5

STAKEHOLDER CONSULTATIONS

This chapter presents key findings from the stakeholder consultations undertaken as part of the review. Chapter 6 then draws together the findings of the stakeholder consultations and documentation review in order to inform conclusions against the review objectives.

5.1 OVERVIEW

One of the striking findings of this review was the variability across stakeholders groups in their perceptions and attitudes about the operation, management and achievements of the Project. This is noteworthy given the diversity of the stakeholder audiences ranging from the funder of the project (DoHA), contract holder (SWAHS), recipient of the funding (MMHA), CALD consumers and carers, national partner agencies/organisations, and various state and territory partners.

While the findings of the stakeholder consultations represent *subjective* opinion, they nevertheless reflect the reality of stakeholders experience, and must be understood and interpreted as such. Perhaps more telling in the context of this review is the degree to which stakeholder perceptions support (or otherwise) the documentation review findings. It should not be assumed, for example, that the documentation of a process/procedure necessarily means there is high awareness and comprehension among relevant stakeholders, nor that these processes/procedures are appropriately and consistently adhered to or applied.

As with the findings of the documentation review, it is not intended for this chapter to provide an exhaustive account of all of the stakeholder consultations. Such an approach would not yield useful/representative data rather this chapter does provide the results of a considered review and synthesis of all stakeholder consultations aimed at elucidating and highlighting the key findings related to the review objectives.

5.2 STAKEHOLDER CONSULTATION FINDINGS

As noted in the previous chapter, questions related to project financial and service management, as well as project reporting and performance measures, were asked of only a small number of respondents (i.e. respondents representative of DoHA, SWAHS and MMHA). Given this, their responses were incorporated with the findings of the documentation review in the previous chapter. This chapter presents the key findings from the broader stakeholder consultations in line with the following broad review domains:

- Project planning
- Project governance
- Project model.

In addition to these broad domains, stakeholder views on the value of the Project are also presented. Specifically, this includes consideration of the continuing need/role for a project like MMHA, and the major learning's from the implementation of the project to date.

Where relevant, quotations from stakeholder consultations are included to illustrate/support the findings. In line with the confidentiality provisions for participation in the review, quotations are not attributed to any individual participant or particular stakeholder sub-group.

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   35

5.2.1 PROJECT PLANNING

With respect to MMHA's **target groups**, many stakeholders held the view that individuals from CALD communities with mental health issues and their carers/family were the key target group. Most stakeholders however identified two broad target groups. The primary target audience was seen as individuals from CALD communities with mental health issues together with their family and carers and mainstream, as well as service providers/workforce (both mainstream and CALD specific) that work directly with CALD communities. A secondary target audience comprised those organisations/entities that supported these activities such as consumer and carer advocates, researchers and academics, and state/federal governments. It was noted that the focus of consulted stakeholders was on primarily addressing mental health issues and less so on addressing issues around suicide prevention. Whether this reflects the existing work program embraced by MMHA (i.e. the project work focus steering the expectations of stakeholders) or the needs of the CALD community (i.e. the stakeholder needs shaping the priority and emphasis of the MMHA work program) is unclear.

FOCUS OF PROJECT

For those stakeholders sufficiently informed to comment on the MMHA's planning processes, it is true to say that overall, most felt that there was **insufficient strategic focus** and input into policy development. The greater focus of planning activities was seen to be on the development of products and services. That is not to say that stakeholders did not see this focus as an appropriate and important component of the Project. Rather, there was a sense that this was overshadowing its equally important strategic and policy input role.

> *'Seems to have been poor responsiveness in relation to strategic policy development. Despite a very strong environment on reform after the 2007 Federal election MMHA seem to have not adequately impacted on the policy environment'*

The review team were however informed by MMHA that it 'takes every opportunity to influence mental health policy either through reviews, consultations or discussions, as well as ongoing advocacy for the needs of its target group'. Since 2007, MMHA has responded to over 30 reviews, enquiries, and policy and plan developments and attended a high number of consultations and discussions held by Government to reform the mental health agenda. It is unclear then why many stakeholders are unaware of MMHAs policy input, or hold the view that it does little in this area. This may reflect the degree of stakeholder involvement with MMHA, or the adequacy of the existing stakeholder communication and engagement processes.

There was a general perception among the broader stakeholder audience that MMHA is good at the practical, tangible, 'on the ground activities' such as organising interpreters, developing resources and fact sheets, delivering training (i.e. tasks with an immediate outcome). It is not however seen to be as effective (as it could be) at providing input/influencing at a strategic national policy level (i.e. task with a long term outcome)..."*MMHA has evolved into a clearinghouse", "a conveyor belt for products".*

The sense among some stakeholders that MMHA is involved in a number of disparate projects (*"it's just a bunch of projects"*) underscores the lack of a clearly articulated **strategic plan**. Moreover, there was a general view that MMHA's planning activities had become too localised and needed to take on more of a national approach. Numerous stakeholders felt that there was an inequitable allocation of projects across the states and territories, noting that this process had become 'too NSW centred'.

