REDUCING STIGMA ABOUT MENTAL ILLNESS IN TRANSCULTURAL SETTINGS: A GUIDE

Leena Bakshi, Rosie Rooney, Krissa O'Neil

Reducing Stigma about Mental Illness in Transcultural Settings: A Guide

Leena Bakshi, Rosie Rooney, Krissa O'Neil

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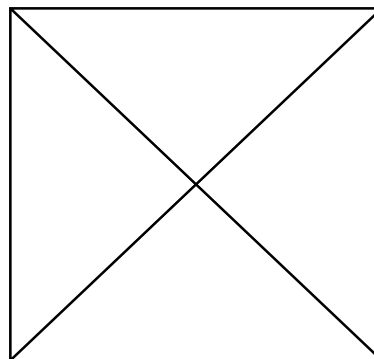

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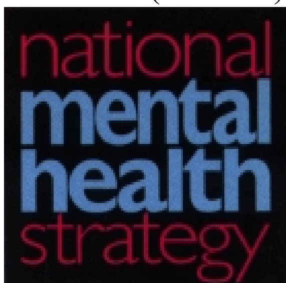

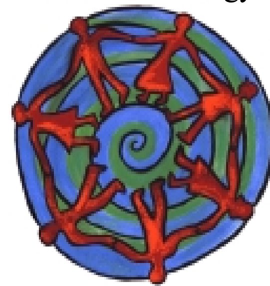

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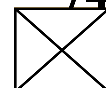

FOREWORD

'Although anecdotal evidence suggests that stigma is more commonly associated with mental illness and psychiatric treatment in many NESB communities, reducing the likelihood of early detection of illness and use of mental health services, there has been no adequate study of this issue in Australia. Nor has any community education approach to the reduction of stigma which is appropriate to NESB communities been developed or evaluated. "(Minas et al. 1993).

This situation prompted the Australian Transcultural Mental Health Network (ATMHN) to issue a tender for a study of stigma towards mental illness in non-English speaking background (NESB) communities and the development of strategies towards it's reduction. As workers within the NESB environment we combined our skills in community development, psychology and health education to undertake this study. Our 'methodology involved 20 focus groups amongst NESB communities, 50 in-depth interviews with health practitioners and in depth interviews with mental health clients, their carers, community health workers and psychiatrists. Conducted nationally over an eight month period in 1997, this research has provided much new learning and enabled the development of this guide. This research has been written up as a Phase One report, available via the ATMHN website or National Information Service.

We would like to convey our sincere acknowledgments and thanks to the communities themselves for cooperating with our research process, our bilingual research assistants, the Steering Committee and everyone involved with the project, (as listed overleaf).

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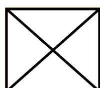

THE PROJECT TEAM

This report and the research that has been carried out has been developed by a project team consisting of the following people:
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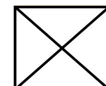
The project team would like Jo thank all of the bilingual workers, community members and clients' carers, without their involvement the project would not have been possible. Also Ruth Lopez, Nilda Shrewsbury, Katrina Markovich and Said Padshah who gave practical advice in refining the strategies, Jaquie Porter and Rachel Sanderson of MOet Equity, Marketing Consultants, for their support and services in compiling and presenting the final report and Ana Theresa Montoya de Calderon an NESB community artist for her artistic work used to illustrate this Guide. Also Chris Gillam for her valuable input and Aroon Dallabh for all his support. Finally, we would like to thank Peter Wellington (ATMHN) for his ongoing support throughout the project.



ABOUT THIS GUIDE

What Is Stigma?

Stigma is the application of a negative label or mark that distinguishes people in the community. It is manifested in negative attitudes, behaviours and feelings towards the identified group.

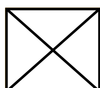
What Is This Guide?

This Guide is intended to be a reference for users to gain an understanding of stigma towards mental illness in NESB communities and an aid to the development of strategies to reduce it.

This guide is an educational tool to increase the understanding of stigma towards mental illness in NESB communities in Australia and as a guide for assisting the development of strategies to break down such stigma. As this manual will show, stigma should not be addressed in isolation from various sectors of the community and many strategies are applicable at many levels (e.g., individual, community and service provider) for mental health promotion in general. It is also a source of reference for further reading and education.

Who Can Best Use This Guide

This guide is intended for use by a wide range of stakeholders. It has been written to assist both those within the mental health field and those with other interests in the reduction of stigma within NESB communities, ie., migrant resource centres, health services, women's health centres, policy makers and service planners.



DEFINITION OF KEY CONCEPTS

Access: The availability of services to eligible people without discrimination or barriers.

Carers: Family, ie., partner, son, daughter or any other relative or friend who is in the role of taking primary responsibility for the person.

C.A.L.D.O.T.A.: Culturally arid linguistically diverse other than indigenous Australian.

Community: A community is a group of people who may be linked by a common social structure which provide a sense of belonging. Such structures may be derived from geographical location, cultural background, gender, political or religious beliefs. There may be sub-communities within communities.

Equity: Implies that all people receive an equitable outcome from the services they receive. There is a large literature on equity in service delivery, and reliance on equity of outcome is a controversial issue.

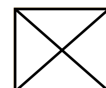
Ethnic: Recognisable as coming from a particular culture (Penguin Macquarie Dictionary).

Ethno-specific: Specific to a particular ethnic group. For example an ethno-specific service caters to the needs of a particular ethnic group and will be familiar with important cultural beliefs, background, language, and traditions.

Individual consumers: Persons with a mental illness who use a mental health service or any other health service with a diagnosed mental illness.

Mental health: A holistic approach to mental health incorporates all those factors that may contribute to the better adjustment and greater sense of well-being of an individual or group.

Mental illness: Mental illness has been described by the DSM-IV manual as clinically significant behavioural or psychological syndromes or patterns that occur in individuals. It is associated with either present distress (eg., very sad or very anxious); and/or disability (eg., problems with work or family relationships); and/or an increased chance of pain, disability, loss of freedom, death, or suffering. It excludes culturally sanctioned or expectable responses to certain events such as the death of a loved one.



NESB: Migrants and refugees to Australia from Non-English-Speaking Countries. These exclude the UK, Ireland, New Zealand, Canada, USA and South Africa. This excludes children born in Australia to NESB parents.

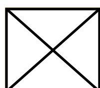
Practitioners: Those who provide a mental health service to those with a mental illness and may include psychiatrists, psychologists, psychiatric nurses, social workers, community mental health nurses, counsellors and bilingual counsellors.

Service: A department that provides health care to the public, and may include psychiatric clinics (outpatient and in-patient), migrant resource centres, information centres, and hospitals.

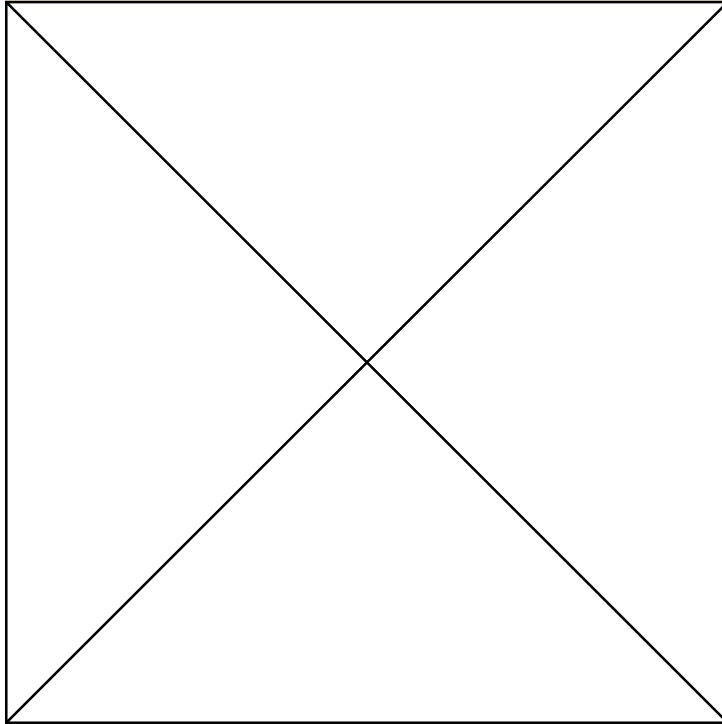
Service providers: Those who provide services to the community and may include, but not limited to, health care workers, psychiatrists, psychologists, ethno-specific workers, social workers, welfare officers and policy officers.

Stigma: Stigma is the application of a negative label or mark that distinguishes people in the community. It is manifested by negative attitudes, behaviours and feelings towards the identified group.

Stigma of mental illness: Stigma toward mental illness is a label, mark or myth that distinguishes people in the community with a mental illness. Many associated negative attitudes, feelings and behaviours are felt by members of the community (including those with a mental illness), toward those with a mental illness. Often the stigma is also extended to carers, helpers, friends and relations of those with a mental illness (Rooney, O'Neil, Bakshi, & Tan-Quigley, 1997).

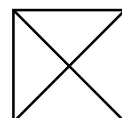


INTRODUCTION



OBJECTIVES

To provide an understanding of the process by which multiple factors interact to produce stigmatisation of those with a mental illness. To carry out strategies of stigma reduction, an understanding of the process by which stigma occurs, how it is recognised, and its consequences, is required.



STIGMA, MENTAL HEALTH AND MENTAL ILLNESS

What Is Stigma?

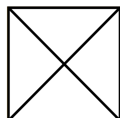
Stigma has been described as a negative outcome or unwanted effect that results from any physical attribute, character or behaviour which deviates from the norm and is perceived to be undesirable (Weiner et al. 1998). During the early and modern periods of western society, marginal populations, such as the “mad” or “insane” were increasingly institutionalised by the state, accentuating any stigma already attached to those who appeared to be different from the norm (Fabrega, 1991). While the meaning and development of stigma in Western societies has begun to be documented (eg., Fabrega, 1991), the stigma of mental illness is also beginning to be understood and is emerging as a major concern in NESB communities negatively affecting the access and use of services.

Stigma is associated with many problems such as isolation, marginalisation, and lack of treatment for those with a mental illness (Ng, 1997). In NESB communities in Perth, a three phase ethnographic study was conducted to determine the meaning of stigma of mental illness, and ways to reduce such stigma amongst Indian, Italian, Vietnamese, Romanian, and Spanish-speaking groups. In each of these groups, the three phases involved:

(i) 20 focus groups,
(ii) interviews with 16 psychiatric clients, their carers & health professionals, and,
(iii) 50 interviews with health professionals from around Australia who worked with NESB communities.

Qualitative analysis of the three phases revealed that stigma toward mental illness was a label, mark or myth that distinguishes people in the community with a mental illness. Many associated negative attitudes, feelings and behaviours are felt by members of the community (including those with a mental illness), toward those with a mental illness. Often the stigma is also extended to carers, helpers, friends and relations of those with a mental illness (Rooney et al. 1997).

Major mental illness has traditionally involved a high degree of stigma for both the mentally ill and their families (Lefley, 1989). In addition, there is evidence that clinicians are similar to their psychiatrically untrained family members in



the amount of stress they perceive to result from mentally ill patient’s behaviours (Lefley, 1987).

Mental Health and Mental Illness

A holistic approach to mental health incorporates all those factors which may contribute to the better adjustment and greater sense of well-being of an individual or group. In an NESB context there are a number or factors to consider which may be crucial to the mental health of individuals or communities. These include:

- Pre-migration.
- The process of resettlement.
- Responding to the stressors of the dominant culture.
- Recognising the cultural differences involved in the expression of mental health or illness (Blignault et al.1998).

All of these factors are potential environmental sources of stress or conflict which may contribute to the expression and experience of mental illness.

Mental Illness

Mental illness has been described by the DSM-IV manual as clinically significant behavioural or psychological syndromes or patterns that occur in individuals.

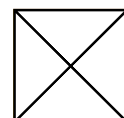
It is associated with either:

- Present distress (eg., very sad or very anxious); and/or
- Disability (eg., problems with work or family relationships); and/or
- An increased chance of pain, disability, loss of freedom, death, or suffering.

Mental illness must be a response that is not considered 'normal' (eg., feelings of sadness when a loved one dies) within the sufferer's culture and be viewed as either a psychological, or biological, or behavioural dysfunction in the individual.

There is a wide range of problems identified by DSM-IV as a mental illness, the more common ones include:

- Anxiety (eg., agoraphobia, post-traumatic stress disorder).
- Mood disorders (eg., depression).
- Personality disorders.
- Psychotic disorders (involving a loss of touch with reality) such as schizophrenia, (American Psychiatric Association, 1994).



In cross-cultural contexts such as the NESB community, symptoms of mental illness can be physical as well as psychological, such as feeling sad or anxious. Physical symptoms of mental illness have been identified as somatic symptoms and may include headaches, tiredness, and/or nausea (American Psychiatric Association, 1994; Rooney et al. 1997).

STIGMA AND MENTAL ILLNESS IN NESB COMMUNITIES

The level of understanding about mental illness in the community is improving (Ng, 1997), although qualitative research has suggested that people from many NESB groups do not know much about the causes, treatment and service delivery options involved for those living with a mental illness (Rooney et al. 1997).

The Causes of Mental Illness

There are a variety of models accounting for the causes of mental illness. A commonly accepted theory is the Western Bio-psycho-social-cultural Model (Kaplan, Saddock, & Grebb, 1998) It is important to recognise the model(s) of mental illness that individuals from diverse cultural context believe. Failure to do so can lead to a number of negative consequences, including misunderstanding, the loss of the client and poor treatment outcomes (Rooney, 1997).

The Bio-Psycho-Social Model

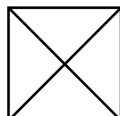
When a person develops a mental illness, it is because of a complex interaction between biological, psychological and social and cultural factors.

Biological Factors: The type of genes (eg., tendency to become extremely anxious under certain situations) that they have inherited from their parents.

Psychological Factors: Their psychological resources (eg., self-esteem or how good they feel about themselves).

Social Factors: What is happening in their lives (eg., a stressful situation such as loss of a partner).

Cultural Factors: The cultural values, beliefs and behaviours in a person's environment (e.g., child-rearing expectations).



The Bio-Psycho-Social-Cultural model of mental illness is widely accepted in Western countries. A major implication of the model is that when a person develops a mental illness, it is not their fault and it is not a sign of weakness. Rather it is a response that has developed in a person for reasons involving an interaction of factors beyond their control.

Many people recover completely from a mental illness and of those that donít, many still are able to lead happy productive lives with the right care and treatment.

Consequently:

> People with a mental illness need to be directed to the right treatment as soon as possible.

