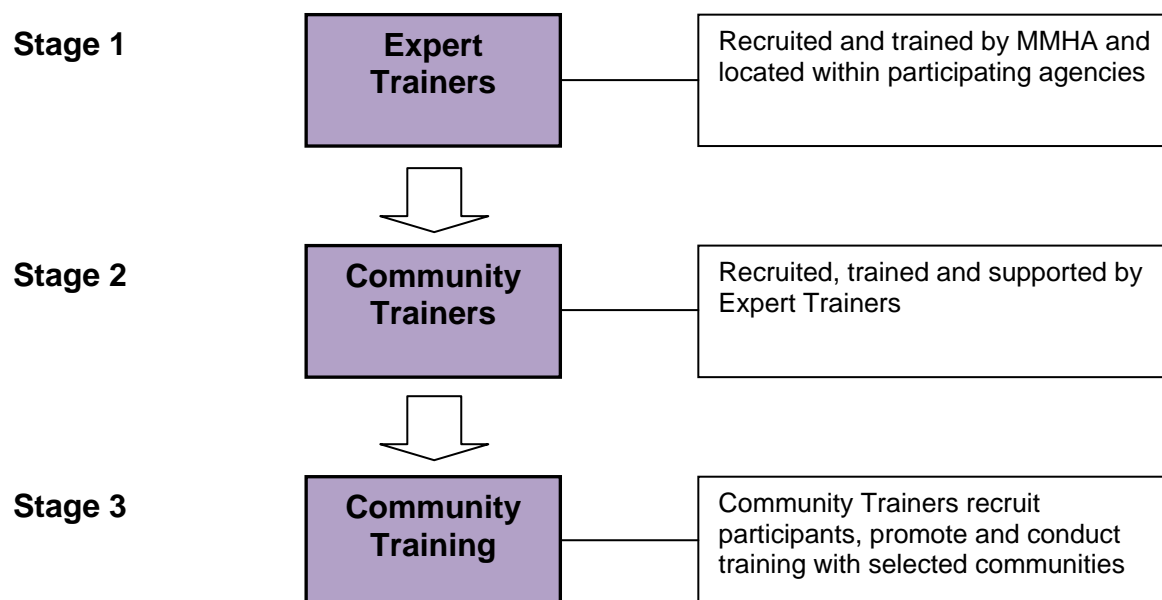
2.1.5 *Program Implementation Funding*

The 'Stepping Out of the Shadows' national program is implemented at the state and territory level via existing funding and infrastructure and in the cases of Victoria, Tasmania and the ACT with the addition of project-specific funding. State and territory project-specific funding has included:

VIC: Goulburn Valley Area Mental Health provided funding to the value of $27,580 (see 'Good Practice Case Study' 6.1 for program details). This covered a 0.6 FTE (3 days per week) Project Officer, eight (8) bi-lingual Community Trainers and some associated project costs (see program budget Table 1., 6.1).

VIC: The Victorian Department of Health funded the state-coordinating agency for the project, Action on Disability in Ethnic Communities (ADEC), to provide participating organisations with $500 per complete community education package and a 0.6 FTE (3 days per week) State Co-coordinator position.

TAS: Funded through the National Suicide Prevention Strategy (requiring the addition of suicide prevention component in the training package). Specific value and allocation of funds not provided.

ACT: funded by ACT Health Promotion Commission for: $45,000 (first year) and $49,000 (second year). The ACT discontinued participation in the 'Stepping Out of the Shadows' project in February 2010.

WA: State Co-ordination role provided the WA Mental Health Commission and at the time of writing this report (April 2010), program funding was being negotiated.

States without discrete funding: NSW, SA, NT

3. EVALUATION AIMS AND METHODOLOGY

3.1 PROCESS EVALUATION

The evaluation of the 'Stepping Out of the Shadows: Stigma Reduction in Multicultural Communities' project was **process focussed** and sought to provide a qualitative assessment of project design and implementation. It identified key issues with the implementation, including strengths, opportunities and limitations of the project to assist MMHA to identify areas for further development and improvement of the 'Stepping Out of the Shadows' project.

As observed by Barry in 'Researching the implementation of community mental health promotion programs': "Implementation research is critical to understanding program strengths, weaknesses, determining how and why programs work, documenting what actually takes place when a program is conducted, and providing feedback for continuous quality improvement program delivery." (Barry 2005).

The evaluation took an emergent approach, adapting and adjusting to the needs of an evolving and complex project. An early feedback and consultative relationship with project staff was established so findings could be made available to project staff and community partners to continuously improve the program. Interim written and verbal reports were used to communicate findings.

3.2 CULTURALLY COMPETENT EVALUATION

Cultural Perspectives recognises that stakeholders' identity group may affect their experiences and views of the evaluation process. Throughout this evaluation, Cultural Perspectives took into consideration the different cultural perspectives of project participants and stakeholders and observed the principles of culturally competent evaluation as identified in 'Commissioning Multicultural Evaluation: a resource guide' (Inouye et al 2005) which are:

- Openness to learning about cultural complexities;

- Flexibility in evaluation design and practice;

- Building rapport and trust with diverse communities;

- Acknowledging power differentials;

- Self reflection for recognising cultural biases;

- Consideration of historical and institutional oppression.

3.3 METHODOLOGY

3.3.1 *Program Logic*

The process evaluation aimed to identify if program processes were facilitating progress towards the achievement of short, medium and longer-term outcomes for CALD communities as articulated in the program logic represented in Diagram 2.

Diagram 2. Program Logic

Processes

Expert Trainers are effectively prepared to recruit, train and support Community Trainers

Community Trainers are trained and supported as planned

Community Education sessions conducted as planned

Effectiveness of the 'Stepping Out' program is enhanced by Consumer and Carer involvement

Intermediate Outcomes

Strengths within CALD communities identified to improve how they can deal with stigma and mental health issues

Different traditions and ways of thinking about mental illness in CALD communities are identified

Ultimate Outcomes

Stigma as a barrier to service access is reduced

CALD communities' capacity to initiate and implement community based stigma reduction activities is increased

3.3.2 Evaluation Methods

Evaluation consultations and document and data review took place between 25 November 2009 and 29 April 2010. Consultations used a mixture of telephone and face-to-face methods. They included in-depth structured interviews and focus group discussions with key informants involved in the MMHA national implementation of the 'Stepping Out of the Shadows' program. In Queensland, the Queensland Transcultural Mental Health Centre (QTMHC) implemented a version of the 'Stepping Out of the Shadows' program separately and on this basis was not included as part of the national evaluation, however, QTMHC program learnings are presented in Section 7.1.3 of this report.

Structured interviews with Discussion Guides were conducted to provide in-depth, detailed information to indicate whether the program was being implemented as originally planned, and if not, why and how the program had changed. Depth interview and focus group transcripts were examined for patterns and themes and categorised into recurring topics and issues both within and across program sites. To ensure that individual differences and contextual factors were not lost, categorising analysis techniques (which focus on similarities) were combined with contextualisation techniques, such as case examples and case studies. These techniques helped preserve connections within particular sites and bring to light contextual factors and individual differences which can be hidden from view when using only categorisation techniques.

Internal program documentation was reviewed to determine the project history, development, goals and intended outcomes, implementation processes and to provide information about important shifts in the program development and maturation. Other multicultural and mainstream mental health education and training program documentation was reviewed to determine relationships and connections with other programs and to identify partnership and development opportunities.

3.3.3 Consultation Summary

The following groups were consulted using a mixture of face-to-face and telephone consultations.

'Stepping Out of the Shadows' Trainers

- Lead Trainers: 1 group (3 members)

- Consumer participants in Expert Training: 1 group (3 members)

- Expert Trainers 4 groups - NSW (5 members); VIC (2 members); SA (4 members); TAS (3 members);

- Expert Trainers one-on-one: VIC x 4; SA x 2; WA x 1

- Community Trainers 4 groups – VIC (8 members); VIC (3 members); TAS (3 members); SA (3 members)

State Coordination and management

- 1 x in depth with Program State Coordinators (or equivalents) in NSW, VIC, SA, ACT, TAS, WA

- NSW Transcultural Mental Health Centre (TMHC) management focus group (4 members)

- VIC Goulburn Valley Area Mental Health management focus group (4 members)

- TAS program manager 1x in-depth

- ACT program Steering Committee focus group (5 members)

Other stakeholders

- MMHA Staff: Manager 1 x in-depth and Program Coordinator 1 x in-depth

- NSW Transcultural Rural and Regional Outreach Program (TRROP) Pilot: CTs 1 x paired in-depth and Coordinator 1 x in-depth

- Quality Control Working Group: focus group (3 members)

- National Implementation Working Group: Focus group

- Mental Health First Aid: Manager 1 x in-depth

MMHA Joint Officers Group (JOG)

- Joint Officers Group members or delegates: 1 x in-depth with NSW delegate; 1 x paired in-depth with TAS delegates; 1 x in-depth with ACT delegate; 1 x in-depth with Victorian delegate; 1 x in-depth with Carer representative; 1 x in-depth with Consumer representative; 1 x in-depth with Federation of Ethnic Communities Council (FECCA) representative.

- SA – 1 x in-depth requested, unable to comment

- WA – 1 x in-depth requested (10 March, 23 March, 10 April) not undertaken

- NT – 1 x in-depth requested (10 March, 23 March, 29 April) not undertaken

- Department of Health and Ageing – 1 x in-depth requested, unable to comment

3.3.4 Document and data review summary

MMHA program documentation

- Expert Trainer and Community Trainer Training Manuals

- Program Funding Proposal

- Program Evaluation Sheets

- National Implementation Working Group (NIWG) meeting documentation

- State participating agency Memorandums of Understanding (MOUs)

- Program Publicity and Promotion documents

- NSW Transcultural Rural and Regional Outreach Program (TRROP) Pilot documentation

- MMHA Speakers Bureau training and publicity documents

CALD-specific Related Program documentation

- 'Fear and Shame' (Macedonian play) Mental Health First Aid (Vietnamese, Croatian, Italian)

- Champions of Mental Health (Vic)

- Mental Illness Fellowships ACT CALD communities program

- BRiTA Futures Project, QLD Transcultural (Youth)

- 'Stepping Out of the Shadows – Promoting Acceptance and Inclusion in Multicultural Communities in Queensland' Queensland Transcultural Mental Health Network (QTMHC)

Mainstream Related Program documentation

- Mental Health First Aid

- SANE

- Beyond Blue

- Mindframe

3.3.5 Outcomes: Early Indications Summary

The 'Stepping Out' project evaluation focused on program processes, however, there are early indications that the program is achieving program outcomes in some locations (See Good Practice Case Study 6.1). Diagram 3. presents a summary of the 'Stepping Out' program inputs, outputs and early outcomes that have been identified during the process evaluation.