Our consultations revealed a general perception across stakeholder groups that **the work program of MMHA** may in fact be too broad/too big. There is for some, a sense that the project is trying to do too much. This is not helped by resourcing problems driven in large part by the 'project time limited' funding. This means that it faces an ongoing challenge to recruit and retain suitably qualified and skilled staff since no certainty of ongoing employment can be offered beyond the current project funding period. There is a view among some stakeholders that one way of addressing this issue would be provision for greater flexibility in achievement of its work program. Rather than undertake this work in collaboration with partner organisations for example, MMHA could commission experts to undertake particular projects on its behalf. In this way, MMHA takes on a greater role as facilitator and supporter and less of a role as a 'doer'.

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   36

Most stakeholders identified one or more **mechanisms (both formal and informal)** through which they or their organisation/agency could contribute to MMHA's planning activities. Most commonly these included:

- The Consortium
- The JOG
- The National CALD Consumer Reference Group
- State based transcultural mental health networks
- Informal discussions with MMHA
- Conferences, seminars.

It is true to say that the Consortium underpinned most discussion around planning activities. Stakeholders generally agreed that the Consortium was/is an appropriate forum or model through which to engage the relevant state/territory stakeholders in the Project's planning activities including need identification and setting of work priorities. Its diverse membership is seen as one of its strengths.

> *'The Consortium had representatives from Transcultural Mental Health Services where they were in existence, consumer groups, universities, clinicians and most significantly, peak CALD organisations who were able to steer the project to this kind of stability. I see the Consortium as having been a key driver in bringing together a range of stakeholders from states around Australia to assist in advancing the implementation of the National Mental Health Strategy for CALD communities'*

It is apparent from our discussions with stakeholders, that in earlier times (pre 2005), the Consortium functioned effectively. This is primarily attributed to a smaller membership, a perceived stronger commitment among the membership to work together collaboratively, and a less complex and diverse transcultural mental health landscape.

Since around 2005/06 however, the view of most respondents supports available documentation: the Consortium became increasingly dysfunctional and ineffective. This is reported to be reflected in limited ability for equitable input by Consortium members into decision-making, little ability of the members to reach consensus/make decisions on issues in a timely manner, poor communication among Consortium members, poor awareness of activities; allocation of projects to a smaller circle of stakeholders (states with transcultural mental health networks/NSW) and dissatisfaction with the quality of some of the work undertaken.

> *'They [MMHA] need to be a lead body and strategic, to push for community development in mental health. They do this, but most is centred in NSW...it's not a national approach'*
>
> *'They need to be more focused beyond NSW. Regional and rural areas need drastic attention'*
>
> *'Working on a national basis...there are so many competing priorities and agendas. It's hard to get things done'*
>
> *'MMHA should either be funded to carry out actual projects/initiatives in conjunction and consultation with individual States/Territories priorities as there is huge variation in not only available funding but also resources and infrastructure or there should be a needs assessment with a population health focus to ensure that the jurisdictions that need assistance to 'come up to speed' can be targeted'*

The ineffectiveness of the Consortium as a forum for planning, informing and monitoring the work program is clearly evident in stakeholder descriptions of the Consortium such as...'a forum for bickering and divisive behaviours, 'destructive', 'a lot of egos', 'dog fights', a battle ground' 'more of a talk fest; 'it became elitist'.

Perceived contributing factors to the Consortium's ineffectiveness include an increase in the number and diversity of members, competing agendas among members, increased running costs, domination by particular members/strong personalities, ongoing tensions between members (some of which is acknowledged to be a carry-over/residual from earlier times); inequitable allocation of projects,

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   37

limited participation by smaller states, insufficient acknowledgement of the changing multicultural mental health landscape.

Some stakeholders saw the strong connection that members have with local state government together with local reporting responsibilities as impeding their ability to have a national focus. Meeting the local needs is focused (as it should) on 'doing' something about local need and is seen to be more about producing services...tangibles. This is viewed as somewhat easier. Seeing immediate results for effort as opposed to adopting a national and more strategic approach/policy input which by its nature is less tangible and does not produce immediate results for effort.

A small number of respondents (both government and non-government) in fact learnt about the cessation of the Consortium in the course of this review. For the majority of stakeholders who were aware of the disbanding of the Consortium in late-2008, it was not unexpected given its history of increasing dysfunction and ineffectiveness.

> *'I'm not surprised that the Consortium no longer operates…based on meetings attended…did not appear to be constructive, seemed to be factions, not co-operative…'*

> *'The Consortium was destructive, dysfunctional and very expensive. It had outlived its usefulness and was not at all representative of all key stakeholders within their states and territories'*

Notwithstanding, stakeholders acknowledged that, with such a diverse membership, and the constant tension between the pressure exerted by local needs and those that represented national level priorities, reaching agreement would not be an easy task. There is also an acknowledgment among stakeholders of logistical aspects and associated costs in operating the Consortium.

Many respondents have been left wondering what forum will 'replace' the Consortium to ensure ongoing engagement of the states/territories in planning activities. There is somewhat of a sense of being 'left out in the cold' ('Is it now up to the states and territories to meet on their own"?)