Beliefs About the Causes of Mental Illness

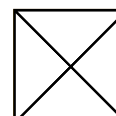
Rooney et al. (1997) noted that in many NESB communities people believed mental illness to be caused by many different things, including biological, psychological, social, migration, cultural and religious factors.

Biological factors:

- Genes.
- Contagious.
- Heredity.

Psychological factors:

- Lack of resources (eg., energy).
- Low self-esteem.
- Lack of self-confidence.
- Personality and temperament.
- Frustration from inability for self expression.
- Negative thoughts.
- Depression related to stress.
- Negative affect/attitude.
- Loneliness (isolation).
- Feelings of professional inadequacy.



Social/migration factors - before arrival:

- Stress of preparing to flee, fleeing, seeking asylum and the process of resettlement.
- War and political instability.
- Torture and physical abuse.
- Brain washing (forced indoctrination).

In transit factors:

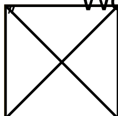
- Stressors involved in living in refugee camps.
- Stress of travelling as a refugee (also see Kung, 1973, cited in Knowles, 1984).

Social/migration factors - after arrival:

- Lack of acceptance in country of resettlement.
- Antisocial and illegal behaviour may cause mental illness.
- Stress of migration process.
- Change in lifestyle and socio economic status.
- Unemployment.
- Racial discrimination.
- Supporting family in home country.
- Financial stress.
- Stress from separation with family members in home country or other countries of resettlement.
- Alcohol and drugs.
- Family dysfunction.
- Australian system of education and attitudes to parenting.
- Dissatisfaction for old people.
- Denying cultural origins and refusing contacts with community. The lack of support and stress that results from this may aid in the development of mental illness.

Cultural and religious factors:

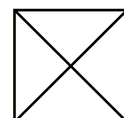
- Evil spirits.
- Bad karma.
- Migration (leaving oneís village, town or land).
- Bad deeds.
- Disengaged community.
- Torture and trauma in country of origin and refugee camps.
- Cultural alienation.
- Language barriers.
- Loss of socio economic status in Australia.
- Women’s role in society (eg., isolation and abuse).



While some of the specified causes do not have negative connotations (eg., social factors causing stress such as migration, cultural alienation, loss of status, women's role in society, and language barriers), others (a disease you can catch, evil spirits and karma) hold varying degrees of negative associations with those living with a mental illness, ie:

- Mental illness occurs because of bad deeds.
- Mental illness is a result of criminal behaviour.
- Mental illness occurs as the result of a previous bad life in one's ances try. People think that it means that ancestors such as their grandparents, uncles or aunties must have done something bad in their lives so people in the current generation are paying for it.
- Mental illness is a result of bad karma.
- Mental illness is caused by evil spirits.
- Mental illness is a disease that you can catch.
- Talking about mental illness can lead to mental illness.
- If you helped someone with a mental illness, you and/or your family would be regarded with many of the associations reserved for those with a mental illness.
- Often the family is viewed as an extension of the individual so the attitudes and behaviours that were directed towards someone with a mental illness were also directed to their family.

The beliefs outlined above cause serious impediments for the acceptance of the mentally ill or mental illness information. They encourage people to blame those who have a mental illness, perceive them as weak, spiritually bad, or dangerous. There are a number of reasons, including those beliefs which result in a reluctance by members of communities to accept those living with a mental illness, and can be called <u>causes of the stigma towards mental illness.</u> In the following section, the causes of the stigma of mental illness will be outlined in detail.



Causes of Stigma Towards Mental Illness

1. Culturally Embedded Attitudes:

   As outlined above, in NESB communities there are culturally embedded attitudes and beliefs that involve negative associations with mental illness. Subsequently the behaviour, feelings and attitudes of community members towards those living with a mental illness promotes the stigma of mental illness within NESB communities. These reactions include avoidance, ridicule, rejection, fear, and viewing people with a mental illness as weak, incurable, bad or dangerous. These attitudes vary both between NESB groups and individuals reflecting a high degree of cultural diversity in communities. They occur in those who are better informed or well educated about mental illness as well as those who are less well informed.

2. Lack of Knowledge About Mental Illness:

   Although people are better informed than they were (Ng, 1997), there is still a lack of understanding about how stressors, genes, and psychological factors interact to cause mental illness (Rooney et al. 1997).

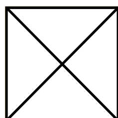
   Education about the Bio-Psycho-Social Model of mental illness is needed in NESB communities. This will decrease the perception that mental illness is a punishment brought upon a person by their own actions or a sign of weakness, and promote tolerance and understanding of why people can develop a mental health problem.

3. Lack of Knowledge About How To Help Those With A Mental Illness.

   Avoidance of a person with a mental illness also stems from not knowing how to help. If people were better informed about support, what role they can play to help a mentally ill person, and treatment options, they would be better equipped to help and be less fearful of becoming involved.

4. Fear:

   Fear of being stigmatised at a number of levels including being unemployed, a migrant, and having a mental illness. The fear of having such a triple stigma that incorporates mental illness increases the reluctance of migrants to acknowledge that there is something wrong with their psychological well-being. Such fear is the negative side of people wishing to participate and become members of the new community in which they have arrived.



5. Community Services:

   The role that community and health services have played in addressing mental illness ìback homeî may also be assumed to exist within Australia. In some home countries, such as Romania, there was much stigma surrounding mental illness and people may have assumed that the same stigma would exist in Australia. As such agencies have not provided information to ethnic communities, members can only assume that the mental health system operates in similar fashion to that operating in their country of origin.

6. Lack of Time, Energy and Cohesion in NESB Communities.

   For some people from NESB groups, particularly recently arrived migrants, time and energy is low due to the strain of establishing themselves. People are often only just able to cope and are without the resources to help others.

   In addition, certain NESB groups (eg., Romanians in Perth) are not cohesive and lack support groups or networks to help those associated with mental illness, including those with the mental illness, their families, carers and friends.

7. Cultural Traditions:

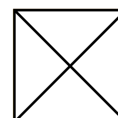
   For most NESB groups, there is a tradition of avoidance and marginalisation of the mentally ill which occurs regardless of the problem or reason. <u>As a part of the community’s belief system, it is a behaviour that is learned and passed on within the community, especially while these beliefs are not discussed or challenged.</u>

8. Stigma Perpetuates Stigma:

   People who have been stigmatised with a mental illness continue to be viewed and treated in a negative way which reinforces the role model of the public treatment and attitudes toward those with a mental illness. People living with a mental illness are treated in a negative way and there are many consequences including lack of aid for problems, isolation and low self-esteem. The lack of assistance and marginalisation reinforces the negative attitudes within the community towards those with a mental illness.

9. By Association:

   Anything associated with a mental illness has become stigmatised, from talking about it through to seeking help, through to contact with psychiatrists and hospitals. Consequently, people donít seek help, don’t talk about it and avoid hospitals.



10. Lack of Role Models:
    There are limited role models in communities to show that openness, support and seeking help are positive things to do, or information to refute stigmatising attitudes.

Stigmatisation occurs regardless of the level of understanding of mental illness. It has been widely reported (eg., Ng, 1997; Rooney et al. 1997) that peopleís knowledge and understanding of mental illness does not lead to greater 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 (eg., bad or dangerous), feelings (eg., fear) and behaviours (eg., avoidance, denial, stigmatising).

It has been shown that stigmatisation of the mentally ill is more likely if:

"The patient is male, of lower socioeconomic class, violent, unpredictable, showing incomprehensible behaviour (eg., hearing voices), lacking social ties and being treated for somatic therapies in state hospitals" (Ng, 1997, p383).

THE MANIFESTION OF STIGMA

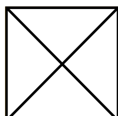
Stigma of mental illness occurs at three levels of society:

- At the level of the individual.
- At community level.
- At the service delivery level.

Individual Level

At the individual level, stigma is often expressed towards a person living with a mental illness, her or his family, friends and carers. People who have been identified as associating with the mentally ill, whether through family connection, help or friendship are often identified in communities with many of the negative associations identified above. Those with a mental illness may have negative attitudes, feelings and beliefs including fear, shame and guilt.

This may consequently lead to maladaptive behaviours in those with a mental illness (and often family and friends) including secrecy and avoidance of treatment.



Community Level
At the community level, stigma can be observed in many different forms from the general NESB community to specific NESB groups. These include social and sporting groups, play groups, music and recreation. The community as a whole will often be aware of members who are living with a mental illness and the stigma can be deeply entrenched.

"To reduce stigma of mental illness, existing attributions and attitudes towards the mentally ill needs to be challenged and changed in communities"
(Rooney et al. 1997).

The stigma of mental illness can be detected in many different forms in the general community. The three major ways in which the stigma of mental illness can be recognised are:
- Attitudes.
- Feelings.
- Behaviours.

Negative attitudes about those with a mental illness include the perception that such people are bad, criminal, weak and/or dangerous.

There is also the view that mental illness is a useful warning that someone bad is nearby. Common feelings felt toward those with a mental illness include fear and lack of trust, anger and suspicion.

Behaviours toward those with a mental illness include avoidance and marginalisation.

Service Delivery Level
At the service delivery level, stigma toward mental illness can exist both in individual and community attitudes towards institutions such as hospitals and by individuals working in such institutions. Community members will often not use hospitals or seek help as they view this as representing all the negative aspects of becoming mentally ill. Many see such behaviour as a defining role in the development of mental illness where one must 'have a mental illness' if one ends up in hospital. Services often do not have sufficient bilingual workers with an understanding of the culture specific issues and symptoms. This results in a lack of understanding of people from NESB groups who do present at clinics. The structure of services does not currently adequately address NESB issues and needs in mental illness. (This issue has been taken up by the work of ATMHN funded and other projects).

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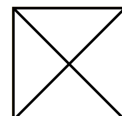


THE IMPACT OF STIGMA

There are many negative consequences of stigma, many of which which operate to perpetuate the existence of negative attitudes, feelings and behaviour directed toward people living with a mental illness:

〃 For the community, the most commonly reported responses to those with a mental illness were fear, anger, and avoidance. This promotes isolation and avoidance of friends, family and those trying to help. The longer term consequences are that those with a mental illness effectively become extremely alienated from their community and it often becomes an entity to be avoided and feared. This in turn:

→ Perpetuates stigma (reinforces existing negative attitudes, beliefs and feelings), and:

→ Leads to under utilisation of services by those with a mental illness due to the negative associations of them.

→ Symptoms (eg., suicide, withdrawal, low self-esteem) may worsen in those with a mental illness due to factors such as lack of treatment, the 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 preventative behaviours. (Rooney et al. 1997)

Scheff's (1996), labelling model (Figure 2) provides an outline of the process by which labelling someone mentally ill results in perpetuating mental illness behaviours in the labelled person. The stigmatising behaviours and attitudes towards mental illness in the community reinforce and exaggerate this labelling process.

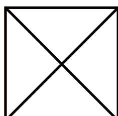
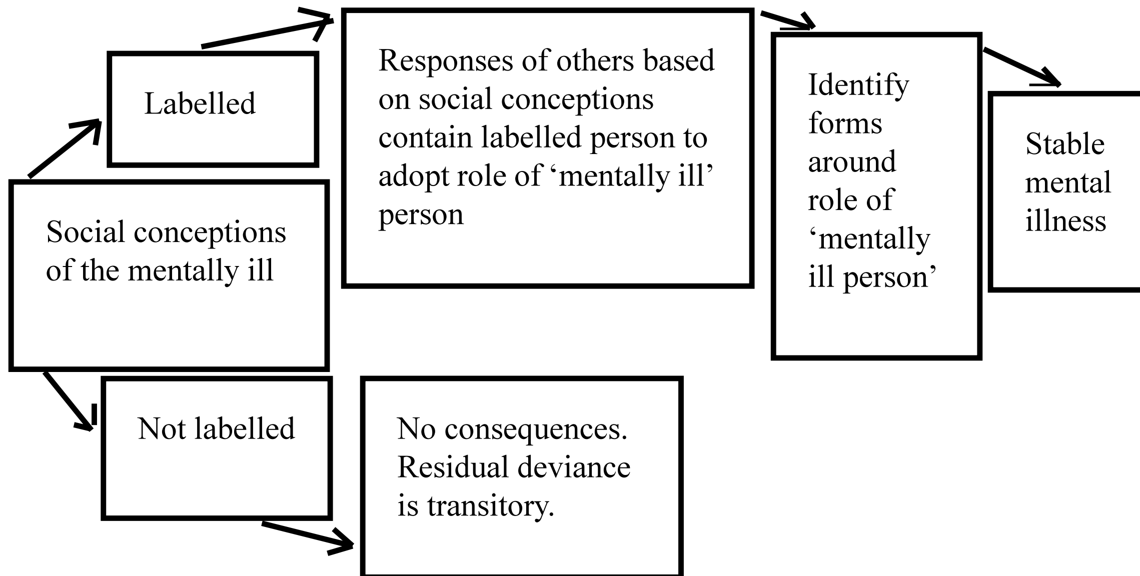
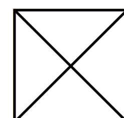


Figure 2.: Scheff's (1996) Labelling Model





WAYS TO REDUCE STIGMA ABOUT MENTAL ILLNESS

There are two critical conclusions made by Rooney et al. (1997) that are critical to the design of a programme to reduce the stigma of mental illness in NESB communities. Firstly:

1. The way to reduce stigma is through increasing community acceptance of mental illness and knowledge of mental illness.

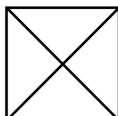
While it is important to know about the identification, causes, treatment, and service delivery for different types of mental illness, knowledge of mental illness is not enough for members of NESB communities to accept individuals, families, and carers affected by mental illness. **Acceptance through 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 community change to take place, the individual and service delivery levels must also be addressed as they reinforce the stigma at the community level, therefore the second conclusion is:

2. Stigma must be reduced at different levels operating simultaneously. These levels are:

- **Service delivery.**
- **Community.**
- **Individual.**

To reduce the stigma surrounding mental illness in NESB communities, strategies need to be multifaceted to provide the maximum chance of accessing all members. At the community level, community change can take place via a number of strategies which involve the whole of the community at various levels.



It must come from within the community, such as through key community representatives (community mobilisers) who act as role models in showing positive attitudes and behaviour towards those with a mental illness. However, strategies must also operate at the individual and service delievery and policy levels. Examples of strategies outlined by Rooney et al. (1997) include include:

1. Policies and practices that addresses the issue of diversity.
2. Programs that cater for NESB communities.
3. Employing bilingual bicultural staff.
4. Employ ethno-specific workers where appropriate.
5. Collaborating with other sectors and services.
6. Use of translated materials.
7. Use of ethnic media (radio and TV).
8. Develop links with strategic community mobilisers to act as role models.
9. Forums and workshops to bring community members and role models together.