Diagram 3. 'Stepping Out' program summary

Inputs	**Outputs**	**Outcomes : Early Indications**		

		Knowledge Change	**Attitudinal Change**	**Behavioural Change**
Manual Development Funding Manual Printing Cost Manual Distribution Cost Program staff, National Manager and Project Officer Expert Trainer Training cost National, State, NGO and Area Health funding for program implementation	Expert and Community Training Manuals Program national launch Expert Trainer Curriculum 4 Expert Trainer workshops (43 trained nationally 29 remaining) Community Trainers trained (total109 nationally) Community Training (total 463 participants nationally) Infrastructure (State Coordinators, reporting mechanisms) Support materials (recruitment and promotion materials) **(Based on data collected in May 2010)**	Different traditions and ways of thinking about mental illness (explanatory models) in CALD communities identified Strengths within CALD communities identified to improve how they can deal with stigma and mental health issues	Stigma related to mental illness is reduced	Stigma as a barrier to service access is reduced: four (4) known referrals directly after Community Training (Cobram VIC) CALD community capacity is built to develop community stigma reduction activities (Afghan community theatre initiative in Shepparton)

'Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014'

Priority 1: Social inclusion and recovery

Outcome: The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness"

Action: Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy

IVES PTY

4.   PROGRAM IMPLEMENTATION

This section provides a breakdown and analysis of each component in the national implementation of the 'Stepping Out of the Shadows' project and corresponding recommendations based on key findings.

4.1   EXPERT TRAINERS

4.1.1   *Recruitment Process*

MMHA used their national networks to invite Expressions of Interest (EOIs) from potential Expert Trainers (ETs) across Australia. A 'National Expert Trainer Information Kit' was developed by MMHA outlining the project aims, evidence base, methodology, content and implementation strategy. Candidates were required to meet specific selection criteria including: experience in delivering training or facilitating groups; their organisation's ability to integrate the program and ensure sustainability; ability to recruit and support bilingual community trainers; their organisation's experience in working with CALD people affected by mental illness; and ability to network with and actively engage CALD communities and leaders.

Of 84 applications, 44 were selected for training by MMHA's National Program Manager and Senior Project Officer Policy and Community Capacity Building. An influencing factor in selection of ETs was ensuring an equitable representation across Australian states and territories and that regional, rural and remote areas were represented. MMHA trained 43 individuals from 38 agencies across Australia to become Expert Trainers. There were 29 Expert Trainers remaining at the time of this report (April 2010).

Consultations and program document review found that a formal "sign off" in the form of a management signature was not included as part of the ET nomination and selection process. This resulted in some agencies reporting that they were not aware of the program commitments and did not have the capacity to participate, despite completing the EOI in the positive. This contributed to some program participation drop out by ETs and participating agencies.

4.1.2   *Recruitment Process Recommendations*

Recommendation 1: Where possible, Expert Trainers are identified, and recruited by agencies engaged to deliver the 'Stepping Out of the Shadows' program, with MMHA providing final approval of nominated candidates.

> **Benefits:** This will relieve MMHA of the responsibility of recruiting Expert Trainers at a national level and devolve this responsibility to a more local level where knowledge and expertise of local demographics, potential partner organisations and suitable workers/individuals can be applied to the selection process. All nominees should be approved by MMHA to ensure selection criteria are met.

Recommendation 2: That a more rigorous process is developed to screen and recruit Expert Trainers who express interest in the program and that agency management provide sign off on application forms/endorsement of participation in the program.

> **Benefit:** Decrease the risk of 'drop out' due to inability to commit or lack of agency support.

4.1.3   *Training Process*

MMHA covered travel and accommodation expenses for all Expert Trainers and provided training free of charge. MMHA independently developed a comprehensive training package to implement training with Expert Trainers. This resource was not part of the original training materials developed for the project. Three 'Lead Trainers' (two internal MMHA staff with training expertise and one person who

participated in the 'Stepping Out' pilot training from WA with training expertise) conducted two-day Expert Training workshops in the following locations:

- 1 workshop in Sydney for NSW, SA and the ACT (conducted 9 and 10 June 2009)

- 1 workshop in Melbourne for VIC, SA and the NT (conducted 15 and 16 June 2009)

- 1 workshop in Adelaide for SA and a small number from VIC (conducted 24 and 25 August 2009)

- 1 workshop in Perth for WA (conducted 23 and 24 July 2009)

All training workshops contained a module on 'Working with Consumers in Education Sessions' and involved consumers from CALD backgrounds participating in this module.

Memorandums of Understanding (MOUs) between MMHA and participating organisations with expectations and training delivery targets were distributed on the first day of training. These targets were interpreted by ETs as difficult to achieve considering the resource limitations of the project. Some ETs reported that they did not have a sufficiently clear understanding of what they were committing to by participating in training.

4.1.4 *Training Process Recommendations*

Recommendation 3: MOUs or delivery agreements are agreed to by agencies prior to the commencement of ET training.

> **Benefit:** Minimise the risk of agencies claiming they do not have the capacity to meet expected targets after ETs have completed training, and therefore, minimise the potential for loss of investment for MMHA.

Recommendation 4: That a dollar value of the ET training be defined, and the benefits of training to individuals and organisations be articulated (possibly through a list of competencies achieved as an outcome of training). That participating organisations make a contribution to the cost of training (possibly by matching the MMHA contribution) or that MMHA offer "scholarships" for training rather than "free" training.

> **Benefit**: To increase perceived value of training at the individual and organisational level and to position training is an investment for participating organisations and individuals to build their capacity to effectively work with CALD communities.

4.1.5 *Perceptions of Training*

ET Training sessions were rated very highly by the majority of participants. The knowledge and skills of trainers were consistently reported as excellent; the information presented was thorough and comprehensive; discussion and the interactive nature of the program were highly valued.

> *"The training was great – the trainers knew their stuff and there was a lot of discussion." ET*

The use of consumers in the Expert Training was considered very positive.

> *"The woman who talked about her experience with bipolar was amazing – she really opened my eyes about what it must be like for her being from a CALD community" ET*

ETs reported that they did not have sufficient knowledge of the training program contents prior to attending training. As much of the information was considered new and "groundbreaking" for many of the participants, sometimes "overwhelming" and "a lot to take in two days".

4.1.6 Perceptions of Training Recommendations

Recommendation 5: Distribute a more detailed summary/outline of training contents, aims and methodology to participants prior to training.

> **Benefit:** Participants are better prepared for training and have clearer knowledge of what the training contains and decreases risk of participants feeling overwhelmed by training materials and information.

Recommendation 6: Continue to encourage and support the use of consumers and carers to participate in delivery of training.

> **Benefit:** The first hand "lived" experience of consumers and carers underscores and complements the other aspects of the training, and contributes to the program using a variety of learning approaches. Consumers and carers are empowered to have their experiences heard and influence the understanding of the impact and influence of stigma for training participants.

4.1.7 Expert Trainer Infrastructure

ETs frequently expressed a preference for "back-up" or a co-trainer to work with, i.e. for more than one ET to be trained in their area or organisation, so they could provide mutual support, build confidence and limit working in isolation.

ETs identified the need for greater dialogue and good practice sharing between states and territories, not only within states and territories. Currently, the National Implementation Working Group (NIWG), which meets quarterly, is the only interstate communication mechanism. This provides limited capacity for information sharing for ETs working on the ground. Other intra-state communication mechanisms include: State Coordinator Network Meetings with ETs; and ET convened meetings with the CTs they work with. MMHA is currently developing a password protected online portal via the MMHA website for project participants to share good practice, resources and ideas.

If an Expert Trainer moves on to another job or no longer participates in the program, there is no clear pathway for new ETs to be trained other than waiting for a new round of ET training to be conducted by MMHA.

Many Expert Trainers expressed the need for a greater level of support and supervision from agency management and State Coordinators, and the opportunity to engage in further training to enhance their ability to provide support to CTs, hone their training skills and their ability to work with CALD communities.

> *"The idea of the State Coordinator is good, but they are too distant, and many people are left floundering – they need someone walking alongside to help them learn the process; two days training is not going to set people in good stead to deliver this program. They need process skills, knowledge about mental health and many people don't know where communities are or how to reach them." ET*

4.1.8 Expert Trainer Infrastructure Recommendations

Recommendation 7: Encourage recruiting ETs to work in pairs within an organisation or geographical region to support each other and share workload.

> **Benefit:** Provides ETs with mutual support, back up and provide a more dynamic learning experience for CTs. Also minimises risk that if one ET leaves, an organisation or geographical region loses its capacity to participate in the program.

Recommendation 8: MMHA provide accredited training for Lead Trainers in each state and territory to replenish supply of ETs and/or provide refresher or ongoing training.

Benefit: Devolves responsibility for conducting training to the states and territories. Builds capacity of states and territories to manage training of ETs and creates local expertise which can be supported at a national level by MMHA.

Recommendation 9: That ongoing training and development opportunities be offered to ETs via their participating agencies or program Lead Trainers in each state and territory.

Benefit: ETs skills are developed and strengthened to benefit program implementation. Further training and development opportunities for ETs could assist retention of ETs in the program.

Recommendation 10: At the time of this report, MMHA was in the process of developing a password protected online information sharing portal for project participants. The findings of this evaluation encourage the support and resourcing of this facility to share ideas, good practice, resources and other relevant information amongst program trainers and coordinators. The management of this could be shared by the MMHA Capacity Building Project Officer and MMHA Communications Officer. A subscriber based news group or newsletter could also be created to update trainers on developments, good news stories and inspiring ideas.

Benefit: Enhance intra and inter-state dialogue, sharing of good practice, resources and ideas. Create a greater sense of community amongst trainers and the sense that they are part of something bigger. Relieve the sense of isolation that some trainers feel, particularly those in regional, rural and remote regions.

4.2   COMMUNITY TRAINERS

4.2.1   Community Trainer Recruitment

ETs generally used their existing CALD networks and contacts to recruit CTs as directed in the 'Stepping Out of the Shadows' training. Those who were located within ethno-specific or multicultural services had greater access and links with communities and drew on the strengths of existing relationships.

