A PLAN FOR TRANSCULTURAL MENTAL HEALTH SERVICES IN QUEENSLAND HEALTH
2018-2021
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A PLAN FOR TRANSCULTURAL MENTAL HEALTH SERVICES IN QUEENSLAND HEALTH 2018-2021

Purpose and scope of our Plan

*Connecting care to recovery 2016-2021 – A plan for Queensland’s State-funded mental health, alcohol and other drug services* allocated new recurrent funding for the expansion of transcultural mental health services in Queensland Health. This new funding provided the context for the development of a plan for transcultural mental health services to ensure public mental health, alcohol and other drug services can meet the mental health and wellbeing needs of people from culturally and linguistically diverse (CALD) backgrounds.

The *Plan for Transcultural Mental Health Services in Queensland Health 2018-2021* (the Plan) will identify the priorities and strategies required to ensure mental health alcohol and other drug services are culturally responsive. The scope of the Plan includes existing state-wide functions of the Queensland Transcultural Mental Health Centre (QTMHC) as well as those services and programs delivered in collaboration with mental health services in participating Hospital and Health Services (HHS).

How did we develop our Plan?

This plan has been developed by the Queensland Transcultural Mental Health Centre which is a statewide service based at Metro South Addiction and Mental Health Service. Planning has involved a review of service utilisation data, emerging evidence, current models and processes, planning workshops, a state-wide survey based on a consultation paper and targeted consultative meetings with key stakeholders including mental health alcohol and other drug services across Hospital and Health Services. Please refer to Appendix A for a list of contributors to the consultation process.

Why expand transcultural mental health services?

The cultural and ethnic diversity of the Queensland population continues to grow. The recently released *Mental Health Alcohol and Other Drug (MHAOD) Workforce Development Framework* identifies a number of challenges in an environment of evolving service models which require new ways of working, including changes to skills mix and notions of contemporary best practice. It also identifies that MHAOD services are treating individuals with a greater range of complex problems and key factors impacting the clinical presentation of individuals accessing MHAOD services include;
• Changes in the availability and supply of both licit and illicit substances
• An ageing population
• Increasing burden of chronic health conditions
• An increasingly diverse population
• Rising incidence of comorbidities and multiple morbidities\(^1\)

The 2016 census revealed that 22% of the Queensland population is born overseas and 11% were from a non-English speaking background. In Queensland, the largest non-English speaking country of birth was India. During 2011-2016 the number of people born overseas increased by 126,698 (14%) and the number of people from a non-English speaking background increased by 109,520 (27%). The largest changes in terms of country of birth for the Queensland population between 2011 to 2016 were for those born in: China (+20,062), India (+18,846), Philippines (+10,206) and New Zealand (+9,184).\(^2\)

Country of birth data identifies where people were born and is not fully indicative of the cultural diversity in Queensland. To get a more complete picture of the cultural diversity of the Queensland population it is also important to consider ancestry and language spoken at home data. The 2016 census showed that 38% of the Queensland population have one or both parents born overseas\(^3\) and that 12% spoke a language other than English. The largest increases in terms of spoken language in the Queensland population between 2011 to 2016 were: Mandarin (+31,394), Punjabi (+10,095), Filipino (+7,297), and Korean (+6,942).\(^4\)

A review of 2015-16 CIMHA (Consumer Integrated Mental Health Application) data by country of birth (COB)\(^5\) revealed that only 7% of individuals born in a non-English speaking country (NESC) received a mental health service and that significant disparities in access and quality of care were evident when compared with individuals born in an English-speaking country (ESC) including Australia.


\(^5\) Country of birth (COB) has been used here in the absence of available ethnicity data. English-Speaking Country (ESC) is defined as people born in the following countries: Australia, Canada, England, Ireland, North Ireland, New Zealand, Scotland, South Africa, United States of America & Wales. Non-English-Speaking Country (NESC) is defined as people born in countries other than those listed in ESC. It is acknowledged that there are some limitations to these standard definitions.
The data also highlighted areas where resources need to be targeted with 80% of NESC individuals accessing mental health services in: Metro South, Metro North, Cairns, Gold Coast and West Moreton Hospital and Health Services. Within these services the most common services types for NESC individuals are adult acute inpatient units, acute care, consultation liaison services, older person’s mental health and adult community care.