These strategies will be covered in detail later in the manual. Those using these strategies need to be aware of the agenda within the community. There is little point in engaging in a campaign while the target group is distracted by issues from the country of origin, housing, education or employment. Within many ethnic communities the social agenda reflects that occurring within the broader community, it is often just more complex.

As well as overlapping strategies, there are some strategies which are particular to each level. For example, at the individual level, individual counselling and support groups need to be made available for those with a mental illness, whereas at the service delivery level, structural changes in policy need to be made about ethno-specific workers being available for each NESB group.

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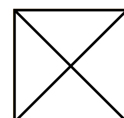


THEORY OF CHANGE FOR STIGMA REDUCTION

The process of investigation of stigma surrounding mental illness at a community level followed by the development of a manual to reduce the identified stigma is consistent with McGuireís Theory of Persuasion Process (McGuire, 1989). This is a model outlining the process by which people change their beliefs, feelings and behaviours as the result of a campaign (Figure 3). The model describes input variables (rows) outlining who (source) says what (message), via what medium (channel), to whom (receiver), directed at what (destination) kind of target. The output variables describe information processing steps that the communication must evoke in the target person for the message of the campaign to act persuasively on the target person. In the case of stigma, this would involve the process of becoming exposed to the information about mental illness and stigma, integrating this information and resulting in behaviour which reduces stigma in their community. This would include behaviours such as accepting those with a mental illness, seeking help quickly if they develop mental illness, helping others with a mental illness and not discriminating against those with mental illness problems.

The manual is also consistent with McGuire's (1989) seven step process for constructing public communication campaigns. The steps involve:

1 Identifying goals suitable for change via mass persuasion.
2 Make sure the change would be for the public good.
3 Identify causes and maintenance of target behaviour (eg., stigma of mental illness).
4 Identify the thoughts, feelings and actions associated with the target behaviour (eg., stigma).
5 Identify the most important themes/aspects from Steps 3 and 4.
6 Use the source, message and channel inputs outlined in Figure 3 that will involve the output steps to change behaviour.
7 Evaluate the effectiveness of the campaign.

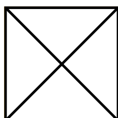
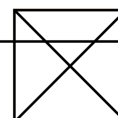


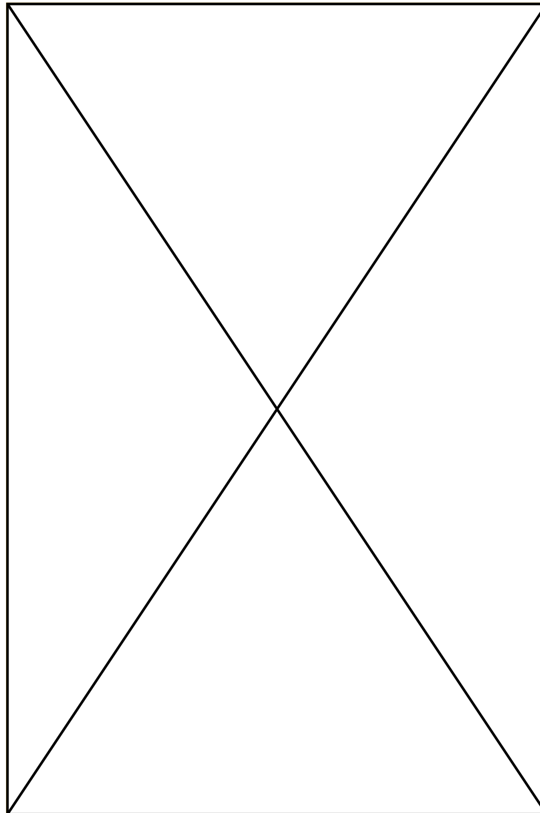
Figure 3: The Communication/Persuasion Model as an Input/Output Matrix

Input: Independent (communication) Variables / Output: Dependent, Variables (Response Steps Mediating Persuasion)	Source	Message	Channel	Receiver	Destination
	Number Unanimity Demographics Attractiveness Credibility	Type appeal Type information Inclusion omission	Modality Directness Context	Demographics Ability Personality Lifestyle	Immediacy /delay Prevention /cessation Direct immunisation
1. Exposure to the communication					
2. Attending to it					
3. Liking, becoming interested in it					
4. Comprehending it (learning what)					
5. Skill acquisition (learning how)					
6. Yielding to it (attitude change)					
7. Memory storage of content and/or agreement					
8. Information search and retrieval					
9. Deciding on basis of retrieval					
10. Behaving in accord with decision					
11. Reinforcement of desired acts					
12. Post Behavioural consolidating					

(Rice & Atkin,1989)



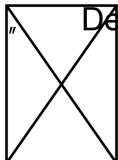
KEY CONCEPTS IN DESIGINING A CAMPAIGN FOR PEOPLE FROM NESB COMMUNITIES



OBJECTIVES

The objectives of this section are to:

- develop an understanding of the need for a health promotion framework and its essential characteristics.
- Define mental health promotion and the essential elements.
- Develop an understanding of the key concepts for designing a campaign: goals, objectives and strategies.
- Develop an understanding of the need for evaluations and the different types of evaluations.

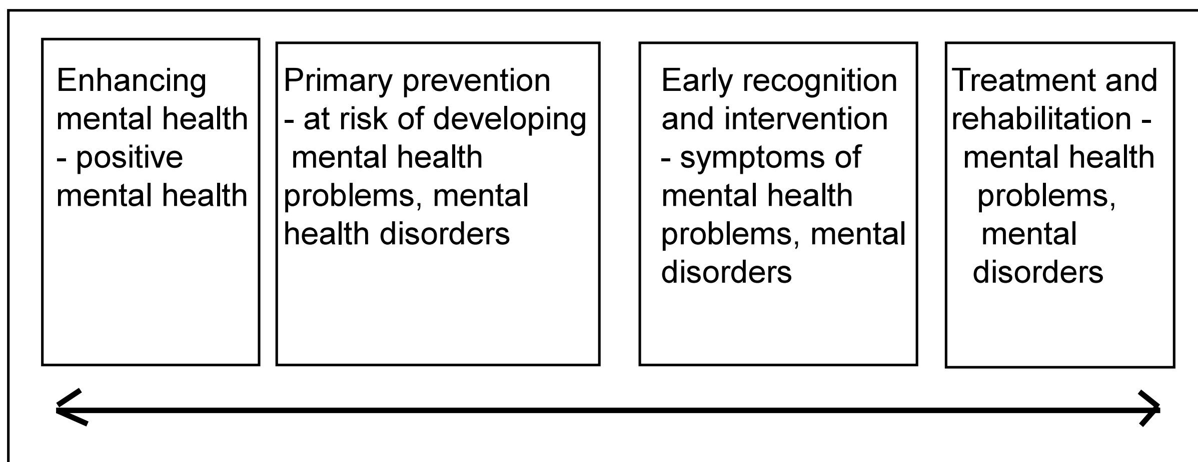


A National Framework for Health Promotion

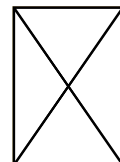
The project's phase one research has demonstrated that stigma is a complex process of labelling that has numerous causes and is maintained by various structures such as culturally embedded attitudes, perceptions of mental health services and individual attitudes. To bring about behavioural change requires a coordinated approach at a national, state and local level utilising a range of strategies. The strategies that are adopted to change behaviour need to be supported by structural changes at a policy and organisational level.

The goal of any successful campaign will be the recognition of mental health being equivalent to physical health. Consequently people with mental health problems and their carers will not be alienated, either by their community or by their own feelings, attitudes and behaviours, and will seek help for their illness in the same way that people with a physical illness will seek help. Of equal importance is the understanding of mental health as being a continuum with mental illness and health promotion (Figure 3) where prevention strategies and early intervention can often prevent more severe problems. The adoption of such an understanding will assist in shifting the emphasis from individual and collective guilt relating to mental illness to a responsibility for management.

Figure 3 - Mental Health Promotion and the Health Care Continuum



(Scanlon, Williams, Fiorillo, Gleeson, & Wallace, 1997)



Strategies to reduce stigma from such a framework are designed to recognise the multiplicity of influential factors and remove the notion of ‘individual blame’. They also are developed to recognise that change in beliefs, attitudes, knowledge and behaviours has to be accompanied by a simultaneous change in the individual and the community - through education and in the environment - through appropriate service delivery, well designed programs, funding for programs and legislation.

At the environmental level a range of barriers within the services and the manner in which funding is made available also contribute to the process of stigmatisation. Factors such as a lack of culturally sensitive and ethno-specific workers, and lack of access to translated materials with information about service delivery can contribute to continuing negative attitudes, feelings and behaviours towards mental illness.

The *Ottawa Charter for Health Promotion*, published in 1986, recognises the need for structural reform in order to build health policy, and consequently takes the responsibility for change away from the individual. This has been further expanded by the Jakarta Convention, published 1997, which has extended this model to incorporate capacity building and social capital.

The five Ottawa Charter strategies are essential for success:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- re-orients health services

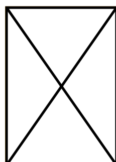


Figure 4: The Ottawa Charter

Build Healthy Public Policy
This area of action places health on the 'agenda of policy-makers at all levels'. It therefore requires that policymakers are aware of the consequences of their policy on the health of a population and bear responsibility for it.

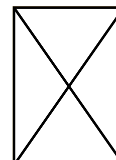
Create Supportive Environments
To encourage 'reciprocal maintenance' of the between individuals, communities and the natural environment, take global responsibility for the conservation of natural resources and create a healthy society. 'Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.'

Strengthen Community Action
Health promotion empowers communities through 'concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health'. This is achieved through access to information, learning opportunities for health and funding support.

Develop Personal Skills
Giving people options to exercise control over their health and over their environment by 'supporting personal and social development through providing information, education for health and enhancing life skills'.

Reorient Health Services
'Health services need to embrace an expanded mandate which is sensitive and respects cultural needs.' In doing so the health sector opens channels with the 'broader social, political, economic and physical environmental components'.

(Ottawa Charter 1986)



In the context of a stigma reduction campaign the following examples illustrate the incorporation of a multileveled approach.

1. Build Healthy Public Policy
Health planners need to address cultural diversity within planning and policies need to be in place to protect programs and ensure that there is an ongoing commitment to funding.

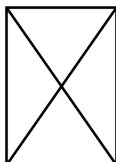
2. Create supportive environments
Acknowledge the global environment and implications of rapid change on mental health and the impact of globalisation on migrants and refugees. There is also a need to recognise that work cannot be carried out in isolation but through working in partnership more effective change can be achieved. Supportive environments are also created by working in partnerships. This is a three way action between consumers, the community and health services.

3. Strengthen community action
Community empowerment can be carried out at a number of levels. Through working with:

1. peak bodies can lobby and develop a framework for action.
2. recognise the work of key community informants who can act as community mobilisers
3. work with consumers of mental health services who can act as role models for change and through their own experiences can make a valuable contribution.

4. Develop personal skills
Conducting education programs at a community level and through this empower people with the information and skills to make informed decisions relating to help seeking behaviour for mental illness. Ensure that people at a community level are informed about accessing services, where to access information, treatment options and information about etiology relating to mental illness.

5. Re-orient health services
Health services were found to be a contributing factor in perpetuating negative attitudes surrounding mental health. Services need to work in partnership with communities and ensure that the delivery of services is responsive to their client group. This is at several levels within the service eg the allocation of resources, policies and procedures for working transculturaly and innitiatives such as the use of bicultural workers and the 'outsourcing' of service delivery.



Since the publication of the Ottawa Charter programs around the world have adopted these principles in working to improve health at a population level. There is now substantial evidence that a comprehensive approach to health development is more effective than single track approaches. The Jakarta Declaration has highlighted a set of priorities for Health Promotion in the 21st Century. These are:

- Promote social responsibility for health
- Increase investments for health development
- Consolidate and expand partnerships for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

The processes that are outlined below have taken into account all of the above priority areas.

CHARACTERISTICS OF A HEALTH PROMOTION CAMPAIGN

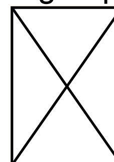
Health promotion programs use a variety of strategies to change risk factors (Watson and James, 1991). The characteristics of such programs can be paraphrased as:

Duration: All health promotion programs have a duration of three to five years. This is to account for the 'current stage of community acceptance of an idea' and the rate of diffusion of the idea into society.

Coordination: The activities of a campaign are coordinated and the strategies for intervention are 'consistent and coherent'.

Multiple strategies: Successful campaigns make use of a range of available strategies.

Multilevel approach: Campaigns require the definition of a primary target group for behaviour change and a secondary/ancillary target group that consists of opinion leaders or 'community mobilisers'.



Adaptability: Long term campaigns may be monitored for their effectiveness enabling change where required. The adaptability of a campaign is also the ability to take advantage of related events occurring during the course of the campaign.

Research-based: The campaign is based on research that defines the problem and suggests outcomes.

Evaluation: Evaluations are imperative considering the high cost of health promotion campaigns. This is covered in more detail in the section under evaluation

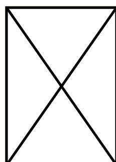
This process of changing attitudes towards mental illness, changing community behaviours towards the mentally ill and ensuring that services are accessible to all people irrespective of their cultural backgrounds can be achieved through a **mental health promotion framework**. This framework is an "application of health promotion approaches to problems in the area of mental health" (Clark, K. & Ibrahim, J., 199?). (See also Victorian Health Promotion Foundation, 1995. Mental Health Promotion Within a National Framework)

Mental health promotion is used to refer to a range of activities:

- Prevention of mental illness.
- Promotion of better mental health.
- De-stigmatisation of mental illness.

It is also a process of enabling individuals and communities to increase control over and maintain their subjective well-being through the development and use of their abilities to relate, think and feel in relation to individual and collective goals consistent with social justice (Clark & Ibrahim).

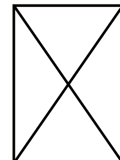
Mental health promotion moves the spotlight of viewing mental health and mental illness from 'treatment' and 'maintenance' to 'promoting mental health' and 'preventing mental illness' (Hodgson, et al,1996). In doing so it encompasses those at risk of developing a mental health problem, to those with a mental health problem 'ranging from mild to severe illness'.