The Phoenix Centre in Tasmania and Goulburn Valley Mental Health Service in Victoria are the only participating agencies that provide remuneration to Community Trainers. The 'Stepping Out of the Shadows' project has discrete funding allowing for CT remuneration in both of these cases.

> *"CTs who come from emerging communities have great demands upon them –*
> *asking them to work for nothing hinders rather than helps build their capacity."*
> *Manager*

Many CTs were motivated by a strong desire to help their communities with what they perceived as a pressing need:

> *"I wanted to do something for my community – people have been through a lot*
> *and it is good for them to know about how they can get help" CT*

> *"I have seen lots of people going through bad times – with migration, being*
> *homesick, lonely, depressed. I think this will be good for them." CT*

Finding CTs with the appropriate skill set, confidence and capacity to deliver the program was considered challenging for many ETs:

> *"People train for years to be able to do this kind of work; some communities are*
> *very enthusiastic, but it's difficult to find people with the right skills or potential*
> *to develop them." ET*

Participating agency's capacity to recruit CTs without funding attached was limited and dependence on "goodwill" resulted in lack of selectivity:

> *"It comes down to priorities – this program is not funded and other programs are." ET*

> *"At the end of the day, it's not like we are turning anyone away." ET*

Potential CTs raised concerns about needing to work "outside of hours" as many training sessions require weekend or after hours delivery to reach target communities. Potential CTs also expressed concerns about the time and skill required to translate and adapt training materials, which are all in English, except for the translated fact sheets and the DVD training tool.

> *"It's not just the time it takes to deliver the sessions… understanding all the material in the kits, translating it, preparing and organising the sessions take a lot of time" CT*

4.2.2 Community Trainer Recruitment Recommendations

Recommendation 11: Provide remuneration to CTs, as in the case of VIC and TAS:

> **Benefits:** Removes a significant barrier to many potentially valuable CTs participating. Enhances the program's capacity to create work and skill development opportunities for communities who are often underemployed and experience difficulty in finding appropriate work that utilises their cultural and/or professional skills.

Recommendation 12: Further promote and encourage recruitment of CTs by tapping into established community networks/groups with existing supports, infrastructure and community links. This could be done by continuing to share details of examples of success through existing program networks and infrastructure; developing a 'tip sheet' on how to approach and recruit community members; encouraging CTs and ETs with strong skills and experience in this area to mentor or support less experienced CTs and ETs. This could be done person-to-person or remotely depending on geographical locations of participants.

> **Benefits:** Increases efficiency and effectiveness of Community Participant recruitment.

Recommendation 13: Further promote and highlight use of Community Leaders to endorse 'Stepping Out' to promote community buy-in and participation:

> *"The Ethnic Council had already identified four community leaders for development projects – there were our CTs. It saved a lot of time." ET*

> *"We engaged the community leaders. An Afghan spiritual leader talked to the community and said: 'Our country has been at war for 30 years… we are kidding ourselves if we think we don't have mental health issues. This is important for our community.'" CT*

> **Benefits:** Community trust and participation is more rapidly achieved; increases community's perception of the safety and validity of participating if endorsed by respected community or spiritual leader.

4.2.3 Training Process

Many CTs reported that they knew significantly more about stigma after the CT training including what stigma means, where it comes from and how to address it:

"We found out about stigma – where does it come from, what is the sign of mental illness, what does stigma mean..." CT

"This program make me know what is stigma, how it can affect someone, how it can affect the people and what you can do to help someone with mental issues." CT

"We don't really know about this thing before this training. In my country, if someone have this problem, people say: he/she not good people; they are mad...don't talk to them. But when we have this training, we know everywhere people who can have this problem.... I know in our community, a lot of people have this problem. Now they feel they can talk." CT

A key factor for positive training experiences for CTs and ETs was a process of reciprocal learning in which there was an exchange of knowledge and mutual learning between ETs and CTs.

"The ET was the expert in training, we are the experts in our community." CT

"I didn't feel like an "expert" – I bet I learnt more from them than they did from me…" ET

Both CTs and ETs reported that the translated community fact sheets in the manual were a valuable resource for explaining concepts of mental health and specific conditions. More mental health literacy training within the training package. Both CTs and ETs expressed a need for there to be additional content in the manual to support the fact sheets which specifically targets mental health literacy. It was acknowledged that not all communities may be ready for this information, but its availability would be useful for those who were, and would strengthen the stigma reduction potential of the package.

The training materials and activities, which are based on Adult Learning Principles, were sometimes considered "too highly pitched" for some communities or individuals who had limited experience of formal education in their country of origin or in Australia. This raised questions of the limits and boundaries for adapting the training material to match community needs. Although the training material states that it can be used flexibly, there was a lack of clarity about what constituted flexibility and what could be considered compromising or diluting the training material so that key messages might be confused or lost. It was agreed that this often depended on the level of skill and experience of the trainer. There was wide agreement that simplifying the training materials and possibly taking a modular approach, with key training modules complemented by optional modules, could provide a more structured approach to package flexibility.

Both ETs and CTs frequently noted that there were often widely varying degrees of experience and knowledge amongst CTs being trained in a group. This was considered both a strength and a limitation, depending on the skill and ability of ETs to manage the diversity of needs:

"The group of CTs was very diverse in their level of knowledge and experience so it was difficult to pitch the training – however, it was also a strength as it brought diverse points of view to the training." ET

"The training was good…I had never heard about this [mental health] talked about like this before in my community…" CT

Case Example

A South Australian CT training group of 12 people consisted of: five (5) people from Bosnia who had been in Australia for 10 years; three (3) **Karen** people who have been in Australia for two years, one of whom had done tertiary studies in London; and four (4) **Iranians**, two of whom worked as psychologists. The group had a varying range of skills, professions and community concerns. The Karen were particularly concerned about their young people and identified the need for additional support with implementing the training materials. Those with professional mental health skills required more support regarding recruitment and setting up venues, while participants with community development backgrounds needed less support in this area. While this posed some challenges for training the group, overall, expertise, skills and knowledge were shared to build the capacity of all CTs to deliver the training program.

4.2.4   Recommendations for Training Process

Recommendation 14: That principles of reciprocal learning be emphasised for ETs during training, possibly drawing upon the body of literature and research in the area, including the reciprocity in education model by Procter (2003) published by MMHA. Supplementary material could be supplied via the MMHA web portal (under construction at the time of this report). The future review of training materials could include a greater emphasis on this topic.

Recommendation 15: That an additional mental health literacy component or module be developed for the ET and CT Training Manuals. MMHA has identified the potential for this to be undertaken in partnership with Mental Health First Aid and was investigating opportunities at the time of this report. The findings of this evaluation support the need to continue to pursue this possibility.

Recommendation 16: In line with the aims of the MMHA 'Stepping Out of the Shadows' Quality Control Working Group, the findings of this evaluation support the need to review training package materials to determine core training elements and optional modules to assist trainers to adapt materials to meet community needs in a structured way and which facilitates greater quality control.

4.2.5   Availability of Interpreters and Translated Materials

All ET and CT training material are in English, except for the mental health fact sheets and DVD teaching tool. A strong concern for CTs is the requirement for them to "translate" significant amounts of content into their community language in order to deliver the training material. Significant time and commitment is required to do this, and there were repeated claims that this is an "unrealistic" expectation of community trainers. The lack of a specific budget allocation for the use of interpreters or translators as part of the overall funding of the program was raised as a concern:

> *"This is a serious oversight of the program – it is sometimes necessary to have interpreter, including for the evaluation at the end." CT*

The training materials require more than literal translations, but the translation of complex terms or ideas that might have no equivalent in a particular community language or culture. This was an issue for both CTs and ETs.

> *"Some terms took a lot of explaining – use of colloquial language like "rub off" was hard to explain, and the term "relapse" was difficult to explain – some concepts were just so alien." ET*

> **Case Example**
>
> A Victorian organisation made funding for interpreters available for the program as part of its core business. This was deemed necessary to assist the CT to interpret more complex terms and ideas in the package that did not exist in the community language e.g: "risk factors" and "protective factors".
>
> An interpreter was used in a support and developmental role to assist the CT, whose first language was that of the community participants, but required some additional support. The DVD teaching tool was not in the language required (Amharic or Tigrinya), so the interpreter was used for the initial training session to assist in the DVD translation.

4.2.6 *Availability of Interpreters and Translated Materials Recommendations*

Recommendation 17: Translate some key components of the Community Training Manual (based on consultation with CTs). This will increase consistency in the way that in-language material is presented in training sessions. Develop a coordinated approach to reduce the likelihood of duplication of translations - ensure that the availability of translated materials is publicised and shared via the MMHA website and other existing program networks.

Recommendation 18: Consider developing guidelines for the use of interpreters and translators for the 'Stepping Out' Project and flag this as an issue that may require a discrete funding allocation.

4.2.7 *Community Capacity Building Opportunities*

Concerns about the capacity of CTs to undertake the tasks of recruiting participants, organising training, adapting and translating training materials and delivering training sessions have been addressed by some participating organisations in a number of ways:

Less experienced CTs are paired with more experienced CTs and their introduction to training is done gradually by presenting some sections only, co-presenting, or simply observing and being mentored by a CT or ET. Several states have mentioned the value of pairing CTs so they work in teams to support each other, provide back up, lighten the load, and complement each others strengths and limitations.

Some states (Tasmania for example) have developed work sheets and templates for recording hours worked by CTs, work plans, Power Points and other practical tools – these could be shared through the MMHA web portal for the project.

Many of the CTs were identified as underemployed or seeking work. By providing opportunities for knowledge and skill development, the program built community members' capacity to seek employment in the future and enhance social inclusion and participation.

> **Case Example**
>
> A participating Victorian organisation has sought funding of $5000 to fund its 12 community trainers to undertake Mental Health First Aid (MHFA) training. The aim is to work with MHFA trainers to make the training more culturally appropriate for the CT group. The project aims to develop CTs mental health knowledge, including identifying early signs and symptoms of mental illness, concepts of early intervention, recovery, and how to support the families where a member is experiencing mental health issues, to enhance their skills and confidence for delivering the 'Stepping Out of the Shadows' program. The CTs, as leaders in their communities, and are able to spread messages formally and informally and become pathways for knowledge into their communities.

4.2.8   Suicide Prevention Issues

Amongst the CT sample who had delivered training sessions to CALD communities, the topic of suicide was raised as an issue of specific concern. The 'Stepping Out of the Shadows' training was considered an important vehicle for raising the often highly stigmatised issue of suicide in communities and assisting in suicide prevention through community education and discussion.