In 2017 Queensland Health released the *Refugee Health and Wellbeing policy and action plan 2017-2020* in response to the complex health and social needs experienced by people from refugee backgrounds. Each year approximately 1800 refugees are resettled in Queensland under the Humanitarian Program from a range of source countries including Iraq, Syria, the Democratic Republic of Congo, Somalia, Eritrea, Myanmar and Afghanistan. In line with the Australian Government’s commitment to resettle an additional 12,000 refugees fleeing conflicts in Syria and Iraq, an additional 1400 Syrians and Iraqis are expected to settle in Queensland. Additionally, the Australian Government’s Humanitarian Program annual intake is set to increase from 13,750 places to 16,250 in 2017-18 and then 18,750 places from 2018-19. Due to these increases the Queensland refugee settlement numbers are projected to increase to 3,000 annually.⁶

**Summary of the priority areas**

The expansion of transcultural mental health services in Queensland will focus on increasing capability in three key priority areas: specialist transcultural clinical capability, strengthening the cultural competence of the mental health workforce, and targeted responses to improve access to mental health services and programs for people from CALD backgrounds in areas of highest need.

**Priority One:**

Transcultural mental health clinical capability will be improved through the provision of clinical leadership, mentoring and support of transcultural mental health clinical positions both internally to the QTMHC and those based in Hospital and Health Services, as well as expansion of a range of clinical services within QTMHC. Improved integration of services across QTMHC and Hospital and Health Services will be a key focus.

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Priority Two:
Strengthen the cultural responsiveness of the mental health workforce through integrated workforce development strategies including, mentoring, supervision, education and training, including flexible online learning packages tailored to clinicians at all stages throughout their career, and by supporting the emerging mental health workforce via academic partnerships, research and field education.

Priority Three:
Improve access by targeting responses to better meet CALD needs through improved use of data and information to plan service development and service improvement. This will be achieved via annual forums, simplifying pathways to care, and addressing inequities in access to services by strengthening input from CALD individuals who have a lived experience of mental illness and better targeting of promotion, prevention and early intervention programs.

Principles of service delivery
The key principles underpinning the new service plan are:

Equitable and accessible
Health inequities occur when health services are not accessible or utilised by certain groups of people. In Queensland, mental health services data show that mental health services are underutilised by people born in non-English speaking countries and that there are issues in the quality of care they receive. An equitable approach to mental health care prioritises at risk groups and those most in need and ensures access to services.

Culturally responsive and effective
The culture based model of cultural consultation pioneered by QTMHC remains at the forefront of the service delivery model for QTMHC with a key focus on cultural explanatory models of mental health and illness within CALD individuals and communities. Culturally responsive mental health care focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.\(^7\)

Person-centred and responsive to individual needs
The mental health and wellbeing of individuals from a CALD background relate to many broader social and economic factors. The term ‘culturally and linguistically diverse’ acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity, as well as language, and reflects intergenerational and contextual issues, not just the migrant experience (Commonwealth Government, 2005). A collaborative approach across sectors, services, agencies and communities is the most effective way to meet individual needs within a broader social-cultural context across the age spectrum and the continuum of care.

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\(^7\) Australian Government National Health and Medical Research Council, Cultural Competency in Health: A Guide for policy, partnerships and participation, 2006
Addresses health inequities
Cultural beliefs about mental illness and wellbeing impact on whether (and how) people from a CALD background access services. Without a focus on the social determinants that shape mental ill-health in CALD communities and on reducing stigma and increasing mental health literacy among multicultural communities, inequities in access and quality of care for people from a CALD background cannot be properly addressed. This includes health systems and policies as important determinants of mental health because they influence the type and quality of services available to a population.

Performance indicators and governance
QTMHC will have governance and responsibility for the implementation of the Plan and will undertake a monitoring and reporting role. It will develop a framework and mechanisms to monitor performance over time. The development of performance indicators is an evolving process as in some instances the data sets are not readily available. In the first instance several performance indicators within the Measurement Strategy for Connecting Care to Recovery will be adopted as they will be available by country of birth as well as Consumer Integrated Mental Health Application (CIMHA) data by country of birth which was reviewed and utilised in the development of this Plan (Table 1).

Performance indicators will be monitored by the QTMHC, and Hospital and Health Services will be engaged in reviewing service utilisation data so that the information can be used to inform service improvement planning. In addition to the identified indicators, QTMHC will also be implementing a number of program level indicators consisting of pre and post measures in relation to group programs and workforce development activities.

Table 1. Proposed key performance indicators for transcultural mental health services

Note about terminology: *Distinct individuals* are defined here as the unique count of persons accessing a particular public mental health service regardless of the amount of services they received. Counts are unique within, but not across, settings and at the level of reporting. *Episode* of mental healthcare is defined here as the count of individuals accessing a continuous period of mental health care. An individual may receive several episodes of care during the reporting period. *Referral* is defined here as the count of individuals who have been referred to a public mental health service. Individuals who are referred may not necessarily go on to receive an episode of care. An individual may be associated with several referrals during the reporting period.