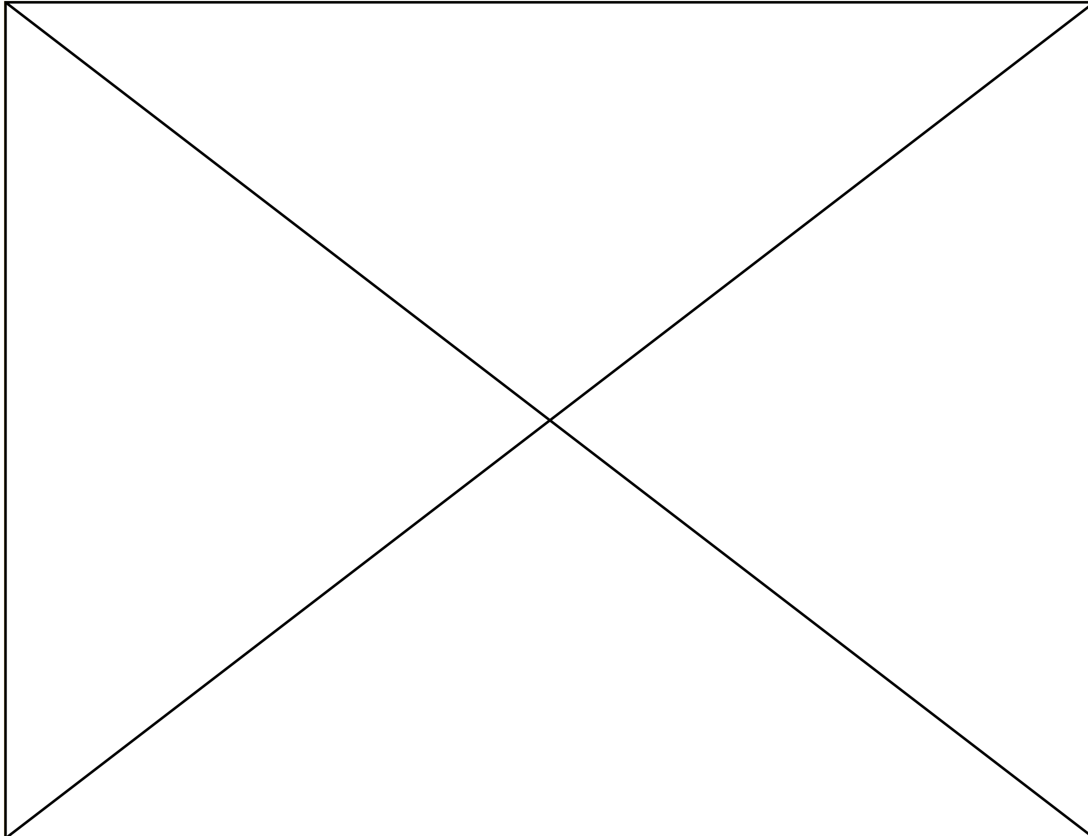
KEY ELEMENTS OF MENTAL HEALTH PROMOTION

- Mental health promotion encompasses a spectrum ranging from promotion of mental health at one end and prevention of mental illness at the other. This is an interactive relationship, ie., promoting mental health leads to prevention of mental illness and vice versa. (Ref needed)
- The opportunity to promote mental health and prevent mental illness exists at any point along the mental health continuum. (See p19 for Mental Health Promotion and Health Care Continuum).
- Physical and mental health are related (See Figure 4: Ottawa Charter).
- Mental health promotion programs should recognise that socio-economic factors, cultural, geographic and environmental factors act as barriers to accessing services.
- A range of strategies are utilised to develop mental health promotion programs.
- An intersectoral approach is necessary. This requires the active involvement of health services, community organisations, community groups, and other relevant stakeholders.
- Mental health promotion programs in stigma reduction combine the five approaches described in the Ottawa Charter: developing personal skills, strengthening community action, building healthy public policy, creating supportive environments and increasing the focus on early prevention and promotion (adapted from the NSW Mental Health Promotion Frame work 1998).
- There exist a range of target audiences in the community.
- There are a range of settings wherein mental health promotion activities can be initiated.
- Initiatives in mental health promotion need to address the issue of access and equity.

Campaigns aim to bring about changes at either a behavioural or structural level. Behavioural change aims to bring about changes in attitudes, beliefs, knowledge and behaviours. It can address be aimed at an individual, community or service provider level. In contrast structural change is the development of supportive structural environments which support the behavioural change. The two processes are interlinked and support each other. While the diagram outlines specific steps it is cyclic and strategies can commence at any level. An explanation of the rationale behind the model will be discussed below. This will be followed by a discussion of the specific strategies that can be used within each area.

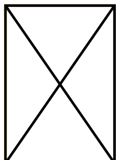


The following model has been adapted from Green & Kreuter to represent the various levels at which a campaign needs to operate.



Community awareness
This is carried out with the aim of placing the issue on the agenda and alerting people to the importance of the issue. It is a process of paving the ground in preparation for more targeted education. Community awareness strategies can be targeted at a community level and also the level of service providers and planners.

Education
Campaigns at this level are carried out with specific audiences to address key areas of education need. The information is chosen according to the needs of the target group with the aim of bringing about changes in attitudes and behaviours.



Advocacy
Advocacy, here, refers to the mobilising of individuals and organisations to work towards change and have input into the program planning process. It provides an avenue for consumers and special interest groups to work in collaboration on programs.

Legislation and regulatory changes
Recommendations that arise through the advocacy process are enacted through legislation and regulatory changes. Legislation refers to legally enacted changes and regulation refers to policies and procedures which exist at an operational level. The impact of the legislation and regulatory changes can influence education and also structural changes.

Environmental, socio cultural and technological changes
In the case of addressing attitudes surrounding mental health most of the strategies to be used will be within the area of behavioural change however there are areas in which changes that are made can support changes in the behavioural area.

Areas to address under each category

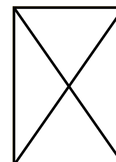
Community Awareness
The role of the community in the stigmatising process cannot be underestimated. It is through lack of knowledge and cultural beliefs about mental illness, and lack of understanding about the role of mental health services that the community keeps stigma alive.

Many migrants live in a 'time warp' and consider what is appropriate to their culture based on their understanding of their culture at the time of migration.

Mental illness was often seen within the context of more severe pathology eg being mad.

Broad community awareness paves the way for providing specific education strategies. Campaigns are not aimed at changing attitudes or behaviour but rather are used to put the issue on the agenda.

Focus group discussions noted that community members had an understanding of mental well being and how to keep well. This included concepts of positive mental health, nutrition, stress management techniques, positive attitudes, exercise. These positive attitudes to mental health awareness and valuing the importance of mental health



can be harnessed and assist in campaigns which are aimed at valuing the importance of mental health in the same light that physical health is valued.

Community attitudes to mental health impact on the way people are viewed and consequently treated. People with a mental illness:

- are seen as mad or crazy;
- often do not participate in their ethnic community as they fear rejection;
- negative attitudes prevent people from sharing general information about mental health services contrasted with physical health problems;
- people are seen a malingering as the illness is not validated by others.

Strategies that can be used at a community awareness level are broad based campaigns which reach the maximum number of people -

- Ensure that messages in mainstream media represent culturally diverse individuals;
- include slogans / short messages on ethnic radio;
- that publicity is given to mental health week;
- include personal stories in the ethnic media about role models who have / had mental illness; and,
- use social marketing strategies eg stickers, balloons, posters.

Community Education

Community education is specific information which provides knowledge and information. This needs to be carried out with -

Community members

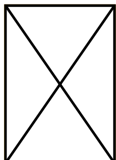
→ individuals in the community with an interest to improve their under standing of mental illness
→ consumers and their carers
→ community mobilisers who can act as role models

Providers

→ Service providers
→ Service planners

The rationale for targeting education at a service provider level is:

- People reported feeling alienated when trying to access mainstream services - due to language barriers and inability to express what was happening mentally and emotionally. In some languages there is no vocabulary to describe mental health complaints and it is expressed in a physical way.



- Lack of concern by health professionals who did not give adequate explanations. People reported that they felt medical practitioners would prescribe medication without fully understanding the issues or what they were feeling.
- Lack of understanding by service providers of cross cultural mental health issues.
- Migrant service workers, not in the mental health area, who need to have an increased understanding of issues their clients may be experiencing and who have a role to play in early identification.

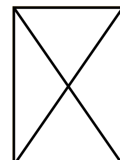
Education for community members needs to cover the following areas -
Increasing knowledge about:
→ types of mental illness
→ causes of mental illness
→ treatment of mental illness
→ awareness of services, including when and how to access them.

At a consumer level:
→ Fear of being admitted to hospital and the way services in Australia operate in comparison to the way they operated in their country of origin.
→ Talking to health practitioners; questions to ask, side effects of medication
→ Preventative and mental health management strategies such as stress management and cognitive behaviour

Providers
→ Understanding transcultural mental health issues
→ Understanding specific issues for migrants.

Strategies to use
→ Workshops / information sessions / forums
→ Courses
→ Ethnic radio - more specific information can be provided by a mental health worker or using a panel discussion format.

Translated material
→ Self help groups - people reported improved health when they were able to share their experiences in their own language
→ Training sessions - production of training kits
→ Case management of cross cultural clients
→ Resources for workers on working transculturally eg pamphlets, articles in journals
→ Videos
→ Library of resources in other languages



Advocacy

This needs to be carried out to bring about change

Strategies
→ Work with consumer representatives
→ Partnerships with other agencies / the community
→ Community mobilisers
→ Service providers
→ Establishment of reference groups
→ National and state networks

Legislative and Regulatory Changes

The enactment of changes that have arisen due to the advocacy these in turn impact on behavioural strategies or structural changes

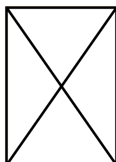
Strategies
→ Strategic planning at a national, state, local and organisational level
→ Allocation of resources based on principles of access

These then impact on behavioural and structural changes

Structural Changes

Strategies
Environmental
→ Services are more responsive to the needs of migrants and refugees eg provision of cross cultural training, use of interpreters
→ Services provide an outreach services to organisations with less stigma attached eg Migrant Resource Centres, Community Houses
→ Code of ethics for media

Socio / cultural
→ Mental health service providers work in partnership with cultural values of their client eg exclusion from counselling, do not negate cultural values eg Karma rather focusing on cause focus on management of issues



Technological

→ Use of internet and other technological processes

These factors will enhance behavioural change

EVALUATING CHANGE

Evaluation theory is well covered in books such as Everyday Evaluation on the Run (Wadsworth) & Degling Hall etc. the importance of evaluation is crucial to assess the effectiveness of a program and to assist in future program planning. Evaluation needs to cover both process and impact.

Process evaluation measures aspects of the program which influence the delivery of the program eg the development of a submission, a change in organisational policy, the number of information sessions conducted.

Impact evaluation measures changes that demonstrate progress towards achieving the outcomes of the project eg increased service usage, increased knowledge about mental illness amongst members who have attended a group.

Comprehensive program evaluation needs to be documented and shared with other program planners to ensure promotion of examples of best practice.

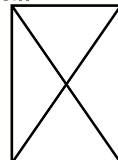
When working with culturally diverse groups methods of evaluation need to take into account the following:

→ feedback questionnaires utilising a lickert scale are often unfamiliar and within a training / group session can consume a disproportinate amount of time explaining how to fill it in;

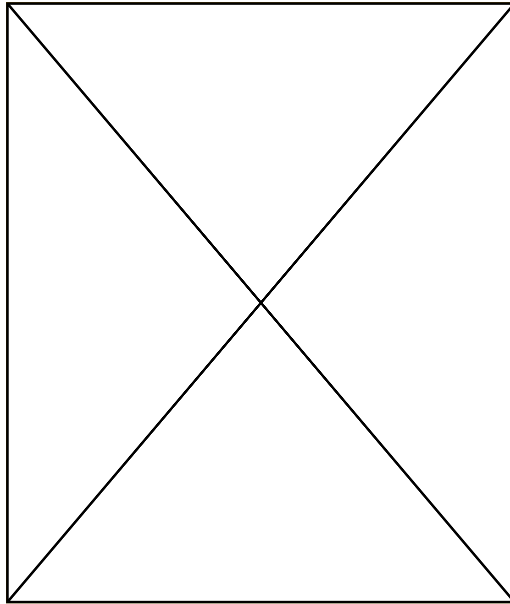
→ verbal self reported feedback at the conclusion of a workshop or within a group setting may be influenced by a dominant few with other members supporting what has already been said rather than stating their own opinions. It may also be impolite to contradict a view that has previously been expressed;

→ One-on-one interviews carried out over the telephone or face-to-face with selected participants have been effectively used in a number of initiatives; and,

→ Interviewing only key informants may not reflect the opinions of all program participants



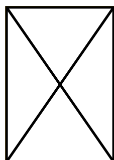
STRATEGY DEVELOPMENT



OBJECTIVES

The objectives of this section are to:

- Develop an understanding of the range of strategies.
- Develop an understanding of the appropriateness of each strategy and when it can be used.
- Develop skills in using each strategy.

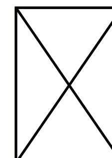


The Interaction of Levels, Strategies and the National Health Promotion Framework

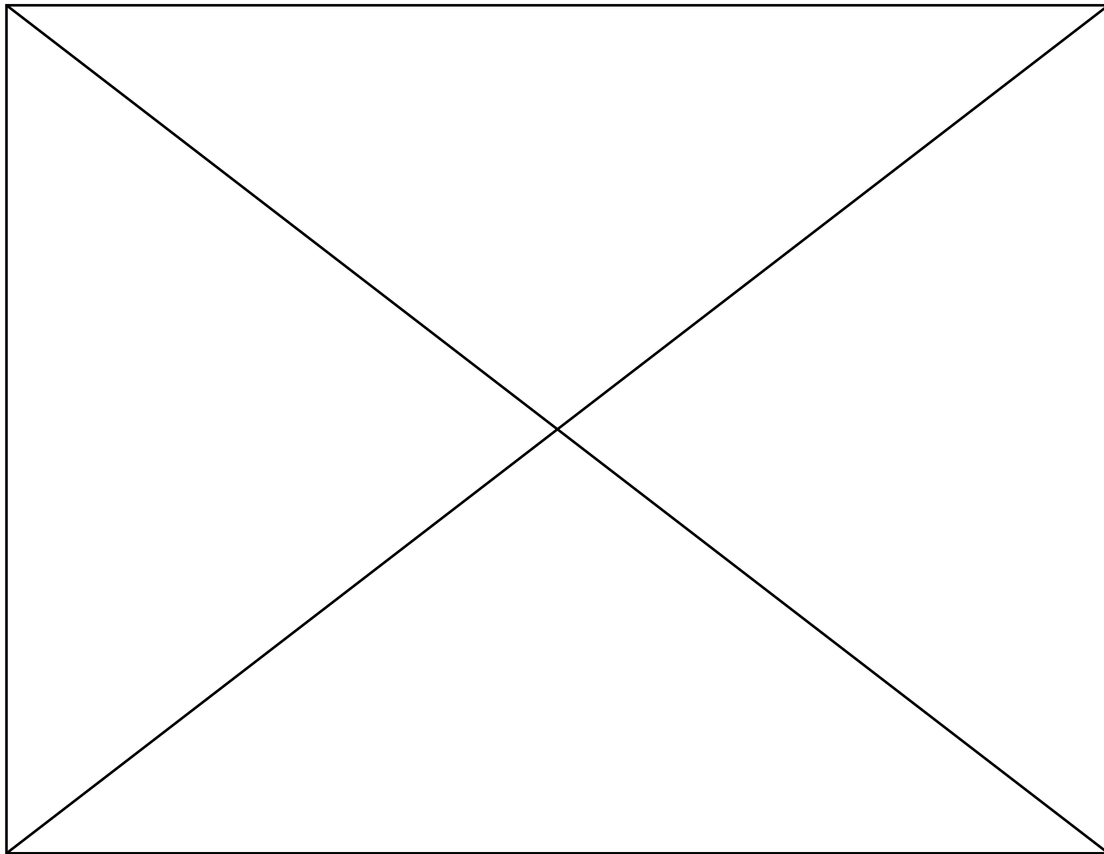
The following section provides a detailed outline regarding the implementation of strategies at the service delivery, community and individual consumer level.

