victorian refugee
health network

National Children’s Mental Health and Wellbeing Strategy

VRHN Contribution, February 2021

Which of the Strategy’s objectives and actions do you consider most critical to improving the mental health and wellbeing of children and families from culturally and linguistically diverse communities?

Are there any additional actions you think are necessary to improve the mental health and wellbeing of children and families from culturally and linguistically diverse communities?

Objective 1.2 – Increased mental health literacy
Objective 1.3 - Community-driven approaches
Objective 2.1 - Improved system navigation
Objective 2.3 - Access and Equity
Objective 2.5 - Skilled workforce
Objective 4.1 - Meaningful data collection

Objective 1.2 – Increased mental health literacy:

- To support child mental health, government should prioritise initiatives to improve both mental health literacy **and** health system literacy among refugee background communities, including those seeking asylum. This must be done in conjunction with initiatives which address mental health stigma in refugee and asylum seeker communities.
- Victorian Refugee Health Network consultations with service providers[1] and bicultural workers have identified a need to promote an understanding that ‘mental health is a part of health’ within refugee communities. This should include a focus on promoting improved understanding of higher prevalence issues such as depression and anxiety, as well the value of prevention and early intervention.
- Preventative health and early intervention are unfamiliar concepts in many refugee communities.
- Victorian service providers and bicultural workers have identified more accessible information about mental health and mental health services, including preventative mental health care is required. This includes culturally informed, translated information.

[1] Consultations undertaken to inform VRHN’s submission to the Royal Commission into Victoria’s Mental Health System

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- There are varied cultural understandings of mental health and illness within and between refugee background communities. Diverse explanatory models for mental illness can mean those living with a mental illness have experienced shame, stigma and exclusion in their countries of origin.
- Stigma presents a significant barrier within refugee background communities to understanding mental health, talking about mental health, and accessing mental health services. Information about mental health and wellbeing among different refugee communities is often lacking. There is also often misinformation regarding mental illness/health. A fear persists within some communities that mental illness means that you are "crazy" and that there is no "cure".
- Fear and shame relating to mental illness inhibits children and families accessing services for mental health concerns. The VRHN has heard reports of some families being reluctant to let their children follow through with mental health plans as these were perceived to have negative effects for a child's future, such as difficulty getting a job or into university.
- The National Children's Mental Health and Wellbeing Strategy must address the mediating influence of stigma on engagement with mental health and wellbeing support and mental health literacy initiatives. The role of stigma is acknowledged in the draft plan, however there is limited information about how this will be addressed in the corresponding actions.[2]

Objective 1.3 - community driven approaches:

- Targeted approaches for decreasing stigma and improving mental health literacy should be developed for different CALD and refugee communities and be co-designed with the target communities.
- Valuable learnings arose from a Victorian government funded capacity building project which aimed to increase Syrian and Iraqi refugee communities' engagement with mental health promotion and to improve mental health literacy. This project engaged bicultural workers, who used conversations about mental health and wellbeing to improve mental health literacy, decrease stigma and increase awareness of services. The project established community advisory groups who worked with the bicultural workers and the project coordinator to develop strategies to engage with key community groups. Learnings included: concepts relating to mental health, mental illness and trauma are considered shameful in some communities (culturally appropriate language and concepts are therefore critical). The project also found that involving primary and tertiary mental health service providers in the program was valuable for reciprocal learning – community advisors learnt about available services and mental health and wellbeing concepts, while service providers learnt about different cultural conceptions of health and wellbeing and barriers to service access and engagement.
- Children of migrant and refugee backgrounds can experience racism and discrimination and bullying from children at school based on their English language proficiency or accent. Programs to address bullying, racism and discrimination in schools and the

[2] Action 1.2, *Plan and implement a program of activities (e.g. campaigns) to increase parents' and carers' understanding of the signs that a child needs mental health support. These activities should directly address any common myths or misconceptions about child mental health and wellbeing.*

broader community would have a protective impact for children and families of refugee background.

Objective 2.1 - Improved system navigation

- **Regarding mental health system literacy:** Newly arrived people of refugee background are managing multiple settlement demands, including navigating an unfamiliar health and human services system, and typically without English language proficiency. Mental health literacy initiatives should include elements which support parents to develop an understanding of the mental health system. Web-based informational resources such as Embrace Multicultural Mental Health could include service information in multiple languages. However, while web-based resources can be useful for families with access to devices and the requisite digital literacy, digital strategies should be coupled with other approaches. For example, building system navigation support into services which already have well-established relationships with different refugee communities would be a good approach and support accessibility for those with limited English, limited access to technology or digital literacy.
- Providing integrated prevention and early-intervention focused mental health services within community health, primary care, and settlement organisations would support system navigation and service access. This could include **e**xtending and enhancing models within the Refugee Health Program to ensure early screening and a proactive approach to early identification and preventive care, or otherwise supporting community-based models combining health and mental health care**.**

Objective 2.3 - Access and equity

- The private mental health service system is generally not accessible for children or adults from refugee backgrounds due to cost, and lack of associated language services. Accessible, culturally responsive (including available and utilised language services) public services are therefore imperative to support child mental health and wellbeing for these communities.
- Equitable service access and inclusion for Culturally and Linguistically Diverse Australians, including refugees, requires a comprehensive approach to cultural responsiveness which recognises the multidimensional nature of cultural competency and includes actions which address the systemic, organisational, professional and individual dimensions cultural competency.
- VRHN supports the proposed action to 'Establish accountability mechanisms (e.g. audit and public reporting) that encourage services to improve their accessibility for children and families, including those from Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.'

Objective 2.5 - Skilled workforce

- The child mental health and wellbeing service system must have the capability to work with children and adults from refugee backgrounds and those with low English proficiency.
  - Mental health staff must be trained in trauma informed care, cultural competency, and working with interpreters.
  - All mental health services must have a language services policy and access to appropriate training and provision of credentialed interpreters.
  - The government can have a role in supporting training for the interpreter workforce for work within mental health services. This could include

incentivizing the uptake of the new NAATI Specialist Health Interpreter qualification (which includes testing on interpreting in mental health settings) and subsidising other training and development for the interpreting workforce.

- The value of strong cultural competence in a mental health workforce is acknowledged in the draft plan. However, the associated action (2.5 e) should be expanded to ensure cultural competency is developed amongst health professionals for work with people of migrant communities, including those of refugee background, as well as Aboriginal and Torres Strait Islander children and families.
- High mental health workforce turnover compromises the development of a skilled, culturally competent workforce. Stable workforce should be considered a priority across the spectrum of care, from prevention and early intervention through to crisis response services. Workforce stability means workers continue to develop experience and expertise in service delivery and investments in staff cultural competency training are maximised. Government should consider mechanisms to improve the attractiveness of work in the public mental health system (e.g., remuneration, , job security, longer term service funding).

Objective 4.1 Meaningful data collection

- VRHN supports draft plan assertion on the value of data to inform policies and services.
- There are limited data on access of people from refugee backgrounds to mental health services (in Victoria) – addressing shortfalls in data is an essential component of evaluating service delivery and outcomes and will be instrumental in measuring reform.
- While country of birth is a part of some minimum data sets (e.g., Perinatal National Minimum Data Set), collecting data on migration and refugee/asylum seeker status as part of mental health reporting would allow meaningful evaluation of service access and outcomes for these cohorts.
- Regarding perinatal mental health screening, cited study also notes screening less likely for those born overseas.
- VRHN supports Action 4.1 (f) Develop measures that appropriately represent cultural conceptualisations of wellbeing in collaboration with the relevant communities, where such measures do not currently exist.