"We experience so much suicide in the camp...now we say, don't think of killing yourself; think of the solution. If we reduce the stigma, then we reduce the suicide." Sudanese CT

"The lack of information; it can happen something really wrong – I know a young girl who commit suicide – 18 years old – we believe she had some mental illness." CT

"I see a man I was in detention with many years ago. He say: I can't sleep at night, I have very bad situation, I have headache. After few days, I hear he commit suicide…I believe this is very serious illness – people think it's better to kill myself not to suffer more pain...it is very good idea to teach the community." CT

- At the time of this report, MMHA was engaged in developing a national project to create suicide prevention resources in partnership with Tasmania (where a discrete suicide prevention component has been developed for the 'Stepping Out Training') and Western Australia.

Case Example

The Tasmanian implementation of the 'Stepping Out of the Shadows' program is funded through the National Suicide Prevention Strategy and incorporates a suicide prevention component developed in partnership with the Lifeline ASIST (Applied Suicide Intervention Skills Training) program. The program uses a 'sharing model' where participating communities share their understanding and ideas around the issue of suicide including how different communities respond to suicide, the impact it has on individuals and communities, and how to respond to people at risk of suicide and bereaved families. The program aims to create awareness and understanding of what services are available in Australia and an understanding of the service gaps and issues for CALD communities. Lifeline was chosen in an effort to create a stronger connection with mainstream services and to allow mainstream services to learn about community needs and for communities to learn about the services available.

4.2.9   Suicide Prevention Issues Recommendations

- **Recommendation 19:** Make a suicide prevention module or session a standard component in the 'Stepping Out of the Shadows' training manual and made available to all participating states and territories.

4.2.10 Regional and Rural Issues

A 'Stepping Out of the Shadows' pilot program was conducted with the Transcultural Regional and Rural Outreach Project (TRROP) in NSW, where a shortened version of the program was delivered to spiritual leaders in selected communities to enable them to act as a conduit for mental health information to their communities. This approach was taken as TRROP consultation with communities identified that in times of stress or worry, many people turn to a spiritual or religious leader. The participants in the pilot identified specific issues in relation to the delivery of the 'Stepping Out of the Shadows' program in rural and regional areas. Program participants in other regional and rural areas of Australia also identified issues specific to rural and regional areas, which included:

- The scattered nature of CALD populations in some regional and rural areas makes it difficult to target and recruit community participants. Low numbers of people in individual language groups makes it difficult to provide in-language training.

- The limited availability of public transport, its cost and the time required to travel long distances to attend training created barriers to participation for both CTs and community participants. For single parents of large families, these issues were compounded by the lack of childcare and the perception that the time required to attend training would compromise the ability to fulfil family duties.

- Community Training sessions needed to take into consideration seasonal work periods (such as fruit picking) as this could impact on CALD communities' ability to attend. Some trainers recommended conducting training after hours or when fruit-picking season was over.

4.2.11 Regional and Rural Issues Recommendations

- **Recommendation 20:** Continue to explore opportunities to modify delivery of the 'Stepping Out of the Shadows' program to respond to the needs of CALD communities in rural and regional areas in Australia.

4.3   COMMUNITY PARTICIPATION IN TRAINING

4.3.1   Recruitment

As is recommended in the Community Trainers Manual, participant recruitment worked well when CTs tapped into existing networks, for example, sewing groups, carer's groups, ethno-specific support and social groups. Some of these pre-existing groups provided access to a training venue and childcare, which are significant enablers to community participation.

The engagement of respected community leaders through pre-training briefings, discussions or introduction sessions provided endorsement of the training in communities and assisted with "word of mouth" promotion:

> *"We held a meeting with a group of spiritual leaders and they spread the message in their communities. It's better coming from them than coming from us." CT*

The time commitment required to complete a full training package was identified as a barrier to many communities, especially those who experienced challenges related to settlement, employment and family responsibilities.

> *"For a lot of communities, this is a big ask." CT*

A reluctance to engage with anything related to "mental health" was identified in some communities, and therefore the term "wellbeing" was often substituted. It was identified that communities are in varying positions along the continuum of 'Community Readiness' as described by Edwards et al (2000), a resource provided to trainers by MMHA, and that some communities may not be ready for this type of training.

The funding provided by the Victorian Department of Health of $500 per completed training package assisted in reducing barriers for participants to attend and provided incentives:

> *"By providing transport and a meal, we greatly increased the opportunities for people to attend." CT*

> *"We paid the women to provide halal catering – that is capacity building." CT*

The program implementation in Tasmania also provides funding for this aspect of the program. Tasmanian CTs report that this greatly assisted in reducing barriers, such as lack of transport and childcare, for many communities to attend.

4.3.2   Community Participant Recruitment Recommendations

Recommendation 21: Provide access to suitable venues, transport and childcare through specifically allocated funding.

Recommendation 22: Provide community incentives and capacity building opportunities by paying community members to provide food, transport, childcare or other suitable activities to support program delivery and accessibility.

4.3.3   Training Process

CTs identified that training participants with little or no literacy in English or their own language and/or limited experience of any formal education, found the training challenging and reported that substantial adaptation of training materials and simplification of language in the manuals was required. This included omitting some activities (for example the 'Determinants of Health' exercise was frequently reported to be confusing and was omitted by some trainers, or the language used in the activity was significantly simplified).

The use of the translated DVD teaching tool was reported as highly successful. Visual material was reported to be effective for communities with limited literacy and education experience. It was also identified as highly suitable for cultures or communities that mainly use oral traditions and storytelling techniques to discuss and address issues. Although the DVD was identified as having some limitations (the recovery seemed rapid; it was not translated into some target community languages such as Amharic and Tigrinya), the use of visual tools and aids was considered to be highly effective.

The 'Stigma Tree' activity, which also used visual elements - the representation of a tree and its roots to discuss where stigma comes from - was also reported to engage communities and worked as a practical tool to get communities openly discussing the "roots" of stigma and how it is manifested.

CTs frequently reported that keeping communities "on track" with the training posed challenges as other issues of concern frequently arose:

> *"One session with Sudanese women kept turning to issues related to parenting – this was the women's main issue – it was difficult to keep them on track and direct them to talking about how this impacts on their mental wellbeing." CT*

CTs have varying levels of skills and qualifications in group facilitation, community training and mental health knowledge. Some CTs required greater support from ETs to deliver and facilitate training sessions. This could be challenging for ETs who had competing priorities and limited time to fulfil what was considered a crucial role for some CTs, and could mean the difference between a CT staying in the program or losing the confidence to persist.

> *"They [CTs] felt they needed time to practice and go through the activities... they did not have the confidence to do it themselves. They wanted to observe someone conducting the package and needed me to sit with them individually and go through the manual together." ET*

Training CTs to work in pairs was reported to be an effective way of assisting them to develop confidence and "lightened the load" of conducting a training session alone. This allowed them to learn from each other and complement each other's skills and limitations.

Concerns were raised regarding CT's abilities to deal with disclosure of mental health issues during a community training session and the risks associated with this. For examples of how this issue has been effectively addressed, see the Case Example on page 28 regarding providing CTs with Mental Health First Aid Training, and the Good Practice Case Study (6.1) where a 'Stepping Out of the Shadows' Project Officer with mental health experience has been assigned to closely support CTs and attends all CT training sessions. The program's implementation through the local Area Mental Health

Service meant clear pathways for referral were identified and one training session in regional Victoria resulted in four (4) referrals of Iraqi men.

It was suggested that clinicians with cross-cultural skills and experience be used as part of training sessions to break down barriers between communities and service providers, engage communities and demystify the system to address barriers and negative community perceptions.

The final module in the Community Training Manual asks communities to consider what they can do in their communities to reduce stigma. In regional Victoria, a response was:

> *"The Afghan leaders are very enthusiastic – they want to turn it into a theatrical production with traditional music." CT*

The CTs interviewed agreed that although the information included in the training manual is new to many of their communities, it is a much-needed resource and mental health and wellbeing are issues that urgently need to be addressed in their communities.

> *"One CT who has a son with mental health issues said to me: if I knew what I know now, I think things would be different." CT*

> *"…A list of reflections from our community – this was one of the activities in training. [Reads from list] The people did not know about this. The people used to didn't talk about this sort of things; it was shame, it was disgraceful. Now they start talking... we know about locations where we can go to find psychiatrist, psychologist, where to get help. When people get together now, we are talking about these things." CT*

> *"My young son is affected by this illness. I tell you I did not have any idea about this; when I come to this office and see this paper [referring to kit and contents] – I see this is the problem of my son. Before, I not have any idea what to do, where to go." CT*

4.4   FURTHER IMPLEMENTATION ISSUES

4.4.1 Evaluation Tools

The evaluation tools included in the 'Stepping Out of the Shadows' program are:

- Session Evaluation Tool: Participant questionnaire

- Program Evaluation Tool: Participant questionnaire and Facilitator questionnaire

- Impact Evaluation Tool: Family Stigma questionnaire and Levels of Stigma questionnaire

- Participant Demographic Data Tool: Participant questionnaire

The evaluation tool instructions in the 'Stepping Out of the Shadows' package comprehensively identify the strengths and weaknesses of each tool and recommend when to use particular tools.

The Participant questionnaire was completed by 100% of participants who completed the Expert Training workshop; however, there is a significant lack of uptake of the evaluation tools amongst Community Trainers and Community Participants. The key challenges identified by program participants were: that there were too many tools to choose from, which caused confusion; that all evaluation forms are in English, causing a significant barrier to use with CALD communities, particularly where literacy is limited; and that evaluation was considered a time consuming activity in a package that already stretched most participants in terms of time commitment.

For the purposes of the overall evaluation of the 'Stepping Out of the Shadows' program, the large number of evaluation options for CTs and Community Participants in the training package limits the capacity of any single tool to generate sufficient data to have integrity for evaluative purposes. In addition, this evaluation found no clear systems or guidelines for the collection of completed evaluation tools, how they were to be used and their secure storage.

4.4.2 Evaluation Tool Recommendations

Recommendation 23: Consider integrating the impact evaluation into the program delivery by applying the questions in the Family Stigma Questionnaire (Corrigan et al, 2004) to the story in the DVD teaching tool at the beginning of each package to gather baseline perceptions of stigma, then showing or recapping the DVD story at the end of training and asking the same questions. This could be done verbally as a focus group, or as a written exercise where appropriate.

Benefit: Streamlines and integrates the evaluation process and increases likelihood that evaluation occurs.