Level	Strategy
Services	1. At the level of the organisation i Strategic plans ii Programs and Budgets iii Marketing iv Recruitment v Use of Interpreters vi Data Collection vii Training 2. Intersectoral Collaboration i Interagency meetings ii Outreach iii Regional Committees
Community	1. Working with groups i Information Sessions ii Community forums iii Community workshops 2. Working with community mobilisers 3. Using ethnic media i newspapers and newsletters ii ethnic radio 4. Translated materials 5. Promotional items
Individual Consumers and Carers	1. Counselling 2. Self help materials and translated material 3. Carers - Support groups

As discussed, earlier strategies need to be developed and implemented across all three levels to work most productively. Additionally, within each level, a number of strategies may be used simultaneously, or in combination, as they address different objectives. Each of these levels also potentially influence and interact with each other. For example stigma at a community level

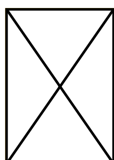


reinforces stigma at an individual level and vice versa (Rooney et al. 1997). Each of the three levels can be directly related related to the adapted model from Green & Kreuter such that all three levels may be operating in any of the five aspects of behaviour and structure change at any one time and all three levels are required to be addressed to bring about stigma reduction.



INDIVIDUAL<<<<>>>>>COMMUNITY<<<>>>>SERVICE PROVIDER

Having outlined a model for the operation of the strategies within the National Framework, strategies which may be involved involved in each of three interacting levels of society will now be described.



•STRATEGIES FOR SERVICE PROVIDERS

Mental health services are part of the stigmatising process (Rooney et al. 1997). Some contributory factors are a lack of information and the myths that exist about mental health services, fear of the system, language barriers, attitudes within the mental health services towards people from NESB backgrounds and appropriateness of programs. Cultural appropriateness and the Western bio-psycho-social-cultural model which frame practitioners' understanding of mental illness are factors that dictate the manner in which services operate. Language plays an important role in understanding and accessing services. Where members of the community have peripheral language skills they are at risk of being misunderstood and misinterpreted by practitioners. This leads to misdiagnosis. For example, whereas in some cultures it is accepted for women to see visions of Mary, these women are often labelled as psychotic and put onto drugs in Westernised cultures (Rooney et al. 1997). Coupled with this is the fear of being caught in the system. A number of people from Asian backgrounds believe that once they are in the system they will be part of a prison. Mental health services are equated to "asylums" where "mad people go to" (Rooney et al. 1997).

Considering the part services play in the process of stigmatising it is essential that strategies be employed at this level to destigmatise mental illness. This can be achieved through programs, policies and intersectoral collaborations.

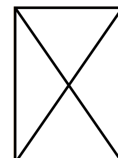
Policies

These are guides to actions and reflect "... management philosophies, principles and strategies, and form the bridge between strategies and operations" (Nankervis, et al, 1993,p33). Policies ensure a commitment from management and provide staff members with a supportive framework to raise concerns.

Policies can:

- Be deliberately framed by the culture of the organisation.
- Reflect the culture of the organisation.
- Restrict change.
- Instil change.
- Be broad.
- Be specific.

For organisational policies to be effective they need to meet the following criteria (Nankervis, et al,1993):



Congruency: is, derived from and supported by broad organisational objectives and other organisational policies. For example: a service develops information brochures regarding services in community languages, but has no recruitment policy that ensures that people with languages other than English will be highly considered to work for this program.

Compatibility: all policies work towards a common organisational goal. For example: one of the goals could be servicing a culturally and linguistically diverse clientele - then all policies will in some form reflect how this goal will be achieved.

Clarity: policies are clear, written and communicated in writing. This can be enforced through continuous training and inductions.

Flexibility: in allowing for discretion, they ensure consistency and equity. Concepts such as access, equity, diversity and appropriateness need to be defined within the policy document.

Cultural appropriateness: to the organisation's structure, it's strategies and culture.

Relationships: help maintain and improve relationships between employees.

Key areas where strategies can be employed are:
At the level of the organisation.
Intersectoral collaboration.

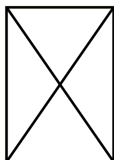
1. At the Level of the Organisation

i. Strategic Plans

Strategic Plans should acknowledge and reflect the diversity in the community. Unless diversity is incorporated at this level, programs within an agency will remain ad-hoc, unrelated to broad objectives and dependent on a well-meaning employee.

Working with issues of diversity can be at various levels in the process of strategic planning. Some of which are:

a) Scanning the environment could include:

Identifying which communities reside within the catchment area.

Identifying their needs.
Establishing if theseneeds are reflected in client data.
Identifying what other ethnic organisations/services exist in the area?

(See Situational Analysis for a detailed discussion.)

b) Conducting a SWOT (strengths, weaknesses, opportunities and threats) analysis of an organisation could focus on:

- The ability to deal with a diverse client population in terms of programs, staff and procedures.
- Organisational systems that allow reflection, ie., ethnicity data.
- Flexibility in terms of procedures and programs.
- Ability to be inclusive and equitable with regard to current programs.
- Intra-organisational support for programs targeting a culturally diverse client group.

c) Organisational objectives and goals should clearly state the intention to work with a diverse client group, this should preferably be at two levels. One wherein an exclusive objective is formulated and secondly by ensuring that all objectives are inclusive of diversity. For example: A general objective can be: “Ensure that services are accessible to the community”. While a specific objective could state: “Culturally appropriate services are made available to members of NESB communities”.

d) Formulating strategies. Ensure that strategies clearly state how the needs of a diverse client group will be met.

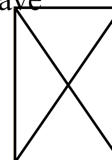
ii. Programs, Funding and Budgets

In recognition of the needs of NESB clients, it is important to provide services which are equitable as opposed to being merely to equal. This requires planning a greater resource allocation within the agency budget. It is no longer excusable to view the core program funding to cater for mainstream clients and providing programs for other groups including migrants, people of Aboriginal and Torres Strait Islander descent and people with disabilities when additional funds have been obtained.

Funding agencies need to ensure that state plans include programs which respond to diversity. There also needs to be a commitment to fund programs where needs are identified.

iii. Marketing

Service providers clearly need to be culturally sensitive with regard to the marketing of services and programs. Not only is it important to target marketing communications appropriately, eg., by selecting appropriate media, there is also a responsibility to ensure that messages are effectively received and understood. Whilst the most obvious example of this is the translation of advertising copy, it also includes the use of culturally appropriate names, symbols, colours and images, eg., colours have strong religious meanings for some communities.



iv. Recruitment Policy and Employing Bicultural Staff
Anecdotal experience indicates that services that have staff from a NESB will attract diverse clients. This is accentuated when staff are recruited to work with particular communities. The contributory factors for stigmatisation within services are misdiagnosis, issues of assessment and the fear of "being caught in the system". Recruiting a diverse staff is one way of overcoming this. Bilingual/bicultural staff can not only bring their community network with them, but also cultural understandings that allow for effective and appropriate assessments, interventions and diagnosis. The role of bicultural staff was conceptualised as 'a bridge between the mainstream and the community'. Their understanding of community supports or lack of supports is invaluable in formulating action and intervention plans for consumers. (See Ziguras & Stankovska,1998,pp49-52)

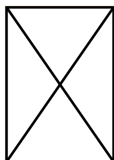
Bicultural staff employed in a number of mental health services have a threefold role: (1) to service clients from a specific culture, (2) provide a cultural consultancy to other staff in the service and (3) community education.

An example of ensuring this validation of skills translated into policy is by incorporating the 'ability to speak another language' under the desirable criteria. Employing staff with bilingual/bicultural skills has several advantages in reducing stigma.

- For consumers of the same client group there is a person within the agency who not only speaks their language but also understands the culture.
- For staff the worker can act as a cultural consultant and place the clients experience within a cultural context thus enhancing case management. These skills of the bicultural/bilingual worker need to be recognised where necessary and allowances or further training should be provided to become a qualified interpreter.
- Clients may feel a sense of kinship when seeing staff members in an organisation who share their understanding of the migration experience.
- Bilingual staff have the cultural understanding to work in two belief systems - the bio-psycho-social and the clients belief system.

v. Policy Requiring the Use of Interpreters
It is suggested that organisational policy clearly define the use of interpreters. This can address:

- How interpreters will be accessed.
- Who will pay the cost of the interpreting.
- Training for using interpreters.
- Issues such as time and client load.



For example: counselling sessions using interpreters take longer than sessions where interpreters are not used. Interpreters need to be briefed before a session and de-briefed afterwards. This requires a recognition from the organisation that the client load of counsellors using interpreters will be smaller than otherwise.

vi. Data Collection and Utilisation of Data in Program Planning
Data collection is an essential tool for planning. It is a reflection of community needs. Absence of certain community members or over representation of some sections of the community can bias the development of new programs. Collecting ethnicity data has always been a contentious issue as a number of variables need to be collected to produce information that can be put to use.

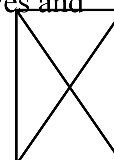
Some suggestions on data variables are:

, Country of birth.
, Language spoken at home.
, English proficiency.
, Year of arrival.
, Religion.
(For a detailed Discussion see Diversity Counts, 1994.)

A cross tabulation of these variables will provide a snapshot of the consumers of the service.

vii. Training for Agency Staff
Training plays a central role in developing services that are accessible and equitable for all members of the community (see Ferns, P. & Madden, M, 1995). The focus of the training is to develop 'good quality' services, policy and 'organisational structures' and provide staff with the skills and the support necessary to implement action plans. Training can become 'tokenistic' if it is not integrated into other organisational activities. It is important that all agency staff are trained. As 'there may be trained staff in the services but often you face the people at the counter, when people are feeling low and they are feeling rejected, they may never return'.

The Phase One Report of this project identified General Practitioners as requiring training in dealing with issues of mental health and cross-cultural sensitivity. Virtually all the individual consumers interviewed for the study had initially consulted their GP and the effectiveness of this varied from unhelpful to very helpful. GPs were also found to be most insensitive to the impact of stigma on their patients lives and both the individual consumers and their carers lacked comprehensive information on their illness.



Types of Training

Six approaches to training in international literature identified by Cope, et al., (1994) are:

1. Ethno-specific Approach:

Within this approach culture is taken to be 'static', a 'set of particular attitudes, values, beliefs and behaviours shared by it's members' (p27). The focus of the training is to understand these patterns and characteristics.

This training can sometimes support 'the racist notion' of 'other being undesirably different from the dominant group' (p28).

2. Psychological/Interpersonal Approaches:

Culture is approached as a 'shared design for living based on the values and practices of a society, a group of people who interact together over time' (p30). The model explores culture as an expression of human needs and desires.

The stress is on developing expertise in exploring participants values, beliefs and attitudes. The training can be very 'in-your-face' and hence requires experienced trainers.

3. Linguistic Approach:

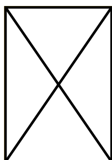
This approach is based on understanding cross-cultural communication. Misunderstanding and breakdowns occur because of a 'lack of contextual or cultural knowledge but are also to do with different ways of structuring discourse and different intonations' (p33). The focus of such training is on problems created by dealing with clients speaking different languages in the workplace and the importance of non-verbal communication.

4. Socio-Historical Approaches:

This approach 'examine(s) the dynamics of migration as source of one of the most important elements of diversity' (p41). The forms of migration are analysed, factual information and related policies are presented.

5. Equal Opportunity/Anti-Discrimination Approach:

This type of training addresses issues of access and equity, and the barriers created by language and culture. Though this training is about equal opportunity and anti-discrimination, it 'creates a dilemma in which the force of law gives teeth to an argument at the same time as it creates resistance' (p51).



6. Diversity as a Productive Resource/Mainstream Management Training Approach: This approach is based on the premise that 'work is itself a cultural activity' (p53). Culture, in this approach, is viewed broadly as the culture of an organisation, the culture of the workplace and the manner in which 'cultural groups interact' (p65). The focus is on processes and on change 'where are we heading to' (p65). The training is about 'the negotiation and the interplay of cultures' (p65).

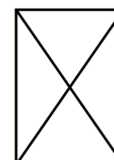
Effective training should (Ferns and Madden, 1995; Cope, et al., 1994):

- Challenge the values and attitudes of trainees and bring about an awareness of stereotypes.
- Challenge institutionalised racism.
- Include a historical perspective of racism in psychiatry.
- Understanding of culture within a Multicultural Australia and the practical needs of the workplace.
- Develop an understanding of migration categories, the process of migration and settlement.
- Provide trainees with an understanding of related Acts, ie., Equal Opportunity Act and Anti-Discrimination Act.
- Develop cross-cultural communication skills.
- Allow trainees to see the benefits of managing diversity.
- Be linked to outcomes.
- Generate action plans.
- Provide trainees with the skills and tools to develop NESB friendly strategies.
- Lead to improved procedures and services for users.

Some Training Outcomes

At the end of the Training, trainees should be able to:

- Reflect on their values, attitudes and practice, and their impact on providing services to a culturally and linguistically diverse audience.
- Recognise the inherent barriers in the system that prohibits NESB communities from accessing services.
- Use cross-cultural communication skills with clients.
- Can relate migration categories and settlement issues.
- Can interact with clients from NES backgrounds.
- Can state related acts.
- Generate action plans to overcome barriers.