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<thead>
<tr>
<th>Indicator</th>
<th>Context</th>
<th>Source</th>
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<tbody>
<tr>
<td>Proportion of NESC population accessing public mental health services: by service type, mental health service organisation (MHSO), by age groups, and by gender.</td>
<td>Based data from the last three years (2013-14, 2014-15, 2015-16) individuals born in a NESC have a persistently lower rate of access to mental health services (when compared with individuals born in an ESC).</td>
<td>CIMHA</td>
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<td>Number of distinct* (see definition below) NESC and ESC individuals receiving an episode of care by service type and HHS.</td>
<td>This indicator enables targeting of resources to services with higher levels of need.</td>
<td>CIMHA</td>
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<tr>
<td>Indicator</td>
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<tr>
<td>Number of distinct NESC and ESC individuals by Mental Health Act 2016 status by service type and HHS.</td>
<td>Based on 2015-16 data, individuals from a NESC are more likely to be treated on a Treatment Authority under the Mental Health Act 2016. This indicator relates to quality of care.</td>
<td>CIMHA</td>
</tr>
<tr>
<td>Number of distinct individuals from NESC by country of birth receiving an episode of public mental health care, inpatient or community by services type and HHS.</td>
<td>This indicator is an important demographic which enables services to tailor programs to the needs of specific communities or population groups.</td>
<td>CIMHA &amp; QHAPDC</td>
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<tr>
<td>Number of referrals to a mental health service for NESC and ESC by referral source.</td>
<td>Based on 2015-16 data, individuals from a NESC were more likely to be referred via the Emergency Department (when compared with individuals born in an ESC). This indicator relates to access.</td>
<td>CIMHA</td>
</tr>
<tr>
<td>Average length of stay (in days) of distinct NESC and ESC individuals receiving an episode of care by service type.</td>
<td>Based on 2015-16 data, individuals from a NESC were more likely to have on average longer lengths of stay in inpatient services (when compared with individuals born in an ESC). This indicator relates to quality of care.</td>
<td>CIMHA &amp; QHAPDC</td>
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<tr>
<td>Number of distinct NESC and ESC individuals receiving an episode of care by diagnostic groups.</td>
<td>Based on 2015-16 data, individuals from a NESC were more likely to be diagnosed with a Psychotic illness (when compared with individuals born in an ESC). This indicator relates to quality of care.</td>
<td>CIMHA</td>
</tr>
<tr>
<td>Number of distinct NESC and ESC individuals who were treated under a Forensic order or identified as Classified patients under the Mental Health Act 2016.</td>
<td>Based on 2015-16 data, individuals from a NESC were more likely to be treated under a Forensic order (when compared with individuals born in an ESC). This indicator relates to quality of care.</td>
<td>CIMHA</td>
</tr>
<tr>
<td>Number of distinct NESC and ESC individuals who were secluded in the time period.</td>
<td>Based on 2015-16 data, individuals from a NESC were twice as likely to be secluded (when compared with individuals born in an ESC).</td>
<td>CIMHA &amp; QHAPDC</td>
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<tr>
<td>Proportion of distinct individuals who received an episode of care by QTMHC and Multicultural Mental Health Coordinators (based in Hospital and Health Services).</td>
<td>This information is not available at present. Changes to coding within CIMHA would allow a comparison of service utilisation across QTMHC and HHSs as it relates to access.</td>
<td>CIMHA</td>
</tr>
<tr>
<td>Qualitative review of experience of mental health service from CALD individuals.</td>
<td>YES survey data has been translated into 23 languages to facilitate response rate from non-English speaking individuals.</td>
<td>YES survey data</td>
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<tr>
<td>Rate of follow up by mental health service within 1-7 days following a referral by country of birth.</td>
<td>Based on 2015-16 data, individuals from a NESC were less likely to followed up within 1-7 day of referral (when compared with individuals born in an ESC). This indicator relates to quality of care.</td>
<td>CIMHA</td>
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<tr>
<td>Indicator</td>
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<td>Rate of face to face community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit by country of birth.</td>
<td>This information is not available at present. This indicator relates to quality of care.</td>
<td>Connecting care to recovery</td>
</tr>
<tr>
<td>Rate of community mental health contact in the 1-7 days prior to admission to an acute mental health inpatient unit by country of birth.</td>
<td>This information is not available at present. This indicator relates to quality of care.</td>
<td>Connecting care to recovery</td>
</tr>
<tr>
<td>Number of distinct NESC and ESC individuals presenting to the Emergency Department due to intentional self-harm who had mental health follow-up within the last 1-7 days by country of birth.</td>
<td>This information is not available at present. This indicator relates to quality of care.</td>
<td>Connecting care to recovery</td>
</tr>
<tr>
<td>Number of distinct individuals by NESC and ESC who were readmitted to specialised mental health care within 28 days of discharge.</td>
<td>This information is not available at present. This indicator relates to quality of care.</td>
<td>Connecting care to recovery</td>
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<tr>
<td>Average duration from initial referral to contact with community mental health service.</td>
<td>This information is not available at present. This indicator relates to quality of care.</td>
<td>Connecting care to recovery</td>
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<tr>
<td>Mortality gap for individuals accessing public mental health services by country of birth.</td>
<td>This information is not available at present.</td>
<td>Connecting care to recovery</td>
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<tr>
<td>Rate of suicide of individuals who have used public health services by country of birth.</td>
<td>This information is not available at present.</td>
<td>Connecting care to recovery</td>
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Priority areas for action