Recommendation 24: Make the evaluation tools available as online surveys for trainers and participants where appropriate. Existing software such as 'Survey Monkey' could be used.

Benefit: Streamlines and centralises the collection of data and makes data readily available for analysis instead of coding information from hard copy evaluation sheets.

Recommendation 25: Develop systems and guidelines for the collection, storage and use of evaluation data from the program. Feed back findings from analysis of evaluation data to participating states and territories to assist in the continuous improvement of program processes.

Recommendation 26: The development of a succinct and simple 'tip sheet' for trainers on the importance of evaluation, which tools to use and how to submit information.

Benefit: Highlight the importance of evaluation and potentially increase completion of evaluation by providing clear, simple instructions.

4.4.3 Reporting and Monitoring

The current reporting and monitoring mechanisms for the MMHA 'Stepping Out of the Shadows' project are:

- Quarterly meetings of the National Implementation Working Group (NIWG) with minutes distributed to all working group members.

- Network meetings of ETs with State Coordinators (where they exist) or their equivalent. MMHA Project Coordinator phones in at conclusion of these meetings to address any issues raised and to share program information.

- Network meetings of CTs within each state with their respective ETs

- 'Stepping Out of the Shadows' reporting template with: program status; positive events; challenges and other comments, to be completed by State Coordinators (or equivalent) and submitted to MMHA quarterly. This information is consolidated and distributed to each State Coordinator.

- State Coordinator Meetings convened quarterly.

- Quality Improvement Working Group.

These activities provide a strong framework for a process of continuous improvement where findings are shared; incremental changes are made, outcomes shared and changes can be applied more

broadly. This process could be formalised and enhanced by applying a Continuous Improvement Plan, which is a set of activities designed to bring gradual, but continual improvement to a process through constant review. The Shewhart Cycle, generally referred to as the PDSA cycle, is among the best known. The tool is dynamic, yet straightforward: it is a wheel divided into four quadrants – Plan, Do, Study and Act. It is very reflective of the "continuous journey" character of continuous quality improvement and allows programs processes to be continually improved through incremental changes.

With a program of this type and scale, there is the risk of creating a reporting burden for participants. The program currently provides a good balance between having a clear reporting framework that is practical and sustainable for program participants.

4.4.4 Reporting and Monitoring Recommendation

Recommendation 27: Implement a Continuous Improvement Plan to enhance the current system's ability to make incremental changes and monitor, measure and share results as part of a process of continuous quality improvement.

4.4.5 Training Manuals

The training manuals are currently provided to all ETs and CTs as full-colour hard copies presented in a ring binder folder. Significant savings could be made on the production of future manuals, without compromising quality, by making them available as PDF documents which could be downloaded from the MMHA website. If some hard copies need to be printed, it would be advisable to convert the current full-colour design to a simple two-colour design, which would reduce hard copy printing costs by approximately two thirds. Updates and additions to manuals could also be made available as PDFs on the MMHA website to reduce printing costs.

4.4.6 Training Manuals Recommendation

Recommendation 28: Reduce the per unit cost of future manuals by making them available online as PDFs and modifying the existing design from a full-colour manual to a two-colour manual, reducing any hard copy costs by approximately two thirds.

5. CONSUMER AND CARER INVOLVEMENT

5.1 SUMMARY OF CONSUMER AND CARER INVOLVEMENT

Consumer and Carer involvement in the 'Stepping Out of the Shadows' program consists of:

- One consumer and one carer representative on the Joint Officers Group (JOG)

- One consumer represented on the National Implementation Working Group (NIWG)

- Three (3) consumers participated in delivering the Expert Training workshops through the 'Consumers in Education Sessions' module

- One (1) CT is identified as being a consumer and one CT as a carer. It is possible that the representation is greater than the identified sample as many CTs or ETs may choose not to disclose this information.

5.2 CONSUMER AND CARER INVOLVEMENT IN TRAINING

Both the CT and ET training manuals contain a section which states that:

> *"One of the most effective ways of reducing stigma is positive and meaningful interaction between consumers of mental health services, (people with mental illness or their carers) and the wider community."*

Three (3) consumers participated in delivering the Expert Training workshops through the 'Consumers in Education Sessions' module. One (1) consumer participated in each of the workshops conducted in NSW, VIC, WA and SA.

The involvement of consumers in Expert Training sessions was positively received by ETs.

> *"The person who talked about their personal experience of having a mental illness was amazing – it really opened my eyes." ET*

There was no involvement of Carers in Expert Training sessions and this was considered an oversight by consumers who participated in the Expert Training sessions.

Consumers considered their involvement in Expert Training sessions as minimal and not well integrated.

> *"I felt a bit like I was rolled in and rolled out. I would have liked my role to be more integrated into the training." Consumer*

> *"There are only two pages in the manuals about how to work with consumers and carers in training." Consumer*

No Community or Expert Trainers reported using consumers or carers in training sessions. They reported that accessing CALD carers and consumers willing to take on this role was difficult due to stigma, privacy concerns (particularly in smaller communities) and lack of confidence and skill of many CALD consumers and carers to undertake the role. Some trainers also reported their own lack of confidence in providing the necessary support to CALD carers and consumers as a barrier to facilitating their participation.

5.2.1   Consumer and Carer Involvement in Training Recommendations

Recommendation 29: Use the MMHA Speakers Bureau (which recruits, trains and supports consumers and carers in speaking engagements) for states to source and support consumers and carer involvement at all levels – including Expert Trainers, Community Trainers and community training sessions.

> *"We have 40 speakers across Australia in the Bureau. We should be using them." Consumer*

Benefits: Uses existing MMHA program infrastructure and builds on its strengths and enhance the capacity of CALD consumers and carers to participate in stigma reduction. MMHA has partnered with *Mindframe,* (the national initiative aiming to influence media representation of issues related to mental illness and suicide) to develop a resource and training package including topics such as information about MMHA and their key messages; tips for public speaking; preparing for a speech and principles and tips for working with the media. Together with a selection of other relevant materials from *Mindframe* and MMHA, the printed resource will be packaged in a "resource pack" for distribution to Speaker's Bureau members.

Issues: The current Speakers Bureau has 40 CALD consumers and carers listed. They do not cover all states and territories. For this to work well, there may need to be broader recruitment across geographical areas and targeting of particular language groups where there is evidence of high demand.

Recommendation 30: Ensure Carers are involved in training by tapping into multicultural carers groups via, ethno-specific carers groups and CALD carer consultants and the MMHA Speakers Bureau and consumer and carer reference groups.

Recommendation 31: A participating consumer identified the benefit of producing a short DVD which presented real life CALD consumer and carer stories to be used as a resource for training sessions, particularly for communities or geographical regions which had difficulty accessing consumers and carers to participate. This could be produced in partnership with other organisations around Australia, or discrete program funding could be sought. For examples of this type of resource, see Information Cultural Exchange (ICE) Digitales projects at www.ice.org.au/projects/digitales/, which work specifically with CALD communities.

This recommendation addresses the previously articulated need to provide visual materials for communities with limited literacy and/or where narrative-based/storytelling methods are preferred method for discussing issues.

> *"We need real stories about real people living real lives, participating and contributing." Consumer*

Recommendation 32: If revisions of training manuals occur, review content relating to carer and consumer involvement in consultation with CALD carers and consumers.

6. GOOD PRACTICE CASE STUDY

6.1 GOULBURN VALLEY AREA MENTAL HEALTH SERVICE

The Goulburn Valley Area Mental Health Service located in Shepparton in regional Victoria commenced implementation of the 'Stepping Out of the Shadows' project in November 2009.

The program implementation is fully funded by the Goulburn Valley Area Mental Health Service (see Table 1.) In addition to committing to fully fund the 'Stepping Out of the Shadows' program, the service has modified the program delivery model to enhance the organisation's capacity to deliver the program (see Program Model, Diagram 3). The model includes the additional role of a 'Stepping Out of the Shadows' Project Coordinator, who supports the ET and provides on the ground support to CTs in all aspects of the delivery of the program. The location of the program within a mental health service means that project staff have mental health knowledge, experience and services links, so if disclosures occur during the training process and referrals are required, program staff have the skills to manage this process appropriately. To-date, there have been four known referrals linked directly to a 'Stepping Out of the Shadows' training session in the region.

Other features of the program implementation include:

- Program integrated into strategic and work plans (access and equity, cultural competency). Strong management support at all levels.

- Dedicated Program Project Officer (Community Trainer trained) has mental health background (funded 3-day per week position).

- CTs recruited through Ethnic Council existing program – existing capacity built upon. CTs paid $20 per hour. Trainers are from following target communities: Congolese, Sudanese, Iraqi and Afghan. Community Trainers are already identified community leaders with community trust and support.

- Program Project Officer provides strong CT support (attends all training sessions), mentoring and skills development.

- $500 per completed package provided by funding from Victorian Department of Human Services covers: transport, childcare, catering. Community members paid to provide some services through this funding (e.g. women provide culturally appropriate catering. Adds to overall capacity building aims of project).

- Certificates of completion awarded to trainers and participants.

- Afghan community members who have completed training are developing ideas to produce a theatrical production (in-language) using traditional music and storytelling techniques to disseminate the stigma reduction message in their community.

> *"Without the funding and the commitment from management, we wouldn't be able to do what we are doing." ET*

The 'Stepping Out of the Shadows' program is viewed by Goulburn Valley Area Mental Health Service management and staff as an opportunity to engage with CALD communities, create awareness and understanding of mental health services and to reach a segment of the community that is traditionally underserved by the service. The 'Stepping Out of the Shadows' Project Coordinator position has been made a permanent part-time position within the service to build on and sustain the significant community and staff capacity that has been developed through the project. The service plans to expand the role of the Project Coordinator to enhance the service ability to develop and implement programs to meet the needs of culturally diverse communities in the region.