2. Intersectoral Collaboration

One of the key elements of health promotion are intersectoral partnerships. The health of a community is the responsibility of all levels from the individual consumer to the social, cultural, economic and political bodies. This places an enormous need for different sectors to collaborate and coordinate in ensuring the well-being of a community.

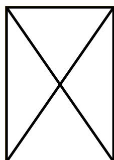
Some suggested intersectoral strategies within the scope of this guide are:

i. Inter-Agency Meetings
These are monthly meetings, based on catchment areas of agencies. The meetings can be formal or unstructured. They have the advantage of:

- Personal contacts, networking, information sharing.
- Building bridges between agencies that otherwise may be 'unlikely bedfellows'.
- Conflict resolution.
- Alignment of efforts.
- Avoiding duplication and allowing for collaborative projects.
- Ensuring that there is a forum where issues can be resolved.
- Acting as a forum for disseminating agency specific information.

Examples:
Interagency meetings chaired by the Northern Suburbs Migrant Resource Centre. These comprise a number of agencies in the catchment area of the Northern Suburbs.
The Tasmanian Transcultural Mental Health Network has been making efforts to coordinate the activities of a number of agencies and lobby for a higher profile for issues raised by the networks members.
In Melbourne the Cross Regional Multicultural Working Group meet bimonthly. The main focus is on the provision of information for ethnic health services. A number of agencies are members of this Network.

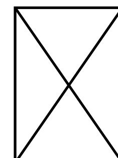
ii. Outreach Programs
Outreach is a process whereby programs operate outside their own agency. They require protocols to be developed between the host agency and the auspicing body. Providing programs at ethno-specific agencies or Migrant Resource Centres is also a strategy for intersectoral collaboration.



Example: Relationships Australia WA outreach a counselling service to the Northern Suburbs Migrant Resource Centre - WA.
Example: Sexual Assault Resource Centre outreach Domestic Violence counsellors to the Catholic Migrant Centre in WA.

iii. Regional Committees
These are committees based within catchment areas of services, with a regional focus and a formalised or semi-formalised structure. Whereas interagency meetings could have a varied and floating membership, a regional committee has a fixed membership and a fixed focus. The committee may also jointly lobby for issues and common concerns, and jointly set up programs within the region.

Example:
The Eastern Suburbs (Perth, WA) Post Natal Depression Committee has members from mental health, community health, public health and general practitioners.



STRATEGIES FOR THE COMMUNITY

The role of the community in the process of stigmatising cannot be underestimated. It is through lack of knowledge and cultural beliefs about mental illness, lack of understanding about the role of mental health services and negative attitudes towards the mentally ill that the community helps to perpetuate stigma. Many migrants live in a 'time-warp' and have an understanding of what is appropriate to their culture based on their understanding of their culture at the time of migration. There is also a perception in the community that there is an 'Anglo' way of 'doing things' which is different to the community's way. Strategies aimed at working with the community includes both an awareness raising and educational components. They are aimed at changing community attitudes and knowledge towards mental illness, the mentally ill and mental health services, thereby bringing about a change in the behaviour, which will lead to a process of reducing stigma. Working with consumer organisations and groups is critical in all steps where possible to maximise the opportunities for community attitude and behavioural change (Rooney et al. 1997).

Community strategies may be divided into:

1. Working with groups:
    - i information Sessions;
    - ii community forums;
    - iii community workshops.

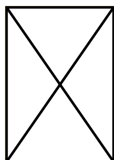
2. Working with community mobilisers.

3. Using ethnic media:
    - i newspapers and newsletters;
    - ii ethnic radio.

4. Translated materials.

5. Promotional Items.

Each strategy has a different focus in terms of its objectives, target audience; the information to be presented the outcomes and the message. Importantly, these strategies can be used most powerfully in combination, eg., raising awareness of issues through ethnic media whilst using community mobilisers to encourage participation in forums where indepth understanding and intervention can take place. Prior to



discussion of each of these strategies there are a number of noteworthy pointsregarding adult learning and working with people from NESB communities.

Adult Learning

All the above strategies whether they are one-off information sessions or intensive workshops, whether the objective is to provide the community with knowledge about mental health services or challenge community attitudes on mental illness, are based on principles of adult learning. These are:

- Adults are often uncomfortable as trainees.
- Adults like to focus on real life problems and experiences.
- Adults want to use new skills acquired and knowledge gained as soon as possible.
- Adults have prior learning and skills that should be recognised.
- Adults like to feel free to question and debate.
- For adults training has to be seen as relevant to what they do.
- Adults learn better if the material is meaningful.
- Learning takes place faster when two or more senses are used by the learner.
- Trainees recall well things they learned first and last in a sequence.
- Learning occurs quicker and more effectively when learners are actively involved in the learning process, ie., learning by doing (experiential learning).

(Malcolm Knowles as quoted in Stone R. J. ,1995).

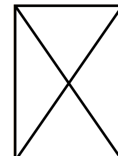
Facilitator Skills and Preparation

Facilitators need to:

- Have a systematic approach to training.
- Remember that there are two sides to training - yours and the participants.
- Think about how participants can practice or adapt the new skills and knowledge.
- Understand the community: culture, mores, norms, migration history and diversity within a community.
- Have the ability to challenge participants attitudes to mental illness.
- Have the ability to create a safe environment in which questions can be asked.

Considerations in Working with People From NESB Communities

- Facilitators may not be asked questions because it is considered rude to question authority.
- Participants may not ask questions for fear of looking stupid.
- Facilitators need to be sensitive to ensuring that the participants have understood the information without being patronising. One way to overcome this is to give plenty of opportunity to practice the skills and allow time for discussion.
- Facilitators to ensure that trainees are aware of what they will achieve at the end of the training.



Some Hints for Sessions that Allow Effective Learning

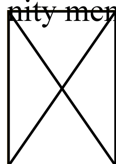
- Plan carefully.
- Know the audience.
- Determine the knowledge base of the group.
- Start with the known and move into the unknown.
- Encourage people to ask questions.
- Remember in some cultures asking questions is considered rude. It does not mean that the participants have not understood.
- Evaluate the learning, perhaps by using simple questionnaires following the session.
- Use multiple aids such as videos, boards, etc.
- Ensure that translated material is available for people to take away. Often with new information participants may be unable to remember everything.
- Provide a mechanism for further information, advice or training after the session.

1. Working with Groups

The focus group discussions with community members revealed though participants had a number of theories of how mental illness is caused, there was a general lack of understanding of the causes of mental illnesses. Though many participants amongst the five communities did know a lot about depression and were sympathetic towards depression other mental illnesses were looked upon as 'madness' and those with a mental illness perceived as dangerous. Depression on the other hand was seen as an almost natural reaction caused by the stress of migration and settling in an alien culture. Added to this was the fear of mental health systems - which in a number of countries have been used against the people. This fear of the system adds to the stigma of seeking help and ensures that individuals only use the system when 'all hell has broken loose'.

Other issues such as 'who will pay' are another reason that people from a NESB may not access services. They are unaware of ìwhat the service offers and what their rights are, these are not explained in a way that people can understand. Working with the community will assist in removing some of the barriers that exist in the community that does not allows them to access the services thereby reducing stigma.

Community education should not be limited to mental illness but also to mental health and how to 'preserve' mental health. Focus group discussions noted community members had a number of understandings of mental we-being and how to keep



well. These ranged form - 'taking control over one's life', swallowing one's suffering, possessing good physical health, living in a social

environment that is accepting and having the ability to cope with one's new life. Acknowledging migration and the concomitant stress for migrants, and the trauma experienced by refugees at the three stages one in leaving the home country, in transit and in coming to Australia is very important. This acknowledgment will give people the 'permission' to seek help and 'normalise' mental illness.

i. Information Sessions

Objectives

- To provide the community with an understanding of the causes and knowledge of the range of mental illnesses.
- To provide the community with a knowledge of the mental health services, how to access the services and issues such as cost, etc.

Target Groups

- Members of the target community/ies.

Outcomes

By the end of the session participants will be able to:

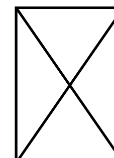
- List the causes of mental illnesses and the range of mental illnesses.
- Name mental health services and demonstrate how they can be accessed.

When To Use a Community Information Session

Community information sessions are strategies whereby information about services or programs are provided to the community in a simple format. These one-off sessions are useful at the commencement of any program. They provide a litmus test for how a program will be received in the community. They are also a useful vehicle to publicise a new program. A suggestion is to make available printed material in community languages that people can take away at the end of the session, including sources of further information and advice.

Community Information Sessions Can Address

- Knowledge on the range of mental illnesses and how to seek help.
- Knowledge on what services are available in the community so as to promote help seeking behaviour.
- Providing knowledge on how the mental health services work.
- Information regarding how to access the services and who can avail of the services.
- Issues such as cost of a service and understanding one's rights can also be dealt with at community information sessions.
- How stigma to mental illness stops people from seeking help.
- Migration and the concomitant stress.



Messages that can be promoted in a community mental health session:

- It's okay to ask for help.
- Migration causes stress.
- There is a range of mental illnesses and treatment is available.
- If you stigmatise mental illness not only could it stop someone you know from seeking help but it may also be a barrier if you want to seek help.

Practical Issues

Step 1: Background Work

Develop an understanding of mental health and mental illness in NESB communities. (See section 1 for a range of causes). Different communities have varying understandings of 'how to be sick' and this is overlaid with not knowing the norms of operating in within the Australian system.

Consult a range of people within the target community, local community organisations and service providers such as Migrant Resource Centres, Women's Health Centres and any ethno-specific service. This process will allow the project to identify and tap into community networks. It may also provide opportunities to collaborate with other projects. This helps in efficient use of resources such as interpreting costs, venue hire, and therefore maximises the value of such networking.

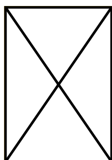
Step 2: Before the Session

Promotion/Fliers/Invitations: Explore the different avenues for promoting the event. These could be the radio, newsletters, notices in churches etc.

Date: Ensure that the date does not coincide with any religious festival or any other community event. Information on festivals can be obtained from state Departments of Multicultural/Ethnic Affairs.

Venue: The venue should be local to where a majority of the community members reside as transport can be an issue with many new migrants. The project may need to make provisions for transport or at least that the venue is easily accessible by public transport and that participants are aware of times and routes.

Time: The times at which information sessions are conducted are important. For women not in the workforce, there is the responsibility of children's school times. Thus for any information session to be successful it is preferable to start any time after 10am and end by 2pm.



Food: Food is an important part of any gathering. Ensuring that food and drinks such as tea, coffee and cool drinks tea are made available as it is a mark of hospitality.

Childcare: Childcare for young children can also be difficult. A large number of migrants do not have the support of extended families. Making childcare available at the venue is also an option.

Publicity and Encouraging Participation: A wide range of techniques are available to publicise information sessions and other community activities, details of which follow this section. Whilst ethnic media and translated materials may be the most cost effective means of raising awareness amongst the largest audience, more personal communication may be more effective at prompting action. Sending out fliers or invitation cards can work well as they are a validation of the community's participation in a formal process. Invitations are best followed by a phone call to participants, such a personal touch is very much a part of working with NESB communities.

Vignettes: If you are using vignettes make sure they have been checked out with someone from the community to make sure that the intended message is not lost on the community.

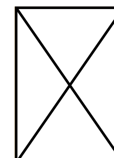
Step 3: Organising the Day

The project will need to consider whether interpreters will be used. Interpreters need to be booked in advance and briefed regarding how the session will be run. Translating and Interpreting Services (TIS) in each state conduct training sessions on how to use interpreters. Due to funding cuts this may need to be negotiated. Arriving late, moving around between sessions and having children present is a part of many non-western cultures and not a sign of rudeness.

After the session allow for time to ask questions and clarify issues. Ensure that any information divulged by the participants to the facilitator will be treated confidentially. Facilitators may also need to have the skill to support or refer any participants who has used this an opportunity to debrief. It is also advisable to have printed information that participants can take away. It is important to evaluate the success of the session in terms of attendance: invitation ratio, the workability of transport, venues, etc., for future planning.

Advantages

- Gives a chance to test the project.
- Ensures that a number of stakeholders are aware of the program, thereby making the project accountable.
- An ideal strategy to introduce any new idea. The questions and answers at the end of the session allow for clarification.



- Provides the participants to make contacts with service providers in an informal setting.
- Can be cost-effective in reaching larger numbers of people.

Disadvantages
- Receiving the information does not guarantee that the participants will act on it.
- The number of participants attending will depend on how strong the contacts with the community are.
- Participants may not feel safe to ask questions that are not ‘the norm’ for the community.

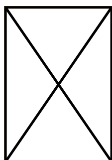
Budgetary Considerations
- The project needs to budget for:
- Translated material.
- Interpreters.
- Food.
- Transport.
- Venue.
- Childcare.
- Promotion of the event.

ii. Community Forums

Objectives
To raise the understanding of mental illness and the effects of stigma among NESB communities. To develop a community understanding of mental health services and available treatments.

Target Groups
Community members from diverse communities.

Outcomes
Participants will:
- have knowledge about mental illnesses;
- be able to list mental health services and treatments available;
- be able to understand the effects of stigma on the life of a person with a mental illness.



When to Use

Community forums may be 'one off' or multiple events, and are an opportunity for a community or a number of communities to participate in a dialogue on issues that are of concern to them. Community forums are also an excellent opportunity for service providers to engage in a dialogue with a community/communities to gain an understanding about their issues, get feedback on programs or solicit suggestions on how best to deliver services. As more than one community can participate in a community forum there is an added advantage of communities learning from each other, sharing information and experiences and exploring commonalties.

Example: A successful family forum was organised by the Northern Suburbs Migrant Resource Centre, Relationships Australia - WA and the Australian Asian Association. The forum focussed on the issues of family relationships. Approximately sixty people attended. Five communities were represented. Communities were provided the opportunity to discuss issues and feedback the issues to the larger group. The issues were then collated at the end of the day, to be acted on by the workers from the participating organisations.

What Can Be Addressed in a Community Forum

- The impact of migration on mental health.
- Community attitudes to mental health.
- The impact of stigma on the life of a person with a mental illness.
- Understanding mental illness, the causes, manifestations and the treatment.
- What services are available and how best to access them.

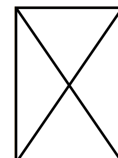
Practical Issues

The process of initiating a community forum is the same as that for community information sessions.

Venue: Where a service plans to have more than one community participate, it is necessary to have a large venue as people need space to work in their own groups. As interpreters may need to be used this is also a consideration for seating arrangements for participants.