> *'I'm surprised that something wasn't put in place (after the Consortium ceased operation) to continue to involve the states…it was the one forum with a sense of involvement. It now feels like MMHA is up there and the states are not part of it anymore'*

> *'It now feels like the states don't have any real control over what happens at MMHA and we should because it is representative of the national level…we should have input into policy design and strategy and what is represented to government'*

Many respondents are unclear how needs analysis and priority setting is being undertaken in the absence of the Consortium since this was their link to the Project.

In absence of the Consortium, most stakeholders identified three key forums to facilitate planning activities:

- the **JOG** – with its membership restricted to state directors of mental health, many respondents were of the view that it did not provide adequate provision for the involvement of all key stakeholders. Its inclusion of a carer and consumer representative is regarded by many as tokenistic

- The **large state based annual forums -** implemented to facilitate involvement of *all* stakeholders. Four such forums have now been held (July 2007 – Tasmania, March 2008 –SA, May 2008 – NT and March 2009 –WA). These 4 states have been targeted first in line with one of the current FA requirements to address needs of CALD communities in smaller under resourced states. There is a view among some stakeholders that these large forums have raised community expectations that may not be able to be met due to inadequate resources. This has the likelihood of creating dissatisfaction among the CALD community and may impact negatively on the relationship with the state providers

- **MMHA national CALD Consumer Reference group** – established as a forum to ensure the needs of this target group are identified. The group advises on relevant and suitable action to be taken by MMHA and these are then built into an action plan.

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   38

For a small number of respondents, the Consortium was considered as having '*outlived its usefulness', 'it's job was done'*. For these respondents, the strengthening of the existing JOG by limiting the membership to state Directors of mental health and MMHA was seen as '*an evolution', a 'natural progression'*.

> *'The role of the Consortium had to be reviewed in light of the large number of new stakeholders that are now in existence in the mental health sector and in light of the creation of the JOG as a key stakeholder group with state and territory jurisdictional decision-making powers for MMHA'*

This however was the view of the minority of stakeholders. **Although an effective forum with decision making power and ability to feed up into government policy, most stakeholders do not see the JOG** as a natural 'replacement' for the Consortium. The JOG is viewed as encompassing a different level of "stakeholder". While across a whole range of issues pertinent to their portfolio, JOG members do not necessarily possess specific knowledge on CALD mental health issues. This forum is generally regarded as lacking input from experts in the transcultural mental health field. I

> *'What is the purpose of JOG? Look at the current membership. Sharing State activities is good, but what else? '*

> *'Ex-members need to be kept in the loop. Don't want to see the hard work of the Consortium wasted.'*

For the majority stakeholders, opportunities for improvement in planning processes centred around three areas:

- **Planning focus** – a need for a greater focus and influence on strategic policy development

- **Stakeholder engagement** – a need for a forum to adequately engage key state/territory stakeholders in planning activities (given the disbanding of the Consortium)

- **Building the evidence base** - a need for collection of data on the metal health needs of CALD communities to inform planning activities, education of service providers and development of culturally appropriate support services and interventions for these individuals.

5.2.2 PROJECT GOVERNANCE AND ACCOUNTABILITY

MMHA ROLE

In general, stakeholders saw the Project as having two broad roles: to advise and support policy development for diverse cultural communities and to provide leadership in the field of mental health service provision, prevention and early intervention. This applied to both people from CALD backgrounds and the different service providers that work with and support these individuals. Many stakeholders expressed a multi-faceted role for MMHA.

> *'To provide resources and expert information to mental health and allied health professionals so that they can better met the needs of CALD client; to undertake advocacy on a range of mental health issues on behalf of CALD communities to services, policy departments and to communities themselves; to promote the benefits of cultural diversity including the various health-protecting aspects of belonging to CALD communities and to promote access and equity principle'*

> *'Part of the role of MMHA is the development and management of a comprehensive implementation plan for the Framework for the Implementation of the National Mental Health Plan in Multicultural Australia'*

> *'To educate CALD communities about mental health issues, reduce the stigma surrounding mental health, influence public policy on issues to do with CALD mental health and develop and distribute resources for sectoral capacity development'*

As noted in the previous chapter, available documentation refers to MMHA as 'a national program'...that 'provides national leadership in mental health and suicide prevention for CALD communities'. As such it would seem fair to interpret MMHA's role as being one of a 'facilitator, 'supporter', 'advisor', 'influencer'

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   39

and 'persuader'. In assuming a leadership role, it should adopt a strategic focus, be proactive and be seen to value-add. Many stakeholders however believed that MMHA had taken on too much of a local/ground level focus. In doing so, it was seen as taking on more of a role as a 'doer' or 'implementor' of projects: a role that most believed should be assumed by the states and territories.

> *'Local agencies have to show leadership/excellence in CALD mental health issues... they need national support and advice to do this'*

> *'To act as a national peak organisation representing multicultural mental health providers in Australia'*

Given this view, and the fact that MMHA receives national funding, some stakeholders questioned whether the funding was actually being spent at a national level. There was some concern whether MMHA could meet its objective as a peak body, but also influence states and territories at a local level.

