ecco
Ethnic Communities Council of Queensland

09/02/2024

Mental Health Community Support Services
Mental Health Community Support Services - Psychosocial Supports Consultation
Queensland Health
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This was an online submission.

Question 1: In your experience, please describe how could the existing Mental Health Community Support Service (MH CSS) programs be further strengthened?

The Ethnic Communities Council of Queensland (ECCQ) believes the existing MH CSS programs may be further strengthened by implementing specialist services, culturally safe practices, social prescribing, and broadening pathways into support.

Multicultural communities in Queensland come from diverse backgrounds in respect to culture, language, and social factors that all impact health outcomes, particularly mental health. Access to specialist mental health services that are trauma-informed and culturally competent is foundational to producing positive health outcomes for multicultural communities. Furthermore, culturally safe practice training should be implemented across mainstream services.

Following a social prescribing may also provide additional support, as this model promotes considering how social and lifestyle factors impact health and addressing these through non-clinical and community-based activities in additional to traditional methods. For multicultural communities who can come from collectivist cultures, more holistic approaches to health and avenues to recentre community in healing through collaboration from multiple disciplines, for example mental health professionals alongside cultural medical practices and remedies, may benefit mental health outcomes. We also advocate for community-led non-clinical support spaces to be decentralised.

Finally, we believe community would benefit from liaison officers in the housing space, as housing stress is a leading concern across multicultural communities, with varying visas statuses, for example. We believe having a dedicated support person in the social housing system who is culturally safe and competent will alleviate some of that pressure.

Question 2: Should the pathways for referral into the current Queensland Mental Health Community Support Services be opened up more broadly?

ECCQ advocates for more self-referral pathways direct to service providers broadly. More specifically, we recommend referrals from agencies such as Settlement Engagement and Transition Support (SETS) program, and all those organisations falling under Community Action for a Multicultural Society (CAMS) to be direct and not involve centralised processes. In this manner, SETS and CAMS will be able to refer a person directly to a mental health professional, without having to go through a

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hospital or general practice for example. Self-referrals should also be considered more seriously, as a number of barriers may keep vulnerable communities from accessing help they need. Many refugees and migrants have experienced trauma, family separation, lack of support systems, forced migration and violence that contribute to mental health challenges. Whilst pre-arrival trauma is often recognised as a catalyst for mental health vulnerability, settlement in a new country increases the likelihood of mental illness as it is associated with multiple stressors. These include, navigating complex government and health systems, language barriers, housing and financial instability, changing family roles, youth disconnect and feeling of loss (refugeehealthguide.org.au/wp-content/uploads/References.pdf). Many stressors continue to be felt and unresolved several years after initial settlement, including restricted social and economic opportunities after 5 years of settlement services and not seeking further supports as this can be overwhelming.

The medical system is very complex in Australia. Navigation of this system is particularly difficult for those from non-English speaking backgrounds or those who may be unfamiliar with the Australian medical system infrastructure and systems (referral processes, specialisation, Medicare guidelines, etc). A community example where referral pathways between community organisations and medical practices have been successful is the liaising between local general practitioners and World Wellness Group (WWG). Based in Stones Corner, this social enterprise offers a range of health services and the local GPs often refer multicultural community members to WWG due to their culturally safe care. ECCQ supports the development of a resource that would provide elected and natural community leaders who require information and support to bridge a community member to the most appropriate services to meet their needs. Alongside this, we advocate for community leaders to be authorities in referring their community members to services.

Question 3a: What are some examples of other psychosocial models or program elements that could be considered for children (ages 0 to 11 years)? Examples can include programs from other states or countries, or in areas other than mental health.