Time: Forums involving more than one community are more time consuming. Considerations should be made for asking questions in a number of languages and the time taken for interpreting. Allow plenty of time for discussion - many people from NESB communities do not often have the chance to voice their opinion and this is an opportunity to do so.

A number of non-Western cultures are very 'wordy' and talking around a topic is very much part of the culture. For people operating from an Anglo-Saxon framework, this appears as unnecessary conversation. Respect this need to 'talk around' without seemingly coming to any conclusion.



Food/Childcare: The same considerations as for information sessions.

Translated Material: Ensure that translated material is made available. This is something participants can take away and refer to at another time.

Other Tools: Videos, speakers, or the use of play back theatre to encourage discussion can be invaluable.

Advantages

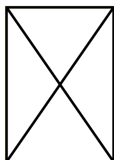
- A range of communities can be involved simultaneously.
- Community forums provide the community with the opportunity to talk through issues.
- Provides the participants the opportunity to learn in a non-threatening manner.
- For the service provider a community forum is an ideal opportunity to interact with a large number of people on neutral ground. This creates a sense of equality and allows for an exchange of ideas.
- Universalises the problem thereby reducing the stigma.

Disadvantages

- Community forums can sometimes become 'feel good' days if they are not followed up by concerted action by the service provider. This can leave the community disillusioned.
- The process of working with a number of communities at one time can become very laborious and it is better not to be too ambitious about what can be achieved.
- Some communities may not want to discuss sensitive issues in the presence of other communities.
- There requires a balance between the participants or else the larger more vocal communities could dominate.

Budgetary Considerations

- Translated material.
- Interpreters.
- Food.
- Transport.
- Venue.
- Childcare.



iii. Community Workshops/Training Sessions

Objectives

- To raise participants' understanding of mental illness.
- To develop an understanding amongst the participants of the effects of stigma to mental illness.
- To stimulate participants to challenge their beliefs and attitudes about mental illness.
- To develop attitudes that lead to a valuing of emotional well-being and mental health.

Target Groups

Community members, Ethno-specific health and other workers, members of management committees, health worker working with large NESB populations requiring culture specific knowledge of stigma and mental illness.

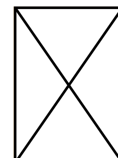
Outcomes

- At the end of the workshops participants will be able to:
- State the various causes of mental illness.
- Challenge their own beliefs and attitudes towards mental illness.
- List treatment options and services available in the community to help those with a mental illness.
- Be of help to those with a mental illness.
- Display behaviours concomitant with the valuing of mental health and emotional well-being.

When to Use

Workshops are sessions wherein participants are provided the opportunity to learn new knowledge and skills through a combination of learning techniques. Workshops are built on the principles of adult learning.

Community workshops are intensive and more suitable to some sections of the community over others. In the case of stigma to mental illness, workshop participants may be given the opportunity to conduct information sessions with members of their community. This train-the-trainer-model has the advantage of empowering members of the community with the skills and knowledge to change their behaviours.



Community Workshops on Stigma to Mental Illness Can Address

- Understanding mental health and mental illness.
- Understanding the causes of mental illness and the effects on the person with a mental illness and their family.
- Community attitudes to mental illness.
- Resources in the community and mental health services.
- How can mental illness be de-stigmatised ñ generation of community suggestions.
- Developing an action plan.

Practical Issues

- Considerations are similar to those when planning information sessions.

Advantages

- Provides members of a community with the opportunity to develop skills.
- Participants can be used as community mobilisers.
- As workshops are intensive, they provide an ideal opportunity to challenge community attitudes.

Disadvantages

- Intensive training requires a time commitment, which may not be possibility for a number of people in the community.
- Participating in the training does not mean that the participants will have either the time or the commitment to take it any further.

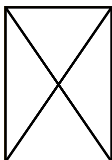
2. Working with Community Mobilisers

Objectives

- To enhance the skills, understanding and knowledge of mental illness of members of the community.
- To increase the use of mental health services and help-seeking behaviour.
- To develop and provide information on the effects of stigma for people with a mental illness and the barriers it creates towards seeking help.

Target Groups

Ethno-specific workers, members of management committees, religious leaders, identified respected members of the community and ethno-specific health workers.



Outcomes
This strategy will result in:

- A number of trained and resourced members of the community with an awareness of mental illness and of the effects of stigma.
- Disseminated knowledge about mental illness to a large number of 'gate-keepers'.

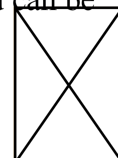
When To Use Community Mobilisers
Community Mobilisers are identified members from any particular community with effective communication skills. As critical educators they provide role models for community acceptance and change in attitudes towards mental illness. As education alone is insufficient to change attitudes, developing the skills and using the power bases of respected community members will greatly facilitate the process of changing deeply entrenched or long held attitudes.

Issues to Address

- Causes, aetiology and treatment of mental illness.
- Service delivery.
- Education about the stigma of mental illness (definition, causes, manifestation and consequences).
- Emphasis on the normalisation of mental illness in order that community members can understand that anyone can develop a mental illness at any time.

Practical Issues
The success of this process rests with the identification of members who will have the time and the commitment to undertake training and in turn educate the community. Do not assume that some member of the community with a mental illness or has a relative with a mental illness will be a suitable mobiliser.

Step 1: Identifying Community Mobilisers
In identifying strategic community mobilisers it is important to gauge where they derive their power, ie., the power base and the source of the power (see Appendix 3 for Theories of Power). Doing so will provide an understanding of their commitment to program, their understanding of the issue, their availability to be trained or be present at community sessions. Workers especially ethno-specific workers need to be targeted as they play a vital role in a community's access/lack of access to information. Priests were sought in a number of cases for spiritual interventions and can be another target group.



Step 2: Training

Having identified community mobilisers, it is recommended that intensive training is conducted. There is usually a high rate of attrition and do not expect that all identified persons will undergo training. The training should ideally consist of the following components:

- Understanding mental health.
- Understanding mental illness.
- Community resources.
- Referral options.
- Facilitation skills.
- Understanding how to use a range of strategies.
- Evaluating the effectiveness of strategies.

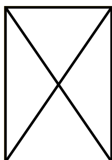
It is recommended that the participants identify the means though which they will disseminate the information in the course of the training. Some suggestions are: community seminars, cultural, social and/or religious meetings, community radio, television and newspapers in relevant languages with accompanying English translation.

Some examples of community mobilisers suggested by three different NESB groups include:

- Members of the Italian community suggested that conferences with Italian dignitaries would be effective. If, for example, the Italian consulate and the Italo-Australian Cultural Centre were seen to be supporting the information, the Italian community would also support it. Italian community members said that running seminars (including a panel) in the community with immediate family and friends is an effective strategy as information spreads via word of mouth.

- Some members of the Indian community identified representatives involved in religious and cultural organisations. These representatives and the organisations they represent can be effective vehicles for educating the community and distributing information regarding stigma reduction.

- Vietnamese community members identified religious leaders as potentially successful community mobilisers. "Religious leaders can help to reduce stigma by assisting people to lead a harmonious life and finding peace in their own mind. People then would not think of mental illness as something bad, abnormal or fearful".



Advantages

- Community mobilisers, if identified effectively, can be a useful tool to disseminate information.
- As they are respected members of the community they have the power to influence community attitudes about issues.
- They are credible role models on issues that affect disadvantaged members in the community, in this case individuals with a mental illness.

Disadvantages

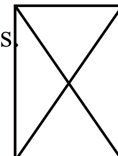
- Community mobilisers due to their positions of power may be closer to the 'mainstream community' in attitudes and thus distanced from their own community.
- They may pose themselves as representatives of the community, but not have the legitimacy from the community.
- Communities are diverse and no one individual can be representative of a community.
- Often those members who have the most time to undergo training may not have the power to influence others.
- Community mobilisers may have concerns with other issues and not all will have either the need to understand issues of mental illness.
- Some mobilises may use this as an opportunity to manoeuvre their position within the community.
- Community workers can often be gate-keepers of information and thereby influence the course of action the community members take.

3. Using Ethnic Media

Ethnic media has been divided into two parts: newspapers and newsletters, and radio. These strategies can be used in two time-frames:

1. Immediate response: In the event of a current affair or crisis in the ethnic or the larger community, ethnic media is a useful tool to counteract the myths perpetuated by mainstream media. This is through 'feel good' stories, facts about mental illnesses, the effects of stigma on the lives of people with a mental illness.

2. Long term change of attitudes, beliefs, knowledge and behaviours via a concerted media campaign. Although the following paragraphs focus on long-term changes, some of the practical issues, the advantages and the disadvantages of using a media strategy are similar to both time-frames.



Media is an effective method for raising the broad community awareness and developing general understanding. It is most effectively used in conjunction with the promotion techniques discussed earlier which allow for longer and moreintenseeducating' to a captive audience.

i. Newspapers and Newsletters

Objectives

- Raise community awareness of the symptoms and treatments for mental illness and illness specific information so as to promote help seeking behaviours.
- Develops an understanding in the community of the effects of stigma on people with a mental illness and the barriers it creates for people to seek help.
- Raise awareness of the availability of mental health services and how to negotiate the mental health system.

Target Groups

Members of a specific ethnic community or language group.

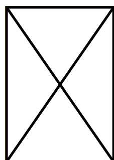
Outcomes

This strategy will provide the community with:

- Information on specific mental illnesses.
- Information on the mental health services.
- Skills to negotiate the system.

When To Use

Practitioners interviewed in the first phase of the study suggested this to be an appropriate strategy. Ethnic newspapers and newsletters have a large audience and are an ideal method to distribute information. Anecdotal evidence from community workers suggests ethnic media as being effective in educating the community, providing information, prompting the community to consider new issues and obtaining feedback on such issues. It is also an ideal tool for publicising new programs and projects. The personal nature of the medium allows for topics that may otherwise have a high stigma value to be discussed in a safe environment. Coverage in printed media may be paid for (advertising) or free of charge (public relations). Whilst the issues listed below are more appropriate public relations, control of content, length, etc., will be reduced.



Issues to Address

- General information on the symptoms and treatments for mental illness.
- Illness specific information.
- Information to promote help seeking behaviour.
- Information on mental health services.
- Information on how to negotiate the mental health system.
- The effects of stigma.

Practical Issues

Newspapers

Step 1:

Contact the State Department of Ethnic Affairs for a list of ethnic newspapers. Most newspapers are based in the Eastern States. Editorial coverage of issues will typically be subject to negotiation.

Step 2:

Decide on the topic. Is this to be a one-off article on the service or a series of articles on an issue. Some suggestions have been made on the issues that can be addressed in reducing stigma to mental illness.

Step 3:

Press releases, videos and other materials can be provided to a newspaper, thus ensuring accuracy of information. Alternatively, journalists or editorial staff may wish to interview program participants or other stakeholders. Either way, strict deadlines must be adhered to.

Newsletters

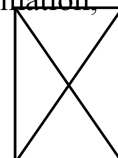
These are quarterly, bimonthly, monthly and fortnightly news magazines produced by a range of organisations. The publication of articles requires individual approaches to each organisation. Whereas newspapers are produced by professionals, newsletters are often produced by members of an organisation in their own time in a voluntary capacity.

Step 1:

Contact the relevant community organisation and establish the frequency of publications.

Step 2:

Prepare the article to be published. Listing a contact number and a name personalises the article and gives the readers references, should they wish to use the information, and the opportunity for direct response or comment and a source of further information.



Advantages

- A large amount of information can be disseminated for very little cost.
- Guarantees a large and diverse audience.
- An easy way to communicate with inaccessible members of any community.
- An effective method to instigate thinking about new issues or topics which may otherwise be taboo in other forums.

Disadvantages

- One way communication does not allow any interaction with the project.
- The information may have to be tailored to the tone of the newspaper/ newsletter, necessitating compromise on the content.
- Selecting the newspaper or newsletter may be difficult, as different newsletters have different readerships and some may be more appropriate than others for the message the service intends to provide.
- It may also be important to run the message in English language newspapers and newsletters at the same time for the message to penetrate.
- Media coverage is recognised as becoming less cost effective at prompting action.

ii. Ethnic Radio

Objectives

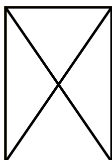
- Raise broad community awareness of the symptoms and treatments for mental illness and illness specific information so as to promote help seeking behaviours.
- Develops an understanding in the community of the effects of stigma on people with a mental illness and the barriers it creates for people to seek help.
- Raise awareness of the availability of mental health services and how to negotiate the mental health system.
- Raise awareness of education forums and opportunities.

Target Groups

Members of a specific community.

Outcomes

- The community on receiving the information will:
- Know where help can be sought.
- Know the causes of mental illness and the associated treatments.
- State the effects of stigma on the lives of people with a mental illness.



When to Use

Multicultural Radio and TV Association is a radio station that rents air time to community based organisations. Groups apply for air time, for which they pay a fee and can broadcast in their own language. The content of the program has to be developed by the community/broadcaster. The information is divided into two types - short community service messages and 10/20 minute information based programs.

Example: NEAMI - an organisation in Melbourne manages rehabilitation services for people who have a psychiatric disability and who wish to live independent lives. The project had three objectives:

1. To produce high quality material on mental illness and psychiatric disability in local community languages foe use in the Northern Metropolitan Region.
2. To increase the information available to NESB people by translating existing local material into community languages.
3. To inform families and care givers living in the Northern Metropolitan Region about mental illness and the Locally available psychiatric disability support services.

The radio programs ran for a total of 230 times over a five month period in five languages. The three announcements were:

- Supported accommodation is available for people with a psychiatric disability.
- Outreach service goes out to people in their own home.
- The existence of two non-residential Day Programs.

The outcome of the project was:

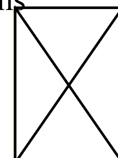
There was an increased awareness of the services in the region due to the programs.

Some recommendations are as follows:

- Use dialogue or radio drama format.
- Radio announcements should be supplemented with at least one interview.
- The information should be supplemented by printed material.
- Involve bilingual workers from the start.
- Focus on who the support is aimed at (in this case the services).

Issues that Can Be Addressed

- Effects of stigma - ie., life story or interviews on radio.
- Services and how to negotiate them.
- The causes of mental illness and the treatments - through interviews with professionals.
- Discussions about cultural beliefs of mental illnesses - panel discussions on the radio, or through interviews.



Practical Issues

It is necessary to negotiate the fee and content with the radio program producers prior to broadcast. Phone numbers for the radio station can be obtained from the White Pages, the Ethnic Communities Councils in each state and state Departments for Ethnic or Multicultural Affairs.

Information may need to be collated in English and then handed over to the producer, or can be presented in the form of tapes to be played over the radio in segments.