> *The role is shifting...they are running projects. If they are funded for priority areas, what are these - capacity building? How can they influence this at the local state/territory level? Are they the right body to do it?'*

As evident from the documentation review, stakeholder consultations revealed inconsistencies and a lack of clarity and confusion with regard to **what MMHA represented.** Stakeholder views ranged from a 'working group', 'project', 'alliance of organisations with an interest in multicultural communities' 'a national program', 'peak body', a consortium'. This is perpetuated by the MMHA Consortium Governance document (2007) which refers to MMHA as a 'program' comprising an alliance of consumers, carers, the community, statewide specialist services in multicultural mental health and suicide prevention, population and public health and the tertiary sector operating as a Consortium'. This issue is discussed further in Chapter 6.

As to whether the project was **actually fulfilling its role**, most stakeholders believed it was not with respect to strategic policy input, or at least there was insufficient focus.

> *'I think it is clear that MMHA has not been as effective as it could have been in relation to raising the profile of issues, making changes at a strategic level, or representing the needs of key stakeholders'*

> *'I would like MMHA to be more upfront about its relationship with the National Mental Health Strategy, and make known to the public and stakeholders the policy and strategic advice that MMHA gives'*

STAKEHOLDER ROLES AND RESPONSIBILITIES

As with the question of what MMHA represented, there was some confusion and diverse opinion among respondents as to **who constituted MMHA 'stakeholders'.** Responses ranged from state and federal governments, CALD communities, general public, mainstream and CALD specific service providers and peak bodies.

> *'What is meant by MMHA stakeholders? Are you talking about DoHA, Consortium, JOG, SWAHS?'*

> *'Are stakeholders the same as MMHAs target groups?'*

Many stakeholders referred to the 2007 Consortium governance document, while some were unclear whether stakeholder roles and responsibilities were actually documented. Despite the existence of the Governance document (which aims to define the Consortium's membership, roles and responsibilities and operation), there is a broad respondent view that the roles and responsibilities of SWAHS, MMHA, and the Consortium are unclear and not well understood. Our consultations (as did particular documentation that was reviewed) revealed in recent years SWAHS has increasingly become too involved in the management and decision-making processes of MMHA. The reported ongoing need for DoHA to clarify their role as a fund holder and not decision maker supports this view.

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   40

DECISION-MAKING AND POWERS OF DELEGATION

This was an area which many of the broader stakeholder audience indicated they were not sufficiently well enough informed to comment upon. Those that were, most often identified the Consortium and the JOG as the decision making forums, as well as the broader consultative mechanisms.

> *'In relation to strategic directions for the project, since the establishment of the JOG, strong links have been made with the Directors of Mental Health in each of the states and with the Commonwealth and this has had quite and immediate impact on advancing CALD issues quite effectively across Australia and in the different states'*

In light of the current auspice arrangements, a small number of stakeholders believed that decision making power and project management rests with the contract holder.

> *'The Consortium's role was to set priorities re issues for MMHA. Decision making sat with the MMHA Secretariat and SWAHS'*

There is a minority view that the MMHA project is 'one of SWAHS's many projects and so falls under its management practices'. This is in conflict with its intended operation as an independent Commonwealth funded project.

> *'I guess the issue is whether MMHA is an organisation with a constitution, governance structure or a government program...it should be treated as a service. Given that, responsibility lies with the provider who has a contract with the Department, thus they carry the risk and should be able to manage the project as they see fit, but with advice from invited experts'*

> *'MMHA is located within the Multicultural Health Network and the Diversity Health Institute (DHI) of SWAHS. This 'service' is placed on the third tier of the organization'. MMHA complies with policies and procedures of SWAHS that have clear guidelines in relation to delegation and decision making re the day to day operations of MMHA. These are transparent and have been reported on regularly to DoHA in compliance with the reporting requirements'.*

The current auspice arrangements are considered by many stakeholders to have contributed to a 'blurring of the lines of accountability', with SWAHS becoming involved in management of the Project. There is also some concern that in the absence of the Consortium the Project will be detracted from its intended focus, and that decision making power will become increasingly centralised within a single organisation.

> *'...The disbanding of the Consortium has created a real challenge for MMHA with little formalised process to provide strategic directions for the organisation. One concern I have is that MMHA will become even more focused on representing public health agencies rather than the diversity of multicultural mental health issues, including consumer and NGO concerns. The fact that more power appears to have been centralised within a single state based agency (NSW Health) is a further concern'*

Only a small number of stakeholders believed that the current governance arrangements were working well.

> *'This is quite an effective model in that it provides effective operational support for the project with strong strategic leadership across the states via the JOG. Each state representative has local networks with mental health and transcultural services. Issues of a strategic nature are raised at the JOG and can also be taken up with the Commonwealth in this forum'*

> *'The current governance model of SWAHS suits and greatly supports MMHA. The only other alternate model could be the NGO community-based structure but is not deemed as successful as the SWAHS one, for common reasons such as poor accountability mechanisms, conflicting interests of a select few, lack of support structures and inadequate infrastructures. Many of the consortium organisations operate under the same governance models and structures as MMHA, through their stage and territory government jurisdictions. As do many national and state-based services and programs funded by the Commonwealth or State governments across Australia'*

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   41

Not surprisingly, given the eventual widespread dissatisfaction with the Consortium's operation, the majority of stakeholders who felt well enough informed about the Project's current governance arrangements believed that changes were required. Interestingly, consideration of alternative governance models raised the need to distinguish between 'governance' and 'accountability'. This issue has clear implications for the future of the project and is discussed in further detail later in the report.