Priority One: Specialist transcultural mental health clinical capability

We want to increase transcultural mental health specialist clinical capability across the mental health workforce. This includes the provision of clinical leadership, mentoring and coordination of transcultural positions based in Hospital and Health Services, championing an understanding of socio-cultural explanatory models of mental health, expansion of clinical specialist positions and bicultural mental health consultants within QTMHC, and working together with Hospital and Health Services across Queensland to improve service delivery and continuity of mental health care for individuals from a CALD background.

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<tr>
<th>What do we want to achieve?</th>
<th>How will this be achieved?</th>
<th>Who is responsible?</th>
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| 1. Develop consistent referral pathways for culturally and linguistically diverse (CALD) individuals across all public mental health services. | - Develop referral pathways to improve access to Multicultural Mental Health Coordinators (MMHC) and QTMHC in collaboration with Hospital and Health Services (HHS). Target priority areas include: MH Call, acute care, emergency departments and consultation liaison services.  
- Use data on a regular basis to identify significant disparities in service provision for specific cohorts (e.g., diagnostic or age groups) and develop targeted service responses (including additional staff education and training or prevention and early intervention programs). | QTMHC, MMHCs/HHSs | Commence July 2018               |
| 2. Improve capacity to deliver transcultural mental health services in a timely way.       | - Determine priority CALD cultural groups based on service utilisation data.  
- Establish & recruit multiple part-time Bicultural Workers to provide cultural and clinical consultation, and to participate in the delivery of prevention, early intervention and workforce education programs. | QTMHC | Commence July 2018               |
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| 3. Ensure roles with QTMHC can function across clinical services, workforce development, prevention and early intervention. | • Review and update position descriptions of staff within QTMHC in consultation with staff and workforce services.  
• Review the organisational structure within QTMHC to ensure adequate support and oversight of an expanded QTMHC. Enhance leadership capacity within QTMHC. | QTMHC & Metro South HHS            | Commence July 2018     |
| 4. Strengthen professional support and functioning of Multicultural Mental Health Coordinators to improve access to a range of mental health services for CALD individuals. | • Recruit 1 FTE Multicultural Mental Health Coordinator Professional Leader to provide clinical oversight and coordination of transcultural mental health services across Hospital and Health Services.  
• Work collaboratively with Hospital and Health Services to review and update Multicultural Mental Health Coordinator position descriptions to ensure the roles and responsibilities reflect the priorities set by the Plan.  
• Provide input to Hospital and Health Services relating to transcultural mental health services (including the functions and performance indicators for Multicultural Mental Health Coordinator positions). | QTMHC & MMHCs & HHSs                | Commence July 2018     |
| 5. Strengthen QTMHC’s capacity to provide advanced transcultural clinical leadership statewide. | • Recruit 1 FTE Advanced Transcultural Mental Health Practice Leader position to provide mentoring and clinical supervision, leadership and advice on best practice to the mental health workforce (including QTMHC, Multicultural Mental Health Coordinators, and the broader mental health workforce).  
• Develop a Transcultural Mental Health Practice Framework to define the key skills, knowledge, attitudes and clinical practices required to provide culturally responsive mental health services to CALD individuals. | QTMHC                                | Commence July 2018     |
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<tr>
<td>6. Facilitate knowledge and skills development in transcultural mental health across the mental health workforce.</td>
<td>• Explore options for the development of a clinical rotation program for existing mental health clinicians to work temporarily at QTMHC (and vice-versa). The program could support existing mental health allied health or nursing staff to further develop transcultural mental health skills and to bring these skills back to their own Hospital and Health Service.</td>
<td>QTMHC, HHSs and Workforce Services</td>
<td>Commence July 2018</td>
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| 7. Increase capacity within QTMHC to provide transcultural clinical governance and leadership | • Redesign and expand transcultural Consultant Psychiatrist position.  
• Explore options for establishing a part-time Psychiatry Registrar position within QTMHC.                                                                 | QTMHC                                                                               | Commence July 2018                    |
| 8. Strengthen knowledge and skills within QTMHC to research, design, and evaluate psychotherapeutic interventions. | • Finalise the evaluation of the Depression Self-Management program and review future directions for the program.  
• Review access to cognitive and functional assessments for CALD individuals.  
• Leverage from collaborations with tertiary sectors                                                                 | QTMHC                                                                               | Commence March 2018                   |
| 9. Build and support capacity to deliver a range of assessment, psychotherapeutic interventions and other culturally appropriate treatments for CALD individuals. | • Review QTMHC role and capacity in delivering psychotherapeutic interventions and to provide recommendations on ways to train other clinicians and build capacity at a local Hospital and Health Service level.  
• Work with mental health services across Hospital and Health Services to build local capacity to deliver psychotherapeutic interventions and assessments to CALD individuals. | QTMHC & HHSs                                                                        | Commence March 2018                   |
| 10. Improve access to transcultural mental health services in HHSs where there is no local Multicultural Mental Health Coordinator. | • Engage with Cairns and Hinterland HHS as a priority to determine local CALD population needs.  
• Work with mental health service providers to develop strategies to improve access to services for CALD individuals and to ensure services are culturally responsive. | QTMHC & HHSs                                                                        | Commence July 2018                    |
### What do we want to achieve?