Table 1. Goulburn Valley Area Mental Health Service Program Budget Jul 09 to Apr 10

Item	Budget	Comment
Project Coordinator	$16,000	$500 P/W x 32 weeks
Bi Lingual trainers x 8 for 3 days training	$ 3,800	$20.00 P/ hour x 192 hours
Bi Lingual trainers x 8 for 12 workshops (2 trainers at each workshop)	$ 3,800	$20.00 P/hour x 192 hours
Venue for 12 community sessions		May be able to use CPOH
Catering for 3 days training	$ 450	$150 P/day
Catering for 12 community sessions	$1,800	$150 P/session
Advertising and training material	$2000	120 participants at $15 per head
Use of car for Project Coordinator		Utilise existing GVAMHS car fleet
Total:	$27,850	

Diagram 4: Goulburn Valley Area Mental Health Service Program Model.
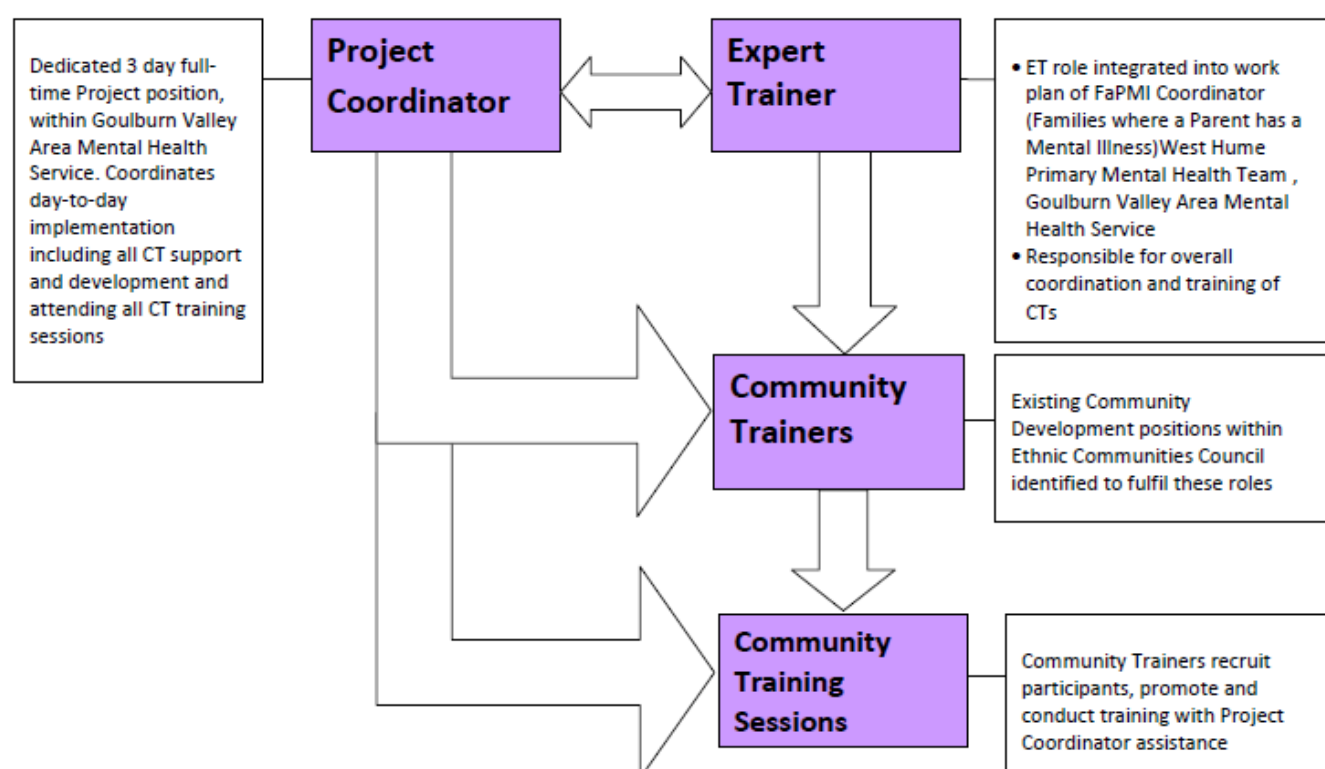
7. REVIEW OF OTHER MENTAL HEALTH EDUCATION PROGRAMS AND LINKAGE OPPORTUNITIES

This section provides a brief overview of other mental health education programs – both CALD-specific and mainstream – across Australia and their potential to link with the 'Stepping Out of the Shadows' program.

7.1 CALD-SPECIFIC MENTAL HEALTH EDUCATION PROGRAMS

7.1.1 'Fear and Shame' (Macedonian play)

The play 'Fear and Shame' explores themes of mental illness and stigma within The Macedonian community. This play was written by Dushan Ristevski, a Mental Health Counsellor with the St George Mental Health Service (Sydney NSW) following a series of research projects and clinical experiences. The research highlighted widespread negative views and discrimination regarding mental illness within the Macedonian community. The theatre production creatively explores mental illness, stigma, and treatment. It aims to promote community awareness of mental illness and community understanding of the impact of stigma on those affected.

The un-intrusive theatre based approach was seen as one of the most culturally appropriate and widely accessible methods to address these issues to all members of the community. At the end of 2006 the play was published in the Macedonian language, and in English in 2009, and is available as a resource to carers, consumers and the general community. In addition to the local artists, consumers and carers were engaged in the production and the play, which was performed by a community theatre group in 2008.

The 'Stepping Out of the Shadows' process evaluation identified that the Afghan community in Shepparton Victoria who completed the community training sessions expressed interest in producing a play about mental illness and stigma using traditional music and storytelling techniques. 'Fear and Shame' is a useful example of this method being used to engage the community, and could be presented as an example of community activity in the 'Stepping Out of the Shadows' training, or as a supporting resource for the program on the MMHA website.

7.1.2 Mental Health First Aid (Vietnamese)

Mental Health First Aid (MHFA) is a fee-based, 12-hour adult mental health literacy education program developed in 2000 by Betty Kitchener and Professor Tony Jorm and is now auspiced by the Orygen Youth Health Research Centre and the University of Melbourne. Mental Health First Aid courses are available in all states and territories in Australia and are delivered by accredited Mental Health First Aid instructors.

The program is currently available in Vietnamese and is delivered by bi-lingual instructors using translated MHFA materials which are available for purchase from the MHFA website. The delivery of the program to Vietnamese communties was evaluated in 2009: 'Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia', Minas et al. 2009. Overall the study demonstrated "significant reductions in stigmatising attitudes, improved knowledge of mental health disorders and improved knowledge about appropriate forms of assistance to give people in the community with a mental health disorder." However, the study also states that "Participants were well educated (almost half had a University degree and more than a third were students at the time of training)" .

An interview with Betty Kitchener for this evaluation confirmed that the MHFA program is best targeted to communities who are literate in their own language and who have reasonable experience of formal education. Betty Kitchener also identified that MHFA sought to develop the program in three languages – Vietnamese, Croatian and Italian – with funding from the ACT government, however,take

up in the Croatian and Italian communities was extremely limited. These language groups were targeted based on ACT population rather than community need or interest. No needs analysis was conducted. Consequently, the program no longer operates in these languages.

Ms Kitchener also identified that two people of African background - one male clinical psychologist and one female, psychiatric nurse - were trained as MHFA instructors in Melbourne as need was articulated by the community. Ms Kitchener reported that there was a need to review why this "did not take off" and believes there were "issues around literacy, on-the-spot translation, cultural appropriateness, the terminology, and dealing with cultural sensitivities". She reported that it would have been beneficial to collaborate with other appropriate organisations to develop a funded project to produce an adapted module for African communities. She confirmed that there is a clear opportunity here with organisations such as MMHA and to tie the initiative in with the Fourth National Mental Health Plan goals of prevention and early intervention and a focus on recovery and social inclusion, but cautioned that funding for such a project was crucial.

7.1.3 *Stepping Out of the Shadows – Promoting Acceptance and Inclusion in Multicultural Communities in Queensland – feedback from Queensland Health*

The Queensland Transcultural Mental Health Centre (QTMHC), which developed the 'Stepping Out of the Shadows' package in partnership with MMHA, commenced implementation of the program at a state level in 2008 and is therefore not included as part of the national implementation of the program by MMHA. The QTMHC has provided details of the learnings from their implementation of the program in Queensland to contribute to the overall findings of this evaluation report. These learnings could be shared with other organisations involved in delivering the program via the MMHA website, CT and ET networks, the National Implementation Working Group and other relevant avenues. A number of resources have been developed by the program, which could be shared amongst all organisations delivering the program to prevent unnecessary duplication of resources.

In 2007, the Queensland Government released the 'Queensland Plan for Mental Health 2007-2017', which included as a key priority programs to increase mental health literacy and reduce stigma and discrimination in CALD communities. The QTMHC received additional resources via enhanced funding for Promotion, Prevention and Early Intervention and commenced the implementation of 'Stepping Out of the Shadows' in 2008.

QTMHC allocated approximately $220,000 in 2008/09 and approximately $100,000 in 2009/10 of the PPEI funds it received to the following resources to facilitate implementation including:

- Coordinator Position (0.8 FTE)

- Sessional Bicultural Community Mental Health Promoters (BCMHPs): this pool was expanded to 13. Some BCMHPs worked across communities, e.g. Iranian and Afghan, and some communities had two BCMHPs working in different geographical areas, e.g. Italian in Brisbane and Cairns. They work around 150 hourrs each per annum in their communities.

- Temporary Project Officer to design and implement communications/ethnic media strategy and engage with the NGO sector and ethnic/multicultural associations in order to deliver the 'Stepping Out of the Shadows' workshops to established groups from additional CALD communities.

In addition,

- The QTMHC's CALD Consumer Participation Co-ordinator played an active, supportive role co-ordinating and training consumers involved in the project.

- The QTMHC's Mental Health Promotion, Prevention and Early Intervention Co-ordinator provided project supervision.

The Queensland program targeted 17 communities: Afghan (Brisbane and Gold Coast); Burundian; Cantonese-speaking; Croatian-speaking; Greek; Italian (Brisbane and Cairns); Iranian (Gold Coast);

Japanese (Cairns); Korean; Mandarin-speaking; Maori; Samoan; Serbian-speaking; Spanish-speaking; Sudanese (predominantly South-Sudanese); Turkish (Gold Coast); Vietnamese.

Key implementation strategies included:

- Train and up-skill the pool of BCMHPs with the stigma reduction program and support them in the delivery of the program in their communities.

- Engage with CALD communities to gain their support in the implementation of project strategies aimed at their own community.

- Develop and deliver effective stigma reduction messages using the most effective communication mechanisms in each community, including ethnic media.

- Involve mental health consumers in the delivery of stigma reduction activities.

- Support community initiatives aimed at decreasing stigma and increasing mental health literacy.

- Integrate relevant components of the project with other QTMHC Programs for sustainability.