> *'If MMHA wants to go to an organisational model, then it must consider its revenue source. I do not think it has the capacity to be a stand-alone body with independent or self-sustaining funding. The simpler the arrangements, therefore, probably the better. An advisory committee may be helpful, including to establish networks but steering structures should depend upon more tangible partnerships. For example, other funding agencies which gives them a direct accountability for how monies are acquitted'*

Whatever the alternative options, the ability of the 'project' to be able to meet its national goals and objectives effectively and efficiently was considered vital. Potential alternative governance arrangements ranged from continuing the current auspice arrangement, but with another agency, to establishment of a national advisory group or adoption of a board model.

> *'MMHA seems to operate as an industry body for public health multicultural agencies managed through a single state based public health agency'*

> *'The available funding could be allocated to States/Territories. The advantage of this is to smaller jurisdictions would be that it might be able to fund dedicated, recurrent CALD resources. The current approach has not attracted the high level representation of decision makers it had hoped to have at JOG'*

> *'As a national body there could be a range of options for consideration including an independently incorporated board/committee model, or auspicing by another national or state agency (other than SWAHS)...it is important that MMHA can act autonomously from the auspice body both in terms of strategic directions, priorities and management of funding'*

> *'It could be a Board model or national advisory group linked to a national advisory committee set up by government on mental health'*

IMPROVING GOVERNANCE/ACCOUNTABILITY

Achievement of enhanced governance and accountability arrangements for the project were seen by most to require a simplification of the management/governance structure and provision for adequate stakeholder engagement and involvement.

> *'Unclutter the management – keep it simple. Focus with a work program agreeable to the funding body and that is appropriate for the target audiences, based on consultation. Don't forget, the program is for the target audiences, not the personalities who attend consortium meetings'*

> *'Clearly a fundamental reorganisation of MMHAs governance structure is required to address the centralisation of power within a single state based agency. Government must be clear who they are funding through, and what outcomes are desirable – this involves a clear view of stakeholders'*

5.2.3 PROJECT MODEL

The MMHA model is widely regarded as unique, both nationally and internationally. There is strong consensus across stakeholder groups with respect to the ongoing need for such a program/model to drive the transcultural mental health agenda in line with the National Mental Health Strategy.

> *'There's nothing like MMHA, situated with the Diversity Health Institute and the Transcultural Mental Health Centre. It's a unique model, including internationally'*

> *'It has been the critical program that provides access, equity and resources to CALD communities, especially given the rather mono-cultural approach to the National Mental Health Strategy but increasingly government incapacity to recognise the cultural dimensions of health'*

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   42

While the service model is seen as appropriate, there is a view among some stakeholders that its potential effectiveness in meeting the mental health needs of CALD communities is being undermined by two key factors. First, compared with the structure of other specialist services, there is a perceived mismatch between the level of funding and the level of target audience need.

> *'The level of funding is not adequate to meet and address the range and size of the mental health needs of this sizable proportion of the Australian population. The mental health needs of CALD consumers and carers are far greater than those of the mainstream community. Only half of the nation has some sort of transcultural mental health service, and the four that exist differ significantly in size, scope and service type, for example, some provide clinical services others only education. Yet there are torture and trauma services in every state and territory of Australia despite the fact that this group is only a fraction of the size of the CALD population who have a mental illness.'*

The issue of funding raised above goes beyond this issue of adequacy of funding of the MMHA and raises more systemic issues regarding service capacity across the jurisdictions, one which should be raised within a policy context by MMHA. Moreover, the low levels of funding and the lack of funding continuity restrict MMHAs ability to build on and develop the priority areas, projects and personnel. These factors impact greatly on MMHA's ability to address the needs of its target groups on a long-term basis *('No sooner has a project or person commenced; it is time to resubmit for funding')*. Having reported this feedback, the evaluation team notes that the project funds for MMHA were unable to be fully expended in two concurrent years.

Second, the National Mental Health Strategy is perceived to assume a basic level of mental health literacy among CALD communities. According to some stakeholders, the reality is that awareness and basic understanding about mental illness among CALD communities are still to be adequately addressed. **The review team was advised that it was not until 2007** that the Commonwealth provided specific resources to MMHA to produce basic information on mental health topics in a variety of community languages. Prior to this, no language specific written material about mental illness and available services was available.

Aside from supportive written material for CALD communities, the degree to which the model meets the needs of CALD communities and service providers is further seen to be impeded by the lack of:

- standardised cultural competencies developed for the mental health workforce to complement and equip themselves to better support people from CALD backgrounds.
- multicultural health or mental health plans in the majority of the states and territories to address the needs of their constituents from CALD backgrounds.
- multilingual mental health counselling help-lines or mental health interpreting services for people who cannot speak English.
- multilingual advertising material (e.g. billboards) promoting the importance of mental wellbeing and where to go for help (as for Beyondblue).