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<td><strong>11. Increase capability within QTMHC to meet the needs of specific priority groups.</strong></td>
<td>• Scope needs for CALD individuals with a mental illness who come into contact with the criminal justice system. Identify how QTMHC services might value-add to existing forensic mental health services.</td>
<td>QTMHC</td>
<td>Commence July 2018</td>
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<td>• Scope needs for CALD older individuals with a mental illness. Establish links with multicultural aged care service providers.</td>
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<td>• Recruit 1 FTE Clinical Specialist to provide state-wide clinical consultation services with a focus on CALD individuals who come into contact with the criminal justice system and to leverage from services provided by forensic mental health services.</td>
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<td></td>
<td>• Recruit 1 FTE Clinical Specialist to provide state-wide clinical consultation services with a focus on CALD older individuals using public mental health services.</td>
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<td><strong>12. Develop a more direct referral protocol for identified ‘at risk’ CALD individuals to improve timely access to transcultural mental health services.</strong></td>
<td>• Explore the feasibility of a direct referral protocol for ‘at risk’ CALD individuals in collaboration with HHSs (for example, prioritise individuals on treatment authorities and/or CALD individuals who have a diagnosis of Schizophrenia).</td>
<td>QTMHC, MMHCs, &amp; HHSs</td>
<td>Commence October 2018</td>
</tr>
<tr>
<td><strong>13. Support Mental Health Alcohol and Other Drugs Branch to improve prevention, early intervention programs to CALD individuals accessing Infant, Child and Youth Mental Health Services.</strong></td>
<td>• Work with the Child and Youth Team within Mental Health Alcohol and Other Drugs Branch on policy directions to ensure improved responses to children and young people from a CALD background across the care continuum.</td>
<td>QTMHC &amp; MHAODB</td>
<td>Commence October 2018</td>
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<td><strong>14. Strengthen referral pathways between mental health and alcohol and other drug services within Queensland Health.</strong></td>
<td>• Work with alcohol and drug prevention teams to identify the specific needs of CALD individuals in relation to a range of prevention activities.</td>
<td>QTMHC</td>
<td>Commence October 2018</td>
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<td>• Use existing alcohol and other drug communication networks to disseminate information about QTMHC.</td>
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Priority Two: Workforce development

We want to strengthen the cultural responsiveness of the mental health workforce by building skills and knowledge in cultural competency. This will be achieved through developing online access to staff training, working with specific professional disciplines to target education and training needs, promoting practice frameworks and guides, and supporting the emerging mental health workforce via academic partnerships, research and field education.