Key learnings from the implementation of the QTMHC program include:

- Multilevel strategies are required eg: ethnic media, stigma awareness sessions, engagement with community leaders and elders, in order to maximise the outcomes of the program. The "Stepping out of the Shadows" program is an important mechanism as part of a broader strategy. As a stand alone strategy or as a separate project it will not achieve sustainable results.

- Sufficient resources are required to train bicultural community mental health promoters and establish ongoing supervision and support mechanisms

- 'Stepping out of the Shadows' training materials and stigma messages has to be tailored to individual cultural communities.

- In some instances the key messages of the ten-hour workshop have been delivered in two-hour and three-hour one-off workshop and achieving positive outcomes.

- The family narrative story (story based on the family scenario in the training DVD) was a highly successfully strategy with the ethnic media resulting in some referrals and attendance to community workshops.

- Creative strategies adapting the "Stepping out of the Shadows" training materials can be successful in promoting the stigma reduction message in other media eg plays and skits in the Burundi and Italian communities.

- Workers who are trained to deliver "Stepping out of the Shadows" must have clear referral pathways to respond to people who are identified as requiring mental health support (and are ideally located in or have close links with a service where clinical services are available.) i.e. the 125 community referrals generated by the project for clinical services.

- The ethnic media strategies will generate responses from people from multicultural communities seeking mental health support for themselves or a family member and a clear process needs to be in place to respond to that.

- 'Stepping out of the Shadows' will generate a need for more mental health literacy information and a strategy needs to be in place to respond so that the momentum created is capitalised on. For example, via the same agency or a partnership with another organisation that has capacity to deliver multicultural mental health literacy programs.

Key outcomes of the program in 2008-2009 included:

- Delivery of 87 stigma reduction programs across 17 communities in Queensland

- Reaching an estimated audience of 112, 000 with stigma reduction messages via workshops, community and ethnic media messages

- 97 ethnic community leaders and elders attending the project launch

- Implementation of a range of creative strategies to deliver the stigma reduction program including a play in the Burundi community (attended by 79 community members) and skits in the Italian community in Dimbulah and Mareeba (attended by more than 200 Italian community members)

- Development of a CALD consumers' perspective stigma education handbook and training three consumers to participate in stigma reduction initiatives.

- 60% of participants who completed the evaluation survey stated that they would behave differently towards a member in their community with mental illness and their family following participation in the program

- The project generated 125 referrals of individuals from multicultural communities to clinical services provided by QTMHC and mental health services. A number of these people had been living with untreated mental illness for many years.

- 18 children and young people were referred by the project to the *BRiTA Futures* Program (group resiliency building program for CALD children and young people)

- Project brochures were developed in 16 languages

- Family Stigma Questionnaire and the Stigma Reduction Program Evaluation Questionnaire translated into the following 12 languages: Arabic, Chinese, Croatian, Farsi, Greek, Italian, Korean, Samoan, Serbian, Spanish, Turkish and Vietnamese.

- Audio recording of 'Stepping Out of the Shadows: A Family's Story' available in: Arabic, Cantonese, Croatian, Dinka, English (script only) Farsi, Greek, Italian, Korean, Mandarin, Samoan, Serbian, Spanish, Swahili, Turkish, Vietnamese.

- Four print 'ads' or chapters of the 'Family Story' in Chinese, Croatian, Greek, Italian, Korean, Samoan, Serbian, Spanish and Vietnamese.

The QTMHC has available a number of strategies to provide pathways to additional mental literacy activities such as mental health literacy modules it has developed ('Building on cultural strengths for better settlement and wellbeing'), 'BRiTA Futures', which is a group resiliency building program for CALD children and adolescents. QTMHC is currently developing a 'BRiTA for Adults' program and 'Mental Health First Aid' training – more than 100 ethnic community leaders and multicultural sector NGOs have been trained by QTMHC to date. QTMHC emphasises that the key to sustaining the outcomes is to ensure that stigma reduction strategies are well integrated into ongoing programs and service delivery models.

7.1.4 *BRiTA Futures Project, Queensland Transcultural Mental Health Centre*

The BRiTA Futures program began in 2002 in response to a study 'Coping in a New World' (2001) that investigated the mental health needs of young people from culturally and linguistically diverse (CALD) populations.

There are two different versions of the BRiTA Futures program, one for adolescents and one for primary school aged children. Both versions of the resiliency building program use creative and interactive activities, discussion questions and take home activities to facilitate the learning of key objectives. Each version of the program includes a facilitators manual, participant's workbook, a training program for facilitators and evaluation materials.The BRiTA Futures program is designed for use with small groups in school or community settings or in CALD or youth related agencies.

BRiTA Futures trains facilitators and co-facilitators in the running of the BRiTA Futures program.There are currently 144 group facilitators trained. At December 2009, a total of 99 children and 412 adolescents in Queensland had participated in the respective versions of the BRiTA Futures Program.

The BRiTA Futures program is evaluated using pre and post-questionnaires developed to measure change in the key learning areas.There are also weekly/sessional questionnaires for both the participants and the facilitators to measure responses to each session and questions for a focus group to be held at the completion of the program.

7.1.5 Champions for Mental Health: Centre for International Mental Health, University of Melbourne

This project aims to increase the depth, range and quality of connectedness between CALD people with mental illness and their families, CALD and mainstream community organisations, and health and social services (particularly mental health services) in the City of City of Maribyrnong in the western region of Melbourne, Victoria. The project aims to achieve this by fostering leadership for mental health within CALD communities through training and supporting 200 CALD community volunteers to become Champions for Mental Health. Expected project outcomes for CALD families are improved social connectedness and participation (reducing social isolation, one of the key social determinants – and consequences - of mental illness), improved understanding of mental health and illness and of how to gain access to mental health and social services, and reduction of stigma and discrimination. The project aims to assist mental health services to understand and to respond appropriately to the needs and preferences of CALD communities, and to engage the capabilities of those communities in promoting the mental health of their members.

This program has some common objectives with the 'Stepping Out of the Shadows' program and could have the potential to link communities to the 'Stepping Out of the Shadows' training programs. At the time of this evaluation, this program had not commenced and direct contact with the program developers was not made.

7.1.6 Mental Illness Education ACT (MIEACT) Culturally and Linguistically Diverse Program

In 2004, MIEACT was involved in a community development project with the Chinese, Finnish and Tongan communities in the ACT. Bilingual Workers recruited in 2004 conducted focus groups with their respective community members. Each of the communities had the opportunity to identify their own mental health issues and to develop, with MIEACT's assistance, a mental health education program that suited the needs and cultural frameworks of their group.

The Bilingual Workers conduct mental health education sessions in their communities and sometimes assisted in presentations to other communities. These sessions initiated discussion about a sensitive topic and aimed to increase the capacity of the communities to talk about and deal with mental health issues.

The report on the project is not publicly available. MIEACT is not currently running a specific CALD focussed community education program. MIEACT Executive Officer, Pam Boyer, was a member of the ACT 'Stepping Out of the Shadows' Project Steering Group. The ACT has withdrawn from participating in the MMHA 'Stepping Out of the Shadows' program as it was perceived to not be meeting community needs. The ACT has expressed interest in seeing how the 'Stepping Out of the Shadows' program develops and does not discount the possibility of linking with MMHA in further stigma reduction activities.

7.2   BUILDING ON EXISTING RELATIONSHIPS

MMHA has existing relationships with national mainstream organisations including Mindframe, beyondblue, Mental Health Council of Australia (MHCA) and SANE. These existing relationships could be harnessed to promote the 'Stepping Out of the Shadows' program as a vehicle to build the capacity of mainstream mental health promotion organisations to be responsive to the needs of CALD communities.

7.2.1 Mindframe

The *Mindframe* National Media Initiative is funded by the Australian Government Department of Health and Ageing and guided by the National Media and Mental Health Group with representatives from peak media and mental health organisations. The *Mindframe* Initiative is a comprehensive strategy that aims to influence media representation of issues related to mental illness and suicide,

encouraging responsible, accurate and sensitive portrayals. The Initiative also supports SANE Australia's Media Centre and *StigmaWatch* program, and specific projects helping to build the evidence base for this work, developing resources for film, television and theatre, developing resources for police and courts, and helping to build evidence base for this work.

MMHA's existing relationship with *Mindframe* includes a project to develop a training package for the MMHA Speakers Bureau. This relationship could be built upon to encourage *Mindframe* to address the specific issues affecting CALD communities in relation to mental illness and suicide and the particular ways that stigmatising attitudes develop in these communities, thereby building mainstream capacity to engage with and understand the particular needs and issues of these communities.

7.2.2   beyondblue

beyondblue acknowledges that cultural diversity is an important aspect of Australia's community with over 40 per cent of the population either born overseas or with a parent born overseas, through their website and associated literature. Multicultural Mental Health Australia has partnered with *beyondblue* to provide information about depression in a number of languages. This information has been translated by accredited translators with input from mental health professionals and consumers and is available on the *beyondblue*, SANE and MMHA websites.

beyondblue has developed TV, radio and print advertisements and posters in Arabic, Chinese (Mandarin), Greek, Italian, Polish and Vietnamese on the following topics: bi-polar disorder; older people; drugs and alcohol; and post-natal depression. These materials are available for download from the *beyondblue* website. This evaluation has identified that translated visual material is greatly appreciated by communities with limited literacy in English and/or their own language. The resources developed by *beyondblue* could potentially be used as supporting visual materials in the 'Stepping Out of the Shadows' training program with permission from *beyondblue.*

7.2.3   Building on Existing Relationships Recommendation

Recommendation 33: Link 'Stepping Out of the Shadows' training to mainstream national training programs by building on existing partnerships with Mindframe, beyondblue, Lifeline and others so that mainstream services can better meet the needs of CALD communities. Link with other existing CALD-specific mental health education programs in order to support mutual capacity building and effectively meet the education needs of people from CALD communities.

8.   LIST OF RECOMMENDATIONS

Following is a list of recommendations contained in this evaluation report. The Executive Summary contains Priority Recommendations, which are drawn from this list and reflect the more immediate and critical issues which need to be addressed in order to support the sustainability and effectiveness of the 'Stepping Out of the Shadows' program.

Recommendation 1: Where possible, Expert Trainers should be identified and recruited by agencies engaged to deliver the 'Stepping Out of the Shadows' program, with MMHA providing final approval of nominated candidates.

Recommendation 2: Develop a more rigorous process to screen and recruit Expert Trainers who express interest in the program and ensure that participating agency management signs off on all application forms to clearly endorse participation in the program.

Recommendation 3: Memorandums of Understanding (MOUs) or delivery agreements should be agreed to by agencies prior to the commencement of Expert Trainer training.