> *'There is a need to improve the education of clinicians, particularly in learning and understanding cultural diversity and improving how they communicate with CALD families*

> *'Need to improve awareness of mental health in ethnic communities through strategic campaigns/strategies and look at models to reduce stigma and shame associated with mental illness in ethnic communities. There is also an added need to develop service models which meet specific cultural needs of CALD communities and improved access and quality of interpreting and translation services'*

ALIGNMENT WITH POLICY

The National Mental Health Strategy (NMHS) and the National Mental Health Plan 2003-08 identifies the continued need for equitable access to mental health services for a range of population groups. There were mixed views among stakeholders with respect to the extent to which they perceived MMHAs activities were aligned/linked with government policy and related initiatives.

> *'Because MMHA is seen as the expert then it should be working with the Commonwealth in a complimentary way about how to build into the National Mental Health Strategy resolution of issues facing people from diverse cultural backgrounds'*

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   43

While there is a clear link (as reflected in the conditions of the Funding Agreement), some stakeholders believe that the NMHS is ahead of the reality of the multicultural mental health landscape.

> *'MMHA's need identification and planning processes do not always align with current Government mental health policies and priorities simply because in many instances Government mental health policies and plans do not capture or consider, as a priority, the unique and special needs of people from CALD backgrounds with a mental illness and their families. In other instances the mental health policies and priorities are way ahead of the base needs of CALD communities. The CALD mental health sector is at its infancy stage, while the mainstream is far more advanced'*

SUSTAINABILITY OF THE MODEL

Given the issues outlined above, it is not surprising that many stakeholders do not consider the model (as it is) to be sustainable. For this to be achieved, the most commonly identified areas for change/improvement were the need to:

- Increase general awareness of the Project and its role and objectives. This calls for a marketing/branding approach
- Secure a greater involvement and integration between mainstream and CALD specific service providers
- Secure buy-in from the states and territories. The challenges of this task are acknowledged given the current differences in mental health funding and resources across Australia
- Secure both an adequate level of funding for the Project together with a longer funding cycle to assist in embedding the model.

> *'Ensuring grassroots awareness of MMHA and mainstream services commitment to its mission and valuing its expertise – look at how Beyondblue is invited everywhere to comment on mental health for mainstream. MMHA needs this sort of exposure and acknowledgement'*

> *'The fact that take up of any of MMHA products/services is voluntary and dependent upon state based policies. For any project to be successful, there has to be buy in from state based providers, either mainstream or multicultural, and this is extremely difficult'*

FACILITATORS TO SUCCESSFUL IMPLEMENTATION

Stakeholder consultations revealed a number of factors that acted to assist the successful implementation of the Project. The major facilitators include:

Dedication of staff – nearly all stakeholders we talked to spoke about the passion, commitment and enthusiasm of the project staff.

> *'Quality of service and staff at MMHA, excellence in contracted work, its promotional activities and the strong professional networks...'*

Co-location of MMHA - having MMHA physically located with other transcultural and mainstream services at Cumberland hospital campus has been advantageous both in terms of cost saving through resource sharing and greater ease of collaboration

> *'Infrastructure support from being part of the DHI and SWAHS which understand the required work program, strong links with ethno specific and CALD organizations, strong links with CALD carer and consumer networks and peak mental health agencies.'*

> *'Being part of the Diversity Health Institute (mainstream multicultural institute), the model is very good as it allows information flow between mental health and multicultural mental health'*

MMHA Products and services – the number and extent of resources produced and distributed by MMHA was highly valued by most stakeholders, however complaints received by DoHA about inaccuracies in the production of some translated material (including during the course of this review raises concerns about the application of quality assurance processes within MMHA.

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   44

> *'Immediate and accessible resources that are relevant, culturally and linguistically appropriate and we have had input into their development'*

BARRIERS TO SUCCESSFUL IMPLEMENTATION/AREAS FOR IMPROVEMENT

Stakeholder consultations also explored the challenges and barriers to the successful implementation of the project. Notably, many more barriers were raised than facilitators. The most commonly reported barriers included:

Funding cycle – the relatively short-term funding cycle has several implications for the Project. First, it has made it difficult to engage in long term planning (beyond 3 years) and adopt a more responsive and strategic response. Second, staff can only be offered contract positions, often resulting in difficulty recruiting suitable staff in a timely manner and in retaining good staff. This presents potential negative impact on achievement of the work program.

> *'A longer funding cycle is seen as preferable (3-5 years) this would allow MMHA to recruit suitable staff and importantly, to build organisational capacity: something it has struggled to do to date. Importantly, a longer funding cycle allows the project to be responsive and strategic rather than reactive'*

> *'You need a minimum of 5 years with annual performance reviews so you can recruit staff otherwise it's reactive, not planned and strategic. We need to be more proactive re issues'*

> *'Funding is allocated in a short term time frame. For a national organisation to make long term changes it is hard to do if staff don't know if their job will exist after 3 years...so end up with a high staff turn over'*

Funding level – compared with similar programs, the funding level is not considered to be adequate given its workload and size of its target audience.