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<tr>
<td>15. Develop a Transcultural Mental Health Workforce Development Plan.</td>
<td>• Once developed, incorporate the Transcultural Mental Health Practice Framework as well as consultation with stakeholders, and an analysis of service utilisation data to inform the development of a Transcultural Mental Health Workforce Development Plan. This plan should identify a range of strategies to develop the capabilities of the mental health workforce to deliver culturally responsive services.</td>
<td>QTMHC</td>
<td>Commence October 2018</td>
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<tr>
<td>16. Strengthen state-wide medical leadership in transcultural mental health.</td>
<td>• Review and update current transcultural mental health education and training content for postgraduate, registrar programs as well as ongoing medical professional development.</td>
<td>QTMHC</td>
<td>Commence October 2018</td>
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<td>• Identify key and sustainable opportunities to deliver transcultural mental health content to medical students with a view to building the transcultural mental health skills and knowledge of the future medical workforce.</td>
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<td>• Develop ongoing links with registrars and consultant psychiatrists to support ongoing professional development and medical leadership in transcultural mental health.</td>
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| 17. Develop academic partnerships to enhance capacity for research, teaching, learning and development in transcultural mental health to drive contemporary best practice. | • Develop arrangements to support a multicultural teaching, research and practice unit inclusive of a transcultural research agenda, and curriculum development for university students.  
• Work with the tertiary education sector to identify mechanisms to support research dissemination and translation into practice and the use of research and evaluation to drive innovation in transcultural mental health service delivery. | QTMHC & Universities | Commence March 2018 |
| 18. Facilitate the inclusion of transcultural mental health content into existing professional development programs and training content. | • Promote linkages between Multicultural Mental Health Coordinators and local educators to establish transcultural mental health learning needs of the workforce and to integrate with existing education and training.  
• Provide service utilisation data to Multicultural Mental Health Coordinators on CALD populations to support the development of local training/education plans in key areas of need.  
• Further develop networks and partnerships with educators across Hospital and Health Services and with existing mental health workforce development activities. | QTMHC & MMHCs | Commence October 2018 |
| 19. Enhance flexibility of access for the mental health workforce to a range of transcultural mental health training modules. | • Conduct a needs analysis to identify priorities for online training module development.  
• Design an evaluation framework for training and education content to ensure workforce development is effective and meets the needs of the workforce.  
• Establish an online platform to deliver a range of training and education content to the mental health workforce. Recruit a temporary project officer or technician with skills to design and integrate an online learning platform that will be accessible by the mental health workforce. | QTMHC | Commence July 2018 |
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<td>(continued from previous page)</td>
<td>• Ensure education and training content aligns with the <em>Framework for Mental Health in Multicultural Australia</em>.</td>
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<td>20. Provide readily accessible training to interpreters working in mental health settings.</td>
<td>• Review and update mental health training for interpreters. Ensure training content meets requirements for professional development points as part of the new credentialing system for interpreters.</td>
<td>QTMHC</td>
<td>Commence July 2018</td>
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<td>• Workshop redeveloped mental health training content with interpreters to ensure content meets the learning needs of interpreters.</td>
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<td>• Provide support to interpreters who have an interest in mental health to be involved in the delivery of training to other interpreters.</td>
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<td>• Establish an online platform to deliver a range of training and education content to interpreters working in mental health settings</td>
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<td>21. Provide readily accessible training to clinicians working with interpreters.</td>
<td>• Establish an online platform to deliver a range of training and education content to mental health clinicians using interpreters.</td>
<td>QTMHC</td>
<td>Commence October 2018</td>
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<td>• Ensure online access to training is widely available and easily accessible through established links with interpreters and mental health clinicians.</td>
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<td>22. Ensure training is tailored to meet needs of clinicians working in specific service settings.</td>
<td>• Utilise expertise in child and youth and older persons mental health services to ensure training content can be tailored to specific service contexts.</td>
<td>QTMHC</td>
<td>Commence October 2018</td>
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Priority Three: Access to services and responding to need

We want to improve access to quality mental health services for CALD individuals by establishing annual forums with stakeholders to review data, identify emerging needs and issues, share best practice and to contribute to joint planning processes. Work with Hospital and Health Services to simplify care pathways and improve access to transcultural mental health services for CALD individuals. Address inequities in access to services by strengthening engagement of CALD individuals with a lived experience, targeting the delivery of prevention & early intervention programs and sustaining links with community organisations and cultural groups.