Recommendation 4: That a dollar value for the Expert Trainer training be assigned and the benefits of training to individuals and organisations be articulated (possibly through a list of competencies achieved as an outcome of training). That participating organisations make a contribution to the cost of training (possibly by matching the MMHA contribution) or that MMHA offer "scholarships" for training rather than "free" training.

Recommendation 5: Distribute a more detailed summary/outline of training contents, aims and methodology to participants prior to training.

Recommendation 6: Continue to encourage and support the use of consumers and carers to participate in delivery of training.

Recommendation 7: Encourage recruiting ETs and CTs to work in pairs within an organisation or geographical region to support each other and share workload.

Recommendation 8: Fund MMHA to provide MMHA-accredited training for Lead Trainers in each state and territory to replenish supply of ETs and/or provide refresher or ongoing training.

Recommendation 9: Offer ongoing training and development opportunities to Expert Trainers via their participating agencies or state or territory Lead Trainer.

Recommendation 10: At the time of this report, MMHA was in the process of developing a password protected online information sharing portal for project participants. The findings of this evaluation encourage the support and resourcing of this facility to share ideas, good practice, resources and other relevant information amongst program trainers and coordinators. The management of this could be shared by the MMHA Capacity Building Project Officer and MMHA Communications Officer (position vacant at the time of this report). A subscriber based news group or newsletter could also be created to update trainers on developments, good news stories and inspiring ideas.

Recommendation 11: Provide remuneration to CTs as already occurs in Victoria and Tasmania.

Recommendation 12: Further promote and encourage recruitment of Community Trainers by tapping into established community networks/groups that already have existing supports, infrastructure and community links. This could be done by continuing to share examples of success through existing program networks and infrastructure; developing a 'tip sheet' on how to approach and recruit community members; encouraging CTs and ETs with strong skills and experience in this area to

mentor or support less experienced CTs and ETs. This could be done person-to-person or remotely depending on geographic locations of participants.

Recommendation 13: Further promote and highlight use of Community Leaders to endorse 'Stepping Out' to promote community buy-in and participation.

Recommendation 14: Emphasise the principles of reciprocal learning to ETs during training, possibly drawing upon the body of literature and research in the area, including the reciprocity in education model by Procter (2003) published by MMHA. Supplementary material could be supplied via the MMHA web portal (under construction at the time of this report). The future review of training materials could include a greater emphasis on this topic.

Recommendation 15: Develop a mental health literacy component or module for the Expert and Community Training Manuals. MMHA has identified the potential for this to be undertaken in partnership with Mental Health First Aid and was investigating opportunities at the time of this report. The findings of this evaluation support the need to continue to pursue this possibility.

Recommendation 16: In line with the aims of the MMHA 'Stepping Out of the Shadows' Quality Control Working Group, the findings of this evaluation support the need to determine core training elements and optional modules, so that trainers can to adapt the program to community needs in a structured way that does not compromise quality.

Recommendation 17: Provide access to suitable venues, transport and childcare for Community Training sessions through specifically allocated funding.

Recommendation 18: Provide community incentives and capacity building opportunities by paying community members to provide food, transport, childcare or other suitable activities to support program delivery and accessibility.

Recommendation 19: Translate key components of the Community Training Manual (based on consultation with CTs). This will increase consistency in the way that in-language material is presented in training sessions. Develop a coordinated approach to reduce the likelihood of duplication of translations - ensure that the availability of translated materials is publicised and shared via the MMHA website and other existing program networks.

Recommendation 20: Consider developing guidelines for the use of interpreters and translators for the 'Stepping Out' Project and seek discrete funding for this purpose.

Recommendation 21: Include a suicide prevention module/session as a standard component in the 'Stepping Out of the Shadows' training manual and make it available to all participating states and territories.

Recommendation 22: Continue to explore opportunities to modify delivery of the 'Stepping Out of the Shadows' program in response to the needs of CALD communities in rural and regional areas in Australia.

Recommendation 23: Consider integrating the impact evaluation into the program delivery by applying the questions in the Family Stigma Questionnaire (Corrigan et al, 2004) to the story in the DVD teaching tool at the beginning of each package to gather baseline perceptions of stigma, then showing or recapping the DVD story at the end of training and asking the same questions. This could be done verbally as a focus group, or as a written exercise where appropriate.

Recommendation 24: Make the evaluation tools available as online surveys for trainers and participants where appropriate. Existing software such as 'Survey Monkey' could be used.

Recommendation 25: Develop systems and guidelines for the collection, storage and use of evaluation data from the program. Report findings from analysis of evaluation data to participating states and territories to assist in the continuous improvement of program processes.

Recommendation 26: Develop a succinct and simple 'tip sheet' for trainers on the importance of evaluation, which tools to use and how to submit information.

Recommendation 27: Implement a Continuous Improvement Plan to enhance the current system's ability to make incremental changes and monitor, measure and share results.

Recommendation 28: Reduce per unit cost of future manuals by making them available online as PDFs and modifying existing design from a full-colour manual to a two-colour manual, reducing any hard copy printing costs by approximately two thirds.

Recommendation 29: Use the MMHA Speakers Bureau (which recruits, trains and supports consumers and carers in speaking engagements) to help states and territories source and support consumers and carer involvement at all levels – including Expert Trainers, Community Trainers and community training sessions. Also use consumer and carer reference groups.

Recommendation 30: Ensure carers are involved in training by tapping into multicultural and ethno-specific carers groups, consumer and carer reference groups, and the MMHA Speakers Bureau.

Recommendation 31: A participating consumer identified the benefit of producing a short DVD which presented real life CALD consumer and carer stories to be used as a resource for training sessions, particularly for communities or geographical regions which had difficulty gaining access to consumers and carers. This could be produced in partnership with other organisations around Australia, or discrete program funding could be sought. This type of resource has been produced for people with disabilities, including a "database" of stories about people with a disability aimed at reducing community stigma and discrimination towards these people. A further example is Information Cultural Exchange (ICE) Digitales projects, which work specifically with CALD communities.

This recommendation addresses the previously articulated need to provide visual materials for communities with limited literacy and/or where narrative-based/storytelling methods are the preferred method for discussing issues.

Recommendation 32: If revisions of training manuals occur, review content relating to carer and consumer involvement in consultation with CALD carers and consumers.

Recommendation 33: Link 'Stepping Out of the Shadows' training to mainstream national training programs by building on existing partnerships with Mindframe, beyondblue, Lifeline and others so that mainstream services can better meet the needs of CALD communities. Link with other existing CALD-specific mental health education programs in order to support mutual capacity building and effectively meet the education needs of people from CALD communities.

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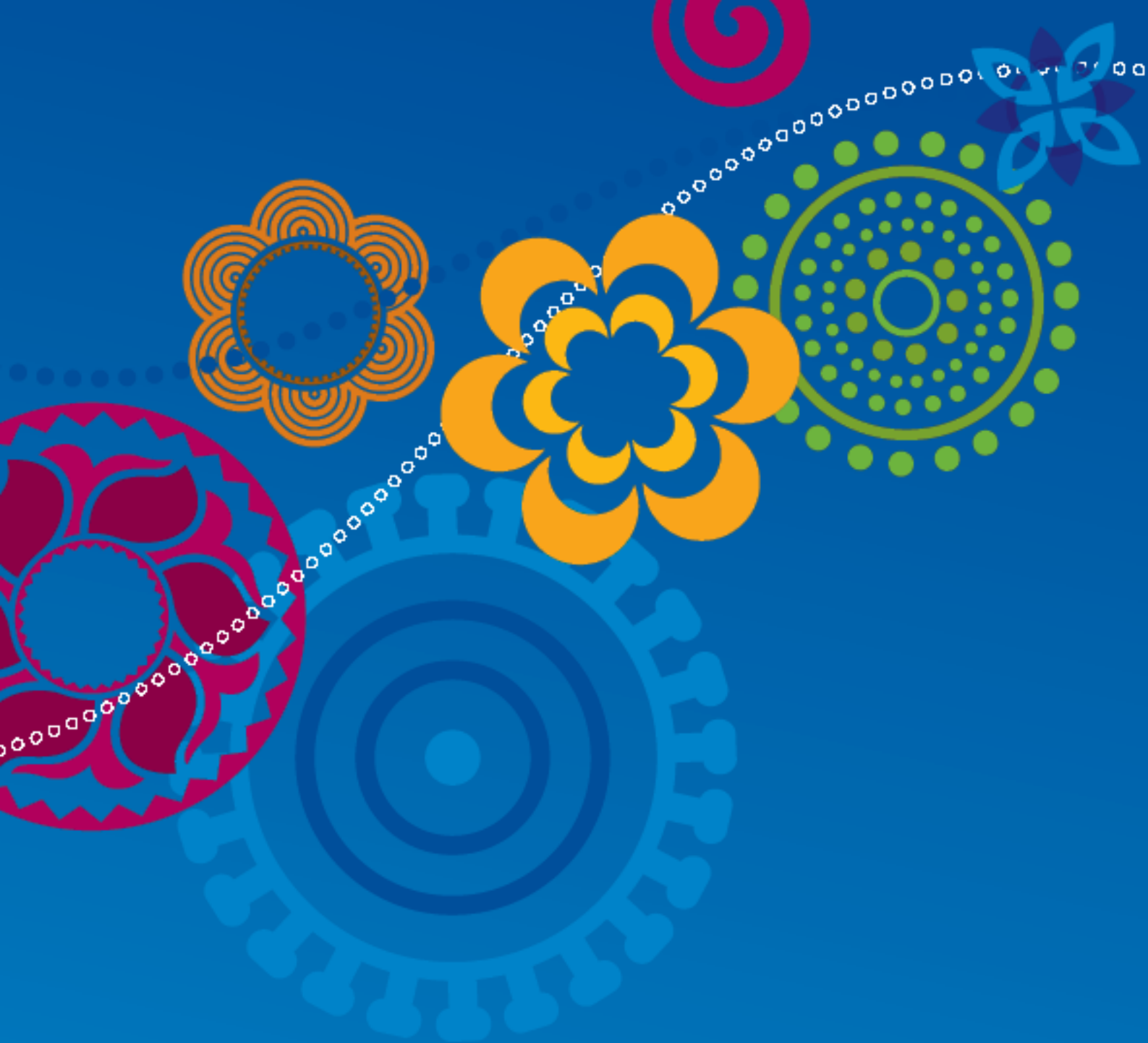
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