> *'Funding should be equitable and on par with the other national peaks like Beyondblue, the Mental Health Council of Australia etc. MMHA deals with a quarter of Australia's population, yet gets a fraction of the funding of similar mainstream programs and services'*

> *'MMHA is expected to work with all mainstream national mental health agencies and government departments to advocate for the needs of the CALD communities. However, the same obligations are not required from them to work with MMHA and include cultural considerations in their policies, practices and programs, thus unfairly increasing MMHA's work volume and complexity. This relationship must be two-directional for it to be effective, and DoHA and the state and territory jurisdictions have a responsibility to make sure this occurs when funding mainstream mental health programs and services'*

The evaluation team notes these comments however expresses reservations that an increase in funding will address project barriers given the inability of the project to fully utilise existing funds over the last two to three years.

Model flexibility and responsiveness – in recent years the multicultural mental health landscape has changed considerably. It is recognised that this has the potential for the program model to become 'out of step' with the needs of its target group. It is important that the model provides for ongoing monitoring of target audience need and timely and appropriate response to identified changes. The ability to do so is currently hampered by a lack of data on the specific mental health issues (and other associated needs) for these new arrivals.

> *'Ensuring it is a flexible, responsive model because of the changes in recent CALD communities. We need to identify their issues. This is a challenge because they are so diverse. To keep up to date is a real challenge'*

Lack of strategic focus – the majority of stakeholders perceived that the project had become too focussed on the generation of products and services rather than on strategy and policy input. The danger of this is a negative impact on the impetus for keeping MC MH issues 'on the table' and of achievement of the Project objectives

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   45

> *'Need to work more at a strategic and policy level and get multicultural mental health back on the agenda'*

Poor evidence base – while the evidence base for more settled immigrants is poor, there is little (if any) data on the mental health issues of the newer arrivals to Australia, many of whom have varied additional needs due to the nature of their background. Attention to the current lack of baseline data is urgently needed. This information is vital to ensuring that service providers communicate and support these individuals appropriately, and to determining the effectiveness of support and interventions.

> *'Need to get the states involved, get solid information on what's happening in CALD communities at local/state level and assist with research and get information fed back into policy areas. The evidence base is not there for a lot of what we do...we do not have the ability to collect data'*

> *'There has been too much focus on products and not enough on the underlying strategy. Needs to be greater involvement in getting good information, doing good research'*

> *'Data collection, we need good data collection system. MMHA could advance national working parties. Need to make sure ethnicity data is considered, such as the National Survey for Mental Health and Wellbeing. Currently it excludes CALD communities, and all major policy decisions are based on this data...'*

Inherent state/national tension – one of the Project's key consultation/planning forums (the Consortium) became ineffective at least in part because of the competing demands on members to meet the demands of their local constituents and the demands of their role at a national level. A major challenge in going forward will be the effective management of this inherent tension.

> *'Working on a national basis...there are so many competing priorities and agendas. It's hard to get things done'*

Systemic commitment to multiculturalism – it is recognised that the MMHA project on its own cannot adequately address cultural diversity issues and the needs of CALD clients. What is also needed is a greater commitment across the health sector in general.

> *'A lack of interest and commitment to multiculturalism – it needs more than just MMHA. There is a systemic failure across the health sector to deal with cultural diversity issues'*

It must be acknowledged that there is limited ability for MMHA to address some of these barriers, such as the funding cycle/level and systemic commitment to multiculturalism). Other barriers however, are within its remit to address, and in fact serve to highlight current gaps/deficiencies in its operation/focus.

5.2.4 FUTURE CONSIDERATIONS

MAJOR LEARNINGS FROM IMPLEMENTATION OF PROJECT

Not surprisingly stakeholders reported a wide range of learnings from implementation of the project. The most commonly reported learning's include:

- **Visibility of MMHA** – many stakeholders believe that MMHA needs to be more visible and see a role for marketing/branding. Numerous stakeholders would like to see MMHA have the level of recognition that Beyondblue does.

    > *'Need to improve awareness of mental health in ethnic communities through strategic campaigns/strategies and look at models to reduce stigma and shame associated with mental illness in ethnic communities.*

- **Project focus** - it is true to say that in recent years, many stakeholders see that the project's focus has shifted away from a **strategic** one to become much more involved in the delivery of projects and development of products and services. That is not to say that these are not important. Indeed these products and services are an equally important part of its role...but it must maintain its national leadership role and be more representative of the states and territories.

    > *'A body that has a greater strategic focus; is more representative, is more research oriented'*

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   46

- **Evidence base - one** of the most striking aspects of the multicultural mental health area is the paucity of data on the mental health needs of CALD communities. This is an urgent need and a recognised gap by all stakeholders and one which is seen as appropriately being taken up by MMHA.