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<th>What do we want to achieve?</th>
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| 23. Facilitate access to public mental health services and improve mental health literacy among CALD communities. | • Develop a comprehensive communications plan for QTMHC. This will include identifying stakeholders and partners as well as a range of mechanisms to provide key messages about our service. Update QTMHC website.  
• Provide targeted workforce training/in-services and other events to engage with the mental health workforce to improve cultural competence.  
• Engage priority communities through consultation with community members and joint development of communication strategies involving ethnic media and other community events.  
• Support QTMHC staff/Multicultural Mental Health Coordinators to utilise online communication platform “Yammer” to share information from cross-sector meetings and other resources relevant to transcultural mental health. | QTMHC | Commence July 2018 |
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| 24. Build capacity of all transcultural mental health positions to adopt prevention and early intervention frameworks. | • Ensure that a prevention and early intervention component is embedded within the *Transcultural Mental Health Practice Framework*.  
• Embed the *Transcultural Mental Health Practice Framework* in orientation information for all new transcultural mental health staff (QTMHC and Multicultural Mental Health Coordinators).  
• Work with all transcultural mental health staff (QTMHC and Multicultural Mental Health Coordinators) to support the delivery of targeted prevention and early intervention programs (as relevant to their role) through ongoing mentoring, supervision and education. | QTMHC & MMHCs | Commence July 2018 |
| 25. Ensure the ongoing sustainability of the Building Resilience in Transcultural Australians (BRiTA) Futures Program. | • Review and update content for BRiTA Futures. Recruit a temporary project officer to conduct literature review, evaluate and update course content and materials.  
• Review current BRiTA Futures model and explore options for sustainability of the program into the future. Conduct a review of the needs of program participants and program facilitators. Identify potential cross-sectors partners and future models for the delivery of BRiTA Futures.  
• Develop a research program for BRiTA Futures as part of a joint partnership with a university. | QTMHC | Commence July 2018 |
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| 26. Expand the reach of the BRiTA Futures program across Queensland. | • Review and identify mechanisms to support and sustain BRiTA Futures program facilitators. This may include the development of online training content including video assessments as an adjunct to face to face BRiTA Futures training, provision of guidelines for program facilitation, options for co-facilitation in the early phases of training, on-going supervision, and other administrative supports.  
• Establish and maintain a network of “expert trainers” in BRiTA Futures who will be able to train program facilitators across a number of organisations including: schools, NGOs, and community groups. | QTMHC | Commence July 2018 |
| 27. Improve mental health literacy for culturally diverse populations. | • Review and update “Stepping out of the Shadows” stigma reduction content in order to integrate into a mental health literacy program.  
• Develop a mental health literacy program for culturally diverse population groups and utilise Bicultural Workers and Peer Workers to train organisations to deliver the program to priority CALD communities. | QTMHC | Commence October 2018 |
| 28. Develop an evidence-based suicide prevention training package for service providers working with CALD population groups. | • Work with the Queensland Mental Health Commission to develop a suicide prevention training package tailored to CALD population groups. | QTMHC & Queensland Mental Health Commission | Commence March 2018 |
| 29. Support Mental Health First Aid instructors to deliver training to culturally diverse communities. | • Train QTMHC staff to deliver Mental Health First Aid to priority communities, age groups and Bicultural Mental Health Consultants as a priority.  
• Contribute transcultural mental health case scenarios to ensure Mental Health First Aid training remains relevant to culturally diverse participants. | QTMHC | Commence February 2019 |
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<td><strong>30. Support initiatives focusing on issues of cultural identity and building community resiliency to counter radicalisation.</strong></td>
<td>• Continue to provide input into networks to support culturally appropriate responses.</td>
<td>QTMHC</td>
<td>Existing (ongoing)</td>
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<td>• Facilitate access to BRiTA Futures for identified priority communities.</td>
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<td><strong>31. Develop a program for CALD individuals that respond to acculturation stressors within a clinical setting.</strong></td>
<td>• Review elements of BRiTA Futures relating to acculturation and adapt to clinical settings. Review current literature and develop an intervention program that responds to acculturation stressors.</td>
<td>QTMHC</td>
<td>Commence July 2018</td>
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<td><strong>32. Ensure mental health services and responses in relation to disaster planning and recovery are culturally responsive.</strong></td>
<td>• Continue to provide input to support culturally appropriate responses.</td>
<td>QTMHC</td>
<td>Existing (ongoing)</td>
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<td>• Share resources and promote linkages to multicultural and mental health services.</td>
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<td><strong>33. Expand the reach of workforce education and prevention and early intervention programs for CALD populations.</strong></td>
<td>• Support NGO access to workforce development, training and education through networks and other communication strategies. Engage NGOs in the development and delivery of workforce education and training. Engage NGOs and other service providers in the delivery of promotion, prevention and early intervention programs for CALD community groups.</td>
<td>QTMHC</td>
<td>Existing (ongoing)</td>
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<td><strong>34. Improve information sharing, networking and peer support amongst transcultural mental health service providers.</strong></td>
<td>• Establish and support communication mechanisms to allow information sharing across Hospital and Health Services as well as across sectors.</td>
<td>QTMHC &amp; MMHCs</td>
<td>Existing (ongoing)</td>
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<td><strong>35. Facilitate cross-sector planning and service improvement.</strong></td>
<td>• Develop and maintain a range of communication mechanisms with cross-sector partners. Host an annual forum with interagency partners to review data, share information, identify emerging issues, share best practice and enhance strategic sector-wide responses. Organise a workshop to determine agreed parameters for data sharing and monitoring and other service improvement actions.</td>
<td>QTMHC</td>
<td>Commence October 2018</td>
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| 36. Support Hospital and Health Services to implement the *Framework for Mental Health in Multicultural Australia* (MHIMA Framework). | - Promote the implementation of the MHIMA Framework across Hospital and Health Services.  
- Provide information and support to facilitate local level implementation. | HHS & QTMHC         | Existing (ongoing)                    |
| 37. Ensure mechanisms are established to fulfil any reporting requirements associated with the MHIMA Framework. | - Identify reporting requirements associated with the framework and coordinate any data requirements at a state-wide level. | QTMHC                | Commence July 2018                    |
| 38. Strengthen engagement with CALD individuals who have a lived experience of mental illness. | - Conduct consultation with stakeholders including mental health NGO sector  
- Conduct consultation with stakeholders including mental health NGO sector providers, individuals with a lived experience, carers, peer workers and public mental health service providers.  
- Lead the development of a state-wide CALD lived experience participation model for mental health service providers (including public and NGO services). | QTMHC                | Commence July 2019                    |
| 39. Integrate a CALD lived experience participation model into all transcultural workforce education and training. | - Engage CALD Peer Workers to provide input into all transcultural workforce education and training and to assist in delivering some workforce education content. | QTMHC                | Commence July 2019                    |
| 40. Integrate a CALD lived experience participation model into promotion, prevention and early intervention programs. | - Work with CALD Peer Workers when developing and delivering mental health promotion prevention and early intervention programs. | QTMHC                | Commence July 2019                    |
| 41. Monitor transcultural mental health performance and establish mechanisms to analyse and report on data. | - Identify performance measures that are relevant to CALD populations based on existing indicators from the *Measurement Strategy for Connecting care to recovery 2016-2021*.  
- Work with Mental Health Alcohol & Other Drugs Branch to identify mechanisms to extract data for additional performance measures related to CALD populations. | QTMHC & MHAODB       | Commence July 2018                    |
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<td>42. Build the capacity of mental health services to use a range of information and data to support service improvement.</td>
<td>- Host an annual forum for Hospital and Health Services to review service utilisation data, showcase examples of excellence in service delivery, identify emerging trends and monitor key benchmarks.</td>
<td>QTMHC &amp; MMHCs</td>
<td>Commence July 2018</td>
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List of contributors to the consultation