Advantages

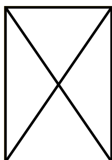
- Potential to be interactive (when used for talk back).
- Information can be provided in English as some program producers may have the skills and be willing to translate the material into the community language.
- Cost effective ñ has a large reach for a small cost.
- Community announcements, eg., changes in welfare benefits, are free of charge. Information of this sort if provided to the station coordinator will be distributed into all community languages and aired free of charge.
- Information can be custom built and tailored to the needs of the community.
- Readers often write letters to the producers, thereby allowing for interaction, promoting help seeking and protecting anonymity.

Disadvantages

- Lack of control on the final information broadcast, as producers may be involved in getting the information to air.
- FM radio has no reach to rural and remote areas.
- Producers may have ìhobby horsesî or biases and that can limit controversial topics.
- Availability of air time limits the length and level of detail of a topic of discussion.
- Difficult to ascertain whether the intended message has been received.

Budgetary Considerations

- Radio program coordinators.
- Translation of relevant information.
- Buying air time.
- Recording and producing tapes.



4. Translated Materials

This includes brochures, posters, videos and other physical media.

Objectives

- Raise community awareness and understanding of the issue of mental health and mental illness.
- Raise the level of community understanding of the effects of stigma.
- Stimulate discussion of community beliefs about mental illness and enhance understanding of their negative effects for the individual consumer and their carer.
- Raise awareness of mental health services and how to negotiate the services.
- Provide illness specific information.

Target Groups

Specific language groups/community groups, carers and individual consumers.

Outcomes

By providing information in multi-lingual form, the community will have:
Access to written information on mental health, mental illness, mental health services.
An understanding of the effects of stigma on the lives of people with a mental illness.
Information to counteract some beliefs about mental illness that have negative effects on the individuals with a mental illness and their carer.

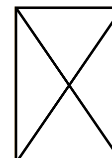
When to Use

Translated information is best used for educative and informative purposes, ie., to raise awareness of services, provide information, about services, mental illness and treatments, and provide the community with skills to negotiate the system. As the process of translating is expensive it is best used when the information is useful in a longer time-frame. Translating material has always been the most preferred option for services whenever issues of accessibility are to be dealt with. Translated material should never be considered a sole option, unless the service has used other strategies to inform the community of its existence. Translated material is an ideal back-up to other strategies.

Practical Issues

Step 1:

Write the information in English. Ensure that the information is not complicated, or academic. It should be in plain simple language that considers cultural issues.



Example: Relationships Australia WA's brochure advertising the services in community languages is titled "Help for Families" and not the name of organisation. This is a cultural consideration as the service was looked upon by the communities and the workers as a place to get ëdivorcedí.

Acronyms should not be used. Limit the use of technical terms. The information should be succinct and presented in a way that is easy to follow and understand.

Step 2:
To translate the information, the Translating and Interpreting Services (TIS) or Language Services should be contacted. Health Departments within some states also have accredited health interpreters who are well versed with technical terms and translating them into community languages.

Step 3:
It is suggested that the translations are re-checked with the community for clarity of meaning. Some of the most well-meaning translations can fail the "community test".
Channels for the distribution of translated materials include:

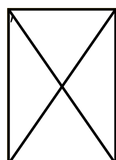
- Community Health Centres.
- Women's Health Centres.
- Doctors surgeries.
- Migrant Resource Centres.
- Ethno-specific workers.
- Others can be obtained from the Department of Immigration and Multicultural affairs.
- Translated brochures on the Australian Transcultural Mental Health Network site.

Advantages

- Potential to reach a large section of the community if distributed appropriately.
- Ideal strategy for providing information about services.
- Ideal back-up to other strategies.
- Can be used in a wide number of instances and retained by individuals for future reference.
- Can be mailed upon request.

Disadvantages

- People may be illiterate in their first language.
- Translations are expensive.



Information is constantly changing and brochures can become redundant.

- Information overload as brochures are constantly produced.
- Reliant upon distribution channels.

5. Promotional Items

Traditionally, sales promotion involves offering incentives or rewards to consumers to make single or multiple purchases. Items or rewards are often branded in order to reinforce advertising messages and awareness. In a social marketing context, such rewards may be used to address the following objectives:

1 To encourage and support continued participation in a program.
2 To raise awareness of a service or program.
3 To extend the visibility of a media campaign message.
4 To encourage word of mouth.

Target Groups
Specific language/community groups.

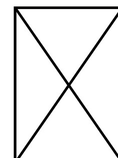
Outcomes
, Community awareness and recognition of a service or program.
, Greater exposure of the mental health issue thus promoting openness, discussion and action.

When to Use
"Incentives" and "rewards" need to be sensitively treated to avoid the connotation of "being bought". Items for personal use such as t-shirts or other merchandise can be effective at an individual level whilst other items can reward community participation. It is recommended that using rewards be incorporated within a specific program or activity and is not a sole activity in itself. It may be combined with community meetings, radio programs (ie., to encourage talk back show callers).

Practical Issues
Items need to be appropriate to the community, the program or issue and the method of 'rewarding'. It is advisable that the selection and design of an item involves a representative of the community. The cost of such items for social marketing purposes may be negotiation with suppliers who may wish to be seen as The Supporter of the cause. Communication of such recognition within brochures, radio programs, etc., will need to be considered.

Advantages
, Flexibility, ie., items may be purchased in bulk and used for a host of activities.
, Endurance of the campaign message for the life of the reward item.

Disadvantages
, The cost effectiveness is difficult to measure.
, Lack of control, ie., an item may be given or thrown away.
, May be perceived as superfluous to the program.



STRATEGIES FOR INDIVIDUAL CONSUMERS AND THEIR CARERS

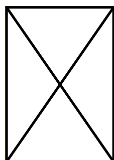
As issues for the carer and the individual with a mental illness are inter-woven this section deals with the two subsections as a whole. Individual consumers reported that were identified with their illness. This manifested in them not being taken seriously and treated as ‘crazy’. They experienced shame and guilt. They perceived they would be rejected by their community and this often led them to self-isolate. Even though consumers were undergoing some form of treatment they had the tendency to somatise the illness and delay help-seeking. They feared passing the disease on their children. Those who had a high level of education and financially security were able to find satisfactory treatment, while those who had low levels of education and low levels of English language fluency had inappropriate treatment and had histories of misdiagnosis. A number of consumers used alternative treatments.

Carers play an important role in the whole process of understanding mental illness and stigmatising. As part of this process they tend to isolate themselves leading to smaller social networks and social supports. Primary carers are often women in their roles as wives, mothers, sisters and daughters. Carers often over-protect their relative and develop compensatory explanations for their behaviour. Often carers can be first generation migrants themselves and this compounded with low literacy levels, their own disempowered state, and their failure to come to terms with the illness may impede the consumers access to services.

In health promotion, individual methods are usually associated with secondary or tertiary prevention (Eggar, G., Spark, R., Lawson, J., 1990. Health Promotion Strategies and Methods, McGraw Hill Book Company, Hong Kong). In the case of stigma to mental illness, individual methods are ideally employed at the time of early detection and treatment.

Strategies targeting the individual are face-to-face interactions. Though most effective in their ability to effect change, they have the disadvantage of being laborious (Degeling, Hall and Hawe, 1990). Education programs aimed at both the client and the carer allow them to develop a better understanding of the mental illness and the treatments available will lead to reducing the stigma of mental illness.

Focusing on the individual is only one aspect of any stigma reduction strategy. Link, et al’s study of stigma reduction wherein strategies such as ‘keeping the history of treatment secret’ (Rooney, et al., 1997):



"Avoiding situations in which rejection might occur" and "educating others about the condition" were used. The impact of these situations was assessed. It was found that the strategies were unsuccessful. "Individuals adopting one or more 'stigma-reduction' strategies shoulder the larger than individual issue of stigma-reduction and breeding" (p21). It must be noted that 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.

Individual Consumers and Carers could address:

- 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 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.

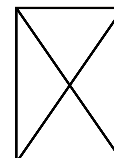
- Providing information about the range of support systems and skills on how to negotiate access.

- Practical and emotional support for carers.

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

Some Examples of Individual Strategies (adapted from Eggar 1990):

Self-Help Materials and Translated Material
This involves developing a range of materials in community languages that specifically target individual consumers and the carers. These are in the form of videos, brochures, computer programs and audio tapes. The focus of these materials is on understanding specific diseases, the treatment options, resources in the community and support services available in the community. Some of the materials produced by SANE Australia are an example of this category.



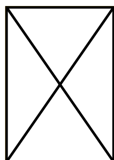
Counselling
Counsellors within the mental health system are an appropriate method for individual education. These can be counsellors with bilingual skills or those working in conjunction with interpreters. As an educational strategy the role of the counsellor is also to provide information to the client about services and where appropriate connect the client to the relevant service. The model of bilingual case managers within the mental health system is successfully used in Victoria and New South Wales. These case managers' role is three fold: to case manage specific clients, to act as cultural consultants to other professionals within the system and to provide community education. Some bilingual workers also run groups for carers. The majority of the workers interviewed for the First Phase of the Project, mentioned where appropriate they involve the carer and the family in the treatment.

Stress Assessment Tests
Individual tools such as stress assessment tests can move the illness away from being a 'fault' to giving people permission to acknowledge the stress created by the process of migration. Individual tools such as The Stress Assessment Test (Holmes and Rahe as quoted in Eggar, 1990) can be developed. These tools should take into account cultural, social, and circumstantial factors of being a migrant.

Carers Support Groups
These are various groups wherein carers are provided with support including information about resources, illness specific information, the chance to meet other carers and professional counselling where appropriate.

In NESB communities carers groups are difficult to initiate (Rooney, O'Neil, Bakshi, Tan-Quigley, et al., 1997). This is due to the stigma of mental illness and the small size of many communities. It maybe possible to form a carers support group from a number of communities rather than any one in particular. Practitioners interviewed for the project noted that often carers are reluctant to come to groups as the communities are small and 'word will get out'. Taking this into consideration practitioners often support carers and involve them in all aspects of decision making.

Messages for Stigma Reduction
- It is "OK to seek help" (both for the carer and the individual consumer)
- There are biological, psychological and social aspects of mental illness (so that self-blame and guilt are invalidated).
- There are services available within the community.
- Support in understanding how the system operates.



Some Considerations:

- In communities where parental influence is high, carers need to be involved in all aspects of the treatment.

- Cultural appropriateness of support services is important. Most mainstream services advocate support groups and independent living skills programs. While these may work well in some communities they can be largely inappropriate in others (ie., NESB communities) with their stress on individualism. Carers often look upon these programs as a way of breaking up the family (Rooney et al. 1997). This aspect needs to be considered when developing such programs.

- Where support services are not available contact with workers/consultants within mental health services can be made available.

- In cases where clients or the family have not been made aware of the side effects of medication the rate of non-compliance is high (Rooney et al. 1997). Practitioners recount incidents where patients cut down the dosage or are forced by the family to seek alternative modes of treatment.

Advantages of Using Individual Methods

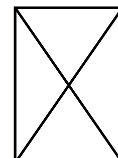
- Individuals consumers and their carers are provided access to specific information.

- Information can be particularly empowering.

- Carers have the information to seek the necessary support.

Disadvantages of Using Individual Methods

- The responsibility of reducing stigma can be placed on the individual consumer and their carer if this the only strategy that is employed to reduce stigma.

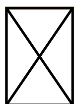


APPENDICES

1. **JAKARTA DECLARATION**

2. **BEHAVIOURAL AND NON-BEHAVIOURAL RISK FACTORS**

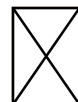
3. **THEORIES OF POWER**



APPENDIX 1: JAKARTA DECLARATION

- Priorities for health promotion in the 21st century.
- Promote social responsibility for health development.
- Increase investment for health development.
- Consolidate and expand partnerships for health.
- Increase community capacity and empower the individual.
- Secure and develop infrastructure for health promotion.

(Ref: World Health Organisation 1997).



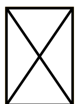
APPENDIX 2.: BEHAVIOURAL AND NON-BEHAVIOURAL RISK FACTORS

Behavioural factors are those directly linked to the individual or the community, while non-behavioural factors are a product of the environment or structural issues, i.e., policy, planning, service delivery, funding availability.

Predisposing Factors:
"Any characteristic of a person or population that motivates behaviour prior to the occurrence of the behaviour." (p434)

Reinforcing Factors:
"Any reward or punishment following or anticipated as a consequence of a behaviour, serving to strengthen the motivation for the behaviour after it occurs." (p434)

Enabling Factors:
"Any characteristic of the environment that facilitates action and any skill or resource required to attain a specific behaviour." (Absence of that resource blocks the behaviour; barriers to the behaviour are included in lists of enabling factors to be developed. Skills are sometimes listed separately as predisposing factors or intermediate outcomes of education.) (p431)



APPENDIX 3.: THEORIES OF POWER

To use community mobilisers as an effective strategy in reducing stigma it is important how power is derived and the bases of power. In marginalised communities access to information and mainstream power bases and issues of 'representation' have to be understood so that service providers do not inadvertently produce ' gate-keepers'.

Power is defined as 'the capacity that person A has to influence the behaviour of B so that B does things she/he would not otherwise do' (Robbins et al,1994,p521). Leadership and power are intertwined. Leaders use their power to achieve goals for the group. However, power may not always be used to achieve the goals of the group, power, unlike leadership, may not be top-down, but could have a lateral influence. Unlike leadership, power is not about styles of leadership but how to control other individuals or groups (Robbins et al, 1994).

Bases of Power: This refers to what the holder of power 'controls that allows them to manipulate the behaviour of others' (p523).

There are four bases of power:

- Coercive Power: Power based on fear.
- Reward Power: The power to control valued rewards.
- Persuasive Power: The power to 'allocate and manipulate symbolic rewards' (p524).
- Knowledge Power: Access to information and the ability to control valuable information.

Sources of Power: How the holder of power 'came to control the bases of power' (p523).

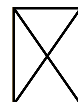
Position Power: A person's structural position, such as lawyers, doctors, teachers.

Personal Power: Personality characteristics such as charismatic personality's, ability to articulate well, and physical stature can also be a source of power.

Expert Power: In this case the power holder is privy to 'specialised information'.

Opportunity Power: This comes from being in the right place at the right time.

(Ref: Robbins, P.S., Waters-Marsh T., Cacioppe, R & Millet, B. [1994] Organisational Behaviour: concepts, Controversies, and Applications, Prenctice Hall, Sydney)



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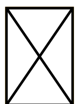

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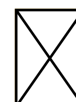

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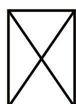

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