    'MMHA should be pushing the CALD agenda but struggles with poor resource to engage in ten atonal reform debate. MMHA should also lead new applied research in Australia to evaluate effectiveness of CALD specific MH services and promulgate effective practice'

- **Planning** – is considered an important component of the project. It means ensuring the project is aligned with target audience need, and that changes in need can be readily identified and responded to in a timely manner.

    'Planning component...it's important to regroup...look back and look forward. It's important because the environment is always changing, so we need to be able to reposition ourselves. We need to make sure we keep our important stakeholders and engage with new and emerging stakeholders...that's a sign of how well we are doing...we can't alienate key stakeholders'

- **Clarification of roles and responsibilities –** most stakeholders believed there was a need for greater delineation/clarification of the direction of MMHA, of the roles and responsibilities of players/key stakeholders, and what is expected of them.

    'Needs to be a clear direction of the purpose of MMHA, the roles and responsibilities of players and what is expected of the players. We need to be able to establish consensus on what the organisation is there for. This is not clearly articulated so a lot of meetings got into dog fights as people pushed their idea of the role of MMHA'

    'Should MMHA be funded to deliver programs nationally or provide money to other bodies to support their objectives would help sustainability'?

- **Governance arrangements -** Getting governance right....needs to be clear accountability and reporting and decision making processes in place.

    The major learning has to be the challenges posed in getting the governance right. Unfortunately, at least from the outside, MMHA has some serious problems in relation to representing its constituents'

    '...the funding and admin structure of SWAHS has posed problems as well as created great benefits and savings. If there was some way of maintaining the function in its current location, but increase the flexibility and independence of the program to recruit and spend resources, that would aid the efficiency and quality of MMHA..."

    While the current auspice arrangement provides obvious cost savings and resource/infrastructure sharing, it is apparent that this has contributed to a 'blurring of the lines'

- **Funding -**The allocation of time-limited funding for the project to date has potential to negatively impact on the achievement of the project's aims. The project has faced, and continues to face, ongoing challenges in recruiting and retaining suitably qualified and experienced staff. This is primarily due to an inability to offer ongoing employment made more difficult by a relatively small workforce pool

    'MMHA should be pushing the CALD agenda more but struggles with poor resources to engage in the national reform debate. It should also lead new applied research in Australia to evaluate the effectiveness of CALD specific mental health services and promulgate effective practice'

    'The main issue with the current situation are the low levels of funding and the lack of funding continuity to build on and develop the priority areas, projects and personnel. These factors impact

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   47

greatly on MMHAs ability to address the needs of its target groups on a long-term basis. No sooner has a project or person commenced, it's time to resubmit for funding'

A longer funding timeframe (e.g. five years) would not only assist with staff recruitment and retention, but would also facilitate more strategic, proactive and long term planning processes. [We note that a longer funding cycle was one of the recommendations of the 2001 Evaluation]

- **Time frame –** for some stakeholders there is a lag between the National Mental Health Strategy and reality of multicultural mental health landscape. What is first needed is to profile the needs of CALD communities and then to educate/train the workforce to deliver culturally appropriate services. It takes time for culturally appropriate practices to become embedded in organisational operations.

  'We cannot ignore pressing health issues such as mental health and try and educate the community as a homogenous block and expect positive outcomes. The work is slow and painful and will need patience to reach a reasonable outcome for CALD communities'

CONTINUING NEED FOR THE PROJECT

Despite diverse stakeholder opinion on the various issues explored in the review, stakeholders were united with respect to the continuing need and role for a project like MMHA, or at least some sort of dedicated structure/body to lead and drive the multicultural mental health agenda. The increasing multicultural nature of Australian society only serves to heighten this need.

> *'We need a body at a national level because we need to get Australian diversity issues back on the agenda...need to take practical steps to make Australian institutes diverse. How? A greater strategic focus, a more representative body, and more research oriented'*

> *'MMHA is unique as the only national body to address mental health in ethnic communities and importantly at a national level. This provides an opportunity to have a national approach to resource the project and research development*

> *'The level of services available to CALD people with mental illness is pathetic. Language services are almost non-existent. MMHA plays a critical role and its cessation would be a significant blow to advocacy in this area'*

It is true to say, that for the majority of stakeholders that took part in this review, the potential effectiveness and impact of the project has to date been undermined. This is primarily attributable to an inability of planning processes to adequately engage all stakeholders; deficiencies in project governance; and a lack of baseline data/insufficient research focus on the mental health of CALD communities.

Critical to the sustainability of the project is the level and term of funding. Short-term project based funding is not regarded as the right fit for achievement of MMHAs objectives. Longer term funding is required to progress MMHA's efforts to more firmly embed transcultural mental health and suicide prevention in the broader mental health reform agenda. This in turn will help to drive more strategic long term planning and contribute to cost savings for government.

> *'There is a continuing need for specialised services for CALD clients, and health professionals in this area. This need is not something that is addressed through short, time-limited program. In a continuing globalised world, these needs will not go away. Effective services, information resources and early intervention programs can help save government revenues in the long term... this is a key message about long-term sustainability'*

Department of Health and Ageing
Report – Review of the Multicultural Mental Health Australia ((MMHA) Project
Nov 2009   48