The following list provides details of people who attended face to face meetings, consultation workshops held 23 June and 21 July 2017 or focus groups. This list excludes over 500 stakeholders who were sent the consultation paper, as well as the written responses received to the consultation paper survey monkey.

**Hospital and Health Services (HHS)**
- Belinda Khong (Children’s Health Queensland)
- Bernarda Krmpotic (Gold Coast)
- Brett Emmerson (Metro North)
- Bruce Hamilton (Court Liaison)
- Danielle Fearn (Metro North)
- David Crompton (Metro South)
- Dolores Cabrera (Metro North)
- Elissa Waterson (Qld Forensic Mental Health)
- Geoffrey Argus (Toowoomba & Darling Downs)
- Greg Neilson (Toowoomba & Darling Downs)
- Judi Krauss (Children’s Health Queensland)
- Karen Grimley (Metro South)
- Ken Meldrum (Metro South)
- Linda Hipper (Metro South)
- Madonna Gassman (Children’s Health Queensland)
- Mary-Ann Kirkman (Townsville)
- Michael Catt (Townsville)
- Michelle Giles (West Moreton)
- Michelle Perrin (Statewide Prison Mental Health)
- Salam El-Merebi (Metro South)
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- Sarah Moakes (Townsville)
- Shane Brennan (Toowoomba & Darling Downs)
- Sophie Morson (Children’s Health Queensland)
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- Dragos Ileana
- Elsa Caledonio
- Elvia Ramirez
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- Natalie Goldsmith
- Ruby Chari
- Sara Burton
- Shameera Osman
- Sharon Were
- Sonia Kumari
- Simone Bell
- Zahra Aboukoura

**Focus Groups**
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- Metro South Consultation Liaison Psychiatry
- Metro North Acute Inpatient Unit
- Arcade Hatungimana (Bicultural Mental Health Consultant)
- Michael Maire (Bicultural Mental Health Consultant)
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**Mental Health Alcohol & Other Drugs Branch**
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- Kristen Breed
- Ruth Fjeldsoe
- Fleur Ward
- Sandra Eyre
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- Betti Chappell (Culture in Mind)
- Fernanda Torresi (QPASTT)
- Megan Leitz (QPASTT)
- Stephanie Long (QPASTT)
- Tracey Worral (QPASTT)

**Queensland Mental Health Commission**
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- Jessica Martin
- Deborah Pratt