Formerly 'Access Community Services' in Logan, now SSI, implemented a school-based program called the Refugee and Asylum Seeker Education Coordination program alongside the Health Impact Program tailored to multicultural communities. These programs delivered sessions were held on school grounds and facilitated by qualified teachers and occupational therapists. Parents were encouraged to bring their below school aged children, and this community hub space allowed for these health professionals to interact and assess children in low-stress, familiar environments. Children felt supported and safe, and this allowed for them to receive help they need in a manner that facilitates positive outcomes; the children were safe to play and behave naturally and professionals could observe. This also allowed for the health professionals to build a trusting relationship with the families and provide information to parents on the potential services that could support them and their children, if required. This model could be replicated with mental health professionals, retaining these elements where children feel safe to be themselves, are connecting with other children, and are introduced to mental health professionals at a low-intensity level.

Question 3b: What are some examples of other psychosocial models or program elements that could be considered for young people (ages 12 to 25 years)? Examples can include programs from other states or countries, or in areas other than mental health.

The Gould Adams centre in Logan provided services to youth from local schools after school. The area has a high population of multicultural students, some from low socio-economic backgrounds, and the programs granted access to sports and music activities for students at no cost. The activities required no prior knowledge or skill, and the venue was accessible. Youth workers/case workers were present at each session, and students were provided with transport to and from the venue. This took place once a week after school and was well attended due to its cultural safety aspects, as the case workers were culturally competent and came from community, and the environment was familiar and conducive to foster genuine relationships between these authority figures and vulnerable children in community. This environment fostered opportunities for case workers to provide information to young people in a safe space.

Asking for help, or knowing where to access help, is one of the bigger obstacles for this age group. By having professionals present and available, young people can begin to seek help.

Question 3c: What are some examples of other psychosocial models or program components that could be considered for this older adults (65 years and over)? Examples can include programs from other states or countries, or in areas other than mental health.

ECCQ's Multicultural Advisory Service (MAS) conducted a series of senior morning teas with older adults in Cairns, in order to promote socialising and foster connection between the diverse senior community members. Loneliness is one of the biggest issues facing elders in community, and small events where individuals can share a piece of their culture, through food for example, is pivotal.

Question 4: Are there examples of programs, models or components that, in your experience, are working well and could be adapted or expanded to improve psychosocial support for people with severe mental illness? Please tell us about the program(s) and supply a link to the program, if applicable.

World Wellness Group is a great example of an organisation who understand the complex and diverse needs of individuals from multicultural backgrounds in reference to mental health support. Their programs take in to account the social barriers and cultural context these populations live in, and their framework addresses participants with psychosocial supports that range from mild to moderate. Their programs include brief interventions and navigation, psychological therapies for moderate conditions, and community based psychosocial support. While they do not have programs specific to people with severe mental illness, the pathways they offer are gateways to understand the complex needs on a holistic level are foundational and can be extrapolated to cater for more severe cases; as at their core they integrate the culturally safe and informed practices needed for multicultural communities.

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More can be found on their webpage here: https://worldwellnessgroup.org.au/mental-health-service/

Question 5: What role could the peer workforce have in psychosocial support models and how can they be supported more effectively?

In Queensland, there is a peer workforce entitled the Mental Health Taskforce (MHT), founded in response to the rise in mental issues. The team bring together community members in a public space regularly where exercise occurs, food is shared and information on health and mental health topics is shared. The team work closely with health professionals and other service providers and after building relationships, support connections to culturally appropriate services. They also provide awareness about mental health information to community leaders, encourage them to implement community-led preventative mechanisms. More support for initiatives such as this one would be extremely beneficial facilitated by grassroots community groups.

An example of outcomes from this group is: Mr. John attended the monthly walk for mental health run by the Mental Health Taskforce in August. When a speaker from TIME informed the attendees about the impact of trauma and how it can manifest in different ways. Mr. John shared that he had noticed some of the signs and symptoms mentioned. He went on to share his difficult journey to Australia and finished by adding that he did not know that someone's past can have such a huge impact on mental health. He further shared that he was also relieved to hear that there is trauma-oriented mental health support available for people like him.